Memorandum of Understanding

between Health Net Community Solutions, Inc., and

Tulare County Health and Human Services Agency, Behavioral Health Branch

This Memorandum of Understanding ("MOU") is entered into by and between Health Net Community Solutions, Inc, ("MCP") and Tulare County Health and Human Services Agency, Behavioral Health Branch ("TCBH"), effective upon signature of both parties ("Effective Date"). MCP and TCBH, which includes Mental Health Plan (MHP) and Drug Medi-Cal-Organized Delivery System Plan (DMC-ODS), as well as their Subcontractors and/or Downstream Subcontractors, may be referred to herein as a "Party" and collectively as "Parties."

WHEREAS, the Parties are required to enter into this MOU, a binding and enforceable contractual agreement, under the Medi-Cal Managed Care Contract Exhibit A, Attachment III, All Plan Letters ("APL") 18-015, 22-005, 22-006, 22-028 and MHP is required to enter into this MOU pursuant to Cal. Code Regs. tit. 9 § 1810.370, MHP Contract, Exhibit A, Attachment 10, Behavioral Health Information Notice ("BHIN") 23-056 and any subsequently issued superseding BHINs, to ensure that Medi-Cal beneficiaries enrolled in MCP who are served by MHP ("Members") are able to access and/or receive mental health services in a coordinated manner from MCP and MHP;

WHEREAS, the Parties are required to enter into this MOU, a binding and enforceable contractual agreement, under the Medi-Cal Managed Care Contract Exhibit A, Attachment III, All Plan Letter ("APL") 22-005, APL 23-029, and subsequently issued superseding APLs, and DMC-ODS is required to enter into this MOU under the DMC-ODS Intergovernmental Agreement Exhibit A, Attachment I, Behavioral Health Information Notice ("BHIN") 23-001, BHIN 23-057 and any subsequently issued superseding BHINs, to ensure that Medi-Cal Members enrolled in MCP who are served by DMC-ODS ("Members") are able to access and/or receive substance use disorder ("SUD") services in a coordinated manner from MCP and DMC-ODS;

WHEREAS, the Parties desire to ensure that Members receive mental health and substance use disorder services in a coordinated manner and to provide a process to continuously evaluate the quality of the care coordination provided; and

WHEREAS, the Parties understand and agree that any Member information and data shared to facilitate referrals, coordinate care, or to meet any of the obligations set forth in this MOU must be shared in accordance with all applicable federal and state statutes and regulations, including, without limitation, 42 Code of Federal Regulations Part 2.

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

1. **Definitions.** Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with the California Department of Health Care

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

a. "MCP Responsible Person" means the person designated by MCP to oversee MCP coordination and communication with MHP/DMC-ODS and ensure MCP's compliance with this MOU as described in Section 4 of this MOU.

b. "MCP MHP/DMC-ODS Liaison" means MCP's designated point of contact responsible for acting as the liaison between MCP and MHP/DMC-ODS as described in Section 4 of this MOU. The MCP- MHP/DMC-ODS Liaison must ensure the appropriate communication and care coordination is ongoing between the Parties, facilitate quarterly meetings in accordance with Section 10 of this MOU, and provide updates to the MCP Responsible Person and/or MCP compliance officer as appropriate.

c. "MHP/DMC-ODS Responsible Person" means the person designated by MHP/DMC-ODS to oversee coordination and communication with MCP and ensure MHP/DMC-ODS compliance with this MOU as described in Section 5 of this MOU.

d. "MHP/DMC-ODS Liaison" means MHP/DMC-ODS's designated point of contact responsible for acting as the liaison between MCP and MHP/DMC-ODS as described in Section 5 of this MOU. The MHP/DMC-ODS Liaison should ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 10 of this MOU, and provide updates to the MHP/DMC-ODS Responsible Person and/or MHP/DMC-ODS compliance officer as appropriate.

e. "Network Provider", as it pertains to MCP, has the same meaning ascribed by the MCP's Medi-Cal Managed Care Contract with the DHCS; and as it pertains to MHP/DMC-ODS, has the same meaning ascribed by the MHP Contract/DMC-ODS Intergovernmental Agreement with the DHCS.

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

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

2. Term. This MOU is in effect as of the Effective Date and continues through December 31, 2028, or as amended in accordance with Section 15 f. of this MOU.

