MEMORANDUM OF UNDERSTANDING

(AMENDED AND RESTATED)

35881

This Memorandum of Understanding ("MOU") is made and entered into effective July 1, 2020 ("Effective Date"), by and between the Local Initiative Health Authority for Los Angeles County operating as L.A. Care Health Plan ("L.A. Care"), a local public agency, and the City of Long Beach, Department of Health and Human Services ("City"), a Local Governmental Agency. City and L.A. Care are each referred to herein as a "Party" and collectively as the "Parties."

RECITALS

A. L.A. Care is licensed to conduct business in the County of Los Angeles, California, under the Knox-Keene Health Care Service Plan Act of 1975, as amended from time to time, and the rules promulgated thereunder ("Act");

B. L.A. Care provides and/or arranges for the provision of health services to certain individuals who select, enroll in, or are assigned to L.A. Care's Medi-Cal Managed Care Programs through contracting with other health plans, hospitals, physicians and other health care providers;

C. City is a Local Governmental Agency ("LGA") responsible for carrying out the various traditional core public health functions mandated by State, federal and local laws;

D. City and L.A. Care, under its respective contract with the California Department of Health Care Services ("DHCS"), are required to enter into a Memorandum of Understanding ("MOU") with the other Party for the coordination of Targeted Case Management ("TCM") to Medi-Cal beneficiaries; and

E. City and L.A. Care desire to enter into this MOU to set forth the responsibilities and coordination requirements between Parties in order to avoid duplication of TCM services and activities.

AGREEMENT

NOW, THEREFORE, the Parties hereto agree as follows:

1. **Incorporation of Recitals**

The above Recitals A-E are hereby incorporated and made a part of this MOU as if fully set forth herein.

2. **Definitions**

In addition to the capitalized terms defined in the body of this MOU, the following capitalized terms shall have the following meaning:

a. "DHCS" shall mean the California Department of Health Care Services.

b. "Local Governmental Agency" shall mean the City of Long Beach, Department of Human and Health Services.

c. "Managed Care Health Plan" shall mean L.A. Care Health Plan.

d. "Medi-Cal Beneficiary" shall mean an individual who is eligible for the Medi-Cal Managed Care Program. For purposes of this MOU, a Medi-Cal Beneficiary is categorized as either a "Client" or a "Member". Client refers to a beneficiary who is not an L.A. Care Member.

e. "Medi-Cal Managed Care Program" shall mean the Federal and State funded program established by Title XIX of the Social Security Act, as amended, which is administered in the State of California by DHCS.

f. "Member" shall mean Medi-Cal Beneficiary who select, are assigned or is enrolled in L.A. Care's Medi-Cal Plan.

g. "Targeted Case Management ("TCM)" shall mean services which assist Medi-Cal Members within specified target groups to gain access to needed medical, social, educational and other services.

3. **Targeted Case Management Program**

Exhibit A, Targeted Case Management Program, attached hereto and incorporated herein by this reference, shall serve to define the respective roles, duties and responsibilities and necessary coordination between the City and L.A. Care in order to avoid duplication of TCM services and activities.

4. **Payment Obligation**

There shall be no monetary obligation hereunder between City and L.A. Care regarding TCM services provided under this MOU.

5. **Compliance with Laws**

City and L.A. Care shall comply with all applicable State, federal or local rules and regulations, ordinances, directives and guidance, including but not limited to those promulgated by the DHCS.

6. **Confidentiality and Use of Information**

The Parties shall maintain the confidentiality of Medi-Cal Members/Clients, including all Protected Health Information ("PHI" or "ePHI"), in compliance with applicable rules and regulations, including the Health Insurance Portability and Accountability Act, ("HIPAA") Health Information Technology for Economic and Clinical Health Act, Welfare and Institutions Code, Sections 10850 et seq. and 17006, Americans with Disability Act,

California Civil Code Sections 56-56.16. The records and sharing of information covered under this MOU shall be used strictly for purposes of coordinating TCM services and activities as defined in Exhibit A, Targeted Case Management Program. When sharing PHI or ePHI (as defined in the HIPAA Rules), the Parties will pursue obtaining HIPAA consents from Members/Clients to allow the sharing of medical information. The provisions of this Section 6 shall survive the expiration or termination of this MOU.

