CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

MEMORANDUMS OF UNDERSTANDING FOR MEDI-CAL MANAGED CARE PLANS AND THIRD-PARTY ENTITIES: ALL PLAN LETTER, BASE, AND BESPOKE MOU TEMPLATES FREQUENTLY ASKED QUESTIONS

The following responses to Frequently Asked Questions (FAQs) provide additional guidance and clarification regarding the All Plan Letter (APL) 23-029, Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities, the Medi-Cal mental health plans (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Behavioral Health Information Notices (BHINs) 23-056 and 23-057, and the associated Memorandums of Understanding (MOUs) Templates for Medi-Cal managed care plans (MCPs) that are required to execute MOUs with certain Third Party Entities (also referred to as Other Party) required by the 2024 Medi-Cal Managed Care Contract (MCP Contract). As the Department of Health Care Services (DHCS) receives additional questions, these FAQs will be updated and the footer will indicate the version number and issue date.

Pursuant to the 2024 MCP Contract, MCPs are required to partner with, and execute MOUs with, the following Third Party Entities:

Effective January 1, 2024

- Specialty Mental Health Services (SMHS);
- Substance Use Disorder (SUD) treatment services including counties participating in DMC-ODS;
- In-Home Supportive Services (IHSS); County Social Services programs and Child Welfare;
- Local Health Department (LHD) including, without limitation:
  - California Children's Services (CCS);
  - Maternal and Child and Adolescent Health; and
  - Tuberculosis Direct Observed Therapy;
- Women, Infants and Children (WIC) Supplemental Nutrition Programs;
- Regional Centers

Effective July 1, 2024

- County-Based Targeted Case Management (TCM);
- Drug Medi-Cal State Plan Counties;

Effective January 1, 2025

- Home and Community Based Services (HCBS) Waiver Agencies and Programs;
- Local Government Agencies (LGAs)/California Department of Corrections and Rehabilitation, county jails, and youth correctional facilities;
- Continuums of Care;

- First 5 Programs;
- Area Agencies on Aging;
- California Caregiver Resource Centers;
- Local Education Agencies; and
- Indian Health Services/Tribal Entities (optional).

Additional resources are available on the MCP MOU website at: https://www.dhcs.ca.gov/Pages/MCPMOUS.aspx.

Questions related to MCP MOUs can be sent to: MCPMOUS@dhcs.ca.gov.

The information provided in these FAQs is not intended to be legal advice, but instead, is intended to provide general information only. Readers of these FAQs should contact their own attorney to obtain advice on any legal matter related to these FAQs.

Table of Contents

General Information

1. What are the goals/intent of the MOUs?

The MOUs are intended to:

- Clarify roles and responsibilities of each party,
- Enhance local engagement,
- Improve care coordination among parties, and
- Develop and document processes and procedures to provide whole-person care to Members.

The MOUs leverage existing requirements and policy and guidance documents, incorporating the relevant components into a single document that can be used by the MCP and Third Party Entities to improve transparency in and accountability for each party to carry out existing requirements as they relate to the provision of services or care delivery and coordination.

Each MOU is a binding, enforceable contractual agreement between the MCP and Third Party Entities such as county Mental Health Plans (MHPs), Drug Medi-Cal (DMC) State Plan counties, or Drug Medi-Cal Organized Delivery System (DMC-ODS) counties. These agreements outline each party's respective responsibilities and obligations in coordinating medically necessary Covered Services and carved-out services for Members served by multiple parties.

The MOUs are not intended to be an exhaustive list of all MCP, MHP, DMC-ODS, or DMC State Plan requirements, but a specific subset of requirements for MCPs to coordinate with Third Party Entities (e.g., MHP, DMC State Plan, DMC-ODS, etc.) to provide care to Members. MCPs must still comply with the 2024 MCP Contract, APLs, and other applicable guidance. MHPs must still comply with the 2022-2027 MHP Contract, DMC State Plan counties must still comply with the 2023-2027 DMC State Plan Contract, and DMC-ODS counties must still comply with the DMC-ODS Contract, as well as BHINs and other applicable guidance.

2. What is the Base MOU Template and what is the intent of each provision?

The Base MOU Template is meant to provide context for the Bespoke MOUs. It includes each of the elements required to be included in all MOUs as set forth in the 2024 MCP Model Contract. The Base MOU Template includes the minimum requirements; MCPs and Third Party Entities may include additional provisions so long as they do not conflict with the minimum required provisions.

The Base MOU contains the following required provisions. The intent of each provision is described below.

- Provision of Services: Lists the services covered by the MOU;
- Party Obligations: Outlines the parties' obligations, to ensure each party is aware of what services the other is required to provide or arrange under existing requirements. This section also requires that each party provide the appropriate

contact information to ensure that the parties know how and who to contact for carrying out the obligations set forth in the MOU;

- Training and Education Requirements: The MOU describes the necessary training and education for the parties' employees who carry out the obligations set forth in the MOU and requires MCPs provide their Subcontractors, Downstream Subcontractors, and Network Providers with information necessary for them to coordinate care with and make referrals to or receive referrals from the Third Party Entities;
- Referral Processes: The referral section is meant to encourage the parties to develop and document how they will each refer Members to one another as appropriate and outline what information may be needed to accompany each referral;
- Care Coordination: Care coordination requirements are intended to encourage the parties to develop and document how the parties will coordinate care, monitor whether those processes are working, and improve the processes, as necessary.
- Quarterly Meetings: Quarterly meetings are required to ensure that the parties have a set time to meet to assess whether the MOU is effective in supporting care coordination and whole-person care, as well as to address specific issues that may have arisen related to carrying out the obligations of the MOU;
- Quality Improvement: This requirement is for the parties to ensure ongoing quality improvement specifically related to carrying out the obligations of the MOU and is intended to encourage the parties to develop and document how they will assess whether the MOU is improving care coordination and whole-person care and to develop metrics to evaluate whether the MOU is effective in achieving its goals;
- Data Sharing and Confidentiality: The parties should determine and document the minimum necessary information that must be shared in order to facilitate referrals and coordinate care, develop processes for how to share that information, and determine whether Member consent is required to share the minimum necessary information and, if so, implement a standardized process if possible to obtain Member consent;
- Dispute Resolution: The parties must develop and document a dispute resolution process to resolve conflicts with regard to each parties' responsibilities under the MOU, including a timeline for resolving disputes and an escalation process for bringing unresolved disputes to DHCS's (and/or other State departments') attention as necessary; and
- General Provisions: These provisions describe general contract requirements, such as the requirements that the MCP must publicly post the executed MOU on its website, that the MCP must annually review the MOU to determine compliance and whether updates are needed, that the MCP cannot delegate the MOU except as permitted under the MCP Contract.

