1 PUBLIC HEALTH SERVICES

1.1 California Children's Services (CCS)

The County of San Diego, Health and Human Services Agency (HHSA), California Children Services (CCS) provides diagnostic and treatment services to eligible, physically disabled children through private medical resources and operates Medical Therapy Units in local schools. The MCP is responsible for establishing a provider network that will work with the County to meet the needs of its Medi-Cal members.

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1.1.1 **LIAISON**	a. Designate a liaison to the Plan, who will be the Program's point of contact for the health plan and its networks to coordinate all related activities. County CCS liaison will organize and coordinate CCS Work Group. b. County CCS staff also available for individual meetings with Plans if subject is particular to individual Plan. CCS contact information: California Children's Services 6160 Mission Gorge Road, Suite 400 San Diego, CA. 92120 Phone 619-528-4000 eFax: 858-514-6514 c. The CCS Work Group will meet, at a minimum, quarterly, to ensure ongoing communication; to resolve operational and administrative problems; and identify policy issues needing resolution at the management level.	a. Designate a liaison to CCS and/or require Plan networks to designate a liaison to coordinate and track referrals. Plan CCS liaison will attend CCS Work Group meetings. b. Attend, at a minimum, quarterly CCS Work Group meetings to facilitate ongoing communication; to resolve operational and administrative problems; and identify policy issues needing resolution at the management level.
1.1.2 **PROVIDER TRAINING**	a. Collaborate with Plan to assist with the development of CCS related policies and procedures, as needed by health plan and CCS. b. Collaborate with health plan to provide training opportunities that will give providers an understanding of the CCS Program and eligibility requirements. c. Provide availability of local Program medical consultant or designee to consult with providers and/or specialty providers on a case-by-case basis.	a. Develop local policies and procedures that will ensure that the providers are informed of CCS eligibility requirements, the need to identify potentially eligible children and refer to the CCS Program. b. Provide training opportunities, in conjunction with the local CCS Program and CCS Work Group, for providers that include organized provider groups and support staff, in order to ensure awareness and understanding of the CCS Program and eligibility requirements.

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	d. Identify training needs based upon input from quarterly Plan meeting or evaluation of referrals for services. e. Support ongoing training opportunities as needed.	c. Collaborate with CCS to develop training materials that will promote providers, specialty providers and hospitals understanding of the respective responsibilities of the health plan and the CCS Program in authorizing services for subscribers with a CCS eligible condition. d. Maintain training opportunities, on at least an annual basis.
1.1.3 **CCS PROVIDER NETWORK**	a. Provide Plans with CCS provider applications to expedite the paneling or approval of specialty and provider network. b. Coordinate with the state office to assure identification of local CCS provider network to health plan. c. Coordinate with Plan to refer to an appropriate CCS paneled specialty provider to complete diagnostic services and treatment as needed.	a. Develop a process to review Plan providers for qualifications for CCS provider panel participation and encourage those qualified to become paneled. b. Identify in trainings to providers and in the provider manual those facilities that are designated with CCS approval, including hospitals and Special Care Centers. c. Ensure access for diagnostic services to appropriate specialty care within the network or medical group. When appropriate specialist not available within network or medical group, ensure access to appropriate Plan specialist.
1.1.4 **CASE IDENTIFICATION AND REFERRAL**	a. Provide technical assistance to plans for the development of Plan policies, procedures, and protocols for making referrals to the Program, including necessary medical documentation. b. County will conduct a second review of a CCS denial if the Plan provides new medical documentation or additional explanation of why the denied referral is medically eligible. c. To the extent possible within available administrative resources, determine medical eligibility within five working days of receiving adequate medical documentation of the suspicion of a CCS eligible condition. d. If a Plan's referral for determination of medical eligibility to CCS exceeds 10	a. Develop procedures, in conjunction with the local CCS Program, for Plan or provider to submit the necessary documentation to determine medical eligibility at the time of referral. b. Develop procedures to specify that providers are to refer a subscriber to the CCS Program within one working day of a suspicion of the presence of a CCS eligible condition. (Referral date will identify the earliest possible date from which medically necessary services may be approved.) c. Inform families of subscribers of referral to the CCS Program and for the need to have care under the direction of an appropriate CCS paneled physician once Program

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	days and no action has been taken by CCS yet, Plan shall escalate to the designated CCS liaison in 1.1.1. e. Ensure that provider, designated Plan personnel, and subscriber family are informed of either Program eligibility or denial upon eligibility determination. f. Provide medical consultation as appropriate during the time period from referral to medical eligibility determination. g. Authorize from referral date medically necessary CCS benefits required to treat a subscriber's CCS eligible condition and be responsible for the reimbursement of care to authorized providers when CCS eligibility is established. h. Coordinate with Plan liaison to share a tracking list of CCS eligible persons who are known to the Plans. The list will include name; CCS case number; DOB; SSN (if known), Medi-Cal Client Identification Number (CIN), or other agreed upon identifier; CCS eligible diagnoses, date of eligibility and status; in case of denial or closure, reason for ineligibility and date closed; referral source and provider on file, if known. i. County will provide availability of County CCS Medical Consultant or medical designee to consult with the Plan Medical Director or designee regarding any eligibility concerns or referral problems that the Plan wishes to discuss. Upon Plan's request for a meeting, CCS County CCS Medical Consultant or medical designee will schedule this meeting within 14 days. j.	eligibility has been determined. e. Arrange for medically necessary care during the period after referral and prior to the CCS eligibility determination. (Medically necessary services provided by a CCS paneled provider during the interim may be authorized by the CCS Program for a condition determined to be CCS eligible.) f. Develop a monthly tracking list to include: name of referred subscriber, address, and telephone number; DOB; SSN (if known), Medi-Cal Client Identification Number (CIN) or other agreed upon identifier; Plan eligibility status; provider name, address, and telephone number; Plan number and enrollment/ disenrollment dates to be used for coordination and follow-up with the local CCS Program.
1.1.5 **CASE MANAGEMENT/**	a. Assist Plan in assessing and alleviating barriers to accessing primary and specialty care related to the CCS eligible condition. Assist	a. Utilize tracking system to coordinate health care services for members receiving services authorized by the

CATEGORY	CALIFORNIA CHILDREN SERVICES	MEDI-CAL MANAGED CARE PLAN
TRACKING AND FOLLOW-UP	subscriber/ subscriber family to complete enrollment into the CCS Program. b. Provide case management services in order to coordinate the delivery of health care services to subscribers with CCS eligible conditions, including services provided by other agencies and programs, such as Local Education Agencies and Regional Centers. c. Develop systems that will result in transmission of medical reports of services provided by CCS authorized providers to the appropriate Plan providers and to the referring Medi-Cal Managed Care Plan (MCP), including reports from the medical therapy clinics and conferences.	CCS Program. b. Develop policies and procedures that will specify providers' responsibility for coordination of specialty and primary care services. c. Develop policies and procedures that will specify coordination activities among providers, specialty providers and hospitals and communication with CCS Program case managers.
1.1.6 **QUALITY IMPROVEMENT AND MONITORING**	a. Conduct jointly with the plans, regular reviews of policies and procedures related to this MOA. b. Participate, at a minimum, in quarterly CCS Work Group meetings with the Plan to update policies and procedures as appropriate. c. Review and update protocol on an annual basis in conjunction with the health plan. d. Develop work plan in conjunction with the Plan that will monitor the effectiveness of the MOA and the Plan/CCS interface.	a. Conduct jointly with the CCS Program, regular reviews of policies and procedures related to this MOA. b. Participate, at a minimum, in quarterly CCS Work Group meetings to update policies and procedures as appropriate. c. Review and update protocols annually in conjunction with the CCS Program. d. Develop work plan in conjunction with CCS that will monitor the effectiveness of the MOA and the Plan/CCS interface.
1.1.7 **PROBLEM RESOLUTION**	a. Assign appropriate CCS Program management and professional/liaison staff to participate with health plan management staff in the resolution of individual subscriber issues, as they are identified. b. Assign appropriate CCS Program/ liaison staff to participate in, at a minimum, quarterly CCS Work Group meetings with health plan management/liaison staff to identify and resolve operational and	a. Assign appropriate health plan management/liaison staff to participate with the local CCS Program management and professional staff in the resolution of individual subscriber issues, as they are identified. b. Assign appropriate health plan management/liaison staff to participate in, at a minimum, quarterly CCS Work Group meetings to identify and resolve operational and

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	administrative issues, including coordination, communication, referral, training, billing, provision of appropriate services and authorization of services. c. County CCS Program will provide health plans with copy of local procedures. d. Refer issue to Department of Health Care Services-Integrated Systems of Care Division if problem cannot be resolved locally.	administrative issues, including coordination, communication, referral, training, billing, provision of appropriate services and authorization of services. c. Develop policies and procedures to implement this section. d. Refer issue to Department of Health Care Services-Integrated Systems of Care Division if problem cannot be resolved locally.

1.2 Child Health and Disability Prevention (CHDP) Program

HHSA Child Health and Disability Prevention (CHDP) Program is responsible for assuring that Medi-Cal eligible children, ages birth through 20, have access to routine and periodic preventive health care via a medical home. The MCP is responsible for establishing a provider network that will meet the needs of the Medi-Cal population assigned.

Both organizations share a common goal of assuring that Medi-Cal members receive preventive health care services based on the federal Early Periodic Screening Diagnosis and Treatment (EPSDT) mandates and the State CHDP medical guidelines.