7. **Term / Renewal and Termination**

a. This MOU shall be effective for the period of five (5) years from the Effective Date and shall continue through June 30, 2025 ("Initial Term"), with option to extend for additional five (5) years ("Renewal Term"), subject to the provision below.

b. At least one hundred eighty (180) calendar days prior to the expiration of the Initial Term of this MOU, the Parties agree to meet and review the existing MOU terms and conditions, as may be amended, to determine whether to extend the MOU for an additional five (5) years to create a Renewal Term, under the same terms and conditions with no further action by both Parties; or for Parties to enter into a new/replacement MOU.

c. The Initial Term and any applicable Renewal Term are collectively referenced herein as "Term", unless terminated subject to the provision below.

d. Either Party may terminate this MOU with or without cause at any time by giving the other Party thirty (30) calendar days' prior written notice.

8. **Miscellaneous**

a. Dispute Resolution. If the Parties are unable to mutually agree on any matters under this MOU, or if either Party believes the other has failed to satisfactorily perform or is otherwise in breach of the terms and conditions of this MOU, the Parties shall submit the matter for resolution in accordance with the following procedures:

i. The disputing Party shall first provide a written statement to the other describing the general nature of the claim, indicating the start of a formal dispute resolution process. The statement shall not limit the claim(s) of either Party in any further action or proceedings.

ii. Within thirty (30) business days of issuance of the written statement by the disputing Party, the Parties shall meet and confer in good faith efforts to discuss and resolve the disputed matter.

iii. Agreed upon resolution of the disputed matter by Parties shall be memorialized via amendment to the MOU, which shall be effective immediately.

iv. If the Parties fail to resolve the matter within ninety (90) days of the issuance of the written statement by the disputing Party, this MOU shall immediately terminate.

b. Indemnification

i. L.A. Care_shall hold harmless and indemnify and defend City, its shareholders, directors, employees, and representatives against any and all liabilities, losses, settlements, claims, demands, and expenses of any kind (including but not limited to reasonable attorneys' fees), which may result or arise out of any business dispute with Client/Member or any defamation, fraud, malpractice, negligence, or intentional misconduct caused or alleged to have been caused by L.A. Care or its agents, employees, or representatives in the performance or omission of any act or responsibility assumed by L.A. Care pursuant to this MOU or from the use of any property or facilities provided by L.A. Care in connection with the performance of any duties under this MOU. The provisions of this Section shall survive the expiration or termination of this MOU.

ii. City shall hold harmless and indemnify and defend L.A. Care, its directors, employees, and representatives against any and all liabilities, losses, settlements, claims, demands, and expenses of any kind (including but not limited to reasonable attorneys' fees), which may result or arise out of any business dispute with Client/Member or any defamation, fraud, malpractice, negligence, or intentional misconduct caused or alleged to have been caused by City or its agents, employees, contractors, or representatives in the performance or omission of any act or responsibility assumed by City pursuant to this MOU or from the use of any property or facilities provided by City in connection with the performance of any duties under this MOU. This provision shall survive the termination or expiration of this MOU.

c. Independent Contractors. This MOU is not intended to and shall not be construed to create the relationship of employee, agent, servant, partnership, joint venture, or association, as between the City and L.A. Care. The provision of this Section shall survive the expiration or termination of this MOU.

d. Governing Law. This MOU shall, in all respects, be interpreted, construed, enforced and given effect according to the laws of the State of California, and Parties further agree that venue of any action brought hereunder shall be conducted exclusively in the City of Long Beach. The provision of this Section shall survive the expiration or termination of this MOU.

e. Notices. Any and all notices, requests, demands or other communication required or permitted to be served on or given to either Party by the other shall be in writing and shall be deemed to have been duly given on the date of service if served personally or sent via telecopy to the Party to whom notice is to be given; on the date of delivery if sent via overnight courier; or on the third day after deposit in the United States mail if mailed to the Party to whom notice is to be given, by first class mail, registered or certified, postage prepaid; and if properly addressed as follows:

L.A. CARE HEALTH PLAN	**CITY OF LONG BEACH**
L.A. Care Health Plan 1055 W. 7th Street, 10th Floor Los Angeles, CA 90017 Attention: CEO	City of Long Beach 411 West Ocean Boulevard Long Beach, CA 90802 Attention: City Manager
Copy to: L.A. Care Health Plan 1055 W. 7th Street, 10th Floor Los Angeles, CA 90017 Attention: Provider Network Management/ Contracts and Relationship Management	Copy to: City of Long Beach 2525 Grand Avenue Long Beach, CA 90815 Attention: Director, Department of Health and Human Services

f. Captions and Construction. The captions used as headings of the sections in this MOU are for convenience only, and the Parties agree that such captions are not to be construed to be part of this MOU or to be used in determining or construing the intent or context of this MOU. The provisions of this Section shall survive the expiration or termination of this MOU.

