

**SUBMITTAL TO THE BOARD OF SUPERVISORS  
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA**



**ITEM: 3.27**  
(ID # 26780)

**MEETING DATE:**  
Tuesday, April 14, 2026

**FROM :** RUHS-BEHAVIORAL HEALTH

**SUBJECT:** RIVERSIDE UNIVERSITY HEALTH SYSTEM - BEHAVIORAL HEALTH: Ratify and Approve the Memorandum of Understanding and the Financial Agreement between SCAN Health Plan (SCAN) and Riverside University Health System – Behavioral Health (RUHS-BH) for Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Services for SCAN Members, effective upon execution through June 30, 2029, All Districts. [Total Cost \$0]

**RECOMMENDED MOTION:** That the Board of Supervisors:

1. Approve the Memorandum of Understanding (MOU) between SCAN Health Plan (SCAN) and Riverside University Health System – Behavioral Health (RUHS-BH) for SMHS and DMC-ODS for SCAN Member services effective upon execution through June 30, 2029;
2. Approve the Financial Agreement between SCAN Health Plan (SCAN) and Riverside University Health System – Behavioral Health (RUHS-BH) for SMHS and DMC-ODS for SCAN Member services effective upon execution through June 30, 2029; and
3. Authorize the Director of RUHS-BH, or their designee, as approved by County Counsel to: 1) sign and execute the MOU and Financial Agreement; and 2) sign and execute renewals and amendments through June 30, 2029.


**ACTION:Policy**

---

**MINUTES OF THE BOARD OF SUPERVISORS**

On motion of Supervisor Perez, seconded by Supervisor Washington and duly carried by unanimous vote, IT WAS ORDERED that the above matter is approved as recommended.

Ayes: Medina, Spiegel, Washington, Perez, and Gutierrez  
Nays: None  
Absent: None  
Date: April 14, 2026  
xc: RUHS-BH

Kimberly A. Rector  
Clerk of the Board  
By:   
Deputy

**SUBMITTAL TO THE BOARD OF SUPERVISORS COUNTY OF RIVERSIDE,  
STATE OF CALIFORNIA**

<b>FINANCIAL DATA</b>	<b>Current Fiscal Year:</b>	<b>Next Fiscal Year:</b>	<b>Total Cost:</b>	<b>Ongoing Cost</b>
<b>COST</b>	\$ 0	\$ 0	\$ 0	\$ 0
<b>NET COUNTY COST</b>	\$ 0	\$ 0	\$ 0	\$ 0
<b>SOURCE OF FUNDS:</b> 100% SCAN Health Plan Funds			<b>Budget Adjustment:</b>	No
			<b>For Fiscal Year:</b>	25/26-28/29

**C.E.O. RECOMMENDATION:** Approve

**BACKGROUND:**

**Summary**

As the Riverside County Mental Health Plan (MHP), RUHS-BH is required to enter into MOUs with Managed Care Plans (MCPs) pursuant to Cal. Code Regs. tit. 9 § 1810.370, MHP/DMC-ODS Contract, Exhibit A, Attachment 10, Behavioral Health Information Notice (“BHIN”) 23- 056. The MOU outlines the responsibilities of both RUHS-BH and SCAN to ensure that Medi-Cal/Medicare beneficiaries enrolled in the MCP can access to services in a coordinated manner. RUHS-BH and SCAN have an established partnership to ensure that SCAN members have access to behavioral health treatment services, including specialty mental health treatment and substance use disorder treatment services. This MOU has incorporated state mandated changes brought about by California Advancing and Innovating Medi-Cal program (CalAIM) to streamline the coordination of care between MCPs and MHPs.

SCAN is authorized to offer benefit plans that cover hospital, medical and other health care services for Medicare beneficiaries who elect to enroll in SCAN.

The Agreement memorializes the general terms upon which RUHS will agree to provide Covered Services to SCAN Members during the Agreement period, in exchange for payment by SCAN at the reimbursement rates listed in Exhibit B, attached and incorporated in the agreement.

**Impact on Citizens and Businesses**

These services are a component of Behavioral Health’s system of care aimed at improving the health and safety of consumers and the community.

**Additional Fiscal Information**

There are no costs associated with this MOU.

**Attachments**

Attachment A: MOU - SCAN Health Plan

Attachment B: Financial Agreement - SCAN Health Plan

**COUNTY BEHAVIORAL HEALTH SERVICES AGREEMENT  
BETWEEN SCAN HEALTH PLAN  
AND  
RIVERSIDE UNIVERSITY HEALTH SYSTEM – BEHAVIORAL HEALTH**

This Agreement (“Agreement”) is effective as of the date of execution, between SCAN Health Plan, a California nonprofit public benefit corporation (“SCAN”), and Riverside University Health System – Behavioral Health (RUHS-BH) (“Provider” or “First Tier Entity”).

**RECITALS**

- A. SCAN has been designated as a Medicare Advantage Organization by the Centers for Medicare & Medicaid Services (“CMS”) of the United States Department of Health & Human Services (“DHHS”).
- B. SCAN has contracted with CMS pursuant to Section 402 of the 1967 Amendments to the Social Security Act and the Department of Health Care Services of the State of California (“DHCS”) pursuant to Article 7 (commencing with Section 14490) of the California Welfare and Institutions Code, and is licensed by the State of California’s Department of Managed Health Care (“DMHC”) as a health care service plan pursuant to the Knox-Keene Health Care Service Plan Act of 1975 as amended (the “Act”).
- C. SCAN is authorized to offer benefit plans that cover hospital, medical and other health care services for Medicare beneficiaries who elect to enroll in SCAN.
- D. SCAN and Provider entered into a Memorandum of Understanding, effective as of the date of execution (“MOU”), and incorporated herein, to ensure that Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) Members enrolled in SCAN are able to access and/or receive Medi-Cal covered mental health services in a coordinated manner.
- E. SCAN and Provider wish to memorialize the general terms upon which Provider will agree to provide Services, as identified in the MOU, and Covered Services, as identified in Exhibit A, (collectively, the Services described in the MOU and in Exhibit A shall be referred to as “Covered Services”) to SCAN Members during this Agreement period, in exchange for payment by SCAN at the reimbursement rates listed in Exhibit B, attached hereto and incorporated hereof.

NOW, THEREFORE, in consideration of the mutual covenants and promises herein contained, the parties agree as follows:

**AGREEMENT**

- 1. **Compliance with Applicable Law.** Both parties shall comply with Applicable Law. Applicable Law shall mean all federal, state and local statutes, rules, regulations, ordinances, and policies applicable to the subject matter of this Agreement or the parties’ performance of their duties and obligations hereunder, including but not limited to, the Act and its implementing regulations, the Social Security Act and its implementing regulations, CMS instructions, including all CMS accountability provisions (42 CFRs 422.504(i)(3) and

WHEN DOCUMENT IS FULLY EXECUTED RETURN  
**CLERK’S COPY**  
to Riverside County Clerk of the Board, Stop 1010  
Post Office Box 1147, Riverside, Ca 92502-1147  
Thank you.

APR 14 2026

3 . 2 7

422.504(i)(4)(v)), the Health Insurance Portability and Accountability Act (“HIPAA”) and its implementing regulations, the Deficit Reduction Act of 2005 and its implementing regulations, and all standards, rules and regulations of all Accreditation Bodies which have jurisdiction over the subject matter of this Agreement or the parties’ performance of their duties hereunder. Any provision required to be in this Agreement by Applicable Law shall bind SCAN and Provider whether or not provided in this Agreement.

2. **Covered Services.** Provider shall provide the Services, as identified in the MOU, and Covered Services, as identified in **Exhibit A**, County Behavioral Health Services, attached hereto and incorporated herein by this reference, to dually eligible Medi-Cal Members enrolled in a SCAN Benefit Plan, in accordance with the terms of this Agreement and as set forth in the applicable Member Evidence of Coverage.
3. **Subcontractors.** All subcontractors used by Provider in the performance of any Covered Services shall execute a binding written agreement requiring such subcontractor to (a) protect the Confidential Information of SCAN to at least the same extent as Provider is required to protect such information pursuant to the terms of the Agreement, and (b) comply with all other obligations, duties and responsibilities required of Provider under the provisions of the Agreement with respect to the Covered Services to be performed by such subcontractor. Notwithstanding the use of any subcontractor to perform any of the Covered Services, Provider shall remain fully responsible for any subcontracted obligations, shall be solely responsible for all fees, compensation, reimbursements and payments due to such subcontractors, and for any breach of the provisions of the Agreement by any subcontractor to the same extent as if such obligations were performed by Provider.
4. **Good Standing.** Provider shall at all times be in good standing with all regulatory agencies, including, but not limited to DHCS and SCAN. Provider shall be responsible for ensuring that Provider or any subcontractor performing Covered Services under this Agreement is duly qualified, registered, credentialed, and/or licensed in good standing in accordance with Applicable Law to provide the Covered Services. Provider shall have a process to document and verify that the qualifications of the individual performing Covered Services under the Agreement meet the applicable requirements, which may include, but is not limited to, background checks, license or certification verification, credentialing, and exclusion monitoring.
5. **Claims or Invoice Submission, Rates and Compensation.** In exchange for the provision of Covered Services, SCAN shall pay Provider, and Provider shall accept compensation pursuant to the terms and conditions described in **Exhibit B** as payment in full for Covered Services. For each claim or invoice submitted by Provider, SCAN shall pay the amount due to Provider within thirty (30) calendar days as required by 42 CFR 422.520(b) following receipt of a clean claim by SCAN. A clean claim or clean invoice shall mean a claim or invoice that is complete and includes all the information reasonably required to adjudicate the claim or an invoice that contains all elements required by DHCS. Provider shall submit claims or invoices, using DHCS requirements, appropriate billing for service rendered (UB04 or HCFA 1500). Provider acknowledges and agrees that if Provider fails to submit claims or invoices as specified by this Section, SCAN reserves the right to deny payment for such claims or invoices. The reimbursement shall be less the Copayment amount that Provider will collect from the

Member, if applicable. This section does not prohibit Provider from collecting applicable Copayments, coordination of benefits payments, deductibles, or reimbursement for Non-Covered Services. The Provider shall accept the rates of reimbursement, as described in this Agreement, as payment in full. The Member cannot be billed for these services beyond any applicable Copayment amount.

- a. Claims: In order to ensure payment of Provider's claim, Provider shall provide an initial submission of a current W-9 Form to SCAN and forward claims to the below address:

SCAN Health Plan  
Attn: Claims Department  
P.O. Box 21543  
Eagan, MN 55121

- b. Provider shall abide by Medi-Cal's appeals, expedited appeals and expedited review procedures for Members, including forwarding information on appeals to SCAN, as necessary.
6. **Records and Access.** Provider agrees to abide by all Federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information, safeguard the privacy of the beneficiary's information, and maintain records and information in an accurate and timely manner and made available to applicable regulatory agencies when necessary.
  7. **Federal Funds; No Suspensions.** Provider understands that payments made by SCAN are, in whole or in part, derived from federal funds, and therefore Provider are subject to certain laws that are applicable to individuals and entities receiving federal funds.
  8. **Provider Operations Manual.** Provider shall comply with all applicable requirements and standards specified in the SCAN Provider Operations Manual, as may be amended from time to time. Provider acknowledges that the Provider Operations Manual contains additional detailed information regarding Provider's responsibilities under this Agreement, and is hereby incorporated by reference into this Agreement. SCAN may amend the Provider Operations Manual at its discretion and communicate such amendment to Provider. In the event Provider disagrees with any amendment, Provider shall notify SCAN in writing of the disagreement within thirty (30) calendar days of receipt of SCAN's communication of the amendment. SCAN and Provider shall discuss the issue and make good faith efforts to reach a mutually agreeable resolution. Notwithstanding Provider's right to notify SCAN of disagreements, the final decision with respect to any amendment shall be made by SCAN.

