



CONTRA COSTA
HEALTH

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**BEHAVIORAL HEALTH SERVICES
MEMORANDUM OF UNDERSTANDING**

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Memorandum of Understanding

between Contra Costa Health Plan and both Behavioral Health Services and Alcohol and Other Drugs

This Memorandum of Understanding (“MOU”) is entered into by and between Contra Costa Health Plan (“MCP”) and both Behavioral Health Services (“MHP”), and Alcohol and Other Drugs (“DMC-ODS”) hereinafter referred to collectively as (“BHS”), effective as of July 1, 2024. BHS, 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”) 22-005 for both DMC-ODS and mental health, APLs 18-015, 22-006, 22-028 for mental health, and any subsequently superseding APLs. DMC-ODS is required to enter this MOU under the DMC-ODS Intergovernmental Agreement Exhibit A, Attachment I, Behavioral Health Information Notice (“BHIN”) 23-001, 23-057 and any subsequently issued superseding BHINs, and BHS is required to enter into this MOU pursuant to Cal. Code Regs. tit. 9 § 1810.370, MHP Contract, Exhibit A, Attachment 10 BHIN 23- 056 and any subsequently issued superseding BHINs, to ensure that Medi-Cal beneficiaries enrolled in MCP who are served by BHS or MHP (“Members”) are able to access and/or receive mental health services in a coordinated manner from MCP and BHS;

WHEREAS, the Parties desire to ensure that Members receive SUD and BHS 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-MHP 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-MHP Liaison must ensure the 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. "BHS Responsible Person" means the person designated by BHS 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 the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the 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. This MOU is in effect as of the Effective Date and continues for a term of THREE years or as amended in accordance with Section 14.f of this MOU.

3. Services Covered by This MOU. 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 APLs, BHINs, executed contract amendments or other relevant guidance. This MOU also 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. In addition to these services, the behavioral health low to moderate services and additional agreements between the parties for delegation and access are included in Exhibit D. 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 for members as provided in the applicable Medical Managed Care Contract and coordinating care from other providers of carve-out programs, services, and benefits.

b. **Oversight Responsibility.** The Deputy Executive Director, 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 no less frequently than quarterly. MCP's compliance officer is responsible for MOU compliance oversight reports as part of MCP's compliance program and must address any compliance deficiencies in accordance with MCP's compliance program policies;

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

iv. ensure the appropriate levels of MCP leadership (i.e., person 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 may 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. BHS Obligations.

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

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

- i. meet at least quarterly with MCP, as required by Section 9 of this MOU;
- ii. report on BHS's compliance with the MOU to BHS's compliance officer no less frequently than quarterly. BHS's compliance officer is responsible for MOU compliance oversight and reports as part of BHS's compliance program and must address any compliance deficiencies in accordance with BHS's compliance program policies;
- iii. ensure there is sufficient staff at BHS to support compliance with and management of this MOU;
- iv. ensure the appropriate levels of BHS 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 BHS'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 BHS, and reporting to the BHS Responsible Person.

c. **Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** BHS 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 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 its Subcontractors and Downstream Subcontractors to provide training on relevant MOU requirements and BHS 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 for services provided by BHS.

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 BHS services may be accessed, including during nonbusiness hours.

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 MCP Covered Services, DMC-ODS services and 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.

iv. MCP must develop and establish policies and procedures for providing Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (“SABRIT”) 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. **Referrals.** The Parties must work collaboratively to develop and establish policies and procedures that ensure that Members are referred to the appropriate MHP services, MCP Covered Services and DMC-ODS 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 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.

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.

v. BHS 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”) or Complex Case Management (“CCM”), or Community Supports. However, if BHS is also an ECM Provider, BHS provides ECM services pursuant to that separate agreement between MCP and BHS for ECM services; this MOU does not govern BHS’s provision of ECM.

vi. MCP must have a process for referring eligible Members for substance abuse 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.

vii. 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.

viii. MCP must have a process by which MCP accepts referrals from DMC-ODS staff, providers, or a self-referred Member for assessment, makes a determination of medical necessity for the Member to receive DMC-ODS Covered Services, and provides referrals within the DMC-ODS provider network; and

ix. 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.

