MHMOU471

MEMORANDUM OF UNDERSTANDING

between

HEALTH NET COMMUNITY SOLUTIONS, INC.

and

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding ("MOU") is entered into by and between the **Health Net Community Solutions, Inc.** ("Health Net", or "Managed Care Plan", or "MCP**"**) and the **Los Angeles County Department of Mental Health** ("LACDMH", or "Mental Health Plan", or "MHP") *,* effective as of the last date of signature indicated on the signature page ("Effective Date"). For the purposes of this MOU, Health Net also includes beneficiaries receiving Medi-Cal services through assignment to the following delegated health plans: Molina Healthcare of California ("MCP"). MHP, MCP, and MCP's relevant 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 desire to ensure that Members receive MHP 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 and ensure MCP's compliance with this MOU as described in Section 4 of this MOU.

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

c. "MHP Responsible Person" means the person designated by MHP to

oversee coordination and communication with MCP and ensure MHP's compliance with this MOU as described in Section 5 of this MOU.

d. "MHP Liaison" means MHP's designated point of contact responsible for acting as the liaison between MCP and MHP as described in Section 5 of this MOU. The MHP Liaison should ensure appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the MHP Responsible Person and/or MHP 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, has the same meaning ascribed by the MHP Contract 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, has the same meaning ascribed by the MHP Contract 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, means a subcontractor of a MHP Subcontractor.

2. Term and Termination.

a. This MOU is in effect as of the last date of signature as indicated on the signature page, also referred to as the full execution date ("Effective Date") and shall continue through December 31, 2029 ("Initial Term"), with an option to extend for an additional five (5) years ("Renewal Term"), unless terminated subject to the provisions below.

b. At least one hundred eighty (180) calendar days prior to the expiration of the Initial Term of this MOU, the Parties agree to meet and review the existing MOU terms and conditions, as may be amended in accordance with Section 14.f of this MOU, to determine whether to extend the MOU for an additional five (5) years to create a Renewal Term, under the same terms and conditions with no further action by both Parties; or for Parties to enter into a new/replacement MOU.

c. The Initial Term and any applicable Renewal Term are collectively referenced herein as "Term", unless terminated subject to the provision below.

d. Termination. Notwithstanding the above, either Party may terminate this MOU with or without cause upon thirty (30) calendar day's written notice to the other Party. This MOU may be terminated immediately upon the mutual written agreement of the Parties.

3. Services Covered by This MOU. 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; Specialty Mental Health Services ("SMHS") covered by MHP and further described in APL 22-003, APL 22-005; 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.

4. MCP Obligations.

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

b. **Oversight Responsibility.** The Community Liaison and Program Manager, the designated MCP Responsible Person listed in Exhibit A of this MOU, is responsible for overseeing MCP's compliance with this MOU. The MCP Responsible Person must:

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

ii. report on MCP's compliance with the MOU to MCP's compliance officer at least quarterly. MCP's compliance officer is responsible for MOU compliance oversight reports as part of MCP's compliance program and must address any compliance deficiencies in accordance with MCP's compliance program policies;

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

iv. ensure the appropriate levels of MCP leadership (i.e., persons with decision-making authority) are involved in implementation and oversight of the MOU engagements and ensure the appropriate levels of leadership from MHP 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 designate a person at MCP to serve, as the MCP- MHP Liaison, the point of contact and liaison with MHP. The MCP-MHP Liaison is listed in Exhibit A of this MOU. MCP must notify MHP of any changes to the MCP-MHP Liaison in writing as soon as reasonably practical but no later than the date of change and must notify DHCS within 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 Obligations.

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

b. **Oversight Responsibility.** The Mental Health Program Manager, the designated MHP Responsible Person listed on Exhibit B of this MOU, is responsible for overseeing MHP's compliance with this MOU. The MHP Responsible Person serves, or may designate a person to serve, as the designated MHP Liaison, the point of contact and liaison with MCP. The MHP Liaison is listed on Exhibit B of this MOU. The MHP Liaison may be the same person as the MHP Responsible Person. MHP must notify MCP of

changes to the MHP Liaison as soon as reasonably practical but no later than the date of change. The MHP Responsible Person must:

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

ii. report on MHP's compliance with the MOU to MHP's compliance officer at least quarterly. MHP's compliance officer is responsible for MOU compliance oversight and reports as part of MHP's compliance program and must address any compliance deficiencies in accordance with MHP's compliance program policies;

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

iv. ensure the appropriate levels of MHP 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 to MHP'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, and reporting to the MHP Responsible Person.

