MEMORANDUM OF UNDERSTANDING BETWEEN GOLD COAST HEALTH PLAN AND THE COUNTY OF VENTURA FOR DATA SHARING ARRANGEMENTS TO PROMOTE CARE DELIVERY AND COORDINATION

This MEMORANDUM OF UNDERSTANDING BETWEEN GOLD COAST HEALTH PLAN AND THE COUNTY OF VENTURA FOR DATA SHARING ARRANGEMENTS TO PROMOTE CARE DELIVERY AND COORDINATION ("MOU-DSA") is made and entered into by and between the County of Ventura ("County"), acting through its Ventura County Health Care Agency and its Ventura County Department of Behavioral Health ("VCBH"), and the Ventura County Medi-Cal Managed Care Commission, dba Gold Coast Health Plan ("GCHP"). Hereinafter, County and GCHP may be referred to individually as a "Party" and collectively as the "Parties."

RECITALS

A. VCBH administers and operates the VCBH Mental Health Plan ("MHP") and a Drug Medi-Cal - Organized Delivery System ("DMC-ODS"), and GCHP operates the Ventura County Managed Care Plan ("MCP").

B. In 2022, the Department of Health Care Services ("DHCS") launched the California Advancing and Innovating Medi-Cal ("CalAIM") initiative to transform Medi-Cal, making the program more equitable, coordinated, and person-centered to help people maximize their health and life trajectory. CalAIM will integrate Medi-Cal enrollees' care coordination and case management across physical health, behavioral health, and local social service providers. CalAIM requires the exchange of a broad range of administrative, clinical, social, and human service information across sectors, which must occur in compliance with federal and state privacy laws, regulations, and other data sharing rules.

C. Under CalAIM, VCBH and GCHP have entered into an AMENDED AND RESTATED MEMORANDUM OF UNDERSTANDING BETWEEN GOLD COAST HEALTH PLAN AND THE COUNTY OF VENTURA FOR SPECIALTY MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES ("Restated MOU") , effective August 5, 2022, to, among other things, (i) define VCBH's responsibilities for providing Specialty Mental Health Services ("SMHS") to Medi-Cal MHP beneficiaries with serious emotional disturbance and serious/persistent mental illness; (ii) GCHP's responsibilities for providing Non-Specialty Mental Health Services ("NSMHS") to Medi-Cal MCP beneficiaries with mild-to-moderate mental, emotional, or behavioral impairment; (iii) set forth VCBH's and GCHP's general process for coordinating Substance Use Disorder ("SUD") treatment services and eating disorder treatment services for Medi-Cal beneficiaries and general commitment to share data; and (iv) memorialize VCBH's and GCHP's commitment to share data in furtherance of the Restated MOU's purpose.

D. Under CalAIM, County and GCHP have entered into a Provider Service Agreement – Enhanced Care Management (the "ECM Agreement") effective January 1, 2022, as amended from time to time, which establishes specific data sharing requirements.

E. Under CalAIM, County and GCHP have entered into a Provider Services Agreement – Community Supports (the "CS Agreement"), effective January 1, 2023, as amended from time to time, which establishes specific data sharing requirements.

F. Under CalAIM, the County participates in the Behavioral Health Quality Improvement Program ("BHQIP"), which is an incentive payment program to support MHPs, Drug Medi-Cal State Plans ("DMC") and DMC-ODS as they prepare to implement changes related to the CalAIM initiative and other priorities.

G. DHCS issues All Plan Letters ("APLs"), Behavioral Health Information Notices ("BHINs"), and other guidance for, among other things, data sharing to implement and administer CalAIM policies and programs.

H. The County and GCHP are signatories to the California Health and Human Services Data Exchange Framework: Single Data Sharing Agreement described at Health and Safety Code section 130290, which requires certain health care entities to exchange health and social services information electronically in real time among health care entities and government agencies. Under Health and Safety Code section 130290(b)(1), those entities listed in Health and Safety Code section 130290(f) are required to exchange health and social services information or provide access to such information to and from every other entity set forth in Health and Safety Code section 130290(f) for treatment, payment, health care operations, or public health activities.

I. The federal Information Blocking Rules at Title 45 of the Code of Federal Regulations ("C.F.R.") Part 171 require health care providers to refrain from practices that are likely to interfere with the access, exchange, or Use of Electronic Health Information (as defined therein) except when the practices are required by law (including the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009, Public Law 111-5, including the regulations promulgated thereunder at 45 C.F.R. Parts 160 and 164 ("HIPAA") and state privacy requirements) or meet an Information Blocking Exception described therein.

J. The Parties desire to satisfy the requirements of the Restated MOU, the ECM Agreement, the BHQIP, and the California Data Exchange Framework and to comply with the requirements of the federal Information Blocking Rules.

Now, therefore, the Parties agree to adhere to the following policies, procedures, and requirements when requesting, Using, and/or Disclosing Member PII or PHI.

I. DEFINITIONS

The following definitions shall apply to this MOU-DSA, including all exhibits thereto:

"Applicable Law" means any federal or state laws governing the privacy, confidentiality, or security of medical, mental health, substance abuse, social services, housing, and/or criminal justice information, records, and other data.

"Authorization" shall mean an authorization that is valid under 45 C.F.R. section 164.508.

"Community Supports" means services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan.

"Consent" means a consent that is valid under 42 C.F.R. Part 2, and complies with the requirements of 42 C.F.R. section 2.31.

"DHCS Guidance" means all APLs, BHINs, and other data sharing guidance issued by DHCS related to the implementation and administration of CalAIM policies and programs, as they may be amended from time to time.

"Disclosure" shall mean "disclose," as defined at 42 C.F.R. section 2.11, and "disclosure," as defined at 45 C.F.R. section 160.103.

"Enhanced Care Management" or "ECM" means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.

"Member" means an eligible beneficiary enrolled with GCHP.

"Minimum Necessary" means (i) when Using or Disclosing PHI or when requesting PHI from another covered entity or business associate, a covered entity or business associate must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the Use, Disclosure, or request, as set forth at 45 C.F.R. section 164.502(b) and (ii) for the Use and Disclosure of any Part 2 Record, any disclosure made under the regulations in 42 C.F.R. Part 2 must be limited to that information which is necessary to carry out the purpose of the disclosure, as set forth at 42 C.F.R. section 2.13(a).

"Non-specialty Mental Health Services" or "NSMHS" means all of the following services that GCHP must provide when they are medically necessary, and are provided by primary care physicians or licensed mental health network providers within their scope of practice: (A) mental health evaluation and treatment, including individuals, group, and family psychotherapy; (B) psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition; (C) outpatient services for the purposes of monitoring drug therapy; (D) psychiatric consultation; and (E) outpatient laboratory, drugs, supplies, and supplements, excluded separately billed psychiatric drugs claimed by outpatient pharmacy providers via Medi-Cal Rx.

"Personally Identifiable Information" or "PII" means any social services, housing, and criminal justice information, records, and other data that is individually identifiable.

"Protected Health Information" or "PHI" means "protected health information" as defined at 45 C.F.R. section 160.103. As used herein, PHI may include Part 2 Records.

"Part 2 Records" means "records" as defined at 42 C.F.R. section 2.11 and subject to Part 2 of Subchapter A of Chapter I of Title 42 of the Code of Federal Regulations.

"Specialty Mental Health Services" or "SMHS" means Medi-Cal covered mental health services provided or arranged by county mental health plans for Medi-Cal beneficiaries in their counties that need medically necessary specialty mental health services.

"Substance Use Disorder" or "SUD" services means a continuum of care modeled after the ASAM Criteria for SUD treatment services provided or arranged by county DMC-ODS plans for Members in their counties that need medically necessary SUD services. "Use" shall mean "use," as defined at 45 C.F.R. section 160.103.

"Universal Release" shall mean a combined Authorization and Consent for Use and Disclosure of PHI, PII, and Part 2 Records for treatment, payment, and health care operations as permitted or required under CalAIM.

II. APPLICABLE PRIVACY LAWS

A. The Parties agree that Members' PII and PHI are subject to the requirements of federal and state confidentiality and privacy laws governing their Use and Disclosure, including HIPAA, Confidentiality of Substance Use Disorder Patient Records statutes and regulations (42 United States Code ("U.S.C") section 290dd-2 et seq., 42 C.F.R. Part 2), Welfare and Institutions Code section 5328 *et seq*., Health and Safety Code sections 11812 and 11845.5, Civil Code section 1798.29, and federal and state laws governing social services, housing, and criminal justice data.

B. The Parties further agree that notwithstanding any other state or local law, including, but not limited to, Welfare and Institutions Code section 5328 and Health and Safety Code sections 11812 and 11845.5, Welfare and Institutions Code section 14184.102(j) expressly permits the sharing of health, social services, housing, and criminal justice information, records, and other data with and among DHCS, other state departments, including the State Department of Public Health and the State Department of Social Services, Medi-Cal managed care plans, Medi-Cal behavioral health delivery systems, counties, health care providers, social services organizations, care coordination and case management teams, and other authorized provider or plan entities, and contractors of all of those entities, to the extent necessary to implement applicable CalAIM components described in Welfare and Institutions Code section 14184.100 et seq., the "CalAIM Terms and Conditions," as defined at Welfare and Institutions Code section 14184.101(c), and to the extent consistent with federal law.

C. The Parties acknowledge that the DHCS CalAIM Data Sharing Guidance issued in March, 2022 states that the waivers set forth under Welfare and Institutions Code section 14184.102 apply to Civil Code section 56 et seq., Health and Safety Code section 120985, Welfare and Institutions Code section 10850, and state and local laws

that may prevent the Disclosure of inmates' release dates and other inmate information relevant to providing services under CalAIM.

D. In the event of any conflict between this MOU-DSA and the Applicable Laws, the rules and requirements of the Applicable Laws shall control the Parties' request, Use, and Disclosure of Members' PHI and Part 2 Records.

III. USE AND DISCLOSURE OF PII AND PHI

A. The Parties will request, Use, and Disclose PII and PHI to carry out their respective roles and responsibilities under CalAIM and only in accordance with Applicable Law.

B. The Parties acknowledge that the use cases set forth in the exhibits to this MOU-DSA represent routine Uses and Disclosures of Member PII and PHI which are consistent with the requirements of DHCS, DHCS Guidance, and Applicable Laws.

C. The Parties agree to collaborate to define routine data sharing required to implement applicable CalAIM components described in Welfare and Institutions Code section 14184.100 et seq. and future GCHP population health assessment and quality initiatives.

D. The Parties agree to collaborate to develop real-time methods for data exchange, including via SSH File Transfer Protocol ("SFTP"), Application Program Interfaces ("API"), or a health information exchange.

IV. MISCELLANEOUS PROVISIONS

A. Term and Termination.

1. This MOU-DSA is effective as of July 1, 2023 and shall automatically renew each fiscal year thereafter, unless terminated in writing by either Party in accordance with the provisions of this MOU-DSA.

2. This MOU-DSA, and any subsequent amendment to this MOU-DSA, shall become effective only upon the written approval by the Parties, and, if required, the written approval of DHCS. If DHCS requires revisions to this MOU-DSA, or any amendment thereto, the Parties agree to use best efforts to negotiate an amendment to this MOU-DSA to incorporate any revisions and/or comments as of any effective date that may be required by DHCS. Notwithstanding the foregoing, any mandatory revisions required by DHCS Guidance shall be incorporated into this MOU-DSA by reference without further action if the Parties fail to agree on an amendment.

3. In the event of an alleged breach of any material provision of this MOU-DSA, the Party claiming the breach will give the other Party written notice of such default or breach, setting forth the facts underlying its claim that the other Party has breached the MOU-DSA. The Party receiving the notice shall have thirty (30) days from the date of receipt of such notice to remedy or cure the alleged breach to the

satisfaction of the other Party. During this thirty (30) day period, the Parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the alleged breach. If the Party receiving the notice has not remedied or cured the breach within such thirty (30) day period, the Party that provided the notice of termination shall have the right to immediately terminate this MOU-DSA and may terminate any agreement or MOU for which compliance with this MOU-DSA is necessary to meet the obligations of either Party.

4. This MOU-DSA may be terminated without cause for convenience by either Party upon at least ninety (90) days' notice to the other Party. In addition, data sharing pursuant to an exhibit to this MOU-DSA may be separately suspended or terminated in accordance with the provisions of the applicable exhibit. Termination or suspension of data sharing pursuant to an exhibit shall not affect other data sharing pursuant to this MOU-DSA, which shall continue under the terms of the MOU-DSA and the applicable exhibit(s).

5. Upon any termination of this MOU-DSA or any exhibit attached hereto, no Party shall have any further obligations under this MOU-DSA or the exhibit terminated, as the case may be.

B. Compliance. The Parties shall comply with all applicable federal, state, and local laws respecting the conduct of their respective businesses and professions. In addition, the Parties shall remain in compliance with all applicable state and federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse including, but not limited to, applicable provisions of the federal and state civil and criminal law, the program integrity requirements of 42 C.F.R. section 438.608, the federal False Claims Act (31 U.S.C. section 3729 et seq.), federal requirements for employee education about false claims recovery (42 U.S.C. section 1396a(a)(68)), the California False Claims Act (Government Code section 12650 et seq.), and the Anti-Kickback Statute (42 U.S.C. section 1320a-7b).