3. What are the Bespoke MOU Templates?

The Bespoke MOU Templates refers to a set of specific templates between an MCP and a Third Party Entity. They contain both the Base MOU Template provisions (listed above) and program-specific provisions that are particular to the MCP and the

specified Third Party Entities. Third Party Entities and MCPs may adjust the language as needed to reflect local agreements, so long as they do not conflict with the minimum required provisions. Please refer to optional provisions and the MOU submission process for more information.

4. Why are some terms capitalized in the APL and the MOU Templates and what is their significance?

Capitalized terms have the meaning ascribed to them by the 2024 MCP Contract between MCPs and DHCS or as defined in the MOU Templates. The terms include, but are not limited to, those listed in Appendix A in anticipation of the posting of the 2024 MCP Contract.

Once executed, the 2024 MCP Contract will be available at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.

Appendix B lists capitalized terms specific to the SMHS with MHPs, and SUD treatment services including counties participating in DMC-ODS and Drug Medi-Cal State Plan Counties. The 2022-2027 MHP Contracts are available at: https://www.dhcs.ca.gov/services/MH/Pages/Contracts_Medicaid_State_Plan.aspx

5. What are the roles and responsibilities of the Liaison/Responsible Person?

- The "MCP Responsible Person" is the person designated by the MCP who is responsible for overseeing the care coordination activities and communications with the Third Party Entity and ensuring the MCP's compliance with the MOU.

  The MCP Responsible Person is responsible for ensuring the following:
  - Meeting at least quarterly with the Third Party Entity to address any issues arising under the MOU;
  - Reporting on the MCP's compliance with the MOU to MCP's compliance officer; and
  - Ensuring there is sufficient staff at MCP to support compliance with and management of the MOU;
  - Serving as, or designating another person to serve as, the point of contact and liaison with the Third Party Entity to ensure the Parties meet regularly, maintain channels of communication, etc.

- The Third Party Entity must also designate a "Responsible Person" responsible for overseeing the Third Party Entity's the care coordination activities, communications with the MCP, and compliance with the MOU. The Responsible Person also serves, or may designate a person to serve, as the designated liaison and the point of contact with the Third Party Entity who carries out a subset of the Responsible Person's obligations on a day-to-day basis such as communicating with the Third Party Entity, coordinating meetings, and reporting to the Responsible Person.

Below are additional roles that are defined, and only relevant for the specific Bespoke MOU Templates referenced in parenthesis:

- (County Child Welfare MOU) The "Foster Care Liaison" is the MCP's designated individual assigned to ensure the needs of Members receiving foster care services, covered under the County Child Welfare MOU, are met.
- (IHSS MOU; Regional Center MOU) APL 23-004 requires MCPs to identify an individual or set of individuals as part of their Provider Relations or related functions to serve as the liaison for Long Term Services and Supports (LTSS) Providers, which includes IHSS Programs and Regional Centers.[1]

6. How will additional policy development in the future impact the MOUs?

The Base and Bespoke MOUs were designed deliberately to refer to requirements and policies relevant to the relationship between the MCP and the Third Party Entity, however, the MOUs do not restate all requirements. The intent of referring to requirements and policies is to allow the MOU to be stable but allowing flexibility for policies to be updated as needed.

For example, DHCS anticipates new policy decisions and operational requirements to: Enhanced Care Management (ECM), including division of case management responsibilities and Regional Center ECM responsibilities; Foster Care Liaison's roles and responsibilities, case management for foster children; Closed Loop Referrals including coordinating and referring the Member to available community resources and following up to ensure services were rendered; and Emergency Preparedness. DHCS does not plan to re-issue new MOU Templates as policies are changed or new policies are implemented, such as the forthcoming Closed Loop Referral policy. MCPs are responsible for identifying new or changed policies or guidance that impact the MOU and should collaborate with the Third Party Entity to amend or add attachments to the MOU as appropriate to reflect such new or changed policies.

Periodically and in future years, DHCS intends to review and revise/re-issue the APL and Templates as it evaluates MCPs' compliance with the APL and MOUs, as parties improve their coordination efforts, and when updated MCP contracts, policies or guidance require revisions to mandatory provisions or definitions.

7. How can Parties be held accountable for policies that are not yet issued?

DHCS will hold MCPs accountable for compliance with policies no sooner than or upon their effective date and will provide notice to MCPs when new policies are issued and their effective date. DHCS has made each party's agreement to comply with the Disaster and Emergency Preparedness and Closed Loop Referrals

[1] For more information on Long-Term Services and Supports Liaison, including the definition and applicable requirements, see APL 23-004, and any subsequent APLs on this topic.

requirements optional (the provisions are italicized and bracketed in the MOU Templates). DHCS intends for MCPs and Third Party Entities to collaborate, assess current gaps in processes and work towards establishing processes in these areas, understanding that these policies will be developed.

See below for additional FAQs related to optional MOU provisions.

8. What if a Third Party Entity is a Network Provider delivering ECM services, does that impact the MOU?

If a Third Party Entity is also an ECM Provider pursuant to a separate agreement between MCP and Other Party for ECM services, the MOU does not govern Other Party's provision of contracted services including ECM. For more information on ECM please see the ECM Policy Guide at: https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf.

9. Does an MCP have to use the Base MOU Template for all MOUs it executes, even for parties that do not have a Bespoke Template?

The Base MOU is foundational as each required MOU with all Third Party Entities includes provisions required in the Base MOU Template and as required in the MCP Contract. MCPs and Third Party Entities may include additional provisions so long as they do not conflict with the minimum required provisions.

10. If there is a Bespoke MOU Template, do I need to also use the Base MOU Template?

No. The Base MOU Template minimum requirements are incorporated into Bespoke MOU Templates. Therefore, if DHCS has issued a Bespoke MOU Template for MCPs to execute with a Third Party Entity, such as the Regional Center MOU Template, the parties do not need to utilize the Base MOU Template.

11. Do Third Party Entities need to take any action prior to contact from the MCP?

DHCS requires MCPs to build partnerships and execute MOUs with various Third-Party Entities. DHCS has released APL 23-029, which requires MCPs to submit executed MOUs to DHCS that include all the minimum requirements for the applicable MOU. These minimum requirements are included in the MOU templates that are posted to the DHCS MOU webpage.

DHCS expects MCPs to proactively partner with Third Party Entities to begin building those partnerships and collaborate on executing the MOUs. DHCS recommends that Third Party Entities work closely with the MCPs to ensure the executed MOU meets the requirements for MCPs as described in APL 23-029.

12. Where can questions or requests for technical assistance regarding MOUs be sent?

DHCS has established a dedicated inbox to address all questions and requests for technical assistance related to MOUs. In order to effectively respond to inquiries in a timely manner, we kindly request that any inquiries or requests pertaining to MOUs be sent to email address: MCPMOUS@dhcs.ca.gov. For inquiries regarding the MOUs for DMC-ODS, DMC State plans, or MHPs, please contact CountySupport@dhcs.ca.gov.

