MEMORANDUM OF UNDERSTANDING
BETWEEN
COUNTY OF EL DORADO
HEALTH AND HUMAN SERVICES AGENCY
TARGETED CASE MANAGEMENT PROGRAM
AND
CALIFORNIA HEALTH AND WELLNESS PLAN

This MEMORANDUM OF UNDERSTANDING (MOU) is made between County of El Dorado, a political subdivision of the State of California, on behalf of County of El Dorado Health and Human Services Agency, Targeted Case Management Program (hereinafter referred to as "County") and California Health and Wellness Plan, a health maintenance organization (hereinafter referred to as "CHWP") whose address is PO Box 1558, Sacramento, CA 95812-1558.

1. BACKGROUND

Targeted Case Management (TCM) consists of comprehensive case management services that assist clients within a specified target population to gain access to needed medical, social, educational and other services. TCM services ensure that the changing needs of the client are addressed on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs. The TCM Program serves the needs of adults and children who qualify for TCM. Both CHWP and the County's TCM Program share a common goal of assuring that Medi-Cal beneficiaries receive a continuum of health care and supportive services across all providers and care settings that are not duplicated.

California's "Bridge to Reform," Section 1115 Medicaid Demonstration Waiver and the related Medi-Cal managed care expansion requires Medi-Cal managed care health plans to be responsible for broader care coordination and case management services for Medi-Cal beneficiaries. This includes coordination and referral of resources for client social support issues. The responsibilities and protocols are clearly defined in the DHCS Policy and Procedure Letters 15-002, 11-006, and 11-008[1].

In order to implement a collaborative approach between County's TCM program and CHWP's Medi-Cal managed care health plan (MCP), and to offer the broadest care possible to clients/members, County is required to enter into a Memorandum of Understanding (MOU) with CHWP as the managed care health plan for County of El Dorado.

This MOU defines protocols to follow in order to avoid duplication of services and activities. These protocols will serve as the basis for the coordination of care and non-duplication of services.

2. PURPOSE

The purpose of this Memorandum is to define the respective responsibilities and necessary coordination between County and CHWP as well as provide assurance that claims for TCM do not duplicate claims for Medi-Cal managed care. The parties to this memorandum agree to adhere to the policies and procedures ensuring coordination and non-duplication of services set forth in this memorandum.

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[1] http://www.dhcs.ca.gov/formsandpubs/Pages/MAATCMPPLs.aspx

3. CASE MANAGEMENT

While both County and CHWP provide case management, there is a distinction between case management provided by County's TCM Program and by CHWP. CHWP 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.

In contrast, County's TCM Program focuses on the management of the whole client, including referring clients to providers to address medical issues, as appropriate. However, the 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:

A. Assessment and Periodic Reassessment.

B. Development of Specific Care Plan.

C. Referral and Related Activities.

D. Monitoring and Follow-Up Activities.

The four component requirement applies to both TCM Program and CHWP case management. TCM services do not include the direct delivery of underlying medical, social, educational, or other services to which an individual has been referred.

The claimable unit of TCM service is the provision of one of these four service components in a face-to-face encounter with the client.

4. ROLES

California Health and Wellness Plan

CHWP will partner with County's TCM Program to ensure that members receive the appropriate level of case management services. The collaborative process will ensure that there is no duplication of services.

A. CHWP will oversee the delivery of primary health care and related care coordination. CHWP 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 CHWP covered health services will be the responsibility of CHWP.

B. CHWP will provide members with linkage and care coordination for any necessary social support need identified by CHWP that do not need medical case management.

County TCM Program

County will provide TCM services for medical, social, educational, and other services needing case management. For client medical issues needing case management, the TCM Program will refer CHWP members with open TCM cases to CHWP when identified by the TCM Case Manager.

