MEMORANDUM OF UNDERSTANDING
BETWEEN
COUNTY OF VENTURA
TARGETED CASE MANAGEMENT PROGRAM
AND
GOLD COAST HEALTH PLAN

This Memorandum of Understanding (MOU) is made between County of Ventura, through its Targeted Case Management Program (hereinafter referred to as the "TCM Program") and VENTURA COUNTY MEDI-CAL MANAGED CARE COMMISSION (dba Gold Coast Health Plan), a public entity (hereinafter referred to as "GCHP").

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 per Title 42, Code of Federal Regulations Section 440.169. The TCM Program manages the whole client, including referring clients to providers to address medical issues, as appropriate. However, the TCM Program does not mange illness or provide medical services. The TCM Program serves the needs of adults and children who qualify for TCM. Both GCHP and the 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 require 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.

In order to implement a collaborative approach between the TCM Program and GCHP and to offer the broadest care possible to clients/members, the TCM Program is required to enter into a memorandum of understanding with GCHP as the managed care health plan for Ventura County.

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

3. CASE MANAGEMENT

While both the TCM Program and GCHP provide case management services, there is a distinction between case management provided by the TCM Program and by GCHP. GCHP 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, the 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 does not manage illness, 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 requirements apply to both the TCM Program's and GCHP's case management services. However, 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

Gold Coast Health Plan

GCHP will partner with the 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. GCHP will oversee the delivery of primary health care and related care coordination. GCHP is responsible for providing or arranging for the provision of 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 as well as medical referrals and linkages to GCHP covered health services will be the responsibility of GCHP.

B. GCHP will provide members with linkage and care coordination for any social support need identified by GCHP that does not rise to the level of needing medical case management and refer members to the TCM Program for any necessary case management of non-medical needs identified by GCHP.

County of Ventura TCM Program

The TCM Program 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 GCHP members with open TCM cases to GCHP for medical needs when identified by the TCM Case Manager.

5. RESPONSIBILITIES

Area of Responsibility	TCM	GCHP
Liaison	a. Designate a contact responsible for facilitating coordination with GCHP, including identifying the appropriate GCHP 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. The PCP will be the contact person responsible for facilitating coordination with the TCM Program. The Care Management Manager or designee will be the primary contact to the TCM Program to resolve all related operational issues.
Client Identification	a. The TCM Program will receive electronic information from DHCS identifying if a client is a GCHP member. The TCM Program will also query all TCM clients to determine if they are assigned to GCHP for their primary medical care. Additionally, the TCM Program will request access to client managed care status and provider information via existing DHCS provider eligibility information access systems (MEDS).	a. Using electronic information from DHCS identifying GCHP members receiving TCM within the last three (3) months, GCHP will notify the member's PCP and/or any case manager that the member is receiving TCM services and provide the appropriate TCM Program contact information. GCHP will notify the TCM Program when the member receiving TCM services is also receiving complex case management services from GCHP, either in batch or client-by-client basis monthly, or, additionally, on request from the TCM Program.

Coordination	a. The TCM Program will share client care plans with GCHP upon request for GCHP members with open TCM cases. b. The TCM Program will communicate with GCHP regarding client 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. For any client with an open TCM case needing medical case management, the TCM Program will communicate at least once every six months with GCHP to ensure that the client/member is receiving the appropriate level of care. The coordination between GCHP and the TCM Program will include, at a minimum, all medical issues and all social support related issues identified by the TCM Program and/or GCHP. d. The TCM Program will comply with Health Insurance Portability and Accountability Act (HIPAA) requirements when sharing medical information with GCHP and will pursue obtaining HIPAA consents from TCM clients to allow the sharing of medical information with GCHP.	a. GCHP will share member care plans with the TCM Program upon request for GCHP members with open TCM cases. b. GCHP will communicate with the TCM Program regarding 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. For any member with an open TCM case needing medical case management, GCHP will communicate at least once every six months with the TCM Program to ensure that the member is receiving the appropriate level of care. d. The coordination between the TCM Program and GCHP will include, at a minimum, all medical issues and all social support related issues identified by GCHP and/or the TCM Program. e. GCHP will pursue obtaining HIPAA consents from GCHP members to allow the sharing of medical information with the TCM Program and will comply with Health Insurance Portability and Accountability Act (HIPAA) requirements when sharing medical information with the TCM Program.