3. Services Covered by This MOU.

a. This MOU governs the coordination between MCP and MHP for Non-specialty Mental Health Services ("NSMHS") covered by MCP and further described in APL 22-006, and Specialty Mental Health Services ("SMHS") covered by MHP and further described in APL 22-003, APL 22-005, and

BHIN 21-073, and any subsequently issued superseding APLs or BHINs, executed contract amendments, or other relevant guidance. The population eligible for NSMHS and SMHS set forth in APL 22-006 and BHIN 21-073 is the population served under this MOU.

b. This MOU governs the coordination between DMC-ODS and MCP for the provision of SUD services as described in APL 22-006, and any subsequently issued superseding APLs, and Medi-Cal Managed Care Contract, BHIN 23-001, DMC-ODS Requirements for the Period of 2022-2026, and the DMC-ODS Intergovernmental Agreement, and any subsequently issued superseding APLs, BHINs, executed contract amendments, or other relevant guidance.

4. MCP Obligations.

a. Provision of Covered Services.

i. For MHP, MCP is responsible for authorizing Medically Necessary Covered Services, including NSMHS, ensuring MCP's Network Providers coordinate care for Members as provided in the applicable Medi-Cal Managed Care Contract, and coordinating care from other providers of carve-out programs, services, and benefits.

ii. For DMC-ODS, MCP is responsible for authorizing Medically Necessary Covered Services and coordinating Member care provided by the MCP's Network Providers and other providers of carve-out programs, services, and benefits.

b. Oversight Responsibility. The designated MCP Responsible Person, Manager, County Relations & MOU Compliance, is responsible for overseeing MCP's compliance with this MOU. The MCP Responsible Person must:

i. Meet at least quarterly with MHP/DMC-ODS, as required by Section 10 of this MOU;

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

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

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

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

Downstream Subcontractors, and Network Providers; and

vi. Serve, or may designate a person at MCP to serve, as the MCP-MHP/DMC-ODS Liaison, the point of contact and liaison with MHP/DMC-ODS MCP must notify MHP/DMC-ODS of any changes to the MCP- MHP/DMC-ODS Liaison in writing as soon as reasonably practical, but no later than the date of change, and must notify DHCS within five (5) Working Days of the change.

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

5. MHP/DMC-ODS Obligations.

a. Provision of Specialty Mental Health Services. MHP is responsible for providing or arranging for the provision of SMHS. Provision of DMC-ODS Services. DMC-ODS is responsible for providing or arranging covered SUD services.

b. Oversight Responsibility**.** The designated MHP/DMC-ODS Responsible Person, Division Manager, Managed Care, is responsible for overseeing MHP/DMC-ODS's compliance with this MOU. The MHP/DMC-ODS Responsible Person serves, or may designate a person to serve, as the designated MHP/DMC-ODS Liaison, the point of contact and liaison with MCP. The MHP/DMC-ODS Liaison may be the same person as the MHP/DMC-ODS Responsible Person. MHP/DMC-ODS must notify MCP of changes to the MHP/DMC-ODS Liaison as soon as reasonably practical but no later than the date of change. The MHP/DMC-ODS Responsible Person must:

i. Meet at least quarterly with MCP, as required by Section 10 of this MOU;

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

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

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

v. Ensure training and education regarding MOU provisions are conducted annually for MHP/DMC-ODS's employees responsible for carrying out activities under this MOU, and as applicable for

Subcontractors, Downstream Subcontractors, and Network Providers; and

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

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

6. Training and Education.

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

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

c. The Parties each must provide the other Party, Members, and Network Providers with training and/or educational materials on how MCP Covered Services and MHP/DMC-ODS services may be accessed, including during nonbusiness hours.

d. The Parties must together develop training and education resources covering the services provided or arranged by the Parties, and each Party must share their training and educational materials with the other Party to ensure the information included in their respective training and education materials includes an accurate set of services provided or arranged for by each Party and is consistent with MCP and MHP/DMC-ODS policies and procedures, and with clinical practice standards.

e. The Parties must develop and share outreach communication materials and initiatives to share resources about MCP and MHP/DMC-ODS with individuals who may be eligible for MCP's Covered Services and/or MHP/DMC-ODS services.

