

California Department of Health Care Services
Targeted Case Management and Managed Care Plan
Memorandum of Understanding Protocols

Background

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 (MCP) to be responsible for broader care coordination and case management services for beneficiaries. This includes coordination and referral of resources for client social support issues.

In order to implement a collaborative approach between Targeted Case Management (TCM) and MCPs, and to offer the broadest care possible to clients/members, Local Governmental Agencies (LGAs) in Geographic Managed Care (GMC), County Organized Health System (COHS), Regional Model, San Benito Model, Imperial Model, and Two-Plan Model Medi-Cal Managed Care counties will be required to enter into a Memorandum of Understanding (MOU) with each MCP serving clients/members in the LGA's county. These MOUs will serve to define the respective responsibilities and necessary coordination between the TCM and the MCP as well as provide assurance that claims for TCM do not duplicate claims for Medi-Cal managed care.

This document serves to define protocols to follow when entering into an MOU between LGAs and MCPs in order to avoid duplication of services and activities. These protocols serve as the basis for this coordination that shall be used by LGAs when entering into the required MOUs.

Case Management

While both MCPs and TCM programs provide case management, there is a distinction between case management provided by TCM programs and by MCPs. The MCP 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 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 four component requirement applies to both TCM and MCP 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.

Roles

Medi-Cal Managed Care Health Plans

MCPs will partner with LGAs 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 MCP will oversee the delivery of primary health care and related care coordination. MCPs are 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 MCP covered health services will be the responsibility of the MCP.

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

LGA TCM Programs

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

Contacts

Contact parties will be designated at both the MCP and the LGA to facilitate the required coordination and to address any and all issues as they arise.

The MCP will designate a contact responsible for facilitating coordination with LGAs, including identifying the appropriate MCP contacts to the LGA and resolving all related operational issues. The MCP primary care provider (PCP), Case Manager, or plan designee, as determined by each MCP, will serve as the contact person for member MCP case management.

The LGA will designate a contact responsible for facilitating coordination with MCPs, including identifying the appropriate MCP contacts to the LGA, and resolving all related operational issues. The TCM Case Manager or LGA designee will serve as the contact person for all clients receiving TCM.

Client Identification

To facilitate proper coordination between the MCP and the LGA, the Department of Health Care Services (DHCS) will provide each MCP with electronic information identifying MCP clients receiving TCM services within the last three months.

MCPs will notify the member's PCP and/or any Case Manager that the member is receiving TCM services along with the appropriate LGA contact information. Additionally, the MCP will notify the LGA when the member is receiving TCM services and is also receiving complex case management from the MCP, either in batch or client-by-client basis monthly, and/or additionally, on request from the LGA.

In addition, the LGA will receive electronic information identifying to which MCP each client is assigned. LGAs will also query all TCM clients to determine if they are assigned an MCP for their primary medical care. Additionally, LGAs may request access to client managed care status and provider information via existing DHCS provider eligibility information access systems.

Coordination

MCPs and LGAs will share client/member care plans with one another upon request from either party for MCP members with open TCM cases. MCPs and LGA TCM programs 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. Both the MCPs and the LGA TCM programs will comply with Health Insurance Portability and Accountability Act (HIPAA) requirements when sharing medical information between MCPs and the LGA TCM program.

For any client/member with an open TCM case needing medical case management, the responsible MCP and LGA will communicate at least once every six months to ensure that the client/member is receiving the appropriate level of care. The coordination between the MCP and the LGA will include, at a minimum, all medical issues and all social support related issues identified by the MCP and/or by the LGA TCM program.

The detailed protocols below shall be used to ensure this coordination takes place in a manner serving all clients' needs and to ensure continuity of care.

Client Health Insurance Portability and Accountability Act Consents

Both the MCPs and the LGA will pursue obtaining HIPAA consents from both MCP members and LGA TCM clients to allow sharing of medical information between them.

Assessment and Care Plan Protocol

Medi-Cal Managed Care Health Plans

MCPs will provide health assessments and care plans for all members as needed.

- MCPs will assess all member medical needs and shall identify medically necessary social support needs, including required annual reassessments.
- MCPs 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.
- MCPs will share care plan information with the member's LGA TCM program as they determine necessary to coordinate member medical issues. In addition, MCPs will share care plans if requested by the LGA TCM program.
- MCP PCPs and Case Managers, when assigned, will communicate with the appropriate LGA TCM program contact to discuss client needs and/or coordinate as deemed necessary by either the MCP PCP/Case Manager or the LGA TCM Case Manager.

LGA TCM Programs

TCM services will be provided to clients who require services, which will assist them in gaining access to needed medical, social, educational, or other services per Title 42 CFR Section 440.169.