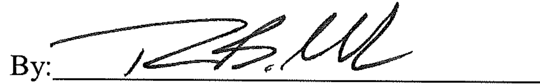
g. Entire MOU / Amendment

i. This MOU supersedes any and all other agreements or understandings, either oral or written, between the Parties with respect to the subject matter hereof, and no other agreement, statement or promise relating to the subject matter of this MOU shall be valid or binding. The terms and obligations set forth in this MOU are limited solely to the subject matter hereof.

ii. This Agreement may not be amended or modified except by an instrument in writing executed by the Parties hereto; provided, however, if at any time during the Term hereof State or Federal statutes or regulations are in conflict with the terms and conditions of this MOU or such State and Federal statutes, or other applicable rules, regulations or requirements are amended or revised in such a manner as to make this MOU, or any portion herein, unlawful or out of compliance with such State and Federal statutes, or other applicable rules, regulations or requirements, then the applicable terms and conditions of this MOU shall automatically be amended to conform with such State and Federal statutes and other applicable rules, regulations, or requirements, as if the Parties had executed a written amendment. Any amendments of this MOU shall comply with Section 1375.7 of the Act.

[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK]

IN WITNESS WHEREOF the Parties have caused this MOU between L.A. Care Health Plan and City of Long Beach, Department of Health and Human Services to be executed by their duly authorized representatives on the day and year herein above first written.

L.A. CARE HEALTH PLAN	**CITY OF LONG BEACH DEPARTMENT OF HEALTH AND HUMAN SERVICES**
By:________________	By: 
Name: ________________	Name: Thomas B. Modica
Title: ________________	Title: City Manager
Date:________________	Date: 11/30/20

APPROVED AS TO FORM:

____

APPROVED AS TO FORM

Nov. 24, 2020

CHARLES PARKIN, City Attorney

By

GARY J. ANDERSON

PRINCIPAL DEPUTY CITY ATTORNEY

IN WITNESS WHEREOF the Parties have caused this MOU between L.A. Care Health Plan and City of Long Beach, Department of Health and Human Services to be executed by their duly authorized representatives on the day and year herein above first written.

L.A. CARE HEALTH PLAN

By: Edward Calles

Name: Edward Calles

Title: Senior Director, Network Development

Date: December 17, 2020

CITY OF LONG BEACH DEPARTMENT OF HEALTH AND HUMAN SERVICES

By: [signature]

Name: Thomas B. Modica

Title: City Manager

Date: 11/30/20

APPROVED AS TO FORM:

APPROVED AS TO FORM
Nov. 24, 2020
CHARLES PARKIN, City Attorney
By [signature]
GARY J. ANDERSON
PRINCIPAL DEPUTY CITY ATTORNEY

EXHIBIT A

TO

MEMORANDUM OF UNDERSTANDING

TARGETED CASE MANAGEMENT PROGRAM

A. BACKGROUND

California's "Bridge to Reform," Section 1115 Medicaid Demonstration Waiver and the related Medi-Cal Managed Care Expansion requires broader Medi-Cal Managed Plans ("MCP") responsibility for care coordination and case management services for Medi-Cal beneficiaries. This includes coordination and referral of resources for social support issues.

In order to implement a collaborative approach under the Targeted Case Management ("TCM") Program, Local Governmental Agencies ("LGA") are required to enter into a Memorandum of Understanding ("MOU") with the MCP serving the Medi-Cal Beneficiaries in LGA's county.

TCM Program consists of comprehensive case management services that assist Medi-Cal Beneficiaries within a specified target population to gain access to needed medical, social, educational and other services. TCM Services ensure that the changing needs of the Medi-Cal Beneficiaries are addressed on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs.