9. **HIPAA and HITECH Compliance.** SCAN and Provider are parties to this Agreement pursuant to which Provider provides a service to, or performs a function on behalf of, SCAN, and in connection therewith, uses or discloses Protected Health Information (“PHI”), which includes electronic (“E PHI”) that is subject to protection under HIPAA (collectively referred to as “PHI”), and certain privacy and security regulations found at 45 CFR Parts 160 through 164 (collectively referred to as the “HIPAA Regulations”) and the Health Information Technology for Economic and Clinical Health and regulations promulgated thereunder (“HITECH Act”).

Except as otherwise limited in this Agreement, Provider shall use and disclose PHI solely to provide the Covered Services, or perform the functions described in this Agreement, and, if applicable, may use or disclose PHI for the proper management and administration of Provider or to provide data aggregation services to SCAN. In the performance of the Covered Services, Provider shall be the Covered Entity for purposes of HIPAA compliance. Provider shall not use or disclose PHI for any purpose prohibited by the HIPAA Regulations or the HITECH Act, including those purposes prohibited by 42 USC § 17935 and § 17936. Provider shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of SCAN and as permitted by the HITECH Act, 42 USC § 17935(D)(2); however, this prohibition shall not affect payment by SCAN to Provider for services provided under this Agreement.

9. **Monitoring and Auditing.** SCAN shall have the right to monitor and audit Provider’s performance and operations as related to this Agreement, including for purposes of determining accuracy of payment, and/or to retain the services of qualified independent auditors to perform such review on its behalf. Provider shall allow SCAN (or its designee) to inspect and make copies of records for monitoring and auditing purposes and, if requested and as appropriate, allow participation of the SCAN Medical Director (or designee) in all utilization management and quality improvement meetings and programs regarding Members conducted by Provider. When reasonably possible, SCAN shall provide at least thirty (30) calendar days’ prior written notice of a request for audit or inspection, or five (5) calendar days’ attendance at meetings. Provider agrees to discuss with SCAN the implementation of any identified corrective action plans resulting from such monitoring or auditing at its sole cost and expense.

10. **Term and Termination.**

- a. **Term.** This Agreement is in effect as of the date of execution and shall automatically renew for successive one-year terms unless otherwise terminated pursuant to the termination provisions of this Section. If this Agreement is auto renewed, it shall continue on the same terms and conditions herein contained, except as otherwise mutually agreed to in writing by the parties.
- b. **Termination For Cause.** Either party hereto may terminate this Agreement for cause upon material breach of this Agreement by the other party. The party asserting cause for termination of this Agreement (the “Terminating Party”) shall provide written notice of termination to the other party specifying the breach or deficiency with sufficient information to allow the receiving party to identify the actions necessary to

cure such breach. The party receiving the written notice of termination shall have thirty (30) calendar days from the receipt of such notice to cure the breach of deficiency to the satisfaction of the terminating party (the "Cure Period"). If such party fails to cure the breach of deficiency to the satisfaction of the Terminating Party within the Cure Period or if the breach of deficiency is not curable, the Terminating Party shall have the right to provide notice of failure to cure the breach or deficiency to the other party following expiration of the Cure Period, and terminate the Agreement effectively immediately or at such later date as may be specified in such notice by the Terminating Party. Grounds for termination for cause shall be as follows: (i) material breach of any term, condition or covenant herein by the other party; (ii) violation of law; or (iii) assignment of this Agreement in violation of this Agreement. In addition, SCAN may terminate this Agreement for cause effective immediately upon the occurrence of one of the following events: (i) cessation of business activities of Provider or the sale of all or substantially all of Provider's assets; (ii) determination by SCAN that Provider has been excluded from participation in federal or state healthcare or other programs. During the Cure Period and the period before the effective time of termination, SCAN may begin transferring Members, cease marketing Provider to Members and prospective Members and/or discontinue assignment of Members to Provider.

- c. **Termination Without Cause.** Either party may terminate this Agreement without cause by providing written notice to the other party no later than April 1 of a calendar year, to be effective January 1 of the following year.
  
- d. **Effect of Termination.** This Agreement shall remain in full force and effect during the period between the date that notice of termination or nonrenewal is given and the effective date of such termination or nonrenewal. Termination or nonrenewal of this Agreement shall not affect any rights or obligations hereunder which shall have previously accrued or shall thereafter arise with respect to any occurrence prior to termination or nonrenewal, and such rights and obligations shall continue to be governed by the terms of this Agreement. Provider shall continue to provide Covered Services to Members, including any Members who become eligible during the termination notice period, beginning on the effective date of termination and continuing until the first to occur of: (a) a period of one hundred and twenty (120) days following termination of this Agreement or such longer period required for any Member as required by Applicable Law; or (b) the date SCAN, or a SCAN participating provider which has financial responsibility for a Member's care, provides notice to Provider that it has made arrangements for Members to receive services from another provider of Covered Services. In addition, Provider will continue to provide Covered Services in accordance with Section 11 of the DHCS Downstream Requirements Exhibit, attached hereto. During the period commencing on the date of the notice of termination or nonrenewal for any reason, SCAN may, in its sole and absolute discretion, transfer Members. Unless otherwise agreed to by SCAN, SCAN shall be solely responsible for notifying Members of the termination or nonrenewal of this Agreement.

10. **Insurance.** Provider, at its sole cost and expense, shall procure and maintain insurance as

shall be necessary to insure it and its employees, contractors and agents against any claim or claims for damages arising by reason of personal or bodily injuries or death occasioned directly by, or indirectly in connection with, the performance of this Agreement, and/or the activities performed by Provider in connection with this Agreement including but not limited to the following minimum coverage: (i) General Liability (\$1,000,000 per claim/occurrence; \$2,000,000 aggregate); (ii) Professional Liability (\$1,000,000 per claim/occurrence; \$3,000,000 aggregate), if applicable; (iii) Fidelity Bond/Employee Dishonesty (\$25,000 per claim/occurrence); (iv) Workers Compensation/Employer Liability (\$1,000,000 per claim/occurrence); (v) technology/privacy/data protection liability insurance (Cyber Liability) (\$5,000,000 per claim/occurrence).

- a. **General Liability; Professional Liability, and Self-Insurance.** Each party will maintain such insurance coverage as is reasonably necessary to support its respective obligations. Upon written request, each party shall provide evidence of such coverage to the other party. Additionally, if applicable, Provider agrees that it will maintain professional liability insurance coverage with limits at least as required by Applicable law. General liability coverage shall include coverage for premises/operations, products/completed operations and contractual liability as applicable. SCAN shall be named as an additional insured by specific endorsement or blanket endorsement. With respect to professional liability insurance, if the coverage is on a "claims made" rather than "occurrence" form, Provider, upon termination of this Agreement, where applicable, shall obtain and present evidence of an extended reporting endorsement ("tail" coverage) or replacement coverage with a retroactive date concurrent with the termination date on any previous insurance in a form acceptable to SCAN with liability limits equal to those most recently in effect prior to the date of termination, or enter into such other arrangements as shall reasonably assure SCAN of the maintenance of coverage applicable to claims arising during the period in which this Agreement was in effect for a period of not less than one (1) year after the date of termination.
- b. **Ratings, Certificates, and Modifications.** The insurance required pursuant to this Agreement must be issued by an insurance company with an AM Best rating of not less than A-, VII, be licensed to do business in the United States and be approved by the Department of Insurance in the state in which the Provider provides Covered Services. The coverage must be primary with respect to any insurance or self-insurance programs maintained by SCAN. Provider shall provide SCAN, prior to the effective date of this Agreement, and upon renewal of required coverage and thereafter, upon request, with standard ACORD certificates of insurance evidencing the insurance coverage required under this Section 10. The certificate shall note all deductibles, self-insured retentions, and retroactive dates. Provider shall provide SCAN no less than (30) calendar days' advance written notice of any intention to materially reduce the required coverage herein and no less than ten (10) calendar days' advance notice of any intention to cancel any of the required coverage herein. Provider shall provide upon request copies of each insurance policy required under this Agreement.

11. **Indemnification.** To the fullest extent allowable under Applicable Law, the parties shall indemnify and hold each other harmless from and against any and all liability, loss, expense

(including reasonable attorneys' fees) or claims for injury or damages arising out of the performance of this Agreement but only in proportion to and to the extent such liability, loss, expense, attorneys' fees, or claims for injury or damages are caused by or the result of the negligent or intentional acts or omissions of the indemnifying party. The foregoing indemnification right and obligation extends to each party's directors, officers, employees and agents, and subcontractors. Nothing in the foregoing shall be construed to be in contravention of California Civil Code section 3428 unless preempted by federal law.

12. **Independent Contractor.** The parties do not intend, nor shall this Agreement be construed, to create, for any purpose, any agency, partnership, joint venture, trust or any other form of separate legal entity or organization or to establish an employer/employee or principal and agent relationship between them. Each party shall be solely responsible for the satisfaction of any and all obligations it may assume with respect to any person retained, contracted, or employed to assist in performance of its obligations arising under this Agreement. Such obligations shall include, but not be limited to, payment of all federal and state withholding taxes applicable to employees, compliance with federal and state wage-hour obligations, workers' compensation obligations, unemployment insurance obligations, and any other applicable taxes and contributions to government mandated employment-related insurance or similar program.
13. **Confidentiality.** The parties acknowledge that Provider, in performing the Covered Services hereunder, may acquire certain Confidential Information (as defined below) relating to SCAN and its affiliated corporations. Provider shall not divulge or disclose, without SCAN's prior written approval, nor use for the benefit of any person or entity other than SCAN, any Confidential Information that may become known to Provider by reason of this Agreement or otherwise. Provider further agrees to prevent its agents and employees from divulging or disclosing any such Confidential Information or from using such Confidential Information for the benefit of any person or entity other than SCAN. "Confidential Information" of Company shall include, but not be limited to, any contact list or roster, the existing or future services, products, operations, management, business, financial information, goals, profits, billings, referral, research services, strategies, technology, trademarks, know how, member lists and objectives of SCAN or its affiliates, except to the extent that such information is generally available or known to the public or becomes known to the public through means other than a breach of this Agreement or by any person or entity having an obligation to keep such information confidential. All information which Provider acquires or becomes acquainted with during the term of this Agreement, whether developed by Provider or by others, which Provider has a reasonable basis to believe to be Confidential Information, or which is treated by the Company as being Confidential Information, shall be presumed to be Confidential Information.
14. **Notices.** All notices, requests or consents required or permitted under this Agreement shall be in writing and shall be given to the other party by email, personal delivery, overnight delivery, or regular certified mail, sent to such party's address as is set forth below or to any other address as any party to whom notice is to be given may have previously furnished to the other as set forth in this provision. Each such notice, request or consent shall be deemed effective upon receipt.

**Notice to SCAN:**

SCAN Health Plan  
Attn: Elizabeth Cordova, Medicare Compliance Officer  
3800 Kilroy Airport Way, Suite 100  
Long Beach, CA 90806  
Email: saffairs@scanhealthplan.com

With a Copy To:  
SCAN Health Plan  
Attn: General Counsel  
3800 Kilroy Airport Way, Suite 100  
Long Beach, CA 90806  
Email: legalnotice@scanhealthplan.com

**Notice to Provider:**

Riverside University Health System  
- Behavioral Health  
Attn: Contracts Administration  
4095 County Circle Drive,  
Riverside, CA 92503

15. **Assignment or Delegation.** The assignment or delegation of this Agreement will be void unless prior written approval is obtained from DHCS and SCAN.
16. **Incorporation of Exhibits.** The Exhibits attached to this Agreement are incorporated herein and shall be considered a part of this Agreement for all purposes as if fully set forth herein.
17. **Governing Law.** This Agreement has been executed and delivered in the State of California and shall be governed by and construed in accordance with the substantive laws of the State of California.
18. **Amendment.** This Agreement can be amended only in a writing signed by both parties, except that this Agreement shall be automatically amended to comply with changes in Applicable Law and, in such cases, SCAN may issue a unilateral amendment to Provider and SCAN may amend the Provider Operations Manual pursuant to the requirements set forth herein.
19. **Severability.** In the event that any provision of this Agreement shall be determined to be illegal or unenforceable, that provision will be limited or eliminated to the minimum extent necessary so that this Agreement shall otherwise remain in full force and effect and enforceable.
20. **Waiver.** The failure of either party to enforce its rights under this Agreement at any time for any period shall not be construed as a waiver of such rights.
21. **Headings.** Headings herein are provided for reference only and shall in no way affect interpretation of the Agreement.