CATEGORY	CHILD HEALTH AND DISABILITY PREVENTION PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.2.1 **LIAISON**	a. Designate CHDP liaison, who will be the Program's point of contact for the Plan and its networks to coordinate all related activities.	a. Designate Plan liaison to the CHDP Program, who will be the point of contact with CHDP to coordinate all related activities.
1.2.2 **PROVIDER CONSULTATION, TECHNICAL ASSISTANCE, AND TRAINING**	a. Consult with the Plan and providers regarding EPSDT and CHDP policies and guidelines, including ongoing policy and programmatic updates. b. Collaborate with Plan in provider training re: CHDP standards as well as other pediatric and public health issues as requested. c. Distribute provider notices in coordination with Plans. d. Assist Plan with evaluation of provider compliance with medical case	a. Require that all providers who see children and youth to age 21 for preventive health exams follow Bright Futures Guidelines as appropriate. b. Provide training to providers on CHDP standards and policies. c. Coordinate with local CHDP program for distribution of provider notices and coordinate with local CHDP staff to ensure provider trainings, provider performance, their offices, etc., are consistent with up-to-date CHDP/

CATEGORY	CHILD HEALTH AND DISABILITY PREVENTION PROGRAM	MEDI-CAL MANAGED CARE PLAN
	management responsibilities and proper use of community resources when requested. e. If CHDP providers or other entities identify Plan performance problems with CHDP guidelines, alert Plan. If problems cannot be resolved locally between CHDP and the Plan, refer issue to the State.	EPSDT program requirements. d. Evaluate and monitor provider activities and take appropriate corrective action when necessary. (This will be done in collaboration with CHDP program if provider is CHDP certified, and the problem affects CHDP certification.)
1.2.3 **PROVIDER NETWORK AND CERTIFICATION**	a. If requested, certify primary care providers to become CHDP providers. b. Assist Plan in performing provider site reviews and provider compliance with CHDP requirements, when requested.	a. May request CHDP certification for Plan providers by CHDP Program.
1.2.4 **DATA COLLECTION AND ANALYSIS**	a. Coordinate with Plan in data collection as requested. b. Review, analyze and share CHDP data with Plan. c. Review and analyze data if available for review of health assessments and problem identification, trends, oversights, inaccuracies, etc. Review this with Plan.	a. Coordinate with CHDP in data collection as requested. Review, analyze, and share data with CHDP if available through Plan reports for review of Health Assessments and problem identification, trends, oversights, inaccuracies, etc. Review these data with CHDP if requested.
1.2.5 **COMMUNITY HEALTH STATUS MONITORING**	a. Monitor county-wide prevalence and trends of conditions related to the child health status and health care, and if requested, provide assistance to the Plan to analyze Plan data.	
1.2.6 **MEMBER OUTREACH**	a. Conduct outreach to potential Medi-Cal eligible persons, 0-20 years of age. b. Maintain responsibility for development of CHDP/DSS Inter-Agency Agreement to ensure that face-to-face informing about entitlement to CHDP services is done by Social Services Agency (SSA). c. Provide intensive informing, referral, and documentation to persons referred by DSS using the PM 357 form or its replacement following SSA basic informing efforts.	a. Inform members 0-20 years of age of their entitlements, including availability of CHDP services, e.g., preventive and well care, by mail, handbooks, newsletter articles, etc. b. Ensure that members 0-20 years of age are assigned to appropriate providers. c. If requested, provide CHDP office with a current list of Plan providers for members 0-20 years of age. d. Contact members 0-20 years of age not utilizing preventive health services on an ongoing basis after provider

CATEGORY	CHILD HEALTH AND DISABILITY PREVENTION PROGRAM	MEDI-CAL MANAGED CARE PLAN
	d. Assist with outreach to Plan's members not utilizing preventive health services when Plan contact efforts have failed. e. Inform Plan providers of funding mechanisms for those under 200 percent of poverty level for Medi-Cal eligible persons (0-20 years of age) who lose full scope eligibility and/or for family members 0-20 years of age who are not Medi-Cal beneficiaries.	member contact has failed. These member contact efforts include preventive care notices and/or phone contacts. Members will be referred to CHDP for outreach assistance as needed if Plan contact efforts have failed. e. Ensure provider trainings include information regarding funding mechanisms for children under 200 percent of poverty who are ineligible for Medi-Cal benefits, in order to obtain CHDP screenings and wellness exams.
1.2.7 **TRACKING AND FOLLOW-UP**	a. Collaborate with health plans to explore the feasibility of assisting plans with tracking high-risk, hard-to-reach plan members, including those lost to care (e.g., multiple missed appointments, no services utilized) and disenrolled. Protocol shall include reporting mechanisms to primary care provider and/or Plan. b. Support and provide technical consultation to providers in various areas, including assistance in making referrals to appropriate community agencies and other resources. c. Provide follow-up for children beginning at one year of age to assure referral to a dental home, when requested.	a. Collaborate with CHDP to explore the feasibility of CHDP assisting plans with tracking high risk, hard to reach plan members, including those lost to care (e.g., multiple missed appointments, no services utilized) and disenrolled. Protocol shall include reporting mechanisms to primary care provider by the Plan. b. If requested, share available information with the CHDP program regarding the member's specific provider and the CHDP services provided c. Inform providers of the need to provide and document primary case management, including: • Coordination of care • Medical referrals • Continuity of care • Follow-up on missed appointments d. Inform parents/guardians about the importance of initial dental assessment for members beginning at six months of age or when the first tooth erupts. e. Notify Plan members when periodic exams are due.

CATEGORY	CHILD HEALTH AND DISABILITY PREVENTION PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.2.8 **APPOINTMENT SCHEDULING AND TRANSPORTATION ASSISTANCE**	a. Follow-up on requests from providers and from members for member assistance with appointment scheduling, dental referrals, and transportation assistance; coordinate with Plan member services or per Plan policy.	a. Inform providers of their responsibility for assisting members in scheduling medical appointments. b. Offer assistance in scheduling appointments for covered medical services and transportation for those services. May refer member to CHDP program for further assistance.
1.2.9 **MEMBER HEALTH EDUCATION**	a. Make health education resources available to providers that support the provision of anticipatory guidance during the CHDP exam.	a. Instruct and support providers to provide anticipatory guidance to children and teens according to Bright Futures guidelines.
1.2.10 **QUALITY ASSURANCE, MONITORING AND PROBLEM RESOLUTION**	a. Meet with the Plan as needed to ensure ongoing communication. b. Review and update protocols on an as needed basis in conjunction with the health plan. c. If an issue arises, CHDP liaison can request a meeting with Plan liaison to identify and resolve operational and administrative issues including, but not limited to: coordination, communication, referrals, training, and provision of appropriate services. d. Participate in Healthy San Diego Quality Improvement (QI) subcommittee or other appropriate meetings with Plan to update this MOA as appropriate.	a. Meet with CHDP liaison/CHDP staff as needed to ensure ongoing communication. b. Review and update protocols on an as needed basis in conjunction with the CHDP Program. c. If an issue arises, Plan liaison can request a meeting with Program liaison to identify and resolve operational and administrative problems including, but not limited to: coordination, communication, referrals, training, and provision of appropriate services. d. Participate in Healthy San Diego Quality Improvement (QI) subcommittee or other appropriate meetings with Program to update this MOA as appropriate.

1.3 Community Epidemiology

Community Epidemiology programs (operated by HHSA Public Health Services, Epidemiology and Immunizations Services Branch) are dedicated to identifying, preventing, and controlling communicable diseases and reportable conditions through a county-wide reporting system which includes, among others, health care providers, public institutions, childcare providers, and Childhood Lead Poisoning Prevention Program case management. The MCP is also committed to working with the County in its efforts to protect its members from communicable diseases and in providing services to meet the needs of its Medi-Cal members.

CATEGORY	COMMUNITY EPIDEMIOLOGY	MEDI-CAL MANAGED CARE PLAN
1.3.1 **LIAISON**	a. Designate a Community Epidemiology Branch (CEB) Plan liaison to coordinate with the Plan and to inform CE staff of their roles and responsibilities.	a. Designate Plan liaison to coordinate activities with CEB as a point of contact.
1.3.2 **PROVIDER CONSULTATION, TECHNICAL ASSISTANCE AND TRAINING**	a. Consult with Plan and providers regarding reporting requirements as stated in Title 17, California Code of Regulations (CCR), Section 2500 Reportable Diseases and Conditions. b. Consult with Plan and providers regarding mandated HIV reporting regulations as stated in Title 17, CCR, Sections 2641.5 through 2645 and provide training as requested. c. Provide Plan providers with consultation for infectious disease precautions, prevention, prophylaxis, diagnosis, treatment, and follow-up of members. d. Assist Plan in conducting provider training on reporting requirements, if requested. e. Provide information on current communicable disease issues through HHSA "Physicians' Bulletin." f. Provide professional materials/resources, as available.	a. Notify providers of availability of CEB program consultation and training for disease reporting, including new HIV reporting regulations. b. Coordinate with CEB staff to provide provider training.

1.3.3 **DISEASE REPORTING**	a. Provide Plan with appropriate reporting forms (Attachments 1.1, 1.2, 1.3 & 1.4) for reportable diseases as described in the California Code of Regulations, Title 17, Section 2500. b. Assist providers in following disease reporting mandates; oversee the disease reporting process, including accuracy, and completeness of information provided. c. Provide Plan and Plan's clinical laboratories with lists of reportable diseases, including required member information and guidelines for providing this information to the CEB program. d. Notify Plan about outbreak investigations and disease control activities through various communication networks.	a. Notify providers of the requirement to submit completed reportable disease reports as described in the California Code of Regulations, Title 17, Section 2500. b. Encourage providers to promptly notify the local health officer of any unusual disease occurrences (e.g., Bioterrorism agents). c. Notify providers about outbreak investigations and disease control activities. d. Notify providers of CEB 24-hour contact information: Business Hours: 619-515-6620; After Hours: 1-858-565-5255.
1.3.4 **COMMUNITY HEALTH STATUS MONITORING**	a. Maintain disease prevalence and trends, provide surveillance reports to Plan.	a. Monitor surveillance trends based on reports provided by the County.
1.3.5 **PROVISION OF SERVICES FOR CHILDHOOD LEAD POISONING PREVENTION PROGRAM (CLPPP)**	a. Provide Case Management and Early Prevention services for children identified with lead poisoning meeting program criteria. b. Assist Plan with educating providers on lead testing policies and local sources of lead poisoning. c. Offer provider training and fingerstick training.	a. Encourage providers to follow required CHDP guidelines for lead testing and assess particular member needs for County Lead Poisoning Prevention Program services, i.e., in-home evaluation and environmental assessment. Refer if appropriate. b. Educate providers on current CHDP guidelines regarding lead testing policies and reimbursements.
1.3.6 **CONTACT INVESTIGATION**	a. Advise on control of spread of infectious disease and advise on prophylactic measures and prevention strategies as needed. b. Intervene with information for contacts as needed. c. Provide Plan with recommendations for prophylaxis as needed.	a. Inform providers regarding importance of rapid notification of contacts so that appropriate prevention strategies can be carried out.