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

6. Training and Education.

a. To ensure compliance with this MOU, the Parties must provide training and orientation for their employees who 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 responsibilities as of the Effective Date, the Parties must provide this training within 60 Working Days of the Effective Date. Thereafter, the Parties must provide this training prior to any such person or entity performing responsibilities under this MOU and to all such persons or entities at least annually thereafter. The Parties must require their Subcontractors and Downstream Subcontractors to provide training on relevant MOU requirements and MHP 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 Providers with educational materials related to accessing Covered Services, including services provided by MHP.

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 services may be accessed, including during nonbusiness hours.

The Parties agree to the following additional requirements:

- The Parties together have developed training and educational resources covering the services provided or arranged by the Parties, and each Party will 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 policies and procedures, and with clinical practice standards.
- The Parties will develop and share outreach communication materials and initiatives to share resources about MCP and MHP with individuals who may be eligible for MCP's Covered Services and/or MHP services.

7. 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 1) sharing the completed screening tool; and 2) confirming acceptance of the referral and that a timely assessment has been made available to the Member by MHP.
4. The process by which MHP:
   a. Accepts referrals from MCP for assessment, and the mechanisms for communicating such acceptance and that a timely assessment has been made available to the Member.
   b. Provides referrals to MCP for assessment, and the mechanisms of sharing the completed screening tool and confirming acceptance of the referral and that a timely assessment has been made available to the Member by MCP.
   c. Provides a referral to an MCP Network Mental Health Provider (if processes agreed upon with MCP), and the mechanisms of confirming the MCP Network Mental Health Provider accepted the referral and that a timely assessment has been made available to the Member by MCP.
   d. Provides a referral to MCP when the screening indicates that a Member under age 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. Coordinates 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.

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.

The Parties agree to additional requirements such as:

Closed Loop Referrals. Effective July 1, 2025, MCP must comply with DHCS CLR Implementation Guidance. For all referrals made to ECM, Community Supports, and future CLR-applicable services, MCP must implement procedures to track, support, and monitor referrals submitted by MHP through referral closure. MCP must also adhere to requirements for notifying the MHP of the authorization status, referral loop closure reason and closure date within timeframes outlined in the guidance to support MHP in their awareness of referral status and outcomes for Members referred to CLR services. The Parties will work together collaboratively to establish the means and methods for MCP notifications for CLRs. DHCS requires MCPs to use electronic methods to notify referring entities of a referral's status, not paper-based methods.

8. **Care Coordination and Collaboration.**

a. **Care Coordination.**

i. The Parties must adopt policies and procedures for coordinating Members' access to care and services that incorporate all the specific requirements set forth in this MOU 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,[1] 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,[2] 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 11(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.

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

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

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

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

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

vi. **Clinical Consultation.**

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

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

vii. **Enhanced Care Management.**

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

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

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

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

viii. **Community Supports.**

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

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

b. Identification of the Community Supports covered by

MCP; and

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

ix. **Eating Disorder Services.**

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

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

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

2. For partial hospitalization and residential eating disorder programs, MHP is responsible for medically necessary SMHS components, while MCP is responsible for the medically necessary physical health components.

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

b. LACDMH is responsible for providing all the administrative components (e.g., contracting with facilities, authorization of stay, issuing payment to the treating facility by paying for 100% of the services on the front-end, and invoicing Health Net for 50% of the cost monthly to Health Net). For members delegated to Molina, LACDMH will invoice Molina directly for 50% of the cost. Health Net and Molina shall remit payment to LACDMH. Within this agreement, LACDMH to confirm with provider(s) that neither Health Net nor Molina will not be invoiced or sent separate claims for any medical services, provided, pursuant to this section, as the 50/50 share of cost agreement is intended to include behavioral health and medical treatment (100% of care). LACDMH and Health Net acknowledge that the 50/50 share of cost agreement is subject to change in the event that DHCS releases superseding APLs or BHINs that provide updated guidance or requirements. LACDMH and Health Net will comply with future APLs and/or BHIN requirements released by the State. LACDMH and Health Net mutually agree upon a 50/50 shared cost to arrange and pay for eating disorder services provided in partial hospitalization program, intensive outpatient programs, and residential treatment center services.

x. **Prescription Drugs.**

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

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

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

9. Quarterly Meetings.

a. The Parties must meet as frequently as necessary to ensure proper oversight of this MOU but at least 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, 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 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 frequency specified by DHCS.