5. RESPONSIBILITIES

Area of Responsibility	County	CHWP
Liaison	a. Designate a contact responsible for facilitating coordination with CHWP, including identifying the appropriate CHWP contacts to the TCM Program, and resolving all related operational issues. The TCM Case Manager will serve as the contact person for all clients receiving TCM.	a. Designate a contact responsible for facilitating coordination with the TCM Program, including identifying the appropriate CHWP contacts to the TCM Program, and resolving all related operational issues. The CHWP primary care provider (PCP) and TCM Case Manager will serve as the contact person for member CHWP case management.
Client Identification	a. County will query all TCM clients to determine if they are assigned to CHWP for their primary medical care. County will request access to client managed care status and provider information via existing DHCS provider eligibility information access systems (MEDS).	a. CHWP will notify the member's PCP and/or any Case Manager that the member is receiving TCM services along with the appropriate County contact information.
Coordination	a. County will share client/member care plans with CHWP upon request for CHWP members with open TCM cases. b. County will communicate regarding client/member status for open medical and related social support issues to ensure that there is no duplication of service and to ensure that the member receives the optimal level of case management services c. County will comply with Health Insurance Portability and Accountability Act (HIPAA) requirements when sharing medical information with CHWP. d. For any client/member with an open TCM case needing medical case management, County will communicate at least once every six months or as frequently as needed with CHWP to ensure that	a. CHWP will share client/member care plans with County for CHWP members with open TCM cases. b. CHWP will communicate regarding client/member status for open medical and related social support issues to ensure that there is no duplication of service and to ensure that the member receives the optimal level of case management services. c. CHWP will comply with Health Insurance Portability and Accountability Act (HIPAA) requirements when sharing medical information with County. d. For any client with an open TCM case needing medical case management, CHWP will communicate at least once every six months or as needed to ensure that the client/member is

	the client/member is receiving the appropriate level of care. e. The coordination between CHWP and County will include, at a minimum, all medical issues and all social support related issues identified by County and/or CHWP. f. County will pursue obtaining HIPAA consents from TCM clients to allow the sharing of medical information with CHWP.	receiving the appropriate level of care. e. The coordination between County and CHWP will include, at a minimum, all medical issues and all social support related issues identified by CHWP and/or County. f. CHWP will pursue obtaining HIPAA consents from CHWP clients to allow the sharing of medical information with County.
Assessment and Care Plan Protocol	a. Per Title 42 CFR Section 440.169, TCM services will be provided to clients who require services to assist them in gaining access to needed medical, social, educational, or other services. b. County will be responsible for creating all TCM assessments, and for the development and revision of care plans related to TCM services. The assessment shall determine the need for any medical, educational, social, or other service. This includes the required semi-annual reassessments. c. County will share TCM care plans with CHWP if requested by CHWP. d. The TCM care plan will specify the goals for providing TCM services to the eligible individual, and the services and actions necessary to address the client's medical, social, educational, or other service needs based on the assessment. e. All clients with open TCM cases will be referred to CHWP by the TCM Case Manager if the client is in need of CHWP case management for medical issues. f. The TCM assessment extends further than the CHWP assessment as it includes all medical, social educational, and any non-medical aspects of case management, including those	a. CHWP will provide health assessments and care plans for all members as needed. b. CHWP will assess member medical needs and shall identify medically necessary social support needs, including required semi-annual reassessments. c. CHWP 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. d. CHWP will share care plan information with County as necessary to coordinate member medical issues. In addition, CHWP will share care plans if requested by County. e. CHWP's Case Managers, when assigned, will communicate with the appropriate County contact to discuss client needs and/or coordinate as deemed necessary by either the CHWP Case Manager or the County TCM Case Manager.

	social support issues that may be related to a medical need. Non-medical issues may include, but are not limited to, life skills, social support, or environmental barriers that may impede the successful implementation of the CHWP care plan.	
Coordination of Care	a. The TCM Case Manager will coordinate with CHWP when CHWP has identified that the client/member receives complex case management from CHWP, and the TCM Case Manager assesses that the client/member is not medically stable. b. The client/member indicates (self-declaration of receiving complex case management) that they are receiving assistance and/or case management for their needs from a Case Manager or other CHWP professional. c. The TCM Case Manager assesses that the client may have an acute or chronic medical issue, and is not medically stable. d. The TCM Case Manager assesses that the client's medical needs require case management. e. The TCM Case Manager assesses that the client may have social support issues that may impede the implementation of the CHWP care plan. f. County will determine what coordination options are appropriate for the client's level of need in order to provide the same level of coordination with CHWP. g. County will also provide any corresponding documentation to the CHWP Case Manager. h. The TCM Case Manager will obtain and review the client/member CHWP care plan. i. The TCM Case Manager will contact the CHWP Case Manager to discuss the client/member	