The City of Long Beach Targeted Case Management ("City TCM") serves the needs of individuals residing in Long Beach who qualify for TCM Services. The Local Initiative Health Authority for Los Angeles County operating as L.A. Care Health Plan, ("L.A. Care"), and local public agency, is part of the Two-Plan Model Medi-Cal Managed Care Plan in Los Angeles County. Both the City TCM and L.A. Care share a common goal of assuring that Medi-Cal Beneficiaries receive a continuum of health care and supportive services under the TCM Program across all providers and care settings that are fully coordinated and not duplicative.

This MOU defines the roles and responsibilities between the City TCM and L.A. Care to avoid duplication of TCM Services and related activities.

B. TCM TARGET POPULATION

Pursuant to Code of Federal Regulations ("CFR") sections 441.18(a)(8)(i) and 441.18(a)(9), persons who are eligible to receive TCM Services shall consist of the following Medi-Cal Beneficiary groups:

1. **Children Under the Age of 21**

Medi-Cal eligible children, under the age of 21 years old, who are:

a) At risk for medical compromise due to one of the following conditions:
   (i) Failure to take advantage of necessary health care services, or
   (ii) Non-compliance with their prescribed medical regime, or
   (iii) An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, or
   (iv) An inability to understand medical directions because of comprehension barriers, or
   (v) A lack of community support system to assist in appropriate follow-up care at home, or
   (vi) Substance abuse, or
   (vii) A victim of abuse, neglect, or violence, and

b) In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

2. **Medically Fragile Individuals**

Medi-Cal eligible individuals, 18 years or older, who are medically fragile, and have multiple diagnoses. Such individuals must also be:

a) At risk for medical compromise due to one of the following conditions:
   (i) Failure to take advantage of necessary health care services, or
   (ii) Non-compliance with their prescribed medical regime, or
   (iii) An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, or
   (iv) An inability to understand medical directions because of comprehension barriers, or
   (v) A lack of community support system to assist in appropriate follow-up care at home, or
   (vi) Substance abuse, or
   (vii) A victim of abuse, neglect, or violence, and

b) In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

3. **Individuals at Risk of Institutionalization**

Medi-Cal eligible individuals 18 years or older, are in frail health, and meet the following criteria:

a) Have been identified as needing assistance due to one of the following reasons:
   (i) Are in need of assistance to access services in order to prevent medical institutionalization, or
   (ii) Exhibits an inability to independently handle personal, medical or other affairs, or
   (iii) Are transitioning to a community setting, who due to socioeconomic status, substance abuse, neglect, or violence have failed to take advantage of necessary health care services, and

b) At high risk for medical compromise due to one of the following conditions:
   (i) Failure to take advantage of necessary health care services, or
   (ii) Noncompliance with their prescribed medical regime, or
   (iii) An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, or
   (iv) An inability to understand medical directions because of comprehension barriers, or
   (v) A lack of community support system to assist in appropriate follow-up care at home, or
   (vi) Substance abuse, or
   (vii) A victim of abuse, neglect, or violence, and

c) In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

4. **<u>Individuals in Jeopardy of Negative Health or Psycho-Social Outcomes</u>**

Medi-Cal eligible individuals who have been determined to be in jeopardy of negative health or psycho-social outcomes and meet the following criteria:

a) At risk due to one of the following disparity factors:
   i. Substance abuse in the immediate environment, or
   ii. History of, or in danger of family violence, or
   iii. History of, or in danger of physical, sexual or emotional abuse.
   iv. Experiencing substandard housing, or v. Illiteracy, and

b) In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

5. **<u>Individuals with a Communicable Disease</u>**

Medi-Cal-eligible individuals infected with a communicable disease, including tuberculosis, HIV/AIDS, etc.; or individuals who have been exposed to

communicable diseases, until the risk of exposure has passed. Such individuals must also be:

a) At risk for medical compromise due to one of the following conditions:
   (i) Failure to take advantage of necessary health care services, or
   (ii) Noncompliance with their prescribed medical regime, or
   (iii) An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, or
   (iv) An inability to understand medical directions because of comprehension barriers, or
   (v) A lack of community support system to assist in appropriate follow-up care at home, or
   (vi) Substance abuse, or
   (vii) A victim of abuse, neglect, or violence, and

b) In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

C. TCM SERVICE COMPONENTS

While both City TCM and L.A. Care TCM programs provide case management, there is a distinction between case management provided by City TCM and L.A. Care. L.A. Care primarily focuses on medical care needs in providing case management as the Member's primary provider, which may include management of acute or chronic illness. In contrast, the City TCM program focuses on the management of the whole Client, including referring Clients to providers to address medical issues, as appropriate. However, the City TCM is not a provider of medical services and does not include the provision of direct services. Refer to Section D, Roles and Responsibilities, below for delineation of functions between City TCM and L.A. Care.