22. **Right to Contract.** Each party hereto represents to the other that it is authorized to enter into this Agreement and to provide the Covered Services to be provided hereunder and that the exercise of the rights granted to the other party hereunder will not conflict with any commitments or agreements previously entered into between the party so representing and any other party.

23. **Signatures.** This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement. In the event that any signature is delivered by e-mail delivery of a ".pdf" format data file, such signature shall create a valid and binding obligation of the party executing (or on whose behalf such signature is executed) with the same force and effect as if such ".pdf" signature page were an original thereof.

**“SCAN”**

**SCAN Health Plan  
a California nonprofit public benefit  
corporation**

By *Karen Schulte*  
Karen Schulte (2025-2026) (03/22/2025)

Name Karen Schulte

Title President

Date 20/01/2026

**“Provider”**

**RIVERSIDE UNIVERSITY HEALTH  
SYSTEM – BEHAVIORAL HEALTH**

By \_\_\_\_\_

Name Matthew Chang, MD

Title Behavioral Health Director

Date \_\_\_\_\_

Tax ID # \_\_\_\_\_

Email: \_\_\_\_\_

**County Counsel  
Approved As To Form:**

By: *Gregg Ju*  
**Deputy County Counsel**

**EXHIBIT A  
COVERED SERVICES**

Provider shall be responsible for providing comprehensive Mental Health Services and Substance Use Disorder (SUD) treatment as listed below and as more specifically outlined in the Memorandum of Understanding, effective as of the date of execution, in accordance with the applicable standard of care. These Covered Services shall be provided to enrolled members in the Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) in Riverside County (“Members”).

Covered Services to Members include those that are listed in the table and referenced as Specialty Mental Health Service (SMHS) and Drug Medi-Cal (DMC) Organized Delivery System for January 1, 2025, and thereafter.

<b>Specialty Mental Health Service (SMHS)</b>	<b>Description</b>
SMHS Twenty-Four Hour Services	<ul style="list-style-type: none"> <li>• Adult Residential</li> <li>• Adult Crisis Residential</li> <li>• Psychiatric Health Facility</li> </ul>
SMHS Day Services	<ul style="list-style-type: none"> <li>• Day Treatment Intensive Full Day</li> <li>• Day Treatment Intensive, Half Day</li> <li>• Day Rehabilitation; Full Day</li> <li>• Day Rehabilitation; Half Day</li> <li>• Crisis Stabilization</li> </ul>
SMHS Mobile Crisis	<ul style="list-style-type: none"> <li>• Transportation Mileage (Community-Based Mobile Crisis Intervention Services)</li> </ul>
SMHS Outpatient	<ul style="list-style-type: none"> <li>• Outpatient Treatment includes Assessment, Crisis, Discharge, Medical Support, Medication Support, Peer Support, Rehabilitation, Referral &amp; Linkage, Supplemental, Therapy, Therapeutic Behavioral Services, Therapy, and Treatment Planning Services</li> </ul>
SMHS Psychiatric Inpatient	<ul style="list-style-type: none"> <li>• Psychiatric Inpatient</li> <li>• Psychiatric Hospital Inpatient Admin Day</li> <li>• Psychiatric Residential Treatment</li> </ul>
<b>Drug Medi-Cal (DMC) Organized Delivery System</b>	
DMC ODS Twenty-Four Hour Services	<ul style="list-style-type: none"> <li>• Behavioral Health Long Term Residential 3.1</li> <li>• Behavioral Health Long Term Residential 3.3</li> <li>• Behavioral Health Long Term Residential 3.5</li> <li>• Alcohol and Drug Services; (Residential Addiction Outpatient). Sub-Acute Detoxification 3.2</li> </ul>
DMC ODS Ambulatory Withdrawal Management	<ul style="list-style-type: none"> <li>• Alcohol and/or drug services; ambulatory detoxification</li> <li>• Alcohol and/or drug services; ambulatory detoxification</li> </ul>
DMC ODS Inpatient Withdrawal Management	<ul style="list-style-type: none"> <li>• Withdrawal Management and Residential Hospital with ASAM 3.7 and 4.0 Services</li> </ul>
DMC ODS Mobile Crisis	<ul style="list-style-type: none"> <li>• Mobile Crisis Transportation</li> </ul>

DMC ODS Outpatient	<ul style="list-style-type: none"> <li>• Outpatient services provided by licensed practitioners</li> </ul>
DMC ODS Partial Hospitalization Rates	<ul style="list-style-type: none"> <li>• Partial Hospitalization Services; less than 24 hours, per diem</li> </ul>
DMC ODS NTP Rates	<ul style="list-style-type: none"> <li>• Methadone Daily Rate</li> <li>• Buprenorphine-Naloxone Combo Film Daily Rate</li> <li>• Buprenorphine Naloxone Combo Tablets Daily Rate</li> <li>• Buprenorphine Mono Daily Rate</li> <li>• Disulfiram Daily Rate</li> <li>• Buprenorphine Injectable (Sublocade) Mo. Rate</li> <li>• Naltrexone Injectable (Vivitrol) Mo. Rate</li> <li>• Naloxone HCL-2 pack (Generic)-As needed</li> <li>• Naloxone HCL-2 pack (Narcan)-As needed</li> <li>• Naltrexone Per Visit</li> </ul>

### **Provider Service Standards**

In addition to any service standards set forth above or in the Agreement, where Provider provides direct services to Members, Provider must meet the following service standards:

1.1.1. Provider must maintain qualified and trained staff adequate to meet the needs of Members. Care must meet minimum standards set forth in this Agreement established by SCAN. All individuals providing services to Members must be appropriately trained and must pass satisfactory background check screens prior to providing services to Members, including any training or criminal background checks required by SCAN or Applicable Law. Where required, staff must meet all licensing and accreditation requirements; non-licensed staff may not administer medications.

1.1.2. All Provider staff receive orientation as to policies and procedures, receive appropriate health screening and have participated in continuing education and/or in-service in accordance with state or federal standards.

1.1.3. Provider shall monitor the Covered Services rendered to Members hereunder and ensure that staff are rendering appropriate and authorized services to Members.

1.1.4. Provider must maintain complete and accurate medical documentation sufficient to support all services provided to Members and provide such documentation at Provider's sole cost to SCAN upon request.

1.1.5. Provider's administrative staff must be available at least Monday through Friday, 8:00 a.m. to 5:00 p.m. local time, with on-call availability 24/7.

1.1.6. If Provider conducts Member satisfaction surveys, survey responses shall be made available to SCAN as requested.

1.1.7. Provider shall notify SCAN if they are aware of a patient that may benefit from disease management or care management services.

1.1.8. Provider shall refer Members to specialist(s), and if necessary, obtain prior authorization pursuant to SCAN's processes and provide supporting documentation, as needed.

1.1.9. Provider is responsible for understanding what services are eligible for payment and that any services rendered not covered under this Agreement is excluded.

1.1.10. Provider shall cooperate with and participate in any Member grievance and appeal procedures, including participation in any independent external review of coverage decisions or binding arbitration proceeding arising from a grievance or appeal; timely provision to SCAN of the information necessary to resolve grievances; and abiding by decisions of any applicable grievance and appeal decision-making body including any final award rendered as a result of binding arbitration.

**EXHIBIT B  
COMPENSATION**

**CONTRACTOR:** SCAN Health Plan  
**PROGRAM:** Administration  
**DEPT. ID:** 4100413649.83600

- I. Submission of Claims. Provider shall submit all Clean Claims for payment for Covered Services under this Agreement to SCAN in accordance with Applicable Law and the Provider Operations Manual and no later than three hundred sixty-five (365) calendar days from the date services are provided to the Member or if SCAN is not the primary payer under coordination of benefits, no later than three hundred sixty-five (365) calendar days from the date of payment or date of contest, denial or notice from the primary payer. In the event SCAN requests additional information in order to process the claim, Provider will provide such additional information within sixty (60) calendar days of SCAN's request. In the event Provider does not submit a Clean Claim for services provided to Member within the time period specified above, it is agreed that SCAN will no longer be responsible for payment of such claim and Provider agrees to waive any right to recover payment for such claim.
- II. RATES. For Covered Services provided by Provider, SCAN shall pay to Provider the applicable reimbursement under the Medi-Cal program as specified by DHCS, excluding any adjustments, recoupments, Copayments, Coinsurance, or Deductibles allowed pursuant to the Agreement. Provider is responsible for collecting any applicable Copayment from the Member.

<b>Line</b>	<b>Description</b>	<b>Rates</b>
1.	AOD Counselor	Payment is based on 100% of the DHCS established fee schedule
2.	Psychiatrist/ Medical Doctor	Payment is based on 100% of the DHCS established fee schedule

3.	Physician's Assistant	Payment is based on 100% of the DHCS established fee schedule
4.	Nurse Practitioner	Payment is based on 100% of the DHCS established fee schedule
5.	Registered Nurse	Payment is based on 100% of the DHCS established fee schedule
6.	Certified Nurse Specialist	Payment is based on 100% of the DHCS established fee schedule
7.	Licensed Vocational Nurse	Payment is based on 100% of the DHCS established fee schedule
8.	Pharmacist	Payment is based on 100% of the DHCS established fee schedule
9.	Licensed Psychiatric Technician	Payment is based on 100% of the DHCS established fee schedule
10.	Psychologist	Payment is based on 100% of the DHCS established fee schedule
11.	LPHA Licensed, Intern, & Student Trainee	Payment is based on 100% of the DHCS established fee schedule
12.	Occupational Therapist	Payment is based on 100% of the DHCS established fee schedule
13.	MH Rehab Specialist	Payment is based on 100% of the DHCS established fee schedule
14.	Peer Recovery Specialist	Payment is based on 100% of the DHCS established fee schedule
15.	Medical Assistant	Payment is based on 100% of the DHCS established fee schedule
16.	Other Qualified Providers	Payment is based on 100% of the DHCS established fee schedule

#### MH Day Service Rates

Line	Description	Rates
1.	Therapeutic Foster Care	Payment is based on 100% of the DHCS established fee schedule
2.	Psychiatric Inpatient	Payment is based on 100% of the DHCS established fee schedule
3.	Psychiatric Inpatient - Admin Rate	Payment is based on 100% of the DHCS established fee schedule
4.	Day Treatment Intensive - Full Day	Payment is based on 100% of the DHCS established fee schedule

5.	Day Treatment Intensive - Half Day	Payment is based on 100% of the DHCS established fee schedule
6.	Day Rehabilitation - Full Day	Payment is based on 100% of the DHCS established fee schedule
7.	Day Rehabilitation - Half Day	Payment is based on 100% of the DHCS established fee schedule
8.	Psychiatric Health Facility	Payment is based on 100% of the DHCS established fee schedule
9.	Crisis Residential	Payment is based on 100% of the DHCS established fee schedule
10.	Adult Residential	Payment is based on 100% of the DHCS established fee schedule
11.	Crisis Stabilization	Payment is based on 100% of the DHCS established fee schedule

Line	Description	Rates
1.	Transportation Mileage	Payment is based on 100% of the DHCS established fee schedule
2.	Mobile Crisis Encounter	Payment is based on 100% of the DHCS established fee schedule
3.	Transportation - Staff Time	Payment is based on 100% of the DHCS established fee schedule