MOU Obligations

13. Do the MOUs add new requirements or obligations on MCPs or Third Party Entities?

No. the MOU Templates do not impose new requirements on the Third Party Entities; the MOU Templates only restate, incorporate or cross-reference existing requirements imposed on the Third Party Entities by federal or State requirements and/or guidance issued by their respective oversight body, if any.

14. How will the MOUs be enforced if Third Party Entities are not required to execute the MOU?

Third Party Entities are encouraged to work with MCPs and develop language that is mutually agreeable. The MOUs restate or cross-reference existing requirements imposed on Third Party Entities by federal or State law and/or guidance and their respective oversight bodies, such as other State departments, including the California Department of Public Health (CDPH), the California Department of Social Services (CDSS), and the California Department of Developmental Services (CDDS). The MOUs are not intended to supersede or conflict with the requirements and/or agreements to which the Third Party are already subject; the MOUs do not change the oversight authority of the Third Party Entities oversight body. DHCS collaborated with, and continues to collaborate with, CDPH, CDSS, and CDDS to discuss the development, oversight, and monitoring of the MOUs.

Dispute Resolution

15. What are the first steps an MCP and a Third Party Entity should take if they have a dispute arising from the MOU?

If there is a dispute between an MCP and the Third Party Entity, all parties are responsible for carrying out all their responsibilities under the MOU without delay, including providing Members with access to services under the MOU.

MCPs must work collaboratively with the Third Party Entity to establish dispute resolution processes and timeframes which must be set forth in the MOU. The dispute resolution process should address how the MCP will work with the Third Party Entity to resolve issues related to the parties' respective roles for coverage and payment of services, and performance of care management for specific Members, or other concerns related to the administered services to Members. See

the Base Template “Dispute Resolution” section for an example of the required language.

Information on specific Bespoke MOU Dispute resolution requirements can be found in the Questions Related to Specific Bespoke Templates section of this FAQ.

16. What if the MCP and Third Party Entity fail to resolve the dispute internally?

If parties cannot resolve the dispute in good faith in accordance with their agreed upon process and timeframe established in the MOU, either party may submit a written “Request for Resolution” to DHCS. The Third Party Entity may submit the dispute to its oversight body (e.g., CDPH, CDSS, and CDDS). If the MCP submits the Request for Resolution, it must be signed by the MCP’s Chief Executive Officer (CEO) or the CEO’s designee. If the Request for Resolution is submitted by the Third Party Entity, it should be signed by an authorized representative of the Third Party Entity. If the Third Party Entity desires to review and sign off on any Request for Resolution submitted by the MCP, the parties should include this requirement in their executed MOU.

MCP’s Request for Resolution to DHCS must include:

1. A summary of the disputed issue(s) and a statement of the desired remedies, including any disputed services that have been or are expected to be delivered to a Member;
2. A history of the attempts to resolve the issue(s) with the Third Party Entity;
3. Justification for the desired remedy; and
4. Any additional documentation relevant to resolve the disputed issue(s), if applicable, including documentation requested by DHCS or the Third Party’s oversight body.

Either party may submit the Request for Resolution to DHCS via secure email to MCQMD@dhcs.ca.gov.

DHCS, in collaboration with the relevant department with oversight of the Third Party Entity as appropriate, will communicate the final decision to the MCP and the Third Party Entity, including any actions the MCP must take to implement the decision.

Optional Provisions

17. What are optional provisions and how can they be identified?

The optional provisions are italicized and bracketed in the MOU Templates. The Parties can choose to add one or more of these optional provisions to the MOUs to increase collaboration and communications. The optional provisions are not required to be included within the MOU.

18. Can MCPs and the Third Party Entities add provisions to their MOUs?

MCPs and the Third Party Entities may agree to include additional provisions, including the optional provisions DHCS has provided (italicized and bracketed) in the

MOU Templates, provided any additional provision does not conflict with the required MOU provisions.

MOU Quarterly Meeting and Quality Improvement Requirements

19. Why are the quarterly meetings required?

Parties are required to meet at least quarterly to address care coordination, Quality Improvement (QI) activities, QI outcomes, systemic and case-specific concerns, and to foster ongoing communication and collaboration among parties. These meetings are intended to increase coordination and communication between the two parties. These meetings may be conducted virtually.

Within 30 Working Days after each quarterly meeting, the MCP must post on its website the date and time the quarterly meeting occurred and distribute to meeting participants a summary of any follow-up action items or changes to processes that are being made as a result of the meetings, as applicable.

20. Why are MCPs required to post quarterly meeting information on their website after the meeting occurs? Are these meetings public?

Within 30 Working Days after each quarterly meeting, the MCP must post on its website the date and time the quarterly meeting occurred. Quarterly meetings serve as a crucial mechanism to bolster coordination and facilitate improved communication between parties, and stakeholders want to know these activities are happening.

These meetings are not intended to be public forums, and there is no current requirement to make meeting materials public. The location of the meeting does not need to be posted.

21. What is the purpose of, and expectations related to MOU Quality Improvement (QI)?

The QI provisions in the MOU Templates are intended to encourage the parties to develop and document activities for how they will assess whether the MOU is improving care coordination and whole-person care and to develop mechanisms to evaluate whether the MOU is effective in achieving its goals. The Parties must develop QI activities specifically for the oversight of the MOU requirements, 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. The MCP must document these QI activities in its policies and procedures. MOU QI does not need to meet the QI regulations governing MCPs and/or QI regulations governing specific Third Party Entities.

Data Sharing and Confidentiality

22. What data and information do the MOUs require parties to share?

MCPs and Third Party Entities are expected to share the minimum necessary information and data to facilitate referrals and address barriers to care coordination in certain cases as the need arises. MCPs and Third Party Entities are required to identify or establish policies and procedures for how this data and information will be shared, when necessary, that comply with all applicable laws and regulations, such as ensuring the parties have a process to obtain Member consent if needed. DHCS has not included detailed requirements for the type and frequency of data to be shared to facilitate negotiations between the parties that cater to the needs and processes of all parties involved.

23. How can MCPs and Third Party Entities (e.g., Regional Centers, IHSS County Offices, Women, Infant, & Children Agencies) share data given that the Third Party Entities may not be able to obtain Members' consent?

The MOU does not supersede any federal or State requirements and parties should share data as allowed under existing law and guidance, and all parties must continue to comply with applicable law and regulations. California Advancing and Innovating Medi-Cal (CalAIM) initiative, and Assembly Bill (AB) 133 permits certain disclosure of personal information if such disclosure helps implement CalAIM and is consistent with federal law and other State laws. The activities between MCPs and Third Party Entities that are subject of the MOUs are directly related to CalAIM implementation as they pertain to coordinating care and providing whole person care approach in caring for the Member. The data sharing authorization requirements of AB 133 and related guidelines can be found in the CalAIM Data Sharing Authorization Guidance document.[2]

24. How can MCPs and Other Parties share information and data if they do not have the infrastructure to share and receive data electronically and in real-time?