7. Mental Health Screening, Assessment, and Referrals.

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

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

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

iii. The policies and procedures must incorporate agreed-upon and/or required timeframes; list specific responsible parties by title or department; and include any other elements required by DHCS for the mandated statewide Adult Screening Tool for adults aged 21 and older, Youth Screening Tool for youth under age 21, and Transition of Care Tool, for adults aged 21 and older and youth under age 21, as well as the following requirements:

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

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

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

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

ii. The Parties must develop and implement policies and procedures addressing the process by which MCP and MHP coordinate referrals based on the completed Adult or Youth Screening Tool in accordance with

APL 22-028 and BHIN 22-065, including:

1. The process by which MHP and MCP transition Members to the other delivery system.
2. The process by which Members who decline screening are assessed.
3. The process by which MCP:
    a. Accepts referrals from MHP for assessment, and the mechanisms of communicating such acceptance and that a timely assessment has been made available to the Member.
    b. Provides referrals to MHP for assessment, and the mechanisms of sharing the completed screening tool and confirming acceptance of referral and that a timely assessment has been made available to the Member by MHP.
    c. Provides a referral to an MHP Network Provider (if processes agreed upon with MHP), and the mechanisms of sharing the completed screening tool and confirming acceptance of the referral and that a timely assessment has been made available to the Member by the MHP.
4. The process by which MHP:
    a. Accepts referrals from MCP for assessment, and the mechanisms for communicating such acceptance and that a timely assessment has been made available to the Member.
    b. Provides referrals to MCP for assessment, and the mechanisms of sharing the completed screening tool and confirming acceptance of the referral and that a timely assessment has been made available to the Member by MCP.
    c. Provides a referral to an MCP Network Mental Health Provider (if processes agreed upon with MCP), and the mechanisms of confirming the MCP Network Mental Health Provider accepted the referral and that a timely assessment has been made available to the Member by MCP.
    d. Provides a referral to MCP when the screening indicates that a Member under age 21 would benefit from a pediatrician/Primary Care Physician (“PCP”) visit.
5. The process by which MCP and MHP coordinate referrals using the Transition of Care Tool in accordance with APL 22-028 and BHIN 22-065.
6. The process by which MCP (and/or its Network Providers):
    a. Accepts referrals from MHP, and the mechanisms of communicating such acceptance, including that the Member has been connected with a Network Provider who accepts their care and that services have

been made available to the Member.

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

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

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

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

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

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

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

d. Closed Loop Referrals**.** By January 1, 2025, or future date set by DHCS, the Parties must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the CalAIM Population Health Management Policy Guide[1], APL 22-024, or any subsequent version of the APL, and as set forth by DHCS through APL, or other, similar guidance. The

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

Parties must work collaboratively to develop and implement a process to ensure that MCP and MHP comply with the applicable provisions of closed loop referrals guidance within 90 Working Days of issuance of this guidance. The Parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar guidance.

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

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

8. Substance Use Disorder Screening, Assessment, and Referrals.

a. Screening and Assessment.

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

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

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

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

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

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

ODS has procedures for accepting referrals from MCP.

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

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

iv. DMC-ODS must refer Members to MCP for Covered Services, as well as any Community Supports services or care management programs for which they may qualify, such as Enhanced Care Management ("ECM") or Complex Case Management ("CCM"). If DMC-ODS is an ECM Provider, DMC-ODS provides ECM services pursuant to that separate agreement between MCP and DMC-ODS for ECM services; this MOU does not govern DMC-ODS's provision of ECM.

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

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

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

viii. Closed Loop Referrals**.** By January 1, 2025, or future date set by DHCS, the Parties must develop a process to implement DHCS guidance regarding closed loop referrals to applicable Community Supports, ECM benefits, and/or community-based resources, as referenced in the CalAIM Population Health Management Policy Guide[2], APL 22-024, or any subsequent version of the APL, and as set forth by DHCS through APL, or other, similar guidance. The Parties must work collaboratively to develop and implement a process to ensure that MCP and MHP comply with the applicable provisions of closed loop referrals guidance within 90 Working Days of issuance of this guidance. The Parties must establish a system that tracks cross-system referrals and meets all requirements as set forth by DHCS through an APL or other, similar guidance.

9. Care Coordination and Collaboration.

a. Mental Health Care Coordination.

i. The Parties must adopt policies and procedures for coordinating Members'

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

access to care and services that incorporate all the specific requirements set forth in this MOU and ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative.