Assessment and Care Plan Protocol	a. TCM services will be provided to clients who require services to assist them in gaining access to needed medical, social, educational, or other services per Title 42 CFR Section 440.169, b. The TCM Program 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. The TCM Program will share TCM care plans with GCHP if requested by GCHP. 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 as identified in the assessment as applicable. e. All clients with open TCM cases that are in need of GCHP case management for medical issues will be referred to GCHP by the TCM Case Manager for evaluation of the medical condition and related needs. f. The TCM assessment will include all medical, social, educational, and other needs. Therefore, it extends further than the GCHP assessment as it specifically includes any non-medical aspects of case management, including those social support issues that may be related to a medical need. Non-medical issues may include, but are not limited to barriers such as life skills, social support, or environmental issues that may impede the successful implementation of the GCHP care plan.	GCHP will provide health assessments and care plans for all members as needed: a. GCHP will assess member medical needs and may identify medically necessary social support needs, including required annual reassessments. b. GCHP 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. c. Where permitted under HIPAA, GCHP may share care plan information with the TCM Program as GCHP determines necessary to coordinate on member medical issues. In addition, where permitted under HIPAA, GCHP will share care plans if requested by the TCM Program. d. Where permitted under HIPAA, GCHP's PCPs and case managers, when assigned, will communicate with the appropriate TCM Program contact to discuss client needs and/or coordinate as deemed necessary by either the PCP/GCHP case manager or the TCM Case Manager.

Coordination of Care	a. The TCM Case Manager will coordinate with GCHP when the TCM Case Manager determines, at a minimum, that: 1. GCHP has identified that the member receives complex case management from GCHP, and the TCM Case Manager assesses that the client/member is not medically stable. 2. The client indicates that they are receiving assistance and/or case management for their needs from a Case Manager or other GCHP professional [client self-declaration of receiving complex case management]. 3. The TCM Case Manager assesses that the client may have an acute or chronic medical issue, and is not medically stable. 4. The TCM Case Manager assesses that the client's medical needs require case management. 5. The TCM Case Manager assesses that the client may have social support issues that may impede the implementation of the GCHP care plan. b. The method and frequency of the coordination shall be dictated by the level of client medical and related social support need. The TCM Program will determine what coordination options are appropriate for the client's level of need in order to provide the same level of coordination with GCHP. c. The TCM Program will also provide any corresponding documentation to the GCHP designated reviewer. d. The TCM Program coordination will include, but may not be limited to, one of the following options: 1. The TCM Case Manager will obtain and review the client's GCHP care plan.	a. When GCHP refers a member to the TCM Program for TCM services for any medically necessary social support needs, coordination will take place as frequently as either GCHP or the TCM Case Manager deems necessary, but no less than quarterly.

	2. The TCM Case Manager will contact the GCHP PCP/case manager to discuss the client's medical issues and/or related social support issues. 3. The TCM Case Manager will notify GCHP via an agreed medium (e.g., specific form, email to the PCP), that the GCHP member is receiving TCM services and has identified a social support issues (s) that may impede the implementation of the GCHP care plan. e. The above coordination procedures must be followed by the TCM Program unless the client has an urgent medical situation necessitating immediate case manager intervention. For clients, needing immediate case manager intervention, the TCM Case Manager may provide all necessary assessments and care plans, medical or otherwise, to address the client's immediate medical need, apprising GCHP as soon as possible.	