	medical issues and/or related social support issues. j. The TCM Case Manager will notify CHWP via an agreed medium (e.g., specific form, email to CHWP), that the client/member is receiving TCM services and has identified a social support issues(s) that may impede the implementation of the CHWP care plan. k. The TCM Case Manager will provide all necessary assessments, and care plans, medical or otherwise, to CHWP as soon as possible to address the client's/member's immediate medical need	
Referral, Follow Up and Monitoring Protocol	a. 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. b. The TCM Case Manager will refer the client to services and related activities that help link the individual with medical, social, educational providers. The TCM Case Manager will also link the client to other programs deemed necessary, and provide follow-up and monitoring as appropriate. c. The TCM Case Manager will contact CHWP directly as needed to ensure the CHWP Case Manager or PCP is aware of the client/member, and the client/member is receiving the proper care. d. The above procedures must be followed by County unless the client has an urgent medical situation needing immediate case management intervention. e. The TC Case Manager shall provide all necessary referrals as appropriate, medical or otherwise,	a. CHWP will refer members for the following services in executing their responsibilities to members for the delivery of primary health care and related care coordination: i. Medical services ii. Non-medical services iii. Basic social support needs b. CHWP 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 include: (1) Member seen by a CHWP Case Manager and the member needs directions to the local Food Bank; (2) CHWP Case Manager provides a member with driving directions to the nearest vocational trade school. This would not constitute the need for TCM services. c. CHWP will refer members to County for TCM services when the individual falls into one of the identified target populations, has undergone and CHWP case management assessment, and meets any of the following criteria:

	to CHWP as soon as possible to address the client's/member's immediate medical need. f. TCM Case Managers will refer client to CHWP for all medically necessary services, and authorization for any out-of-network medical services. g. TCM Case Manager will refer client to CHWP when a medical need develops or escalates after a CHWP assessment and notification of any related medically necessary support issues. h. TCM Case Manager will refer clients to CHWP when the client needs assistance with medical related services, e.g., scheduling appointments with CHWP; and delays in receiving authorization for specialty health services. i. If County determines that the client needs or qualifies for TCM, the 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. j. The TCM Case Manager will provide linkage and referrals as needed, and will monitor and follow-up as appropriate. k. County may obtain and review CHWP's client care plan to assist in assessing the referred issue. l. The TCM client case shall remain open until the issue referred by CHWP has been resolved, and no other TCM service is determined to be necessary by County. m. County will notify CHWP when the referred issues have been resolved.	i. Member is determined to be in need of case management services for non-medical needs. ii. CHWP has determined that the member has demonstrated an on-going inability to access CHWP services. iii. CHWP has determined that member would benefit from TCM face-to-face case management. iv. CHWP has concerns that the member has an inadequate support system for medical care. v. CHWP 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 CHWP care plan. d. CHWP shall share information with the TCM Case Manager that informs the TCM Case Manager of the issue for which the referral was made. e. Referral does not automatically confirm enrollment into a TCM program. f. Prior to the referral for TCM, CHWP will identify the social, educational, and/or other non-medical issues the member has that require case management. g. When CHWP refers a member to County for TCM services for any medically necessary or social support needs, coordination will take place as frequently as either CHWP or the TCM Case Manager deems necessary, but no less than quarterly.

The above procedures must be followed by LGA TCM providers unless the client has an urgent medical situation needing immediate case management intervention.

When a member is not referred to County's TCM Program by CHWP and enters the county health system through the County operated health clinics, County will refer the member to CHWP as needed to provide and document CHWP case management services. These services include:

1. Coordination of care
2. Medical referrals
3. Continuity of care
4. Follow-up on missed appointments
5. Communication with specialists

6. TIME OF PERFORMANCE

The effective date of this Memorandum shall be the date of execution and shall continue in effect until modified or terminated by either party.