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

iii. The Parties must establish policies and procedures to maintain collaboration with each other and to identify strategies to monitor and assess the effectiveness of this MOU. The policies and procedures must ensure coordination of inpatient and outpatient medical and mental health care for all Members enrolled in MCP and receiving SMHS through MHP, and must comply with federal and State law, regulations, and guidance, including Cal. Welf. & Inst. Code Section 5328.

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

1. The specific point of contact from each Party, if someone other than each Party's Responsible Person, to act as the liaison between Parties and be responsible for initiating, providing, and maintaining ongoing care coordination for all Members under this MOU;
2. A process for coordinating care for individuals who meet access criteria for and are concurrently receiving NSMHS and SMHS consistent with the No Wrong Door for Mental Health Services Policy described in APL 22-005 and BHIN 22-011 to ensure the care is clinically appropriate and non- duplicative and considers the Member's established therapeutic relationships;
3. A process for coordinating the delivery of Medically Necessary Covered Services with the Member's PCP, including, without limitation, transportation services, home health services, and other Medically Necessary Covered Services for eligible Members;
4. Permitting Members to concurrently receive NSMHS and SMHS when clinically appropriate, coordinated, and not duplicative consistent with the No Wrong Door for Mental Health Services Policy described in APL 22-005 and BHIN 22-011.
5. A process for ensuring that Members and Network providers can coordinate coverage of Covered Services and carved-out services outlined by this MOU outside normal business hours, as well as providing or arranging for 24/7 emergency access to admission to psychiatric inpatient hospital.

v. **Transitional Care.**

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

community-based settings,[3] or transitions from outpatient therapy to intensive outpatient therapy. For Members who are admitted to an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, including, but not limited to, Short-Term Residential Therapeutic Programs and Psychiatric Residential Treatment Facilities, where MHP is the primary payer, MHPs are primarily responsible for coordination of the Member upon discharge. In collaboration with MHP, MCP is responsible for ensuring transitional care coordination as required by Population Health Management,[4] including, but not limited to:

a. Tracking when Members are admitted, discharged, or transferred from facilities contracted by MHP (e.g., psychiatric inpatient hospitals, psychiatric health facilities, residential mental health facilities) in accordance with Section 12(a)(iii) of this MOU.

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

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

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

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

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

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

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

4. The Parties must have policies and procedures for addressing changes in a Member's medical or mental health condition when transferring

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

between inpatient psychiatric service and inpatient medical services, including direct transfers.

vi. **Clinical Consultation**.

1. The Parties must establish policies and procedures for MCP and MHP to provide clinical consultations to each other regarding a Member's mental illness, including consultation on diagnosis, treatment, and medications.
2. The Parties must establish policies and procedures for reviewing and updating a Member's problem list, as clinically indicated (e.g., following crisis intervention or hospitalization), including when the care plan or problem list must be updated, and coordinating with outpatient mental health Network Providers.

vii. **Enhanced Care Management.**

1. Delivery of the ECM benefit for individuals who meet ECM Population of Focus definitions (including, but not limited to, the Individuals with Severe Mental Illness and Children Populations of Focus) must be consistent with DHCS guidance regarding ECM, including:
    a. That MCP prioritize assigning a Member to an SMHS Provider as the ECM Provider if the Member receives SMHS from that Provider and that Provider is a contracted ECM Provider, unless the Member has expressed a different preference or MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions;
    b. That the Parties implement a process for SMHS Providers to refer their patients to MCP for ECM if the patients meet Population of Focus criteria; and
    c. That the Parties implement a process for avoiding duplication of services for individuals receiving ECM with SMHS Targeted Case Management ("TCM"), Intensive Care Coordination ("ICC"), and/or Full-Service Partnership ("FSP") services as set forth in the CalAIM ECM Policy Guide, as revised or superseded from time to time, and coordination activities.

viii. **Community Supports.**

1. Coordination must be established with applicable Community Supports providers under contract with MCP, including:
    a. The identified point of contact, from each Party to act as the liaison to oversee initiating, providing, and maintaining ongoing coordination as mutually agreed upon in MCP and MHP protocols;
    b. Identification of the Community Supports covered by MCP; and
    c. A process specifying how MHP will make referrals for Members eligible for or receiving Community Supports.

