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MEMORANDUM OF UNDERSTANDING WITH BESPOKE MOU ATTACHMENTS

between

Orange County Health Authority dba CalOptima Health

and

Orange County Health Care Agency

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Memorandum of Understanding

between CalOptima Health and Orange County Health Care Agency

This Memorandum of Understanding ("**MOU**") is entered into by Orange County Health Authority, a public agency dba CalOptima Health, ("**MCP**") and County of Orange, through its agency, the Orange County Health Care Agency, a political subdivision of the State of California ("**HCA**"), effective as on the first day following execution of this Contract by both parties ("**Effective Date**"). HCA, MCP, and MCP's relevant Subcontractors and/or Downstream Subcontractors are referred to herein individually as a "**Party**" and collectively as "**Parties**."

RECITALS

WHEREAS, MCP is required under its Medi-Cal Managed Care Contract, Exhibit A, Attachment III, with California Department of Health Care Services ("**DHCS**") 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 HCA; and

WHEREAS, the Drug Medi-Cal Organized Delivery System ("**DMC-ODS**") program administered by HCA and MCP through their respective agreements with DHCS are required to enter into an MOU for Substance Use Disorder ("**SUD**") services under the Medi-Cal Managed Care Contract Exhibit A, Attachment III, All Plan Letter ("APL") 22-005, APL 23-029, and subsequently issued superseding APLs, and HCA is required to enter into this MOU under the Drug Medi-Cal Organized Delivery System Intergovernmental Agreement ("**DMC-ODS Intergovernmental Agreement**") Exhibit A, Attachment I, Behavioral Health Information Notice ("**BHIN**") 23-001, BHIN 23-057 and any subsequently issued superseding BHINs, to ensure that Medi-Cal Members enrolled in MCP who are served by HCA are able to access and/or receive SUD services in a coordinated manner from MCP and HCA; and

WHEREAS, the Parties desire to ensure that Members receive services available through HCA, including HCA 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**") and exchanged in furtherance of this MOU, including facilitating referrals, coordinating care, or meeting any other obligation under this MOU, the Parties will comply with (i) all applicable federal and State of California ("**State**") statutes and regulations that pertain to such PHI and/or PII, including, but not limited to, the Health Insurance Portability and Accountability Act of 1993 and its implementing regulations at 45 Code of Federal Regulations ("**C.F.R.**") Parts 160 and 164, as it may now exist or may be hereafter amended ("**HIPAA**"), the Health Information Technology for Economic and Clinical Health ("**HITECH**") Act, the California Confidentiality of Medical Information Act (found at California Civil Code § 56 *et. seq.*), California Welfare and Institutions Code Sections 5328 through 5329, 42 C.F.R. Part 2, and (ii) any terms and conditions that impose restrictions on access to, use of, and disclosure

of PHI or PII applicable to such data from each Party's underlying agreement with their respective regulator(s), including, but not limited to, DHCS.

NOW, THEREFORE, in consideration of the Recitals above and the mutual agreements and promises herein, the Parties agree, as follows:

1. **Definitions.** Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with the 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 HCA and ensure MCP's compliance with this MOU as described in Section 4 of this MOU.

b. "**MCP-HCA Liaison**" means MCP's designated point of contact responsible for acting as the liaison between MCP and HCA as described in Section 4 of this MOU. The MCP-HCA 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 designated MCP Responsible Person, Population Health Management Director II and/or MCP compliance officer as appropriate.

c. **"Network Provider"** as it pertains to MCP, has the same meaning ascribed by the MCP's Medi-Cal Managed Care Contract with the DHCS; and as it pertains to HCA, has the same meaning ascribed by the DMC-ODS Intergovernmental Agreement or the Mental Health Plan Contract ("**MHP Contract**") with the DHCS, as applicable.

d. "**HCA Responsible Person**" means the person designated by HCA to oversee coordination and communication with MCP and ensure HCA's compliance with this MOU as described in Section 5 of this MOU.

e. "**HCA Liaison**" means HCA's designated point of contact responsible for acting as the liaison between MCP and HCA as described in Section 5 of this MOU. The HCA Liaison 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 provide updates to the HCA Responsible Person as appropriate.

f. "**Subcontractor**" as it pertains to MCP, has the same meaning ascribed by the MCP's Medi-Cal Managed Care Contract with the DHCS; and as it pertains to HCA, has the same meaning ascribed by the DMC-ODS Intergovernmental Agreement or the MHP Contract with the DHCS, as applicable.

g. "**Downstream Subcontractor**" as it pertains to MCP, has the same meaning ascribed by the MCP's Medi-Cal Managed Care Contract with the DHCS; and as it pertains to HCA, means a subcontractor of an HCA Subcontractor under either the DMC-ODS Intergovernmental Agreement or the MHP Contract with the DHCS, as applicable.

2. **Term.** This MOU is in effect as of the Effective Date first noted above and shall continue for a term of three (3) years or as amended in accordance with Section f) of this

MOU.

3. **Services Covered by This MOU.** This MOU governs the coordination between HCA and MCP for the delivery of care and services for Members who reside in HCA's jurisdiction and who may be eligible for services provided, made available, or arranged for by HCA. Specifically, the Parties will coordinate and provide services as further outlined in each of the following exhibits ("**Program Exhibits**"):

a. Exhibit C - Local Health Department Services, Local Health Department Services.

b. Exhibit D, Specialty Mental Health Services.

c. Exhibit E – Substance Use Disorder, Substance Use Disorder Services.

d. Exhibit F - Supplemental Nutrition Program for Women, Infants, and Children (WIC), Special Supplemental Nutrition Program for Women, Infants, and Children.

e. Exhibit G, County-Based Targeted Case Management.

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. MCP obligations, in addition to those outlined in this Section 4 and specific to a type of service, are specifically outlined in Exhibit C - Local Health Department Services through G.

b. **Oversight Responsibility.** The Population Health Management, Director II, the designated MCP Responsible Person listed in Exhibit A of this MOU is responsible for overseeing MCP's compliance with this MOU, and as specifically outlined in the Program Exhibits. The MCP Responsible Person, Population Health Management Director II must:

i. Meet at least quarterly with HCA, 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 HCA are invited to participate in the MOU engagements, as appropriate;

v. Ensure training and education regarding MOU provisions are

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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-HCA Liaison, the point of contact and liaison with HCA or HCA programs. The MCP-HCA Liaison is listed in Exhibit A - MCP Responsible Person(s) of this MOU. MCP must notify HCA of any changes to the MCP-HCA Liaison in writing as soon as reasonably practical but no later than the date of change and must notify DHCS within five (5) 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. **HCA Obligations.**

a. **Provision of Services.** HCA is responsible for services provided or made available by HCA. HCA obligations, in addition to those outlined in this Section 5 and specific to a type of service, are specifically outlined in Exhibits C through G.

b. **Oversight Responsibility.** The Senior Procurement Contract Manager, the HCA Responsible Person, listed in Exhibit B of this MOU, is responsible for overseeing HCA's compliance with this MOU and as specifically outlined in each Program Exhibit. The HCA Responsible Person serves, or may designate a person to serve, as the designated HCA Liaison, the point of contact and **liaison** with MCP. The HCA Liaison is listed in Exhibit B of this MOU. The HCA Liaison may be the same person as the Responsible Person. HCA may designate a liaison by program or service line. HCA must notify MCP of changes to the HCA Liaison as soon as reasonably practical but no later than the date of change.

6. **Training and Education.**

a. To ensure compliance with this MOU, the Parties must provide training and orientation for their employees who carry out responsibilities under this MOU and, as applicable, Network Providers, Subcontractors, and Downstream Subcontractors who assist MCP with carrying out MCP's responsibilities under this MOU and Program Exhibits. The training must include information on MOU requirements, what services are provided or arranged for by each Party under the Program Exhibits, as applicable, and the policies and procedures outlined in this MOU. For persons or entities performing responsibilities as of the Effective Date, the Parties must provide this training within sixty (60) working days of the Effective Date. Thereafter, the Parties 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. The Parties must require their respective Subcontractors and Downstream Subcontractors to provide training on relevant MOU and Program Exhibit requirements and HCA programs and services to their contracted providers.

b. In accordance with health education standards required by the Medi-Cal Managed Care Contract, the Parties must provide Members and Network Providers with

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

educational materials related to accessing Covered Services, including for services provided by HCA.

c. The Parties each must provide the HCA, Members, and Network Providers with training and/or educational materials on how MCP Covered Services, any carved-out services, and HCA 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 HCA program and/or services.

b. The Parties must facilitate referrals to the relevant HCA program for Members who may potentially meet the criteria of HCA program and/or services and ensure HCA has procedures for accepting referrals from MCP or responding to referrals where HCA cannot accept additional Members. MCP must refer Members using a patient-centered, shared decision-making process. HCA should assist MCP in identifying the appropriate HCA program and/or services when assistance is required.

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

8. **Care Coordination and Collaboration.**

a. 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, including those in the applicable Program Exhibits.

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

c. MCP must have policies and procedures in place to maintain cross-system collaboration with HCA and to identify strategies to monitor and assess the effectiveness of this MOU.

d. The Parties will comply with care coordination and collaboration outlined in the Program Exhibits. Notwithstanding any other parts of this MOU, including its Program Exhibits, the Parties may not disclose any information in their possession that is subject to 42 C.F.R. Part 2 unless such disclosure is permitted under 42 C.F.R. Part 2.

9. **Quarterly Meetings.**

a. The Parties must meet as frequently as necessary to ensure proper oversight of this MOU and the Program Exhibits, 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.

b. Within thirty (30) working days after each quarterly meeting, the Parties must post on their respective websites 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 the Parties' obligations under the Medi-Cal Managed Care Contract, this MOU, and as applicable, the DMC-ODS Intergovernmental Agreement or the MHP Contract.

c. The Parties must invite the HCA's Responsible Person, applicable program liaisons, and appropriate program executives to participate in quarterly meetings to ensure appropriate committee representation, including a local presence, to discuss and address care coordination and MOU-related issues. The Parties' Subcontractors and Downstream Subcontractors, as well as applicable program staff should be permitted to participate in these meetings, as appropriate.

d. As applicable, the Parties must report to DHCS updates from quarterly meetings in a manner and frequency specified by DHCS.

e. **Local Representation.** MCP must participate, as appropriate, in meetings or engagements to which MCP is invited by HCA, such as local county meetings, local community forums, and HCA engagements, to collaborate with HCA 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 health information and related 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, including, but not limited to, HIPAA, 42 C.F.R. Part 2, California Welfare and Institutions Code Sections 5328 through 5329, and any other applicable State and/or federal laws. All Member health information and related data exchanged pursuant to this MOU must be in accordance with the Business Associate Agreement as set forth in Exhibit H, and the applicable confidentiality provisions specified in each of the Program Exhibits that pertain to the respective program's data and records Notwithstanding any other parts of this MOU, including its Program Exhibits, the Parties may not disclose any information in their possession that is subject to 42 C.F.R. Part 2 unless such disclosure is permitted under 42 C.F.R. Part 2.

a. **Data Exchange.** MCP must, and HCA 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 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 to be shared as agreed upon by the Parties specific to a program are outlined in the applicable Program Exhibit. The Parties must annually review and, if appropriate, update the information and data elements shared pursuant to a Program Exhibit of this MOU to facilitate sharing of information and data.

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

12. **Dispute Resolution.** Unless otherwise provided for in a Program Exhibit to this MOU, the Parties will abide by the following dispute resolution mechanism:

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 HCA 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. If the dispute cannot be resolved within fifteen (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 HCA that cannot be resolved in a good faith attempt between the Parties must be forwarded by MCP to DHCS and may be reported by HCA to DHCS, as appropriate. 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 this 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.** Nothing in this MOU is intended to benefit or prioritize Members over persons served by HCA who are not Members. Pursuant to Title VI of the Civil Rights Act and Title 42 of the United States Code Section 2000d, *et seq.*, HCA 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 HCA.

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14. **General.**

a. **MOU Posting.** MCP and HCA must each post this executed MOU on its respective website.

b. **Documentation Requirements.** MCP and HCA must retain all documents demonstrating compliance with this MOU for at least ten (10) years as required by the Medi-Cal Managed Care Contract, the MHP Contract, and DMC-ODS Intergovernmental Agreement. If DHCS requests a review of any existing MOU, the Party that received the request must submit the requested MOU to DHCS within ten (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 and HCA may each delegate its obligations under this MOU to a Fully Delegated Subcontractor or Partially Delegated Subcontractor as permitted by and defined 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 the Parties' obligations under this MOU. However, in no event is either Party allowed to delegate obligations under this MOU beyond the extent permitted by applicable law and their respective agreements with their regulators and/or the State agency governing the services provided under this MOU. Other than in these circumstances, the Parties cannot delegate the obligations and duties contained in this MOU.

e. **Annual Review.** MCP and HCA 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 and HCA 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, the MHP Contract, and subsequently issued superseding APLs,

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

BHINs, HCA's local agency agreement with California Department of Public Health ("**CDPH**"), 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 HCA 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 HCA 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.

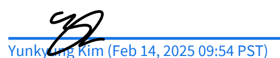
i. **Counterpart Execution.** This MOU may be executed in counterparts, signed electronically and sent via PDF, each of which is deemed an original, but all of which, when taken together, constitute one and the same instrument.

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



Yunkyung Kim (Feb 14, 2025 09:54 PST)

Signature:

Name: Yunkyung Kim

Title: COO

Notice Address:

HCA

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Signature:

Name: Dr. Veronica Kelley

Title: Director, Health Care Agency

Notice Address:

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Exhibit A - MCP Responsible Person(s)

This Exhibit A lists the MCP individuals responsible for ensuring oversight and compliance of this MOU and applicable Program Exhibits. Capitalized terms in this Exhibit A will have the meaning ascribed to them by the MOU or the respective Program Exhibit.