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

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

11. Data Sharing and Confidentiality. The Parties must establish and implement policies and procedures to ensure that the minimum necessary Member information and data for accomplishing the goals of this MOU are exchanged timely and maintained securely, confidentially, and in compliance with the requirements set forth below to the extent permitted under applicable State and federal law. For members delegated to Molina, Health Net will share LACDMH data with Molina. 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), 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.[3]

a. **Data Exchange.** Except where prohibited by law or regulation, MCP and MHP must share the minimum necessary data and information to facilitate referrals and coordinate care under this 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, for ensuring the confidentiality of exchanged information and data and, if necessary, for obtaining Member consent, when required. The minimum necessary information and data elements to be shared as agreed upon by the Parties are set forth in Exhibit 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 and MCP must establish policies and procedures to implement the following with regard to information sharing:

i. A process for timely exchange of information about Members eligible for ECM, regardless of whether the SMHS provider is serving as an ECM provider;

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

iii. A process for MHP to send admission, discharge, and transfer data to MCP when Members are admitted to, discharged from, or transferred from facilities contracted by MHP (e.g., psychiatric inpatient hospitals, psychiatric health facilities, residential mental health facilities) and for MCP to receive this data. This process may incorporate notification requirements as described in Section 8(a)(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, psych inpatient, and crisis stabilization; and MCP alerts MHP of Members' visits to emergency departments and hospitals); and

v. A process for MCP to send admission, discharge, and transfer data to MHP when Members are admitted to, discharged from, or transferred from facilities contracted by MCP (e.g., emergency department, inpatient hospitals, nursing facilities) and for MHP to receive this data. This process may incorporate notification requirements as described in Section 8(a)(v)(3).

The Parties agree to additional requirements such as:

- MCP and MHP will enter into the State's Data Exchange Framework Data Sharing Agreement ("DSA") for the safe sharing of information.
- If Member authorization is required, the Parties agree to a standard consent form

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

to obtain a Member's authorization to share and use information for the purposes of treatment, payment, and care coordination protected under 42 Code of Federal Regulations Part 2.

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

c. **Interoperability.** 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 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).

d. **Disaster and Emergency Preparedness.** The Parties will 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 services and MCP's Covered Services for impacted Members.

12. Dispute Resolution.

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

b. Disputes between MCP and MHP that cannot be resolved in a good faith attempt between the Parties must be forwarded to DHCS via a written "Request for Resolution" by either MHP or MCP within three 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 Exhibit E, Section 1.21 (Contractor's Dispute Resolution Requirements).

c. A dispute between MHP and MCP must not delay the provision of medically

necessary SMHS, physical health care services, or related prescription drugs and laboratory, radiological, or radioisotope services to beneficiaries as required by Cal. Code Regs. tit. 9, § 1850.525.

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

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

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

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

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

f. The Parties may agree to an expedited dispute resolution process if a Member has not received a disputed service(s) and the Parties determine that the routine dispute resolution process timeframe would result in serious jeopardy to the Member's life, health, or ability to attain, maintain, or regain maximum function. Under this expedited process, the Parties will have one 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.

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

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

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

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

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

14. General.

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

b. **Documentation Requirements.** MCP and MHP 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. 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 may delegate their 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 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 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; 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. **Policies and Procedures.** All Parties to this MOU shall maintain and adhere to all pertinent policies and procedures referenced herein. Any modifications or updates to these policies and procedures must be discussed jointly and collaboratively by all Parties. No changes shall be implemented without the prior approval and mutual consent of all other Parties to ensure alignment and consistency in the implementation of this MOU.

h. **Governance.** This MOU is governed by and construed in accordance with the laws of the state of California.

i. **Independent Contractors.** No provision of this MOU is intended to create, nor is any provision deemed or construed to create any relationship between MHP 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 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.

j. **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.

k. **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.

15. Indemnification. MCP and MHP shall indemnify, defend and hold harmless each other, their elected and appointed officers, directors, employees, and agents from and against any demands, claims, damages, liability, loss, actions, fees, costs, and expenses, including reasonable attorneys' fees, or any property, resulting from the misconduct, negligent acts, errors or omissions by the other party or any of its officers, directors, employees, agents, successor or assigns related to this MOU, its terms and conditions, including, without limitation, a breach or violation of any State or federal privacy and/or security laws, regulations and guidance relating to the disclosure of PHI, personally identifiable information or other confidential information of a party hereunder. The terms of this Article shall survive termination of this MOU.

16. Insurance. General Provisions for all Insurance Coverage: Without limiting either party's indemnification of the other, and during the pendency of this MOU, each party shall provide and maintain at its own expense insurance coverage, which may include self-insurance, sufficient for liabilities which may arise from or relate to this MOU.

