

Memorandum of Understanding

between

Monterey County Health Department (MCHD)

and

Central California Alliance for Health (The Alliance)

Kathy Neal, RN
Alliance Chief Health Services Officer

Ray Bullick, Director
Monterey County Health Department

Dale Bishop, MD
Alliance Chief Medical Officer

Date: _____

Date: _____

In order to implement a collaborative approach between and Medi-Cal managed care health plans, and to offer the broadest care possible to clients/members, Local Government Agencies (LGAs) are required to enter into this MOU with each Medi-Cal managed care health plan serving clients/members in the LGA's county. This MOU serves to define the respective responsibilities and necessary coordination between MCHD and the Alliance, to assure that claims for Targeted Case Management (TCM) do not duplicate claims for Medi-Cal managed care under the Alliance.

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Targeted Case Management (TCM) MOU

Subject	MCHD	Alliance
Case Management	MCHD TCM program focuses on the management of the whole client, including referring clients to providers to address medical issues, as appropriate. However, the MCHD TCM program is not a provider of medical services and does not include the provision of direct services. Case management services, as defined in Title 42 CFR Section 440.169, include the following four service components: 1. Assessment and Periodic Reassessment. 2. Development of Specific Care Plan. 3. Referral and Related Activities. 4. Monitoring and Follow-Up Activities. The claimable unit of MCHD TCM service is the provision of one of these four service components in a face-to-face encounter with the client. MCHD TCM services do not include the direct delivery of underlying medical, social, educational, or other services to which an individual has been referred.	The Alliance primarily focuses on member medical needs in providing case management as the primary provider of client medical care. This may include management of acute or chronic illness. Case management services, as defined in Title 42 CFR Section 440.169, include the following four service components: 1. Assessment and Periodic Reassessment. 2. Development of Specific Care Plan. 3. Referral and Related Activities. 4. Monitoring and Follow-Up Activities.
Roles	MCHD will provide TCM services for medical, social, educational, and other services needing case management. For client medical issues needing case management, MCHD TCM programs will refer Alliance members with open TCM cases to the Alliance when identified by the MCHD TCM Case Manager. MCHD will provide the TCM target populations with a description of each population to the Alliance at least annually.	The Alliance will partner with MCHD to ensure that members receive the appropriate level of case management services. The collaborative process will ensure that there is no duplication of services. The Alliance will oversee the delivery of primary health care and related care coordination. The Alliance is responsible for providing all medically necessary health care identified in the care plan including medical education that the member may need as well as any necessary medical referral authorizations. Case management for member medical issues and linkages to the Alliance's covered health services will be the responsibility of the Alliance. The Alliance will provide members with linkage

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		and care coordination for any necessary social support needs identified by the Alliance that do not need medical case management.
Contacts	Contact parties will be designated at MCHD to facilitate the required coordination and to address any and all issues as they arise. MCHD will designate a contact responsible for facilitating coordination with the Alliance, including identifying the appropriate Alliance contacts to MCHD, and resolving all related operational issues. The MCHD TCM Program Manager or their designee will serve as the contact person for all clients receiving MCHD TCM.	Contact parties will be designated at the Alliance to facilitate the required coordination and to address any and all issues as they arise. The Alliance will designate a contact responsible for facilitating coordination with MCHD, including identifying the appropriate Alliance contacts to the MCHD and resolving all related operational issues. The Alliance primary care provider (PCP), Case Manager, or plan designee, as determined by the Alliance, will serve as the contact person for Alliance case management.
Client Identification	MCHD will identify TCM clients who are members of the Alliance and query those members to obtain the name of their patient centered medical home (PCMH) for primary medical care services. Additionally, MCHD may request access to client managed care status and provider information via existing DHCS provider eligibility information access systems.	To facilitate proper coordination between the Alliance and MCHD, the Department of Health Care Services (DHCS) will provide the Alliance with electronic information identifying the Alliance clients receiving MCHD TCM services within the last three months. The Alliance will notify the member's PCP and/or any Case Manager that the member is receiving MCHD TCM services along with the appropriate MCHD contact information. Additionally, the Alliance will notify the MCHD when the member is receiving MCHD TCM services and is also receiving complex case management from the Alliance, either in batch or client-by-client basis monthly, and/or additionally, on request from MCHD.
Coordination	MCHD will share client/member care plans with the Alliance upon request for Alliance members with open MCHD TCM cases. The MCHD TCM programs will communicate to the Alliance regarding client/member status for open medical and related social support issues	The Alliance will share client/member care plans with MCHD upon request for the Alliance members with open MCHD TCM cases. The Alliance programs will communicate regarding member status for open medical and related social support issues to ensure that there is no