Line	Description	Rates
1.	Partial Hospitalization	Payment is based on 100% of the DHCS established fee schedule
2.	Inpatient Withdraw Management 3.7	Payment is based on 100% of the DHCS established fee schedule
3.	Inpatient Withdraw Management 4.0	Payment is based on 100% of the DHCS established fee schedule
4.	Level 3.1 Residential	Payment is based on 100% of the DHCS established fee schedule
5.	Level 3.2 Residential	Payment is based on 100% of the DHCS established fee schedule

6.	Level 3.3 Residential	Payment is based on 100% of the DHCS established fee schedule
7.	Level 3.5 Residential	Payment is based on 100% of the DHCS established fee schedule
8.	Ambulatory Withdraw Management 1.0	Payment is based on 100% of the DHCS established fee schedule
9.	Ambulatory Withdraw Management 2.0	Payment is based on 100% of the DHCS established fee schedule

<b>Line</b>	<b>Description</b>	<b>Rates</b>
1.	Buprenorphine-Naloxone Film	Payment is based on 100% of the DHCS established fee schedule
2.	Buprenorphine-Naloxone Film (PERI)	Payment is based on 100% of the DHCS established fee schedule
3.	Buprenorphine Injectable	Payment is based on 100% of the DHCS established fee schedule
4.	Buprenorphine Injectable (PERI)	Payment is based on 100% of the DHCS established fee schedule
5.	Bup and Nal Combo NTP	Payment is based on 100% of the DHCS established fee schedule
6.	Bup and Nal Combo NTP (PERI)	Payment is based on 100% of the DHCS established fee schedule
7.	Buprenorphine NTP	Payment is based on 100% of the DHCS established fee schedule
8.	Buprenorphine NTP (PERI)	Payment is based on 100% of the DHCS established fee schedule
9.	Disulfiram NTP	Payment is based on 100% of the DHCS established fee schedule
10.	Disulfiram NTP (PERI)	Payment is based on 100% of the DHCS established fee schedule

11.	Naloxone NTP	Payment is based on 100% of the DHCS established fee schedule
12.	Naloxone NTP (PERI)	Payment is based on 100% of the DHCS established fee schedule
13.	Methadone NTP	Payment is based on 100% of the DHCS established fee schedule
14.	Methadone NTP (PERI)	Payment is based on 100% of the DHCS established fee schedule
15.	Naltrexone Injectable	Payment is based on 100% of the DHCS established fee schedule
16.	Naltrexone Injectable (PERI)	Payment is based on 100% of the DHCS established fee schedule

**EXHIBIT C**  
**MEDICARE REGULATORY REQUIREMENTS**

1. Definitions. All capitalized terms shall have the following meanings:

1.1. "Completion of Audit" means completion of audit by the Department of Health and Human Services ("HHS"), the Government Accountability Office, or their designees of a Medicare Advantage Organization, First Tier, Downstream or Related Entity.

1.2. "Downstream Entity" means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between an MAO or applicant or a Part D plan sponsor or applicant and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. A Downstream Entity may be, but is not limited to, physicians, ancillary providers and other health care providers contracted with Provider to provide Covered Services. 42 CFR §§ 422.500; 423.501.

1.3. "FDR" means First Tier, Downstream Entity, or Related Entity.

1.4. "Final Contract Period" means the final term of the contract between CMS and the Medicare Advantage Organization.

1.5. "First Tier Entity" means any party that enters into a written arrangement, acceptable to CMS, with an MAO or Part D plan sponsor or applicant to provide administrative services or health care services to a Medicare eligible individual under the MA program or Part D program. Provider is a First Tier Entity. 42 CFR §§ 422.500; 423.501.

1.6. "Medicare Advantage Organization" ("MAO") means a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements. SCAN is an MAO.

1.7. "Preclusion List" means a CMS-compiled list of individuals and entities that – (I) Meet all of the following requirements: (i) The individual or entity is currently revoked from Medicare under § 424.535; (ii) The individual or entity is currently under a reenrollment bar under § 424.535(c); And (iii) CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program. In making this determination under subsection (iii), CMS considers the following factors: (A) The seriousness of the conduct underlying the individual's or entity's revocation; (II) The degree to which the individual's or entity's conduct could affect the integrity of the Medicare program; (C) Any other evidence that CMS deems relevant to its determination; or (D) Meet both of the following requirements: (i) The individual or entity has engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable had they been enrolled in Medicare; and (ii) CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. In making this determination under subsection (ii), CMS considers the following factors: (A) The seriousness of the conduct involved; (B) The degree to which the individual's or entity's conduct could affect the integrity of the Medicare program; and (C) Any other evidence that CMS deems relevant to its determination. 42 CFR § 422.2.

1.8. "Related Entity" means any entity that is related to an MAO or Part D sponsor by common ownership or control and: (1) performs some of the MAO or Part D plan sponsor's management

functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MAO or Part D plan sponsor at a cost of more than two thousand five hundred dollars (\$2,500) during a contract period. 42 CFR §§ 422.500 and 423.501.

2. Records and Access. Provider shall retain and Provider agrees (i) HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any books, contracts, computer or other electronic systems, including medical records and documentation of Provider and Downstream Entities related to CMS' contract with SCAN, and (ii) HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under subsection (i) above directly from Provider or any Downstream Entity. HHS's, the Comptroller General's, or their designee's right to inspect, evaluate, and audit any pertinent information for any contract period will exist through 10 years from the Final Contract Period or from the date of Completion of an Audit, whichever is later. 42 CFR § 422.504(i)(2).

3. Privacy and Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (2) ensuring that medical information is released only in accordance with applicable federal or State law, or pursuant to court orders or subpoenas; (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by Members to the records and information that pertain to them. 42 CFR §§ 422.504(a)(13) and 422.118, Medicare Managed Care Manual (MMCM) Chapter 11, 100.4.

4. Hold Harmless. Provider agrees to hold harmless and protect Members from incurring financial liabilities that are the legal obligation of SCAN or Provider. Provider agrees that in no event including, but not limited to, nonpayment or breach of an agreement by SCAN, Provider or a Downstream Entity, or the insolvency of SCAN, or its designee, shall Provider or a Downstream Entity bill, charge, collect a deposit from or receive other compensation or remuneration from a Member. Neither Provider nor any Downstream Entity shall take any recourse against the Member, or a person acting on behalf of the Member, for Covered Services provided. This provision does not prohibit collection of applicable Coinsurance, Deductibles or Copayments, as specified in SCAN's Evidence of Coverage and Disclosure Information. This provision also does not prohibit collection of fees for non-Covered Services delivered to a Member on a fee-for-service basis, provided that Provider or a Downstream Entity shall not require or arrange for a Member to pay for a non-Covered Service unless Provider or the Downstream Entity has first obtained a denial from SCAN or its designee for such service or unless the service is explicitly described in the Member's Evidence of Coverage and Disclosure Information as a non-Covered Service. With respect to Covered Services furnished prior to the termination of the Agreement, this Section shall survive the termination of this Agreement (regardless of the reason for termination, including insolvency of SCAN), shall be construed to be for the benefit of Members, and shall supersede any oral or written contrary agreement now existing or later entered into during the term of the Agreement between Provider or a Downstream Entity and a Member or persons acting on a Member's behalf. 42 CFR §§422.504 (g) and (i)(3)(i).

5. Cost-Sharing. For all Members eligible for both Medicare and Medicaid, Provider agrees that such Members will not be held liable for Medicare Part A and B cost-sharing when the State is responsible for paying such amounts. Provider will be informed of Medicare and Medicaid benefits and rules for Members eligible for Medicare and Medicaid. Provider will: (1) accept the SCAN payment as payment in full; or (2) bill the appropriate state source. 42 CFR §§ 422.504(i)(3)(i) and 422.504(g)(1)(i).

6. Compliance with Contractual Obligations. Provider agrees that any services or other activity performed by Provider or a Downstream Entity in accordance with the Agreement is consistent and

complies with SCAN's contractual obligations with CMS. 42 CFR § 422.504(i)(3)(iii).

7. **Accountability.** Provider hereby acknowledges and agrees that SCAN shall oversee the provision of services under the Agreement and be accountable under its contract with CMS for services provided to Members by Provider. 42 C.F.R. § 422.504(i)(4)(iii). SCAN will perform auditing and monitoring of Provider to assess whether Provider is in compliance with the requirements of Parts C & D, Medicare Managed Care Manual Chapter 21, and other applicable law, including monitoring/auditing to confirm that Provider is applying appropriate compliance program requirements to Downstream Entities with which the Provider contracts. Provider agrees to cooperate with SCAN's monitoring and auditing efforts and to provide documentation requested by SCAN to certify compliance with Parts C & D, Chapter 21, or other applicable law. Chapter 21, 50.6.

8. **Compliance with Law.** Provider and any Downstream Entity, contractor or subcontractor will comply with all Applicable Laws, including Medicare laws and regulations and CMS instructions, and SCAN's policies and procedures. 42 CFR §§ 422.504(i)(4)(v), (i)(3)(ii) and 422.504(i)(4)(v), Chapter 11, 100.4.

9. **Delegation.** If any of the SCAN activities or responsibilities under its contract with CMS are delegated to Provider, the terms of such delegation are set forth in a delegation agreement supplement, attached hereto. Each and every delegation agreement shall: (i) specify the delegated activities and reporting responsibilities; (ii) either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MAO determine that such parties have not performed satisfactorily; (iii) specify that the performance of the parties is monitored by the MAO; and (iv) must specify that either - (A) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MAO; or (B) The credentialing process will be reviewed and approved by the MAO and the MAO must audit the credentialing process on an ongoing basis. 42 CFR § 422.504(i)(4)(i).

10. **Exclusion.** Provider represents and warrants that it is not currently and has never been excluded or suspended from participation in any federal health care program including, but not limited to, the Medicare or state Medicaid programs. Provider will review the Department of Health and Human Services Office of the Inspector General's ("OIG") and the System for Award Management's (SAM) exclusions lists prior to the hiring or contracting of any new employee, temporary employee, volunteer, consultant, governing body member, or vendor, and monthly thereafter, to ensure that none of these persons or entities is excluded or becomes excluded from participation in a federal health care program. Provider further certifies that, if an employee or contractor of Provider is on such lists, such employee or contractor will immediately be removed from any work related directly or indirectly to all federal health care programs and the Provider will take appropriate corrective action, including, but not limited to, notifying SCAN. MMCM Chapter 21, 50.6.8 - OIG/SAM Exclusion, Social Security Act §§1862(e)(1)(B), 1128, 1128A, 42 CFR §§422.422.752(a)(8), 423.752(a)(6).

11. **Program Integrity.** Provider shall immediately notify SCAN in the event that Provider, any employee or any Downstream Entity is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services. CMS Contract, Article III.H.2

12. **Services Provided by Physicians or Practitioners Opted Out of Medicare or on the Preclusion List.**

12.1. Provider acknowledges and agrees that SCAN is prohibited from paying, directly or indirectly on any basis, for services, other than emergency or urgently needed services furnished to a Member, provided by any physician, as defined in Section 1861(r)(1) of the Social Security Act, or practitioner, as defined in Section 1842(b)(18)(C) of the Social Security Act, who has filed with the

Medicare Administrative Contractor (“MAC”) an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts with the beneficiaries under Section 1802(b) of the Social Security Act. Provider shall notify SCAN immediately in the event that Provider files such an affidavit with a MAC. This Exhibit shall terminate upon the effective date of Provider’s opt out status with Medicare. In the event that SCAN has paid claims for such services, SCAN reserves the right to recover any such payments from Provider. 42 C.F.R. § 422.220.

12.2 Provider acknowledges and agrees that SCAN may not pay, directly or indirectly, on any basis, for items or services furnished to a Member by any individual or entity that is excluded by the HHS Office of the Inspector General or is included on the Preclusion List. Provider acknowledges and agrees that, after the expiration of the sixty (60) day period specified in 42 C.F.R. § 422.222: (a) Provider will no longer be eligible for payment from SCAN and will be prohibited from pursuing payment from the Member as stipulated by the terms of the contract between CMS and SCAN per 42 C.F.R. § 422.504(g)(1)(iv); and (b) Provider will be financially liable for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point Provider will have already received notification of the preclusion. 42 C.F.R. § 422.224; 422.504(g)(1)(v).