1.3.7 **MEMBER HEALTH EDUCATION**	a. Provide member education materials.	a. Provide health education information to members about communicable disease.
1.3.8 **CLAIMS MANAGEMENT & REIMBURSEMENT**	a. The County has the option to bill Plan at the current Medi-Cal fee-for-service rates and according to health plan billing policy and procedures. b. If the County does not bill and if the member identifies they are in a Plan and signs a release of confidential information form, County sends encounter information to the Plan.	a. Health plan will reimburse the County according to health plan billing policies and procedures if County requests reimbursement and services were needed and appropriately given.
1.3.9 **PROBLEM RESOLUTION**	a. If an issue arises, CEB liaison can request a meeting with Plan liaison to identify and resolve operational and administrative issues, including coordination, communication, referral, training, and the provision of appropriate resources.	a. If issues arise, Plan liaison can request a meeting with Program liaison to identify and resolve operational and administrative issues, including coordination, communication, referral, training, and the provision of appropriate services.
1.3.10 **QUALITY IMPROVEMENT AND MONITORING**	a. Conduct jointly with Plan, regular reviews of policies and procedures related to in this MOA. b. Participate in Healthy San Diego Quality Improvement (QI) subcommittee meetings with Plans to update this MOA as appropriate.	a. Conduct jointly with Program, regular reviews of policies and procedures related to in this MOA. b. Participate in Healthy San Diego Quality Improvement (QI) subcommittee meetings with Program to update this MOA as appropriate.

1.4 Immunization Program

HHSA Immunization Program is committed to protecting the County's residents from those communicable diseases that are preventable by vaccination. The MCP is committed to protecting the health of its Medi-Cal members through the provision of quality preventive services and age-appropriate immunizations.

CATEGORY	IMMUNIZATION PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.4.1 **LIAISON**	a. Designate an Immunization Program (IP) liaison to the Plan to coordinate all related activities.	a. Designate a Plan liaison to the Immunization Program as a point of contact.
1.4.2 **PROVIDER CONSULTATION AND TECHNICAL ASSISTANCE**	a. Consult with Plan and providers regarding immunization policies, procedures, and guidelines, including ongoing policy and programmatic updates. b. Collaborate with Plan in provider training regarding pediatric and youth immunization standards as requested. c. Provide consultation on vaccine risks/ benefits and valid/invalid contraindications. d. Provide information regarding schedule changes to providers through HHSA "Physicians' Bulletin." e. Provide community-wide professional educational opportunities. Provide "in-office" immunization management consultative services, such as assessment of level of immunization coverage for infants and toddlers in providers practices. f. Provide professional materials/resources, as available. g. Provide consultation on vaccine-preventable disease diagnosis, treatment, contact follow-up and management.	a. Require that all providers who see children and youth to age 21 follow the current year Recommended Childhood Immunization Schedule, United States. b. Collaborate with IP and provide training to providers on immunization standards and policies. c. Notify providers of availability of IP consultation and immunization coverage level in practices. d. Notify and encourage providers to utilize IP distance learning and other training/ education programs. e. Notify providers about availability of IP infant and toddler member follow-up services and prerequisite provider outreach activities. f. Notify providers about the State's expectations for providers to participate in the San Diego Immunization Registry.

1.4.3 **DISEASE REPORTING**	a. Provide Plan with appropriate reporting forms (Attachments 1.1, 1.2, 1.3 & 1.4) for reportable diseases as described in the California Code of Regulations, Title 17, Section 2500. b. Assist providers in following disease reporting mandates; oversee the disease reporting process, including accuracy and completeness of information provided. c. Provide the Plan information about outbreak and disease control activities.	a. Inform providers of the requirement to submit timely completed reportable disease reports as described in the California Code of Regulations, Title 17, Section 2500. b. Notify providers about outbreak and disease control activities.
1.4.4 **COMMUNITY HEALTH STATUS MONITORING**	a. Monitor vaccine-preventable disease prevalence and trends. b. Monitor community immunization coverage levels.	
1.4.5 **PROVISION OF VACCINE**	a. Provide information about Vaccines for Children (VFC) Program so Plan's providers can obtain free vaccines.	a. Inform providers about VFC and encourage them to obtain the vaccine.
1.4.6 **PROVISION OF SERVICES**	a. Provide routine immunization services to encourage access by all citizens. b. Inform members of their rights regarding release of confidential information to their Plan provider. c. Encourage the members to obtain follow-up services from their Plan providers.	a. Require that providers fully immunize members according to current year Recommended Childhood Immunization Schedule, United States.
1.4.7 **CLAIMS MANAGEMENT AND REIMBURSEMENT**	a. The County has the option to bill the Plan at the current Medi-Cal fee-for-service rate according to health plan billing policy and procedures. The County obtains a signed release of information from the member. b. If the County does not bill and if the member identifies they are in the Plan and signs a release of confidential information form, County sends encounter information to the Plan.	a. Health plan will reimburse the County according to health plan billing policies and procedures if County requests reimbursement and services were needed and appropriately given.

1.4.8 **MEMBER OUTREACH**	a. Assist in locating children under two (2) years of age who fail to return for follow-up, assess immunization status, and where indicated, assist family in returning to Plan's provider through the Registry. b. Provide results of outreach to provider through the Registry and by monthly letter. c. Provide access to San Diego Immunization Registry. d. Provide reminder/recall advice when requested. e. Provide the Plan with outreach Program information.	a. Inform providers of availability of infant-to-toddler outreach services through the Registry. b. Inform providers of the following prerequisite activities: (1) utilize the Registry, (2) conduct one patient reminder, and (3) contact families of members under the age of two (2) years lacking recommended immunizations to encourage their return to providers. Children failing to return may be referred to IP.
1.4.9 **MEMBER HEALTH EDUCATION**	a. Provide member education materials. b. Provide community-wide member education campaigns.	a. Provide health education information to members about immunizations.
1.4.10 **PROBLEM RESOLUTION**	a. If an issue arises, IP liaison can request a meeting with Plan liaison to identify and resolve operational and administrative issues, including coordination, communication, referral, training, and the provision of appropriate services. b. Refer issue to State Immunization Branch if problem cannot be resolved locally between the Plan and Immunization Program.	a. If an issue arises, Plan liaison can request a meeting with Program liaison to identify and resolve operational and administrative issues, including coordination, communication, referral, training, and the provision of appropriate services. b. Refer issue to State Immunization Branch if problem cannot be resolved locally between the Plan and Immunization Program.
1.4.11 **QUALITY ASSURANCE AND MONITORING**	a. Conduct jointly with Plans, regular reviews of this MOA. b. Participate in Healthy San Diego Quality Improvement (QI) subcommittee meetings with Plan to update this MOA as appropriate. c. To assist Plan in meeting HEDIS measures related to program services.	a. Conduct jointly with Program, regular reviews of this MOA. b. Participate in Healthy San Diego Quality Improvement (QI) subcommittee meetings with Program to update this MOA as appropriate. c. Notify IP of needs related to HEDIS measures.

1.5 Hansen's Disease (HD) Program

The HHSA Hansen's Disease (HD) Program is responsible for assuring that all residents of San Diego have access for the evaluation and treatment of suspected and/or active HD. The MCP is responsible for establishing a network of certified providers or referring to the local HD control program to manage and treat members with suspected or active HD. Both agencies share common goals of the control of active communicable diseases and the prevention of deformity and disability by using national programmatic guidelines for the treatment of HD.

CATEGORY	HANSEN'S DISEASE PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.5.1 **LIAISON**	a. Appoint HD Program Manager, or designee, as liaison to coordinate activities with the Plan and to notify HD staff of their roles and responsibilities.	a. Designate a HD liaison to coordinate activities with HD Program staff and to notify Plan staff of their roles and responsibilities.
1.5.2 **PROVIDER CONSULTATION AND TECHNICAL ASSISTANCE *(See Section 1.5.11 Provider Certification)***	a. Provide ongoing technical assistance to certified providers, including programmatic updates and consultation.	
1.5.3 **DISEASE REPORTING**	a. Provide the Plan with California Morbidity Report (CMR) forms and guidelines for reporting. Monitor the disease-reporting process, including accuracy and completeness of information provided. b. Complete surveillance report (CDC 52.18 REV 8-84); route to State HD and National Program.	a. Notify HD program of suspected or confirmed Hansen's Disease members. b. Submit Confidential Morbidity Report (CMR) Card to the HD program.
1.5.4 **COMMUNITY HEALTH STATUS MONITORING**	a. Monitor county-wide prevalence and trends, provide data to the Plan, and if requested, provide assistance to the Plan to analyze Plan data.	
1.5.5 **PROVISION OF SERVICES**	a. Provide diagnostic and treatment services for all patients referred from the Plan. b. Assess Plan enrollees that "self-refer"	a. The Plan's providers that have County HD provider certification may provide diagnostic and treatment services. b. Provide protocols and information to

CATEGORY	HANSEN'S DISEASE PROGRAM	MEDI-CAL MANAGED CARE PLAN
	and if not in need of immediate care, refer back to the Plan for care. Communicate and coordinate with the Plan HD liaison to ensure patient is referred to and seen by a Plan certified provider. c. Provide services in accordance with the Standards of the National Ambulatory Hansen's Disease Program.	providers as to when and how to refer their patients to County HD Program. c. Provide services in accordance with the Standards of the National Ambulatory Hansen's Disease Program.
1.5.6 **REIMBURSEMENT**	a. Obtain signed release of confidential information from the referred patients in order to release information to the providers that referred them. b. Provide all required encounter data for patient being billed to the Plan for each visit, medication issued, etc., with each claim submitted to the Plan for reimbursement at the current Medi-Cal fee-for-service rates within 90 days of the encounter.	a. Inform members that they are being referred to experts within the County for diagnosis and treatment and that the Plan will pay the County for this care and the County will inform the Plan's provider about the member's care (after the member signs the release of information). b. When a claim has been satisfactorily submitted, reimburse the County at the current Medi-Cal fee-for-service rates within 90 days of receipt of satisfactory claim.
1.5.7 **PATIENT OUTREACH**	a. Provide targeted outreach to disenrolled persons as identified from Enrollment Unit's information or by Plan. Ensure new Plan is immediately informed about patient's HD diagnosis (per confidentiality guidelines) or if patient is no longer eligible for Medi-Cal that patient obtains services from HD Program. (They may have previously received services from HD Program, but with reimbursement to the County from the Plan.)	a. Inform patients with active HD of need to immediately obtain care from new Plan if they change Plans, or go to County HD program if no longer eligible for Medi-Cal.
1.5.8 **CONTACT FOLLOW UP**	a. Assist in locating and the follow-up of hard-to-reach Plan patients who are contacts. b. Perform screening exams on contacts who are non-Plan members.	a. Ensure that the close contacts of members are screened for clinical evidence of HD per HD program protocols by either (a) referral to certified provider in the Plan (if contact is a Plan member), or (b) referral to HD program.
1.5.9 **PATIENT HEALTH EDUCATION**	a. Provide community education regarding HD. b. Make patient education resources available to the Plan's certified	a. Certified providers of the Plan managing a member with HD should provide education to the member with HD.