TCM Services are defined in 42 CFR Section 440.169 as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. TCM Services includes the following service components.

1. Comprehensive assessment and periodic reassessment of individual Client needs, to determine the need for any medical, social, educational or other services. These assessment activities include:

   - Taking Client history;
   - Identifying the Client's needs and completing related documentation; and
   - Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible Client.

Assessment and/or periodic reassessment to be conducted at a minimum of once every six (6) months to determine if a Client's needs, conditions, and/or preferences have changed.

2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:

   - Specifies the goals and actions to address the medical, social, educational, and other services needed by the Client;
   - Includes activities such as ensuring the active participation of the eligible Client and working with the Client (or the authorized health care decision maker) and others to develop those goals; and
   - Identifies a course of action to respond to the assessed needs of the eligible Client.

3. Referral and related activities (such as scheduling appointments for the Client) to help the eligible individual obtain needed services including:

   - Activities that help link the individual with medical, social, educational providers or other programs, and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

4. Monitoring and follow-up activities:

   Activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible Client's needs. This may involve the Client, individual, family members, services providers, or other entities or individuals, and should be conducted as frequently as necessary with at least one (1) annual monitoring to determine whether the following conditions are met:

   - Services are being furnished in accordance with the Client's care plan;
   - Services in the care plan are adequate; and
   - Changes in the needs or status of the Client are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

   Periodic Reviews will be completed at least every six (6) months. These activities may be conducted as specified in the care plan or as frequently as necessary to ensure execution of the care plan.

   Monitoring does not include ongoing evaluation or check-in of a Client when all care plan goals have been met.

D. ROLES / DUTIES AND RESPONSIBILITIES

<table>
<tr><th>CITY TCM</th><th>L.A. CARE</th></tr>
<tr><th colspan="2">ROLES</th></tr>
<tr><td>City TCM focuses on case management for the whole Client, including referring them to needed medical, mental health, educational, social and other service providers to address their comprehensive, yet unmet needs, as appropriate. However, the City TCM is not a provider of medical services and does not include the provision of direct medical or other services.

City TCM will provide TCM services for medical, social, educational, and other services to Clients needing case management. For L.A. Care Members with open TCM medical issues needing case management, the City TCM shall refer them to L.A. Care for medical case management.

When a Member with need for medical case management services has been referred to City TCM Program by an entity other than L.A. Care, the City TCM will refer the Member, as needed, to L.A. Care. These services may include: a) coordination of care, b) medical referrals, c) continuity of care, d) follow-up on missed appointments, and e) communication with specialists.</td><td>L.A. Care will partner with City TCM to ensure that Members receive the appropriate level of case management services. The collaborative process will ensure that there is no duplication of services.

• L.A. Care primarily focuses on Member medical needs in providing case management as the primary provider of medical care. This may include management of acute or chronic illness.

• L.A. Care will oversee the delivery of primary care and related health care coordination. L.A. Care is responsible of providing all medically necessary health care identified in the care plan including medical education that the Member may need as well as any necessary medical referral authorizations. Case management for Member medical issues and linkages to L.A. Care covered health services will be the responsibility of L.A. Care. For these members, L.A. Care will also provide linkage and care coordination for any necessary social support needs identified, as appropriate.

• L.A. Care will provide Members with linkage and care coordination for any necessary social support needs identified by L.A. Care.