Nothing in this MOU-DSA is intended or shall be construed to require either Party to violate the state or federal laws described in this MOU-DSA, and this MOU-DSA shall not be interpreted to: (i) require County to generate business for GCHP; or (ii) require GCHP to provide for payments in excess of the fair market value or comparable compensation paid for similar services in comparable locations and circumstances.

C. Amendment. This MOU-DSA may be amended at any time upon written agreement of the Parties. No obligation under this MOU-DSA or an attachment hereto shall be waived by any Party except by an instrument in writing in the form of an Amendment.

D. Entire Agreement. This MOU-DSA and any amendments shall constitute the entire agreement between the Parties respecting the subject matter hereof. No oral representations shall be binding on either Party unless such representations are reduced to writing and made an amendment to this MOU-DSA.

E. Governing Law. The laws of the State of California, the laws of the United States of America, and the contractual obligations of the Parties will govern the validity, construction, interpretation, and enforcement of this MOU-DSA. In the event of a conflict between this MOU-DSA and any agreement of either Party with the State of California, including but not limited to DHCS, the covenants, terms, and conditions of any agreement with the State of California shall govern and the Party's performance thereunder shall not be a default or breach of this MOU-DSA.

F. Signature. The Parties agree that this MOU-DSA may be transmitted and signed by electronic or digital means by either/any or both/all parties and that such signatures shall have the same force and effect as original signatures, in accordance with Government Code section 16.5 and Civil Code section 1633.7.

IN WITNESS WHEREOF, the Parties have executed this MOU-DSA through their duly authorized representatives as of the last date written below.

COUNTY OF VENTURA	VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (dba GOLD COAST HEALTH PLAN)
By: Name: Title: Date:	By: Name: Title: Date:
	By: Name: Title: Date:

Exhibit A
Data Sharing for Enhanced Care Management/Community Supports

I. DHCS AND GCHP CONTRACT REQUIREMENTS.

A. DHCS Required Contract Provisions for ECM and CS Providers.

The DHCS contract with GCHP to plan and provide for services to Medi-Cal beneficiaries (the "Medi-Cal Agreement") requires that GCHP must develop policies and procedures to ensure that Members authorize information sharing with GCHP and all others involved in the Member's care as needed to support the Member and maximize the benefits of ECM and CS. The Medi-Cal Agreement also requires that GCHP network providers, including County, communicate any Authorization or Consent required by federal law to allow data sharing (once obtained) back to GCHP.

B. Data Sharing Obligations Under the ECM Agreement.

Attachment C, Article III – Data Sharing, Documentation, and Reporting defines the obligations of the Parties under the ECM Agreement. The pertinent provisions are set forth below.

1. *GCHP Obligations*.

Attachment C, Article III, Section 3.1 of the ECM Agreement requires GCHP to provide to the County the following data at the time of assignment and periodically thereafter, and following DHCS Guidance for data sharing where applicable: (a) Member Information Files, defined as a list of Medi-Cal Members authorized for Enhanced Care Management and assigned to County; (b) encounter and/or claims data; (c) physical, behavioral, administrative, and social determinants of health data for all assigned Members; and (d) reports of performance on quality measures and/or metrics, as requested.

2. *County Obligations*.

a. Care Management System. Attachment C, Article III, Section 3.2 of the ECM Agreement requires County to use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of a care plan for a participant in ECM ("Participant") that can be shared with other providers and organizations involved in each Participant's care.

b. Member Information File Transmission. Attachment C, Article III, Section 3.4 of the ECM Agreement requires County to follow the communication processes established by GCHP for the transmission of the Member Information File (as defined in the ECM Agreement), including acknowledgement of receipt of Member Information File, communicating or updating Member Information File, information and reconciling identified errors or other inaccurate or outdated information. County shall

communicate new and updated Member information back to GCHP in a Member Information File Return Transmission (as defined in the ECM Agreement) in accordance with DHCS Guidance.

c. Consent Management. Attachment C, Article III, Section 3.5 of the ECM Agreement requires County to obtain, document, and manage Participant Authorization or Consent for the sharing of PII and PHI between GCHP and ECM and other providers involved in the provision of Participant care, to the extent that Authorization or Consent is required by federal law. Participant Authorization or Consent for ECM-related data sharing is not required for the County ECM provider to initiate delivery of ECM unless such Authorization or Consent is required by federal law. County shall provide GCHP timely access to Participant Consent forms.

d. GCHP Data and Information Requests. Attachment C, Article III, Section 3.6 of the ECM Agreement requires County to share requested data and information with GCHP in a mutually agreed upon format and timeframe that is consistent with GCHP protocols or provide a valid justification if request cannot be met within this timeframe.

e. Encounter Data Submission. Attachment C, Article III, Section 3.7 of the ECM Agreement requires County to submit complete and accurate encounter data as requested by GCHP in a timely manner and in accordance with GCHP processes and format to satisfy DHCS requirements using national standard specifications and code sets.

f. Documentation of Social Determinants of Health Diagnoses. Attachment C, Article III, Section 3.8 of the ECM Agreement requires County to screen, document, and report DHCS Priority Social Determinants of Health ICD-10-CM codes for Participants in accordance with GCHP encounter coding and billing guidance.

g. Reporting. Attachment C, Article III, Section 3.9 of the ECM Agreement requires County to report data on Enhanced Care Management Services, quality measures, and outcomes to GCHP, as per DHCS ECM reporting requirements, and as requested by GCHP, at regular intervals. GCHP will work with County to determine which specific data County will be responsible for reporting, depending on services provided and access to data sources.

3. *GCHP and County Collaborative Efforts*.

Attachment C, Article III, Section 3.3 of the ECM Agreement requires GCHP and County to collaborate to facilitate implementation of a health information exchange to share relevant information about Participants with other entities providing services to the Participant as needed for effective care coordination and reporting and subject to state and federal laws regarding confidentiality of health information.

C. <u>Other Obligations Under the ECM Agreement</u>.

1. Records, Audits and Inspections. ECM Information maintained by County

pursuant to this Exhibit A hall be subject to audit and inspection pursuant to Sections 2.6(e) and 2.7 of the ECM Agreement.

2. Dispute Resolution. Disputes arising under this Exhibit A relating to the Parties' obligations under the ECM Agreement will be subject to the provider grievances and disputes procedure described in Article 6 of the ECM Agreement.

3. Liability and Indemnity. Section 7.1 of the ECM Agreement shall apply to all liabilities, losses, damages, claims, and expenses of any kind arising from the acts or omissions of the indemnifying Party under this Exhibit A.

4. Notices. All notices required or permitted to be given under this Exhibit A relating to the ECM Agreement shall be delivered in accordance with Section 7.24 of the ECM Agreement.

5. Oversight. GCHP may utilize a corrective action plan, or other mutually agreed upon or DHCS required mechanism, to facilitate County's compliance with the terms of the ECM Agreement.

D. Data Sharing Obligations Under the CS Agreement.

Attachment C, Article III – Data Sharing, Documentation, and Reporting defines the obligations of the Parties under the CS Agreement. The pertinent provisions are set forth below.

1. *GCHP Obligations.*

Attachment C, Article III, Section 3.1 of the CS Agreement requires GCHP to provide to the County the following data at the time of assignment and periodically thereafter, and in accordance with DHCS Guidance for data sharing where applicable: (a) Member Information Files, defined as a list of Medi-Cal Members authorized for Community Supports and assigned to the County; (b) encounter and/or claims data; (c) physical, behavioral, administrative and social determinants of health data for all assigned Members; (d) reports of performance on quality measures and/or metrics, as requested, and (e) any billing information necessary to support the County's ability to submit invoices or claims to GCHP.

2. *County Obligations.*

a. Member Information File Transmission. Attachment C, Article III, Section 3.4 of the CS Agreement requires County to follow the communication processes established by GCHP for the transmission of the Member Information File (as defined in the CS Agreement), including acknowledgement of receipt of Member Information File, communicating or updating Member Information File, information and reconciling identified errors or other inaccurate or outdated information. County shall communicate new and updated Member information back to GCHP in a Member Information File Return Transmission (as defined in the CS Agreement) in accordance with DHCS Guidance.

b. GCHP Data and Information Requests. Attachment C, Article III, Section 3.5 of the CS Agreement requires County to share requested data and information with GCHP in a mutually agreed upon format and timeframe that is consistent with GCHP protocols or provide a valid justification if request cannot be met within this timeframe.

c. Consent Management. Attachment C, Article III, Section 3.6 of the CS Agreement requires County to obtain, document, and manage Recipient authorization for the sharing of PII between GCHP and ECM providers, CS providers, and other providers involved in the provision of Recipient care to the extent required by federal law. Recipient authorization for CS-related data sharing is not required for the County CS provider to initiate delivery of CS unless such authorization is required by federal law. County shall provide GCHP timely access to CS authorization forms.

d. Homeless Management Information System Documentation ("HMIS"). Attachment C, Article III, Section 3.7 of the CS Agreement requires County to document housing status information and housing services for CS Recipients Experiencing Homelessness in the HMIS administered by the Ventura County Continuum of Care when applicable.

e. Encounter Data Submission. Attachment C, Article III, Section 3.8 of the CS Agreement requires County to submit complete and accurate encounter data as requested by GCHP in a timely manner and in accordance with GCHP processes and format to satisfy DHCS requirements using national standard specifications and code sets.

f. Documentation of Social Determinants of Health Diagnoses. Attachment C, Article III, Section 3.9 of the CS Agreement requires County to screen, document, and report DHCS Priority Social Determinants of Health ICD-10-CM codes for CS Recipients in accordance with GCHP encounter coding and billing guidance.

g. Reporting. Attachment C, Article III, Section 3.10 of the CS Agreement requires County to report data on CS, quality measures, and outcomes to GCHP, as per DHCS CS reporting requirements, and as requested by GCHP, at regular intervals. GCHP will work with County to determine which specific data County will be responsible for reporting, depending on services provided and access to data sources.

3. *GCHP and County Collaborative Efforts*

Attachment C, Article III, Section 3.3 of the CS Agreement requires GCHP and County to share relevant Recipient information with other entities providing services to the Recipient as needed for effective care coordination and reporting and subject to State and federal laws regarding confidentiality of health information.

E. Other Obligations Under the CS Agreement.

1. Records Audits and Inspections. CS Information maintained by County pursuant to this Exhibit A shall be subject to audit and inspection pursuant to Sections

2.6(e) and 2.7 of the CS Agreement.

2. Dispute Resolution. Disputes arising under this Exhibit A relating to the Parties' obligations under the CS Agreement will be subject to the provider grievances and disputes procedure described in Article 6 of the CS Agreement.

3. Liability and Indemnity. Section 7.1 of the CS Agreement shall apply to all liabilities, losses, damages, claims, and expenses of any kind arising from the acts or omissions of the indemnifying Party under this Exhibit A. Notices. All notices required or permitted to be given under this Exhibit A relating to the CS Agreement shall be delivered in accordance with Section 7.25 of the CS Agreement.

4. Oversight. GCHP may utilize a corrective action plan, or other mutually agreed upon or DHCS required mechanism, to facilitate County's compliance with the terms of the CS Agreement.

F. Term and Termination. Unless earlier terminated in accordance with the terms of this Exhibit A, this Exhibit A shall remain in effect during the term of the ECM Agreement and CS Agreement, and shall be terminated upon termination or expiration of the ECM Agreement and CS Agreement.

1. Either Party may terminate this Exhibit A without cause by giving the other Party thirty (30) days' written notice of its intent to terminate. Upon any such termination, the ECM Agreement and CS Agreement shall remain in effect. If compliance with the terms of this MOU-DSA is a mandatory requirement of the ECM or CS Agreement, then termination of the MOU-DSA shall constitute a breach of the ECM or CS Agreement, as applicable, and may be grounds for termination of such agreement.

2. Notwithstanding the foregoing, sharing of data pursuant to this Exhibit A may be suspended or terminated immediately by either Party if continued sharing of data would result in unauthorized Use or Disclosure of PHI or PII, a material violation of Applicable Law, or otherwise jeopardize the privacy and/or security of Member information.

II. DATA SHARING USE CASES FOR ECM.

Use Cases	Description	Data Flow Between County and GCHP
1. ECM Enrollee identification, review, and Authorization for ECM and Community Supports	GCHP identifies ECM populations by compiling and analyzing administrative, physical, behavioral, dental and social service data and	County sends records with Enrollee information to GCHP

	information received from DHCS, counties, Providers, Enrollee, and others.	
2. ECM assignment and Enrollee engagement	GCHP assigns Enrollees to County based on their previous provider relationships, health needs, and known preferences, and County uses available information to reach out to and engage with Enrollees qualifying for the ECM benefit.	GCHP sends assignment files to County County reports Enrollee engagement activity back to GCHP
3. Care coordination and referral management	County supports care coordination and care transitions for engaged Enrollees, including supporting referrals across GCHP's community, county, social services and Community Supports Provider networks.	GCHP access and reviews coordination activities and referrals.
4. Billing and encounter reporting practices	County submits claims/invoices to GCHP for services rendered, and GCHP reports complete and accurate encounters of all services provided to DHCS.	County sends claims to GCHP
5. GCHP coordination of behavioral health services	GCHP is responsible for coordinating mental health services with County Mental Health Plans and SUD services with County Drug Medi-Cal / Drug Medi-Cal Organization Delivery System (DMC / DMC-ODS)	GCHP sends referral to County County notifies GCHP of the services provided

III. DATA SHARING POLICIES, PROCEDURES, AND OBLIGATIONS FOR IMPLEMENTATION OF THE ECM AGREEMENT.

To fulfill the contractual requirements set forth above in accordance with DHCS Guidance, County shall implement the following:

A. Care Management System. County shall provide direct access to HealtheCare through Cerner for all GCHP ECM case managers and coordinators for care coordination and referral management.