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 requirements 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 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; 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 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. 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 BHS 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,² level of care transitions that occur within the facility, or transition from outpatient therapy to intensive outpatient therapy and vice versa.

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

2. 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,³ 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 as outlined by the Population Health Management Policy Guide³.

g. 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;

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

i. 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 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>

³ Expectations for transitional care are defined in the PHM Policy Program Guide: <https://www.dhcs.ca.gov/CalAIM/Documents/2023-PHM-Program-Guide-a11y.pdf>; see also PHM Roadmap and Strategy: <https://www.dhcs.ca.gov/CalAIM/Documents/Final-Population-Health-Management-Strategy-and-Roadmap.pdf>

3. 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.

4. 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.

5. 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 care 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.

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 BHS Provider as the ECM Provider if the Member receives BHS 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 BHS 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 BHS 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.

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.

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 BHS protocols;

b. Identification of the Community Supports covered by MCP.

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

ix. Eating Disorder Services.

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

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

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

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

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

x. Prescription Drugs.

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.

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

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

b. MCP is obligated to provide MCP's procedures for obtaining authorization of prescribed rugs 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 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, 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 BHS, such as local county meetings, local community forums, and BHS engagements, 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 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 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), and to the

fullest extent permitted under the Health Insurance Portability and Accountability Act and its implementing regulations, as amended (“HIPAA”) and 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.⁴

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 exchanging information about Members eligible for ECM, regardless of whether the Specialty Mental Health provider is serving as an ECM provider;
- ii. A process for MHP to send regular, frequent batches of referrals to ECM and Community Supports to MCP in as close to real time as possible;
- iii. A process for MHP to send admission, discharge, and transfer data to MCP when Members are admitted to, discharged from, or transferred from facilities contracted by MHP (e.g., psychiatric inpatient hospitals, psychiatric health facilities, residential mental health facilities), and for MCP to receive this data. This process may incorporate notification requirements as described in Section 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).

⁴ CalAIM Data Sharing Authorization Guidance VERSION 2.0 June 2023 available at: <https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance-Version-2-Draft-Public-Comment.pdf>.

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

c. **Interoperability.** MCP and DMC-ODS must exchange data in compliance with the payer-to-payer data exchange requirements pursuant to 45 Code of Federal Regulations Part 170. MCP and BHS must make available to Members their electronic health information held by the Parties 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 BHS'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.

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 DMC-ODS that cannot be resolved in a good faith attempt between the Parties must be forwarded by MCP and/or DMC-ODS to DHCS.

b. 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 DMC-ODS is required to deliver SUD services to a Member and DMC-ODS has incorrectly determined the Member's 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. 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 BHS'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, BHS is responsible for providing or arranging and paying for those services until the dispute is resolved.
- e. if decisions rendered by DHCS find MCP is financially liable for services, MCP must comply with the requirements in 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. Unless otherwise determined by the Parties, the DMC-ODS Liaison must be the designated individual responsible and MHP must designate a person or process to receive notice of actions, denials, or deferrals from MCP, and to provide any additional information requested in the deferral notice as necessary for a medical necessity determination.
- h. MCP must monitor and track the number of disputes with BHS 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 BHS 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 BHS.

14. General.

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

b. **Documentation Requirements.** MCP and BHS must retain all documents demonstrating compliance with this MOU for at least 10 years as required by the Medi-Cal Managed Care Contract, the MHP Contract and the 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 BHS 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 BHS 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 Medical Managed Care Contract, the MHP Contract, and DMC-ODS Intergovernmental Agreement, and 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 BHS 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 BHS nor MCP, nor any of their respective contractors, employees, agents, or representatives, is construed to be the contractor, employee, agent, or representative of the other.