DHCS will continue to collaborate with CDPH, CDSS, and CDDS regarding long-term solutions to facilitate data sharing at the state-level to support Third Party Entities who do not have the technical infrastructure to share/receive data. In the interim, parties should share data as permitted under applicable law as quickly and expansively as possible.

25. How can Third Party Entities legally receive and share protected health information (PHI) if they are not covered entities under the Health

[2] For more information please see the CalAIM Data Sharing Authorization Guidance at: https://www.dhcs.ca.gov/Documents/MCQMD/CalAIM-Data-Sharing-Authorization-Guidance-Version-2-Draft-Public-Comment.pdf.

Insurance Portability and Accountability Act (HIPAA) and their systems may not protect the PHI once received?

DHCS expects MCPs and Third Party Entities to share the minimum necessary information and data needed to carry out the goals of the MOU. The MOUs do not take precedence over any prevailing federal or State laws or regulations governing the ability of the MCP or Third Party Entity to exchange information. Instead, the MOUs underscore the necessity for all parties involved to engage in data sharing activities strictly in accordance with the existing laws and guidance at both the federal and State levels.

Under HIPAA, covered entities are permitted to shared PHI with noncovered entities in certain instances for the purposes of treatment, payment and health care operations (which includes care coordination), even if the noncovered entity does not comply with HIPAA. MCPs should consult with their counsel to assess whether they may share PHI for these purposes with Third Party Entities.[3]

MCP Quarterly Report and Executed MOU Submission Processes

26. What is the submission process for completed MOUs?

The Base MOU and Bespoke MOU Templates include the minimum mandatory requirements the parties must include in their executed MOUs as well as optional provisions the parties may choose to include. If the parties execute the MOU without altering or removing any of the minimum mandatory requirements, regardless of whether they include the optional provisions, the MCPs must submit the executed MOU to their appropriate submission portal for file and use. In its submission, MCPs must attest that they did not modify or remove any of the mandatory requirements set forth in the relevant MOU Template except to add provisions that do not conflict with or materially change either party's obligations under the MOU.

If the parties modify or remove any of the mandatory requirements from their negotiated MOU that were set forth in the applicable MOU Template, the MCP must submit a redlined version of the of the proposed changes to the MOU to DHCS for review and approval prior to execution. If the MCP chooses to add additional or optional provisions a redline is not required as long as the additional or optional provisions do not conflict with the relevant MOU Template.

If the parties agree to combine multiple Bespoke Templates into a single MOU, without altering or removing any of the minimum mandatory requirements, the combined MOU may be submitted without redline for file and use, as described above. If the parties modify or remove any of the mandatory requirements, the MCP

[3] DHCS, Health Care Providers, and MCPs are Covered Entities under HIPAA. Third Party Entities typically receive PHI by way of a Business Associate Agreement or the like. Please consult with your own legal counsel for more information on this topic. For more information on HIPAA please see: https://www.dhcs.ca.gov/formsandpubs/laws/hipaa/Pages/1.00WhatisHIPAA.aspx.

must submit a redlined version of the proposed MOU for review and approval prior to execution.

27. What are the applicable Subcontractor requirements for MCPs and do all Subcontractors need to be signatories to the MOU? What does being an "express party" to the MOU mean?

The 2024 MCP Contract sets forth what functions can and cannot be delegated by the MCPs. Only when MCP has a Subcontractor or Downstream Subcontractor arrangement delegating part or all of the responsibilities related to effectuating the MOU to a Knox-Keene licensed health care service plan(s), the MOU must be signed by the MCP, that Subcontractor or Downstream Subcontractor, and the Third Party Entity. In such instance, the Subcontractor or Downstream Subcontractor would be considered an “express party” in this scenario and would be required also to acknowledge and agree to the terms of the MOU between Third Party Entity and MCP. For avoidance of doubt, the Subcontractor or Downstream Subcontractor are not going to enter into a separate MOU with the Third Party Entity but also become a signatory to the MOU between the MCP and Third Party Entity. The reason for requiring Subcontractors and/or Downstream Subcontractors that are Knox-Keene licensed health care service plans to sign the MOU is because they provide Member care services and should participate in care coordination and referral processes outlined in the MOU, as compared to other Subcontractors and/or Downstream Subcontractors that provide purely administrative functions.

28. Why are the MCPs required to publish the executed MOUs and annual reports?

MCPs must publish executed MOUs and annual reports on its website within 30 Working Days of MOU execution and report due date, respectively. The requirement for MCPs to post executed MOUs and the annual report to its website is intended to provide transparency of compliance to stakeholders, and ensure annual reviews of the executed MOU are completed. DHCS only has authority to require certain Third Parties to post the MOUs on their websites. At this time, DHCS will not be housing all executed MOUs in a centralized location or website.

29. How will DHCS oversee and hold MCPs accountable for executing and meeting the obligations set forth in the MOUs?

MCPs are required under the Medi-Cal Managed Care Contract, Exhibit A, Attachment III, to make good faith efforts to enter into MOUs with Third Party Entities, to ensure Members ability to access and/or receive services in a coordinated manner from MCPs and Third Party Entities. DHCS will monitor MCPs’ progress toward this goal through quarterly reports on the status of execution of each required MOU and in annual reports describing the collaboration among the parties.

In addition, MCPs are responsible for ensuring that their Subcontractors, Downstream Subcontractors, and Network Providers comply with all applicable State

and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters.[4]

30. What is the submission process for the quarterly reports to DHCS?

DHCS is aware that engaging in negotiations to execute MOUs will take some time and that the Third Party Entities have certain processes that need to be followed. MCPs must demonstrate a good faith effort to meet the MOU requirements of APL 23-029. MCPs that are unable to execute the required MOUs by the required execution date must submit quarterly progress reports and documentation to DHCS demonstrating evidence of their good faith effort to execute the MOUs. The Third Party Entities are not required to submit or sign the quarterly reports, as the quarterly reports are specific to the MCPs compliance with the MOU requirements.

DHCS has released an MOU Quarterly Reporting Template and instructions for submitting the required quarterly reports with the finalized template. The Quarterly Reporting Template is available on the MOU website.

MCPs are encouraged to collaborate with Third Party Entities and cooperate with Third Party Entities review and approval processes for executing MOU in order to achieve MOU execution in a respectful, meaningful way.

31. If counties have multiple services or programs under one agency, do they need to execute each MOU separately?

No. To reduce administrative burden on the parties, and to account for local variation in the county structure, to the extent that multiple MOU Templates apply to a single Third Party Entity, multiple services or programs may be included under a single MOU.