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

MCP	**Health Net Community Solutions, Inc.**	**MHP**	**Los Angeles County Department of Mental Health**
Signature:		Signature:	
Name:	Dorothy Seleski	Name:	Lisa H. Wong, Psy.D.
Title:	Medi-Cal President	Title:	Director, Department of Mental Health
Date:	07/13/2025	Date:	07/14/25
Notice Address:		Notice Address:	
	21281 Burbank Blvd. Woodland Hills, CA 91367		510 S. Vermont Ave., Los Angeles, CA 90020

Subcontractor	**Molina Healthcare of California**
Signature:	
Name:	Abbie Totten
Title:	Plan President
Date:	7/14/2025
Notice Address:	
	200 Oceangate, Long Beach, CA 90802

Exhibits A & B

MCP	**Health Net Community Solutions, Inc.**	
	MCP Responsible Person: Program Manager	MCP Liaison: Community Liaison
MCP	**Molina Healthcare**	
	MCP Responsible Person: Behavioral Health Director	MCP Liaison: Behavior Health Program Manager
MHP	**Los Angeles County Department of Mental Health**	
	MHP Responsible Person: Mental Health Program Manager Email: icdcct@dmh.lacounty.gov	Mental Health Liaison: Mental Health Program Analyst III Email: icdcct@dmh.lacounty.gov

Exhibit C

Data Elements and Data Exchange Protocol

I. Data Elements:

The Parties agree to additional data elements to incorporate and/or include a Data Sharing Agreement between the Parties.

MCP and MHP agree to sharing the following data elements:

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

II. Data Exchange Protocol:

A. Behavioral Health Data

1. Background

This section of the document describes the data exchange protocol for the purpose of coordinating physical health, primary care, and specialty Behavioral Health (BH) care among enrollees of Health Net Community Solutions, Inc. (HEALTH NET), who are also clients of Los Angeles County Department of Mental Health (LACDMH or DMH). This document serves as a protocol for the exchange of protected health and identifying information between the two Parties.

2. Data Exchange Details-Data Matching

a. HEALTH NET Eligibility File Demographic Data. HEALTH NET shall extract a file of current Members enrolled in its Medi-Cal Managed Care program on the date the file is extracted from its eligibility system, as applicable ("HEALTH NET Eligibility File"). DMH will provide a secured location for HEALTH NET to place the HEALTH NET Eligibility File, initially in the form of a flat text file or an X12 834 file, on an interval agreed upon by DMH and HEALTH NET. The HEALTH NET Eligibility File shall contain the following demographic data elements as available to HEALTH NET:

- Member First Name
- Member Last Name
- Member Client Identification Number (CIN)
- Member Date of Birth
- Member Residence Address
- Member Residence City
- Member Residence State
- Member Residence Zip code
- Member Gender
- Member Ethnicity
- Member Race
- HEALTH NET Internal Member Identification Number
- Primary Care Physician Name
- Primary Care Physician Contact Phone Number
- Primary Care Physician Address
- Member Redetermination Date

The above data in the HEALTH NET Eligibility File shall be referred to as "Eligibility Data".

3. DMH Purpose

a. Match to Identify Common Beneficiaries.DMH shall use the HEALTH NET Eligibility File and the Eligibility Data therein to conduct a match of Members who are also DMH clients and receiving Mental Health services at DMH (Common Beneficiary(ies)) on an interval agreed upon by both Parties. Upon receipt of the HEALTH NET Eligibility File, DMH shall load the Eligibility Data to the DMH Data Warehouse.

   Upon completion of the match, DMH shall permanently delete and destroy from all systems and files, including the DMH Data Warehouse, any Eligibility Data of Members who did not match and are also not current DMH clients receiving Mental Health services at DMH (Non-matched Members). DMH shall attest to the destruction of data (shown in Exhibit C.1) with respect to the permanent deletion and destruction of Eligibility Data of Non-matched Members. DMH shall not use any data or information of Non-matched Members for any purpose.

   DMH will provide HEALTH NET with a file representing Common Beneficiaries and the data elements as provided in Section 3 below. DMH will include Common Beneficiaries data and MH Provider contact information in the file sent to HEALTH NET.

b. Care Coordination of Common Beneficiaries. DMH may use the Eligibility Data of Common Beneficiaries for care and treatment purposes, including care coordination, and internal operational purposes as allowable under the Privacy Rules.

   DMH shall not use the Eligibility File or any Eligibility Data therein for any other purpose except as permitted under this MOU.

c. Match Details

Upon receipt of the Member file DMH shall load the data to the DMH Enterprise Data Warehouse. DMH shall maintain a historical table of beneficiaries and their respective eligibility information. DMH shall conduct a match of concomitant beneficiaries between MCP and DMH on an interval agreed upon by both parties. The match process shall utilize the demographic data to identify or "match" like clients of DMH and MCP. The match is performed in "tiers" where client data cascades through multiple algorithms to identify like records. When a record does not meet criteria, it is passed to the next algorithm. This process continues until a positive match is found or the record has been passed through all tier criteria. For example, records that do not match on Tier 0 will pass to Tier 1, etc. Each Tier contains unique criteria which must be met in order to match records. The criteria may contain fuzzy match variables weighted at specified degrees, where a higher weight specifies that the variable must match to a greater precision. The following is a summary of criteria and variable weights:

Tier 0:

- Member Client Identification Number weighted at 100%
- Member Date of Birth weighted at 100%

Tier 1:

- Member Client Identification Number weighted at 85%
- Member Full Name weighted at 90%

Tier 2:

- Member Client Identification Number weighted at 85%
- Member Last Name weighted at 85%

Tier 3:

- Member Client Identification Number weighted at 100%
- Member Year of birth weighted at 100%

Tier 4:

- Member Full Name weighted at 90%
- Member Date of Birth weighted at 100%
- Member Gender weighted at 100%

Tier 5:

- Member Full Name weighted at 80%
- Member Date of Birth weighted at 100%
- Member Gender weighted at 100%

OR

- Member Full Name Order reversal weighted at 80%
- Member Date of Birth weighted at 100%
- Member Gender weighted at 100%

4. DMH Data Exchange/Response Data File

a. Response Data File to HEALTH NET.Upon completion of the match as provided above, DMH shall extract and provide (as described below) of Common Beneficiaries including those who currently have an open and active episode in DMH's Integrated Behavioral Health Information System (IBHIS) or successor Managed Care Information System (MCIS) or any successor information system thereto to HEALTH NET in the form of a flat text file or an X12 834 file. DMH's data file shall be referred to as the "Response Data File". DMH will provide the following data elements in the Response Data File as available to DMH:

Report # 1: Common Beneficiary Demographic Data File:

- Medicare-Medicaid Plan (MMP) Internal Member Number
- Common Beneficiary CIN
- Common Beneficiary Last Name
- Common Beneficiary First Name
- Common Beneficiary Gender
- Common Beneficiary Date of Birth
- Common Beneficiary Residence Address 1
- Common Beneficiary Residence Address 2
- Common Beneficiary City
- Common Beneficiary State
- Common Beneficiary Zip code
- Common Beneficiary Cell Phone
- Common Beneficiary Work Phone
- Common Beneficiary Home Phone
- Common Beneficiary Health Plan ID

Report #2: Common Beneficiary Service Data File:

- Common Beneficiary CIN
- Common Beneficiary ID
- Claim Number
- Service Line Sequence Number
- Date of Service or Fill Date
- Distinct Procedures (Current Procedural Terminology [CPT]) or other applicable codes
- Episode Admit Date
- Last Contact Date
- Provider Number
- Provider Name
- Service Location National Provider Identifier (NPI)
- Servicing Provider NPI
- Place of service
- Provider - Contact Name
- Provider Phone Number
- Provider Address 1
- Provider City
- Provider State
- Provider Zip code
- Practitioner Name
- Practitioner NPI
- Claim Status
- Services Receiving (including but not limited to ECM, TCM, ICC, FSP)

Report #3: Common Beneficiary Diagnostic Data File:

- Common Beneficiary CIN
- Common Beneficiary ID
- Claim Number
- Diagnosis Sequence Number
- Date of Service
- ICD Type (9 or 10)
- Distinct Diagnosis (ICD Code)

Report #4: Common Beneficiary Inpatient Data:

- Common Member CIN
- Member Last Name
- Member First Name
- DMH Client ID
- Member Date of Birth
- Facility Name
- Facility Type
- Admission Date

- Discharge Date
- Primary Admission Diagnosis (ICD 10)
- Primary Discharge Diagnosis (ICD 10)
- Additional diagnosis if more than 1 primary diagnosis

The Response Data File will be placed on a secure server administered and maintained by DMH. DMH shall ensure that the disclosure complies with this MOU, and all applicable rules and regulations prior to uploading the Response Data File to the secure server. HEALTH NET will retrieve the Response Data File.

5. HEALTH NET Purpose re: Care Coordination

HEALTH NET will use the information in the Response Data File for the purposes of coordinating Common Beneficiaries' care, treatment, benefits and services rendered. HEALTH NET may distribute and further disclose the information in the Response Data File, including but not limited to mental health provider contact information to its providers, including but not limited to Primary Care Providers (PCP), Plan Partners and Participating Provider Groups (PPG's) (collectively LAC Providers), as appropriate using one of the following methods or another secure method as allowable under applicable laws, rules and regulations:

- A list will be generated for the PCP's own assigned members and distributed via provider portal or any other secure method, to be mutually agreed upon by DMH and HEALTH NET, e.g., sFTP site, which is compliant with applicable rules and regulations.
- The data may be accessible via a Provider Portal or other secure electronic platform with security controls which limit display to the PCP's assigned Members based on user credentials.
- A list will be generated to the Participating Provider Group (PPG) via provider portal, or another secure method, e.g., sFTP site, which is compliant with applicable rules and regulations, for its respective PCPs. The PPG can then forward a list to PCPs of their respective assigned members.
- HEALTH NET may also distribute the Common Beneficiary's information to other providers and plan partners who arrange for and/or render care, treatment, benefits, and services to the Common Beneficiary in a secure manner, as allowable under applicable rules and regulations. That provider may then forward the Member's information to other providers and entities who provide care, treatment and other services, e.g. coordination of care, to the Member and may use such information as allowable under applicable rules and regulations.