CATEGORY	HANSEN'S DISEASE PROGRAM	MEDI-CAL MANAGED CARE PLAN
	providers treating members with HD.	
1.5.10 **MEDICAL CASE MANAGEMENT**	a. Assist Plan in identifying and following high risk, hard-to-reach Plan members. b. Provide medical case management for those Plan members that are referred to the County for out-of-Plan service.	a. Ensure that certified Plan providers that are caring for a member with HD provide and document medical case management activities which include: coordination of care; medical referrals; continuity of care; and follow-up on missed appointments. b. Request help from County HD for follow-up if member is missing appointments and is hard to reach.
1.5.11 **PROVIDER CERTIFICATION**	a. Provide mechanism for certification if requested by service provider in Plan. b. Inform service providers about training programs at National Ambulatory Hansen's Disease Center conducted semi-annually and facilitate access. c. Review certification applications and approve or disapprove. If disapproved, provide reasons and provide an appeal process.	a. All providers of services for HD patients must have certification from the HD Program. Plan will issue referral to an out-of-plan provider if there is no certified provider within the Plan. b. Initial certification: Each provider must have an established system for formal case consultation with the HD Program Medical Director. Provider must have provided care to an appreciable number of patients with active HD over the last two years. Past cases must be submitted for HD Medical Director and Program Manager review to assure that required services were performed. If the provider does not have this experience, the provider must submit proof of completion of training within the last two years at the National Hansen's Disease Center in Louisiana. c. Annual certification: Each provider must have an established system for formal case consultation with the HD Program Medical Director. All cases treated since initial certification must be submitted for HD Program review to assure that required services were performed. If they were not, the provider will be decertified until the provider submits proof of completion of training at the National Hansen's Disease Center at Carville, Louisiana.

1.6 Sexually Transmitted Disease (STD) Control Program

The HHSA Sexually Transmitted Disease (STD) Control Program oversees and directs policy for the prevention and control of STDs for the citizens of San Diego County. An objective of the STD Program is to assure that members have easy access to quality prevention and clinical services primarily for the control of bacterial (i.e., curable) STDs. The MCP is committed to providing quality STD prevention and control services.

CATEGORY	SEXUALLY TRANSMITTED DISEASE CONTROL PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.6.1 **LIAISON**	a. Appoint the STD Control Officer or designee as the liaison person to coordinate activities with the Plan, facilitate timely exchange of specific information, and notify STD Program staff of their roles and responsibilities.	a. Designate a STD liaison person to facilitate timely exchange of specific information and to inform Plan staff of their roles and responsibilities in regard to STD services. b. Work in concert with STD Program to coordinate rapid response to STD disease outbreak situation involving Plan members.
1.6.2 **PROVIDER CONSULTATION, TECHNICAL ASSISTANCE AND TRAINING**	a. Provide Plan and providers with consultation for STD diagnosis, treatment, follow-up, and referral of Plan members. b. Provide updated information on STD prevention and control standards and guidelines. c. Assist Plan, if requested, in developing risk-assessment tools and screening protocols. d. If requested, assist Plan in policy development for prevention and control of STDs in a managed care setting. e. Assist Plan in conducting provider training on STD clinical standards and treatment guidelines, as well as on reporting requirements if requested.	a. Inform Plan providers that STD Program consultation is available. b. Encourage providers to attend available trainings on STD clinical standards and treatment guidelines, as well as on reporting requirements. c. Disseminate reporting requirements and STD clinical and treatment guidelines to providers.
1.6.3 **DISEASE REPORTING**	a. Provide the Plan with Confidential Morbidity Report (CMR) forms and guidelines for reporting and monitoring the disease-reporting process, including accuracy and completeness of information provided.	a. Require providers to send to County STD Program completed Confidential Morbidity Reports (CMRs) on Plan members with reportable STDs as described in the California Code of Regulations, Title 17, Division 1,

CATEGORY	SEXUALLY TRANSMITTED DISEASE CONTROL PROGRAM	MEDI-CAL MANAGED CARE PLAN
	b. Provide the Plan's clinical laboratories with lists of reporting requirements, including required member information and guidelines for providing these data to the STD program.	Chapter 4, Subchapter 1, Article 1. b. Ensure the Plan's clinical laboratories provide County STD program with required information on Plan members with reportable STDs as described in the California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 1, Article 1.
1.6.4 **COMMUNITY HEALTH STATUS MONITORING**	a. Monitor Countywide STD disease prevalence and trends, provide data to the Plan, and if requested, provide assistance to the Plan to analyze and evaluate Plan data.	
1.6.5 **PROVISION OF SERVICES**	a. In County STD Clinic, provide STD screening, diagnosis, counseling/education, and treatment for Plan members (if member requests), including sensitive services to minors (age 12 and over) without prior authorization for diagnosis and treatment of STDs. b. Inform Plan members of their rights regarding release of confidential information to their Plan provider. c. Encourage members to obtain follow-up services from their Plan providers.	a. Provide STD screening, diagnosis, counseling/education, and treatment for its members, including sensitive services to minors (age 12 and over) for diagnosis and treatment of STDs. b. Make available to providers STD risk-assessment tools for all Plan members and screening protocols for asymptomatic Plan members. c. Inform all Plan members of their right to access out-of-Plan STD services without prior authorization, including sensitive services for minors without parental consent. Inform members of their rights to confidentiality. Also inform Plan members that these services are available at County STD clinics. d. Services shall be provided in accordance with the latest Centers for Disease Control and Prevention (CDC) standards.
1.6.6 **CONTINUITY OF CARE**	a. Encourage Plan members to obtain follow-up services from their Plan providers. b. If the County does not bill and if the Plan member requests that information be sent to the Plan and signs a release of confidential information form, County sends the	a. Encourage providers to provide appropriate follow-up care and request information from the County if Plan member signs release of information form.

CATEGORY	SEXUALLY TRANSMITTED DISEASE CONTROL PROGRAM	MEDI-CAL MANAGED CARE PLAN
	clinical record to the provider.	
1.6.7 **CLAIMS MANAGEMENT AND REIMBURSEMENT**	a. The County has the option to bill the Plan at the current Medi-Cal fee-for-service rate and shall provide encounter data for the Plan member being billed. The County shall obtain the signed release of information form from the Plan member.	a. Health plan will reimburse the County according to health plan billing policies and procedures, if the County requests reimbursement and services were needed and appropriately given.
1.6.8 **PARTNER NOTIFICATION AND REFERRAL**	a. Locate sex partners of infected Plan members according to STD Program disease control priorities, and ensure they are tested and receive appropriate counseling and treatment. b. Advise Plan on partner-referral efforts and assist in locating and follow-up of hard-to-reach Plan member partners.	a. Inform providers regarding the importance of rapidly notifying sex partners of infected Plan members so they can be tested and receive appropriate counseling and treatment at the earliest opportunity. b. Encourage providers to contact the Plan member's sex partners who are Plan members to ensure they are tested, treated, and counseled according to (CDC) partner management guidelines. Request assistance from County STD Program for hard-to-reach partners according to established protocol. Notification of sex partners shall be done directly by the provider and not through Plan administration. c. Encourage providers to ensure that Plan members who are sexual contacts to a Plan member who has an STD are tested, treated, and counseled in accordance with STD management best practices and clinical guidelines.

CATEGORY	SEXUALLY TRANSMITTED DISEASE CONTROL PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.6.9 **MEMBER HEALTH EDUCATION**	a. Provide technical assistance to Plans on needs of target population and assistance in designing appropriate health education programs. b. Provide health education technical assistance, assist in training and choosing STD-specific educational materials for Plan providers to enhance their ability to assess high-risk individuals and deliver effective STD health education programs. c. Provide technical assistance to Plan and providers to improve quality and effectiveness of STD prevention education efforts for Plan members.	a. Provide STD Program with update on needs of Plan members and design of existing health education programs when requesting technical assistance. b. Offer health education information to providers that they can use for their Plan members at risk for STDs, including materials on the prevention of STDs and availability of screening and treatment. c. With assistance from the STD Program, provide training and resources to Plan providers to enhance their ability to assess high-risk individuals and deliver effective STD health education programs. (May request County assistance for this.)
1.6.10 **PROBLEM RESOLUTION**	a. If an issue arises, STD liaison can request a meeting with Plan liaison to identify and resolve operational and administrative issues, including coordination, communication, referral, training, and the provision of appropriate services. b. Refer issue to California Department of Public Health (CDPH) STD Control Branch if problem cannot be resolved locally between the Plan and STD program.	a. If an issue arises, Plan liaison can request a meeting with STD Program liaison to identify and resolve operational and administrative issues, including coordination, communication, referral, training, and the provision of appropriate services. b. Refer issue to California Department of Public Health (CDPH) STD Control Branch if problem cannot be resolved locally between the Plan and STD Program.
1.6.11 **QUALITY ASSURANCE AND MONITORING**	a. Conduct jointly with Plans, regular reviews of this MOA. b. Participate in Healthy San Diego Quality Improvement (QI) subcommittee meetings with Plan to update this MOA as appropriate.	a. Conduct jointly with Program, regular review of this MOA. b. Participate in Healthy San Diego Quality Improvement (QI) subcommittee meetings with STD Program to update this MOA as appropriate.

1.7 Office of AIDS Coordination (OAC) Program

The HHSA Office of AIDS Coordination (OAC) is responsible for the development and coordination of a comprehensive continuum of services for the prevention of HIV disease and for the provision of care and treatment services to persons living with HIV/AIDS. The Medi-Cal Managed Care Plan is committed to working with the County in protecting the health of its Medi-Cal members, in encouraging its members to determine their HIV status, and in ensuring access to standard-of-care medical services for HIV+ members.