1. **General MCP responsible individuals:**

    a. **MCP Responsible Person:** Katie Balderas, Population Health Management, Director II Population Health Management

    b. **MCP-HCA Liaison:** Katie Balderas, Population Health Management, Director II Population Health Management

2. **Exhibit C, Local Health Department MCP responsible individuals**:

    a. **MCP Responsible Person:** Katie Balderas, Population Health Management, Director II Population Health Management

    b. **MCP-LHD Liaison(s) for Local Health Department Services Coordination:**

Programs (*e.g.*, California Children's Services)	**Designated MCP Liaison**	**Designated MCP Liaison Contact**
Tuberculosis	Hannah Kim	hannah.kim@caloptima.org
Maternal Child and Adolescent Health	Katie Balderas	katie.balderas@caloptima.org

3. **Exhibit D, Specialty Mental Health Services MCP responsible individuals:**

    a. **MCP Responsible Person:** Natalie Zavala, Behavioral Health Integration Director III Behavioral Health Services

    b. **MCP HCA Liaison:** Natalie Zavala, Behavioral Health Integration Director III Behavioral Health Services

4. **Exhibit E, Substance Use Disorder MCP responsible individuals:**

    a. **MCP Responsible Person:** Natalie Zavala, Behavioral Health Integration Director III Behavioral Health Services

    b. **MCP-DMS-ODS Liaison:** Natalie Zavala, Behavioral Health Integration Director III Behavioral Health Services

5. **Exhibit F, Supplemental Nutrition Program for Women, Infants, and Children**

responsible individuals:

a. **MCP Responsible Person:** Katie Balderas, Population Health Management, Director II Population Health Management

b. **MCP-Agency Laison:** Katie Balderas, Population Health Management, Director II Population Health

6. **Exhibit G, County-Based Targeted Case Management responsible individuals:**

a. **MCP Responsible Person:** Annabel Vaughn, Director of Medi-Cal Compliance

b. **MCP-TCM Laison:** Hannah Kim, Director of Case Management

Exhibit B - HCA Responsible Persons

This Exhibit B lists the HCA individuals responsible for ensuring oversight and compliance of this MOU and applicable Program Exhibits. Capitalized terms in this Exhibit B will have the meaning ascribed to them by the MOU or the respective Program Exhibit.

1. **General HCA responsible individuals:**

   a. **HCA Responsible Person: Juan Corral, Senior Procurement Contract Manager jcorral@ochca.com**

   b. **HCA Liaison:** Brittany Davis, Procurement Contract Manager bdavis@ochca.com

2. **Exhibit C, Local Health Department HCA responsible individuals**

   a. **LHD Responsible Person:** See table below

   b. **LHD Program Liaison(s) for Local Health Department Services Coordination:**

Programs (*e.g.*, California Children's Services)	Designated LHD Liaison	Designated LHD Liaison Contact
Tuberculosis	April Orozco, Assistant Deputy Director	AOrozco@ochca.com
Maternal Child and Adolescent Health	April Orozco, Assistant Deputy Director	AOrozco@ochca.com
Specialty Mental Health Services	Azahar Lopez, Assistant Deputy Director	AzLopez@ochca.com
Substance Abuse Disorder	Azahar Lopez , Assistant Deputy Director	AzLopez@ochca.com
Supplemental Nutrition Program for Women, Infants, and Children (WIC)	LaRisha Baker, Assistant Deputy Director Maridet Ibanez, Health Services Manager	Lbaker@ochca.com Mibanez@ochca.com
County-Based Targeted Case Management	Joanna Huang, Fiscal Administrator	johuang@ochca.com
BAA Contract	Adil Siddiqui, Chief Information Officer	Asiddiqui@ochca.com Ksabet@ochca.com

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

	Kelly Sabet, Chief Compliance Officer	

3. **Exhibit D, Specialty Mental Health Services HCA responsible individuals:**

   a. **MHP Responsible Person:** Azahar Lopez, Assistant Deputy Director Azlopez@ochca,com

   b. **MHP Liaison: Same as MHP Responsible Person**

4. **Exhibit E, Substance Use Disorder responsible individuals:**

   a. **DMC-ODS Responsible Person:** Azahar Lopez, Assistant Deputy Director Azlopez@ochca.com

   b. **DMC-ODS Liaison:** Same as Responsible Person

5. **Exhibit F, Supplemental Nutrition Program for Women, Infants, and Children responsible individuals:** LaRisha Baker, Assistant Deputy Director Lbaker@ocahca.com and Maridet Ibanez, Health Services Manager Mibanez@ocahca.com

   a. **Agency Responsible Person:** LaRisha Baker, Assistant Deputy Director Lbaker@ocahca.com and Maridet Ibanez, Health Services Manager Mibanez@ocahca.com

   b. **Agency Liaison: Same as Responsible Person**

6. Exhibit **G, County-Based Targeted Case Management responsible individuals:**

   a. **LGA TCM Program Responsible Person:** Joanna Huang, Fiscal Administrator johuang@ocahca.com

   b. **LGA TCM Program Liaison**: Same as Responsible Person

Exhibit C - Local Health Department Services

In addition to the provisions of the MOU, this Exhibit C - Local Health Department Services and any sub-exhibits ("**Exhibit C**") govern the provision and coordination of services between MCP and the Local Health Department (defined below). If any provision of this Exhibit C - Local Health Department Services conflicts with any provision of the MOU, the provisions of this Exhibit C - Local Health Department Services shall control as to the provision and coordination of services between MCP and the Local Health Department (defined below).

1. **Definitions.** The following definitions shall apply to this Exhibit C - Local Health Department Services.

a. "**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 4 of this Exhibit C - Local Health Department Services. 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 Exhibit C - Local Health Department Services, and should provide updates to the LHD Responsible Person as appropriate. The LHD Program Liaison is listed in Exhibit B.

b. "**LHD Responsible Person**" means the person designated by LHD to oversee coordination and communication with MCP, facilitate quarterly meetings in accordance with Section 9 of this Exhibit C, and ensure LHD's compliance with this Exhibit C as described in Section 5 of this Exhibit C. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in LHD practices. The LHD Responsible Person is listed in Exhibit B.

c. **"Local Health Department"** ("**LHD**") shall mean HCA for purposes of this Exhibit C.

d. "**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 3 of this Exhibit C. 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 9 of this Exhibit C, and must provide updates to the MCP Responsible Person, Population Health Management Director II and/or MCP compliance officer as appropriate. The MCP-LHD Liaison is listed in Exhibit A.

e. "**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 this Exhibit C and ensure MCP's compliance with this Exhibit C as described in Section 3 of this Exhibit C. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in MCP practices. The MCP Responsible Person, Population Health Management Director II for this Exhibit C is listed in Exhibit A.

2. **Services Covered by this Exhibit C.** This Exhibit C 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 sub-exhibits, each labeled with the specific program or service.

3. **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 designated MCP Responsible Person, Population Health Management Director II is responsible for overseeing MCP's compliance with this Exhibit C. The MCP Responsible Person, Population Health Management Director II must:

i. Meet at least quarterly with the LHD Responsible Person and LHD Program Liaisons, as required by Section 9 of this Exhibit C;

ii. Report no less frequently than quarterly on MCP's compliance with the Exhibit C 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 Exhibit C;

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

v. Ensure training and education regarding Exhibit C provisions are conducted annually for MCP's employees responsible for carrying out activities under this Exhibit C, 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. 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 (5) working days of the change.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MCP will comply with Section c), Compliance by Subcontractors, Downstream Subcontractors, and Network Providers, of the MOU.

4. **LHD Obligations.**

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

available by LHD.

b. **Oversight Responsibility.** The designated LHD Responsible Person Assistant Deputy Director is responsible for overseeing LHD's compliance with this Exhibit C. 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 (1) person to serve as the designated LHD Program Liaison, the point of contact and liaison with MCP, for the programs relevant to this Exhibit C. It is recommended that this person be in a leadership capacity at the program level. 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 (5) working days of the change.

5. **Training and Education.** The Parties will comply with Section 6, Training and Education, of the MOU.

6. **Referrals.**

a. **Referral Process.** In addition to the referral process outlined in Section 7 of the MOU, the Parties will comply with the following:

i. MCP must refer Members to LHD for direct service programs as appropriate including, without limitation, those set forth in Section 6 of this Exhibit C.

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

7. **Care Coordination and Collaboration.** Parties will comply with Section 8, Care Coordination and Collaboration, of the MOU.

8. **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 Title 17 of the California Code of Regulations 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 (6) years of age with no record of receiving a required blood lead screening and/or Medically

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

Necessary follow-up blood lead tests in accordance with CDPH requirements[1] 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.

9. **Quarterly Meetings.** The Parties will comply with Section 9, Quarterly Meetings, of the MOU.

10. **Quality Improvement.** The Parties will comply with Section 10, Quality Improvement, of the MOU.

11. **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.[2] 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

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[1] 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.

[2] 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.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

applicable provisions of the PNA guidance within ninety (90) days of issuance.

12. **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-1 of this Exhibit C.

13. **Data Sharing.** The Parties will comply with Section 11, Data Sharing and Confidentiality, of the MOU and the following provisions:

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 Exhibit C. 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 C-4 of the MOU. The Parties must annually review and, if appropriate, update Exhibit C-4 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 6 of this Exhibit C and further set forth in the sub-exhibits. The data elements to be shared must be agreed upon jointly by the Parties, reviewed annually, and set forth in Exhibit C-4.

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 C-4.

iii. All data exchanged pursuant to this Exhibit C must be in accordance with the Business Associate Agreement, as set forth in Exhibit H, and the additional confidentiality provisions specified in Exhibits C-1 through C-3, if any.

b. **Interoperability.** The Parties will comply with Section 11(b), Interoperability, of the MOU.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

14. **Dispute Resolution.** The Parties will comply with Section 12, Dispute Resolution, of the MOU.

15. **Equal Treatment.** The Parties will comply with Section 13, Equal Treatment, of the MOU.

16. **General.** The Parties will comply with Section 14, General, of the MOU.

Exhibit C-1 - Non-Contracted LHD Services

This Exhibit C-1 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.

1. **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.

a. MCP must reimburse LHD for immunization services provided under this Exhibit C-1 at no less than the Medi-Cal FFS rate.

b. 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.

2. **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 Title 42 of the United States Code Sections 1396a(a)(23) and 1396n(b) and 42 C.F.R. Section 431.51.

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

b. MCP must reimburse LHD for STI services under this Exhibit C-1 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.

c. 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.

d. 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, Title 42 of the United States Code Sections 1396a(a)(23) and 1396n(b) and 42 C.F.R. 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.

3. **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.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

Exhibit C-2 - 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[3] The CDPH TB Risk Assessment Tools[4] 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,[5] and/or the American Thoracic Society ("**ATS**")[6] 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.

iv. **LTBI Treatment.** MCP should instruct Network Providers to ensure

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[3] AAP, Red Book Report of the Committee on Infectious Diseases, 32nd Ed., available at: https://publications.aap.org/redbook/book/347/chapter/5748923/Introduction.
[4] CDPH, TB Risk Assessment Tools, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/TB-Risk-Assessment.aspx.
[5] 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/.
[6] 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.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

Members have access to LTBI treatment in accordance with the updated 2023 USPSTF Recommendation[7] and CDC LTBI Treatment Guidelines[8], 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[9] known or suspected cases of active TB disease for any Member residing within Orange County within one (1) day of identification in accordance with Title 17 California Code of Regulations 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.[10]

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 (3) 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

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[7] 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.

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

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

[10] 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.

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.

v. **Case and Contact Investigations.**

i. As required by Cal. Health & Safety Code Sections 121362 and

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

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,[11] 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.

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,[12] 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 (7) days.

3. Ensuring Member access to LTBI testing and treatment and following LTBI Treatment Guidelines published by the CDC.[13]

4. Requiring that its Network Providers to provide the examination results to LHD within one (1) 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

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[11] 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.

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

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

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

c. Assessment and diagnostic/treatment plans, following evaluation by 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 C-2 for the purpose of measurable and reasonable quality assurance and improvement.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

Exhibit C-3 - Maternal Child and Adolescent Health

This Exhibit C-3 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**"),[14] MCP must ensure the provision of all screening, preventive, and Medically Necessary diagnostic and treatment services for Members under twenty-one (21) years of age.

b. The MCP Responsible Person, Population Health Management Director II 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 3 of Exhibit C.

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[15] 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 4 of Exhibit C.

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

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[14] Additional guidance available in APL 23-005: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL 23-005.pdf

[15] 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.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

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.[16]

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 seven (7) 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.[17]

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 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.

[16] 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.

[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.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

4. **Coordination of Medi-Cal for Kids and Teens (formerly EPSDT) Services.**[18]

a. Where MCP and LHD have overlapping responsibilities to provide services to Members under twenty-one (21) years of age, MCPs must do the following:

i. Assess the Member's need for Medically Necessary EPSDT services, including mental, behavioral, social, and/or developmental services, utilizing the AAP Periodicity Table[19] and the CDC's ACIP child vaccination schedule[20], the required needs assessment tools.

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

iii. 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 sixty (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 Exhibit C-3.

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[18] Additional guidance available in APL 23-005: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2023/APL23-005.pdf.
[19] AAP Periodicity Table available at: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf .
[20] CDC ACIP Child Vaccination Schedule available at: https://www.cdc.gov/vaccines/hcp/acip-recs/index.html.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

Exhibit C-4 - Additional Data Elements for LHD Services

The Parties will update referral processes and policies with additional data elements to address barriers and concerns related to referrals and ensure Members receive appropriate LHD services and MCP's Covered Services.

Exhibit D - Specialty Mental Health Services

In addition to the provisions of the MOU, this Exhibit D and any sub-exhibits ("**Exhibit D**") govern the provision and coordination of services between MCP and the Mental Health Plan (defined below). If any provision of this Exhibit D conflicts with any provision of the MOU, the provision of this Exhibit D shall control as to the provision and coordination of services between MCP and the Mental Health Plan (defined below).

1. **Definitions.** The following definitions shall apply to this Exhibit D.

a. "**MCP-MHP Liaison**" means MCP's designated point of contact responsible for acting as the liaison between MCP and MHP as described in Section 32 of this Exhibit D. The MCP-MHP Liaison must ensure the appropriate communication and care coordination is ongoing between the Parties, facilitate quarterly meetings in accordance with Section 8 of this Exhibit D, and provide updates to the MCP Responsible Person, Behavioral Health Integration Director II and/or MCP compliance officer as appropriate. The MCP-MHP Liaison is listed in Exhibit A.

b. "**MCP Responsible Person**" means the person designated by MCP to oversee MCP coordination and communication with MHP and ensure MCP's compliance with this Exhibit D as described in Section 32 of this Exhibit D. The MCP Responsible Person, Behavioral Health Integration Director II for this Exhibit D is listed in Exhibit A.

c. **"Mental Health Plan"** ("**MHP**") for purposes of this Exhibit D shall mean HCA.

d. "**MHP Liaison**" means MHP's designated point of contact responsible for acting as the liaison between MCP and MHP as described in Section 33 of this Exhibit D. The MHP Liaison should ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 8 of the MOU, and provide updates to the MHP Responsible Person and/or MHP compliance officer as appropriate. The MHP Liaison for this Exhibit D is listed in Exhibit B.

e. "**MHP Responsible Person**" means the person designated by MHP to oversee coordination and communication with MCP and ensure MHP's compliance with this Exhibit D as described in Section 33 of this Exhibit D. The MHP Responsible Person for this Exhibit D is listed in Exhibit B.