HEALTH NET may also use the Common Beneficiary information for the care and treatment of a Member, including, but not limited to, care coordination; provision of covered benefits to the Member; provision of services required or allowable under applicable rules and regulations (e.g., health education); health plan operations (e.g., quality improvement); and as allowable under applicable rules and regulations. HEALTH NET shall not use or disclose the information for any other purpose except as allowable under the MOU and applicable

rules and regulations.

B. Housing Status and Housing Program/Services Data

1. Background

This section of the document describes the data exchange protocol for the purpose of performing member matching and sharing information on housing status of Common Beneficiaries. DMH will conduct this matching based upon the agreed approach. This section of the document serves as a protocol for the exchange of protected health and identifying information between the two parties.

2. Data Elements from HEALTH NET to DMH

a. Enhanced Care Management (ECM)/Community Supports (CS) Data. HEALTH NET shall extract a file of current Members enrolled in its Medi-Cal Managed Care program who are enrolled in the ECM and/or CS programs and/or receiving ECM and CS services (ECM/CS Members) in its systems, as applicable. DMH will provide a secured location for HEALTH NET to place a data file of these ECM/CS Members, initially in the form of a flat text file or an X12 834 file, on an interval agreed upon by DMH and HEALTH NET. The data file shall be referred to as the "ECM/CS File" and shall contain the following demographic and housing status data elements of ECM/CS Members as available to HEALTH NET on the date the data is extracted:

- Member CIN
- Program Name (for any ECM or CS programs, not to include Sobering Centers CS)
- Program eligibility effective date
- Program eligibility term date
- Program Enrollment effective date
- Program Enrollment Term date
- Servicing Provider's Name
- Servicing Provider's Physical address line 1
- Servicing Provider's Physical address line 2
- Servicing Provider's Physical City
- Servicing Provider's Physical Zip Code
- Servicing Provider's State
- Servicing Provider's Phone number

b. DMH Purpose and ECM/CS File Match Details. Upon receipt of the ECM/CS file, DMH shall load the data to the DMH Data Warehouse. DMH shall conduct a match of ECM/CS Members who are also DMH clients and have received services at DMH (ECM/CS Common Beneficiaries), on an interval agreed upon by both Parties.

Upon completion of the match, DMH shall permanently delete and destroy from all systems and files, including the DMH Data Warehouse, any data and information of ECM/CS

Members who did not match and are not current DMH clients receiving Mental Health services at DMH (Non-matched ECM/CS Members). DMH shall provide a certificate of data destruction with respect to the permanent deletion and destruction of data and information of Non-matched ECM/CS Members. DMH shall not use any data or information of Non-matched ECM/CS Members for any purpose.

DMH will use the ECM/CS File to identify the ECM/CS Common Beneficiary to determine housing status, program name, eligibility and services at DMH. DMH will provide HEALTH NET with a file identifying these ECM/CS Common Beneficiaries, as provided below, which shall also include the ECM/CS Common Beneficiary's contact information and housing/homelessness status. DMH may use the data of the ECM/CS Common Beneficiaries for care and treatment purposes, including care coordination and internal operational purposes, as allowable under the Privacy Rules.

DMH shall not use the ECM/CS File or any data therein for any other purpose except as provided in this Exhibit.

3. Data Elements from DMH to HEALTH NET

a. Housing Response File to HEALTH NET.Upon completion of the match, DMH shall extract and provide (as described below) Common Beneficiary data to HEALTH NET in the form of flat text files or X12 834 files (Housing Response File). DMH shall ensure that DMH will provide the following data elements as available to DMH:

DMH Common Beneficiary Housing Resource File Data:

- Common Beneficiary CIN
- DMH Client ID
- Category of Housing Resource
- Name of specific resource (if applicable)
- Date ECM/CS Common Beneficiary was housed
- Date ECM/CS Common Beneficiary exited resource (if applicable)

DMH Common Beneficiary Homeless Event File Data:

- Common Beneficiary CIN
- DMH Client ID
- Type of event associated to homelessness
- Date of homelessness event
- DMH team/service program associated with event
- DMH staff name who delivered service/entered problem
- DMH email address of staff associated to event

The Housing Response Data Files will be placed on a secure server administered and maintained by DMH. DMH shall ensure that the disclosure complies with this MOU and all applicable rules and regulations prior to uploading the Housing Response Data File to the secure server. HEALTH NET will retrieve the Housing Response Data Files.