13. Compliance with Other Federal Laws. Provider agrees to comply with Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. § 3729 et seq.) and the anti-kickback statute (42 U.S.C. § 1320a-7b(b)); the HIPAA administrative simplification rules at 45 C.F.R. parts 160, 162 and 164; and all laws applicable to recipients of federal funds. 42 C.F.R. § 422.504(h)(1).

14. Federal Funds. Provider acknowledges that payments Provider receives from SCAN to provide services to Members are, in whole or part, from Federal funds. Therefore, Provider and any of its Downstream Entities are subject to certain laws that are applicable to individuals and entities receiving Federal funds, which may include but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 C.F.R. Part 80; the Age Discrimination Act of 1975 as implemented by 45 C.F.R. Part 91; the Americans with Disabilities Act; Section 504 of the Rehabilitation Act of 1973 as implemented by 45 C.F.R. Part 84. MMCM Chapter 11, Section 120.

15. Services Performed Outside the United States. Provider shall not perform or contract with any third parties to perform any of the services to be provided under the Agreement outside of the United States, nor shall Provider either on its own or through an offshore subcontractor receive, process, transfer, handle, store or access Member protected health information in connection with the Agreement, without the prior written approval of SCAN. HPMS Memos 07/23/2007, 09/20/2007 and 8/26/2008.

16. SCAN Compliance Program Requirements.

16.1. Compliance Program. Provider certifies that it has implemented written compliance policies and procedures and Standards of Conduct compliant with the requirements of Chapter 21 of the Medicare Managed Care Manual. If Provider has not implemented written compliance policies and procedures and Standards of Conduct compliant with the requirements of Chapter 21, Provider will distribute to all Employees SCAN’s Standards of Conduct and compliance policies and procedures. Chapter 21, Section 50.1.3.

16.2. General Compliance Training. Provider will require its Employees, at least annually, to take general compliance training. The general compliance training must also be made part of the orientation of new Employees of Provider. Provider may develop and provide its own general compliance training so long as it meets the requirements of Chapter 21. Provider further agrees to communicate to its Employees general compliance information provided by SCAN. Chapter 21, Section 50.3.1.

16.3. Fraud, Waste, and Abuse (“FWA”) Training. Unless Provider has met the FWA certification requirements through enrollment in the Medicare program or through accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and, as such, is “deemed” compliant with the FWA training requirements of Chapter 21, Provider must provide all of its Employees who have involvement in the administration or delivery of Parts C or D benefits under the Agreement FWA training compliant with the requirements of Chapter 21 within 90 days of hire/contracting with SCAN and annually thereafter. Provider shall require its Employees to take training developed by CMS and available through the CMS Medicare Learning Network. Per CMS guidance, SCAN must be able to demonstrate that FDRs have fulfilled these training requirements as applicable and, therefore, Provider must keep appropriate documentation of said training which may include copies of sign-in sheets, employee attestations and electronic certifications from the employees taking and completing the training. Provider further must maintain records for a period of 10 years of the time, attendance, topic, certificates of completion (if applicable), and test scores of any tests administered to their employees under this paragraph. Chapter 21, Section 50.3.2.

16.4. Communication and Reporting Mechanisms. Provider will report compliance concerns and suspected or actual violations related to the Medicare program to SCAN. Chapter 21, 50.4.2.

16.5. Corrective Action. CMS requires that SCAN undertake appropriate corrective actions in response to potential noncompliance or potential FWA by Provider (or other FDR) that are designed to correct the underlying problem that results in program violations and to prevent future noncompliance. CMS further requires that SCAN ensure that Provider (or other FDR) corrects any deficiencies. To meet this requirement, Provider agrees to cooperate with SCAN’s corrective action efforts including complying with corrective actions required by SCAN of Provider. In order to ensure that the Provider has implemented any corrective actions required by SCAN, SCAN may conduct audits or review Provider’s monitoring or audit reports. Chapter 21, 50.7.2, 42 CFR §§ 422.503(b)(4)(vi)(G), 423.504(b)(4)(vi)(G). Nothing in this Section 16.5. shall be deemed or construed to limit SCAN’s right to terminate the Agreement in accordance with its terms.

17. Modification of Exhibit. The parties agree to include in this Exhibit such other terms and conditions as CMS may find necessary and appropriate in order to implement requirements of Medicare Part C. 42 C.F.R. § 422.504(j).

**EXHIBIT D**  
**DHCS DOWNSTREAM REQUIREMENTS**

This Exhibit is required to comply with terms of the Fully Integrated Dual Eligible Special Needs Plan ("FIDE SNP") contract between SCAN and California's Department of Health Care Services ("DHCS"). SCAN has contracted with DHCS to provide Covered Services to dually eligible Medi-Cal beneficiaries who are covered by a SCAN Benefit Plan and may subcontract those services if, among other things, Provider agrees to the requirements set forth herein.

1. Subcontract Requirements. In accordance with the contract between SCAN and DHCS, Provider acknowledges and agrees:

1.1. That this Agreement shall be governed by and construed in accordance with all laws and applicable regulations governing this Agreement, including the Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Chapter 2.2 of Division 2 of the Code (28 CCR § 1300.67.4); Title 28, CCR, Section 1300 et seq.; W&I Code Section 14200 et seq.; Title 22, CCR, Section 53100 et seq.; and applicable federal and State laws and regulations. Provider also acknowledges and agrees that this Agreement is governed by and construed in accordance with all laws and applicable regulations governing the contract between SCAN and DHCS.

1.2. That this Agreement specifies the services to be provided by Provider in previous Exhibits, the term of the Agreement, including the beginning and ending dates as well as methods of extension, renegotiations, and termination in Section 7 of the General Terms and Conditions, the method and amount of compensation or other consideration to be received in following Exhibits, Provider's right to submit a grievance and formal process to resolve grievances in Paragraph 11 of the General Terms and Conditions, and Provider's responsibilities with respect to delegated quality improvement activities, if so delegated, are set forth in the delegation attached to this Agreement.

1.3. That the effectiveness of this Agreement and any amendments are subject to approval by DHCS.

1.4. That Provider must comply with all monitoring provisions of SCAN's contracts with DHCS, and to make all of its books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination or copying:

1.4.1. By DHCS, HHS, Department of Justice ("DOJ"), California's Department of Managed Health Care ("DMHC"), and other authorized agencies.

1.4.2. At all reasonable times at the subcontractor's place of business or at such other mutually agreeable location in California.

1.4.3. In a form maintained in accordance with the general standards applicable to such book or record keeping.

1.4.4. For a term of at least ten (10) years from the final date of the Agreement period or from the completion of any audit, whichever is later.

1.4.5. Including all Encounter data for a period of at least ten (10) years.

1.4.6. If DHCS, CMS, or the HHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Provider at any time. Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; seek recovery of payments made to the Provider; impose other sanctions provided under the State Plan, and direct SCAN to terminate this Agreement due to fraud.

1.5. To submit reports as required by SCAN.

1.6. To comply with Title 22, CCR, Section 53855 where Provider is at risk for non-contracted Emergency Services.

1.7. To maintain and make available to DHCS, upon request, copies of all Provider subcontracts and to ensure that such subcontracts are in writing and require that the subcontractor:

1.7.1. To make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Agreement available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the HHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees.

1.7.2. To retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

1.8. To assist SCAN, at the termination of this Agreement, with the orderly transfer of necessary data and history records maintained by Provider from SCAN to DHCS or to a successor contractor.

1.9. To assist SCAN in the transfer of care in the event of termination of any of Provider's subcontracts for any reason.

1.10. To notify DHCS in the event the agreement with SCAN is amended or terminated. Notice is considered given when properly addressed and deposited in the United States

Postal Service as first-class registered mail, postage attached.

1.11. That assignment or delegation of this Agreement will be void unless prior written approval is obtained from DHCS.

1.12. To hold harmless both the State and Members in the event SCAN cannot or will not pay for services performed by Provider or Provider's subcontractor pursuant to this Agreement.

1.13. To timely gather, preserve, and provide to DHCS, any records in the Provider's possession, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, relating to threatened or pending litigation by or against DHCS, and to use all reasonable efforts to immediately notify SCAN of any subpoenas, document production requests, or requests for records related to this Agreement.

1.14. To provide interpreter services for Members at all provider sites in accordance with Cal H&S 1367.04, and cooperate with SCAN by providing any information necessary to assess compliance.

1.15. It has the right to submit a grievance in accordance with SCAN's process to resolve provider grievances, consistent with 28 CCR § 1300.68.

1.16. To participate and cooperate in SCAN's quality improvement system.

1.17. To comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program.

2. Financial Statements. Provider agrees to file monthly Financial Statements at DHCS's request if DHCS requires it. (Ex. A, Att. 2, Section 2 of the SCAN/DHCS agreement)

3. Service Level Data. Provider agrees to provide its service level data to SCAN to allow SCAN to meet its administrative functions and the requirements set forth in Ex. A, Att. 3, Section 2 of the SCAN/DHCS agreement.

4. Smoke-Free Workplace Certification. (Applies to Providers that provide children's services as described in Public Law 103-227 (the Pro-Children Act of 1994). The term "children's services" means the provision on a routine or regular basis of health, day care, education, or

library services (A) that are funded, after March 31, 1994, directly by the Federal Government or through State or local governments, by Federal grant, loan, loan guarantee, or contract programs (i) administered by either the Secretary of Health and Human Services or the Secretary of Education (other than services provided and funded solely under titles XVIII and XIX of the Social Security Act [42 U.S.C.A. §§ 1395 et seq. and 1396 et seq.]); or (ii) administered by the Secretary of Agriculture in the case of a clinic (as defined in 7 CFR 246.2) under section 17(b)(6) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(6)), or (iii) that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds, as determined by the appropriate Secretary in any enforcement action under this subchapter, 20 U.S.C. § 6082.

4.1. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.

4.2. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to one thousand dollars (\$1,000) for each violation and/or the imposition of an administrative compliance order on the responsible party.

4.3. By signing this Agreement, Provider certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

4.4. The Plan must insert this certification into any subcontracts entered into

that provide for children's services as described in the Act. (Ex. D(F) Section 20).

5. Lobbying. If this Agreement involves a subaward of one hundred thousand dollars (\$100,000) or more to Provider, Provider agrees to comply with the following requirements related to lobbying:

5.1. Prohibition on Use of Federal Funds for Lobbying: Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

5.2. Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds \$100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. (Ex. D(F), Section 31 of the SCAN/DHCS agreement)

6. Key Personnel. Provider agrees to provide disclosures to SCAN as required by federal regulations 42 Code of Federal Regulations (CFR) 455.104 (Disclosure by providers and fiscal agents: Information on ownership and control), 42 CFR 455.105

(Disclosure by providers: Information related to business transactions), and 42 CFR 455.106 and 42 CFR 438.610 (Prohibited Affiliations with Individuals Debarred by Federal Agencies). (Ex. A, Att. 1, Section 3.B)

7. Conflict of Interest. Provider agrees to comply with 22 Cal. Code Regs. 53874 related to conflict of interest requirements and 42 CFR 438.3(f)(2). (Ex. A, Att. 1, Section 4.A)

8. Public Records. Prior to providing Covered Services under the Agreement, Provider shall provide SCAN with information on its officers and other persons associated with Provider as required by California Welfare & Institutions Code § 14452(a) and Ex. A, Att. 6, Section 16.E of the SCAN/DHCS agreement.

9. Non-Discrimination Clause. In accordance with Ex. C, Paragraph 10 of the SCAN/DHCS agreement, Provider shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40), marital status, and denial of family care leave. Provider shall insure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment.

9.1. Provider shall comply with the provisions of the Fair Employment and Housing Act (Cal. Gov't Code, § 12900, et seq.), the regulations promulgated thereunder (2 Cal. Code Regs. § 11000, et seq.), the provisions of Article 9.5, Chapter 1, Part 1, Division 3, Title 2 of the Government Code (Cal. Gov't Code, §§ 11135-11139.5), and any regulations or standards adopted by DHCS to implement such article, unless otherwise exempted by law or regulation.