2. **Services Covered by this Exhibit D.** This Exhibit D governs the coordination between MCP and MHP for Non-Specialty Mental Health Services ("**NSMHS**") covered by MCP and further described in APL 22-006, and Specialty Mental Health Services ("**SMHS**") covered by MHP and further described in APL 22-003, APL 22-005, and BHIN 21-073, and any subsequently issued superseding APLs or BHINs, executed contract amendments, or other relevant guidance. The population eligible for NSMHS and SMHS set forth in APL 22-006 and BHIN 21-073 is the population served under this Exhibit D.

3. **MCP Obligations.**

a. **Provision of Covered Services.** MCP is responsible for authorizing Medically Necessary Covered Services, including NSMHS, ensuring MCP's Network Providers coordinate care for Members as provided in the applicable Medi-Cal Managed

Care Contract, and coordinating care from other providers of carve-out programs, services, and benefits.

b. **Oversight Responsibility.** The designated MCP Responsible Person, Behavioral Health Integration Director II as listed in Exhibit A of this MOU is responsible for overseeing MCP's compliance with this Exhibit D. The MCP Responsible Person, Behavioral Health Integration Director II must:

i. Meet at least quarterly with MHP, as required by Section 41 of this Exhibit D;

ii. Report on MCP's compliance with this Exhibit D 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 a sufficient staff at MCP who support compliance with and management of this Exhibit D;

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

v. Ensure training and education regarding Exhibit D provisions are conducted annually for MCP's employees responsible for carrying out activities under this Exhibit D, 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- MHP Liaison, the point of contact and liaison with MHP. MCP must notify MHP of any changes to the MCP-MHP Liaison in writing as soon as reasonably practical but no later than the date of change and must notify DHCS within five (5) working days of the change.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MCP will comply with Section 4(c), Compliance by Subcontractors, Downstream Subcontractors, and Network Provider, of the MOU.

4. **MHP Obligations.**

a. **Provision of Specialty Mental Health Services.** MHP Is responsible for providing or arranging for the provisions of SMHS.

b. **Oversight Responsibility.** The designated MHP Responsible Person, Assistant Deputy Director as listed in Exhibit B of this MOU is responsible for overseeing MHP's compliance with the MOU. The MHP Responsible Person serves, or may designate a person to serve, as the designated MHP Liaison, the point of contact and liaison with MCP. The MHP Liaison may be the same person as the MHP Responsible Person. MHP must notify MCP of changes to the MHP Liaison as soon as reasonably practical but no later than the date of change. The MHP Responsible Person must:

i. Meet at least quarterly with MCP, as required by Section 41 of this Exhibit D;

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

iii. Ensure there is sufficient staff at MHP to support compliance with and management of this Exhibit D;

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

v. Ensure training and education regarding Exhibit D provisions are conducted annually to MHP's employees responsible for carrying out activities under this Exhibit D, and as applicable for Subcontractors, Downstream Subcontractors, and Network providers; and

vi. Be responsible for meeting Exhibit D and MOU compliance requirements, as determined by policies and procedures established by MHP, and reporting to the MHP Responsible Person.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MHP must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this Exhibit D.

5. **Training and Education**. The Parties will comply with training and education requirements as outlined in Section 6 of the MOU.

6. **Screening, Assessment, and Referrals.**

a. **Screening and Assessment.** The Parties must develop and establish policies and procedures that address how Members must be screened and assessed for mental health services, including administering the applicable Screening and Transition of Care Tools for Medi-Cal Mental Health Services as set forth in APL 22-028 and BHIN 22-065.

i. MCP and MHP must use the required screening tools for Members who are not currently receiving mental health services, except when a Member contacts the mental health provider directly to seek mental health services.

ii. MCP and MHP must use the required Transition of Care Tool to facilitate transitions of care for Members when their service needs change.

iii. The policies and procedures must incorporate agreed-upon and/or required timeframes; list specific responsible parties by title or department; and include any

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other elements required by DHCS for the mandated statewide Adult Screening Tool for adults aged twenty-one (21) and older, Youth Screening Tool for youth under age twenty-one (21), and Transition of Care Tool, for adults aged twenty-one (21) and older and youth under age twenty-one (21), as well as the following requirements:

1. The process by which MCP and MHP must conduct mental health screenings for Members who are not currently receiving mental health services when they contact MCP or MHP to seek mental health services. MCP and MHP must refer such Members to the appropriate delivery system using the Adult or Youth Screening Tool for Medi-Cal Mental Health Services based on their screening result.

2. The process by which MCP and MHP must ensure that Members receiving mental health services from one delivery system receive timely and coordinated care when their existing services are being transitioned to another delivery system or when services are being added to their existing mental health treatment from another delivery system in accordance with APL 22-028 and BHIN 22-065.

b. **Referrals.** The Parties must work collaboratively to develop and establish policies and procedures that ensure that Members are referred to the appropriate MHP services and MCP Covered Services**.**

i. The Parties must adopt a "no wrong door" referral process for Members and work collaboratively to ensure that Members may access services through multiple pathways and are not turned away based on which pathway they rely on, including, but not limited to, adhering to all applicable No Wrong Door for Mental Health Services Policy requirements described in APL 22-005 and BHIN 22-011. The Parties must refer Members using a patient-centered, shared decision-making process.

ii. The Parties must develop and implement policies and procedures addressing the process by which MCP and MHP coordinate referrals based on the completed Adult or Youth Screening Tool in accordance with APL 22-028 and BHIN 22-065, including:

1. The process by which MHP and MCP transition Members to the other delivery system.

2. The process by which Members who decline screening are assessed.

3. The process by which MCP:

a. Accepts referrals from MHP for assessment, and the mechanisms of communicating such acceptance and that a timely assessment has been made available to the Member.

b. Provides referrals to MHP for assessment, and the mechanisms of sharing the completed screening tool and confirming acceptance of referral and that a timely assessment has been made available to the Member by MHP.

c. Provides a referral to an MHP Network Provider (if

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processes agreed upon with MHP), and the mechanisms of sharing the completed screening tool and confirming acceptance of the referral and that a timely assessment has been made available to the Member by MHP.

4. The process by which MHP:

a. Accepts referrals from MCP for assessment, and the mechanisms for communicating such acceptance and that a timely assessment has been made available to the Member.

b. Provides referrals to MCP for assessment, and the mechanisms of sharing the completed screening tool and confirming acceptance of the referral and that a timely assessment has been made available to the Member by MCP.

c. Provides a referral to an MCP Network Mental Health Provider (if processes agreed upon with MCP), and the mechanisms of confirming the MCP Network Mental Health Provider accepted the referral and that a timely assessment has been made available to the Member by MCP.

d. Provides a referral to MCP when the screening indicates that a Member under age twenty-one (21) would benefit from a pediatrician/PCP visit.

5. The process by which MCP and MHP coordinate referrals using the Transition of Care Tool in accordance with APL 22-028 and BHIN 22-065.

6. The process by which MCP (and/or its Network Providers):

a. Accepts referrals from MHP, and the mechanisms of communicating such acceptance, including that the Member has been connected with a Network Provider who accepts their care and that services have been made available to the Member.

b. Provides referrals to MHP and the mechanisms of sharing the completed transition tool and confirming acceptance of the referral, including that the Member has been connected with a provider who accepts their care and that services have been made available to the Member.

c. Provides a referral to an MHP Network Provider (if processes have been agreed upon with MHP), and the mechanisms of sharing the completed transition tool and confirming acceptance of the referral, including that the Member has been connected with a provider who accepts their care and that services have been made available to the Member.

d. MCP must coordinate with MHP to facilitate transitions between MCP and MHP delivery systems and across different providers, including guiding referrals for Members receiving NSMHS to transition to an SMHS provider and vice versa, and the new provider accepts the referral and provides care to the Member.

7. The process by which MHP (and/or its Network Providers):

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

a. Accepts referrals from MCP, and the mechanisms of communicating such acceptance, including that the Member has been connected with a Network Provider who accepts their care and that services have been made available to the Member.

b. Provides referrals to MCP, and the mechanisms of sharing the completed transition tool and confirming acceptance of the referral, including that the Member has been connected with a Network Provider who accepts their care and that services have been made available to the Member.

c. Provides a referral to an MCP Network Provider (if processes have been agreed upon with MCP), and the mechanisms of sharing the completed transition tool and confirming acceptance of the referral, including that the Member has been connected with a Network Provider who accepts their care and that services have been made available to the Member.

iii. MHP must refer Members to MCP for MCP's Covered Services, as well as any Community Supports services or care management programs for which Members may qualify, such as ECM, CCM, or Community Supports. However, if MHP is also an ECM Provider, MHP provides ECM services pursuant to a separate agreement between MCP and MHP for ECM services; Exhibit D does not govern MHP's provision of ECM.

iv. MCP must have a process for referring eligible Members for substance use disorder ("**SUD**") services to a Drug Medi-Cal-certified program or a DMC-ODS program in accordance with the Medi-Cal Managed Care Contract.

7. **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 Exhibit D and ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative.

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

iii. The Parties must establish policies and procedures to maintain collaboration with each other and to identify strategies to monitor and assess the effectiveness of this Exhibit D. The policies and procedures must ensure coordination of inpatient and outpatient medical and mental health care for all Members enrolled in MCP and receiving SMHS through MHP, and must comply with federal and State law, regulations, and guidance, including, but not limited to, California Welfare and Institutions Code Sections 5328 through 5329.

iv. The Parties must establish and implement policies and procedures that align for coordinating Members' care that address:

1. The specific point of contact from each Party, if someone other

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than each Party's Responsible Person, to act as the liaison between Parties and be responsible for initiating, providing, and maintaining ongoing care coordination for all Members under this Exhibit D;

2. A process for coordinating care for individuals who meet access criteria for and are concurrently receiving NSMHS and SMHS consistent with the No Wrong Door for Mental Health Services Policy described in APL 22-005 and BHIN 22-011 to ensure the care is clinically appropriate and non-duplicative and considers the Member's established therapeutic relationships;

3. A process for coordinating the delivery of Medically Necessary Covered Services with the Member's PCP, including, without limitation, transportation services, home health services, and other Medically Necessary Covered Services for eligible Members;

4. Permitting Members to concurrently receive NSMHS and SMHS when clinically appropriate, coordinated, and not duplicative consistent with the No Wrong Door for Mental Health Services Policy described in APL 22-005 and BHIN 22-011.

5. A process for ensuring that Members and Network Providers can coordinate coverage of Covered Services and carved-out services outlined by this Exhibit D outside normal business hours, as well as providing or arranging for 24/7 emergency access to admission to psychiatric inpatient hospital.

v. **Transitional Care.**

1. The Parties must establish policies and procedures and develop a process describing how MCP and MHP will coordinate transitional care services for Members. A "transitional care service" is defined as the transfer of a Member from one setting or level of care to another, including, but not limited to, discharges from hospitals, institutions, and other acute care facilities and skilled nursing facilities to home or community-based settings,[21] or transitions from outpatient therapy to intensive outpatient therapy. For Members who are admitted to an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, including, but not limited to, Short-Term Residential Therapeutic Programs and Psychiatric Residential Treatment Facilities, where MHP is the primary payer, MHPs are primarily responsible for coordination of the Member upon discharge. In collaboration with MHP, MCP is responsible for ensuring transitional care coordination as required by Population Health Management,[22] including, but not limited to:

a. Tracking when Members are admitted, discharged, or transferred from facilities contracted by MHP (*e.g.*, psychiatric inpatient hospitals,

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[21] Expectations for transitional care are defined in the PHM Policy Program Guide: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf. .

[22] Expectations for transitional care are defined in the PHM Policy Program Guide: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf; *see also* PHM Roadmap and Strategy: https://www.dhcs.ca.gov/CalAIM/Documents/Final-Population-Health-Management-Strategy-and-Roadmap.pdf.

psychiatric health facilities, residential mental health facilities) in accordance with Section 10(a)(iii) of this Exhibit D.

b. Approving prior authorizations and coordinating services where MCP is the primary payer (*e.g.*, home services, long-term services and supports for dual-eligible Members);

c. Ensuring the completion of a discharge risk assessment and developing a discharge planning document.

d. Assessing Members for any additional care management programs or services for which they may qualify, such as ECM, CCM, or Community Supports and enrolling the Member in the program as appropriate;

e. Notifying existing CCM Care Managers of any admission if the Member is already enrolled in ECM or CCM; and

f. Assigning or contracting with a care manager to coordinate with behavioral health or county care coordinators for each eligible Member to ensure physical health follow up needs are met as outlined by the Population Health Management Policy Guide.

2. The Parties must include a process for updating and overseeing the implementation of the discharge planning documents as required for Members transitioning to or from MCP or MHP services.

3. For inpatient mental health treatment provided by MHP or for inpatient hospital admissions or emergency department visits known to MCP, the process must include the specific method to notify each Party within 24 hours of admission and discharge and the method of notification used to arrange for and coordinate appropriate follow-up services.

4. The Parties must have policies and procedures for addressing changes in a Member's medical or mental health condition when transferring between inpatient psychiatric service and inpatient medical services, including direct transfers.

vi. **Clinical Consultation.**

1. The Parties must establish policies and procedures for MCP and MHP to provide clinical consultations to each other regarding a Member's mental illness, including consultation on diagnosis, treatment, and medications.

2. The Parties must establish policies and procedures for reviewing and updating a Member's problem list, as clinically indicated (*e.g.*, following crisis intervention or hospitalization), including when the care plan or problem list must be updated, and coordinating with outpatient mental health Network Providers.

vii. **Enhanced Care Management.**

1. Delivery of the ECM benefit for individuals who meet ECM

Population of Focus definitions (including, but not limited to, the Individuals with Severe Mental Illness and Children Populations of Focus) must be consistent with DHCS guidance regarding ECM, including:

a. That MCP prioritize assigning a Member to an SMHS Provider as the ECM Provider if the Member receives SMHS from that Provider and that Provider is a contracted ECM Provider, unless the Member has expressed a different preference or MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions;

b. That the Parties implement a process for SMHS Providers to refer their patients to MCP for ECM if the patients meet Population of Focus criteria; and

c. That the Parties implement a process for avoiding duplication of services for individuals receiving ECM with SMHS Targeted Case Management ("**TCM**"), Intensive Care Coordination ("**ICC**"), and/or Full-Service Partnership ("**FSP**") services as set forth in the CalAIM ECM Policy Guide, as revised or superseded from time to time, and coordination activities.

viii. **Community Supports.**

1. Coordination must be established with applicable Community Supports providers under contract with MCP, including:

a. The identified point of contact, from each Party to act as the liaison to oversee initiating, providing, and maintaining ongoing coordination as mutually agreed upon in MCP and MHP protocols;

b. Identification of the Community Supports covered by MCP; and

c. A process specifying how MHP will make referrals for Members eligible for or receiving Community Supports.

ix. **Eating Disorder Services.**

1. MHP is responsible for the SMHS components of eating disorder treatment and MCP is responsible for the physical health components of eating disorder treatment and NSMHS, including, but not limited to, those in APL 22-003 and BHIN 22-009, and any subsequently issued superseding APLs or BHINs, and must develop a process to ensure such treatment is provided to eligible Members, specifically:

a. MHP must provide for medically necessary psychiatric inpatient hospitalization and outpatient SMHS.

b. MCP must also provide or arrange for NSMHS for Members requiring eating disorder services.