B. Consent Management.

1. To the extent that Authorization/Consent is required by Applicable Law to Disclose PHI or PII to GCHP or DHCS, County shall implement a Universal Release or other Authorization/Consent form to allow sharing of PII and PHI on or before the County's first encounter with a patient that is a GCHP Member for the ECM use cases set forth in Part II of this Exhibit A.

2. County shall allow GCHP access to Authorization and/or Consent forms for assigned Members and will use its reasonable best efforts to respond to GCHP requests for Member Authorization/Consent forms within twenty four (24) hours.

3. In the event that Applicable Law, including those waivers of state law restrictions for CalAIM purposes, permit Disclosure of PII or PHI without Authorization/Consent, neither Party shall withhold PII or PHI where the Disclosure or exchange or such information would fall within the use cases set forth in Part II of this Exhibit A.

C. GCHP Data and Information Requests.

1. GCHP may request Minimum Necessary information from County, as needed. Such request shall include information on the purpose of the request, the required data elements, and the date by which the PII or PHI is needed, the frequency of the data exchange (if ongoing), the method of the data exchange, and with whom such data will be shared. County shall submit PHI and PII on Participants with GCHP for services received if requested by GCHP in electronic format (i.e., CSV or HL7 format) within the time frame requested by GCHP or shall provide a written response regarding why such request cannot be met within five (5) business days of receipt of the request. Such data may include, but is not limited to the following types of information:

Data Type	ECM Providers
Assigned Members	S
Available social needs data	R/S
Claims and encounter data, including FFS data (and All Plan Data Feed)	R

Disengaged member reports (e.g. assigned members who have not utilized any services; are missing immunizations)	R/S
Electronic health records	R
Enrollment/Eligibility Information	S
For members under 21 years of age, information on developmental and adverse childhood experiences (ACEs) screenings	R/S
Housing data	R/S
Immunizations	R
Member Contact Information	R/S
Lab results data	R/S
Pharmacy data	R/S
Race/ethnicity data	R/S
Referral data	R/S
Screening or assessment data	R/S
Sexual orientation and gender identity data	R/S
Utilization data	R/S

R = GCHP Receives
S = GCHP Sends
R/S = Receive and Send

D. Encounter Data Submission.

County shall submit ECM and CS encounter and claims data, including FFS data (and All Plan Data Feed) on services received by Participants in accordance with GCHP Policies *EDM-001, Encounter Data Processing Policy and Procedure and EDM-002, GCHP Encounter Data Processing Policy*, all in accordance with *ECM-006, Data Sharing with ECM and CS Providers* (See Attachment A-1). The ECM and Community Supports encounter data submissions shall follow the DHCS CalAIM Data Guidance: Billing and Invoicing between ECM/Community Support Providers and MCPs.

E. Reporting.

a. The following files will be exchanged between County and GCHP via SSH File Transfer Protocol ("SFTP"), through an API, or via another method mutually agreed by the Parties on the ECM services furnished, quality measures, and outcomes in accordance with DHCS CalAIM Guidance: Member-Level Information Sharing Between MCPs and ECM Providers and DHCS CalAIM Data Guidance: Community Supports Member Information Sharing Guidance in the following frequency:

i. Potential ECM Member Referral File (optional) – County will transmit to GCHP by the 1st of each month or the following business day.
ii. ECM Provider Initial Outreach Tracker File – County will transmit to GCHP by the 10th of each month or the following business day.
iii. ECM Provider Return Transmission File – County will transmit to GCHP by the 10th of each month or the following business day.
iv. MCP Community Supports Authorization Status File – GCHP will transmit to County by the 1st of each month or the following business day.
v. Community Supports Provider Return Transmission File – County will transmit to GCHP by the 10th of each month or the following business day.
vi. MCP Member Information File - GCHP will transmit to County by the 1st of each month or the following business day beginning September 1, 2023.

b. County shall submit accurate ECM and Community Supports data in accordance with DHCS ECM and Community Supports Quarterly Implementation Monitoring Report Requirements. Each submission shall be made via SFTP or another method mutually agreed by the Parties thirty (30) days in advance of the last day of each quarter. All submission shall be in accordance with the ECM-CS Quarterly Reporting Template, which is attached as Attachment A-2. GCHP shall pre-populate Member Information; County shall populate any remaining data fields.

c. GCHP shall notify County of any outstanding issues regarding data submission or accuracy or completeness of submitted data no later than ten (10) days after receipt from County of the ECM and Community Supports data. Any data for which timely notice is not provided shall be deemed accepted by GCHP. County shall use its

reasonable best efforts to resolve any outstanding issues regarding data submission or accuracy or completeness of submitted data by the fifth (5^{th}) of the month prior to the quarterly submission.

ATTACHMENT A-1
ENCOUNTER DATA SUBMISSION POLICIES
ENHANCED CARE MANAGEMENT, COMMUNITY SUPPORT DATA SHARING

POLICY AND PROCEDURE	
TITLE: Encounter Data Processing Policy and Procedure	
DEPARTMENT: Information Technology	**POLICY #:** EDM-001
EFFECTIVE DATE: 10/01/2021	**REVIEW/REVISION DATE:** 10/21
COMMITTEE APPROVAL DATE: 10/12/21	**RETIRE DATE:** N/A
PRODUCT TYPE: Medi-Cal	**REPLACES:** N/A
	CEO SIGNATURE: Robert Franco for CEO

I. Purpose

A. Encounter Data reporting is a shared obligation of Gold Coast Health Plan (GCHP) and contracted Providers. Centers for Medicare and Medicaid Services (CMS)/California Department of Health Care Services (DHCS) has mandated encounter data report formats and reporting timelines with which GCHP is required to comply. GCHP, in turn, contractually requires Providers to provide encounter data based on GCHP's regulatory obligations. GCHP has streamlined reporting requirements, to the extent possible, and implemented electronic methodologies for Providers to transfer encounter data as securely, economically, and efficiently as possible.

II. Policy

A. In accordance with GCHP companion guides, GCHP requires Delegated Providers (also referred to as Submitters and/or Trading Partners) to submit encounter data within ninety (90) days from the date of service. Encounter data must be submitted for all covered services provided to assigned Members. Covered services include primary care provider (PCP) visits as well as sub capitated services, regardless of place of service, type of service, or method of reimbursement to the Provider of Services. The attached Companion Guides describe specific data element and format requirements for submission of encounter data to GCHP.

B. When submitting encounter data, GCHP requires Submitters to send HIPAA Compliant 837I & 837P Version 5010 files: in accordance with the most current HIPPA 837P & 837I Implementation Guides.
C. GCHP Companion Guides must be used in conjunction with the HIPAA X12N 837 Institutional and Professional Standards for electronic data Interchange.
D. Encounter Data Records are identified by a unique Claim Control Number (CCN) assigned by the submitter, agreed upon by the plan.
E. Upon receipt of an encounter data file, GCHP will generate a (999) Functional Acknowledgement response file and (277CA) - Claims Acknowledgement Report which are returned to the submitter via their assigned SFTP file folder.
F. All accepted encounters will be forward to GCHP's regulatory bodies (i.e., DHCS) based on the Member's line of business for the date of service that was rendered. Each Submitter will be directed to a GCHP proprietary and secure system (i.e.. unique SFTP file, Core System) to access their unique assigned response reports. All Rejected encounters must be corrected and resubmitted within 15 days or notification.

III. Definitions

Centers for Medicare & Medicaid Services (CMS): is part of the Department of Health and Human Services (HHS).

Department of Health Care Services (DHCS): The single State Department responsible for administration of the Federal Medicaid (referred to as Medi-Cal in California) Program, and other health related programs.

EDI 837i (Institutional) & 837p (Professional): The standard format used by institutional providers to transmit health care claims electronically.

EDI (Electronic Data Interchange) Team: GCHP business unit responsible for this specific area of work within the Plan.

Delegated Provider: A provider by which GCHP gives the authority and responsibility to perform certain functions on its behalf through a contractual arrangement. Also known as Trading Partners or Submitters.

IV. Procedure

A. Method of File Transmission
B. All Encounter data files must be submitted to GCHP PGP encrypted and placed in the assigned Secure File Transfer Protocol (SFTP) folder. If the Submitter experiences difficulties accessing GCHP's SFTP server, the

Submitter is to contact the GCHP EDI Team via email at EDI_CLAIMS_ENCOUNTERS@goldchp.org. If the server is down, please contact the GCHP Provider Help Desk at (888) 301-1228.

C. Professional/Institutional Inbound File Naming Convention

1. Example (07090486_152792.P86.output)
    a. Two digit month.
    b. Two digit day
    c. Four digit Batch ID
    d. Trading partner ID (Submitted ID)
    e. File Type
    f. File extension name

D. Response Report Transmission

E. GCHP places all response reports on the SFTP server in the RESPONSE_PROD folder in the Submitter's folder, (Example: /XXX/5010/Encounters/RESPONSE_PROD/). The 'All Response Report' will be placed in the Submitters response folder within three (3) working days from the receipt date, provided the files conform to GCHP naming conventions and procedures. It is the Submitter's responsibility to check their assigned SFTP folder for any response reports within three (3) working days from file submission. The submitter will receive the response file in their assigned SFTP folder file. If a Response report is not received within three (3) working days from submission date, the Submitter may email the EDI Team at EDI_CLAIM_ENCOUNTERS@goldchp.org. The GCHP EDI team will respond to incoming messages within 48 hours.

F. GCHP Inbound Encounter Submission Response Files

1. TA1 Acknowledgment Report
    a. All submitters will receive this report at the time of submission.

2. 999 Acknowledgment Report
    a. A 999 Acknowledgement Report is generated for every file submission and is used to inform submitters of the processing status of the functional group and transaction sets included in the file.

3. 277CA Acknowledgment Report
    a. A 277CA Acknowledgement Report provides the status of each encounter records as either accepted or rejected due to GCHP encounter data processing edits.

4. GCHP Response File Naming Convention Examples
5. The TA1, 999, 277CA response reports will be produced for every inbound 837

G. Encounter file where applicable and will have the same file name as the inbound encounter file except for the extension (i.e., TA1, 999, 277CA) according to the version. There will also be a corresponding outbound DHCS EVR (XML) response file provided where applicable. These response reports communicate the final processing status for inbound encounters accepted by GCHP and then forwarded on to the appropriate Regulatory Body based on the line of business.

H. Inbound Response File Naming Convention Example If the inbound encounter filename was “06070734_154554.P85”, then the response file created for this submission will be named “06070734_154554.P85.837.999”.

1. Item # File Naming Convention Examples Description
2. 1 <Inbound File Name>.837.TA1 GCHP TA1 Response
3. 2 <Inbound File Name>.837.999 GCHP 999 Response
4. 3 <Inbound File Name>.837.277 GCHP 277 Response

I. Outbound Regulatory Agency Response File Naming Convention Example: The Trading Partner outbound regulatory response filename will consist of the following:

1. Example (GCHP-INT-O_515_837I_MCE_20191218_00303.dat)
   b. GCHP
   c. INT or EXT (Internal or External – Delegated Entities)
   d. File status
      i. O – Original
      ii. R- Replacement
      iii. V – Void
   e. Three-digit DHCS ID for GCHP
   f. FILE TYPE
   g. MCE – MediCal Encounter
   h. Submission Date
   i. File iteration
   j. File Extension

2. If you have any questions, please contact the GCHP EDI Team at EDI_CLAIMS_ENCOUNTERS@goldchp.org.

J. Questions and Answers

1. Q: How is Accuracy determined?
    a. A: Data is accurate when it correctly depicts the real-world events and entities that it purports to represent. The medical records of the Medi-Cal beneficiaries will be the standard against which encounter data will be measured. Inaccurate data is of limited value for analysis and reporting since analytic results will not represent reality. Accuracy is determined by calculating the number of unique Claim Control Number (CCN) submitted in the file minus the number of errors. The number of valid CCNs is divided by the result. The accumulation of all encounter data records submitted with the same file name must be at least 95% accurate in order to meet GCHP validity standards. Note: Validity reports will be placed in assigned Secure File Transfer Protocol (SFTP) folder on a quarterly basis.

2. Q: What is an encounter file?
    a. A: On the submissions, an encounter file reflects all medical claims and capitated services submitted to GCHP in an ANSI 5010 format (837p/837i).

3. Q: Are Submitters required to submit all data with the exception of claims routed incorrectly and denied for a member not being on file?
    a. A: All Submitters must submit all encounter data for medical claims and capitated encounters that have been paid or finalized from all types of services to GCHP for the collection of Encounter Data.

4. Q: Will the National Provider Identification (NPI) number be required for claims submission?
    a. A: Yes, NPI will be required for Billing, Rendering, and Attending providers.