CATEGORY	OFFICE OF AIDS COORDINATION PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.7.1 **LIAISON**	a. Designate OAC liaison to coordinate with the Plan and to inform OAC staff of their roles and responsibilities.	a. Designate Plan liaison to OAC as a point of contact.
1.7.2 **PROVIDER CONSULTATION, TECHNICAL ASSISTANCE AND TRAINING**	a. Consult with Plan and providers regarding Centers for Disease Control and Prevention (CDC) Standards and Guidelines for HIV Counseling, Testing, and Referral. b. Consult with Plan and providers regarding Department of Health and Human Services (DHHS) HIV/AIDS Treatment Guidelines. c. Assist Plan in conducting provider training on HIV standards and guidelines, and on the availability of community resources and services, as requested.	a. Inform providers that OAC staff consultation is available. b. Coordinate with OAC for provider training on HIV Counseling, Testing, and Referral Standards and Guidelines, as needed. c. Coordinate with OAC for provider training on HIV/AIDS Treatment Guidelines, as needed.
1.7.3 **COMMUNITY HEALTH STATUS MONITORING**	a. Coordinate with Community Epidemiology to monitor county-wide disease prevalence and trends, provide data to the Plan, and if requested, provide assistance to the Plan to analyze and evaluate Plan data.	a. Inform providers of their requirements to submit completed reportable disease reports for HIV and AIDS as described in the California Code of Regulations, Title 17, Section 2465.

1.7.4 **PROVISION OF SERVICES**	a. In County HIV testing sites, provide HIV screening, counseling, and education for Plan members, subject to member request, on an anonymous or confidential basis. b. Inform members of their rights regarding release of confidential information to their Plan provider. c. Encourage the members to obtain services from their Plan providers. d. Provide referrals to HIV Positive Early Intervention Program services for Plan members meeting Program criteria. e. Provide HIV outreach and public education campaigns in accordance with locally developed plans and priorities.	a. Recommend that providers provide HIV risk assessment, screening, diagnosis, counseling/education, and treatment for members. b. Recommend that all members are informed of their rights to access out-of-Plan anonymous or confidential testing, counseling, and education without prior authorization. Inform members of their rights to confidentiality. Also, inform members that these services are available at County HIV testing sites and assist in making referrals upon request. c. Recommend that providers provide HIV Counseling, Testing, and Referral Services in accordance with Centers for Disease Control and Prevention (CDC) Standards and Guidelines, including offering HIV information, counseling, and testing to all pregnant Plan members not previously identified as HIV+. d. Recommend that providers provide HIV treatment services in accordance with Department of Health and Human Services (DHHS) HIV/AIDS Treatment Guidelines, as appropriate. e. Recommend that providers assess per protocol particular member needs for County HIV Positive Early Intervention Program, i.e., for case management, education, and social support. Refer as appropriate.

CATEGORY	OFFICE OF AIDS COORDINATION PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.7.5 **REIMBURSEMENT AND CLAIMS MANAGEMENT**	a. If HIV testing is provided on a confidential basis, the County has the option to bill the Plan at the current Medi-Cal fee-for-service rate and provide encounter data on the member to be billed. The County obtains a signed release of information from the member.	a. The plan will cover at the Medi-Cal fee-for-service rates the charges for services. The plan will reimburse the County according to health plan billing policies and procedures, if the County requests reimbursement and the services were needed and appropriately provided.
1.7.6 **INFORMATION SHARING**	a. If the County does not bill the member in a confidential setting, and if the member identifies they are in the Plan, the County will encourage the member to sign a release of confidential information form, County sends encounter information to the Plan. The ultimate decision to release information to the Plan will be at the client's discretion.	
1.7.7 **MEDICAL RECORDS DOCUMENTATION AND CONFIDENTIALITY**		a. Recommend that providers implement procedures for documenting HIV status in the medical records that ensure member's confidentiality in compliance with State law. (Health and Safety Code (HSC), sec. 120980; Civil Code, sec. 56 et seq.)
1.7.8 **DEVELOPMENT OF SCREENING PROTOCOLS**		a. Recommend that providers implement HIV screening protocols that ensure compliance with State law regarding obtaining consent for confidential testing (HSC sec. 120990) and obtaining consent for disclosure of HIV test results (HSC sec. 120980 & 121010).

CATEGORY	OFFICE OF AIDS COORDINATION PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.7.9 **PARTNER COUNSELING AND REFERRAL**	a. Upon receipt of a referral obtained with appropriate education, counseling, and voluntary consent, identify, educate, and counsel non-Plan members who are sex and/or needle sharing partners of HIV positive Plan members, upon request of the provider or Plan. b. Provide provider training on Partner Counseling and Referral Services and Guidelines, as requested.	a. Inform providers regarding the importance of rapid notification of contacts and State law (HSC 121015) regarding education, counseling, and acquisition of voluntary consent to notify contacts, so that appropriate prevention strategies can be carried out. b. Notify providers of their ability to refer to OAC the notification of an HIV+ Plan member's contacts, upon the voluntary informed consent of the Plan member.
1.7.10 **PLANNING AND POLICY DEVELOPMENT**	a. Assist Plan in developing appropriate HIV screening, prevention, and treatment plans, as requested.	a. Inform providers that OAC consultation is available.
1.7.11 **PROBLEM RESOLUTION**	a. If an issue arises, OAC liaison can request a meeting with Plan liaison to identify and resolve operational and administrative issues, including coordination, communication, referral, training, and the provision of appropriate services.	a. If an issue arises, Plan liaison can request a meeting with Program liaison to identify and resolve operational and administrative issues, including coordination, communication, referral, training, and the provision of appropriate services.
1.7.12 **QUALITY IMPROVEMENT AND MONITORING**	b. Conduct jointly with Plans, regular reviews of this MOA. c. Participate in Healthy San Diego Quality Improvement (QI) sub-committee meetings with Plan to update this MOA as appropriate.	a. Conduct jointly with Program, regular reviews of this MOA. b. Participate in Healthy San Diego Quality Improvement (QI) subcommittee meetings with Program to update this MOA as appropriate.

1.8 Maternal, Child, Adolescent Health (MCAH) Program

The HHSA Maternal, Child, and Adolescent Health (MCAH) Program is committed to ensuring that all pregnant women are enrolled in early and continuous prenatal care and receive preventive care and treatment for periodontal disease, that infants and children have a medical home and regular preventive care, and that women of childbearing age receive preconception care and education. The MCAH Program is responsible for providing the core public health functions of assessment, policy development, and assurance as it relates to the MCAH Program. The MCAH populations. The MCAH Program encompasses the following programs: The Perinatal Care Network (PCN) Toll-Free Line and Public Health Nurse Case Management, California Home Visiting Program, Comprehensive Perinatal Services Program, the Black Infant Health Program, the Fetal and Infant Mortality Review Program, the Sudden Infant Death Syndrome Program, the Perinatal Equity Initiative, the Office of Violence Prevention, and the Oral Health Programs. The MCP is dedicated to meeting the needs and providing quality prenatal and continual services to its Medi-Cal members.

CATEGORY	MATERNAL,CHILD, AND ADOLESCENT HEALTH PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.8.1 **LIAISON**	a. Designate MCAH liaison to coordinate activities with the Plan and notify MCAH staff of their roles and responsibilities.	a. Designate Plan liaison to coordinate activities with MCAH and notify Plan staff of their roles and responsibilities.
1.8.2 **PROVIDER CONSULTATION, TECHNICAL ASSISTANCE, TRAINING**	a. Assist providers and Plans with training, such as implicit bias, and technical assistance in order to deliver comprehensive perinatal services to Plan members, as needed. b. As requested, provide consultation to the Plan regarding American College of Obstetricians and Gynecologists (ACOG) Guidelines for Perinatal Care and Title 22 Regulations. c. Assist the Plan, as requested, with dissemination of information to providers regarding ACOG Guidelines for Perinatal Care, implementation of ACOG Guidelines and evaluation of providers' adherence to ACOG Guidelines. d. Assist the Plan in developing and implementing standardized risk management tools and risk intervention protocols which are consistent with requirements stated in Title 22, CCR, 51348 & 51348.1, if requested. e. Assist the Plan and providers, as requested, in developing procedures to ensure risk assessment protocols	a. Disseminate information and provide training to providers in order to assure quality perinatal services. b. Require that all perinatal care providers, upon entry to the Plan, receive orientation to State approved perinatal care standards (unless they are already approved CPSP providers). c. Inform all perinatal care providers, upon entry to the Plan, of the Perinatal Care Network (PCN). d. Inform MCAH regarding technical assistance needs of Plan and their providers. e. Assist providers in maintaining or improving comprehensive services, including staff education, education materials, resources, and referrals. f. Collaborate with MCAH to organize, conduct and/or participate in information sharing activities (roundtables, letters, community education resources, etc.) for CPSP providers and other interested obstetrical providers.

CATEGORY	MATERNAL,CHILD, AND ADOLESCENT HEALTH PROGRAM	MEDI-CAL MANAGED CARE PLAN
	are utilized during each trimester and during the postpartum period, and that appropriate interventions will occur. f. Provide consultation on high-risk, perinatal populations such as African Americans, teens, homeless, and substance-abusing women. g. Assist the Plan to implement and maintain policies and procedures for appropriate referrals of high-risk pregnant women to specialists, including genetic screening, substance abuse treatment, and domestic violence counseling, if requested. h. As requested, provide group trainings or individual technical assistance to providers on: educational needs of staff of optimal provision of the comprehensive perinatal services; relevant protocols and assessment tools; up-to-date referral resources; and other identified topics as needed. i. Make perinatal health education resources available to providers.	
1.8.3 **PROVIDER NETWORK AND CERTIFICATION**	a. Provide mechanism for Comprehensive Perinatal Services Program certification if requested by service provider in the Plan. b. Assist perinatal providers in obtaining state CPSP certification, including providing information about the purpose of CPSP, regulations, models of implementation, receive and review applications.	a. Provide MCAH with a current list of perinatal providers, if requested. b. Request information as needed on CPSP certification from MCAH. c. Encourage all perinatal care providers to become CPSP certified and to be added to the provider referral list with the PCN Toll-Free Line.
1.8.4 **COMMUNITY HEALTH STATUS MONITORING**	a. Monitor county-wide prevalence and trends of conditions related to the health status of women of child-bearing age, especially of pregnant women and of infants. If requested, provide assistance to the Plan for analysis of Plan data.	a. Report the health indicators as required by the State and share upon request.