ix. **Eating Disorder Services.**

1. MHP is responsible for the SMHS components of eating disorder treatment and MCP is responsible for the physical health components of eating disorder treatment and NSMHS, including, but not limited to, those in APL 22-003 and BHIN 22-009, and any subsequently issued superseding APLs or BHINs, and must develop a process to ensure such treatment is provided to eligible Members, specifically:
    a. MHP must provide for medically necessary psychiatric inpatient hospitalization and outpatient SMHS.
    b. MCP must also provide or arrange for NSMHS for Members requiring eating disorder services.
2. For partial hospitalization and residential eating disorder programs, MHP is responsible for medically necessary SMHS components, while MCP is responsible for the medically necessary physical health components.
    a. MCP is responsible for the physical health components of eating disorder treatment, including emergency room services, and inpatient hospitalization for Members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and who do not meet criteria for psychiatric hospitalization.
3. Division of Financial Responsibility
    a. MHP agrees to establish contracts detailing payment mechanisms with providers. MHP shall invoice MCP.
    b. *"MHP and MCP will split costs equally for Partial Hospitalization Program ("PHP") or Residential Treatment Centers' ("RTC") eating disorder program in accordance with the guidance outlined in APL 22-003 and BHIN 22-009. MHP is responsible for providing all the administrative components (E.g., contracting with facilities, authorization of stay, paying for 100% of the services on the front-end, and invoicing MCP for 50% of the cost post-discharge). Within this agreement, MCP requires MHP to confirm with provider(s) that MCP will not be invoiced or sent separate claims for any medical services, as the 50/50 share of cost agreement is intended to include behavioral health and medical treatment (100% of care). MHP and MCP acknowledge that the 50/50 share of cost agreement is subject to change if DHCS releases superseding APLs or BHINs that provide updated guidance or requirements. MHP and MCP will comply with future APLs and/or BHIN requirements released by the State."*

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

1. MHP is obligated to provide the names and qualification of prescribing physicians to the MCP.
2. MCP is obligated to provide the MCP's procedures for obtaining authorization of prescribed drugs and laboratory services, including a list of available pharmacies and laboratories.

b. Substance Use Disorder Care Coordination.

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

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

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

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

1. The requirement for DMC-ODS to refer Members to MCP to be assessed for care coordination and other similar programs and other services for which they may qualify provided by MCP including, but not limited to, ECM, CCM, or Community Supports;
2. The specific point of contact from each Party, if someone other than each Party's Responsible Person, to act as the liaison between Parties and be responsible for initiating, providing, and maintaining ongoing care coordination for all Members under this MOU;
3. A process for how MCP and DMC-ODS will engage in collaborative treatment planning to ensure care is clinically appropriate and non-duplicative and considers the Member's established therapeutic relationships;
4. A process for coordinating the delivery of Medically Necessary Covered Services with the Member's Primary Care Provider, including without limitation transportation services, home health services, and other Medically Necessary Covered Services for eligible Members;
5. A process for how MCP and DMC-ODS will help to ensure the Member is engaged and participates in their care program and a process for ensuring the Members, caregivers, and providers are engaged in the development of the Member's care;
6. A process for reviewing and updating a Member's problem list, as clinically indicated. The process must describe circumstances for updating problem lists and coordinating with outpatient SUD providers;
7. A process for how the Parties will engage in collaborative treatment planning and ensure communication among providers, including procedures for exchanges of medical information; and

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

v. **Transitional Care.**

1. The Parties must establish policies and procedures and develop a process describing how MCP and DMC-ODS will coordinate transitional care services for Members. A "transitional care service" is defined as the transfer of a Member from one setting or level of care to another, including, but not limited to, discharges from hospitals, institutions, and other acute care facilities and skilled nursing facilities to home- or community-based settings,[5] level of care transitions that occur within the facility, or transitions from outpatient therapy to intensive outpatient therapy and vice versa.

2. For Members who are admitted for residential SUD treatment, including, but not limited to, Short-Term Residential Therapeutic Programs and Psychiatric Residential Treatment Facilities where DMC-ODS is the primary payer, DMC-ODS is primarily responsible for coordination of the Member upon discharge. In collaboration with DMC-ODS, MCP is responsible for ensuring transitional care coordination as required by Population Health Management,[6] including, but not limited to:

   a. Tracking when Members are admitted, discharged, or transferred from facilities contracted by DMC-ODS in accordance with Section 12(a)(iii) of this MOU;

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

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

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

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

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

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

Management Policy Guide.4[7]

3. The Parties must include in their policies and procedures a process for updating and overseeing the implementation of the discharge planning documents as required for Members transitioning to or from MCP or DMC-ODS services;
4. For inpatient residential SUD treatment provided by DMC-ODS or for inpatient hospital admissions or emergency department visits known to MCP, the process must include the specific method to notify each Party within 24 hours of admission and discharge and the method of notification used to arrange for and coordinate appropriate follow-up services.