5. Q: What does adjudication mean?
    a. A: Adjudicated claims are those that have been finalized as paid, denied, or capitated.

6. Q: Are Submitters required to submit encounter data weekly or monthly?

a. A: Currently, Submitters are required to submit encounter data monthly. However, GCHP strongly recommends that delegated providers and trading partners/submitters submit more frequently.

7. Q: For replacement submissions, how will Submitters reference the original encounter?
   a. A: For the encounters submitted with frequency code “7” in CLM05-3 (replacement/correction), the original claim ID must be placed in REF*F8 segment.

8. Q: For void submissions, how will Submitters reference the original encounter?
   a. A: For the encounters submitted with frequency code “8” in CLM05-3 (void). the original claim ID must be placed in REF*F8 segment.

V. Attachments

A. N/A

VI. References

A. N/A

VII. Revision History

STATUS	DATE REVISED	REVIEW DATE	REVISION SUMMARY
	10/01/2021		James Sproule
Approved	10/12/2021		PRC
		12/01/2021	Margaret Tatar, CEO

Gold Coast Health Plan Approval: Signatures on File in C360

POLICY AND PROCEDURE	
TITLE: GCHP ENCOUNTER DATA REPORTING POLICY	
DEPARTMENT: Information Technology	**POLICY #:** EDM-002
EFFECTIVE DATE: 10/01/2021	**REVIEW/REVISION DATE:** 10/21
COMMITTEE APPROVAL DATE: 10/12/21	**RETIRE DATE:** N/A
PRODUCT TYPE: Medi-Cal	**REPLACES:** N/A
	CEO SIGNATURE: Robert Franco for CEO

I. Purpose

A. Encounter Data Submission Requirements for Medical Fee for Service Providers

1. Trading Partners are required to submit this data to enable GCHP to comply with regulatory requirements, accurately capture data for various medical programs, and help improve medical and financial performance.
2. This policy applies to all GCHP (Gold Coast Health Plan) Delegated Providers (also referred to as Submitters and/or Trading Partners).

B. Encounter Data Submission Requirements for Directly Contracted Capitated Providers

1. Directly contracted Capitated Providers are required to submit this data to enable GCHP to comply with regulatory requirements, accurately capture data for various medical programs and help improve medical and financial performance.

II. Policy

A. Encounter Data Submission Requirements for Medical Fee for Service Providers

2. GCHP ensures complete, accurate, and timely submissions of encounter data to DHCS for all items and services furnished to its Members, whether directly or through its Trading Partners, including capitated Providers.
3. On an annual basis, GCHP re-evaluates the Completeness and Accuracy standards based on state regulatory changes, results of the Healthcare Effectiveness Data and Information Set (HEDIS®) audit and historical encounter data experience.
4. GCHP is responsible for monitoring and picking up all response files in a timely manner.

B. Encounter Data Submission Requirements for Directly Contracted Capitated Providers

1. GCHP ensures complete, accurate, reasonable, and timely submission of encounter data to Department of Health Care Services (DHCS) for all items and services furnished by directly contracted Capitated Providers to its Members.
2. This policy applies to all GCHP Medi-Cal directly contracted Capitated Providers.

III. Definitions

Department of Health Care Services(DHCS): The single State Department responsible for administration of the Federal Medicaid (referred to as Medi-Cal in California) Program, and other health related programs.

DHCS All Plan Letter (APL): The means by which the DHCS Medi-Cal Managed Care conveys information or interpretation of changes in policy or procedure at the Federal or State levels, and provides instruction to contractors, if applicable on how to implement these changes on an operational basis.

Centers for Medicare & Medicaid Services (CMS), is part of the Department of Health and Human Services (HHS).

EDI 837i (Institutional) & 837p (Professional): The standard format used by institutional providers to transmit health care claims electronically.

GCHP Department: EDI (Electronic Data Interchange) Team - GCHP business unit responsible for this specific area of work within the Plan.

Delegated Provider: A provider by which GCHP gives the authority and responsibility to perform certain functions on its behalf through a contractual arrangement. Also known as Trading Partners or Submitters.

IV. Procedure (Encounter Data Submission Requirements for Medical Fee for Service Providers)

A. GCHP must conform with the Department of Health Care Services (DHCS) Quality Measures for Encounter Data. Additional information can be found at: http://www.dhcs.ca.gov/dataandstats/Pages/QualityMeasurementAndReporting.aspx
B. Trading Partners must submit, via Secure File Transfer Protocol (SFTP), the appropriate encounter information in the Health Insurance Portability and Accountability Act (HTRADING PARTNERA) Compliant 837 Version 5010 transaction set format (ASC X12 Health Care Claim Type 3 Technical Report (TR3)), referred to as the Implementation Guide (IG)).
C. Encounter and utilization data must be submitted to GCHP within three (3) months after the month in which services are rendered to a Member, unless otherwise stipulated in the provider contract.

3. Department of Health Care Services (DHCS)-GCHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 3, Provision 2, Encounter Data Reporting
4. DHCS All Plan Letter (APL) 17-004, “Sub-contractual Relationships and Delegation”
5. DHCS-GCHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 3, Provision 2, Encounter Data Reporting
6. DHCS APL 14-019 Supersedes APL 13-006, “Encounter Data Submission Requirements”
7. DHCS APL 14-020, “Quality Measures for Encounter Data,” Quality Measures for Encounter Data (QMED) Version 1.1

D. Trading Partners must submit data for all covered services provided to a member, including Primary Care Provider (PCP) visits and delegated services.
E. Each month, the encounter data submitted to GCHP must meet three (3) requirements as set forth by GCHP: **Completeness, Accuracy, and Timeliness**. Each month is reviewed on an aggregate basis.

1. Completeness - Data is complete when:

a. All real-world events (in this case, an encounter between a Medi-Cal beneficiary and a managed care provider) are represented in the data
b. Only real-world events are represented in the data The first part addresses missing data; the second part addresses surplus or duplicate data.
c. For example, when health care services are provided but the encounter data is not successfully submitted to DHCS, data is incomplete, and analysis of that data is untrustworthy. When duplicate data is submitted, it also undermines the credibility of analyses based on that data. When the data is incomplete, it reduces the confidence that can be placed in analysis and reporting based on that data.

2. Accuracy:
   a. Data is accurate when it correctly depicts the real-world events and entities that it purports to represent. The medical records of the Medi-Cal beneficiaries will be the standard against which encounter data will be measured. Inaccurate data is of limited value for analysis and reporting, since analytic results will not represent reality.

3. Timeliness:
   a. Data is timely when the span of time between the occurrence of a real-world event and its appearance in the data is short enough that the occurrence can be included in data analysis and reports. In this case, the date the real-world event occurred is the Date of Service (DOS) of the encounter, and the date when the event is considered part of the data is the Submission Date to DHCS. The number of calendar days between those dates is the “lagtime”. Data completeness and data timeliness are closely related, but not identical. If the average lagtime is excessive, even if data completeness is eventually achieved, it becomes difficult to use the data for timely analysis and reporting.

F. Within three (3) business days of receipt of the encounter data file, GCHP processes the data and places error reports that summarize the data received and rejected due to errors on the SFTP portal in the Trading Partners specified file location. Please Reference – “GCHP Encounter Data Processing Procedure Policy”

G. GCHP utilizes the “Official ICD-10-CM Guidelines for Coding and Reporting” as part of the validation process.
H. Age and gender rules for Current Procedural Terminology (CPT) codes will be enforced.
I. For all TRADING PARTNER medical encounters, the Individual (‘person type’) National Provider Identifier (NPI) is required to be submitted as Provider ID for Billing, Rendering and Attending Provider. According to ASC X12 837 Implementation Guides the exceptions are limited to the atypical providers. Examples: taxi drivers, carpenters, personal care providers, etc.
J. For all hospital encounters, the Individual (‘person type’) NPI must be submitted as the “Attending Provider ID.”
K. It is the responsibility of the TRADING PARTNER to retrieve the error reports; then correct and resubmit the encounter data rejected due to errors within the specified timeframe. All encounters that are rejected MUST be resubmitted, regardless of whether or not the threshold has been met.
L. GCHP works with each TRADING PARTNER to ensure that any problem areas can be corrected in a timely manner. For assistance in working through the details of encounter submission, e-mail the GCHP Encounter Team at EDI_CLAIMS_ENCOUNTERS@goldchp.org.
M. At the request of GCHP, the TRADING PARTNER will need to provide primary source verification data upon request to support encounter data validation activities.
N. For a comprehensive outline of the SFTP, Encounter Data error reports, etc., please refer to the EDI Manual.
O. The responsibility for Encounter Data reporting, as outlined above, continues until all services rendered during the timeframe of a Capitated Agreement have been reported.
P. * Per Member Per Month (PMPM) = encounters / member months
Q. * Accuracy standards based on state regulatory guidelines, HEDIS® audit results and
R. historical encounter data experience

V. Procedure (Encounter Data Submission Requirements for Directly Contracted Capitated Providers)

A. GCHP must conform with the Department of Health Care Services (DHCS) Quality Measures for Encounter Data. Additional information can be found at: http://www.dhcs.ca.gov/dataandstats/Pages/QualityMeasurementAndReporting.aspx.
B. Directly contracted Capitated Providers must submit either in the appropriate EDI format or on a CMS 1500 for professional, or UB04 on an institutional and all appropriate encounter information to GCHP within sixty (60) days after

the month in which the services are rendered to a member. Submission can be done through GCHP's EDI Gateway or the secure Provider portal.

C. Directly contracted Capitated Providers must submit data for all covered services provided to a member, including Primary Care Provider (PCP) visits and sub-capitated services, and must include all available diagnosis codes related to the service provided.

1. Department of Health Care Services (DHCS)-GCHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 3, Provision 2, Encounter Data Reporting
2. DHCS All Plan Letter (APL) 17-004, "Sub contractual Relationships and Delegation"
3. DHCS-GCHP Two-Plan Contract, 1/10/20 (Final Rule A27), Exhibit A, Attachment 3, Provision 2, Encounter Data Reporting

D. Each month, the encounter data submitted to GCHP must meet the
E. following three (3) requirements as set forth by GCHP: **Completeness, Accuracy and Timeliness**. Each month is reviewed on an aggregate basis.

1. Completeness - Data is complete when:

   b. All real-world events (in this case, an encounter between a Medi-Cal beneficiary and a managed care provider) are represented in the data
   c. Only real-world events are represented in the data The first part addresses missing data; the second part addresses surplus or duplicate data.
   d. For example, when health care services are provided but the encounter data is not successfully submitted to DHCS, data is incomplete, and analysis of that data is untrustworthy. When duplicate data is submitted, it also undermines the credibility of analyses based on that data. When the data is incomplete, it reduces the confidence that can be placed in analysis and reporting based on that data.

1. Accuracy:

   a. Data is accurate when it correctly depicts the real-world events and entities that it purports to represent. The medical records of the Medi-Cal beneficiaries will be the standard against which encounter data will be measured. Inaccurate data is of limited value for analysis and reporting, since analytic results will not represent reality.

2. Timeliness:

    b. Data is timely when the span of time between the occurrence of a real-world event and its appearance in the data is short enough that the occurrence can be included in data analysis and reports. In this case, the date the real-world event occurred is the Date of Service (DOS) of the encounter, and the date when the event is considered part of the data is the Submission Date to DHCS. The number of calendar days between those dates is the “lagtime”. Data completeness and data timeliness are closely related, but not identical. If the average lagtime is excessive, even if data completeness is eventually achieved; it becomes difficult to use the data for timely analysis and reporting.

F. On an annual basis, GCHP re-evaluates the Accuracy standards based on state regulatory changes, results of the Healthcare Effectiveness Data and Information Set (HEDIS®) audit and historical encounter data experience.
G. GCHP utilizes the “Official ICD-10-CM Guidelines for Coding and Reporting” as part of the validation process.
H. Age and gender rules for Current Procedural Terminology (CPT) codes will be enforced.
I. For all medical encounters submitted, the National Provider Identifier (NPI) is required to be submitted as the “Billing Provider NPI”.
J. GCHP monitors and works with each Provider to ensure that any problem areas can be corrected in a timely manner. For assistance in working through the details of encounter submission, please e-mail the GCHP Encounter Team at EDI_CLAIMS_ENCOUNTERS@goldchp.org.
K. The responsibility for Encounter Data reporting, as outlined above, continues until all services rendered during the timeframe are reported, while the Capitated Agreement is in place.
L. If you have any questions, please contact the GCHP EDI Team at EDI_CLAIMS_ENCOUNTERS@goldchp.org.

1. Per Member Per Month (PMPM) = encounters / member months
2. Accuracy standards based on state regulatory guidelines, HEDIS® audit results and
3. historical encounter data experience

VI. Attachments

A. N/A

VII. References

A. N/A

VIII. Revision History

STATUS	DATE REVISED	REVIEW DATE	REVISION SUMMARY
	10/01/2021		James Sproule
Approved	10/12/2021		PRC
		12/01/2021	Margaret Tatar, CEO

Gold Coast Health Plan Approval: Signatures on File in C360

POLICY AND PROCEDURE	
TITLE: Data Sharing with ECM and CS Providers	
DEPARTMENT: Information Technology	**POLICY #:** ECM-006
EFFECTIVE DATE: 01/01/22	**REVIEW/REVISION DATE:** 6/11/22, 8/2/22, 5/10/23
COMMITTEE APPROVAL DATE: 10/27/2022	**RETIRE DATE:**
PRODUCT TYPE: Medi-Cal	**REPLACES:**
	CEO SIGNATURE: *Robert Franco* for CEO

Purpose

A. To establish a consistent approach for all Gold Coast Health Plan (GCHP) Enhanced Care Management (ECM) and Community Supports (CS) Providers to receive required data in compliance with Department of Health Care Services (DHCS) requirements.