CATEGORY	MATERNAL,CHILD, AND ADOLESCENT HEALTH PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.8.5 **OUTREACH**	d. Conduct outreach to potential Medi-Cal eligible women of childbearing age. e. Identify pregnant women and refer them to Medi-Cal for eligibility determination and health plan enrollment as appropriate. f. Collaborate with health plans to explore the feasibility of assisting plans with tracking and follow-up of high-risk, hard-to-reach clients of plan who are lost to care (e.g., multiple missed appointments, no services utilized) or who are disenrolled. Protocol should include reporting results of member follow-up to primary care provider and plan.	a. Contact members in need of services, missing appointments, etc. and for high-risk members, per plan protocol, refer them to MCAH for assistance with tracking and follow-up as needed. b. Collaborate with MCAH to explore the feasibility of MCAH assisting plans with tracking high-risk, hard-to-reach plan members, including those lost to care (e.g., multiple missed appointments, no services utilized) and disenrolled. Protocol shall include reporting mechanisms to primary care provider by the Plan.
1.8.6 **ACCESS, APPOINTMENT SCHEDULING, AND TRANSPORTATION ASSISTANCE**	a. MCAH Program staff, via the Public Health Nurses, Perinatal Care Network Toll-Free Line, and Black Infant Health, will assist their members who are health plan members with appointment scheduling and transportation assistance as requested. b. Work closely with the health plans and community groups regarding access to care issues for eligible and ineligible pregnant women. c. Share transportation resource information with health plans for its use in assisting members.	a. Participate with MCAH staff and community groups to address access to care issues of eligible pregnant women. b. Provide transportation assistance to members in accordance with the Plan's transportation policy.
1.8.7 **CASE MANAGEMENT**	a. Assist with referrals for pregnant women who lose Plan coverage, as requested. b. Provide technical assistance and consultation to Plans on available prenatal and community resources and linkages, as requested. c. Responsible for tracking/follow-up of pregnant women to determine if they receive Medi-Cal application, complete processing and are enrolled in prenatal care.	a. Inform providers of requirement to follow-up missed appointments. b. Inform providers of requirement to assess and refer pregnant women, when appropriate, to available community resources, including genetic screening and counseling, public health nursing, lactation services, and Women, Infants and Children (WIC) Supplemental Nutrition Program. c. Plans will have case management services for high-risk pregnant women available.

CATEGORY	MATERNAL,CHILD, AND ADOLESCENT HEALTH PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.8.8 **PLANNING AND REFERRAL SERVICE**	a. Assist Plans in identifying community resources for Plan members.	a. Educate providers about community resources that are available for pregnant women.
1.8.9 **HEALTH EDUCATION**	a. Collaborate with health plans in developing appropriate health education resources or making them available to health plans and providers in support of provision of services for women and their infants, children, and adolescents, i.e., brochures, videos, staff training, etc.	a. Collaborate or consult with MCAH in developing appropriate health education resources or making them available to providers in support of provision of services for women and their infants, children, and adolescents, i.e., brochures, videos, staff training, etc.
1.8.10 **PROBLEM RESOLUTION**	a. If an issue arises, MCAH liaison can request a meeting with Plan liaison to identify and resolve operational and administrative issues, including coordination, communication, referral, training, provider reimbursement, provision of appropriate services, and authorization of services.	a. If an issue arises, Plan liaison can request a meeting with Program liaison to identify and resolve operational and administrative issues, including coordination, communication, referral, training, provider reimbursement, provision of appropriate services, and authorization of services.
1.8.11 **QUALITY ASSURANCE**	a. Conduct jointly with the plans, regular reviews of this MOA as needed. b. Participate in quarterly CPSP/MCMC plan meetings with the Plan to review quality of care and other pertinent issues, as appropriate. c. Participate in Healthy San Diego Quality Improvement (QI) subcommittee and other appropriate meetings with Plan to update this MOA and review quality of care issues, as appropriate.	a. Conduct jointly with MCAH Program, regular reviews of this MOA as needed. b. Participate in quarterly CPSP/MCMC plan meetings with the MCAH staff to review quality of care and other pertinent issues, as appropriate. c. Participate in Healthy San Diego Quality Improvement (QI) subcommittee and other appropriate meetings with Program to update this MOA and review quality of care issues, as appropriate.

1.9 Tuberculosis (TB) Control Program

The HHSA Tuberculosis (TB) Control Program is dedicated to identifying and treating individuals with TB, as well as providing consultation services to the medical community. The MCP is committed to working with the County and complying with the state guidelines regarding the identification and treatment of active TB cases. Both organizations share the goal of providing quality services to Medi-Cal members.

CATEGORY	TUBERCULOSIS CONTROL PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.9.1 **LIAISON**	a. Appoint the TB Control Program Manager, or designee, as the liaison to coordinate activities with the Plan and to notify the TB Control Program staff of their roles and responsibilities.	a. Designate a TB Control liaison to coordinate activities between the Plan and TB Control Program, and to notify Plan staff of their roles and responsibilities.
1.9.2 **PROVIDER CONSULTATION, TECHNICAL ASSISTANCE AND TRAINING**	a. Provide Plan and providers with consultation for TB screening (including skin testing), diagnosis, treatment, follow-up, and referral of members. b. Provide updated information on TB prevention and control standards and guidelines. c. Assist Plan, if requested, in developing protocols. d. Assist Plan in conducting provider training on TB clinical standards and treatment guidelines, as well as reporting requirements if requested.	a. Inform Plan providers that TB Program consultation is available. b. Conduct provider training on TB clinical standards and treatment guidelines, as well as reporting requirements.

1.9.3 **DISEASE REPORTING**	a. Provide the Plan with Tuberculosis Suspect Case Report (Attachment 1.5) and Tuberculosis Discharge Care Plan forms (Attachment 1.6) and guidelines for reporting. Monitor the disease-reporting process, including accuracy and completeness of information provided. When appropriate, notify Plan of providers not in compliance of the reporting process. b. Provide the Plan's clinical laboratories with lists of reporting requirements, including required member information and guidelines for providing these data to the TB Program.	a. Inform providers of the requirement to provide County TB Control Program with completed Tuberculosis Suspect Case Report (Attachment 1.5) on members with reportable TB as described in the California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 1, Article 1, Section 2500. Plan will assist TB Control Program in following up with providers not in compliance of the reporting process. b. Inform providers of the requirement to follow discharge approval guidelines for all suspect TB members as described in California Health and Safety Code, Division 105, Part 5, Chapter 1, Section 121362 and provide County TB Control Program with completed Tuberculosis Discharge Care Plan (Attachment 1.6). c. Inform clinical laboratories of the requirement to provide County TB Control Program with required information on members with reportable TB, as described in the California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 1, Article 1, Section 2500. d. Inform providers of the requirement to submit treatment plan updates, including dosage changes and drug susceptibility results, to TB Control Program at regular intervals. Notify TB Control Program when treatment is completed or when member becomes non-adherent to the treatment plan.
1.9.4 **COMMUNITY HEALTH STATUS MONITORING**	a. Monitor Countywide TB prevalence and trends, provide data to the Plan, and if requested, provide assistance to the Plan to analyze Plan data. Annual reports will be posted on TB Control Program's website.	

CATEGORY	TUBERCULOSIS CONTROL PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.9.5 **PROVISION OF SERVICES**	a. Provide TB services to Plan members that present for testing and/or treatment at a Public Health Center or through Field Services, without prior authorization. b. Provide outpatient diagnostic work-up and treatment for active disease and Latent Tuberculosis Infection (LTBI) for all members referred from the Plan for this service. c. May refer back to the Plan when appropriate. Communicate and coordinate with their Plan TB liaison to ensure the member is referred to a Plan provider. d. The TB Control Program will assign a case manager to each active case who will visit the member to address barriers to successful treatment completion, to evaluate community and household transmission, and to collect clinical and epidemiologic information as needed. The case manager will be a liaison between the Plan provider and the TB Control Program's supportive services.	a. Provide preventive and active disease therapy for all Plan members to include transportation and interpreting services commensurate with DHCS requirements. b. Provide information to providers as to how and when to refer their TB patient members to County TB Control Program. c. Provide services in accordance with the standards of Centers for Disease Control (CDC) and the American Thoracic Society (ATS), and the American Academy of Pediatrics (AAP). d. Inform the Plan providers of the requirement to supply requested information to the case manager to assure appropriate monitoring, contact investigation, and supportive services are provided.
1.9.6 **REIMBURSEMENT**	a. Submit claims for reimbursement at the current Medi-Cal fee-for service rate and shall provide encounter data for the plan member being billed within 120 days of the encounter. The County shall obtain a signed release of information form from the Plan Member. b. Contact Plan Liaison with regards to denied and/or underpaid claims.	a. Health plan will reimburse the County at Medi-Cal fee-for-service rates according to health plan billing policies and procedures if the County requests reimbursement. b. Plan Liaison will assist TB Control Program in addressing denied claims.
1.9.7 **MEMBER OUTREACH**	a. Provide targeted outreach to disenrolled persons with active disease as identified from Enrollment Unit's information or by Plan. Assist Plan provider to ensure that new Plan is informed about member's TB diagnosis (per confidentiality guidelines); or if no longer eligible for Medi-Cal that member obtains services from appropriate medical provider.	a. Inform providers of the importance of maintaining continuity of care in patients with active TB disease. b. Plan will facilitate the transfer by providers of the care of disenrolled persons to appropriate new provider(s) that is approved by the TB Control program.