2. For partial hospitalization and residential eating disorder

programs, MHP is responsible for medically necessary SMHS components, while MCP is responsible for the medically necessary physical health components.

a. MCP is responsible for the physical health components of eating disorder treatment, including emergency room services, and inpatient hospitalization for Members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization.

x. **Prescription Drugs.**

1. The Parties must establish policies and procedures to coordinate prescription drug, laboratory, radiological, and radioisotope service procedures. The joint policies and procedures must include:

a. MHP is obligated to provide the names and qualifications of prescribing physicians to MCP.

b. MCP is obligated to provide MCP's procedures for obtaining authorization of prescribed drugs and laboratory services, including a list of available pharmacies and laboratories.

8. **Quarterly Meetings.** The Parties will comply with the quarterly meeting requirements set forth in Section 9 of the MOU.

9. **Quality Improvement.** The Parties must develop QI activities specifically for the oversight of the requirements of this Exhibit D, 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. Such QI activities must include processes to monitor the extent to which Members are able to access mental health services across SMHS and NSMHS, and Covered Service utilization. The Parties must document these QI activities in policies and procedures.

10. **Data Sharing and Confidentiality.** The Parties must establish and implement policies and procedures to ensure that the minimum necessary Member information and data for accomplishing the goals of this Exhibit D are exchanged timely and maintained securely and confidentially and in compliance with the requirements set forth below to the extent permitted under applicable state and federal law. The Parties will share PHI for the purposes of medical and behavioral health care coordination pursuant to Title 9 of the California Code of Regulations, Section 1810.370(a)(3), and to the fullest extent permitted under HIPAA, 42 C.F.R. Part 2, Welfare and Institutions Code, Sections 5328 through 5329, 14184.102(j), and other State and federal privacy laws, as applicable. For additional guidance, the Parties should refer to the CalAIM Data Sharing Authorization Guidance.[23] All data exchanged under this MOU for purposes of this Exhibit D must be in accordance with the specified provisions herein and Exhibit H.

[23] CalAIM Data Sharing Authorization Guidance VERSION 2.0 June 2023 available at: https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance-Version-2-Draft-Public-Comment.pdf.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

a. **Data Exchange.** Except where prohibited by law or regulation, MCP and MHP must share the minimum necessary data and information to facilitate referrals and coordinate care under this Exhibit D. The Parties must have policies and procedures for supporting the timely and frequent exchange of Member information and data, including behavioral health and physical health data; for ensuring the confidentiality of exchanged information and data; and, if necessary, for obtaining Member consent, when required. The minimum necessary information and data elements to be shared as agreed upon by the Parties, are set forth in Exhibit D-1 of the MOU. To the extent permitted under applicable law, the Parties must share, at a minimum, Member demographic information, behavioral and physical health information, diagnoses, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the Member's health and/or welfare. The Parties must annually review and, if appropriate, update Exhibit D-1 of the MOU to facilitate sharing of information and data. MHP and MCP must establish policies and procedures to implement the following with regard to information sharing:

i. A process for timely exchanging information about Members eligible for ECM, regardless of whether the Specialty Mental Health provider is serving as an ECM provider;

ii. A process for MHP to send regular, frequent batches of referrals to ECM and Community Supports to MCP in as close to real time as possible;

iii. A process for MHP to send admission, discharge, and transfer data to MCP when Members are admitted to, discharged from, or transferred from facilities contracted by MHP (*e.g.*, psychiatric inpatient hospitals, psychiatric health facilities, residential mental health facilities), and for MCP to receive this data. This process may incorporate notification requirements as described in Section 7(a)(v)(3) of this Exhibit D;

iv. A process to implement mechanisms to alert the HCA of behavioral health crises (*e.g.*, MHP alerts MCP of Members' uses of mobile health, psych inpatient, and crisis stabilization and MCP alerts MHP of Members' visits to emergency departments and hospitals); and

v. A process for MCP to send admission, discharge, and transfer data to MHP when Members are admitted to, discharged from, or transferred from facilities contracted by MCP (*e.g.*, emergency department, inpatient hospitals, nursing facilities), and for MHP to receive this data. This process may incorporate notification requirements as described in Section 7(a)(v)(3) of this Exhibit D.

b. **Behavioral Health Quality Improvement Program**. If MHP is participating in the Behavioral Health Quality Improvement Program, then MCP and MHP are encouraged to execute a Data Sharing Agreement ("**DSA**"). If MHP and MCP have not executed a DSA, MHP must sign a Participation Agreement to onboard with a Health Information Exchange that has signed the California Data Use and Reciprocal Support Agreement and joined the California Trusted Exchange Network.

c. **Interoperability**. The Parties will comply with interoperability requirements outlined in Section 11(b) of the MOU.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

11. **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 Exhibit D, the Parties must attempt, in good faith, to promptly resolve the dispute mutually between themselves. The Parties must document the agreed-upon dispute resolution procedures in policies and procedures. Pending resolution of any such dispute, MCP and MHP must continue without delay to carry out all responsibilities under this Exhibit D unless the MOU is terminated. If the dispute cannot be resolved within fifteen (15) working days of initiating such negotiations, either Party may pursue its available legal and equitable remedies under California law. Disputes between MCP and MHP that cannot be resolved in a good faith attempt between the Parties must be forwarded by MCP and/or MHP to DHCS.

b. Disputes between MCP and MHP that cannot be resolved in a good faith attempt between the Parties must be forwarded to DHCS via a written "Request for Resolution" by either MHP or MCP within three (3) business days after failure to resolve the dispute, consistent with the procedure defined in Title 9 California Code of Regulations Section 1850.505, "Resolutions of Disputes between MHPs and Medi-Cal Managed Care Plans" and APL 21-013. Any decision rendered by DHCS regarding a dispute between MCP and MHP concerning provision of Covered Services is not subject to the dispute procedures set forth in the Primary Operations Contract, Exhibit D, Section 1.21 (Contractor's Dispute Resolution Requirements).

c. A dispute between MHP and MCP must not delay the provision of medically necessary SMHS, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries as required by Title 9 of California Code of Regulations Section 1850.525.

d. Until the dispute is resolved, the following must apply:

i. The Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided; or

ii. When the dispute concerns MCP's contention that MHP is required to deliver SMHS to a Member either because the Member's condition would not be responsive to physical health care-based treatment or because MHP has incorrectly determined the Member's diagnosis to be a diagnosis not covered by MHP, MCP must manage the care of the Member under the terms of its contract with the State until the dispute is resolved. MHP must identify and provide MCP with the name and telephone number of a psychiatrist or other qualified licensed mental health professional available to provide clinical consultation, including consultation on medications to MCP provider responsible for the Member's care; or

iii. When the dispute concerns MHP's contention that MCP is required to deliver physical health care-based treatment of a mental illness, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose or treat the mental illness, MHP is responsible for providing or arranging and paying for those services until the dispute is resolved.

e. if decisions rendered by DHCS find MCP is financially liable for services, MCP must comply with the requirements in Title 9 of the California Code of Regulations Section 1850.530.

f. The Parties may agree to an expedited dispute resolution process if a Member has not received a disputed service(s) and the Parties determine that the routine dispute resolution process timeframe would result in serious jeopardy to the Member's life, health, or ability to attain, maintain, or regain maximum function. Under this expedited process, the Parties will have one (1) working day after identification of a dispute to attempt to resolve the dispute at the plan level. All terms and requirements established in APL 21-013 and BHIN 21-034 apply to disputes between MCP and MHP where the Parties cannot agree on the appropriate place of care.

g. MHP must designate a person or process to receive notice of actions, denials, or deferrals from MCP, and to provide any additional information requested in the deferral notice as necessary for a medical necessity determination.

h. MCP must monitor and track the number of disputes with MHP where the Parties cannot agree on an appropriate place of care and, upon request, must report all such disputes to DHCS.

i. Once MHP receives a deferral from MCP, MHP must respond by the close of the business day following the day the deferral notice is received, consistent with Cal. Welf. & Inst. Code § 14715.

j. Nothing in this Exhibit D 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.

12. **Equal Treatment.** The Parties will comply with Section 13, Equal Treatment, of the MOU.

13. **General.** The Parties will comply with Section 14, General, of the MOU.

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Exhibit D-1 – Additional Data Elements for Specialty Mental Health Services

The Parties will update referral processes and policies with additional data elements to address barriers and concerns related to referrals and ensure Members receive appropriate Specialty Mental Health Services and MCP's Covered Services.

Exhibit E – Substance Use Disorder

In addition to the provisions of the MOU, this Exhibit E and any sub-exhibits ("**Exhibit E**") govern the provision and coordination of services between MCP and the Drug Medi-Cal Organized Delivery System (defined below). The terms of this Exhibit E are in addition to any other terms of the MOU. If any provision of this Exhibit E conflicts with any provision of the MOU, the provision of this Exhibit E shall control as to the provision and coordination of services between MCP and the Drug Medi-Cal Organized Delivery System (defined below). Notwithstanding any other parts of this MOU, including its Program Exhibits, the Parties may not disclose any information in their possession that is subject to 42 C.F.R. Part 2 unless such disclosure is permitted under 42 C.F.R. Part 2.

Definitions. The following definitions shall apply to this Exhibit E.

a. "**DMC-ODS Liaison**" means DMC-ODS's designated point of contact responsible for acting as the liaison between MCP and DMC-ODS as described in Section 4 of this Exhibit E. The DMC-ODS Liaison should ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 8 of this Exhibit E, and provide updates to the DMC-ODS Responsible Person and/or DMC-ODS compliance officer as appropriate. The DMC-ODS Liaison for this Exhibit E is listed in Exhibit B.

b. "**DMC-ODS Responsible Person**" means the person designated by DMC-ODS to oversee coordination and communication with MCP and ensure DMC-ODS compliance with this Exhibit E as described in Section 4 of this Exhibit E. The DMC-ODS Responsible Person for this Exhibit E is listed in Exhibit B.

c. "**Drug Medi-Cal Organized Delivery System**" ("**DMC-ODS**") for purposes of this Exhibit E shall mean HCA.

d. "**MCP Responsible Person**" means the person designated by MCP to oversee MCP coordination and communication with DMC-ODS and ensure MCP's compliance with this Exhibit E as described in Sections 3 and 4 of this Exhibit E. The MCP Responsible Person for this Exhibit E is Behavioral Health Integration Director II as listed in Exhibit A.

e. **"MCP-DMC-ODS Liaison**" means MCP's designated point of contact responsible for acting as the liaison between MCP and DMC-ODS as described in Section 3 of the MOU. The MCP-DMC-ODS Liaison must ensure the appropriate communication and care coordination is ongoing between the Parties, facilitate quarterly meetings in accordance with Section 8 of this Exhibit E, and provide updates to the MCP Responsible Person, Behavioral Health Integration Director II and/or MCP compliance officer as appropriate. The MCP-DMC-ODS Liaison for this Exhibit E is listed in Exhibit A.

2. **Services Covered by this Exhibit E.** This Exhibit E governs the coordination between DMC-ODS and MCP for the provision of SUD services as described in APL 22-006, and any subsequently issued superseding APLs, and Medi-Cal Managed Care Contract, BHIN 23-001, DMC-ODS Requirements for the Period of 2022-2026, and the DMC- ODS Intergovernmental Agreement, and any subsequently issued superseding

APLs, BHINs, executed contract amendments, or other relevant guidance.

3. **MCP Obligations.**

a. **Provision of Covered Services**. MCP will comply with Section 4(a), Provision of Covered Services, of the MOU.

b. **Oversight Responsibility**. The designated MCP Responsible Person, Behavioral Health Integration Director II as listed in Exhibit A of this MOU is responsible for overseeing MCP's compliance with this Exhibit E. The MCP Responsible Person, Behavioral Health Integration Director II must:

i. Meet at least quarterly with DMC-ODS, as required by Section 8 of this Exhibit E;

ii. Report on MCP's compliance with this 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 Exhibit E;

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

v. Ensure training and education regarding Exhibit E provisions are conducted annually for MCP's employees responsible for carrying out activities under this Exhibit E, 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- DMC-ODS Liaison, the point of contact and liaison with DMC-ODS. MCP must notify DMC-ODS of any changes to the MCP-DMC-ODS Liaison in writing as soon as reasonably practical, but no later than the date of change, and must notify DHCS within five (5) working days of the change.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MCP will comply with Section 4(c), Compliance by Subcontractors, Downstream Subcontractors, and Network Providers, of the MOU.

4. **DMC-ODS Obligations.**

a. **Provision of DMC-ODS Services.** DMC-ODS is responsible for providing or arranging covered SUD services.

b. **Oversight Responsibility.** The designated DMC-ODS Responsible Person, Assistant Deputy Director as listed in Exhibit B of this MOU is responsible for overseeing

DMC-ODS's compliance with this Exhibit E. The DMC-ODS Responsible Person serves, or may designate a person to serve, as the designated DMC-ODS Liaison, the point of contact and liaison with MCP. The DMC-ODS Liaison may be the same person as the DMC-ODS Responsible Person. DMC-ODS must notify MCP of changes to the DMC-ODS Liaison as soon as reasonably practical but no later than the date of change. The DMC-ODS Responsible Person must:

i. Meet at least quarterly with MCP, as required by Section 8 of this Exhibit E;

ii. Report on DMC-ODS compliance with this Exhibit E to DMC-ODS' compliance officer no less frequently than quarterly. The compliance officer is responsible for MOU compliance oversight and reports as part of DMC-ODS's compliance program and must address any compliance deficiencies in accordance with DMC-ODS's compliance program policies;

iii. Ensure there is sufficient staff at DMC-ODS to support compliance with and management of this Exhibit E;

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

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

vi. Be responsible for meeting Exhibit E and MOU compliance requirements, as determined by policies and procedures established by DMC-ODS, and reporting to the DMC-ODS Responsible Person.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** DMC-ODS must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this Exhibit E.

5. **Training and Education.** The Parties will comply with training and education requirements outlined in Section 6 of the MOU.