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	to ensure that there is no duplication of service and to ensure that the client receives the optimal level of case management services. For any client/member with an open MCHD TCM case needing medical case management, the Alliance and MCHD staff will communicate at least quarterly to ensure that the client/member is receiving the appropriate level of care. The coordination between the Alliance and MCHD will include, at a minimum, all medical issues and all social support related issues identified by the Alliance and/or by the MCHD TCM program.	duplication of service and to ensure that the member receives the optimal level of case management services. For any client/member with an open MCHD TCM case needing medical case management, the Alliance and MCHD staff will communicate at least quarterly to ensure that the client/member is receiving the appropriate level of care. The coordination between the Alliance and MCHD will include, at a minimum, all medical issues and all social support related issues identified by the Alliance and/or by the MCHD TCM program.
Client Health Insurance Portability and Accountability Act (HIPAA) Consents	MCHD TCM programs will comply with Health Insurance Portability and Accountability Act (HIPAA) requirements when sharing medical information between the Alliance and MCHD TCM program. MCHD will obtain HIPAA-compliant consents from Alliance members receiving MCHD TCM to allow sharing of medical information with Alliance designated contact.	The Alliance will comply with Health Insurance Portability and Accountability Act (HIPAA) requirements when sharing medical information between the Alliance and the MCHD TCM program. The Alliance will obtain HIPAA-compliant consents from Alliance members receiving MCHD TCM services to allow sharing of medical information with MCHD TCM designated contact.
Assessment and Care Plan Protocol	MCHD will provide TCM services to clients needing case management services to assist them in gaining access to needed medical, social, educational, or other services per Title 42 CFR Section 440.169. • MCHD will be responsible for conducting all TCM assessments and for developing and revising care plans related to TCM service domains (medical, educational, social, and other needed services). All MCHDTCM clients will receive reassessments as frequently as needed and at minimum once every six months. • MCHD will share TCM care plans with the Alliance if requested by the Alliance.	The Alliance will provide health assessments and care plans for all members as requested. • The Alliance will assess all member medical needs and shall identify medically necessary social support needs, including required annual reassessments. • The Alliance will be responsible for the development and revision of member care plans related to all assessed client medical needs and services related to the medical diagnosis as needed. • The Alliance will share care plan information with the member's MCHD TCM program as they determine necessary to coordinate member medical issues. In addition, the Alliance will share care plans if requested

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	- Based on the assessment, the TCM care plan will specify the goals for providing MCHD TCM services to the eligible individual, and the services and actions necessary to address the client's medical, social, educational, or other service needs. - All clients with open TCM cases will be referred to the Alliance by the MCHD TCM Case Manager if client is in need of Alliance case management for medical issues. The TCM assessment extends further than the Alliance assessment as it includes all medical, social, educational, and any non-medical aspects of case management, including those social support issues that may be related to a medical need. Nonmedical issues may include, but are not limited to, life skills, social support, or environmental barriers that may impede the successful implementation of the Alliance care plan. Any client qualifying for TCM through MCHD will have a TCM assessment and care plan created as described above. The care plan will include any need identified by the Alliance. The MCHD TCM Case Manager will coordinate with the Alliance when the MCHD TCM Case Manager determines, at a minimum, that: - The Alliance has identified that the client/member receives complex case management from the Alliance, and the MCHD TCM Case Manager assesses that the client/member is not medically stable. - The client/member indicates (self-declaration of receiving complex case management) that they are receiving assistance and/or case management for	by the MCHD TCM program. The Alliance PCPs and Case Managers, when assigned, will communicate with the appropriate MCHD TCM program contact to discuss client needs and/or coordinate as deemed necessary by either the Alliance PCP/Case Manager or the MCHD TCM Case Manager. The Alliance will support MCHD's Case Manager in developing TCM assessment and care plan (as outlined at left). Provide any additional coordination, as deemed necessary by either MCHD or the Alliance, to all other MCHD TCM clients who are also the Alliance members, based on DHCS provided client information for TCM services provided in the last three months. The MCHD TCM Case Manager shall provide all necessary assessments, and care plans, medical or otherwise, to the Alliance as soon as possible to address the client's/ member's immediate medical need upon request.