Policy

A. GCHP complies with the DHCS Managed Care Plan (MCP) ECM and CS Contract Template, ECM and CS Provider Standard Terms and Conditions, as well as DHCS Contract requirements.
B. GCHP complies with data sharing requirements to ensure compliance with the federal Health Insurance Portability and Accountability Act (HIPAA) Confidentiality of Medical Information Act, and 42 CFR Part 2.
C. GCHP shall follow DHCS guidance on data sharing.
D. GCHP and the ECM provider will share specific data files as specified by DHCS in CalAIM Data Guidance: Member-Level Information Sharing Between MCPs and ECM Providers (hereafter ECM Data Guidance), namely;

    1. MCP Member Information File
    2. ECM Provider Return Transmission File
    3. ECM Provider Initial Outreach Tracker File
    4. Potential ECM Member Referral File

E. Definitions and files specifications for the above listed files are detailed in the ECM Data Guidance and subject to change by the DHCS. Both GCHP and the ECM provider are required to adhere to the regulatory requirements specified in the ECM Data Guidance.
F. Transmission Method: As per the Data Guidance, the transmission method shall be mutually agreed upon between GCHP and the ECM provider. As of this revision, the preferred method for file transmission for GCHP is Secure File Transfer Protocol (SFTP).

Definitions

Community Supports (CS): Services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. CS are optional for both GCHP and the Member and must be approved by DHCS.

Community Supports Provider (CS Provider): A contracted Provider of DHCS-approved CS. CS Providers are entities with experience and expertise providing one or more of the Community Supports approved by DHCS.

Department of Health Care Services (DHCS): The single State Department responsible for administration of the Federal Medicaid (referred to as Medi-Cal in California) Program, and other health related programs.

Enhanced Care Management (ECM): A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.

ECM Provider: A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

Member: Means any Eligible Beneficiary who is enrolled with GCHP.

Primary Care Physician (PCP): Means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN).

Procedure

A. Members Authorized for ECM and Assignment to an ECM Provider
   1. ECM Providers may submit and track Authorization requests, either via the GCHP Provider Portal or manually via fax to GCHP, for GCHP Medi-Cal Members they believe qualify for ECM Services for review and approval by GCHP Care Management and Health Services personnel.
   2. Member(s) authorized for ECM services will be assigned to an ECM Provider. The Member assignment will be communicated within ten (10) business days of ECM authorization in accordance with ECM-002.
   3. ECM Provider-specific Member assignment files, defined as a list of GCHP Medi-Cal Members authorized for ECM and assigned to the ECM Provider, will be sent to ECM Providers via SFTP on a recurring basis.

B. Securely Share Data with ECM Providers

   1. GCHP complies with security requirements as detailed in
      a. HI-041 Information Assets Security Policy
      b. HI-046 IT Audit Program Policy
      c. HI-047 Information Risk Management Policy
      d. HI-048 Vulnerability and Penetration Testing Policy
      e. HI-052 Patch Management Policy
      f. HI-054 Backup and Restore Policy
      g. HI-057 Log and Event Collection Policy
      h. HI-058 Encryption and Key Mgt Policy

C. The GCHP Provider Portal is secure and has the following safeguards:
   1. Data Encryption (in-transit and at-rest)
   2. Server and Network Security
   3. Patch Management
   4. Anti-Malware Software
   5. Firewalled from other network environments
   6. Intrusion Detection and Response
   7. Redundant Power and Internet
      a. User IDs and Password controls (may include multifactor authentication (MFA))
         1. On and Offboarding Procedures
         2. Account Lockout(s) with notification
   8. Session Timeouts (expiration of session)
   9. Access Controls (permissions to data elements – data masking)
   10. Physical Datacenter/Facility Security Controls
      a. Fire Suppression

b. Bio-Metrics Authentication
c. Video Monitoring
d. Geographical Redundancy

11. RTO (recovery time objectives) for failed or degraded services
12. 3rd Party Security Testing (Vulnerability and Penetration Testing)

    a. To include qualified certifications (ISO27001, HIPAA, HI-TRUST, SOC Type II, or equivalent

D. Member Level Data Sharing Between GCHP and CS Provider

1. GCHP and the CS provider will share specific data files as specified by DHCS in CalAIM Data Guidance: Community Supports Member Information Sharing Guidance (hereafter CS Data Guidance), namely;
    a. MCP Community Supports Authorization Status File
    b. Community Supports Provider Return Transmission File

2. Definitions and files specifications for the above listed files are detailed in the CS Data Guidance and subject to change by the DHCS. Both GCHP and the ECM provider are required to adhere to the regulatory requirements specified in the CS Data Guidance.

3. Transmission Method: As per the Data Guidance, the transmission method shall be mutually agreed upon between GCHP and the ECM provider. As of this revision, the preferred method for file transmission for GCHP is SFTP, but alternatives such as secure email are possible if no other option is available.

E. Members Authorized for ECM and Assignment to an ECM Provider

1. CS Providers may submit and track Authorization requests, either via the GCHP Provider Portal or manually via fax to GCHP, for GCHP Medi-Cal Members they believe qualify for CS Services for review and approval by GCHP Care Management and Health Services personnel.
2. Member(s) authorized for CS services will be assigned to an CS Provider. The Member assignment will be communicated within ten (10) business days of CS authorization in accordance with CS-001.

F. CS Provider-specific Member assignment files, defined as a list of GCHP Medi-Cal Members authorized for CS and assigned to the CS Provider, will be sent to CS Providers via SFTP on a recurring basis.
    1. Referrals from ECM Provider for CS

a. GCHP will accept CS referrals from ECM Providers in accordance with the guidelines set forth in CS-001 for Members enrolled in ECM via the Provider Portal and/or submission by fax.
b. GCHP will ensure the coordination of the CS referral with the CS Provider and communicate the status of the referral back to the ECM Provider (i.e., using closed loop referrals) in accordance with CS-001.

G. ECM Provider Responsibility
1. Identify Members who would benefit from ECM and send a referral to GCHP.
2. Notify GCHP of discontinuation of ECM for Members when any of the following circumstances are met as detailed in ECM-003.
3. Immediately notify GCHP if they do not have capacity to accept a referral or a Member assignment.
4. Submit data as specified in the ECM Data Guidance
5. Keep records of Members receiving ECM and Member consent forms necessary for sharing Electronic Health Information (EHI) and Personally Identifiable Information (PII) between ECM Provider and GCHP, other providers, family member(s) and/or support person(s) obtained by the ECM Provider. The ECM Provider will manage and maintain consent forms for assigned Members receiving ECM services.
6. Allow GCHP real-time access to consent forms for assigned Members or respond to GCHP requests for Member ECM consent forms within 24 hours.
7. Comply with HIPAA, 42 CFR Part 2, and all other applicable state and federal data sharing requirements.

H. CS Provider Responsibility
1. Identify Members who would benefit from CS and submit a referral to GCHP.
2. Notify GCHP of discontinuation of CS for Members when any of the following circumstances are met as detailed in CS-001.
3. Immediately notify GCHP if they do not have capacity to accept a Member assignment.
4. Submit data as specified in the CS Data Guidance.
5. Keep records of Members receiving CS and Member consent forms necessary for sharing Electronic Health Information (EHI) and Personally Identifiable Information (PII) between CS Provider and GCHP, other providers, family member(s) and/or support person(s) obtained by the CS Provider. The CS Provider will manage and

maintain consent forms for assigned Members receiving ECM services.
6. Allow GCHP real-time access to consent forms for assigned Members or respond to GCHP requests for Member CS consent forms within 24 hours.
7. Comply with HIPAA, 42 CFR Part 2, and all other applicable state and federal data sharing requirements.

A. Attachments

1. CS-001 Community Supports: Provider Requirements and Identification, Eligibility, Referral, Consent, Authorization and Assignment Processes

B. References

California Civil Code §56 - §56.37 Confidentiality of Medical Information Act

DHCS Contract

DHCS MCP ECM and CS Contract Template Provisions

DHCS ECM and CS Standard Provider Terms and Conditions

ECM-003 Enhanced Care Management Care Coordination (including WPC transition)

CS-001 Community Supports: Provider Requirements and Identification, Eligibility, Referral, Consent, Authorization and Assignment Processes

GCHP Provider Manual

HI-027 Limited Data Sets and Data Use Agreements

CalAIM Data Guidance: Member-Level Information Sharing Between MCPs and ECM Providers in CalAIM Data Guidance: Community Supports Member Information Sharing Guidance

C. Review History

STATUS	DATE REVISED	REVIEW DATE	REVISION SUMMARY
Revised	6/12/22		Updated references to ILOS to Community Supports (CS); included additional GCHP data sets that will be utilized to identify Members potentially eligible for ECM for Populations of Focus launching January 1, 2023, per DHCS policy guidance and requirements.
Created	8/3/2021		Rachel Lambert, Director Care Management
Approved		9/28/2021	PRC
Approved		11/16/2021	DHCS
Approved		5/27/2022	Nick Liguori, CEO
Revised	6/12/22		Updated references to ILOS to Community Supports (CS); included additional GCHP data sets that will be utilized to identify Members potentially eligible for ECM for Populations of Focus launching January 1, 2023, per DHCS policy guidance and requirements.
Approved		6/24/2022	PRC
Reviewed		7/14/2022	DEI reviewed for inclusive language. Compliant, no edits needed.
Reviewed		8/2/2022	Care Management Managers
Reviewed		8/2/2022	DEI reviewed for inclusive language. Compliant, no edits needed.
Approved		9/14/2022	Policy Review Committee
Approved		10/27/2022	Utilization Management Committee
Revised	05/10/2023		David Kirkpatrick: Revisions due to updated data sharing guidance from DHCS.
Approved		05/25/2023	PRC
		05/25/2023	Nick Liguori, CEO

Gold Coast Health Plan Approval: Signatures on File in C360

ATTACHMENT A-2
ECM-CS QUARTERLY REPORTING TEMPLATE

ECM and Community Supports Quarterly Reporting Template Instructions

The Department of Health Care Services (DHCS) is issuing this Enhanced Care Management (ECM) and Community Supports (ILOS) Quarterly Reporting Template to collect data about the implementation and for monitoring of ECM and Community Supports, across multiple domains including Membership, Service Provision, and Provider Capacity.

The ECM and Community Supports Reporting Template is due to DHCS quarterly according to the schedule below. When the due date falls on Saturday, Sunday or a holiday, data must be submitted by COB the business day before the due date.

Reports must be submitted to "DHCS-MCQMD-Monitoring" folder on the DHCS eTransfer site (https://etransfer.dhcs.ca.gov/). The file name must include the ECM-CS, MCP health plan name, the appropriate reporting period and date of submission. For example: ECM-CS_MCPName_2022Q1_20210531 is a report for the 2022 Q1 submission. Each MCP must submit only one data file per reporting period. All subcontractors must be rolled up into the main MCP's data. File must be in Excel format. When submitting revised files, includes REV and the number at the end of the file name. For example, ECM-CS_MCPName_2022Q1_2020531_REV1.