In addition, DHCS encourages but does not require multi-party MOUs, which may include more than one MCP and/or Third Party Entity signing an MOU as long as the goals of the MOU can be fulfilled at the local level. MOUs serve as instruments aimed at promoting and facilitating collaboration and communication on a local-level. It is essential to bear this fundamental purpose in mind when multiple parties are entering into MOUs. The MOUs are designed to foster cooperation, and their successful implementation relies on a shared commitment to enhance collaboration and maintain open lines of communication among all involved parties.

MCPs only need to execute MOUs in the counties in which the Third Party Entity have responsibilities and not all MOUs are required for every MCP and Third Party Entity. For example, the MCP will only need to execute a DMC-ODS MOU in the

[4] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

counties in which the DMC-ODS operates.[5] This will also apply to County-Based Targeted Case Management.

If the parties agree to combine multiple Bespoke Templates into a single MOU, without altering or removing any of the minimum mandatory requirements, the combined MOU may be submitted without redline for file and use, as described in question 26 above. If the parties modify or remove any of the mandatory requirements, the MCP must submit a redlined version of the proposed MOU for review and approval prior to execution.

For any questions related to multi-party MOUs please contact MCPMOUS@dhcs.ca.gov.

Questions Related to Specific Bespoke Templates

SMHS MOU Questions

32. Are MHPs and MCPs allowed to enter into agreements outside of the MCP/MHP MOU?

Yes, DHCS acknowledges that there may be other written agreements between the Parties relating to the MHP services specified within the agreement. Other written agreements may exist but should not conflict with the provisions within the MOU. The 2023 Bespoke MOU is the required for MCPs and is meant to replace previous MOUs.

33. Are Mental Health Plan and Drug Medi-Cal Organized Delivery System County network/contracted providers required to be a signatory to their delivery system's respective MOUs?

No. The required signatories (in addition to the MHP/DMC-ODS County and the MCP) are MCP Subcontractors or Downstream Subcontractors that are Knox-Keene licensed health care plans and have entered into agreements with MCPs to delegate all or part of their responsibilities relating to sending/receiving referrals and care coordination for members served by both parties of the MOU. This does not include network/contracted MHP and DMC-ODS providers. DHCS will be releasing additional iterations of FAQs which will include clarification.

SUD MOU Questions

34. Should MCPs use the DMC-ODS MOU template for SUD services provided in all counties or will DHCS issue a separate MOU template for DMC State Plan Counties?

A DMC State Plan MOU Template is currently being developed for use by DMC State Plan Counties. The DMC-ODS MOU Template should not be used by DMC

[5] For more information on counties participating in the DMC-ODS Pilot please see: https://www.dhcs.ca.gov/provgovpart/Pages/county-implementation-plans.aspx

State Plan Counties. MCPs in counties participating in DMC-ODS should use the DMC-ODS Template provided with the APL and BHIN.

35. What is the submission process for quarterly reports to DHCS for DMC-ODS and MHPs?

DMC-ODS counties and MHPs that are unable to execute their MOUs by January 1, 2024, must submit quarterly progress reports and documentation to DHCS demonstrating evidence of their good faith effort to execute the MOU as required by BHIN 23-056 and 23-057.

County Child Welfare MOU Questions

36. What is AB 2083 and why is it referenced in the CCW MOU?

AB 2083 (Chapter 815, Statutes of 2018), Children and Youth System of Care (SOC), requires each county to develop and implement a MOU setting forth roles and responsibilities of agencies and other entities, such as regional centers, county offices of education, county child welfare, juvenile probation, and behavioral health agencies, that serve children and youth in foster care who have experienced severe trauma as outlined in the All County Letter No. 19-116 /BHIN 19-053 . The purpose of AB 2083 MOUs (also referred to as SOC/ILT MOUs) are to ensure that children and youth in foster care receive coordinated, timely, and trauma-informed services. While AB 2083 focuses on children and youth in foster care who have experienced severe trauma, it reflects a priority to build a locally governed interagency or interdepartmental model on behalf of all children and youth across California that have similar needs, that interact with and are served by multiple agencies.

These AB 2083 MOUs are between counties and other local entities that serve children in child welfare/foster care include California's Integrated Core Practice Model (ICPM) which establishes practices and leadership behaviors through which individuals and organizations must partner and collaborate with one another, and children and families, to ensure an integrated approach to meeting the needs of children and families. MCPs are not required to be parties to AB 2083 MOUs. However, counties may wish to align their MOUs with MCPs with their AB 2083 MOUs to ensure coordination across all entities providing services and coordinating care for children and youth in child welfare/foster care. DHCS encourages MCPs and Third Party Entities to collaborate to identify opportunities for coordination and alignment between the MCP required MOUs and AB 2083 MOUs to meet the goal of ensuring Members receive comprehensive, whole person care.

LHD Questions

37. Does Exhibit F of the LHD MOU apply to Whole Child Model (WCM) counties when the county acts as a "Classic" county for CCS-Only/FFSMC population?

Exhibit F of the LHD MOU does not apply to the WCM counties. The MOU is for the coordination between the MCP and the county for MCP's Members enrolled, or

eligible to enroll, in the CCS Program. Because the CCS-Only/FFSMC populations are not served by the MCPs, this MOU exhibit would not be applicable. The WCM MOU is available at: https://www.dhcs.ca.gov/services/ccs/Pages/CCSWholeChildModel.aspx.

38. Who should be involved in the MOU development, execution, and coordination of the LHD MOU from the department/agency?

LHD leadership with decision-making authority on behalf of the department/agency and jurisdiction may be involved in MOU development, execution, and coordination.

IHSS Questions

39. Can a different IHSS MOU Template be used as long as all language from DHCS' templates is incorporated? Can language from the IHSS MOU Template be incorporated into an existing agreement?

DHCS requires MCPs to build partnerships and execute MOUs with Counties for IHSS. APL 23-029 requires that MCPs include all of the minimum requirements in the Base Template or Bespoke Templates. However, the MCP and the Other Party may agree to include additional provisions, provided any additional provision does not conflict with the required minimum provisions.

Upon submission to DHCS, MCPs must attest that they did not modify any of the provisions of the Base Template or Bespoke Templates except to add provisions that do not conflict with or reduce either party's obligations under the Base Template or Bespoke Templates. If the MCP modifies any of the provisions of the Base Template or Bespoke Templates, the MCP must submit a redlined version of the MOU to DHCS for review and approval, prior to execution.

We recommend MCPs work closely with counties to ensure the executed MOU meets the requirements for MCPs as described in APL 23-029.

40. Does the MOU require MCPs to determine or authorize IHSS hours or providers?

IHSS eligibility and authorized hours are determined by county social service agencies, and the county social services agency works with an IHSS recipient to connect the recipient with an IHSS providers. MCPs do NOT determine or authorize IHSS hours or providers.

41. Does this MOU require counties to share IHSS data for all county IHSS recipients with MCPs?

No, the MOU template is intended to support coordination between counties and MCPs for their shared clients – IHSS recipients who are MCP Members. The data sharing requirements are focused on the need to share information for select Members that counties and MCPs need to discuss together for care coordination.