9.2. Provider shall permit access by representatives of the Department of Fair Employment and Housing and DHCS upon reasonable notice at any time during the normal business hours, but in no case less than twenty-four (24) hours' notice, to such of its books, records, accounts, other sources of information, and its facilities as said departments shall require to ascertain compliance with this clause, unless otherwise exempted by law or regulation.

9.3. Provider shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

10. Federal Equal Opportunity Requirements. In accordance with Ex. D(F), Paragraph 1 of and the SCAN/DHCS agreement, Provider agrees to the following:

10.1. Provider will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Provider will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Provider's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

10.2. Provider will, in all solicitations or advancements for employees placed by or on behalf of Provider, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental

handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

10.3. Provider will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Provider's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

10.4. Provider will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

10.5. Provider will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

10.6. In the event of Provider's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and Provider may be declared ineligible for further federal and state contracts in accordance with procedures

authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Fed Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

10.7. Provider will include these provisions (10.1 through 10.7) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. Provider will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event Provider becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, Provider may request in writing to DHCS, which, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

11. Continuation of Care after Termination for Certain Conditions. If the Agreement is terminated by either Party for any reason other than termination for a medical disciplinary cause or reason, or fraud or other criminal activity, Provider will, at the request of the Member and SCAN and to the extent required by Applicable Law with respect to the particular Member, continue to provide Covered Services to Members with certain medical conditions as described in

and pursuant to the California Health & Safety Code §1373.96, as amended, until the services are completed or the time limitations described therein have been reached. The provision of the continued services for Members with these medical conditions is subject to the same contractual terms and conditions that were imposed upon Provider prior to termination, including the rate of compensation. Upon termination of the Agreement, SCAN, or other financially responsible party, is liable for the Covered Services rendered by Provider (other than any permissible Copayments, Coinsurance or Deductibles) to a Member who retains eligibility under the applicable SCAN Evidence of Coverage (EOC) or by operation of law and who is under Provider's care at the time of termination of the Agreement until the Covered Services the Provider renders to the Member are completed or until SCAN makes reasonable and medically appropriate provisions for the assumption of such services by another contracted provider. The provisions of this section shall not be applicable for Members who only receive services under a SCAN Medicare Advantage plan. [H&S 1373.95,1373.96, and 28 CCR § 1300.67.4(a)(10)]

12. Revocation. Consistent with 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867, Provider agrees that delegation of activities or obligations may be revoked in instances where DHCS or SCAN determine that Provider has not performed satisfactorily.

13. Utilization Data. To the extent that the Provider is responsible for the coordination of care for Members, SCAN agrees to share with Provider any utilization data that DHCS has provided to SCAN, and Provider agrees to receive the utilization data provided and use it as the Provider is able for the purpose of Member care.

14. Notice of New DHCS Requirements. SCAN will inform Provider of prospective requirements added by DHCS to the SCAN DHCS agreement before the requirements are effective, and Provider will comply with the new requirements within thirty (30) days of the

effective date, unless otherwise instructed by DHCS and to the extent possible.

15. No Balance Billing. Provider agrees that in no event, including, but not limited to nonpayment or breach of this Agreement by SCAN, Provider, or other intermediary, or the insolvency of SCAN, Provider or other intermediary, shall Provider bill, charge, collect a deposit from or receive other compensation or remuneration from a Member. Provider shall not take any recourse against the Member, or a person acting on behalf of the Member, for Covered Services provided, including any action at law against a Member to collect sums owed by SCAN. Cal. Health & Safety Code §1379.

15.1. Provider is prohibited from imposing cost-sharing requirements on Members that would exceed the amounts permitted under the California Medicaid State Plan, Section 1852(a)(7) of the Social Security Act, and 42 CFR section 422.504(g)(1)(iii).

15.2. Contracted Medicare providers agree to accept SCAN's Medicare reimbursement as payments in full for services rendered to Dual Eligible Members, or to bill Medi-Cal or the Member's Medi-Cal plan as applicable for any additional Medicare payments that may be reimbursed by Medi-Cal. Such providers must comply with Welfare and Institutions Code section 14019.4.

15.3. Surcharges are prohibited for Covered Services and whenever SCAN receives notice of any such surcharge, it shall take appropriate action. 28 CCR § 1300.67.8(d).

16. Diversity and Sensitivity Training. SCAN and/or Provider shall provide cultural competency, sensitivity, and diversity training.

17. Provider's Bill of Rights. SCAN and Provider acknowledge that Provider is entitled to all protections afforded to it under Cal. Health & Safety Code §1375.7.

18. Non-Contracting Emergency Services. To the extent Provider is at risk for non-

contracting Emergency Services, the following provisions apply:

18.1. Provider is responsible for coverage and payment of Emergency Services and must cover and pay for Emergency Services regardless of whether the provider that furnishes the services has an agreement with Provider.

18.2. Provider may not deny payment for treatment obtained when a Member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition. Further, Provider may not deny payment for treatment obtained when a representative of Provider instructs the Member to seek Emergency Services.

18.3. Provider may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms or refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's primary care provider, the Provider, SCAN, or DHCS of the Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services. A Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to provide stabilization

18.4. Provider shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition, including Medically Necessary inpatient services rendered to a Member until the Member's condition has stabilized sufficiently to permit referral and transfer in accordance with instructions from Provider, or the Member is stabilized sufficiently to permit discharge. The attending emergency physician, or the provider treating the Member is responsible for determining when the Member is sufficiently stabilized for transfer or discharge and that determination is binding on the Provider. Emergency Services shall not be subject to Prior Authorization by Provider.

18.5. At a minimum, Provider must reimburse the non-contracting emergency department and, if applicable, its affiliated

providers for physician services at the lowest level of emergency department evaluation and management CPT (Physician's Current Procedural Terminology) codes, unless a higher level is clearly supported by documentation, and for the facility fee and diagnostic services such as laboratory and radiology.

18.6. For all non-contracting providers, reimbursement by Provider, or by a subcontractor who is at risk for out-of-plan Emergency Services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with USC Section 1396u-2(b)(2)(D) and California Welfare and Institutions code Section 14091.3.

18.7. Disputed Emergency Services claims may be submitted to DHCS, Office of Administrative Hearings and Appeals, 1029 J Street, Suite 200, Sacramento, California, 95814 for resolution under the provisions of Welfare and Institutions Code Section 14454 and 22 CCR 53620 et. seq., except Section 53698. Provider agrees to abide by the findings of DHCS in such cases, to promptly reimburse the non-contracting provider within thirty (30) calendar days of the effective date of a decision that Provider is liable for payment of a claim and to provide proof of reimbursement in such form as the DHCS Director may require. Failure to reimburse the non-contracting provider and provide proof of reimbursement to DHCS within thirty (30) calendar days shall result in liability offsets in accordance with Welfare and Institutions Code Sections 14454(c) and 14115.5, and 22 CCR 53702.

19. Delegation of Quality Improvement Activities. To the extent quality improvement activities are the responsibility of Provider and consistent with 28 CCR § 1300.70, Provider and SCAN must specify:

19.1. Quality improvement responsibilities, and specific delegated functions and activities of SCAN and Provider.

19.2. SCAN's oversight, monitoring, and evaluation processes and Provider's agreement to such processes consistent with 28 CCR § 1300.51, Item J-5.

19.3. SCAN's reporting requirements and approval processes. The agreement between

SCAN and Provider must include Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.

19.4. SCAN's remedies/actions if Provider's obligations are not met.

20. Reporting of and Access to Provider Data. Provider shall submit to SCAN complete, accurate, reasonable, and timely Provider data needed by SCAN in order for SCAN to meet its provider data reporting requirements to DHCS, including any applicable network data. SCAN shall have access at reasonable times upon demand to the books, records and papers of the Provider relating to the health care services provided to Members, to the cost thereof, to payments received by the Provider from Members of the plan. 28 CCR § 1300.67.8(c).

21. Reporting of Encounter Data. Provider shall submit to SCAN complete, accurate, reasonable, and timely Encounter Data needed by SCAN in order for SCAN to meet its encounter data reporting requirements to DHCS.

22. Dispute Resolution. Provider shall have access to SCAN's dispute resolution mechanism, per Cal. Health & Safety Code Section 1367(h).








# 4. County Behavioral Health Services Agreement - Scan Health Plan & RUHS- BH FY24.25 - FY28.29

Final Audit Report

2026-01-20

Created:	2026-01-15
By:	Edgardo Guevara (e.guevara@ruhealth.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAAr3dh1DzPv14U2Sbwf4f432-LKEaGmW

## "4. County Behavioral Health Services Agreement - Scan Health Plan & RUHS- BH FY24.25 - FY28.29" History

-  Document created by Edgardo Guevara (e.guevara@ruhealth.org)  
2026-01-15-11:19:25 PM GMT
-  Document emailed to Karen Schulte Umcgougan@scanhealthplan.com) for signature  
2026-01-15-11:19:31 PM GMT
-  Edgardo Guevara (e.guevara@ruhealth.org) replaced signer Karen Schulte Umcgougan@scanhealthplan.com) with Karen Schulte (kschulte@scanhealthplan.com)  
2026-01-20 - 3:46:05 PM GMT
-  Document emailed to Karen Schulte (kschulte@scanhealthplan.com) for signature  
2026-01-20 - 3:46:05 PM GMT
-  Email viewed by Karen Schulte (kschulte@scanhealthplan.com)  
2026-01-20 - 5:31:29 PM GMT
-  Document e-signed by Karen Schulte (kschulte@scanhealthplan.com)  
Signature Date: 2026-01-20 - 5:32:17 PM GMT-Time Source: server
-  Agreement completed.  
2026-01-20 - 5:32:17 PM GMT

**MEMORANDUM OF UNDERSTANDING**  
**BETWEEN**  
**SCAN HEALTH PLAN**  
**AND**  
**RIVERSIDE UNIVERSITY HEALTH SYSTEM – BEHAVIORAL HEALTH**  
**COVER PAGE**

402450513.2

APR 14 2026

3.27

WHEN DOCUMENT IS FULLY EXECUTED RETURN

**CLERK'S COPY**

to Riverside County Clerk of the Board, Stop 1010  
Post Office Box 1147, Riverside, Ca 92502-1147  
Thank you.

1

**Memorandum of Understanding**

**between**

**SCAN Health Plan**

**and**

**Riverside University Health System – Behavioral Health**

This Memorandum of Understanding (“MOU”) is entered into by SCAN Health Plan, a California nonprofit public benefit corporation (“MCP”) and Riverside University Health System – Behavioral Health (“MHP/DMC-ODS”), effective as of the date of execution (“Effective Date”). MHP/DMC-ODS, MCP, and MCP’s relevant Subcontractors and/or Downstream Subcontractors may be referred to herein as a “Party” and collectively as “Parties.”