Submission schedule:

- 2022 Q1 (January – March 2022) is due May 15, 2022
- 2022 Q2 (April – June 2022) is due August 15, 2022
- 2022 Q3 (July – September 2022) is due November 14, 2022
- 2022 Q4 (October – December 2022) is due February 14, 2023
- 2023 Q1 (January – March 2023) is due May 16, 2023
- 2023 Q2 (April – June 2023) is due August 14, 2023
- 2023 Q3 (July – September 2023) is due November 14, 2023
- 2023 Q4 (October – December 2023) is due February 14, 2024
- 2024 Q1 (January – March 2024) is due May 15, 2024
- 2024 Q2 (April – June 2024) is due August 14, 2024

1. ECM Members and Services	
Column Name	**Explanation**
Plan Name (column A)	From the drop-down list, select the plan name.
Plan Code (column B)	From the drop down menu, select the plan code. This plan code must match the county listed in the county column.
County (column C)	From the drop down menu, select the county name. The county must match the plan code listed in the plan code column.
Reporting Period (column D)	From the drop-down list, select the reporting period.
Member CIN (column E)	Enter the member's CIN as a nine-character number that consists of eight numbers and one letter.
Member Last Name (column F)	Enter the member's last name.
Member First Name (column G)	Enter the member's first name.
Member Date of Birth (column H)	Enter member's date of birth. (MM/DD/YYYY)
For columns I - T, mark all applicable Populations of Focus that are known to the MCP to apply to the member, based on the Populations of Focus that are eligible for ECM in the county during the reporting period.	
Adult – Experiencing Homelessness (column I)	Was the member an adult experiencing homelessness? Enter 1 for Yes. Enter 0 for No.
Adult – High Utilizer (column J)	Was the member an adult high utilizer? Enter 1 for Yes. Enter 0 for No.
Adult – SMI or SUD (column K)	Was the member an adult with a Serious Mental Illness (SMI) or Substance Use Disorder (SUD)? Enter 1 for Yes. Enter 0 for No.
Adult – Transitioning from Incarceration (column L)	Was the member an adult transitioning from incarceration? Enter 1 for Yes. Enter 0 for No.
Adult – LTC At-Risk for Institutionalization (column M)	Was the member an adult long-term care (LTC) eligible at-risk for institutionalization? Enter 1 for Yes. Enter 0 for No.
Adult – NF Transitioning to Community (column N)	Was the member an adult nursing facility (NF) resident transitioning to the community? Enter 1 for Yes. Enter 0 for No.
Child – Experiencing Homelessness (column O)	Was the member a child/youth experiencing homelessness? Enter 1 for Yes. Enter 0 for No.
Child – High Utilizer (column P)	Was the member a child/youth high utilizer? Enter 1 for Yes. Enter 0 for No.
Child – SED or CHR for Psychosis (column Q)	Was the member a child/youth with a Serious Emotional Disturbance (SED) or identified to be at Clinical High Risk (CHR) for psychosis or experiencing a first episode of psychosis? Enter 1 for Yes. Enter 0 for No.
Child – CCS/CCS WCM with Additional Needs (column R)	Was the member a child/youth enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition? Enter 1 for Yes. Enter 0 for No.
Child – Child Welfare (column S)	Was the member a child/youth involved in, or with a history of involvement in, child welfare (including foster care up to age 26)? Enter 1 for Yes. Enter 0 for No.
Child – Transitioning from Incarceration (column T)	Was the member a child/youth transitioning from incarceration? Enter 1 for Yes. Enter 0 for No.
ECM Benefit Start Date (column U)	Enter the member's ECM benefit start date (MM/DD/YYYY). The date is defined as the date upon which the MCP enrolled the Member in ECM.
ECM Benefit End Date (column V)	Enter the member's ECM service end date (disenrollment date) (MM/DD/YYYY or blank). Leave blank if member was receiving ECM through the end of the reporting period. Members who cease to receive ECM should not be reported in subsequent reports unless the member is reenrolled in ECM. If a member ends ECM and is subsequently reenrolled in ECM in the same reporting period, report the member on a new row with the new ECM benefit start date.
ECM Discontinuation Reason (column W)	From the drop-down list, select the reason code for discontinuation of ECM if the member has been disenrolled and the benefit has ended during the reporting period. Drop-down reason code descriptions: 1. The Member has met all care plan goals 2. The Member is ready to transition to a lower level of care 3. The Member no longer wishes to receive ECM 4. The ECM Provider has not been able to connect with the Member after multiple attempts 5. Other
Member's ECM Provider NPI (column X)	Enter the member's assigned ECM provider NPI.
Number of In-Person ECM Encounters (column Y)	Enter the number of in-person ECM encounters the member received during the reporting period.
Number of Telephonic or Telehealth ECM Encounters (column Z)	Enter the number of telephonic or telehealth ECM encounters the member received during the reporting period.

2. ECM Requests for Services and Outreach	
Column Name	**Explanation**
Plan Name (column A)	From the drop-down list, select the plan name.
Plan Code (column B)	From the drop down menu, select the plan code. This plan code must match the county listed in the county column.
County (column C)	From the drop down menu, select the county name. The county must match the plan code listed in the plan code column.
Reporting Period (column D)	From the drop-down list, select the reporting period.
Columns E - G are cumulative for the calendar year and should include all members that have been identified to date. Data from each reporting period should be added to the data from the previous reporting period. These columns reset when submitting Q1 of each year.	

Number of Members Identified as ECM Eligible (column E)	Enter the number of unique members identified as eligible for ECM for the calendar year. This number should include all of the pathways members can be identified: via receipt of requests from ECM providers and other providers or community-based entities; self or family-referrals; analysis of MCP's own enrollment, claims, and other relevant data and available information. This number is cumulative for the calendar year and should include all members that have been identified to date.
Number of ECM Eligible Members with One or More Outreach Attempts (column F)	Enter the number of unique members identified as eligible for ECM that received one or more outreach attempts for initiation into ECM for the calendar year. Denominator for this count is column E. An "outreach attempt" is defined as an in-person or telephonic/electronic attempt to connect with an individual member for the purpose of enrolling the member in the ECM benefit. Outreach attempts from all entities (ECM providers / staff, MCPs) should be included in this reporting. This number is cumulative for the calendar year and should include all members that have been identified to date.
Number of Members Enrolled in ECM with One or More Outreach Attempt (column G)	Enter the number of unique members that received one or more outreach attempts that were ultimately enrolled in ECM for the calendar year. Denominator for this count is column F. This number is cumulative for the calendar year and should include all members that have been identified to date.
Columns H - I are data only for the reporting period.	
Number of Members with External ECM Request (column H)	Enter the number of unique members for whom the MCP received a request for ECM services from all external sources, (e.g., ECM providers and other providers or community-based entities, members/families directly), during the reporting period.
Number of Members with External ECM Request Denied (column I)	Enter the number of unique members for whom the MCP received a request for ECM services from all external sources (e.g., ECM Providers and other Providers or community-based entities, Members/families directly), for which MCP determined the member ineligible/denied, during the reporting period. Denominator for this count is column H.

3. ECM Provider Capacity	
Column Name	**Explanation**
Plan Name (column A)	From the drop-down list, select the plan name.
Plan Code (column B)	From the drop down menu, select the plan code. This plan code must match the county listed in the county column.
County (column C)	From the drop down menu, select the county name. The county must match the plan code listed in the plan code column.
Reporting Period (column D)	From the drop-down list, select the reporting period.
ECM Provider NPI (column E)	Enter the ECM provider's NPI.
ECM Provider Type (column F)	From the drop-down list, select the ECM provider type. Drop-down choices are: County County behavioral health provider Primary care or specialist physician or physician group Federally Qualified Health Center Community Health Center Hospital or hospital-based physician group or clinic Public hospital, district/municipal public hospital or healthcare system Rural Health Center/Indian Health Center Local health department Behavioral health entity Community mental health center Substance use disorder treatment provider Organization serving individuals experiencing homelessness Organization serving justice-involved individuals Other qualified provider or entity not listed above
For columns G - R, mark all applicable Populations of Focus served by the provider.	
Adult – Experiencing Homelessness (column G)	Did the provider serve an adult experiencing homelessness? Enter 1 for Yes. Enter 0 for No.
Adult – High Utilizer (column H)	Did the provider serve an adult high utilizer? Enter 1 for Yes. Enter 0 for No.
Adult – SMI or SUD (column I)	Did the provider serve an adult with a Serious Mental Illness (SMI) or Substance Use Disorder (SUD)? Enter 1 for Yes. Enter 0 for No.
Adult – Transitioning from Incarceration (column J)	Did the provider serve an adult transitioning from incarceration? Enter 1 for Yes. Enter 0 for No.
Adult – LTC At-Risk for Institutionalization (column K)	Did the provider serve an adult long-term care (LTC) eligible at-risk for institutionalization? Enter 1 for Yes. Enter 0 for No.
Adult – NF Transitioning to Community (column L)	Did the provider serve an adult nursing facility (NF) resident transitioning to the community? Enter 1 for Yes. Enter 0 for No.
Child – Experiencing Homelessness (column M)	Did the provider serve a child/youth experiencing homelessness? Enter 1 for Yes. Enter 0 for No.
Child – High Utilizer (column N)	Did the provider serve a child/youth high utilizer? Enter 1 for Yes. Enter 0 for No.
Child – SED or CHR for Psychosis (column O)	Did the provider serve a child/youth with a Serious Emotional Disturbance (SED) or identified to be at Clinical High Risk (CHR) for psychosis or experiencing a first episode of psychosis? Enter 1 for Yes. Enter 0 for No.
Child – CCS/CCS WCM with Additional Needs (column P)	Did the provider serve a child/youth enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition? Enter 1 for Yes. Enter 0 for No.
Child – Child Welfare (column Q)	Did the provider serve a child/youth involved in, or with a history of involvement in, child welfare (including foster care up to age 26)? Enter 1 for Yes. Enter 0 for No.
Child – Transitioning from Incarceration (column R)	Did the provider serve a child/youth transitioning from incarceration? Enter 1 for Yes. Enter 0 for No.
Number of Adult Members the ECM Provider is Serving (column S)	Enter the number of adult members the ECM provider is currently serving, at the end of the reporting period.
Number of Child Members the ECM Provider is Serving (column T)	Enter the number of child/youth members the ECM provider is currently serving, at the end of the reporting period.
Number of Adult Members the ECM Provider can Serve (column U)	Enter the approximate total number of adult members the ECM provider is able to serve, beyond who they are currently serving, at the end of the reporting period. This number should reflect the ECM provider's capacity to serve this MCP's membership, not the ECM provider's overall capacity.
Number of Child Members the ECM Provider can Serve (column V)	Enter the approximate total number of child/youth members the ECM provider is able to serve, beyond who they are currently serving, at the end of the reporting period. This number should reflect the ECM provider's capacity to serve this MCP's membership, not the ECM provider's overall capacity.

4. Community Supports Members and Services	
Column Name	**Explanation**
Plan Name (column A)	From the drop-down list, select the plan name.
Plan Code (column B)	From the drop down menu, select the plan code. This plan code must match the county listed in the county column.
County (column C)	From the drop down menu, select the county name. The county must match the plan code listed in the plan code column.
Reporting Period (column D)	From the drop-down list, select the reporting period.
Member CIN (column E)	Enter the member's CIN as a nine-character number that consists of eight numbers and one letter.
Member Last Name (column F)	Enter the member's last name.
Member First Name (column G)	Enter the member's first name.
Member Date of Birth (column H)	Enter member's date of birth. (MM/DD/YYYY)
Member received Community Supports Services (column I)	Did the Member receive Community Supports services during the reporting period? Enter 1 for Yes. Enter 0 for No.
For columns J - X, indicate which Community Supports services the member was **approved for**, during the reporting period, by entering 1 for Yes and 0 for No.	

Approved for Housing Transition/Navigation Services (column J)	Was the member approved for Community Supports housing transition/navigation services? Enter 1 for Yes. Enter 0 for No.
Approved for Housing Deposits (column K)	Was the member approved for Community Supports housing deposits? Enter 1 for Yes. Enter 0 for No.
Approved for Housing Tenancy and Sustaining Services (column L)	Was the member approved for Community Supports housing tenancy and sustaining services? Enter 1 for Yes. Enter 0 for No.
Approved for Short-Term Post-Hospitalization Housing (column M)	Was the member approved for Community Supports short-term post-hospitalization housing? Enter 1 for Yes. Enter 0 for No.
Approved for Recuperative Care (column N)	Was the member approved for Community Supports recuperative care (medical respite)? Enter 1 for Yes. Enter 0 for No.
Approved for Respite Services (column O)	Was the member approved for Community Supports respite services? Enter 1 for Yes. Enter 0 for No.
Approved for Day Habilitation Programs (column P)	Was the member approved for Community Supports day habilitation programs? Enter 1 for Yes. Enter 0 for No.
Approved for NF Transition to ALF (column Q)	Was the member approved for Community Supports nursing facility (NF) transition/diversion to assisted living facilities (ALF)? Enter 1 for Yes. Enter 0 for No.
Approved for NF Transition to a Home (column R)	Was the member approved for Community Supports nursing facility (NF) transition to a home? Enter 1 for Yes. Enter 0 for No.
Approved for Personal Care and Homemaker Services (column S)	Was the member approved for Community Supports personal care and homemaker services? Enter 1 for Yes. Enter 0 for No.
Approved for Environmental Accessibility Adaptations (column T)	Was the member approved for Community Supports environmental accessibility adaptations (home modifications)? Enter 1 for Yes. Enter 0 for No.
Approved for Medically-Supportive Food (column U)	Was the member approved for Community Supports medically-supportive food/meals/medically tailored meals? Enter 1 for Yes. Enter 0 for No.
Approved for Sobering Centers (column V)	Was the member approved for Community Supports sobering center services? Enter 1 for Yes. Enter 0 for No.
Approved for Asthma Remediation (column W)	Was the member approved for Community Supports asthma remediation? Enter 1 for Yes. Enter 0 for No.
Approved for Other Services (column X)	Was the member approved for any other Community Supports services not previously listed? Enter 1 for Yes. Enter 0 for No.
For columns Y - AM, indicate which Community Supports services the member **received,** during the reporting period, by entering 1 for Yes and 0 for No.	
Received Housing Transition/Navigation Services (column Y)	Did the member receive Community Supports housing transition/navigation services? Enter 1 for Yes. Enter 0 for No.
Received Housing Deposits (column Z)	Did the member receive Community Supports housing deposits? Enter 1 for Yes. Enter 0 for No.
Received Housing Tenancy and Sustaining Services (column AA)	Did the member receive Community Supports housing tenancy and sustaining services? Enter 1 for Yes. Enter 0 for No.
Received Short-Term Post-Hospitalization Housing (column AB)	Did the member receive Community Supports short-term post-hospitalization housing? Enter 1 for Yes. Enter 0 for No.
Received Recuperative Care (column AC)	Did the member receive Community Supports recuperative care (medical respite)? Enter 1 for Yes. Enter 0 for No.
Received Respite Services (column AD)	Did the member receive Community Supports respite services? Enter 1 for Yes. Enter 0 for No.
Received Day Habilitation Programs (column AE)	Did the member receive Community Supports day habilitation programs? Enter 1 for Yes. Enter 0 for No.
Received NF Transition to ALF (column AF)	Did the member receive Community Supports nursing facility (NF) transition/diversion to assisted living facilities (ASL)? Enter 1 for Yes. Enter 0 for No.
Received NF Transition to a Home (column AG)	Did the member receive Community Supports nursing facility (NF) transition to a home? Enter 1 for Yes. Enter 0 for No.
Received Personal Care and Homemaker Services (column AH)	Did the member receive Community Supports personal care and homemaker services? Enter 1 for Yes. Enter 0 for No.
Received Environmental Accessibility Adaptations (column AI)	Did the member receive Community Supports environmental accessibility adaptations (home modifications)? Enter 1 for Yes. Enter 0 for No.
Received Medically-Supportive Food (column AJ)	Did the member receive Community Supports medically-supportive food/meals/medically tailored meals? Enter 1 for Yes. Enter 0 for No.
Received Sobering Centers (column AK)	Did the member receive Community Supports sobering center services? Enter 1 for Yes. Enter 0 for No.
Received Asthma Remediation (column AL)	Did the member receive Community Supports asthma remediation? Enter 1 for Yes. Enter 0 for No.
Received Other Service (column AM)	Did the member receive any other Community Supports services not previously listed? Enter 1 for Yes. Enter 0 for No.