CATEGORY	TUBERCULOSIS CONTROL PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.9.8 **CONTACT INVESTIGATION**	a. Carry out needed investigations to identify and care for contacts of active TB cases. b. When notified by the Plan of contacts to a case that are not within the Plan, follow-up to provide screening and care for the contact.	a. When the Plan identifies a member that is or is suspected to be an active case, the Plan provider is to ask the patient about contacts. Inform TB Control Program, not only about the patient, but also about the contacts. The provider is to inform the patient that TB Control Program may also directly request information about contacts from the member. b. Inform providers of the requirement to care for contacts identified as Plan members according to standards of CDC, ATS and AAP.
1.9.9 **DIRECTLY OBSERVED THERAPY (D.O.T.)**	a. Follow-up on all referrals from the Plan for members in need of Directly Observed Therapy (D.O.T.) and provide D.O.T. if the member meets County criteria for D.O.T. b. Keep the member's provider up to date on the status of the D.O.T., upon request. c. Provide technical assistance to the Plan and providers about protocols for assessing the risk of members for noncompliance with TB treatment.	a. Inform providers of the current D.O.T. standards of care. b. Inform providers of the requirement to refer all patients in need of D.O.T. to County TB Control Program. c. For instances where D.O.T. is not recommended by Plan providers, reasons for this decision should be noted by Plan providers and communicated to the TB Program for review.
1.9.10 **MEMBER HEALTH EDUCATION**	a. Provide technical assistance to Plans on needs of TB Control target population and in designing appropriate health education programs. b. Provide updated information on TB prevention and control standards and guidelines.	a. When requesting technical assistance, provide TB Control Program with update on needs of Plan members and design of existing health education programs and communicated to the TB Program for review.
1.9.11 **PROBLEM RESOLUTION**	a. If an issue arises, TB liaison can request a meeting with Plan liaison to identify and resolve operational and administrative issues, including coordination, communication, referral, training, and the provision of appropriate services. b. Refer issue to State Tuberculosis Branch if problem cannot be resolved locally between the Plan and TB	a. If an issue arises, Plan liaison can request a meeting with TB Program liaison to identify and resolve operational and administrative issues, including coordination, communication, referral, training, and the provision of appropriate services. b. Refer issue to State Tuberculosis Branch if problem cannot be resolved locally between the Plan and TB

CATEGORY	TUBERCULOSIS CONTROL PROGRAM	MEDI-CAL MANAGED CARE PLAN
	Program.	Program.
1.9.12 **QUALITY IMPROVEMENT AND MONITORING**	a. Conduct jointly with Plans, regular reviews of this MOA. b. Participate in Healthy San Diego Quality Improvement (QI) subcommittee meetings with Plan to update this MOA as appropriate.	a. Conduct jointly with Program, regular reviews of this MOA. b. Participate in Healthy San Diego Quality Improvement (QI) subcommittee meetings with Program to update this MOA as appropriate.

1.10 Refugee Health Assessment Program (RHAP)

The County of San Diego, Health and Human Services Agency (HHSA), Refugee Health Assessment Program (RHAP) is a State-funded program to provide basic health assessment to refugees coming to San Diego. Unless otherwise stated contrary, the word refugees in this MOA shall be used to include primary refugees, secondary refugees, asylees, humanitarian parolees, and certified human trafficking victims. Definitions of these groups are below.

- **Primary Refugees** – Individuals who have been granted special immigration status ("refugee") by the U.S. Citizenship and Immigration Services (USCIS) while outside the U.S. These refugees are unable to return to their country of origin because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion. The definition for refugee also includes individuals who have been subject to or have a well-founded fear of being subject to coercive population control methods such as forced abortion or involuntary sterilization. (CDPH-ORH)
- **Secondary Refugees** – Individuals who have been resettled in one location and, once settled, moved to a new location. These refugees often relocate to be nearer to similar ethnic groups or to escape initial resettlement areas that have high crime or poverty rates. Minnesota and Iowa have the highest rates of secondary refugee intake while New York has one of the highest rates of refugees leaving the state.
- **Asylees** – Individuals who are in the U.S., either legally or without documents, and fear that they will be persecuted if they return to their home country. To become an asylee, the person must go through an immigration hearing or court process and granted asylum by USCIS. (CDPH-ORH)
- **Humanitarian Parolees** – This status is used sparingly to allow someone who is otherwise inadmissible into the U.S. for a temporary period, usually in response to an emergency. There is also a parolee program for the families of Cubans – the Cuban Family Reunification Parole. Under this program, eligible U.S. citizens and migrants can bring their families into the country without waiting for immigrant visas.
- **Certified Human Trafficking Victims** – Victims of modern-day slavery, which include young children, teenagers, men, and women. Victims of human trafficking are subjected to force, fraud, or coercion, for the purpose of sexual exploitation or forced labor. The Trafficking Victims Protection Act of 2000 made adult victims of severe forms of trafficking who have been certified by the U.S. Department of Health and Human Services eligible for benefits and services to the same extent as refugees. The Trafficking Victims Protection Reauthorization Act of 2003 made certain family members of trafficking victims also eligible for benefits and services to the same extent as refugees. Victims of severe forms of trafficking who are under 18 years of age are also eligible for benefits to the same extent as refugees but do not need to be certified. (CDPH-ORH)

The purpose of providing health assessment services to refugees is twofold; to protect the domestic population through early identification and treatment of communicable conditions and to enhance self-sufficiency for incoming refugees by rapidly diagnosing acute and chronic conditions and referring them for treatment. Because refugees come from different nations around the globe, they bring with them different languages, customs, and beliefs regarding health, diseases, and treatment. Refugees admitted to the U.S. are eligible for Medi-Cal upon arrival.

MCPs are interested in working with the County in identification of arriving refugees, prompt assessment of their health status, treatment of communicable conditions, and ongoing health services to meet the needs of these populations. HHSA and the MCPs share the goal of providing healthcare services to refugees in a manner that is linguistically and culturally appropriate to that population.

CATEGORY	REFUGEE HEALTH ASSESSMENT PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.10.1 **LIAISON**	a. Appoint an RHAP contact person to coordinate activities with Plans and to regularly update Plans on refugee health status. b. Meet periodically with Plans' administrators to resolve problems and issues. c. Jointly develop a system to identify status of refugees. d. Coordinate to ensure services are provided in a timely manner.	a. Designate an RHAP Liaison to coordinate activities between the Plans and the RHAP, and to share information with RHAP staff on Medi-Cal related matters/issues. b. Meet with RHAP liaison periodically to discuss and resolve problems or issues. c. Jointly develop a system to identify status of refugees. d. Arrange for services to be provided in a timely manner.
1.10.2 **PROVIDER CONSULTATION & TECHNICAL ASSISTANCE**	a. Provide Plans and providers with information on the Refugee Health Assessment Program. b. Assist Plans in conducting provider training on refugee health needs and issues, as well as reporting requirements for certain health conditions.	a. Conduct provider training on refugee health issues and treatment guidelines on certain health conditions. b. Encourage Plan providers to report conditions in accordance with California Code of Regulation (CCR) §2500 (b) to the local health officer.
1.10.3 **OUTREACH & PATIENT CONTACT**	a. Interface with Centers for Disease Control and Prevention, Division of Global Migration and Quarantine, and local refugee resettlement agencies regarding notification of new arrivals to San Diego. b. Contact new arrivals within 30 days of arrival to San Diego.	

CATEGORY	REFUGEE HEALTH ASSESSMENT PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.10.4 **REFUGEE HEALTH ASSESSMENTS**	a. Complete health assessments per State guidelines/ protocols. b. Prepare and maintain medical records. c. Furnish a complete copy of medical records to the Plan providers and provide notice for continued treatment for communicable diseases or other conditions noted in the RHAP assessment.	a. To encourage physicians to incorporate refugee medical records for continuation, when needed, of treatment initiated or recommended by RHAP, and to limit duplication of services
1.10.5 **CASE FINDING, REFERRAL, AND FOLLOW-UP**	a. Report results of case follow-up and special problems through the RHAP Liaison. b. Refer refugees to Plans for follow-up and routine care. c. Identify and refer tuberculosis suspects and cases to Tuberculosis Control Branch for evaluation. d. Refer to Plans for further evaluation and treatment of other conditions identified during the RHAP assessment.	a. Request such help as needed for hard-to-find patients or those not responding to outreach. b. Coordinate with RHAP Liaison to encourage appropriate follow-up. c. Refer tuberculosis patients who require Direct Observed Therapy (DOT) to TB Control Branch.
1.10.6 **PROVISION OF SERVICES**	a. Provide services to Plan members that present for testing and/or treatment at Public Health Center without prior authorization. b. Provide outpatient diagnostic work-up and treatment of active disease and LTBI for members referred from the Plan for this service. c. Assess Plan enrollees that “self-refer” and if not in need of immediate care, refer to the Plan for care. Communicate and coordinate with Plan Liaison to help member referred to Plan certified provider.	a. Provide services to eligible Plan members in accordance with standards of care.

CATEGORY	REFUGEE HEALTH ASSESSMENT PROGRAM	MEDI-CAL MANAGED CARE PLAN
1.10.7 **PAYMENT FOR SERVICES PROVIDED**	a. Submit claims for reimbursement at the current Medi-Cal fee-for-service rate and provide encounter data for the Plan member being billed within 120 calendar days of the encounter. The County shall obtain a signed release of information form from the Plan Member. b. Contact Plan Liaison with regards to denied claims.	a. Reimburse the County at the current Medi-Cal fee-for-service rates within 60 calendar days of receipt of satisfactory claim. b. Plan Liaison will assist TB Control Program in addressing denied claims.
1.10.8 **QUALITY IMPROVEMENT & MOA REVIEW**	a. Work with Plans to ensure all refugees receive a proper initial health assessment. b. Monitor patient progress to ensure appropriate referral and follow-up. c. Identify opportunities to improve health assessments, referral and follow-up process and work with Plans to develop common solutions and strategies. d. Conduct jointly with Plans regular reviews of this MOA. e. Participate in Healthy San Diego Quality Improvement (QI) subcommittee meetings with Plan to update this MOA as appropriate.	a. Work with RHAP to monitor referral and follow-up. b. Work with RHAP to develop common solutions and strategies. c. Identify opportunities to improve health assessments, referral and follow-up process and work with RHAP to develop common solutions and strategies. d. Conduct jointly with Program regular reviews of this MOA. e. Participate in Healthy San Diego Quality Improvement (QI) subcommittee meetings with Program to update this MOA as appropriate.
1.10.9 **MEMBER EDUCATION**	a. Educate Plans' staff and contracting providers on RHAP. b. Provide recommendations and assistance to Plan contracting providers on refugee patient education materials in a primary language and on linguistic and culturally appropriate services.	a. Educate RHAP staff on Plans' policies and that of contracting providers. b. Collaborate with RHAP to encourage Plan providers to learn about RHAP and medical issues specific to refugee populations.
1.10.10 **PROBLEM RESOLUTION**	a. RHAP liaison will maintain open communication with Plans Liaison to identify and resolve any operational and administrative issues that may arise, including coordination, communication, referral, training, and provision of appropriate services.	a. Plan liaison will maintain open communication with RHAP liaison to identify and resolve any operational and administrative issues that may arise, including coordination, communication, referral, training, and provision of appropriate services.