6. **Screening, Assessment, and Referrals.**

a. **Screening and Assessment.**

i. The Parties must work collaboratively to develop and establish policies and procedures that address how Members must be screened and assessed for MCP Covered Services and DMC-ODS services.

ii. MCP must develop and establish policies and procedures for providing

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Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment ("**SABIRT**") to Members aged eleven (11) and older in accordance with APL 21-014. MCP policies and procedures must include, but not be limited to:

1. A process for ensuring Members receive comprehensive substance use, physical, and mental health screening services, including the use of American Society of Addiction Medicine (ASAM) Level 0.5 SABIRT guidelines;

2. A process for providing or arranging the provision of medications for Addiction Treatment (also known as Medication-Assisted Treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings.

b. **Referral Process.** The Parties must work collaboratively to develop policies and procedures that ensure Members are referred to the appropriate MCP Covered Services and DMC-ODS services.

i. The Parties must facilitate referrals to DMC-ODS for Members who may potentially meet the criteria to access DMC-ODS services and ensure DMC-ODS has procedures for accepting referrals from MCP.

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

iii. MCP must develop and implement an organizational approach to the delivery of services and referral pathways to DMC-ODS services.

iv. DMC-ODS must refer Members to MCP for Covered Services, as well as any Community Supports services or care management programs for which they may qualify, such as ECM or CDM. If DMC-ODS is an ECM Provider, DMC-ODS provides ECM services pursuant to that separate agreement between MCP and DMC-ODS for ECM services; this Exhibit E does not govern DMC-ODS's provision of ECM.

v. The Parties must work collaboratively to ensure that Members may access services through multiple pathways. The Parties must ensure Members receive SUD services when Members have co-occurring SMHS and/or NSMHS and SUD needs.

vi. MCP must have a process by which MCP accepts referrals from DMC-ODS staff, providers, or a self-referred Member for assessment, and a mechanism for communicating such acceptance to DMC-ODS, the provider, or the self- referred Member, respectively; and

vii. DMC-ODS must have a process by which DMC-ODS accepts referrals from MCP staff, providers, or a self-referred Member for assessment, and a mechanism for communicating such acceptance to MCP, the provider, or the self- referred Member, respectively.

7. **Care Coordination and Collaboration.**

a. **Care Coordination.** In addition to the requirements outlined in Section 8 of

the MOU, the following care coordination requirements apply:

i. The Parties must implement policies and procedures that align for coordinating Members' care that address:

1. The requirement for DMC-ODS to refer Members to MCP to be assessed for care coordination and other similar programs and other services for which they may qualify provided by MCP including, but not limited to, ECM, CCM, or Community Supports;

2. The specific point of contact from each Party, if someone other than each Party's Responsible Person, to act as the liaison between Parties and be responsible for initiating, providing, and maintaining ongoing care coordination for all Members under this Exhibit E;

3. A process for how MCP and DMC-ODS will engage in collaborative treatment planning to ensure care is clinically appropriate and non- duplicative and considers the Member's established therapeutic relationships;

4. A process for coordinating the delivery of Medically Necessary Covered Services with the Member's Primary Care Provider, including without limitation transportation services, home health services, and other Medically Necessary Covered Services for eligible Members;

5. A process for how MCP and DMC-ODS will help to ensure the Member is engaged and participates in their care program and a process for ensuring the Members, caregivers, and providers are engaged in the development of the Member's care;

6. A process for reviewing and updating a Member's problem list, as clinically indicated. The process must describe circumstances for updating problem lists and coordinating with outpatient SUD providers;

7. A process for how the Parties will engage in collaborative treatment planning and ensure communication among providers, including procedures for exchanges of medical information; and

8. Processes to ensure that Members and providers can coordinate coverage of Covered Services and carved-out services outlined by this Exhibit E outside of normal business hours, as well as providing or arranging for 24/7 emergency access to Covered Services and carved-out services.

ii. **Transitional Care.**

1. The Parties must establish policies and procedures and develop a process describing how MCP and DMC-ODS will coordinate transitional care services for Members. A "transitional care service" is defined as the transfer of a Member from one setting or level of care to another, including, but not limited to, discharges from hospitals, institutions, and other acute care facilities and skilled nursing facilities to home- or

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community-based settings,[24] level of care transitions that occur within the facility, or transitions from outpatient therapy to intensive outpatient therapy and vice versa.

2. For Members who are admitted for residential SUD treatment, including, but not limited to, Short-Term Residential Therapeutic Programs and Psychiatric Residential Treatment Facilities where DMC-ODS is the primary payer, DMC-ODS is primarily responsible for coordination of the Member upon discharge. In collaboration with DMC-ODS, MCP is responsible for ensuring transitional care coordination as required by Population Health Management,[25] including, but not limited to:

a. Tracking when Members are admitted, discharged, or transferred from facilities contracted by DMC-ODS in accordance with Section 10(a)(iii) of this Exhibit E.

b. Approving prior authorizations and coordinating services where MCP is the primary payer (*e.g.*, home services, long-term services, and supports for dual-eligible Members).

c. Ensuring the completion of a discharge risk assessment and developing a discharge planning document.

d. Assessing Members for any additional care management programs or services for which they may qualify, such as ECM, CCM, or Community Supports, and enrolling the Member in the program as appropriate;

e. Notifying existing CCM Care Managers of any admission if the Member is already enrolled in ECM or CCM; and

f. Assigning or contracting with a care manager to coordinate with county care coordinators to ensure physical health follow-up needs are met for each eligible Member as outlined by the Population Health Management Policy Guide.[26]

3. The Parties must include in their policies and procedures a process for updating and overseeing the implementation of the discharge planning documents as required for Members transitioning to or from MCP or DMC-ODS services.

4. For inpatient residential SUD treatment provided by DMC- ODS or for inpatient hospital admissions or emergency department visits known to MCP, the process must include the specific method to notify each Party within twenty-four (24) hours of admission and discharge and the method of notification used to arrange for and

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[24] Expectations for transitional care are defined in the PHM Policy Program Guide: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf.
[25] Expectations for transitional care are defined in the PHM Policy Program Guide: https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf; *see also* PHM Roadmap and Strategy: https://www.dhcs.ca.gov/CalAIM/Documents/Final-Population-Health-Management-Strategy-and-Roadmap.pdf.
[26] CalAIM Population Health Management Policy Guide available at https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Policy-Guide.pdf.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

coordinate appropriate follow-up services.

iii. **Clinical Consultation.** The Parties must establish policies and procedures to ensure that Members have access to clinical consultation, including consultation on medications, as well as clinical navigation support for patients and caregivers.

iv. **Enhanced Care Management.**

1. Delivery of the ECM benefit for individuals who meet ECM Population of Focus definitions (including, but not limited to, the Individuals with Severe Mental Illness and Children Populations of Focus) must be consistent with DHCS guidance regarding ECM, including:

a. That MCP prioritize assigning a Member to a DMC- ODS Provider as the ECM Provider if the Member receives DMC-ODS services from that Provider and that Provider is a contracted ECM Provider, unless the Member has expressed a different preference or MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions; and

b. That the Parties implement a process for DMC-ODS Providers to refer their patients to MCP for ECM if the patients meet Population of Focus criteria.

2. The Parties must implement a process for avoiding duplication of services for individuals receiving ECM with DMC-ODS care coordination. Members receiving DMC-ODS care coordination can also be eligible for and receive ECM.

3. MCP must have written processes for ensuring the non-duplication of services for Members receiving ECM and DMC-ODS care coordination.

v. **Community Supports.** Coordination must be established with applicable Community Supports providers under contract with MCP, including:

1. The identified point of contact from each Party to act as the liaison to oversee initiating, providing, and maintaining ongoing coordination as mutually agreed upon in MCP and DMC-ODS protocols;

2. Identification of the Community Supports covered by MCP; and

3. A process specifying how DMC-ODS will make referrals for Members eligible for or receiving Community Supports.

vi. **Prescription Drugs.** The Parties must develop a process for coordination between MCP and DMC-ODS for prescription drug and laboratory, radiological, and radioisotope service procedures, including a process for referring eligible Members for SUD services to a Drug Medi-Cal-certified program or a DMC-ODS program in accordance with the Medi-Cal Managed Care Contract.

8. **Quarterly Meetings**. The Parties will comply with Section 9, Quarterly Meetings, of

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the MOU.

9. **Quality Improvement.** The Parties will comply with Section 10, Quality Improvement, of the MOU.

10. **Data Sharing and Confidentiality**. The Parties must establish and implement policies and procedures to ensure that the minimum necessary Member information and data to accomplish the goals of this Exhibit E are exchanged timely and maintained securely and confidentially and in compliance with the requirements set forth below to the extent permitted under applicable state and federal law. The Parties will share PHI for the purposes of medical and behavioral health care coordination pursuant to Welfare and Institutions § 14184.102(j), and to the fullest extent permitted under HIPAA, 42 C.F.R. Part 2, and any other applicable State and federal privacy laws. For additional guidance, the Parties should refer to the CalAIM Data Sharing Authorization Guidance.[27] All data exchanged under this MOU for purposes of this Exhibit E must be in accordance with the specified provisions herein, including 42 C.F.R. Part 2, and the Business Associate Agreement set forth in Exhibit H.

a. **Data Exchange.** Except where prohibited by law or regulation, MCP and DMC-ODS must share the minimum necessary data and information to facilitate referrals and coordinate care under this Exhibit E. The Parties must have policies and procedures for supporting the timely and frequent exchange of Member information and data, including behavioral health and physical health data; maintaining the confidentiality of exchanged information and data; and obtaining Member consent, when required. The minimum necessary information and data elements to be shared as agreed-upon by the Parties are set forth in Exhibit E-1 of the MOU. To the extent permitted under applicable law, the Parties must share, at a minimum, Member demographic information, behavioral and physical health information, diagnoses, assessments, medications prescribed, laboratory results, referrals/discharges to/from inpatient or crisis services and known changes in condition that may adversely impact the Member's health and/or welfare. The Parties must annually review and, if appropriate, update Exhibit E-1 of the MOU to facilitate sharing of information and data. DMC-ODS and MCP must establish policies and procedures to implement the following with regard to information sharing:

i. A process for timely exchanging information about Members eligible for ECM, regardless of whether the DMC-ODS Provider is serving as an ECM Provider;

ii. A process for DMC-ODS to send regular frequent batches of referrals to ECM and Community Supports to MCP in as close to real time as possible;

iii. A process for DMC-ODS to send admission, discharge, and transfer data to MCP when Members are admitted to, discharged from, or transferred from facilities contracted by DMC-ODS (*e.g.*, residential SUD treatment facilities, residential SUD withdrawal management facilities), and for MCP to receive this data. This process may incorporate notification requirements as described in Section 7(a)(ii)(3) of this Exhibit E;

[27] CalAIM Data Sharing Authorization Guidance VERSION 2.0 June 2023 available at: https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance-Version-2- Draft-Public-Comment.pdf.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

iv. A process to implement mechanisms to alert the HCA of behavioral health crises (*e.g.*, DMC-ODS alerts MCP of uses of SUD crisis intervention); and

v. A process for MCP to send admission, discharge, and transfer data to DMC-ODS when Members are admitted to, discharged from, or transferred from facilities contracted by MCP (*e.g.*, emergency department, inpatient hospitals, nursing facilities), and for DMC-ODS to receive this data. This process may incorporate notification requirements as described in Section 7(a)(ii)(3) of this Exhibit E.

b. **Behavioral Health Quality Improvement Program.** If DMC-ODS is participating in the Behavioral Health Quality Improvement Program, then MCP and DMC-ODS are encouraged to execute a DSA. If DMC-ODS and MCP have not executed a DSA, DMC-ODS must sign a Participation Agreement to onboard with a Health Information Exchange that has signed the California Data Use and Reciprocal Support Agreement and joined the California Trusted Exchange Network.

c. **Interoperability.** MCP and DMC-ODS must exchange data in compliance with the payer-to-payer data exchange requirements pursuant to 45 C.F.R. Part 170. MCP must make available to Members their electronic health information held by the Parties and 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 and DMC-ODS's respective websites pursuant to 42 C.F.R. Sections 438.242(b) and 438.10(h). The Parties must comply with DHCS interoperability requirements set forth in APL 22-026 and BHIN 22-068, or any subsequent version of the APL and BHIN, as applicable.

11. **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 Exhibit E, the Parties must attempt, in good faith, to promptly resolve the dispute mutually between themselves. The Parties must document the agreed-upon dispute resolution procedures in policies and procedures. Pending resolution of any such dispute, MCP and DMC-ODS must continue without delay to carry out all responsibilities under this Exhibit E unless the MOU is terminated. If the dispute cannot be resolved within fifteen (15) working days of initiating such negotiations 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. Disputes between MCP and DMC-ODS that cannot be resolved in a good faith attempt between the Parties must be forwarded by MCP and/or DMC-ODS to DHCS.

b. Unless otherwise determined by the Parties, the DMC-ODS Liaison must be the designated individual responsible for receiving notice of actions, denials, or deferrals from MCP, and for providing any additional information requested in the deferral notice as necessary for a medical necessity determination.

c. MCP must monitor and track the number of disputes with DMC-ODS where the Parties cannot agree on an appropriate place of care and, upon request, must report all such disputes to DHCS.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

d. Until the dispute is resolved, the following provisions must apply:

i. The Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided; or

ii. When the dispute concerns MCP's contention that DMC-ODS is required to deliver SUD services to a Member and DMC-ODS has incorrectly determined the Member's diagnosis to be a diagnosis not covered by DMC-ODS, MCP must manage the care of the Member under the terms of its contract with the DHCS, including providing or arranging and paying for those services until the dispute is resolved.

iii. When the dispute concerns DMC-ODS's contention that MCP is required to deliver physical health care-based treatment, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose, DMC-ODS is responsible for providing or arranging and paying for those services until the dispute is resolved.

e. Nothing in this Exhibit E 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.

12. **Equal Treatment.** The Parties will comply with Section 13, Equal Treatment, of the MOU.

13. **General.** The Parties will comply with Section 14, General, of the MOU.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

Exhibit E-1 – Additional Data Elements for Substance Use Disorder Program

The Parties will update referral processes and policies with additional data elements to address barriers and concerns related to referrals and ensure Members receive appropriate Substance Use Disorder services and MCP's Covered Services.

Exhibit F - Supplemental Nutrition Program for Women, Infants, and Children (WIC)

In addition to the provisions of the MOU, this Exhibit F, including any sub-exhibits, govern the provision and coordination of services between MCP and the Agency (defined below). If any provision of this Exhibit F conflicts with any provision of the MOU, the provisions of this Exhibit F shall control as to the provision and coordination of services between MCP and Agency (defined below).