5. Community Supports Provider Capacity	
Column Name	**Explanation**
Plan Name (column A)	From the drop-down list, select the plan name.
Plan Code (column B)	From the drop down menu, select the plan code. This plan code must match the county listed in the county column.
County (column C)	From the drop down menu, select the county name. The county must match the plan code listed in the plan code column.
Reporting Period (column D)	From the drop-down list, select the reporting period.
Community Supports Provider NPI (column E)	Enter the Community Supports provider's NPI.
Community Supports Provider Type (column F)	From the drop-down list, select the Community Supports provider type. Drop-down choices are: County County behavioral health provider Primary care or specialist physician or physician group Federally Qualified Health Center Community Health Center Hospital or hospital-based physician group or clinic Public hospital, district/municipal public hospital or healthcare system Rural Health Center/Indian Health Center Local health department Behavioral health entity Community mental health center Substance use disorder treatment provider Organization serving individuals experiencing homelessness Organization serving justice-involved individuals Other qualified provider or entity not listed above

Community Supports Offered by Provider (column G)	From the drop-down list, select the Community Supports offer by the provider. If multiple Community Supports are offered by the same provider, report separate rows for each Community Supports. Drop-down choices are: Housing Transition Navigation Services Housing Deposits Housing Tenancy and Sustaining Services Short-term Post-Hospitalization Housing Recuperative Care (Medical Respite) Respite Services Day Habilitation Programs Nursing Facility (NF) Transition/Diversion to Assisted Living Facilities (ALF), such as Residential Care Facilities for Elderly & Adult (RCFE) and Adult Residential Facilities (ARF) Nursing Facility (NF) Transition to a Home Personal Care (beyond In Home Services and Supports) and Homemaker Services Environmental Accessibility Adaptations (Home Modifications) Medically-Supportive Food/Meals/Medically Tailored Meals Sobering Centers Asthma Remediation Other
Number of Members the Provider is able to serve (column H)	Enter the number of members the Community Supports provider is able to serve, at the end of the reporting period, for each Community Supports.

6. Community Supports Requests and Denials	
Column Name	**Explanation**
Plan Name (column A)	From the drop-down list, select the plan name.
Plan Code (column B)	From the drop down menu, select the plan code. This plan code must match the county listed in the county column.
County (column C)	From the drop down menu, select the county name. The county must match the plan code listed in the plan code column.
Reporting Period (column D)	From the drop-down list, select the reporting period.
Number of Members with External Community Supports Request (column E)	Enter the number of unique members for whom the MCP received a request for Community Supports services from all external sources, (e.g., Community Supports providers and other providers, members/families directly), during the reporting period.
Number of Members with External Community Supports Request Denied (column F)	Enter the number of unique members for whom the MCP received a request for Community Supports services from all external sources (e.g., Community Supports providers and other providers, members/families directly), for which MCP determined ineligible/denied, during the reporting period. Denominator for this count is column E.

Plan Name	Plan Code	County	Reporting Period	Member CIN	Member Last Name	Member First Name	Member Date of Birth	Adult – Experiencing Homelessness	Adult – High Utilizer	Adult – SMI or SUD	Adult – Transitioning from Incarceration	Adult – LTC At-Risk for Institutionalization	Adult – NF Transitioning to Community	Child – Experiencing Homelessness	Child – High Utilizer	Child – SED or CHR for Psychosis	Child – CCS/CCS WCM with Additional Needs	Child – Child Welfare	Child – Transitioning from Incarceration	ECM Benefit Start Date	ECM Benefit End Date	ECM Discontinuation Reason	Member's ECM Provider NPI	Number of In-Person ECM Encounters	Number of Telephonic or Telehealth ECM Encounters

Plan Name	Plan Code	County	Reporting Period	Number of Members Identified as ECM Eligible	Number of ECM Eligible Members with One or More Outreach Attempts	Number of Members Enrolled in ECM with One or More Outreach Attempt	Number of Members with External ECM Request	Number of Members with External ECM Request Denied

Plan Name	Plan Code	County	Reporting Period	ECM Provider NPI	ECM Provider Type	Adult – Experiencing Homelessness	Adult – High Utilizer	Adult – SMI or SUD	Adult – Transitioning from Incarceration	Adult – LTC At-Risk for Institutionalization	Adult – NF Transitioning to Community	Child – Experiencing Homelessness	Child – High Utilizer	Child – SED or CHR for Psychosis	Child – CCS/CCS WCM with Additional Needs	Child – Child Welfare	Child – Transitioning from Incarceration	Number of Adult Members the ECM Provider is Serving	Number of Child Members the ECM Provider is Serving	Number of Adult Members the ECM Provider can Serve	Number of Child Members the ECM Provider can Serve

Plan Name	Plan Code	County	Reporting Period	Member CIN	Member Last Name	Member First Name	Member Date of Birth	Member received Community Supports Services	Approved for Housing Transition/ Navigation Services	Approved for Housing Deposits	Approved for Housing Tenancy and Sustaining Services	Approved for Short-Term Post-Hospitalization Housing	Approved for Recuperative Care	Approved for Respite Services	Approved for Day Habilitation Programs	Approved for NF Transition to ALF	Approved for NF Transition to a Home	Approved for Personal Care and Homemaker Services	Approved for Environmental Accessibility Adaptations	Approved for Medically-Supportive Food	Approved for Sobering Centers	Approved for Asthma Remediation	Approved for Other Services	Received Housing Transition/ Navigation Services	Received Housing Deposits	Received Housing Tenancy and Sustaining Services	Received Short-Term Post-Hospitalization Housing	Received Recuperative Care	Received Respite Services	Received Day Habilitation Programs	Received NF Transition to ALF	Received NF Transition to a Home	Received Personal Care and Homemaker Services	Received Environmental Accessibility Adaptations	Received Medically-Supportive Food	Received Sobering Centers	Received Asthma Remediation	Received Other Service

Plan Name	Plan Code	County	Reporting Period	Community Supports Provider NPI	Community Supports Provider Type	Community Supports Offered by Provider	Number of Members the Provider is able to serve

Plan Name	Plan Code	County	Reporting Period	Number of Members with External Community Supports Request	Number of Members with External Community Supports Request Denied

EXHIBIT B
SPECIALTY MENTAL HEALTH DATA AND DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM SHARING

I. DHCS AND GCHP MOU REQUIREMENTS

A. DHCS Requirements for Coordination of SMHS and NSMHS

Timely and complete information exchange is required to support referral and care coordination as required by DHCS APL 22-003 (Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders) and Behavioral Health Information Notice ("BHIN") 22-009 and 22-005 (No Wrong Door for Mental Health Services Policy). In relevant part, APL 22-003 and BHIN 22-009 state that "MCPs [managed care plans] are contractually responsible for providing Comprehensive Medical Case Management Services, including coordination of care, to ensure the provision of all medically necessary services, whether those services are delivered within or outside of the MCP's provider network." Additionally, APL 22-003 and BHIN 22-009 both state that"[T]he MOU must specify procedures to ensure timely and complete exchange of information by both the MHP [county mental health plan] and the MCP for the purposes of medical and behavioral health care coordination to ensure the member's medical record is complete and the MCP can meet its care coordination obligations."

B. Data Sharing Purposes under the Restated MOU

Section XI of the Restated MOU requires both Parties to have policies and procedures for clinical coordination and care coordination, including the data sharing for medical, mental health, and SUD care coordination.

1. *Clinical Integration*.

a. Section VI., subsection A1 of the Restated MOU states that the Parties shall manage Beneficiaries and Members at the point of care to ensure clinical integration between the Parties, which shall include but are not limited to the following, in pertinent part:

- Care coordination and effective communication among providers including procedures for exchanges of medical information;
- Navigation support for patients and caregivers; and
- Facilitation and tracking of referrals between systems including bidirectional referral protocol.

b. Section VI. Subsection A.2 of the Restated MOU states that the Parties have developed and agreed to policies and procedures for coordinating medical, SMHS, and SUD services for the Beneficiary/Member receiving services through VCBH and GCHP, including, but not limited to, the following, in pertinent part:

- Designation of liaisons who will ensure that ongoing care is initiated, provided, maintained, and coordinated as mutually agreed upon in GCHP and VCBH protocols;

- Coordination of care for inpatient mental health treatment provided by VCBH, including a notification process between the inpatient mental health facility within 24 hours of admission and discharge to arrange for appropriate follow-up services;

- A process for reviewing and updating the care plan of the Beneficiary/Member, as clinically indicated (i.e., following crisis intervention or hospitalization). The process must include triggers for updating care plans and coordinating with outpatient mental health providers; and

- Regular meetings, at no less than two times per year, to review referral, care coordination, and information exchange protocols and processes.

2. *Eating Disorders Care Coordination/Clinical Consultation*. Section VI. Subsection B. of the Restated MOU states, in pertinent part:

a. GCHP is contractually responsible for providing Comprehensive Medical Case Management Services, including coordination of care, to ensure the provision of all medically necessary services, whether those services are delivered within or outside of GCHP's provider network. These services are provided through either basic case, complex case, or Enhanced Care Management activities based on the medical needs of the Beneficiary. GCHP must coordinate all medically necessary care for Members, including locating, arranging, and following up to ensure services were rendered for partial hospitalization and residential eating disorder programs, with the active participation, cooperation, and timely exchange of information by VCBH, when such treatment is medically necessary for a Member.

b. GCHP is responsible for the physical health components of eating disorder treatment and NSMHS, and VCBH is responsible for the SMHS components of eating disorder treatment, specifically:

- Any medically necessary service requiring shared responsibility (such as partial hospitalization and residential treatment for eating disorders) requires coordinated case management and concurrent review by both GCHP and VCBH.

c. Subject to all Applicable Laws, timely and complete exchange of information by both GCHP and VCBH is required for purposes of medical and behavioral health care coordination and to ensure the Beneficiary's/Member's medical record is complete and GCHP can meet its care coordination obligations.

C. VCBH and GCHP Responsibilities

1. *Information Exchange*. Section XI of the Restated MOU requires the Parties to have policies and procedures, consistent with federal and state privacy laws, to ensure the timely sharing of client and patient information and data necessary for their performance under the Restated MOU, and to further develop policies and procedures so that their respective professionals and providers may access the Parties' client and patient data for care coordination purposes. The policies and procedures shall describe roles and responsibilities for sharing PHI for the purposes of medical, mental health and SUD care coordination in accordance with Title 9 of the California Code of Regulations ("CCR") section 1810.370(a)(3) and in compliance with HIPAA, the Confidentiality of Substance Use Disorder Patient Records (42 U.S.C. 290-dd-2, 42 C.F.R Part 2), the Lanterman-Petris Short Act (Welfare and Institutions Code section 5000 et seq.) and other state and federal privacy laws.

a. For mental health purposes, VCBH and GCHP shall share the following PHI and records for treatment and care coordination purposes: Beneficiary/Member demographic information, diagnosis, treatment plan, medications prescribed, laboratory results, referrals/discharges to/from inpatient and crisis services and known changes in condition that may adversely impact the Beneficiary's/Member's health and/or welfare. The specific data elements to be exchanged are set forth in Attachment B-1.

b. For SUD, the information should include any information, whether recorded or not, created by, received, or acquired by VCBH relating to a patient (e.g., diagnosis, treatment and referral for treatment information, billing information, emails, voice mails, and texts) including both paper and electronic records.

c. All Uses and Disclosures must be consistent with the requirements of Applicable Laws to ensure that the Parties' providers with medical and psychological responsibility for the patient are able to access one another's records for the benefit of the patient's treatment and care coordination.

d. To the extent that any of the information exchanged includes Part 2 Records, the Party sharing such data shall ensure that it has obtained valid Consent to Disclose records to the other Party for care coordination and reporting purposes.