WHEREAS, SCAN and the Department of Health Care Services (“DHCS”) are parties to a Primary Fully-Integrated Dual Eligible Special Needs Plan (“FIDE-SNP”) Contract (“Primary FIDE-SNP Contract”), under which SCAN treats individuals dually eligible for Medicare and Medi-Cal, and in the event there is an inconsistency between the Primary FIDE-SNP Contract and a DHCS All Plan Letter (“APL”) or Policy Letter (“PL”), the Contract shall prevail.; and

WHEREAS, the Parties are required to enter into this MOU, a binding and enforceable contractual agreement, under applicable All Plan Letters issued by DHCS. MHP/DMC-ODS is required to enter into this MOU pursuant to Cal. Code Regs. tit. 9 § 1810.370, MHP/DMC-ODS Contract, Exhibit A, Attachment 10, Behavioral Health Information Notice (“BHIN”) 23-001, 23- 056, BHIN 23-057 and any subsequently issued superseding BHINs, as applicable, to ensure that Medi-Cal beneficiaries enrolled in MCP who are served by MHP/DMC-ODS (“Members”) are able to access and/or receive mental health services and/or substance use disorder (“SUD”) services in a coordinated manner from MCP and MHP/DMC-ODS;

WHEREAS, the Parties desire to ensure that Members receive MHP/DMC-ODS 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 the DHCS Primary FIDE-SNP Contract, unless otherwise defined herein.

a1. "MCP Responsible Person" means the person designated by MCP to oversee MCP coordination and communication with MHP/DMC-ODS and ensure MCP's compliance with this MOU as described in Section 4 of this MOU.

a2. "MCP-MHP/DMC-ODS Liaison" means MCP's designated point of contact responsible for acting as the liaison between MCP and MHP/DMC-ODS as described in Section 4 of this MOU. The MCP-MHP/DMC-ODS Liaison must ensure the appropriate communication and care coordination is ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the MCP Responsible Person and/or MCP compliance officer as appropriate.

a3. "MHP/DMC-ODS Responsible Person" means the person designated by MHP/DMC-ODS to oversee coordination and communication with MCP and ensure MHP/DMC-ODS's compliance with this MOU as described in Section 5 of this MOU.

a4. "MHP/DMC-ODS Liaison" means MHP/DMC-ODS's designated point of contact responsible for acting as the liaison between MCP and MHP/DMC-ODS as described in Section 5 of this MOU. The MHP/DMC-ODS Liaison should ensure the appropriate communication and care coordination are ongoing between the Parties, facilitate quarterly meetings in accordance with Section 9 of this MOU, and provide updates to the MHP/DMC-ODS Responsible Person and/or MHP/DMC-ODS compliance officer as appropriate.

a5. "Network Provider" as it pertains to MCP, has the same meaning ascribed by the Primary FIDE-SNP Contract; and as it pertains to MHP/DMC-ODS, has the same meaning ascribed by the MHP/DMC-ODS Contract with the DHCS.

a6. "Subcontractor" as it pertains to MCP, has the same meaning ascribed by the Primary FIDE-SNP Contract; and as it pertains to MHP/DMC-ODS, has the same meaning ascribed by the MHP/DMC-ODS Contract with the DHCS.

a7. "Downstream Subcontractor" as it pertains to MCP, has the same meaning ascribed by the Primary FIDE-SNP Contract; and as it pertains to MHP/DMC-ODS, means a subcontractor of a MHP/DMC-ODS Subcontractor.

**2. Term.** This MOU is in effect as of the Effective Date and continues for a term of three (3) calendar 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 MCP and MHP/DMC-ODS for Specialty Mental Health Services (“SMHS”) covered by MHP and further described in APL 22-003, APL 22-005, and BHIN 21-073, and any subsequently issued superseding APLs or BHINs, executed contract amendments, or other relevant guidance. The population eligible for NSMHS and SMHS set forth in APL 22-006 and BHIN 21-073 is the population served under this MOU. This MOU governs the coordination between MCP and MHP/DMC-ODS for the provision of SUD services as described in APL 22-006, and any subsequently issued superseding APLs, and Medi-Cal Managed Care Contract, BHIN 23-001, DMC-ODS Requirements for the Period of 2022-2026, and the DMC-ODS Intergovernmental Agreement, and any subsequently issued superseding APLs, BHINs, executed contract amendments, or other relevant guidance, and as described in the Primary FIDE-SNP Contract.

**4. MCP Obligations.**

a1. **Provision of Covered Services.** MCP is responsible for authorizing Medically Necessary Covered Services, including SMHS and SUD services, ensuring MCP’s Network Providers coordinate care for Members as provided in the applicable Primary FIDE-SNP Contract, and coordinating care from other providers of carve-out programs, services, and benefits.

a2. **Oversight Responsibility.** The President, Medicare 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/DMC-ODS, 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/DMC-ODS are invited to participate in the MOU engagements, as appropriate;

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

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

**a3. Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MCP must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this MOU.

## **5. MHP/DMC-ODS Obligations.**

**a1. Provision of Specialty Mental Health Services and Substance Abuse Disorder Services.** MHP/DMC-ODS is responsible for providing or arranging for the provision of SMHS and/or SUD.

**a2. Oversight Responsibility.** The Behavioral Health Director, the designated MHP/DMC-ODS Responsible Person, listed on Exhibit B of this MOU, is responsible for overseeing MHP/DMC-ODS's compliance with this MOU. The MHP/DMC-ODS Responsible Person serves, or may designate a person to serve, as the designated MHP/DMC-ODS Liaison, the point of contact and liaison with MCP. The MHP/DMC-ODS Liaison is listed on Exhibit B of this MOU. The MHP/DMC-ODS Liaison may be the same person as the MHP/DMC-ODS Responsible Person. MHP/DMC-ODS must notify MCP of changes to the MHP/DMC-ODS Liaison as soon as reasonably practical but no later than the date of change. The MHP/DMC-ODS Responsible Person must:

- i. Meet at least quarterly with MCP, as required by Section 9 of this MOU;
- ii. Report on MHP's compliance with the MOU to MHP/DMC-ODS's compliance officer no less frequently than quarterly. MHP/DMC-ODS compliance officer is responsible for MOU compliance oversight and reports as part of MHP/DMC-ODS compliance program and must address any compliance deficiencies in accordance with MHP/DMC-ODS compliance program policies;
- iii. Ensure there is sufficient staff at MHP/DMC-ODS to support compliance with and management of this MOU;

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

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

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

**a3. Compliance by Subcontractors, Downstream Subcontractors, and Network Providers.** MHP/DMC-ODS must require and ensure that its Subcontractors, Downstream Subcontractors, and Network Providers, as applicable, comply with all applicable provisions of this MOU.

## **6. Training and Education.**

a1. To ensure compliance with this MOU, the Parties must provide training and orientation for their employees who carry out activities under this MOU and, as applicable, Network Providers, Subcontractors, and Downstream Subcontractors who assist MCP with carrying out MCP's responsibilities under this MOU. The training must include information on MOU requirements, what services are provided or arranged for by each Party, and the policies and procedures outlined in this MOU. For persons or entities performing these 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 MHP/DMC-ODS services to their contracted providers.

a2. In accordance with health education standards required by the Primary FIDE-SNP Contract, the Parties must provide Members and Providers with educational materials related to accessing Covered Services, including for services provided by MHP/DMC-ODS.

a3. The Parties each must provide the other Party, Members, and Network Providers with training and/or educational materials on how MCP Covered Services and MHP/DMC-ODS services may be accessed, including during nonbusiness hours.

**7. Screening, Assessment, and Referrals.**

a1. **Screening and Assessment (MCP and MHP Only).** The Parties must develop and establish policies and procedures that address how Members must be screened and assessed for mental health services, including administering the applicable Screening and Transition of Care Tools for Medi-Cal Mental Health Services as set forth in APL25-010, as applicable to SCAN's Primary FIDE-SNP Contract and BHIN 22-065, as applicable.

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 65 and older, and Transition of Care Tool, for adults aged 65 and older, 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 25-010, as applicable to SCAN's Primary FIDE-SNP Contract and BHIN 22-065, as applicable.

a2. **Screening and Assessment (MCP and DMC-ODS Only).**

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

ii. MCP must develop and establish policies and procedures for providing Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment

("SABIRT") to Members aged sixty-five (65) and older in accordance with APL 21-014, as applicable to the DHCS Primary FIDE-SNP Contract. MCP policies and procedures must include, but not 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 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;

b1. **Screening and Assessment (MCP and MHP Only).** The Parties must work collaboratively to develop and establish policies and procedures that ensure that Members are referred to the appropriate MHP services and MCP Covered Services.

- i. The Parties must adopt a "no wrong door" referral process for Members and work collaboratively to ensure that Members may access services through multiple pathways, and are not turned away based on which pathway they rely on, including, but not limited to, adhering to all applicable No Wrong Door for Mental Health Services Policy requirements described in APL 22-005, as applicable to SCAN's Primary FIDE-SNP Contract 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 Screening Tool in accordance with APL 25-010, as applicable to the Primary FIDE-SNP Contract, and BHIN 22-065, including:

1. The process by which MCP and MHP 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.

5. The process by which MCP and MHP/DMC-ODS coordinate referrals using the Transition of Care Tool in accordance with APL 25-010, as applicable to the Primary FIDE-SNP Contract and BHIN 22-065. The process by which MCP and MHP/DMC-ODS coordinate referrals using the Transition of Care Tool in accordance with APL 25--010, as applicable to the Primary FIDE-SNP Contract and BHIN 22-065, as applicable.

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 or care management programs for which Members may qualify or Complex Care Management ("CCM").

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 Primary FIDE-SNP Contract.

**b2. Screening and Assessment (MCP and DMC-ODS Only).** The Parties must work collaboratively to develop policies and procedures that ensure Members are referred to the appropriate MCP Covered Services and DMC-ODS services.

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

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

iii. MCP must develop and implement an organizational approach to the delivery of services and referral pathways to DMC-ODS services. iv. DMC-ODS must refer Members to MCP for Covered Services, as well as any care management programs for which they may qualify, such as Complex Case Management ("CCM").

iv. The Parties must work collaboratively to ensure that Members may access

services through multiple pathways. The Parties must ensure Members receive 402450505.2 SUD services when Members have co-occurring SMHS and/or NSMHS and SUD needs.

v. 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

vi. 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 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 MHP-DMC-ODS to identify strategies to monitor and assess the effectiveness of this MOU. The MHP 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 requirement for DMC-ODS to refer Members to MCP to be assessed for care coordination and other similar programs and other services for which they may qualify provided by MCP including, but not limited to CCM;

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 MHP individuals who meet access criteria for and are concurrently receiving SMHS consistent with the No Wrong Door for

Mental Health Services Policy described in APL 22-005, as applicable under the Primary FIDE-SNP Contract, and BHIN 22-011, as applicable to ensure the care is clinically appropriate and non-duplicative and considers the Member's established therapeutic relationships; A process for how MCP and DMC-ODS will engage in collaborative treatment planning to ensure care is clinically appropriate and non-duplicative and considers the Member's established therapeutic relationships;

4. A process for coordinating the delivery of medically necessary Covered Services with the Member's PCP, including, without limitation, transportation services, home health services, and other Medically Necessary Covered Services for eligible Members.

5. For MHP only, 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, as applicable to the Primary FIDE-SNP Contract and BHIN 22-011, as applicable;

6. For DMC-ODS only, 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 a member's care;

7. For DMC-ODS only, 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;

8. For MHP only, a process for ensuring that Members and Network Providers can coordinate coverage of Covered 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;

9. For DMC-ODS only, process for how the Parties will engage in collaborative treatment planning and ensure communication among providers, including procedures for exchanges of medical information; and For DMC-ODS only, process for how the Parties will engage in collaborative treatment planning and ensure communication among providers, including procedures for exchanges of medical information; and

10. For DMC-ODS Only, processes to ensure that Members and providers can coordinate coverage of Covered Services and carved-out services outlines by this MOU outside of normal business hours, as well as providing or arranging for 24/7 emergency access to Covered Services and carved-out services.

**v. Transitional Care.**

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

2. For MHP Members who are admitted to an acute psychiatric hospital, psychiatric health facility, adult residential, or crisis residential stay, or DMC-ODS Members who are admitted for residential SUD treatment, including, but not limited to, Short-Term Residential Therapeutic Programs and Psychiatric Residential Treatment Facilities, where MHP/DMC-ODS is the primary payer, MHP/DMC-ODS are primarily responsible for coordination of the Member upon discharge.

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/DMC-ODS services.

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

5. For MHP only, 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. For MHP Only, the parties must establish policies and procedures for MCP and MHP to provide clinical consultations to each other regarding Member’s mental illness, including consultation on diagnosis, treatment, and medications.

