MEMORANDUM OF UNDERSTANDING
BETWEEN
THE COUNTY OF SHASTA
TARGETED CASE MANAGEMENT PROGRAM
AND
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

This MEMORANDUM OF UNDERSTANDING (MOU) is made between the County of Shasta, a political subdivision of the State of California through its Health and Human Services Agency Targeted Case Management Program (hereinafter referred to as "County") and PARTNERSHIP HEALTHPLAN OF CALIFORNIA (hereinafter referred to as PHC), a public entity contracted with the Department of Health Care Services ("DHCS") (collectively, the "Parties" and individually a "Party").

1. BACKGROUND

A. Targeted Case Management (TCM) consists of comprehensive case management services that assist clients/members 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/member 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 PHC and 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.

B. 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/member social support issues.

C. In order to implement a collaborative approach between County's TCM program and PHC's Medi-Cal managed care health plan (MCP), and to offer the broadest care possible to client/members/members, County is required to enter into a MOU with PHC as the managed care health plan for Shasta County.

D. 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 PHC 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 Procedures ensuring coordination and non-duplication of services set forth in this MOU.

3. CASE MANAGEMENT

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

1) PHC primarily focuses on client/member medical needs in providing case management as the primary payer of client/member medical care. This may include management of acute or chronic illness.

2) In contrast, County's TCM Program focuses on the management of the whole client/member, including referring clients/members to providers to address medical issues, as appropriate. However, the County's TCM Program is not a provider of medical services and does not include the provision of direct services.

B. Case management services, as defined in Title 42 Code of Federal Regulations (CFR) Section 440.169, include the following four service component requirements:

1) Assessment and Periodic Reassessment.

2) Development of Specific Care Plan.

3) Referral and Related Activities.

4) Monitoring and Follow-Up Activities.

C. The four component requirement applies to both TCM Program and PHC 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.

D. 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/member.

4. ROLES

Partnership HealthPlan of California

A. PHC 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.

1) PHC will oversee the delivery of primary health care and related care coordination. PHC 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 PHC covered health services will be the responsibility of PHC.

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

County TCM Program

A. County may contract with other providers to provide TCM services. County's Contractors ("Contractors") shall be required to provide services in accordance with all terms and conditions of this MOU.

B. County will ensure the provision of TCM services for medical, social, educational, and other services needing case management. For client/member medical issues needing case management, the TCM Program will refer PHC members with open TCM cases to PHC when identified by the TCM Case Manager.

5. PROCEDURES

Area of Responsibility	County TCM Program (TCM Program)	PHC
A. Liaison	1) TCM Program shall be responsible for facilitating coordination with PHC Liaison, and resolving operational issues related to care coordination and non-duplication of services. 2) Each TCM Program Case Manager will serve as the primary contact for their respective client/members receiving TCM services.	1) PHC Liaison will be responsible for facilitating coordination with the County Liaison, and resolving operational issues related to care coordination and non-duplication of services. 2) The PHC primary care provider (PCP) and PHC Case Manager will serve as the primary contact for client/members receiving PHC case management.
B. Client/member Identification	1) TCM Program will provide a quarterly report to PHC with a list of their PHC client/members receiving TCM services.	1) PHC will notify the client/member's PCP and/or PHC Case Manager that the client/member is receiving TCM services and provide the appropriate TCM Program contact information. 2) PHC will provide a monthly report to the appropriate TCM Program Case Manager with a list of TCM client/members receiving PHC case management services. 3) PHC will acknowledge in writing if there are no client/members receiving PHC case management services.
C. Coordination	1) TCM Program will share client/member care plans with PHC upon request for their respective PHC client/members with open TCM cases. TCM Program shall limit communication with PHC regarding client/member status, to only to those clients/members they directly provide service to. 2) TCM Program will communicate regarding client/member status	1) PHC will share client/member care plans with TCM Program upon request for PHC client/members with open TCM cases. 2) PHC 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 client/member