• When decided to be appropriate by L.A. Care and City TCM to discuss and coordinate, L.A. Care will refer Members to City TCM who may benefit from shared coordination and case management services.</td></tr>
</table>

CITY TCM	L.A. CARE
DUTIES AND RESPONSIBILITIES	
A. LIAISON(S)	
Designate TCM Liaison(s) as point of contact for L.A. Care to address referral and coordination related activities.	Designate TCM Liaison(s) as point of contact for City TCM to address referral and coordination related activities.
B. CLIENT IDENTIFICATION	
City TCM will query all TCM Clients to determine their managed health care plan assignment (Health Net or L.A. Care) for their primary health care coverage. City TCM will validate and confirm Client managed care status and provider information via existing DHCS provider eligibility information access systems (MEDS). For Members with open TCM medical issues needing case management support, City TCM will refer Members to L.A. Care for medical case management.	L.A. Care will notify the Member's Primary Care Physician (PCP) and/or responsible Case Manager that the Member is receiving, or may be eligible for TCM services, along with the appropriate City TCM contact information. L.A. Care will notify City TCM when the Member is receiving complex medical case management from L.A. Care.
C. COORDINATION OF CARE	
a. City TCM will share care plans with L.A. Care, upon request, Clients/Members with open TCM cases. b. City TCM will communicate regarding Client/Member status for open medical and related social support issues to ensure that there is no duplication of services and to ensure that the Member receives the optimal level of case management services. c. For Clients/Member with open TCM cases needing medical case management, City TCM will communicate at least once every six (6) months with L.A. Care to ensure that the Clients/Members are receiving the appropriate level of care. d. The coordination between L.A. Care and City TCM will include, at a minimum, all medical issues and all social support related issues identified by City TCM and/or L.A. Care.	a. L.A. Care will share care plans with City TCM, upon request, for L.A. Care Members identified with open TCM cases. b. L.A. Care will communicate status for open medical and related social support issues to ensure that there is no duplication of services and to ensure that the Member receives the optimal level of case management services. c. For Members with an open TCM case needing medical case management, L.A. Care will communicate at least once every six (6) months to ensure that the Member is receiving the appropriate level of care. d. The coordination between City TCM and L.A. Care will include, at a minimum, all medical issues and all social support related issues identified by L.A. Care and/or City TCM.
D. ASSESSMENT AND CARE PLAN PROTOCOL	
a. City TCM will be responsible for conducting all TCM assessments, and for the development and revision of care plans related to TCM services. The assessment shall determine the need for any medical, social, educational, or other service. This includes the required semi-annual reassessment.	a. L.A. Care will provide health assessments and care plans for all Members, as needed. b. L.A. Care will assess Members' medical needs and shall identify medically necessary social support needs and health education information, including required annual reassessments.

CITY TCM	L.A. CARE
b. City TCM, upon request from L.A. Care, will share TCM assessments and care plans of Clients/Members for TCM services. c. The City TCM care plan will specify the goals for providing TCM services to Clients/Members, and the services and actions necessary to address the Client's/Member's medical, social, educational, or other service needs based on the assessment. d. All Clients/Members with open TCM cases with "medical needs" will be referred to L.A. Care by City TCM, in alignment with TCM program roles. e. The TCM assessment extends further than the L.A. Care assessment as it includes all medical, social, educational and any non-medical aspects of case management, including those social support issues that may be related to a medical need. Non-medical issues may include, but are not limited to, life skills, social support, or environmental barriers that may impede the successful implementation of the L.A. Care's care plan. f. The City TCM will accept referrals of L.A. Care Members based on City TCM's capacity. A referral does not guarantee enrollment into the City TCM Program.	c. L.A. Care will be responsible for the development and revision of Member care plans related to all assessed Member medical needs and services related to the medical diagnosis as needed. d. L.A. Care will share care plan information with City TCM, as necessary, to coordinate Member medical issues. In addition, L.A. Care will share Member care plans, upon request by City TCM. e. L.A. Care will communicate with the appropriate City TCM contact to discuss Client/Member needs and/or coordinate as deemed necessary.
E. CASE MANAGEMENT*	
a. The City TCM Case Manager will coordinate with L.A. Care when: • The City TCM Case Manager has identified that the Member receives complex case management from L.A. Care, and the City TCM Case Manager assesses that the Member is not medically stable and/or; • The Client/Member indicates (self-declaration of receiving complex case management) that they are receiving assistance and/or case management for their needs from City TCM Case Manager or other L.A. Care professional, and City TCM Case Manager assesses that the Client/Member may have an acute or chronic medical issue and is not medically stable, and the City TCM Case Manager assesses that the Client/Member's medical needs require L.A. Care case management and/or; • The City TCM Case Manager assesses that the Client/Member may have social support issues that	a. The L.A. Care Case Manager will coordinate with City TCM Case Manager when: • L.A. Care has identified that the Member receives TCM services, and the L.A. Care Case Manager assesses that the Member is not medically stable and/or; • The Client/Member indicates (self-declaration of receiving complex case management) that they are receiving assistance and/or case management for their needs from City TCM Case Manager or other L.A. Care professional, and L.A. Care Case Manager assesses that the Client/Member may have an acute or chronic medical needs and is not medically stable requiring L.A. Care case management, and/or; • L.A. Care Case Manager assesses that the Client/Member may have social support issues that may impede the implementation of the L.A. Care's care plan.