1.11 Targeted Case Management (TCM)

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 are provided by County of San Diego Health and Human Services Agency (HHSA). 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 high-risk adults and children who meet the criteria for TCM. The scope of TCM programs include: Aging and Independence Services, Public Health Nursing and Community Based Organizations. Other Programs may be added if they meet TCM requirements. The Medi-Cal Managed Care Plan (hereinafter referred to as Plan) is responsible for establishing a medical provider network that will meet the needs of the Medi-Cal population and assure referral to and coordination with supports within the Plans' benefit package. Both Plans and HHSA'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.

Case Management Services, as defined in Title 42CFR Section 440.169, include the following four service components: Comprehensive Assessment and Periodic Reassessment, Development of Specific Care Plan, Referral and Related Activities, and Monitoring and Follow-up Activities. The four-component requirement applies to both TCM Program and the Plan's 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. An outline of services provided by the HHSA TCM and MCPs are outlined below:

CATEGORY	HHSA TARGETED CASE MANAGEMENT	MEDI-CAL MANAGED CARE PLAN
1.11.1 **ROLE**	a. HHSA will coordinate TCM services for medical, social, educational, and other services needing case management. For client medical issues, the TCM Program will refer Plan members with open TCM cases to Plan as needed as identified by the TCM case manager. b. When a member is referred to HHSA's TCM Program by the County health system, HHSA TCM Program will refer the member to Plan as needed.	a. Plan will oversee the delivery of primary health care and related care coordination. Plan is responsible for providing all covered medically necessary health care including medical education that the member may require. b. Case management for member medical issues and linkages to Plan covered health services will be the responsibility of Plan. These services include:

CATEGORY	HHSA TARGETED CASE MANAGEMENT	MEDI-CAL MANAGED CARE PLAN
	c. The TCM program role is to manage the whole client, including referring clients to local public resources and providers for addressing medical issues as appropriate, but do not manage illness, nor are providers of medical services.	• Coordination of care • Medical referrals • Continuity of Care • Follow-up on missed medical appointments • Communication with specialists c. Plan will provide members with linkage and care coordination as needed for any necessary social support need identified by Plan.
1.11.2 **LIAISON**	a. HHSA will designate a contact responsible for facilitating coordination with the Plan, including identifying the appropriate Plan contacts for the TCM Program and resolving all related operational issues. The TCM case manager (TCM-CM) will serve as the contact person for all clients receiving TCM.	a. Plan will designate a contact responsible for facilitating coordination with the TCM Program, including identifying the appropriate Plan contacts for the TCM Program, and resolving all related operational issues.
1.11.3 **CLIENT IDENTIFICATION**	a. HHSA will query all TCM clients to determine if they are assigned to Plan for their primary medical care. HHSA will request access to client managed care status and provider information via existing DHCS provider eligibility information access systems (MEDS).	a. Plan will notify the member's PCP and/or any case manager that the member is receiving TCM services as identified by DHCS report. b. Plan will share client/member care plans with HHSA upon request for Plan members with open TCM cases as allowed by Health Insurance Portability and Accountability Act (HIPAA) and California law. This includes member consent for communication among the parties. The transmission may be via encrypted electronic mail or secure fax.
1.11.4 **COORDINATION**	a. HHSA will share client/member care plans with Plan upon request for Plan members with open TCM cases as allowed by Health Insurance Portability and Accountability Act (HIPAA) and California law. b. HHSA will coordinate with plan for client/member as needed for additional medical services or supports.	a. Plan will share client/member care plans with HHSA upon request for Plan members with open TCM cases as allowed by Health Insurance Portability and Accountability Act (HIPAA) and California law. This includes member consent for communication among the parties. The transmission may be via encrypted electronic mail or secure fax.

CATEGORY	HHSA TARGETED CASE MANAGEMENT	MEDI-CAL MANAGED CARE PLAN
	c. HHSA will comply with HIPAA requirements when sharing relevant medical/case management information with Plan. d. HHSA will communicate with the appropriate Plan staff at least once every six months to ensure that the client/member is receiving appropriate care. e. HHSA will pursue obtaining HIPAA consents from TCM clients to allow the sharing of relevant medical/case management information with Plan as needed.	b. Plan will coordinate with HHSA for client/member in need of additional social services or supports. c. Plan will comply with HIPAA requirements when sharing relevant medical/case management related information with HHSA. d. Plan will communicate with the appropriate HHSA staff at least once every six months to ensure that the client/member is receiving the appropriate level of care. e. Plan will pursue obtaining HIPAA consents from Plan members to allow the sharing of relevant medical/case management related information with HHSA as needed.
1.11.5 **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. b. HHSA will be responsible for creating all TCM assessments and development and revision of care plans related to TCM services. The assessment shall determine the need for any medical, educational, social, or other services or supports including the required semi-annual reassessments. c. HHSA will share TCM care plan information with Plan as necessary to coordinate member medical and social support issues, or if requested by Plan. 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.	a. Plan will be responsible for providing health assessments for its members in the TCM program and when appropriate, establish and implement care plans for its members as needed. b. Plan will be responsible for the development and revision of member care plans related to medical needs and medical diagnoses as appropriate. c. Plan will share care plan information with HHSA as necessary to coordinate member medical and social support issues, or if requested by HHSA. d. Plan's case managers, when assigned, will communicate with the appropriate HHSA contact to discuss client/member needs and/or coordinate as deemed necessary by either the Plan case manager or the HHSA TCM case manager.

CATEGORY	HHSA TARGETED CASE MANAGEMENT	MEDI-CAL MANAGED CARE PLAN
	e. TCM case manager will refer all active TCM clients in need of Plan case management for medical issues to Plan. f. The TCM assessment extends further than the Plan 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. g. The TCM case manager will coordinate with Plan when: • Client/member is assessed as having an urgent medical issue. • The TCM case manager assesses that the client/ member may have an acute or chronic medical condition. • Client/member indicates that they are receiving assistance and/or case management for their needs from a case manager or other Plan professional (self-declaration of receiving complex case management). h. The TCM Case Manager will notify Plan via an agreed upon medium (e.g., secure email, fax, etc.), that the client/member is receiving TCM services. i. The TCM Case Manager will provide all necessary assessments and care plans to Plan when/as appropriate.	
1.11.6 **REFERRAL, FOLLOW UP AND MONITORING**	a. TCM case managers will provide referral, linkage, follow-up, and monitoring services to help clients/members obtain needed services and to ensure the TCM care plan is implemented and adequately	a. Plan will provide covered healthcare services. b. Plan will refer eligible client/members in need of social services and supports beyond underlying medical

CATEGORY	HHSA TARGETED CASE MANAGEMENT	MEDI-CAL MANAGED CARE PLAN
PROTOCOL	addresses the client/member needs. b. The TCM case manager will refer the client/member to services and related activities that help link the individual with medical, social, and educational providers. The TCM case manager will also link the client to other programs as deemed necessary and provide follow-up and monitoring as appropriate. c. The TCM case manager will contact Plan to notify of any urgent medical issue. d. The above procedures will be followed by HHSA unless the client has an urgent medical need, at which time HHSA will provide the necessary referrals/actions and notify the Plan of the client/ member status as soon as possible. e. The TCM case manager shall communicate need for all necessary referrals as appropriate, medical or otherwise, to Plan or PCP as soon as possible to address the client's/ member's immediate medical need and avoid duplication of services. f. TCM Case Managers will refer client to Plan or PCP for all medically necessary services. g. TCM Case Manager will refer client to Plan when a medical need develops or escalates. h. TCM Case Manager will refer clients/members to Plan when the client needs assistance with medical related services. i. If HHSA determines that the client/member needs or qualifies for TCM, the TCM case manager will assess and specifically identify the issue for which the member was	condition or covered social supports and/or treatment to the HHSA TCM program. c. Plan will refer members to HHSA TCM Program services when: • Client/Member is determined to be in need of case management services for non-medical needs. • Plan has determined that the member has demonstrated an ongoing inability to access Plan services. • Plan has determined that client/member would benefit from TCM face-to-face/telehealth visit case management. • Plan has concerns that the client/member has an inadequate support system for medical care. • Plan has concerns that the client/member may have a life skill, social support, or an environmental issue affecting the member's health and/or successful implementation of the Plan care plan. d. Upon request, Plan shall share information with the TCM case manager related to the issue for which the referral was made as allowed by HIPAA. e. Referral does not automatically confirm enrollment into a TCM program. f. Prior to the referral for TCM, Plan case manager will identify the social, educational, and/or other non-medical issues the member has that require case management. g. When Plan refers a member to HHSA for TCM services for any medically necessary or social support needs, coordination will take place as frequently as either Plan or the TCM

CATEGORY	HHSA TARGETED CASE MANAGEMENT	MEDI-CAL MANAGED CARE PLAN
	referred as well as all other case management needs and develop a care plan. j. The TCM case manager will provide linkage and referrals as needed and will monitor and follow-up as appropriate. k. HHSA may obtain and review Plan's client/member care plan to assist in assessing the referred issue. l. The TCM client/member case shall remain open until the issue referred by Plan has been resolved and no other TCM service is determined to be necessary by HHSA.	case manager deems necessary.
1.11.7 **QUALITY IMPROVEMENT AND ISSUE RESOLUTION**	a. TCM Liaison or designee will participate in the monthly Health Plan Workgroup meetings as needed to address and resolve quality, administrative or operational issues and ensure ongoing communication between TCM programs and the Plan. b. TCM Liaison or designee will facilitate TCM Management Team staff to address and resolve quality, administrative or operational issues presented by Plan in the monthly Health Plan Workgroup meetings as needed. c. TCM Liaison or designee will participate in Healthy San Diego Quality Improvement (QI) subcommittee meetings with Plan to update this MOA as appropriate. d. TCM Liaison or designee Participate in or convene ad hoc meetings with Plans as needed.	a. Plan liaison or designee will participate in the monthly Health Plan Workgroup meetings to address and resolve quality, administrative or operational issues and ensure ongoing communication between TCM programs and the Plan as needed. b. Plan liaison or designee will facilitate appropriate staff to address and resolve quality, administrative or operational issues present by TCM team in the monthly Health Plan Workgroup meetings or as needed. c. Plan liaison or designee will participate in Healthy San Diego Quality Improvement (QI) Subcommittee meetings to report QI activities and update this MOA as appropriate. d. Plan liaison or designee will participate in or convene ad hoc meetings with TCM providers and/or HHSA as needed.
1.11.8 **PROVIDER TRAINING**	a. When feasible, TCM staff will provide training to Plan staff and providers on TCM Programs as requested by Plan.	a. Plan may request training from TCM for providers and Plan staff on TCM programs as needed.