Referral, Follow Up and Monitoring Protocol	a. TCM Case Managers will provide referral, follow-up, and monitoring services to help clients 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, or other programs deemed necessary, and provide follow-up and monitoring as appropriate. c. The TCM Case Manager will contact GCHP directly as needed to ensure the issue for which the client is being referred has the attention of GCHP, the PCP, or the GCHP case manager as appropriate. d. The above procedures must be followed by the TCM Program unless the client has an urgent medical situation needing immediate case management intervention. e. The TCM Case Manager may provide all necessary referrals as appropriate, medical or otherwise, to address the client's immediate medical need, apprising GCHP as soon as possible. f. TCM Case Managers will refer client to GCHP for all medically necessary services, and authorization for any out-of-network medical services. TCM Case Manager will refer client to GCHP when a medical need develops or escalates after a GCHP assessment and notification of any related medically necessary support issues.	a. GCHP will provide members with the following referral services in executing its responsibilities to members for the delivery of primary health care and related care coordination: 1. Referral to needed medical services. 2. Referral to needed non-medical services. i. Basic social support needs when there is no need for a more intensive level of case management (i.e., member needs directions to local food bank or vocational trade school) ii. GCHP does not follow-up or monitor the non-medical service to which the member has been referred. 3. Referral to the TCM Program for case management of non-medical needs when the member falls into one of the identified target populations, has undergone an GCHP 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. GCHP has determined that the member has demonstrated an on-going inability to access GCHP services and the TCM Program may provide member with assistance in accessing these services. iii. GCHP has determined that the member would benefit from TCM face-to-face case management. iv. GCHP has concerns that the member has an inadequate support system for medical care. v. GCHP has concerns that the member may have a life skill, social support, or an environmental issue

	h. TCM Case Manager will refer clients to GCHP when the client needs assistance with medical related services, e.g., scheduling appointments with GCHP; and delays in receiving authorization for specialty health services. i. If the TCM Program 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. The TCM Program may obtain and review GCHP's client care plan to assist in assessing the referred issue. l. The TCM Program's client case shall remain open until the issue referred by GCHP has been resolved, and no other TCM service is determined to be necessary by the TCM Program. m. The TCM Program will notify GCHP when the referred issues have been resolved.	affecting the member's health and/or successful implementation of the GCHP care plan. • When GCHP makes such referrals to the TCM Program, GCHP shall share information with the TCM Case Manager that informs the TCM Case Manager of the issue for which the referral was made. • Referral does not automatically confirm enrollment into the TCM Program.

When a member is not referred to the TCM Program by GCHP and enters the County of Ventura health system operated through a Ventura County Public Health Department operated health clinic, the Ventura County Public Health Department will refer the member to GCHP as needed to provide and document GCHP 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

This MOU shall be effective as of the date the MOU is countersigned by GCHP ("Effective Date") and shall continue in effect until modified or terminated by either party.

7. CHANGES AND AMENDMENTS

This MOU 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. REPORT TO DHCS ON DEFAULT

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 may be reported to DHCS by the non-defaulting party.

9. TERM AND TERMINATION

This MOU shall begin on the Effective Date and shall continue in effect for a term of two (2) years. Thereafter this MOU shall automatically renew for consecutive two-year terms unless terminated by either party with ninety (90) days' written notice to the other party prior to the start of the next two-year term. This MOU may be terminated at such other time upon mutual agreement of the parties.

10. DISPUTE RESOLUTION

If the parties fail to mutually agree on any matters under this MOU or if either party believes the other has failed to satisfactorily perform or is otherwise in breach of this MOU 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 MOU, 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 MOU.

11. CONFORMANCE

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

12. INDEMNIFICATION

A. Except where prohibited by law, the TCM Program agrees to indemnify and hold harmless GCHP 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 the TCM Program, its employees or agents.

B. Except where prohibited by law, GCHP agrees to indemnify and hold harmless the TCM Program, 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 GCHP, its employees or agents.

13. ENTIRE AGREEMENT

This MOU constitutes the entire agreement between GCHP and the TCM Program regarding the subject matter hereof. There are no terms, conditions or obligations made or entered into by the parties regarding the subject matter hereof other than those contained in it.

EXECUTION

The undersigned hereby warrant that they have the requisite authority to enter into this MOU on behalf of the parties and thereby bind the parties to the terms and conditions of the same.

County of Ventura	Gold Coast Health Plan
By: _____	By: _____
Rigoberto Vargas – Public Health Director	
Date: _____	Date: _____