DHCS already shares key IHSS data with MCPs for their Members on a monthly basis, although that data sharing is not “real time.”

42. What happens in a county with multiple MCPs, can the county sign the same MOU language with each plan?

DHCS recognizes that a county may want to use the same language for all IHSS MOUs with MCPs and DHCS encourages but does not require MCPs to align their MOU language within the same county.

43. Are counties required to sign MOUs with MCPs?

To support the needs of IHSS recipients and improve coordination for care at home and in the community, DHCS and CDSS strongly encourage counties to work with MCPs and develop language that is mutually agreeable.

For example, individuals who need help with activities of daily living may get referrals to IHSS from their MCP or health care provider. And sometimes there is a need for an expedited IHSS application, or reassessment, when someone is transitioning from a hospital or nursing facility stay. For these situations and others, having the county and health plan working together can improve the individual’s experience of care.

44. If a county and MCP already have an MOU established, does that MOU need to be amended?

Yes. The IHSS MOU Template imposes new requirements with which MCPs must comply. If the currently established MOU includes requirements that go above and beyond those in the IHSS MOU Template, the parties may incorporate those requirements into their executed IHSS MOU so long as they do not conflict with the requirements set forth in the IHSS MOU Template.

APPENDIX A: MCP Contract Terms

Capitalized terms have the meaning ascribed by MCP's Medi-Cal Managed Care Contract with DHCS, unless otherwise defined. In anticipation of the 2024 The Medi-Cal Managed Care Contract, the following definitions of terms will apply to the Base Templates and the Bespoke Templates. The finalized 2024 The Medi-Cal Managed Care Contract will be posted to DHCS's webpage at www.dhcs.ca.gov.

All Plan Letter (APL) or **Policy Letter (PL)** means a binding document that has been dated, numbered, and issued by DHCS that provides clarification of Contractor's contractual obligations, implementation instructions for Contractor's contractual obligations due to changes in State and federal law or judicial decisions, and/or guidance with regulatory force and effect when DHCS interprets, implements, or makes specific relevant State statutes under its authority.

Authorized Representative means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member.

Basic Population Health Management (Basic PHM) means an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.

Behavioral Health means mental health conditions and Substance Use Disorders (SUD).

Behavioral Health Services means Specialty Mental Health Services (SMHS), Non-specialty Mental Health Services (NSMHS), and Substance Use Disorders (SUD) treatment.

Behavioral Health Treatment (BHT) means services and treatment programs for the treatment of Autism Spectrum Disorder (ASD), as specified in the California Medicaid State Plan, including applied behavioral analysis and other evidence-based intervention programs that develop or restore, to the maximum extent practicable, the functioning of a Member less than 21 years of age who has been diagnosed with ASD, or for whom a licensed physician, surgeon, or psychologist has determined BHT is Medically Necessary.

BHT Provider means a Qualified Autism Services (QAS) Provider, QAS Professional, or QAS Paraprofessional.

Bright Futures Periodicity Schedule means the Bright Futures/American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care and guidelines published by the American Academy of Pediatrics and Bright Futures, in accordance

with which all Members under 21 years of age must receive well child assessments, screenings, and services.

California Advancing and Innovating Medi-Cal (**CalAIM) Terms and Conditions** means those terms and conditions issued and approved by the federal Centers for Medicare and Medicaid Services (CMS), including any attachments, appendices, or similar documents, and subsequent amendments thereto, that govern implementation of the respective components of the CalAIM initiative pursuant to Article 5.1 of Chapter 7 of Part 3 of Division 9 of Welfare and Institutions (W&I) Code. CalAIM Terms and Conditions must include, at a minimum, any terms and conditions specified in the following:

(1) California Advancing and Innovating Medi-Cal Demonstration, Number 11-W-00193/9, as approved by the federal Centers for Medicare and Medicaid Services pursuant to Section 1315 of Title 42 of the United States Code, including for any applicable extension period, or for any period otherwise approved therein.

(2) Any associated Medicaid Waivers as approved by CMS pursuant to Section 1396n of Title 42 of the United States Code, including but not limited to the CalAIM Section 1915(b) Waiver Control Number CA 17.R10, that are necessary to implement a CalAIM component, including for any applicable extension period, or for any period otherwise specified in the CalAIM Terms and Conditions.

California Children's Services (CCS)-Eligible Condition means a medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 CCR section 41515.1 et seq.

CCS Case Manager means an individual identified as a single point-of-contact responsible for the provision of case management services and facilitation of Care Coordination for a Member receiving services under the CCS program.

CCS Program means a State and county program providing Medically Necessary services to treat California Children's Services (CCS)-eligible conditions.

Care Coordination means Contractor's coordination of care delivery and services for Members, either within or- across delivery systems including:

A. Services the Member receives by the Contractor;
B. Services the Member receives from any other managed care health plan;
C. Services the Member receives in Fee-For-Service (FFS);
D. Services the Member receives from out-of-Network Providers;
E. Services that the Member receives through carve-out programs, such as pharmacy, SUD, mental health and dental services; and
F. Services the Member receives from community and social support Providers.

Community Supports means substitute services or settings to those required under the California Medicaid State Plan that Contractor may select and offer to their Members pursuant to 42 CFR section 438.3(e)(2) when the substitute service or

setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.

Community Supports Provider means entities that Contractor has determined can provide the Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees).

Complex Care Management (CCM) means an approach to care management that meets differing needs of high and rising-risk Members, including both longer-term chronic Care Coordination for chronic conditions and interventions for episodic, temporary needs. Contractors must provide CCM in accordance with all National Committee for Quality Assurance (NCQA) CCM requirements.

Covered Services means those health care services, set forth in Welfare and Institutions Code (W&I) sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the Contract, and All Plan Letters (APL) that are made the responsibility of Contractor pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

Covered Services do not include:

A. HCBS Program services as specified in Exhibit A, Attachment III, Subsections 4.3.16 (Services for Persons with Developmental Disabilities), 4.3.21 (HCBS Programs) regarding waiver programs, 4.3.22 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver. HCBS Programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the Contract, as specified in Exhibit A, Attachment III, Subsection 5.3.4 (Services for Members less than 21 Years of Age). Contractor is financially responsible for the payment of all EPSDT services;

B. CCS as specified in Exhibit A, Attachment III, Subsection 4.3.15 (California Children's Services (CCS)), except for Contractors providing Whole Child Model (WCM) services;

C. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Mental Health Services);

D. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, with the exception of medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.14 (Alcohol and SUD Treatment Services);

E. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members);

F. Direct Observed Therapy for Treatment of Tuberculosis as specified in Exhibit A, Attachment III, Subsection 4.3.19 (Direct Observed Therapy for Treatment of Tuberculosis);

G. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Dental) regarding dental services;

H. Prayer or spiritual healing as specified in 22 CCR section 51312;

I. Educationally Necessary Behavioral Health services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, Contractor is responsible for all Medically Necessary Behavioral Health services as specified in Exhibit A, Attachment III Subsection 4.3.17 (School-Based Services);

J. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health;

K. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services;

L. State Supported Services;

M. Targeted Case Management (TCM) services as set forth in 42 United States Code (USC) section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.12 (Targeted Case Management (TCM) Services). However, if Members less than 21 years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, Contractor must ensure access to comparable services under the EPSDT benefit in accordance with All Plan Letter (APL) 23-005;

N. Childhood lead poisoning case management provided by county health departments;

O. Non-medical services provided by RCs to individuals with developmental disabilities, including but not limited to respite, out-of-home placement, and supportive living;

P. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and APL 16-006; and

Q. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional produces when appropriately billed by a pharmacy on a pharmacy claim, in accordance with All Plan Letter (APL) 22-012.