b. HEALTH NET Use of Housing Response Data Files. HEALTH NET will use the Housing Response Data Files and the data therein for the purposes of arranging for and supporting the provision of ECM/CS benefits/services to Common Beneficiaries, including re homelessness and housing, as well as coordinating care and treatment, and providing other covered services and benefits to the Common Beneficiary. HEALTH NET may distribute the data in the Housing Resource File to its providers and plan partners who arrange for and/or render care, treatment, and other covered benefits and services to members, including PCPs, Plan Partners and PPG' s as applicable. HEALTH NET may also use the Housing Common Beneficiary information for the provision of services required or allowable under applicable rules and regulations (e.g., health education, health plan operations (e.g., quality improvement)) and as allowable under applicable rules and regulations. HEALTH NET shall not use or disclose the information for any other purpose except as allowable under the MOU and applicable rules and regulations.

Exhibit C.1

Attestation Form for Data Destruction

MCP Name: Health Net Community Solutions, Inc.

MHP Name: Los Angeles County Department of Mental Health (LACDMH)

Los Angeles County Department of Mental Health must attest to the following:

☐ LACDMH attests that the eligibility data of non-matched members will be destroyed in compliance with the requirements and agreed upon approach stated in the MOU between the MCP and LACDMH dated July 14, 2025, so that no non-matched Client's information is retained by the LACDMH.

The execution of this Attestation of Data Destruction is applicable to all data matches between the MCP and LACDMH outlined in Exhibit C.

I attest: _____ 7/15/2025

Signature Date

Presley Becerra

Exhibit D

Definitions, Gray Area Services, and Pharmacy and Laboratory Services

I. Definitions:

"Adult and Youth Screening Tools for Medi-Cal Mental Health Services (Screening Tools)" – Used to determine the appropriate mental health delivery system referral for Members who are not currently receiving mental health services when they contact the MCP or MHP seeking mental health services.

"California Advancing and Innovating Medi-Cal (CalAIM)" - A long-term commitment to transform and strengthen Medi-Cal, offering Californians a more equitable, coordinated and person-centered approach to maximizing their health and life trajectory. Its goals are to identify and manage comprehensive needs through whole person care approaches and social drivers of health; improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform; and make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility.

"California Department of Health Care Services (DHCS)" - A department within the California Health and Human Services Agency that finances and administers a number of individual health care service delivery programs, including Medi-Cal, which provides health care services to low-income people.

"**Community Supports (CS)"** - Pursuant to 42 CFR 438.3(e)(2), Community Supports (previously known as In-Lieu-Of Services) are 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. Community Supports are optional for both Contractor and the Member and must be approved by DHCS.

"Enhanced Care Management (ECM)" – A Medi-Cal managed care benefit that addresses 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 supports the highest intensity level.

"Health Insurance Portability and Accountability Act (HIPAA)" - Of 1996, a federal law, Public Law 104-191 and its implementing regulations, including the Privacy, Security,

Breach Notification, and Enforcement Rules at 45 Code of Federal Regulations (C.F.R.) parts 160 and 164, which provide federal rights and protections for individually identifiable health information held by covered entities, as defined therein.

"Managed Care Plan (MCP)" Healthcare services that are contracted through established networks of organized systems of care, which emphasize primary and preventative care. Managed Care Plans are a cost-effective use of health care resources that improve health care access and assure quality of care. For the purposes of this MOU, MCP shall mean Health Net Health Plan and subcontractor, Molina Healthcare of California.

"Medically Necessary" or **"Medical Necessity"** - Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. When determining the medical necessity of covered services for a Medi-Cal beneficiary under the age of 21, "medical necessity" is expanded to include the standards set forth in Title 22 CCR Sections 51340 and 51340.1. Medical necessity for Specialty Mental Health Services is defined at Title 9, CCR, Sections 1820.205, 1830.205, and 1830.210.1

"Mental Health Plan (MHP)" - An entity that enters into a contract with DHCS to provide directly or arrange and pay for Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries in a county. For the purposes of this MOU, MHP shall mean the Los Angeles County Department of Mental Health (DMH)

"Minimum Necessary" - Refers to the minimum necessary standard in 45 C.F.R. § 162.502 (b) as in effect or as amended.

“Non-Specialty Mental Health Services (NSMHS)” – All of the following services as defined by BHIN 21-073, and referenced in WIC Section 1418.402, that MCP must provide when they are Medically Necessary, and are provided by PCPs or by licensed mental health Network Providers within their scope of practice:

- Mental health evaluation and treatment, including individual, group, and family psychotherapy;
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;
- Outpatient services for purposes of monitoring drug therapy;
- Psychiatric consultation; and
- Outpatient laboratory, drugs, supplies, and supplements, excluding separately billable psychiatric drugs claimed by outpatient pharmacy providers via Medi-Cal Rx.