CITY TCM	L.A. CARE
may impede the implementation of the L.A. Care's care plan. b. City TCM Case Manager will determine what coordination options are appropriate for the Client's level of need in order to coordinate care with L.A. Care; and will provide any corresponding documentation to the L.A. Care Case Manager when appropriate. c. When appropriate, the City TCM Case Manager will obtain and review the Client/Member care plan, and will contact the L.A. Care Case Manager to discuss the Client/Member medical issues and/or related social support issues. d. The City TCM Case Manager will notify L.A. Care via an agreed medium (e.g., specific form such as TCM Coordination/Non-Duplication Report Form, email to L.A. Care), that the Client/Member is receiving TCM services and has identified a social support issues(s) that may impede the implementation of the L.A. Care's care plan. e. When appropriate, the City TCM Case Manager will provide all necessary assessments, and care plans, medical or otherwise, to L.A. Care as soon as possible to address the Client's/Member's immediate medical needs. * These procedures must be followed by City TCM Case Managers, unless the Client/Member has an urgent medical situation needing immediate L.A. Care case management intervention.	b. L.A. Care Case Manager will work together with the City TCM Case Manager to determine what coordination options are appropriate for the Client/Member level of needs; and will provide any corresponding documentation to the City TCM Case Manager when appropriate. c. When appropriate, the L.A. Care Case Manager will obtain and review the Client/Member TCM care plan, and will contact the City TCM Case Manager to discuss the Client/Member medical issues and/or related social support issues. d. The L.A. Care Case Manager will notify City TCM Case Manager via an agreed medium (e.g., specific form, email to City TCM), that the Client/Member is receiving L.A. Care services and has identified a social support issues(s) that may impede the implementation of the L.A. Care's care plan. e. When appropriate, the L.A. Care Case Manager will provide all necessary assessments, and care plans, medical or otherwise, to City TCM Case Manager as soon as possible to address the Client's/Member's immediate medical needs.
F. PROVIDER TRAINING	
a. The City TCM will provide training to L.A. Care, as requested, and within the capacity of City TCM to accommodate such training requests.	a. L.A. Care will provide training to City TCM, as requested, and within the capacity of L.A. Care to accommodate such training request.
G. REFERRAL, FOLLOW UP AND MONITORING PROTOCOL *	
a. City TCM Case Managers will provide referral, follow-up, and monitoring services to help Clients/Members obtain needed services, and to ensure the TCM care plan is implemented and adequately addresses the Client's/Member's needs. b. The City TCM Case Manager will refer the Client/Member to services and related activities that	a. L.A. Care will refer Members for the following services in executing their responsibilities to Members for the delivery of primary health care and related care coordination: • Medical services • Non-medical services • Health Education services and resources • Basic Social support needs