Department of Health Care Services (DHCS) or **Department** means the single state department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health-related programs, as provided by statute and/or regulation.

DHCS Contract Manager or **DHCS Program Contract Manager** means the designated DHCS employee who is the primary contact within DHCS for the Contract, and responsible for receiving and sending notices and other documents from/to Contractor relating to the Contract.

Downstream Subcontractor means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

Downstream Fully Delegated Subcontractor means a Downstream Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, through the Subcontractor, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Downstream Fully Delegated Subcontractor.

Downstream Partially Delegated Subcontractor means a Downstream Subcontractor that contractually assumes some, but not all, duties and obligations of a Subcontractor under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Downstream Partially Delegated Subcontractors.

Downstream Subcontractor Agreement means a written agreement between a Subcontractor and a Downstream Subcontractor or between any Downstream Subcontractors. The Downstream Subcontractor Agreement must include a delegation of Contractor's and Subcontractor's duties and obligations under the Contract.

Drug Medi-Cal (DMC) means the State system wherein Members receive Covered Services from DMC-certified Substance Use Disorder (SUD) treatment Providers.

Drug Medi-Cal Organized Delivery System (DMC-ODS) means a program for the organized delivery of Substance Use Disorder (SUD) services to Medi-Cal-eligible individuals with SUD residing in a county that has elected to participate in the DMC-ODS. Critical elements of DMC-ODS include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria® for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment, and increased coordination with other systems of care.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) means the provision of Medically Necessary comprehensive and preventive health care services provided to Members less than 21 years of age in accordance with requirements in 42 USC sections 1396a(a)(43) and 1396d(a)(4)(B) and (r), 42 CFR section 441.50 et seq., and as required by W&I sections 14059.5(b) and 14132(v). Such services may also be Medically Necessary to correct or ameliorate defects and physical or Behavioral Health conditions.

Emergency Preparedness and Response Plan means the plan identified and described in Exhibit A, Attachment III, Section 6.1 (General Guidance).

Enhanced Care Management (ECM) means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus eligibility criteria through a systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

ECM Populations of Focus/Populations of Focus means the populations identified in Exhibit A, Attachment III, Subsection 4.4.2 (Populations of Focus for ECM).

ECM Provider means community-based entities with experience and expertise providing intensive, in-person care management services to Members in one or more of the Populations of Focus for Enhanced Care Management (ECM).

File and Use means a submission to DHCS that does not need review and approval prior to use or implementation, but for which DHCS can require edits on or after implementation.

Fully Delegated Subcontractor means a Subcontractor that contractually assumes all duties and obligations of Contractor under the Contract, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subcontractor.

In-Home Supportive Services (IHSS) means services provided to Members by a county in accordance with the requirements set forth in W&I sections 12300 et seq., 14132.95, 14132.952, and 14132.956.

Intermediate Care Facility (ICF) means a residential facility certified and licensed by the State to provide medical services at a lower level of care than is provided at Skilled Nursing Facilities (SNFs), and meets the standards specified in 22 CCR section 51212.

Knox-Keene Health Care Service Plan Act of 1975 (KKA) means the law that regulates health care service plans and is administrated by DMHC, commencing with H&S section 1340 et seq.

Local Educational Agency (LEA) means a school district, county office of education, charter school, community college district, California State University campus or University of California campus.

Local Government Agency (LGA) means a local governmental entity including, but not limited to, a county child welfare agency, county probation department, county Behavioral Health department, county social services department, county public health department, school district, or county office of education.

Long-Term Care (LTC) means specialized rehabilitative services and care provided in a Skilled Nursing Facility (SNF), subacute facility, pediatric subacute facility, Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N) home that lasts longer than the remainder of the month of admission plus one (1) month.

Long-Term Services & Supports (LTSS) means services and supports designed to allow a Member with functional limitations and/or chronic illnesses the ability to live or work in the setting of the Member's choice, which may include the Member's home, a worksite, a Provider-owned or controlled residential setting, a nursing facility, or other institutional setting. LTSS includes both LTC and HCBS Programs, and includes carved-in and carved-out services.

Medically Necessary or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Member or **Enrollee** means a Potential Member who has enrolled with Contractor.

Memorandum of Understanding (MOU) means a formal written agreement between Contractor and local government agencies, county programs, and third-party entities.

Network Provider means any Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under the Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

Network Provider Agreement means a written agreement between a Network Provider and Contractor, Subcontractor, or Downstream Subcontractor.

No Wrong Door means Members receive timely Behavioral Health Services without delay, regardless of delivery system where they seek care and are able to maintain treatment relationships with trusted Providers without interruption. This includes concurrent service provision, whereby Contractor must cover Medically Necessary Non-specialty Mental Health Services (NSMHS) for a Member concurrently receiving Specialty Mental Health Services (SMHS) covered by the county Mental Health Plan (MHP), and ensure those services are coordinated and not duplicative. Contractor must ensure compliance with No Wrong Door pursuant to W&I section 14184.402.

Non-specialty Mental Health Services (NSMHS) means all of the following services that Contractor must provide when they are Medically Necessary, and is provided by PCPs or by licensed mental health Network Providers within their scope of practice:

A. Mental health evaluation and treatment, including individual, group and family psychotherapy;

B. Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;

C. Outpatient services for the purposes of monitoring drug therapy;

D. Psychiatric consultation; and

E. Outpatient laboratory, drugs, supplies, and supplements, excluding separately billable psychiatric drugs claimed by outpatient pharmacy providers via Medi-Cal Rx.

Partially Delegated Subcontractor means a Subcontractor that contractually assumes some, but not all, duties and obligations of Contractor under the Contract, including, for example, obligations regarding specific Member populations or

obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Partially Delegated Subcontractors.

Population Health Management (PHM) means a whole-system, person-centered, population-health approach to ensuring equitable access to health care and social care that addresses Member needs. It is based on data-driven risk stratification, analytics, identifying gaps in care, standardized assessment processes, and holistic care/case management interventions.