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

3. For DMC-ODS only, the Parties must establish policies and

procedures to ensure that Members have access to clinical consultation, including consultation on medications, as well as clinical navigation support for patients and caregivers.

vii. **Prescription Drugs.**

1. The Parties must establish policies and procedures to coordinate prescription drug, laboratory, radiological, and radioisotope service procedures, including developing a process for coordination between MCP and DMC-ODS and a process for referring eligible Members for SUD services to a Drug Medi-Cal certified program or a DMC-ODS program in accordance with Primary FIDE-SNP Contract.. 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 drugs and laboratory services, including a list of available pharmacies and laboratories.

9. **Quarterly Meetings.**

a. The Parties must meet as frequently as necessary to ensure proper oversight of this MOU but 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 SCAN's Primary FIDE-SNP Contract, the MHP/DMC-ODS Contract, and this MOU.

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

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

e. **Local Representation.** MCP must participate, as appropriate, in meetings or engagements to which MCP is invited by MHP/DMC-ODS, such as local county meeting, local community forums, and MHP/DMC-ODS engagements, to collaborate with MHP/DMC-ODS 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.<sup>4</sup>

---

<sup>4</sup> 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>.

a. **Data Exchange.** Except where prohibited by law or regulation, MCP and MHP/DMC-ODS must share the minimum necessary data and information to facilitate referrals and coordinate care under this MOU. The Parties must have policies and procedures for supporting the timely and frequent exchange of Member information and data, including behavioral health and physical health data; 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/DMC-ODS and MCP must establish policies and procedures to implement the following with regard to information sharing:

a. A process for MHP/DMC-ODS to send admission, discharge, and transfer data to MCP when Members are admitted to, discharged from, or transferred from facilities contracted by MHP/DMC-ODS (e.g., psychiatric inpatient hospitals, psychiatric health 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);

b. A process to implement mechanisms to alert the other Party of behavioral health crises (e.g., MHP/DMC-ODS alerts MCP of Members' uses of mobile health, psych inpatient, and crisis stabilization and MCP alerts MHP/DMC-ODS of Members' visits to emergency departments and hospitals); and

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

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

c. **Interoperability.** 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 MHP/DMC-ODS must make available to Members their electronic health information held by the Parties and make available an application programming interface ("API") that makes complete and accurate Network Provider directory information available through a public-facing digital endpoint on MCP's and MHP's respective websites pursuant to 42 Code of Federal Regulations 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 BHIN22-068, or any subsequent version of the APL and BHIN, as applicable

## 12. Dispute Resolution - MCP and MHP Only.

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 negotiations, either Party may pursue its available legal and equitable remedies under California law. Disputes between MCP and MHP that cannot be resolved in a good faith attempt between the Parties must be forwarded by MCP and MHP to DHCS.

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

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

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

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

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

medications to MCP provider responsible for the Member's care; or

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

e. If decisions rendered by DHCS find MCP 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, as applicable to SCAN's Primary FIDE-SNP Contract and BHIN 21-034, as applicable apply to disputes between MCP and MHP where the Parties cannot agree on the appropriate place of care. Nothing in this MOU or provision must constitute a waiver of any of the government claim filing requirements set forth in Title I, Division 3.6, of the California Government Code or as otherwise set forth in local, state, and federal law.

g. MHP must designate a person or process to receive 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 MHP where the Parties cannot agree on an appropriate place of care and, upon request, must report all such disputes to DHCS.

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

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

### **13. Dispute Resolution - MCP and DMCS-ODS Only**

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 DMC-ODS must continue without delay to carry out all responsibilities under this MOU unless the MOU is terminated. If the dispute cannot be resolved within 15 Working Days of initiating such negotiations or such other period as may be mutually agreed to by the Parties in writing, 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. Unless otherwise determined by the Parties, the DMC-ODS Liaison must be the designated individual responsible for receiving notice of actions, denials, or deferrals from MCP, and for providing any additional information requested in the deferral notice as necessary for a medical necessity determination.

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

d. Until the dispute is resolved, the following provisions 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 to be a diagnosis not covered by DMC-ODS, MCP must manage the care of the Member under the terms of its contract with the State, including providing or arranging and paying for those services until the dispute is resolved.

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

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

**14. Equal Treatment.** Nothing in this MOU is intended to benefit or prioritize Member or person served by MHP/DMC-ODS who are not Members. Pursuant to Title VI, 42 United States Code Section 2000d, et seq., MHP/DMC-ODS cannot provide any service, financial aid, or other benefit,

to an individual which is different, or is provided in a different manner, from that provided to others provided by MHP/DMC-ODS.

15. **General.**

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

b. **Documentation Requirements.** documents demonstrating compliance with this MOU for at least 10 years as required by the Primary FIDE-SNP Contract and the MHP/DMC-ODS Contract. If DHCS requests a review of any existing MOU, the Party that received the request must submit the requested MOU to DHCS within 10 Working Days of receipt of the request.

c. **Notice.** Any notice required or desired to be given pursuant to or in connection with this MOU must be given in writing, addressed to the noticed Party at the Notice Address set forth below the signature lines of this MOU. Notices must be (i) delivered in person to the Notice Address; (ii) delivered by messenger or overnight delivery service to the Notice Address; (iii) sent by regular United States mail, certified, return receipt requested, postage prepaid, to the Notice Address; or (iv) sent by email, with a copy sent by regular United States mail to the Notice Address. Notices given by in-person delivery, messenger, or overnight delivery service are deemed given upon actual delivery at the Notice Address. Notices given by email are deemed given the day following the day the email was sent. Notices given by regular United States mail, certified, return receipt requested, postage prepaid, are deemed given on the date of delivery indicated on the return receipt. The Parties may change their addresses for purposes of receiving notice hereunder by giving notice of such change to each other in the manner provided for herein.

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

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

or renewed as a result.

f. **Amendment.** This MOU may only be amended or modified by the Parties through a writing executed by the Parties. However, this MOU is deemed automatically amended or modified to incorporate any provisions amended or modified in the Primary FIDE-SNP Contract, the MHP/DMC-ODS Contract, and subsequently issued superseding APL's, BHINs, or guidance, or as required by applicable law or any applicable guidance issued by a State or federal oversight entity.

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

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

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

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.

**SCAN HEALTH PLAN**

**RIVERSIDE UNIVERSITY HEALTH SYSTEM –  
BEHAVIORAL HEALTH**

By: *Karen Schulte*  
402450513.2

By: \_\_\_\_\_

**Karen Shulte  
President, Medicare**

**Matthew Chang, MD  
Behavioral Health Director**

**Notice Address:  
SCAN Health Plan  
3800 Kilroy Airport Way, Suite 100  
Long Beach, CA 90806**

**Notice Address:  
Riverside University Health System - Behavioral  
Health  
4095 County Circle Drive  
Riverside, CA 92503**

**County Counsel  
Approved As To Form:**

By: *Gregg Gu*  
**Deputy County Counsel**

**Exhibit A**

**Refer to Appendix A for exhibits to contain MCP-MHP/DMC-ODS Plan and MHP Liaisons as referenced in Sections 4.b and 5.b of this MOU**

**SCAN Responsible Person**

(Oversight and Compliance)

<b>SCAN</b>	<b>Address</b>	<b>Telephone</b>
Karen Schulte, President, Medicare	3800 Kilroy Airport Way, Suite 100, Long Beach, CA 90806	562-997-1819

**SCAN Liaison**

(Point of Contact between SCAN and RUSH-BH)

<b>SCAN</b>	<b>Address</b>	<b>E-mail</b>
Jill McGougan, Director, Medi-Cal Compliance	3800 Kilroy Airport Way, Suite 100, Long Beach, CA 90806	saffairs@scanhealthplan.com

**Exhibit B**

**Riverside University Health Systems-Behavioral Health**

(Oversight and Compliance)

<b>MHP-RUHS – Behavioral Health</b>	<b>Address</b>	<b>Telephone</b>
Matthew Chang, M.D., MMM Director	4095 County Circle Drive Riverside, CA 92503	(951) 358-4501

**Riverside University Health Systems-Behavioral Health- MHP/DMC-ODS Plan Liaison**

(Point of Contact between RUSH-BH and SCAN)

<b>RUHS-BH</b>	<b>Address</b>	<b>Telephone</b>
Matthew Chang, M.D., MMM Director	4095 County Circle Drive Riverside, CA 92503	(951) 358-4501

**Exhibit C**

**Data Elements**

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









# CLEAN MCP.MHP MOU Template 3.17.23 (Manatt edits)-1 compared with CLEAN MCP.MHP MOU Template 3.20.23 (Manatt edits)-1

Final Audit Report

2026-01-20

Created:	2026-01-15
By:	Edgardo Guevara (e.guevara@ruhealth.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAAXIMI3CovsYaO2tQ4BC-KdBXiPDommdcl

## "CLEAN MCP.MHP MOU Template 3.17.23 (Manatt edits)-1 compared with CLEAN MCP.MHP MOU Template 3.20.23 (Manatt edits)-1" History

-  Document created by Edgardo Guevara (e.guevara@ruhealth.org)  
2026-01-15-11:16:53 PM GMT
-  Document emailed to Karen Shulte Umcgougan@scanhealthplan.com) for signature  
2026-01-15-11:16:59 PM GMT
-  Email viewed by Karen Shulte Umcgougan@scanhealthplan.com)  
2026-01-16 - 8:05:19 AM GMT
-  Edgardo Guevara (e.guevara@ruhealth.org) replaced signer Karen Shulte Umcgougan@scanhealthplan.com) with Karen Schulte (kschulte@scanhealthplan.com)  
2026-01-20 - 3:46:25 PM GMT
-  Document emailed to Karen Schulte (kschulte@scanhealthplan.com) for signature  
2026-01-20 - 3:46:26 PM GMT
-  Email viewed by Karen Schulte (kschulte@scanhealthplan.com)  
2026-01-20 - 5:33:21 PM GMT
-  Document e-signed by Karen Schulte (kschulte@scanhealthplan.com)  
Signature Date: 2026-01-20 - 5:35:09 PM GMT - Time Source: server
-  Agreement completed.  
2026-01-20 - 5:35:09 PM GMT

 **Riverside  
University**  
**HEALTH SYSTEM**  
**Behavioral Health**

Behavioral Health Patient Accounts  
P.O. Box 7549  
Riverside, CA 92513-7549

RONNIE MARQUEZ  
28030 MISSOURI TRL  
PERRIS CA 92570-9262

APRIL 15, 2026  
CLIENT #: 970051794  
FAMILY #: 189950

Dear MR. / MS. MARQUEZ

In order for us to bill all available resources for service(s) rendered to YOURSELF  
at ETS it is necessary that you provide us with the following:

Please complete the attached financial liability questionnaire so we may determine any 3<sup>rd</sup> party coverage and the family's share of cost under the "California Uniform Method of Determining Ability to Pay" program.

         Please provide us the patient's Medi-Cal card or photo-static copy for the month(s) of         

         Please complete and sign the attached form(s) where indicated by **red** marks. Attach a copy of your Insurance/ Medicare Card(s) and return within 10 days.

Other information requested         

In the event that we do not hear from you within ten days, we will assume that you intend to pay the total cost of services, and billing in full will be initiated. Our office hours are 8:00 a.m. – 5:00 p.m. Monday through Thursday and 8:00 a.m. – 4:00 p.m. Friday.

**SPECIAL NOTICE TO MEDI-CAL BENEFICIARIES\***: Your Medi-cal benefits may be denied or stopped by failing to provide certain information including information about your primary health coverage. As a condition of Medi-cal eligibility, all payments for medical services for yourself and any eligible persons you are legally responsible for are automatically assigned to the State. In the event that we do not hear from you within ten days, we will generate a claim to your primary health plan based on the information you provided to the Department of Health Care Services, assume that you intend to pay the total cost of services, and/or initiate full pay billing.

Respectfully,

CS  
PATIENT ACCOUNTS  
PHONE (951) 358-6900  
IAR

CONFIDENTIAL PATIENT INFORMATION  
SEE CALIFORNIA WELFARE AND  
INSTITUTIONS CODE SECTION 5328