D. Other Obligations Under the Restated MOU

1. *Dispute Resolution*. Disputes arising under this Exhibit B will be subject to the dispute resolution provisions described in Article X of the Restated MOU.

2. *Liability and Indemnity*. Article XXI of the Restated MOU shall apply to the acts or omissions of the Parties under this Exhibit B.

3. *Notices*, All notices required or permitted to be given under this Exhibit B shall be *delivered* in accordance with Article XXIII of the Restated MOU.

E. Term and Termination.

1. Unless earlier terminated in accordance with the terms of this Exhibit B, this Exhibit B shall remain in effect during the term of the Restated MOU, and shall be terminated upon termination or expiration of the Restated MOU.

2. Either Party may terminate this Exhibit B without cause by giving the other Party thirty (30) days' written notice of its intent to terminate. Upon any such termination, the Restated MOU shall remain in effect. If compliance with the terms of this MOU-DSA is a mandatory requirement of the Restated MOU, then termination of the MOU-DSA shall constitute a breach of the Restated MOU and may be grounds for termination of such agreement.

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3. Notwithstanding the foregoing, sharing of data pursuant to this Exhibit B may be suspended or terminated immediately by either Party if continued sharing of data would result in an unauthorized Use or Disclosure of PHI or PII, a material violation of Applicable Law, or otherwise jeopardize the privacy and/or security of Member information.

II. DATA SHARING POLICIES, PROCEDURES, AND OBLIGATIONS UNDER THIS MOU-DSA FOR IMPLEMENTATION OF THE RESTATED MOU

A. The Parties shall each develop internal policies and procedures to ensure the timely sharing of Member PII and PHI for care coordination/management purposes per Title 9 CCR section 1810.370(a)(3). Such policies shall be approved and implemented by September 30, 2023.

B. Subject to Applicable Law, the Parties agree that each Party may request, Use, and Disclose Member PII and PHI in relation to the performance of their respective roles and responsibilities under this Exhibit B.

C. Subject to Applicable Law, the Parties shall engage in bi-directional ongoing exchange of the data elements in Attachment B-1 at the frequencies defined therein in a manner mutually agreed by the Parties, which may include via an SFTP or API.

D. If required by Applicable Law, the disclosing Party shall obtain Authorization or Consent to share the patient's PHI or PII on or before the disclosing Party’s first treatment encounter with a patient that is a GCHP Member. Such Authorization or Consent shall allow Disclosure of PHI and PII for the purposes set forth in Section II.G.

E. In the event that Applicable Law, including those waivers of state law restrictions for CalAIM purposes, permit Disclosure of PII or PHI without Authorization or Consent, neither Party shall withhold PII or PHI where the Disclosure or exchange of such information would fall within the purposes set forth in this Exhibit B.

F. VCBH shall allow GCHP access to Authorization and/or Consent forms for

assigned Members and shall use its reasonable best efforts to respond to requests for a Member's Authorization or Consent forms within twenty-four (24) hours.

G. Subject to Applicable Law, each Party may Use the PHI, PII, and related data Disclosed under this Exhibit B for the purposes of treatment, payment, quality improvement, clinical integration, and care coordination.

H. As required by Applicable Law, each Party shall limit access to PHI, PII, and related data to their respective employees, subcontractors, or agents who have a legitimate purpose for accessing such data .

I. Each Party shall protect the PHI and PII received from the other Party in accordance with Applicable Law.

ATTACHMENT B-1
CLINICAL CARE COORDINATION DATA ELEMENTS

Data Item	VCBH Notes
MEMBER FILE MONTHLY	**NOTE: VCBH will be implementing a new EHR July 1, 2023.** **Data may change as a result of new processes / sources.** ****This Member list file will be used to match/filter GCHP data for VCBH members.**
Medi-Cal Client Index Number (Primary Identifier)	**Individuals with billed VCBH service in the prior 12 months;** **Will only include MediCal beneficiaries with a Ventura County code and Gold Coast assigned**
Member Last Name	
Member First Name	
Member Date of Birth	

Data Item	Recommended Column Name	Field Type	Format	Required?	VCBH Notes
CLINICAL FILE MONTHLY					**NOTE: VCBH will be implementing a new EHR July 1, 2023. Data may change as a result of new processes / sources.**
Member Match	*member_unique_id*	*String*	*599745*	*Required*	
Medi-Cal Client Index Number (Primary Identifier)					**Will only include MediCal beneficiaries with aVentura County code and Gold Coast assigned**
Member Last Name					
Member First Name					
Member Date of Birth					
Member Gender					
Member Residence Address 1					
Member Residence Address 2					
Member City					
Member State					
Member Zip Code					
Member Cell Phone					
Member Work Phone					
Member Home Phone					
Date of Service					
Place of Service					
ICD-10 Diagnosis (Primary)					
ICD-10 Diagnosis (Secondary)					
CPT/HCPCS Code					
CPT/HCPCS Descriptor					
Category of Service					
Future Scheduled Appointment (When Available)					
Provider Data					
Behavioral Health Provider Number (NPI)					
Behavioral Health Provider Taxonomy					
Behavioral Health Provider Name					
Behavioral Health Service/Rendering Provider					
Behavioral Health Phone #					
Behavioral Health Provider Address 1					
Behavioral Health Provider City					
Behavioral Health Provider State					
Behavioral Health Provider Zip code					
Behavioral Health Practitioner Name/Attending Practitioner					
Behavioral Health Admitting provider					
Last date of service					

Data Item
CLINICAL FILE (MONTHLY)
Member Match
Medi-Cal Client Index Number (Primary Identifier)
Member Last Name
Member First Name
Member Date of Birth
Member Gender
Member Residence Address 1
Member Residence Address 2
Member City
Member State
Member Zip Code
Member Cell Phone
Member Work Phone
Member Home Phone
Date of Service
Place of Service
ICD-10 Diagnosis
CPT/HCPCS Code
CPT/HCPCS Descriptor
Category of Service
Future Scheduled Appointment (When Available)
Behavioral Health Provider Number (NPI)
Behavioral Health Provider Taxonomy
Behavioral Health Provider Name
Behavioral Health Service/Rendering Provider
Behavioral Health Phone #
Behavioral Health Provider Address 1
Behavioral Health Provider City
Behavioral Health Provider State
Behavioral Health Provider Zip code
Behavioral Health Practitioner Name/Attending Practitione
Behavioral Health Admitting provider
Last date of service
Medication name
NDC code
Quantity dispensed
Days Supply
Drug Unit of Measure
Prescription Filled Date
Claim line type / action code
Prescriber NPI
Prescriber name
Prescriber clinic / organization

Data Item	VCBH Notes
VCBH INPT PSYCH HOSPITAL (IPU) FILE (Weekly)	**NOTE: VCBH will be implementing a new EHR July 1, 2023. Data may change as a result of new processes / sources.**
Medi-Cal Client Index Number (Primary Identifier)	**Yes, we can provide this; Will only include MediCal beneficiaries with a Ventura County code and Gold Coast assigned**
Member Last Name	
Member First Name	
Member Date of Birth	
Member Gender	
Member Residence Address 1	
Member Residence Address 2	
Member City	
Member State	
Member Zip Code	
Member Cell Phone	
Member Work Phone	
Member Home Phone	
Data Field	
Client ID /Medi-Cal ID	
Hospital Name	
Hospital Admit Date	
Hospital Discharge Date	
Hospital Disposition (e.g. to home, etc.)	
Hospital Admit Diagnosis (Primary)	
Hospital Admit Diagnosis (Secondary)	

Data Item
ED/HOSPITAL FILE (DAILY)
Member Match
Medi-Cal Client Index Number (Primary Identifier)
Member Last Name
Member First Name
Member Date of Birth
Member Demographics Encounter
Member Gender
Member Residence Address 1
Member Residence Address 2
Member City
Member State
Member Zip Code
Member Cell Phone
Member Work Phone
Member Home Phone
ED Encounter/ADT DATA
ED Name
ED Admit Date
ED Admit DX
ED Discharge date
Discharge Disposition (to home, to IPU, etc.)
HOSPITAL Encounter/ADT DATA
Hospital Name
Hospital Admit DX (Primary)
Hospital Admit DX (Secondary)
Hospital Admit Date
Hospital Discharge Date
Hospital Discharge DX (Primary)
Hospital Discharge DX (Secondary)
Discharge Disposition (to home, to IPU, etc.)

EXHIBIT C
BEHAVIORAL HEALTH QUALITY IMPROVEMENT PROGRAM DATA SHARING

I. DHCS REQUIREMENTS FOR DATA EXCHANGE UNDER THE BEHAVIORAL HEALTH QUALITY IMPROVEMENT PROGRAM

Improved data exchange capabilities is one of the three key goals for the CalAIM Behavioral Health Quality Improvement Program ("BHQIP") as required by the DHCS Guidance entitled "Behavioral Health Quality Improvement Program: CalAIM Program Implementation Plan and Instructions for County Behavioral Health Plans."

The BHQIP data exchange is intended to promote bi-directional data exchange between county behavioral health plans and MCPs in order to improve health outcomes and health equity through enhanced coordination of care by, among other things(1) meeting Center for Medicare and Medicaid Services ("CMS")-mandated interoperability standards, (2) supporting implementation of MCP Enhanced Care Management/Community Supports, and (3) improving performance on Core Set measures of health care quality (i.e., s Follow-up After Emergency Department Visit for Mental Illness ("FUM"), Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence ("FUA") and Pharmacotherapy for Opioid Use Disorder ("POD")). Demonstrating direct data sharing between a county behavioral health plan and the local MCP and demonstrating onboarding to a health information exchange are two options for county behavioral health plans to satisfy the BHQIP goal of improved data exchange capability.

II. DATA SHARING OBLIGATIONS UNDER BHQIP

A. Subject to Applicable Law, the Parties agree that each Party may request, Use, and Disclose Member PII and PHI in relation to the performance of their roles and responsibilities under this Exhibit C.

B. Subject to Applicable Law, the Parties shall engage in bi-directional ongoing exchange of the data elements specified in Attachment B-1 at the frequencies defined therein and in the manner defined by DHCS, or if not defined by DHCS, then as mutually agreed by the Parties, which may include via an SFTP or API.

C. If required by Applicable Law, the disclosing Party shall obtain Authorization or Consent to share the patient's PHI or PII on or before the disclosing Party's first treatment encounter with a patient that is a GCHP Member. Such Authorization or Consent shall allow Disclosure of PHI and PI for the purposes set forth in Section II.H.

D. In the event that Applicable Law, including those waivers of state law restrictions for CalAIM purposes, permit Disclosure of PII or PHI without Authorization or Consent, neither Party shall withhold PII or PHI where the Disclosure or exchange of such information would fall within the purposes set forth in this Exhibit C.

E. VCBH shall allow GCHP access to Authorization and/or Consent forms for assigned Members and shall use its reasonable best efforts to respond to requests for

a Member's Authorization or Consent forms within twenty-four (24) hours.

F. The Parties shall develop and implement an active Fast Healthcare Interoperability Resources ("FHIR") API that will allow GCHP and VCBH to be compliant with CMS-mandated interoperability rules.

G. The Parties shall map their respective data elements in Attachment B-1 according to the United States Core Data for Interoperability ("USCDI") standard set.

H. Subject to Applicable Law, each Party may Use PHI, PII, and related data exchanged under this Exhibit C for the purposes of treatment, payment, quality improvement, clinical integration, and care coordination for all programs under CalAIM, including but not limited to ECM, CS, and No Wrong Door, and for population health.

I. As required by Applicable Law, each Party shall limit access to PHI, PII, and related data to those employees, subcontractors, or agents who have a legitimate purpose for accessing such data.

J. Each Party shall protect the PHI and PI received from the other Party in accordance with Applicable Law.

III. OTHER OBLIGATIONS UNDER THE RESTATED MOU

A. *Dispute Resolution*. Disputes arising under this Exhibit C will be subject to the dispute resolution provisions described in Article X of the Restated MOU.

B. *Liability and Indemnity*. Article XXI of the Restated MOU shall apply to the acts and omissions of the Parties under this Exhibit C.

C. *Notices*. All notices required or permitted to be given under this Exhibit C shall be delivered in accordance with Article XXIII of the Restated MOU.

IV. TERM AND TERMINATION.

A. Unless earlier terminated in accordance with the terms of this Exhibit C, this Exhibit C shall remain in effect during the term of the Restated MOU, and shall be terminated upon termination or expiration of the Restated MOU.

B. If compliance with the terms of this MOU-DSA is a mandatory requirement of the Restated MOU, then termination of the MOU-DSA shall constitute a breach of the Restated MOU and may be grounds for termination of such agreement.Either Party may terminate this Exhibit C without cause by giving the other Party thirty (30) days' written notice of its intent to terminate. Upon any such termination, the Restated MOU shall remain in effect.

C. Notwithstanding the foregoing, sharing of data pursuant to this Exhibit C may be suspended or terminated immediately by either Party if continued sharing of data

would result in an unauthorized Use or Disclosure of PHI or PII, a material violation of Applicable Law, or otherwise jeopardize the privacy and/or security of Member information.