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

vii. **Enhanced Care Management.**

1. Delivery of the ECM benefit for individuals who meet ECM Population of Focus definitions (including, but not limited to, the Individuals with Severe Mental Illness and Children Populations of Focus) must be consistent with DHCS guidance regarding ECM, including:
    a. That MCP prioritize assigning a Member to a DMC-ODS Provider as the ECM Provider if the Member receives DMC-ODS services from that Provider and that Provider is a contracted ECM Provider, unless the Member has expressed a different preference or MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions; and
    b. That the Parties implement a process for DMC-ODS Providers to refer their patients to MCP for ECM if the patients meet Population of Focus criteria.
2. The Parties must implement a process for avoiding duplication of services for individuals receiving ECM with DMC-ODS care coordination. Members receiving DMC-ODS care coordination can also be eligible for and receive ECM.
3. MCP must have written processes for ensuring the non-duplication of services for Members receiving ECM and DMC-ODS care coordination.

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

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

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

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

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

10. Quarterly Meetings.

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

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

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

d. The Parties must report to DHCS updates from quarterly meetings in a manner and at a frequency specified by DHCS.

e. Local Representation. MCP must participate, as appropriate, in meetings or engagements to which MCP is invited by MHP/DMC-ODS, such as local county meetings, local community forums, and MHP/DMC-ODS engagements, to collaborate with MHP/DMC-ODS in equity strategy and wellness and prevention activities.

11. Quality Improvement. The Parties must develop QI activities specifically for the oversight of the requirements of this MOU, including, without limitation, any applicable performance measures and QI initiatives, including those to prevent duplication of services, as well as reports that track referrals, Member engagement, and service utilization. For MHP such QI activities must include processes to monitor the extent to which Members are able to access mental health services across SMHS and NSMHS, and Covered Service utilization. The Parties must document these QI activities in policies and procedures.

12. Data Sharing and Confidentiality. The Parties must establish and implement policies and procedures to ensure that the minimum necessary Member

information and data to accomplish the goals of this MOU are exchanged timely and maintained securely and confidentially and in compliance with the requirements set forth below to the extent permitted under applicable State and federal law. The Parties will share protected health information ("PHI") for the purposes of medical and behavioral health care coordination pursuant to Cal. Code Regs. tit. 9, Section 1810.370(a)(3, Welfare and Institutions § 14184.102(j), and to the fullest extent permitted under the Health Insurance Portability and Accountability Act and its implementing regulations, as amended ("HIPAA"), 42 Code Federal Regulations Part 2, and other State and federal privacy laws. For additional guidance, the Parties should refer to the CalAIM Data Sharing Authorization Guidance[8].

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

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

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

iii. A process for MHP/DMC-ODS to send admission, discharge, and transfer data to MCP when Members are admitted to, discharged from, or transferred from facilities contracted by MHP/DMC-ODS (e.g., psychiatric inpatient hospitals, psychiatric health, residential mental health facilities, residential SUD treatment facilities, SUD withdrawal management facilities), and for MCP to receive this data. This process may incorporate notification requirements as described in Sections 9(a)(v)(3) and 9(b)(v)(3);

iv. A process to implement mechanisms to alert the other Party of behavioral health crises (e.g., MHP alerts MCP of Members' uses of mobile health,

[8] CalAIM Data Sharing Authorization Guidance available at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/CalAIM-Data-Sharing-Authorization-Guidance.pdf

psych inpatient, and crisis stabilization and MCP alerts MHP of Members' visits to emergency departments and hospitals, DMC-ODS alerts MCP of uses of SUD crisis intervention); and

v. A process for MCP to send admission, discharge, and transfer data to MHP/DMC-ODS when Members are admitted to, discharged from, or transferred from facilities contracted by MCP (e.g., emergency department, inpatient hospitals, nursing facilities), and for MHP/DMC-ODS to receive this data. This process may incorporate notification requirements as described in Sections 9(a)(v)(3) and 9(b)(v)(3).

vi. MCP and MHP/DMC-ODS must enter into the State's Data Exchange Framework Data Sharing Agreement ("DSA") for the safe sharing of information.