Potential Member or **Potential Enrollee** means a Medi-Cal beneficiary who resides in Contractor's Service Area and is subject to mandatory enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan.

Primary Care Provider (PCP) means a Provider responsible for supervising, coordinating, and providing initial and Primary Care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For Senior and Person with Disability (SPD) Members, a PCP may also be a Specialist or clinic.

Prior Authorization means a formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.

Provider means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.

Quality Improvement (QI) means systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for Members.

Regional Center (RC) means a non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases, and manages services for Members with Developmental Disabilities and their families.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services means comprehensive, integrated delivery of early intervention and treatment services for Members with Substance Use Disorders (SUD), as well as those who are at risk of developing SUDs.

Service Area means the county or counties that Contractor is approved to operate in under the terms of the Contract. A Service Area may be limited to designated ZIP codes (under the U.S. Postal Service) within a county.

Skilled Nursing Facility (SNF) means any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program.

Specialty Mental Health Provider means a person or entity who is licensed, certified, otherwise recognized, or authorized under the California law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide Specialty Mental Health Services.

Specialty Mental Health Service (SMHS) means a Medi-Cal covered mental health service provided or arranged by county mental health plans for Members in their counties that need Medically Necessary specialty mental health services.

Subcontractor means an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under the Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

Subcontractor Agreement means a written agreement between Contractor and a Subcontractor. The Subcontractor Agreement must include a delegation of Contractor's duties and obligations under the Contract.

Substance Use Disorder (SUD) means those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

Targeted Case Management (TCM) means services which assist Members within specified target groups to gain access to needed medical, social, educational, and other services, as set forth in 42 USC section 1396n(g). In prescribed circumstances, TCM is available as a Medi-Cal benefit and a discrete service through State or local government entities and their contractors.

Transitional Care Service means a service provided to all Members transferring from one institutional care setting, or level of care, to another institution or lower level of care, including home settings.

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

APPENDIX B: MHP, DMC-ODS, and State Plan Terms

Capitalized terms have the meaning ascribed by MHP's Contract with DHCS, unless otherwise defined. MHP Contracts are available at: https://www.dhcs.ca.gov/services/MH/Pages/Contracts_Medicaid_State_Plan.aspx. DMC-ODS Contracts are available at: https://www.dhcs.ca.gov/services/MH/Pages/Contracts_Medicaid_State_Plan.aspx.

Behavioral Health Information Notice (BHIN)- means a binding document that has been dated, numbered, and issued by DHCS that provides clarification of county Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) counties contractual obligations, implementation instructions for contractual obligations due to changes in State and federal law or judicial decisions, and/or guidance with regulatory force and effect when DHCS interprets, implements, or makes specific relevant State statutes under its authority.

Behavioral Health Quality Improvement Program (BHQIP): an incentive payment program to support MHP, DMC State Plans and DMC-ODS, also referred to as County Behavioral Health Plans, as they prepare for changes in the California Advancing and Innovating Medi-Cal (CalAIM) initiative and other approved administration priorities.

Full Service Partnership (FSP): the collaborative relationship between the County and the client, and when appropriate the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals. (9 CCR section 3200.130)

Intensive Care Coordination (ICC): a targeted case management service that facilitates assessment of, care planning for, and coordination of services to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service.

Medi-Cal RX: the collective pharmacy benefits and services that are administered through the fee-for-service delivery system.

Mental Health Plan: the county entity responsible for providing or arranging for the provision of Specialty Mental Health Services (SMHS) to Medi-Cal beneficiaries in their county.

Protected Health Information (PHI): The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes.

Psychiatric Residential Treatment Facilities: licensed by DHCS and provide 24-hour inpatient care for mentally disordered, incompetent, or other persons as

described in Division 5 (commencing with Section 5000) or Division 6 (commencing with Section 6000) of the Welfare and Institutions Code.

Short-Term Residential Therapeutic Programs: a residential facility operated by a public agency or private organization and licensed by the department pursuant to Section 1562.01 that provides an integrated program of specialized and intensive care and supervision, services and supports, treatment, and short-term, 24-hour care and supervision to children that is trauma-informed, as defined in standards and regulations adopted by the department.

Specialty Mental Health Targeted Case Management (TCM): TCM is a service that assists a beneficiary in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination and referral; monitoring service delivery to ensure beneficiary access to services and the service delivery system; monitoring of the beneficiary's progress, placement services, and plan development. TCM services may be face to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the MHP to be qualified to provide the service, consistent with the scope of practice and state law.

APPENDIX C: Resources

All County Letter No. 19-116, AB 2083 (2018) Memorandum of Understanding Guidance, is available at: https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACLs/2019/19-116.pdf.

APLs and PLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/MgdCarePlanPolicyLtrs.aspx.

BHINS and MHSUDS can be found at: https://www.dhcs.ca.gov/formsandpubs/Pages/Behavioral_Health_Information_Notice.aspx.

BHQIP information is available at: https://www.dhcs.ca.gov/bhqip.

Information regarding **CalAIM**, including updates regarding the implementation of various components of CalAIM, can be found at: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx.

The **Community Supports** Policy Guide is available at: https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-Community-Supports-Policy-Guide.pdf.

Medi-Cal managed care boilerplate **contracts** are available at: http://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx.

County Mental Health Plan Information is available at: https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.

The **ECM Policy Guide** is available on the ECM and ILOS webpage that can be found at: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

The finalized **ECM and Community Supports MCP Contract** Template is available at https://www.dhcs.ca.gov/Documents/MCQMD/MCP-ECM-and-ILOS-Contract-TemplateProvisions.pdf.

The **ECM and Community Supports webpage** is located at: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

The “Policy and Operational Guide for Planning and Implementing CalAIM **Justice-Involved** Reentry Initiative” will be available on the Justice Involved Initiative page of the DHCS website, at: https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Pages/home.aspx.

Medi-Cal Rx Frequently Asked Questions are available at: https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-Cal-Rx-

FAQ.aspx#:~:text=Medi-Cal%20Rx%20is%20the,Assumption%20of%20Operations%20(AOO).

The **PHM Policy Guide** is available at: https://www.dhcs.ca.gov/CalAIM/Documents/2023- PHM-Policy-Guide.pdf.

The DHCS **PHM webpage** is located at: https://www.dhcs.ca.gov/CalAIM/Pages/PopulationHealthManagement.aspx.

Psychiatric Health Facilities information is available at: https://www.dhcs.ca.gov/psychiatric-health-facilities.

State law is searchable at: https://leginfo.legislature.ca.gov/.

TCM Program overview is available at: https://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/TCM/TCM_FactSheet_01212016.pdf.

APL 21-004, Standards for Determining **Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services** is available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-004.pdf.

APL 22-008, **Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses FAQ** is available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2022/APL22-008-NEMT-NMT-FAQ.pdf