- LGAs 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.
- LGAs will share TCM care plans with MCPs if requested by the MCP.
 - Based on the assessment, 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.
 - All clients with open TCM cases will be referred to the MCP by the TCM Case Manager if client is in need of MCP case management for medical issues.

The TCM assessment extends further than the MCP 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 MCP care plan.

Any client qualifying for TCM either through the LGA or the MCP will have a TCM assessment and care plan created as described above. The care plan will include any need identified by the MCP. The LGA TCM Case Manager will coordinate with the MCP when the LGA TCM Case Manager determines, at a minimum, that:

- The MCP has identified that the client/member receives complex case management from the MCP, and the 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 their needs from a Case Manager or other MCP professional.
- The TCM Case Manager assesses that the client may have an acute or chronic medical issue, and is not medically stable.
- The TCM Case Manager assesses that the client's medical needs require case management.
- The TCM Case Manager assesses that the client may have social support issues that may impede the implementation of the MCP 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. The LGA 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 MCP. The LGA will also provide any corresponding documentation to the MCP PCP/Case Manager. This coordination will include, but not limited to, the following:

- The LGA TCM Case Manager will obtain and review the client/member MCP care plan.

- The LGA TCM Case Manager will contact the MCP PCP/Case Manager to discuss the client/member medical issues and/or related social support issues.
- The LGA TCM Case Manager will notify the MCP via an agreed medium (e.g. specific form, email to PCP), that the client/member is receiving TCM services and has identified a social support issue(s) that may impede the implementation of the MCP care plan.

For all other LGA TCM clients who are also MCP members, DHCS will provide client information to the MCPs and LGAs for TCM services provided in the last three months. Any additional coordination will occur as deemed necessary by either the MCP or the TCM Case Manager.

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

MCP Members Needing Immediate Case Management Intervention

The TCM Case Manager shall provide all necessary assessments, and care plans, medical or otherwise, to the MCP as soon as possible to address the client's/member's immediate medical need.

Referral, Follow Up, and Monitoring Protocol

Medi-Cal Managed Care Health Plans

MCPs 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
 - MCPs 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 a MCP 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.
 - MCP Case Manager provides a member with driving directions to the nearest vocational trade school. This would not constitute the need for TCM services.
- TCM Case Management for Non-Medical Needs.

- MCPs will refer members to the LGA for TCM services when the individual falls into one of the identified target populations, has undergone an MCP case management assessment, and meets any of the following criteria:
 1. Member is determined to be in need of case management services for non-medical needs.
 2. MCP has determined that the member has demonstrated an on-going inability to access MCP services.
 3. MCP has determined that member would benefit from TCM face-to-face case management.
 4. The MCP has concerns that the member has an inadequate support system for medical care.
 5. The MCP 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 MCP care plan.
- The MCP shall share information with the TCM Case Manager that informs the LGA TCM Case Manager of the issue for which the referral was made.
- Referral does not automatically confirm enrollment into a TCM program.

LGA TCM Programs

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 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.
- The TCM Case Manager will contact the MCP directly as needed to ensure the MCP, PCP, or Case Manager is aware of the client/member, and the client/member is receiving the proper care.

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

MCP Members Needing Immediate Case Management Intervention

The TCM Case Manager shall provide all necessary referrals as appropriate, medical or otherwise, to the MCP as soon as possible to address the client's/member's immediate medical need.

- TCM Case Managers will refer client to MCPs:
 - For all medically necessary services, and authorization for any out-of-network medical services.
 - When a medical need develops or escalates after an MCP assessment and notification of any related medically necessary support issues.
 - When the client needs assistance with medical related services.
 - Examples:
 - Scheduling appointments with PCP.
 - Delays in receiving authorization for specialty health services.
- Prior to referral for TCM, the MCP will identify the social, educational, and/or other non-medical issues the member has that require case management.
 - If the LGA 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.
 - The TCM Case Manager will provide linkage and referrals as needed, and will monitor and follow-up as appropriate.
 - The LGA may obtain and review the MCP's client care plan to assist in assessing the referred issue.
 - The TCM client case shall remain open until the issue referred by the MCP has been resolved, and no other TCM service is determined to be necessary by the LGA. The LGA will notify the MCP when the referred issues have been resolved.
 - When an MCP refers a member to the LGA for TCM services for any medically necessary or social support needs, coordination will take place as frequently as either the MCP or the TCM Case Manager deems necessary, but no less than quarterly.
- When a member is not referred to a TCM program by an MCP and enters the county health system through the LGA, the LGA will refer the member to an MCP as needed to provide and document MCP 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