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

c. Interoperability.

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

ii. MCP and DMC-ODS must exchange data in compliance with the payer-to-payer data exchange requirements pursuant to 45 Code of Federal Regulations Part 170. MCP must make available to Members their electronic health information held by the Parties and make available an application program interface that makes complete and accurate Network Provider directory information available through a public-facing digital endpoint on MCP's and DMC-ODS's respective websites pursuant to 42 Code of Federal Regulations Section 438.242(b) and 42 Code of Federal Regulations Section 438.10(h). The Parties must comply with DHCS interoperability requirements set forth in APL 22-026 and BHIN 22-068, or any subsequent version of the APL and BHIN, as applicable.

iii. Disaster and Emergency Preparedness. Implementation by 2025-The Parties must develop policies and procedures to mitigate the effects of natural, man-made, or war-caused disasters involving emergency situations and/or broad health care surge events greatly impacting the Parties' health care delivery system to ensure the continued coordination and delivery of MHP/DMC-ODS services and MCP's Covered Services for impacted

Members.

13. Dispute Resolution.

a. The Parties must agree to dispute resolution procedures such that in the event of any dispute or difference of opinion regarding the Party responsible for service coverage arising out of or relating to this MOU, the Parties must attempt, in good faith, to promptly resolve the dispute mutually between themselves. The Parties must document the agreed-upon dispute resolution procedures in policies and procedures. Pending resolution of any such dispute, MCP and MHP/DMC-ODS must continue without delay to carry out all responsibilities under this MOU unless the MOU is terminated. If the dispute cannot be resolved within 15 Working Days of initiating such negotiations for both MHP and DMC-ODS , either Party may pursue its available legal and equitable remedies under California law. Disputes between MCP and MHP/DMC-ODS that cannot be resolved in a good faith attempt between the Parties must be forwarded by MCP and/or MHP/DMC-ODS to DHCS.

b. Disputes between MCP and MHP

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

ii. A dispute between MHP and MCP must not delay the provision of medically necessary SMHS, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries as required by Cal. Code Regs. tit. 9, § 1850.525;

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

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

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

Member's care; or

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

iv. If decisions rendered by DHCS find MCP is financially liable for services, MCP must comply with the requirements in Cal. Code Regs. tit. 9, § 1850.530.

v. The Parties may agree to an expedited dispute resolution process if a Member has not received a disputed service(s) and the Parties determine that the routine dispute resolution process timeframe would result in serious jeopardy to the Member's life, health, or ability to attain, maintain, or regain maximum function. Under this expedited process, the Parties will have one Working Day after identification of a dispute to attempt to resolve the dispute at the plan level. All terms and requirements established in APL 21-013 and BHIN 21-034 apply to disputes between MCP and MHP where the Parties cannot agree on the appropriate place of care. Nothing in this MOU or provision must constitute a waiver of any of the government claim filing requirements set forth in Title I, Division 3.6, of the California Government Code or as otherwise set forth in local, state, and federal law.

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

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

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

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

c. Disputes between MCP and DMC-ODS

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

ii. MCP must monitor and track the number of disputes with DMC-ODS where the Parties cannot agree on an appropriate place of care and,

upon request, must report all such disputes to DHCS.

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

1. The Parties may agree to an arrangement satisfactory to both Parties regarding how the services under dispute will be provided; or
2. When the dispute concerns MCP's contention that DMC-ODS is required to deliver SUD services to a Member and DMC-ODS has incorrectly determined the Member's diagnosis to be a diagnosis not covered by DMC-ODS, MCP must manage the care of the Member under the terms of its contract with the State, including providing or arranging and paying for those services until the dispute is resolved.
3. When the dispute concerns DMC-ODS's contention that MCP is required to deliver physical health care-based treatment, or to deliver prescription drugs or laboratory, radiological, or radioisotope services required to diagnose, DMC-ODS is responsible for providing or arranging and paying for those services until the dispute is resolved.

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

14. Equal Treatment.

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

15. General.

a. MOU Posting. MCP and MHP/DMC-ODS must each post this executed MOU on its website.