1. **Definitions.** The following definitions shall apply to this Exhibit F.

a. "**Agency**" for purposes of this Exhibit F shall mean HCA.

b. "**Agency Liaison**" means Agency's designated point of contact responsible for acting as the liaison between MCP and Agency as described in Section 4 of this Exhibit F. 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 the 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.

c. "**Agency Responsible Person**" means the person designated by Agency to oversee coordination and communication with MCP and ensure Agency's compliance with this Exhibit F as described in Section 4 of this Exhibit F. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in Agency practices. The Agency Responsible Person for this Exhibit F is listed in Exhibit B.

d. "**Children"** means persons over one (1) year of age and up five (5) years of age.

e. "**Infant**" means persons up to their first birthday (one (1) year of age).

f. "**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 the MOU, and ensure MCP's compliance with this Exhibit F as described in Section 3 of this Exhibit F. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in MCP practices. The MCP Responsible Person, Population Health Management Director II for this Exhibit F is listed in Exhibit A.

g. "**MCP-Agency Liaison**" means MCP's designated point of contact responsible for acting as the liaison between MCP and Agency as described in Section 3 of this Exhibit F. 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 the MOU, and provide updates to the MCP Responsible Person, Population Health Management Director II and/or MCP compliance officer as appropriate. The MCP-Agency Liaison for this Exhibit F is listed in Exhibit F.

2. **Services Covered by this Exhibit F.**

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**"). (Title 42 of the United States Code Section 1786; 7 C.F.R. Section 246; Health and Safety Code Section 123275 *et seq.*; Title 22 of the 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 C.F.R. Sections 246.1, 246.7(b), 246.10, 246.11.)

c. Nothing in this Exhibit F 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 Exhibit F 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 (1) year postpartum who are breastfeeding their Infants ("**Breastfeeding Women**"), women up to six (6) months after termination of pregnancy ("**Postpartum Women**"), Infants, and Children who are receiving supplemental foods or food instruments or cash-value vouchers under the WIC Program, and the breastfed Infants of participant Breastfeeding Women. (7 C.F.R. 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 C.F.R. 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.*, Title 42 of the United States Code Section 1786(d); 7 C.F.R. Sections 246.2, 246.7)

as well as the terms of Agency's local agency agreement with CDPH.

3. **MCP Obligations.**

a. **Provision of Covered Services.** MCP will comply with Section 4(a), Provision of Covered Services, of the MOU.

b. **Oversight Responsibility.** The designated MCP Responsible Person, Population Health Management Director II as listed in Exhibit A of this MOU, is responsible for overseeing MCP's compliance with this Exhibit F. The MCP Responsible Person, Population Health Management Director II must:

i. Meet at least quarterly with Agency, as required by Section 8 of this Exhibit F;

ii. Report on MCP's compliance with Exhibit F 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 Exhibit F;

iv. Ensure the appropriate levels of MCP leadership (*i.e.*, persons with decision-making authority) are involved in implementation and oversight of the Exhibit F engagements and ensure the appropriate levels of leadership from Agency are invited to participate in the Exhibit F 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 Exhibit F, 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 the 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 (5) working days of the change.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MCP will comply with Section c), Compliance by Subcontractors, Downstream Subcontractors, and Network Providers, of the MOU.

4. **Agency Obligations.**

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

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

b. **Oversight Responsibility.** The designated Agency Responsible Person, Assistant Deputy Director as listed in Exhibit B of the MOU, is responsible for overseeing Agency's compliance with this Exhibit F. 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 the 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 (5) working days of the change.

5. **Training and Education.**

a. The Parties will comply with the training and education requirements of Section 6(a) of the MOU.

b. In accordance with health education standards required by the Medi-Cal Managed Care Contract, the Parties 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 therapeutic formulas; and care coordination approaches; and

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

c. The Parties 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.[28]

d. Provided Agency obtains the appropriate approvals required by its local agency agreement with CDPH prior to using or developing materials for the WIC Program, the Parties may together develop training and education resources covering the services provided or arranged for by the Parties.

e. The Parties may share their applicable training and educational materials with each other to ensure the information in their respective training and educational materials includes an accurate set of services provided or arranged for by each Party and is consistent with MCP and Agency policies and procedures, and with clinical practice

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

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standards.

f. Provided Agency obtains the appropriate approvals required by its local agency agreement with CDPH prior to using or developing materials for the WIC Program, the Parties may develop and share outreach communication materials and develop initiatives to share resources about MCP and Agency with individuals who may be eligible for MCP's Covered Services and/or WIC Services.

g. MCP may include Agency outreach communications to inform Members about WIC on its website and in its Member education materials, Member handbook, and other appropriate materials, including placing the WIC website link [www.myfamily.wic.ca.gov and/or local WIC link] on its website.

h. Agency must provide the Agency Liaison and Agency staff and providers with training and educational materials on MCP's Covered Services to support Agency in assisting Members with accessing MCP's Covered Services.

i. When staff resources allow, Agency must ensure the WIC Regional Breastfeeding Liaison, as defined by the CDPH Regional Breastfeeding Liaison Program (or designee), offers WIC orientation and breastfeeding group training quarterly to MCP's Network Providers and support staff, including providing information on breastfeeding policy across the continuum of care, such as the California Department of Public Health's 9 Steps to Breastfeeding Friendly: Guidelines for Community Health Centers and Outpatient Care Settings 2015, workplace lactation accommodation, and hospital breastfeeding policy regulations.

j. MCP may coordinate with the WIC Regional Breastfeeding Liaison to communicate and schedule Network Provider training on WIC orientation and breastfeeding.

6. **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 Exhibit F and any policies and procedures related thereto must comply with Section 12 of this Exhibit F.

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 C.F.R. Section 431.635(c) and any relevant DHCS guidance. MCP must have policies and procedures to identify and

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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 twelve (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.

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 ECM or CCM. 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 Exhibit F 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 C.F.R. Section 246.7(f) and Title 22 of the California Code of Regulations Section 40675.

ix. As Agency is the payor of last resort, MCP and Agency must coordinate

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to ensure MCP understands Agency's processes and procedures for providing Members with therapeutic formula as appropriate. MCP must ensure its Network Providers are informed of and follow the requirements for assisting Members in obtaining therapeutic formula 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 therapeutic formula, 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, a qualifying medical diagnosis, the name of the therapeutic formula 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.

b. **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 C.F.R. 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, 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, 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 C.F.R. 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. 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.

7. **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 Exhibit F.

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

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

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 Exhibit F.

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,[29] 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.

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 therapeutic formula from the appropriate source in a timely manner.

v. With prior written approval from CDPH, MCP and Agency may collaborate to collect feedback from WIC Participants on topics of interest to the Parties through surveys, focus groups, or other agreed-upon methods, and in accordance with Section 8 of this Exhibit F. Such activities must comply with Section 10 of this Exhibit F.

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[29] Ibid.

8. **Quarterly Meetings.**

a. The Parties will comply with Section 9, Quarterly Meetings, of the MOU.

9. **Quality Improvement.** The Parties will comply with Section 10, Quality Improvement, of the MOU.

10. **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 Exhibit F 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 HIPAA, 42 C.F.R. 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 C.F.R. Section 246.26(d)(1)(i).) Agency's sharing of confidential WIC Applicant and WIC Participant information with MCP must comply with 7 C.F.R. Section 246.26.

a. **Data Exchange.** MCP must share the minimum necessary data and information to facilitate referrals and coordinate care under this Exhibit F. Agency is encouraged to share the necessary minimum information and data to facilitate referrals and coordinate care under this Exhibit F. 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 C.F.R. 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 F-1, contingent on the receipt of Members' appropriate written consent. The Parties must annually review and, if appropriate, update Exhibit F-1 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 Exhibit F in a manner that complies with applicable laws and requirements.

c. **Interoperability.** The Parties will comply with Section 11(b), Interoperability, of the MOU.

11. **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 Exhibit F, 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 Exhibit F, including providing Members with access to services under this Exhibit F, unless this MOU or Exhibit F is terminated.

b. Disputes between MCP and Agency that cannot be resolved in a good faith attempt between the Parties within fifteen (15) 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 the MOU, this Exhibit F, or this 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.

12. **Equal Treatment.**

a. Pursuant to 7 C.F.R. Section 246.3(b), Title VI of the Civil Rights Act, and Title 42 of the 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 Exhibit F 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

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

13. **General.** The Parties will comply with Section 14, General, of the MOU.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

Exhibit F-1 – Additional Data Elements for WIC Services Program

The Parties will update referral processes and policies with additional data elements to address barriers and concerns related to referrals and ensure Members receive appropriate WIC Services and MCP's Covered Services.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

Exhibit G – County-Based Targeted Case Management

This Exhibit G shall be effective July 1, 2024. In addition to the provisions of the MOU, this Exhibit G and any sub-exhibits ("**Exhibit G**") govern the provision and coordination of services between MCP and Local Government Agency County-based Targeted Case Management Program administered by HCA ("**LGA TCM Program**"). LGA TCM Program is a county program that delivers Targeted Case Management ("**TCM**") services to limited federally approved target populations. TCM services encompassed in this Exhibit G are distinct from TCM services provided as a component of Specialty Mental Health Services. The terms of this Exhibit G are in addition to any other terms of the MOU. If any provision of this Exhibit G conflicts with any provision of the MOU, the provision of this Exhibit G shall control as to the provision and coordination of services between MCP and the LGA TCM Program.

1. **Definitions**. The following definitions shall apply to this Exhibit G.

a. "**LGA TCM Program Liaison**" means LGA TCM Program's designated point of contact responsible for acting as the liaison between MCP and LGA TCM Program as described in Section 4 of this Exhibit G. The LGA TCM Program Liaison should ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 8 of this Exhibit G, and provide updates to the LGA TCM Program Responsible Person as appropriate.

b. "**LGA TCM Program Responsible Person**" means the person designated by LGA TCM Program to oversee coordination and communication with MCP, facilitate quarterly meetings in accordance with Section 8 of this Exhibit G, and ensure LGA TCM Program's compliance with this Exhibit G as described in Section 4. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in LGA TCM Program practices.

c. "**LGA TCM Program Services**" means those services provided by LGA TCM Program that meet the requirements set forth in Title 22 of the California Code of Regulations Section 51351(a).

d. "**MCP Responsible Person**" means the person designated by MCP to oversee MCP coordination and communication with LGA TCM Program, facilitate quarterly meetings in accordance with Section 8 of this Exhibit G, and ensure MCP's compliance with this Exhibit Gas described in Section 3. It is recommended that this person be in a leadership position with decision-making authority and authority to effectuate improvements in MCP practices.

e. "**MCP-TCM Liaison**" means MCP's designated point of contact responsible for acting as the liaison between MCP and LGA TCM Program as described in Section 3 of this Exhibit G. The MCP-TCM Liaison must ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 8 of this Exhibit G, and provide updates to the MCP Responsible Person, Director of Medi-Cal Compliance and/or MCP compliance officer as appropriate.

2. **Services Covered by this Exhibit G.** This Exhibit G governs the coordination between LGA TCM Program and MCP for the delivery of care and services for Members who reside in LGA TCM Program's jurisdiction and may be eligible for services provided, made available, or arranged for by LGA TCM Program.

3. **MCP Obligations.**

a. **Provision of Covered Services.** MCP will comply with Section 4(a), Provision of Covered Services, of the MOU.

b. **Oversight Responsibility.** MCP will comply with Section 4(b), Oversight Responsibility, of the MOU.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MCP will comply with Section 4(c), Compliance by Subcontractors, Downstream Subcontractors, and Network Providers, of the MOU.

4. **LGA Program Obligations.**

a. **Provision of Services.** LGA TCM Program is responsible for services that will assist Members in gaining access to needed medical, social, educational, or other services per 42 C.F.R. Section 440.169 provided or made available by LGA TCM Program and applicable TCM State Plan Amendments, the TCM Provider Manual, Policy and Procedure Letters, and the Annual Participation Prerequisite ("**APP**") submitted by LGA TCM Programs to DHCS.

b. **Oversight Responsibility.** The designated LGA TCM Program Responsible Person, Fiscal Administrator as listed in Exhibit B of this MOU, is responsible for overseeing LGA TCM Program's compliance with this Exhibit G. The LGA TCM Program Responsible Person serves, or may designate a person to serve, as the designated LGA TCM Program Liaison, the point of contact and liaison with MCP. The LGA TCM Program Liaison is listed in Exhibit B of this MOU. LGA TCM Program must notify MCP of changes to the LGA TCM Program Liaison as soon as reasonably practical but no later than the date of change, except when such prior notification is not possible, in which case, such notice should be provided within five (5) working days of the change.

c. **Assessments and Care Plans.** LGA TCM Program is responsible for conducting comprehensive assessments and periodic reassessments for LGA TCM Program-eligible Members, and for the development and revision of LGA TCM Program's Member care plans based on such assessments related to LGA TCM Program Services.

i. LGA TCM Program's Member assessments shall determine the need for any medical, educational, social, or other service.

ii. Based on the assessment, LGA TCM Program's Member care plans must specify the goals for providing LGA TCM Program's services to the eligible Member, and the services and actions necessary to address the Member's medical, social, educational, or other service needs.

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iii. LGA TCM Program must share Member care plans for Members receiving LGA TCM Program Services with MCP upon MCP's request.

5. **Training and Education.** The Parties will comply with training and education requirements outlined in Section 6 of the MOU.