"**Protected Health Information (PHI)"** - Defined in Health Insurance Portability and Accounting Act of 1996 (HIPAA), and implementing regulations.

“Quality Improvement" - The systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.

"Specialty Mental Health Services (SMHS)" – Medi-Cal covered mental health services provided or arranged by MHP for members that need Medically Necessary SMHS. These services include:

- Mental Health Services
- Medication Support Services
- Targeted Case Management
- Crisis Intervention Services
- Crisis Stabilization Services
- Adult Residential Treatment Services
- Crisis Residential Treatment Services
- Day Treatment Intensive Services.
- Day Rehabilitation
- Psychiatric Inpatient Hospital Services
- Psychiatric Health Facility Services
- Peer Support Services
- Mobile Crisis Services

"Transition of Care Tool for Medi-Cal Mental Health Services (Transition of Care Tool)" – Ensures that Members who are receiving mental health services from one delivery system receive timely and coordinated care when their existing services need to be transitioned to the other delivery system, or when services need to be added to their existing mental health treatment from the other delivery system.

"**Working Day(s)**" - Monday through Friday, except for State holidays as identified at the California Department of Human Resources State Holidays page.

II. Gray Area Services:

DMH is responsible for SMHS for covered diagnoses. However, a member may have a covered diagnosis as well as a diagnosis related to fixed neurological deficits with behavioral manifestations. If a member has a co-occurring mental health diagnoses, SMHS may be authorized by DMH to treat the symptoms related to the covered diagnosis only. Gray area cases will be addressed within the Behavioral Health Oversight and Coordination Meeting.

1. Electroconvulsive Treatment (ECT): If the member has been assessed by DMH to meet the criteria for ECT treatment to address their included diagnosis, and other less invasive treatments are found to be ineffective, then DMH may coordinate ECT services with the MCP. DMH will be responsible for payment of the psychiatric professional services only. The MCP will be responsible for payment of facility fees and anesthesia service.
2. Traumatic Brain Injury (TBI): While Traumatic Brain Injury and its manifestations are not a DMH included diagnosis, if a member is assessed

by DMH as having a co-occurring covered diagnosis that meets the criteria, SMHS may be authorized. NSMHS will be covered by the MCP.

3. Dementia: While Dementia and its manifestations are not a DMH included diagnosis, if a member is assessed by DMH as having a co-occurring covered diagnosis that meets the criteria, SMHS may be authorized. NSMHS will be covered by the MCP.
4. Medical Inpatient Hospitalization Requiring Transfer to a Psychiatric Bed: Medi-Cal beneficiaries initially hospitalized on a medical floor for treatment of a medical condition who have co-occurring psychiatric symptoms and meet criteria for involuntary detention cannot be transferred to an acute psychiatric hospital until medically cleared, other than occasions when their combined treatment needs can be met within the Department of Mental Health hospital network.
5. Transcranial Magnetic Stimulation (TMS): MHP offers TMS for members who meet SMHS criteria and for whom the service is medically necessary (e.g., not responding to psychotropic medications/resistant to medication treatment or are unable to tolerate medications). LACDMH will be responsible for payment of services related to the treatment of TMS for members who meet SMHS criteria.

III. Pharmacy and Laboratory Services:

1. DMH contracts with a Pharmacy Benefits Management (PBM) vendor to adjudicate claims and manage the pharmacy network for uninsured members. For clients with Medi-Cal, DMH providers will use the Medi-Cal or MCP formulary and send clients to a local retail pharmacy of the members choosing to access obtain behavioral health medications. Retail pharmacies may send claims directly to the State or the Medi-Cal MCP for payment based on their coverage provisions.
2. The MCP should be made aware that DMH has a "chargeback" process, whereby DMH reviews medication claims processed over the previous month and determines if another payor has financial responsibility for that claim (i.e. State, MCP, etc.). DMH then contacts the pharmacy to validate whether the claim was incorrectly billed to and paid for by DMH. If appropriate, the pharmacy will reverse the claim and rebill the appropriate payor. This process can take place up to 60 days after the medication was dispensed.
3. MCP should honor the State's timeline of 120 days for claims adjudication.
4. DMH contracts with a Laboratory Service Provider (LSP) for laboratory services for DMH clients. Due to the volume of clients and the client population, DMH offers onsite phlebotomy services. Clients may also go to draw stations of the LSP, as needed. DMH only maintains financial responsibility and, therefore, will only pay the LSP for clients who are

uninsured. The LSP must enter into an agreement with the MCP so that the LSP can bill the MHP when appropriate.

a. The MCP agrees to use the DMH laboratory service list as the available list of labs that DMH providers can order for MHP covered Members of Health Net.
b. The MCP will not require any preauthorization for labs ordered by DMH providers for MHP covered clients.