	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. 3) TCM Program will comply with all privacy and security requirements, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements when sharing medical information with PHC by obtaining the appropriate consents from their TCM client/members. 4) For any client/member with an open TCM case needing medical case management, TCM Program will communicate at least once every six months with PHC to ensure that their client/member is receiving the appropriate level of care. 5) The coordination between PHC and TCM Program will include, at a minimum, all medical issues and all social support related issues identified by TCM Program and/or PHC.	receives the optimal level of case management services. 3) PHC will comply with HIPAA requirements when sharing medical information with TCM Program and will obtain the appropriate consents from PHC client/members. 4) For any client/member with an open TCM case needing medical case management, PHC will communicate with TCM Program as applicable and at least once every six months to ensure that the client/member is receiving the appropriate level of care. 5) The coordination between TCM Program and PHC will include, at a minimum, the PHC Case Manager's name and contact information, all medical issues and all social support related issues identified by PHC and/or TCM Program.
D. Assessment and Care Plan	1) TCM services will be provided to client/members who require services to assist them in gaining access to needed medical, social, educational, or other services per Title 42 CFR Section 440.169. 2) 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.	1) PHC will provide health assessments and care plans for all client/members as needed. 2) PHC will assess client/member medical needs and shall identify medically necessary social support needs, including required annual reassessments. 3) PHC will be responsible for the development and revision of client/member care plans related to all assessed client/member medical needs and services related to the medical diagnosis as needed. 4) PHC will share care plan information with TCM Program as necessary to coordinate

	3) TCM Program will share TCM care plans only for their respective clients/members with PHC if requested by PHC. 4) The TCM care plan will specify the goals for providing TCM services to the eligible client/member, and the services and actions necessary to address the client/member's medical, social, educational, or other service needs based on the assessment. 5) All client/members with open TCM cases will be referred to PHC by the TCM Case Manager if the client/member is in need of PHC case management for medical issues. 6) The TCM assessment extends further than the PHC 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. 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 PHC care plan.	client/member medical issues. In addition, PHC will share care plans if requested by TCM Program. 5) PHC's Case Managers, when assigned, will communicate with the appropriate TCM Program contact to discuss client/member needs and/or coordinate as deemed necessary by either the PHC Case Manager or TCM Case Manager.
E. Coordination of Care	1) TCM Case Manager will coordinate with PHC when: a. PHC has identified that the client/member receives complex case management from PHC, and the TCM Case Manager assesses that their client/member is not medically stable. b. The client/member indicates (self-declaration of receiving complex case management) that he/she is receiving assistance and/or case management for his/her needs from a PHC Case Manager or other PHC professional.	1. The PHC Case Manager will coordinate with the TCM Case Manager when: a. The client/member indicates (self-declaration) he/she is receiving TCM services. b. PHC identifies that a member, having received TCM services, may require PHC Case Management intervention due to an acute or chronic illness and/or medical instability.

	c. TCM Case Manager assesses that their client/member may have an acute or chronic medical issue, and is not medically stable. d. TCM Case Manager assesses that their client/member's medical needs require PHC medical case management. e. The TCM Case Manager assesses that the client/member may have social support issues that may impede the implementation of the PHC care plan. 2) TCM Program will determine what coordination options are appropriate for their respective client/member's level of need in order to provide the same level of coordination with PHC. 3) TCM Program will also provide any related corresponding documentation to the PHC Case Manager. 4) TCM Program will obtain and review their client/member's PHC care plan. 5) TCM Program will contact the PHC Case Manager to discuss their clients/members medical issues and/or related social support issues. 6) TCM Program will notify PHC via an agreed medium (e.g., specific form, email to PHC), that their client/member is receiving TCM services and has identified a social support issues(s) that may impede the implementation of the PHC care plan. 7) TCM Program will provide all necessary assessments, and care plans, medical or otherwise, to PHC as soon as possible to address their client/member's immediate medical need.	c. PHC will review the TCM Care Plan with the TCM Case Manager as necessary to ensure there is no duplication of service and the needs of the member are met. d. Method and frequency of communication will be determined between the TCM and PHC Case Managers as appropriate to meet the clients/member's needs, but not less than quarterly.
F. Referral, Follow Up and	1) TCM Program will provide referral, follow-up, and monitoring services to help their	1) PHC will provide referrals to clients/members for the following services in executing their

Monitoring Protocol	client/member obtain needed services, and to ensure the TCM care plan is implemented and adequately addresses their client/member's needs per Title 42 CFR Section 440.169. 2) TCM Case Manager will refer their client/member to services and related activities that help link the individual with medical, social, educational providers. TCM Case Manager will also link their client/member to other programs deemed necessary, and provide follow-up and monitoring as appropriate. 3) TCM Case Manager will contact PHC directly as needed to ensure the PHC Case Manager or PCP is aware of their client/member's immediate medical need. 4) The above procedures must be followed by TCM Program unless their client/member has an urgent medical situation needing immediate case management intervention. 5) TCM Case Manager shall provide all necessary referrals as appropriate, medical or otherwise, to PHC as soon as possible to address their client member's immediate medical need. 6) TCM Case Manager will refer their client/member to PHC for all medically necessary services, and authorization for any out-of-network medical services. 7) TCM Case Manager will refer their client/member to PHC when a medical need develops or escalates after a PHC assessment and notification of any related medically necessary support issues. 8) TCM Case Manager will refer their client/member to PHC when their client/member needs assistance with medical related services, e.g., scheduling appointments with PHC; and	responsibilities to clients/members for the delivery of primary health care and related care coordination: i. Medical services ii. Non-medical services iii. Basic social support needs 2) PHC 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: i. Client/member seen by a PHC Case Manager and the client/member needs directions to the local food bank; ii. PHC Case Manager provides a client/member with driving directions to the nearest vocational trade school. This would not constitute the need for TCM services.