6. **Eligibility Screening and Referrals to LGA TCM Program and MCP.** The Parties must work collaboratively to develop policies and procedures that ensure Members are referred to LGA TCM Program where LGA TCM Program offers services that are more intensive, extensive, and specialized than what MCP offers its Members through CCM, other care management programs, or Community Supports. Members who meet ECM Population of Focus criteria[30] should be enrolled in ECM and may not be enrolled in ECM and LGA TCM Program at the same time (except as described in Section 6(f) below).

a. LGA TCM Program must refer Members, including all Members eligible for ECM, to MCP for MCP's Covered Services, such as ECM, CCM, other care management programs, and any Community Supports that MCP offers for which Members may qualify.

b. The Parties must facilitate referrals to LGA TCM Program for LGA TCM Program-eligible Members who are ineligible for ECM (*i.e.*, do not meet the ECM Population of Focus criteria) and who may potentially meet the criteria for LGA TCM Program Services. The Parties must ensure LGA TCM Program has procedures for accepting referrals from MCP or responding to referrals where LGA TCM Program cannot accept additional Members. MCP must refer Members using a patient-centered, shared decision-making process.

c. To the extent LGA TCM Program or the agency housing the TCM Program is a contracted ECM Provider, MCP is encouraged to contract with LGA TCM Program or the agency housing the TCM Program as an ECM Provider. If LGA TCM Program is an ECM Provider pursuant to a separate agreement between MCP and LGA TCM Program for ECM services, this Exhibit G does not govern LGA TCM Program's provision of ECM services.

d. LGA TCM Program may continue providing LGA TCM Program Services to Members who are ineligible for ECM but remain eligible for LGA TCM Program Services.

e. MCP and LGA TCM Program must coordinate to ensure the non- duplication of Member services in LGA TCM Program and CCM, other care management programs and Community Supports as well as ensure the non-duplication of Member enrollment in LGA TCM Program and ECM (except as described in Section 6(f) below). MCP must notify LGA TCM Program of any Members enrolled in CCM, other care management programs, Community Supports, and ECM on a timeline agreed to by both parties.

f. During the period from July 1, 2024, through June 30, 2025, Members who are receiving LGA TCM Program Services for (1) addressing a communicable disease or

[30] CalAIM Enhanced Care Management Policy Guide, available at https://www.dhcs.ca.gov/CalAIM/ECM/Pages/Resources.aspx.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

(2) the sole purpose of receiving home visiting programs to support the healthy development and well-being of children and families may be in both ECM and LGA TCM Program. The ECM Provider must remain primarily responsible for the overall coordination across the physical and behavioral health delivery systems and social supports. As of July 1, 2025, Members who fall under one of the two exceptions set forth above and meet ECM Population of Focus criteria should be enrolled in ECM and can no longer be enrolled in both ECM and LGA TCM Program Services.

g. For the small number of Members receiving both LGA TCM Program services and ECM services as of the July 1, 2024, policy change effective date, the Member may (1) choose to remain enrolled in both programs until their care plan goals are achieved, (2) choose to transition care management entirely to their LGA TCM Program, or (3) choose to transition their care management entirely to the ECM Provider. MCP will remain responsible for ensuring non-duplication of services in these scenarios.

7. **Coordination and Collaboration Between MCP and LGA TCM Program.**

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

b. The Parties must discuss and address care coordination issues for specific Members or barriers to care coordination efforts at least quarterly.

c. MCP and LGA TCM Program must have policies and procedures in place to maintain collaboration and to identify strategies to monitor and assess the effectiveness of this Exhibit G.

d. MCP must access and review the Monthly Plan Data Feed files in order to identify Members receiving LGA TCM Program Services and to coordinate with LGA TCM Program to ensure non-duplication of services.

e. For Members receiving LGA TCM Program Services, MCP must notify the Member's PCP that the Member is receiving LGA TCM Program Services and will provide contact information for the Member's PCP, ECM Provider, and any other MCP case manager to the LGA TCM Program Liaison.

f. MCP must provide to the LGA TCM Program Liaison and other LGA TCM Program staff, as provided by the LGA TCM Program Liaison, information (including name and date of birth) on Members receiving LGA TCM Program Services, as applicable, that identifies Members' Medically Necessary social support needs relative to eligibility for LGA TCM Program Services.

8. **Quarterly Meetings.** The Parties will comply with Section 9, Quarterly Meetings, of the MOU.

9. **Quality Improvement.** The Parties will comply with Section 10, Quality

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Improvement, of the MOU.

10. **Data Sharing.** The Parties will comply with Section 11, Data Sharing and Confidentiality, of the MOU.

a. **Data Exchange.** MCP must, and LGA TCM Program 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 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 to be shared as agreed upon by the Parties are set forth in Exhibit G-1 of this MOU. The Parties must annually review and, if appropriate, update Exhibit G-1 to facilitate sharing of information and data. For additional information see CalAIM Data Sharing Authorization Guidance.[31]

b. **Interoperability.** The Parties will comply with Section 11(b), Interoperability, of the MOU.

11. **Dispute Resolution.** The Parties will comply with Section 12, Dispute Resolution, of the MOU

12. **Equal Treatment.** The Parties will comply with Section 13, Equal Treatment, of the MOU. Section 13 of the MOU does not diminish the responsibility of LGA TCM Program and MCP to assure adequate administrative capacity, network capacity, and timely services to Members in accordance with existing standards.

13. **General.** Except as otherwise provided in this Section 13, the Parties will comply with Section 14, General, of the MOU.

a. **Termination.** Either Party may terminate this Exhibit G if (1) the MCP no longer provides services in the LGA TCM Program's jurisdiction or (2) the LGA TCM Program withdraws from the LGA TCM Program. The Parties must provide each other with prior written notice of such termination.

[31] CalAIM Data Sharing Authorization Guidance, available at: https://www.dhcs.ca.gov/dataandstats/Pages/DHCS-Data-Exchange-and-Data-Sharing.aspx.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

Exhibit G-1 – Additional Data Elements for County-Based Targeted Case Management

The Parties will update referral processes and policies with additional data elements to address barriers and concerns related to referrals and ensure Members receive appropriate LGA TCM Program Services and MCP's Covered Services.

Docusign Envelope ID: A0A5BD33-C01F-4865-8257-4814CADF551B

Exhibit H – Business Associate Agreement

This Exhibit H shall only apply if one Party is acting as a business associate (as that term is defined in 45 C.F.R. § 160.103) of the other Party. References to "**Covered Entity**" in this Exhibit H shall refer to HCA when MCP is acting as the County's Business Associate and shall refer to MCP when HCA is acting as the MCP's Business Associate. References to "**Business Associate**" in this Exhibit H shall refer to HCA when HCA is acting as a Business Associate to MCP and shall refer to MCP when MCP is acting as a Business Associate to HCA.

1. **Definitions.** The terms in this section and otherwise defined in this Business Associate Agreement shall have the definitions set forth below for purposes of this Business Associate Agreement. Terms used, but not otherwise defined, in this Business Associate Agreement shall have the same meaning as those terms in HIPAA, the HITECH Act, the IPA (as defined below), and/or regulations promulgated thereunder.

a. **Agreement** as used in this document means both this Business Associate Agreement and the MOU and Program Exhibits to which this Business Associate Agreement applies, as specified in such Program Exhibit.

b. **Breach** means, unless expressly excluded under 45 C.F.R. § 164.402, the acquisition, access, Use, or Disclosure of PHI in a manner not permitted under Subpart E of 45 C.F.R. Part 164 which compromises the security or privacy of the PHI and as more particularly defined under 45 C.F.R. § 164.402.

c. **Business associate** has the meaning given such term in 45 C.F.R. § 160.103.

d. **Confidential Information** refers to information not otherwise defined as PHI in Section 1(o) below, but to which state and/or federal privacy and/or security protections apply.

e. **Data Aggregation** has the meaning given such term in 45 C.F.R. § 164.501.

f. **Designated Record Set** has the meaning given such term in 45 C.F.R. § 164.501.

g. **Disclose** and **Disclosure** mean the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

h. **Electronic Health Record** has the meaning given such term in 42 U.S.C. § 17921.

i. **Electronic Media** means:

i. Electronic storage material on which data is or may be recorded electronically including, for example, devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or

ii. Transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the internet, extranet or intranet, leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via Electronic Media, because the information being exchanged did not exist in electronic form before the transmission.

j. **Electronic Protected Health Information** (“**ePHI**”) means Individually Identifiable Health Information, including PHI, that is transmitted by or maintained in Electronic Media.

k. **Health Care Operations** has the meaning given such term in 45 C.F.R. § 164.501.

l. **Individual** means the person who is the subject of PHI and shall include a person who qualifies as a personal representative in accordance with 45 C.F.R. § 164.502(g).

m. **Individually Identifiable Health Information** means health information, including demographic information collected from an Individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an Individual, the provision of health care to an Individual, or the past, present, or future payment for the provision of health care to an Individual, that identifies the Individual or where there is a reasonable basis to believe the information can be used to identify the Individual, as set forth under 45 C.F.R. § 160.103.

n. **Information System** means an interconnected set of information resources under the same direct management control that shares common functionality. A system normally includes hardware, software, information, data, applications, communications, and people.

o. **Protected Health Information** (“**PHI**”), as used in this Agreement and unless otherwise stated, refers to and includes both PHI as defined at 45 C.F.R. § 160.103 and personal information (“**PI**”) as defined in the Information Practices Act at California Civil Code § 1798.3(a) (“**IPA**”). PHI includes information in any form, including paper, oral, and electronic.

p. **Reproductive Health Care** means health care, as defined at 45 C.F.R. § 160.103, that affects the health of an Individual in all matters relating to the reproductive system and to its functions and processes.

q. **Required by Law** means a mandate contained in law that compels an entity to make a Use or Disclosure of PHI and that is enforceable in a court of law. Required by Law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health care providers participating in the program; and statutes or regulations that require the

production of information, including statutes or regulations that require such information if payment is sought under a government program providing benefits.

r. **Secretary** means the Secretary of the U.S. Department of Health and Human Services or the Secretary's designee.

s. **Security Incident** means the attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an Information System.

t. **Services** has the same meaning as in the MOU and the Program Exhibits.

u. **Unsecured Protected Health Information** ("**Unsecured PHI**") means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of technology or methodology specified by the Secretary in the guidance issued under 42 U.S.C. § 17932(h)(2).

v. **Use** and **Uses** mean, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within the entity that maintains such information.

2. Covered Entity intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute PHI and/or Confidential Information protected by federal and/or state laws.

3. Business Associate is the business associate of Covered Entity acting on Covered Entity's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of Covered Entity, and may create, receive, maintain, transmit, aggregate, Use or Disclose PHI in order to fulfill Business Associate's obligations under this Agreement.

4. **Permitted Uses and Disclosures of PHI by Business Associate.** Except as otherwise indicated in this Agreement, Business Associate may Use or Disclose PHI, inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of Covered Entity, provided that such Use or Disclosure would not violate HIPAA, including the Privacy Regulations, or other applicable laws if done by Covered Entity.

a. **Specific Use and Disclosure Provisions.** Except as otherwise indicated in this Agreement, Business Associate may Use and Disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may Disclose PHI for this purpose if the Disclosure is Required by Law, or the Business Associate obtains reasonable assurances, in writing, from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as Required by Law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of

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Business Associate.

b. **Data Aggregation.** If authorized as part of the Services provided to Covered Entity under the MOU, Business Associate may use PHI to provide Data Aggregation services relating to the Health Care Operations of Covered Entity.

5. **Prohibited Uses and Disclosures of PHI.**

a. **Restrictions on Certain Disclosures to Health Plans.** Business Associate shall not Disclose PHI about an Individual to a health plan for payment or Health Care Operations purposes if the PHI pertains solely to a health care item or service for which the health care provider involved has **been** paid out of pocket in full and the Individual requests such restriction in accordance with HIPAA and the HITECH Act, including 45 C.F.R. § 164.522(a). The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103.

b. **Prohibition on Sale of PHI; No Remuneration.** Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written authorization of Covered Entity and Covered Entity's regulator(s), as applicable, and then, only as permitted by HIPAA and the HITECH Act. The term PHI, as used in this Section, only refers to PHI as defined in 45 C.F.R. § 160.103.

c. **Prohibition of Disclosure of PHI Related to Reproductive Health Care.** Business Associate shall comply with 45 C.F.R. Part 164, Subpart E regarding uses and disclosures of Reproductive Health Care-related information, including the following:

i. Business Associate shall comply with requirements of 45 § C.F.R. 164.502(a)(5)(iii) and shall not Use or Disclose PHI related to lawful Reproductive Health Care for the purpose of (i) conducting a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; (ii) imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating Reproductive Health Care; or (iii) to identify any person for any purpose previously described (each a "**Prohibited Purpose**").

ii. To the extent applicable, if Business Associate receives a request for Reproductive Health Care-related information for a non-Prohibited Purpose that is otherwise permissible under HIPAA, HITECH, the Privacy Regulations, and the Security Regulations, Business Associate shall obtain a valid attestation under 45 C.F.R. § 164.509 if the requested release of Reproductive Health Care-related information is for: (i) health oversight activities under 45 C.F.R. § 164.512(d); (ii) judicial or administrative proceedings under 45 C.F.R. § 164.512(e); (iii) disclosures for law enforcement purposes under 45 C.F.R. § 164.512(f); or (iv) disclosures about decedents to coroners and medical examiners under 45 C.F.R. § 164.512(g)(1).

6. **Compliance with Other Applicable Laws.**

a. To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, "more protective") privacy and/or security protections to PHI or other Confidential Information covered under this Agreement beyond those provided

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through HIPAA, Business Associate agrees:

i. To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the Individuals whose information is concerned; and

ii. To treat any violation of such additional and/or more protective standards as a Breach or Security Incident, as appropriate, pursuant to Section 17 of this Agreement.

b. Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or Confidential Information, as defined in Section 1 of this Agreement, include, but are not limited to the IPA (*i.e.*, California Civil Code §§ 1798-1798.78), Confidentiality of Medical Information Act ("**CMIA**") (*i.e.*, California Civil Code Section 56 *et seq.*), Confidentiality of Alcohol and Drug Abuse Patient Records (*i.e.*, 42 C.F.R. Part 2), Welfare and Institutions Code §§ 5328 through 5329, and California Health and Safety Code § 11845.5. . Business Associate shall ensure that any Medical Information related to Sensitive Services (as those terms are defined under Civil Code § 56.05) received or accessed under this Agreement is kept confidential, segregated, and only disclosed, accessed, transferred, transmitted, or processed in accordance with CMIA requirements, including Civil Code §§ 56.10, 56.11, 56.107, 56.108, and 56.110, as applicable.

c. If Business Associate is a Qualified Service Organization ("**QSO**") as defined in 42 C.F.R. § 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 C.F.R. § 2.11.

7. **Additional Responsibilities of Business Associate.**

a. **Nondisclosure.** Business Associate shall not Use or Disclose PHI or other Confidential Information other than as permitted or required by this Agreement or as Required by Law.

b. **Safeguards and Security.**

i. Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with Subpart C of 45 C.F.R. Part 164 with respect to ePHI, to prevent Use or Disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels. Business Associate shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of Subpart C of 45 C.F.R. Part 164, in compliance with 45 C.F.R. § 164.316. Business Associate shall maintain a comprehensive written information privacy and security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities.

ii. Business Associate shall, at a minimum, utilize National Institute of Standards and Technology Special Publication (NIST SP) 800-53 compliant security

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framework when selecting and implementing its security controls, and shall maintain continuous compliance with NIST SP 800-53 as it may be updated from time to time.

iii. Business Associate shall employ FIPS 140-3 compliant encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other Confidential Information, including, but not limited to, encryption of all workstations, laptops, and removable media devices containing PHI and data transmissions of PHI.

iv. Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other Confidential Information may be used.

v. Business Associate shall ensure that all members of its workforce with access to PHI and/or other Confidential Information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

vi. Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 C.F.R. Part 164, Subpart C.

c. **Minimum Necessary.** With respect to any permitted Use, Disclosure, or request of PHI under this Agreement, Business Associate shall make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of such Use, Disclosure, or request respectively, as specified in 45 C.F.R. § 164.502(b).

d. **Business Associate's Agent.** Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "**Agents**") that Use or Disclose PHI and/or Confidential Information on behalf of Business Associate agree through a written agreement to the same restrictions, conditions, and requirements that apply to Business Associate with respect to such PHI and/or Confidential Information.