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

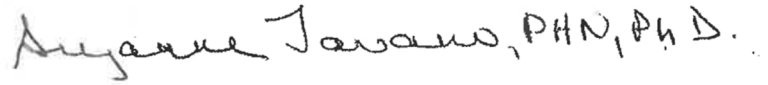
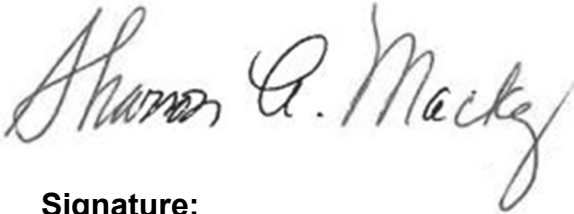
j. **Superseding MOU.** This MOU constitutes the final and entire agreement between the Parties and supersedes any and all prior oral or written agreements, negotiations, or understandings between the Parties that conflict with the provisions set forth in this MOU. It is expressly understood and agreed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

(Remainder of this page intentionally left blank)

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

MCP

BHS



Signature:

**Name: Sharron A. Mackey
Title: Chief Executive Officer
Notice Address:**

**597 Center Avenue #200
Martinez, CA 94553**

Signature:

**Name: Dr. Suzanne Tavanno
Title: Behavior Health Director
Notice Address:**

**1340 Arnold Drive #200
Martinez, CA 94553**

Exhibits A & B

Designated MCP Liaisons	Designated BHS Liaisons
Sharron A. Mackey, CEO	Dr. Suzanne Tavanno, Behavioral Health Director
David Chen, Senior Program Manager	Dr. Stephen Field, Medical Director
TBD, Director of Compliance	Katy White, Chief of Managed Care
TBD, Health Service IT	

Exhibit C
Data Elements

The Parties agree to share the required data elements within 15 Working Days.

If Member authorization is required, the Parties must agree to a standard consent form 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.

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Exhibit D **Additional Provisions**

Since 2014, Contra Costa Health Plan (CCHP) has delegated the treatment of Non-Specialty Mental Health Services of Medi-Cal members to the BHS Care Management Unit (CMU) and BH Access Line.

1. Care Management Unit (CMU) Non-Specialty Provider Network for CCHP Medi-Cal Members

The Care Management Unit (CMU) manages the outpatient CCMH Provider Network for service definitions covered by Medi-Cal Clinical Criteria and for consumers with full scope Medi-Cal who meet Medi-Cal medical and service necessity.

CCHP agrees to delegate the contracting of the Non-Specialty Mental Health Provider network for Medi-Cal members to the BHS CMU. BHS CMU will monitor and maintain this NSMHS network to ensure timely access as defined by federal and state requirements. This delegation of Non-Specialty Mental Health Services for Medi-Cal eligible individuals includes the NSMHS network and contract agreements, claims made by said network and any disputes by NSMHS network providers contracted with BHS CMU.

Additionally, BHS CMU agrees to accept and respond to CCHP Medi-Cal member requests for Continuity of Care with non-contracted providers – including but not limited to provider outreach and Letter of Agreement / Single-Case Agreement.

2. Access Line Call Center

The Behavioral Health Access Line is the main point of entry into the County's "Mental Health System of Care" and Substance Use Disorder treatment programs. The line offers 24-hour availability (licensed clinicians/county employees including psychiatric consultants on staff weekdays from 8:00am -5:00pm) and assistance in all languages via staff or interpreters.

The Access Line is available to individuals who have Medi-Cal insurance or may be Medi-Cal eligible. It is also a behavioral health resource line for Contra Costa County residents, providing information, referrals, and crisis triage/support to all callers. Callers include consumers, Beneficiaries, family members, caregivers/advocates, social workers, discharge planners, and other health providers.

CCHP agrees to delegate mental health and substance use screening and referral duties to the Access Line who will triage and refer CCHP members for services according to their level of need.

Per this delegation, the Access line will conduct screening and triage according to State criteria – e.g. DHCS Screening and Transition Tools. BHS agrees to accept referrals from CCHP staff, member self-referrals, and providers. BHS Access line will maintain staffing adequate to process incoming referrals in a timely manner independent of their source.

3. CCHP Survey of BHS

By virtue of this delegation, BHS agree to provide CCHP materials necessary to ensure adequate completion of delegated responsibilities – including but not limited to summary reports, case file review, and audit interviews as indicated.

CCHP agrees to perform an annual review of this delegation agreement utilizing DHCS Technical Assistance Guides as the framework. The review will cover topics including relevant BHS Programs, Workplan, Annual Evaluation, P&Ps, reports, and file review as related to the CMU and Access Line.

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