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

c. Notice. Any notice required or desired to be given pursuant to or in connection with this MOU must be given in writing, addressed to the noticed Party at the Notice Address set forth below the signature lines of this MOU. Notices must be (i) delivered in person to the Notice Address; (ii) delivered by messenger or overnight delivery service to the Notice Address; (iii) sent by regular United States mail, certified, return receipt requested, postage prepaid, to the Notice Address; or (iv) sent by email, with a copy sent by regular United States mail to the Notice Address. Notices given by in-person delivery, messenger, or overnight delivery service are deemed given upon actual delivery at the Notice

Address. Notices given by email are deemed given the day following the day the email was sent. Notices given by regular United States mail, certified, return receipt requested, postage prepaid, are deemed given on the date of delivery indicated on the return receipt. The Parties may change their addresses for purposes of receiving notice hereunder by giving notice of such change to each other in the manner provided for herein.

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

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

f. Amendment**.** This MOU may only be amended or modified by the Parties through a writing executed by the Parties. However, this MOU is deemed automatically amended or modified to incorporate any provisions amended or modified in the Medi- Cal Managed Care Contract, the MHP Contract, and/DMC-ODS Intergovernmental Agreement, any subsequently issued superseding APLs, BHINs, or guidance, or as required by applicable law or any applicable guidance issued by a State or federal oversight entity.

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

h. Independent Contractors**.** No provision of this MOU is intended to create, nor is any provision deemed or construed to create, any relationship between MHP/DMC-ODS and MCP other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this MOU. Neither MHP/DMC-ODS nor MCP, nor any of their respective contractors, employees, agents, or representatives, is construed to be the contractor, employee, agent, or representative of the other.

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

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

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

Health Net Community Solutions, Inc.:

Signature: Dorothy Selesky
B9C33EEC816C499...

Print Name: Dorothy Selesky

Title: Senior President, Medi-Cal

Date: 05/29/2025

Signature: Signed by: Amber Kemp
F7DDDD538058413...

Print Name: Amber Kemp

Title: Vice President, Medi-Cal

Date: 05/28/2025

Mail To:
Health Net Community Solutions, Inc.
21281 Burbank Blvd,
Woodland Hills, CA 91367

County of Tulare:

Signature: _____

Print Name: Pete Vander Poel III

Title: Chair, Board of Supervisors

Date: 10/24/2025

Mail To: Attention Contracts Unit
HEALTH & HUMAN SERVICES AGENCY
5957 S. Mooney Boulevard
Visalia, CA 93277
Phone No.: 559-624-8000
Fax No.: 559-737-4059

With a Copy to:

COUNTY ADMINISTRATIVE OFFICER
2800 W. Burrel Ave.
Visalia, CA 93291
Phone No.: 559-636-5005
Fax No.: 559- 733-6318

ATTEST: JASON T. BRITT
County Administrative Officer/Clerk of the Board of Supervisors of the County of Tulare

By _____ Date 10/24/2025
Deputy Clerk

Approved as to Form:
County Counsel

By Eric M. Scott Date 05/29/205
Deputy

Matter # 2025512

Exhibit A

MCP Liaisons as referenced in Section 4.b of this MOU

Liaisons	**HealthNet Community Solutions, Inc.**
MCP Responsible Person	Bryan Weiss, Program Manager, County Relations & MOU Compliance
MCP-MHP Liaison	Perry Shelton Jr., Community Liaison – Service Coordination

Exhibit B

MHP/DMC-ODS Liaisons as referenced in Section 5.b of this MOU

Liaison	**MHP/DMC-ODS**
MHP Responsible Person	Angela Sahagun, Division Manager Managed Care
MHP Liaison	Betsy Ellis, QI Manager
DMC-ODS Responsible Person	Angela Sahagun, Division Manager Managed Care
DMC-ODS Liaison	Chandler Bailey, QI Manager

Exhibit C

Data Elements

a. MCP and MHP must share the following data elements:
    i. Member demographic information (Medi-Care ID and Medi-Care Beneficiary Identification (MBI) if/as applicable);
    ii. Behavioral, dental, and physical health information;
    iii. Diagnoses, progress notes, and assessments;
    iv. Medications prescribed;
    v. Laboratory results; and
    Known changes in condition that may adversely impact the Member's health and/or welfare and that are relevant to the services.