7. CHANGES AND AMENDMENTS

This Memorandum may be amended at any time by mutual agreement of the parties. Such amendments shall not be binding upon either party unless they are in writing and signed by the personnel authorized to bind each of the parties.

8. TERMINATION OF THE MEMORANDUM

A. This Memorandum may be terminated by either party, at any time, with good cause, upon 30 days written notice one to the other.

B. If either party defaults in its performance, the non-defaulting party shall promptly notify the other in writing. If the defaulting party fails to cure a default within 30 days after notification or if the default requires more than 30 days to cure and the defaulting party fails to commence to cure the default within 30 days after notification, then that failure shall terminate this Memorandum.

9. NOTICE TO PARTIES

Written notices under this MOU will be to the following:

Health and Human Services Agency
County of El Dorado
3057 Briw Road, Suite A
Placerville, CA 95667

California Health and Wellness Plan
PO Box 1558
Sacramento, CA 95812

10. ADMINISTRATOR

The County Officer or employee with responsibility for administering this Agreement is Jayle Goucher, Program Manager, or successor.

11. DISPUTE RESOLUTION

If the parties fail to mutually agree on any matters under this Memorandum or if either party believes the other has failed to satisfactorily perform or is otherwise in breach of this Memorandum the parties shall submit the matter to resolution in accordance with the following procedures:

A. If there is a disagreement, dispute or alleged breach arising out of or in connection with this Memorandum, the disputing party shall first provide a written statement to the other describing the general nature of the claim.

B. The statement must indicate that it is the first statement of a formal dispute resolution process.

C. The statement need not be complete and does not limit the claim(s) of either party in any further action or procedure.

D. Within ten (10) business days of the receipt of the statement, the respective parties shall meet and confer in good faith to either: (1) Resolve the matter and set forth such resolution in writing; or, (2) Define the dispute in writing including a description of each party's position, proposed resolution(s) and projects or tasks that would be affected.

E. If the respective parties fail to resolve the matter, within ten (10) business days of such failure to agree, at least one (1) representative from each party shall meet and confer in good faith to attempt to further resolve the matter. The description of the dispute as written by the respective parties shall serve as the basis for further attempts at resolution.

F. A resolution of the matter shall be memorialized in writing and incorporated into this Agreement.

G. If the parties fail to resolve this matter, this Agreement shall immediately terminate.

12. CONFORMANCE

If any provision of this agreement violates any statute or law of the State of California, it is considered modified to conform to that statute or law.

13. INDEMNIFICATION

A. County agrees to indemnify and hold harmless CHWP and its employees, agents and elective and appointive boards from and against any damages including costs and attorney's fees arising out of negligent or intentional acts or omissions of County, its employees or agents.

B. CHWP agrees to indemnify and hold harmless County, its employees, agents and elective and appointive boards from and against any damages including costs and attorney's fees arising out of negligent or intentional acts or omissions of Customer, its employees or agents.

14. ENTIRE AGREEMENT

This Memorandum constitutes the entire agreement between CHWP and County of El Dorado. There are no terms, conditions or obligations made or entered into by the parties other than those contained in it.

15. EXECUTION

The undersigned hereby warrants that s/he has the requisite Authority to enter into this Agreement on behalf of the parties and thereby bind the parties to the terms and conditions of the same.

REQUESTING DEPARTMENT HEAD CONCURRENCE:

By: _____ Dated: 8/31/2015

Don Ashton, M.P.A.
Director
Health and Human Services Agency

County of El Dorado
Health and Human Services Agency
("County ")

Signature: _____

Print Name: Brian Veerkamp

Title: Chair, Board of Supervisors

Dated: _____

ATTEST:
James S. Mitrisin
Clerk of the Board of Supervisors

By: _____
Deputy Clerk

California Health and Wellness Plan
("CHWP")

Signature: _____

Print Name: *Gregory Buchert, MD*

Title: *Chief Executive Officer*

Dated: 8/17/15

Dated: _____