8. **Mitigation of Harmful Effects.** Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of PHI and other Confidential Information in violation of the requirements of this Agreement.

9. **Access to PHI.** Business Associate shall, to the extent Covered Entity determines that any PHI constitutes a Designated Record Set, make the PHI specified by Covered Entity available to the Individual(s) identified by Covered Entity as being entitled to access and copy that PHI. Business Associate shall provide such access for inspection of that PHI within fifteen (15) calendar days after receipt of request from Covered Entity. Business Associate shall also provide copies of that PHI ten (10) calendar days after receipt of request from Covered Entity. If Business Associate maintains an Electronic Health Record with PHI, and an Individual requests a copy of such information in electronic format, Business Associate shall make such information available in that format as required under the HITECH Act and 45 C.F.R. § 164.524.

10. **Amendment of PHI.** Business Associate shall, to the extent Covered Entity determines that any PHI constitutes a Designated Record Set, make PHI available for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526 as requested by Covered Entity in the time and manner designated by Covered Entity.

11. **Accounting of Disclosures.** Business Associate shall document and make available to Covered Entity or (at the direction of Covered Entity) to an Individual, such disclosures of PHI and information related to such disclosures as necessary to respond to a proper request by the subject Individual for an accounting of disclosures of PHI in accordance with HIPAA, the HITECH Act and implementing regulations, including 45 C.F.R. § 164.528. Unless directed by Covered Entity to make available to an Individual, Business Associate shall provide to Covered Entity, within thirty (30) calendar days after receipt of request from Covered Entity, information collected in accordance with this Section 11 to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528. Any accounting provided by Business Associate under this Section shall include:

a. The date of the disclosure;

b. The name, and address if known, of the entity or person who received the PHI;

c. A brief description of the PHI disclosed; and

d. A brief statement of the purpose of the disclosure.

For each Disclosure that could require an accounting under this Section, Business Associate shall document the information enumerated above, and shall securely maintain the information for six (6) years from the date of the Disclosure.

12. **Compliance with HITECH Act.** Business Associate shall comply with the requirements of Title XIII, Subtitle D, of the HITECH Act, which are applicable to business associates, and shall comply with the regulations promulgated thereunder.

13. **Compliance with Obligations of Covered Entity or DHCS.** To the extent Business Associate is to carry out an obligation of Covered Entity or DHCS under 45 C.F.R. Part 164, Subpart E, Business Associate shall comply with the requirements of such Subpart E that apply to Covered Entity or DHCS, as applicable, in the performance of such obligation.

14. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the Use and Disclosure of PHI on behalf of Covered Entity available to Covered Entity upon reasonable request, and to the DHCS and the Secretary for purposes of determining Covered Entity's compliance with 45 C.F.R. Part 164, Subpart E. Business Associate also agrees to make its internal practices, books and records relating to the Use and Disclosure of PHI on behalf of Covered Entity available to DHCS, Covered Entity, and the Secretary for purposes of determining Business Associate's compliance with applicable requirements of HIPAA, the HITECH Act, CMIA, and implementing regulations. Business Associate shall immediately notify Covered Entity of any requests made by DHCS or the Secretary and provide Covered Entity with copies of any documents produced in response to such request.

15. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return to Covered Entity or, if agreed to by Covered Entity, destroy all PHI and other Confidential Information received from, or created or received by Business Associate on behalf of, Covered Entity that Business Associate or its Agents still maintains in any form, and shall retain no copies of such information. If Covered Entity elects destruction of PHI and/or other Confidential Information, Business Associate shall ensure such information is destroyed in accordance with the destruction methods specified in Sections 15(a) and 15(b) below, and shall certify in writing to Covered Entity that such information has been destroyed accordingly. If return or destruction is not feasible, Business Associate shall notify Covered Entity of the conditions that make the return or destruction infeasible. Subject to the approval of Covered Entity's regulator(s) if necessary, if such return or destruction is not feasible, Covered Entity shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall also extend the protections of this Agreement to the information and limit further Uses and Disclosures to those purposes that make the return or destruction of the information infeasible.

a. **Data Destruction.** Data destruction methods for Covered Entity PHI or Confidential Information must conform to the NIST Special Publication 800-88. Other methods require prior written permission of Covered Entity and, if necessary, Covered Entity's regulator(s).

b. **Destruction of Hard Copy Confidential Data.** Covered Entity PHI or Confidential Information in hard copy form must be disposed of through confidential means, such as crosscut shredding and pulverizing.

16. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of Covered Entity that was verified by or provided by the Social Security Administration ("**SSA Data**") and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by Covered Entity, a list of all employees and Agents and employees who have access to such SSA Data, including employees and Agents of its Agents, to Covered Entity.

17. **Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any Breach or Security Incident, and take the following steps:

a. **Notice to Covered Entity.**

i. **Immediate Notice.** Business Associate shall notify Covered Entity immediately upon the discovery of a suspected Breach or Security Incident that involves SSA Data. This notification will be provided by email upon discovery of the Breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to Covered Entity.

ii. **24-Hour Notice.** Business Associate shall notify Covered Entity within twenty-four (24) hours by email (or by telephone if Business Associate is unable to email Covered Entity) of the discovery of the following, unless attributable to treatment provider that is not acting as a business associate of Business Associate:

1. Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

2. Any suspected Security Incident which risks unauthorized access to PHI and/or other Confidential Information;

3. Any intrusion or unauthorized access, Use or Disclosure of PHI in violation of this Agreement; or

4. Potential loss of confidential data affecting this Agreement.

iii. Notice shall be provided to the Covered Entity Privacy Officer ("**Covered Entity Contact**") using the Covered Entity Contact Information at Section 17(g) below. Such notification by Business Associate shall comply with Covered Entity's form and content requirements for reporting privacy incident and shall include all information known at the time the incident is reported.

b. **Required Actions.** Upon discovery of a Breach or suspected Security Incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

i. Prompt action to mitigate any risks or damages involved with the Security Incident or Breach;

ii. Any action pertaining to such unauthorized disclosure required by applicable federal and state law; and

iii. Any corrective actions required by Covered Entity or Covered Entity's regulator(s).

c. **Investigation.** Business Associate shall immediately investigate such Security Incident or confidential Breach. Business Associate shall comply with Covered Entity's additional form and content requirements for reporting such privacy incident.

i. Incident details including the date of the incident and when it was discovered;

ii. The identification of each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been accessed, acquired, used or disclosed during the Breach;

iii. The nature of the data elements involved and the extent of the data involved in the Breach;

iv. A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data;

v. A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized;

vi. A description of the probable causes of the improper Use or Disclosure;

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vii. Any other available information that the Business Associate is required to include in notification to the Individual under 45 C.F.R. § 164.404(c);

viii. Whether the PHI or confidential data that is the subject of the Security Incident, Breach, or unauthorized Use or Disclosure of PHI or confidential data included Unsecured PHI;

ix. Whether a law enforcement official has requested a delay in notification of Individuals of the Security Incident, Breach, or unauthorized Use or Disclosure of PHI or Confidential Information because such notification would impede a criminal investigation or damage national security and whether such notice is in writing; and

x. Whether Section 13402 of the HITECH Act (codified at 42 U.S.C. § 17932), California Civil Code §§ 1798.29 or 1798.82, or any other federal or state laws requiring individual notifications of breaches are triggered.

d. **Complete Report.** Business Associate shall provide a complete written report of the investigation ("**Final Report**") to the Covered Entity Contact within seven (7) working days of the discovery of the Security Incident or Breach. Business Associate shall comply with Covered Entity's additional form and content requirements for reporting of such privacy incident.

i. The Final Report shall provide a comprehensive discussion of the matters identified in Section 17(c), above and the following:

1. An assessment of all known factors relevant to a determination of whether a Breach occurred under HIPAA and other applicable federal and state laws;

2. A full, detailed corrective action plan describing how Business Associate will prevent reoccurrence of the incident in the future, including its implementation date and information on mitigation measures taken to halt and/or contain the improper Use or Disclosure and to reduce the harmful effects of the Breach. All corrective actions are subject to the approval of Covered Entity and Covered Entity's regulator(s), as applicable; and

3. The potential impacts of the incident, such as potential misuse of data and identity theft.

ii. If Covered Entity or Covered Entity's regulator(s) requests additional information, Business Associate shall make reasonable efforts to provide Covered Entity with such information. A supplemental written report may be used to submit revised or additional information after the Final Report is submitted.

iii. Covered Entity and Covered Entity's regulator(s), as applicable, will review and approve or disapprove Business Associate's determination of whether a Breach occurred, whether the Security Incident or Breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

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iv. **New Submission Timeframe.** If Business Associate does not complete a Final Report within the seven (7) working day timeframe specified in Section 17(d) above, Business Associate shall request approval from Covered Entity within the seven (7) working day timeframe of a new submission timeframe for the Final Report. Business Associate acknowledges that a new submission timeframe requires the approval of Covered Entity and, if necessary, Covered Entity's regulator(s).

e. **Notification of Individuals.** If the cause of a Breach is attributable to Business Associate or its Agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate shall notify Individuals accordingly and pay all costs of such notifications, as well as costs associated with the Breach. The notifications shall comply with applicable federal and state law. All such notifications shall be coordinated with Covered Entity. Covered Entity and Covered Entity regulator(s), as applicable, shall approve the time, manner and content of any such notifications. Business Associate acknowledges that such review and approval by Covered Entity and Covered Entity regulator(s), as applicable, must be obtained before the notifications are made.

f. **Responsibility for Reporting of Breaches to Entities Other than Covered Entity.** If the cause of a Breach of PHI is attributable to Business Associate or Agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate agrees that Covered Entity shall make all required reporting of the Breach as required by applicable federal and state law, including any required notifications to media outlets, the Secretary, and other government agency/regulator.

g. **Covered Entity Contact Information.** To direct communications to Covered Entity Privacy Officer, the Business Associate shall initiate contact as indicated here. Covered Entity reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

If to MCP's Privacy Officer:

Privacy Officer
c/o: Office of Compliance
CalOptima
505 City Parkway West
Orange, CA 92868

Email: privacy@caloptima.org

Telephone: (714) 246-8400 (ask the operator to connect to Privacy Officer)

If to HCA's Privacy Officer:

[Add contact information for HCA Privacy Officer]

18. **Responsibilities of Covered Entity.**

a. Covered Entity agrees to not request the Business Associate to Use or Disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

b. **Notification of SSA Data.** Covered Entity shall notify Business Associate if Business Associate receives data that is SSA Data from or on behalf of Covered Entity.

19. **Indemnification.** Business Associate will immediately indemnify and pay Covered Entity for and hold it harmless from (i) any and all fees and expenses Covered Entity incurs in investigating, responding to, and/or mitigating a Breach of PHI or Confidential Information caused by Business Associate or its Agents; (ii) any damages, attorneys' fees, costs, liabilities or other sums actually incurred by Covered Entity due to a claim, lawsuit, or demand by a third party arising out of a Breach of PHI or Confidential Information caused by Business Associate or its Agents; and/or (iii) for fines, assessments and/or civil penalties assessed or imposed against Covered Entity by any government agency/regulator based on a Breach of PHI or Confidential Information caused by Business Associate or its Agents. Such fees and expenses may include, without limitation, attorneys' fees and costs and costs for computer security consultants, credit reporting agency services, postal or other delivery charges, notifications of Breach to Individuals and regulators, and required reporting of Breach. Acceptance by Covered Entity of any insurance certificates and endorsements required under the MOU does not relieve Business Associate from liability under this indemnification provision. This provision shall apply to any damages or claims for damages whether or not such insurance policies shall have been determined to apply.

20. **Audits, Inspection and Enforcement.**

a. From time to time, Covered Entity and/or Covered Entity's regulator(s) may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the Covered Entity Privacy Officer in writing. Whether or how Covered Entity or Covered Entity's regulator(s) exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

b. If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify Covered Entity unless it is legally prohibited from doing so.

21. **Term and Termination.**

a. **Term.** This Exhibit G is effective as of the Effective Date and shall terminate (i) when the MOU terminates, (ii) in accordance with this Section 21, or (iii) when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is

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infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in Section 15.

b. **Termination for Cause.** Upon Covered Entity's knowledge of a violation of this Agreement by Business Associate, Covered Entity may in its discretion:

i. Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by Covered Entity; or

ii. Terminate this Agreement if Business Associate has violated a material term of this Agreement.

iii. **Judicial or Administrative Proceedings.** Covered Entity may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. **Miscellaneous Provisions.**

a. **Disclaimer.** Covered Entity makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other Confidential Information.

b. **Amendment.**

i. Any provision of this Agreement which is in conflict with current or future applicable federal or state laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the Parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the Parties.

ii. This Agreement shall be deemed amended to comply with future changes in applicable laws or regulations (a "**Regulatory Change**") as of the date a Regulatory Change goes into effect, even if the Regulatory Change is not reduced to writing and formally agreed upon and executed by the Parties.

iii. Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22(b)(i) or 22(b)(ii) shall constitute a material violation of this Agreement.

c. **Assistance in Litigation or Administrative Proceedings.** Business Associate shall make itself and its employees and Agents available to Covered Entity or Covered Entity's regulator(s) at no cost to Covered Entity or Covered Entity's regulator(s), as applicable, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against Covered Entity or Covered Entity's regulator(s), their respective directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

d. **No Third-Party Beneficiaries.** Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

e. **Interpretation.** The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

f. **No Waiver of Obligations.** No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

g. **Statutory or Regulatory Reference.** Any reference to statutory or regulatory language in this Agreement shall be to such language as in effect or as amended.

h. **Injunctive Relief.** Notwithstanding any rights or remedies provided in this Agreement, Covered Entity retains all rights to seek injunctive relief to prevent or stop the unauthorized Use or Disclosure of PHI or Confidential Information by Business Associate or any agent, subcontractor, employee or third party that received PHI or Confidential Information, and Business Associate agrees that Covered Entity may seek injunctive relief under this section without any requirement to prove actual monetary damage or post a bond or other security.

i. **Monitoring.** As applicable, Business Associate shall comply with monitoring requirements of Covered Entity's contracts with regulator(s) or any other monitoring requests by Covered Entity's regulator(s).