	delays in receiving authorization for specialty health services. 9) If TCM Program determines that their client/member needs or qualifies for TCM, the TCM Case Manager will assess and specifically identify the issue for which the client/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 5.D. of this MOU. 10) TCM Case Manager will provide linkage and referrals as needed, and will monitor and follow-up as appropriate.	

G. The above Procedures must be followed by Local Governmental Agency (LGA) TCM Program unless the client/member has an urgent medical situation needing immediate case management intervention.

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

1) Coordination of care
2) Medical referrals
3) Continuity of care
4) Communication with specialists

6. TIME OF PERFORMANCE

The effective date of this MOU shall be effective June 1, 2018 and shall continue in effect until June 30, 2023.

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. TERMINATION OF THE MOU

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

B. If either Party defaults in its performance, the non-defaulting Party shall promptly notify the defaulting Party in writing. If the defaulting Party fails to cure a default within 30 days after receiving written 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 written notification, then the defaulting Party's failure shall terminate this MOU effective 30 days from date of written notice of default.

9. 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.

10. INDEMNIFICATION

A. County agrees to indemnify and hold harmless PHC 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, except when the injury or loss is caused by sole negligence or intentional wrongdoing of PHC.

B. PHC agrees to indemnify and hold harmless County, its officials, officers, employees, agents, volunteers, and elective and appointive boards from and against any damages including costs and attorney's fees (including County Counsel's fees) arising out of negligent or intentional acts or omissions of PHC, its employees or agents, except when the injury or loss is caused by sole negligence or intentional wrongdoing of County.

11. INSURANCE

1. County and PHC and any subcontractor shall each secure and maintain in full force and effect during the full term of this agreement commercial general liability insurance or participation in a self-insurance program, including coverage for owned and non-owned automobiles and other insurance necessary to protect the public, with limits of liability of not less than $1 million combined single limit bodily injury and property damage. Policies shall be written by carriers reasonably satisfactory to each party. On request, a certificate evidencing the insurance requirements of this paragraph shall be provided.
2. County and PHC and any subcontractor shall obtain and maintain continuously required Workers' Compensation and Employer's Liability Insurance to cover Consultant, subcontractor, Consultant's partner(s), subcontractor's partner(s), Consultant's employees, and subcontractor'(s') employees with an insurance carrier authorized to transact business in the State of California covering the full liability for compensation for injury to those employed by Consultant or subcontractor. Each such policy shall be endorsed to state that the Workers' Compensation carrier waives its right of subrogation against the County, its elected officials, officers, employees, agents, and volunteers which might arise in connection with this agreement. Consultant hereby certifies that Consultant is aware of the provisions of section 3700 of the Labor Code, which requires every employer to insure against liability for workers' compensation or to undertake self-insurance in accordance with the provisions of the Labor Code, and Consultant shall comply with such provisions before commencing the performance of the work or the provision of services pursuant to this agreement.
3. County and PHC and any subcontractor shall obtain and maintain continuously a policy of Errors and Omissions and Medical Malpractice coverage with limits of liability of not less than $1 million.

12. ENTIRE AGREEMENT

This MOU constitutes the entire agreement between Partnership HealthPlan of California and County of Shasta. There are no terms, conditions or obligations made or entered into by the Parties other than those contained in it.

13. EXECUTION

The undersigned hereby warrants that s/he has 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 SHASTA

By _____

LES BAUGH, CHAIRMAN
Board of Supervisors
County of Shasta
State of California

ATTEST:

LAWRENCE G. LEES
Clerk of the Board of Supervisors

By: _____

Deputy

APPROVED AS TO FORM
RUBIN E. CRUSE, JR
County Counsel

By _____ 3/20/18
Alan B. Cox, Deputy County Counsel III

RISK MANAGEMENT APPROVAL

By _____ 08/21/18
James Johnson, Risk Management Analyst

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

By _____
Elizabeth Gibboney, Executive Director

_____
Robert Moore, MD, MPH, MBA
Chief Medical Officer

_____
Wendi West,
Northern Region Executive Director