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	their needs from a Case Manager or other Alliance professional. • The MCHD TCM Case Manager assesses that the client may have an acute or chronic medical issue, and is not medically stable. • The MCHD TCM Case Manager assesses that the client's medical needs require case management. • The MCHD TCM Case Manager assesses that the client may have social support issues that may impede the implementation of the Alliance care plan. The method and frequency of TCM coordination will be dictated by the level of the client's medical and related social support needs. MCHD will determine what coordination options are appropriate for the client's level of need in order to provide the same level of coordination with the Alliance. MCHD will also provide any corresponding documentation to the Alliance PCP/Case Manager upon request. This coordination will include, but not limited to, the following: • The MCHD TCM Case Manager will obtain and review with the client/member, the Alliance care plan. • The MCHD TCM Case Manager will contact the Alliance PCP/Case Manager to discuss the client/member medical issues and/or related social support issues. The MCHD TCM Case Manager will notify the Alliance via an agreed medium (e.g. specific form, email to PCP, phone referral line), that the client/member is receiving TCM services and has identified social support issue(s)	

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	that may impede the implementation of the Alliance care plan. MCHD will provide any additional coordination, as deemed necessary by either MCHD or the Alliance, to all other TCM clients who are also Alliance members, based on DHCS provided client information for TCM services provided in the last three months. The above procedures will be followed by MCHD TCM providers unless the client has an urgent medical situation needing immediate case management intervention.	
Referral, Follow Up, and Monitoring Protocol	MCHD TCM Case Managers will provide referral, follow-up, and monitoring services to help members obtain needed services, and to ensure the TCM care plan is implemented and adequately addresses the client's needs per Title 42 CFR Section 440.169. • The MCHD TCM Case Manager will refer the client to services and related activities that help link the individual with medical, social, educational providers. The MCHD TCM Case Manager will also link the client to other programs deemed necessary, and provide follow-up and monitoring as appropriate. • The MCHD TCM Case Manager will contact the Alliance directly as needed to ensure the Alliance PCP, or Case Manager is aware of the client/member, and the client/member is receiving the proper care. The above procedures will be followed by MCHD TCM providers unless the client has an urgent medical situation needing immediate case management intervention.	The Alliance will refer members for the following services in executing their responsibilities to members for the delivery of primary health care and related care coordination: • Medical Services • Non-Medical Services • Basic Social Support Needs - o The Alliance will provide referrals for basic social support needs when an intensive level of case management is not needed, and does not require follow-up or monitoring. Examples: ▪ Member seen by an Alliance Case Manager and the member needs directions to the local Food Bank. The simple act of assisting the member with linking him/her to the Food Bank would not constitute the need for TCM services. ▪ The Alliance Case Manager provides a member with driving directions to the nearest vocational trade school. This would not constitute the need for TCM services.

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	For Alliance members needing immediate case management intervention, the MCHD TCM Case Manager shall provide all necessary referrals as appropriate, medical or otherwise, to the Alliance as soon as possible to address the client's/ member's immediate medical need. • MCHD TCM Case Managers will refer client to the Alliance: - o For all medically necessary services, and authorization for any out-of network medical services. - o When a medical need develops or escalates after an Alliance assessment and notification of any related medically necessary support issues - o When the client needs assistance with medical related services. ▪ Examples: - o Scheduling appointments with PCP. - o Delays in receiving authorization for specialty health services. • Prior to referral for MCHD TCM, the Alliance will identify the social, educational, and/or other non-medical issues the member has that require case management. - o If the MCHD determines that the client needs or qualifies for TCM, the MCHD TCM Case Manager will assess and specifically identify the issue for which the member was referred as well as all other case management needs and develop a care plan as described in the "Assessment and Care Plan Protocol" section. - o The MCHD TCM Case Manager will provide linkage and referrals as needed, and will	• TCM Case Management for Non-Medical Needs. - o The Alliance will refer members to the MCHD for TCM services when the individual falls into one of the identified target populations, has undergone an Alliance case management assessment, and meets any of the following criteria: i. Member is determined to be in need of case management services for non-medical needs. ii. The Alliance has determined that the member has demonstrated an on-going inability to access the Alliance services. iii. The Alliance has determined that member would benefit from TCM face-to-face case management. iv. The Alliance has concerns that the member has an inadequate support system for medical care. v. The Alliance has concerns that the member may have a life skill, social support, or an environmental issue affecting the member's health and/or successful implementation of the Alliance care plan. - o The Alliance shall share information with the MCHD TCM Case Manager that informs the MCHD TCM Case Manager of the issue for which the referral was made. Referral does not automatically confirm enrollment into a TCM program.

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	monitor and follow-up as appropriate. - o The MCHD may obtain and review the Alliance client care plan to assist in assessing the referred issue. - o The TCM client case shall remain open until the issue referred by the Alliance has been resolved, and no other TCM service is determined to be necessary by the MCHD. MCHD will notify the Alliance when the referred issues have been resolved. - o When the Alliance refers a member to MCHD for TCM services for any medically necessary or social support needs, coordination will take place as frequently as either the Alliance or the MCHD TCM Case Manager deems necessary, but no less than quarterly. • When a member is not enrolled in a case management program by the Alliance and enters the county health system through MCHD, MCHD will refer the member to the Alliance as needed to provide and document case management services. These services may include: 1) Coordination of care 2) Medical referrals 3) Continuity of care 4) Follow-up on missed appointments 5) Communication with specialists	