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help link the individual with medical, social, educational, or other service providers. The City TCM Case Manager will also link the Client/Member to other programs deemed necessary and provide follow-up and monitoring as appropriate. c. The City TCM Case Manager will contact L.A. Care directly, as needed, to ensure the L.A. Care Case Manager or PCP is aware of the Member receiving the proper care. d. The City TCM Case Manager shall provide all necessary referrals as appropriate, medical or otherwise, to L.A. Care as soon as possible to address the Client's/Member's immediate medical needs. e. The City TCM Case Managers will refer Members to L.A. Care for all medically necessary services, and authorization for any out-of-network medical services. f. The City TCM Case Manager will refer Client/Member to L.A. Care when a medical need develops or escalates after a L.A. Care assessment and notification of any related medically necessary support issues. g. The City TCM Case Manager will refer Members to L.A. Care when the Member needs assistance with medical related services, e.g., scheduling appointments with L.A. Care; and delays in receiving authorization for specialty health services. h. If the City TCM determines that the Client/Member needs or qualifies for TCM services, the City TCM Case Manager will assess and specifically identify the issue for which the Client/Member was referred, as well as all other case management needs, and develop a care plan as described in the "Assessment and Care Plan Protocol" area of this Section. i. The City TCM Case Manager will provide linkage and referrals, as needed and will monitor and follow-up as appropriate. j. The City TCM may obtain and review L.A. Care's Member care plan to assist in assessing the referred issue.	b. L.A. Care will provide referrals for basic social support needs when an intensive level of case management is not needed and does not require follow-up or monitoring. Examples include: • Member seen by a L.A. Care Case Manager and the Member needs directions to the local Food Bank • L.A. Care Case Manager provides a Member with driving directions to the nearest vocational trade school. This would not constitute the need for TCM services. • L.A. Care will refer Members to City TCM services when the Member falls into one of the identified target populations, has undergone L.A. Care case management assessment, and meets any of the following criteria: ✓ Member is determined to need case management services for non-medical needs ✓ L.A. Care has determined that the Member has demonstrated an on-going inability to access L.A. Care services ✓ L.A. Care has determined that Member would benefit from TCM face-to-face case management ✓ L.A. Care has concerns that the Member has an inadequate support system for medical care ✓ L.A. Care has concerns that the Member may have a life skill, social support, or an environmental issue affecting the Member's health and/or successful implementation of the L.A. Care's care plan. c. L.A. Care shall share information with the City TCM Case Manager that informs of the outcome for which the initial referral from TCM was made. d. Referral of Members to City TCM does not automatically confirm enrollment of Members into the City TCM Program. Prior to the referral to City TCM Program, L.A. Care will identify the social, educational, and/or other non-medical issues the Member has that require case management. e. When L.A. Care refers a Member to City TCM for TCM services for any medically necessary or social support needs, coordination will take place as frequently as deems necessary either by L.A. Care or City TCM Case Manager, but no less than on a six-month basis.

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k. The TCM Member case shall remain open until the issue referred by L.A. Care has been resolved, and no other TCM service is necessary ad determined by City TCM. If the Member is uncooperative or becomes lost to follow-up, the TCM Member case will be closed by the City TCM Case Manager. l. City TCM Case Manager will notify L.A. Care when the referred issues have been resolved. m. Referral by L.A. Care of a Member to the City TCM does not automatically confirm enrollment into the City TCM program. * These procedures must be followed by City TCM Case Managers, unless the Client/Member has an urgent medical situation needing immediate L.A. Care case management intervention.	
H. COMMUNICATION	
The City TCM will: a. Provide instructions on how to make referrals to City TCM Program. b. Provide L.A. Care with City TCM staff roster and liaison list. c. Facilitate TCM case discussions with L.A. Care, as needed. d. Refer Member with an open TCM case to the Member's L.A. Care Primary Care Physician (PCP) when the City TCM Case Manager identifies Member's medical need. e. Provide L.A. Care PCP with Member status update when a TCM assessment is performed on a referred Member with a new medical need. f. Notify L.A. Care PCP with Member's enrollment status in City TCM Program via agreed upon notification form.	L.A. Care will: a. Facilitate communications regarding mutual client population and provide instructions on how to make referrals to L.A. Care. b. Provide City TCM with a L.A. Care liaison/staff roster to facilitate case management upon request. c. Share with City TCM Case Manager the Member's Health/Medical Care Plan and History/Physical (HP), upon request, to ensure the most appropriate service delivery for mutual Client Member population. d. Identify and refer Members who meet the City TCM targeted population definition and have identified with non-medical needs or issues where comprehensive TCM may be beneficial. Note that referral does not automatically confirm participation of the referred Members, and also of limited capacity, into the City's TCM Program. e. L.A. Care's will plan and coordinate with Member's PCP the medical care for the newly identified medical need of a Member in a timely manner.

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	f. For Members identified eligible for TCM services are not enrolled in City TCM Program, L.A. Care retains responsibility for low or no cost referral to local resources.

I. DATA EXCHANGE / REPORTING	
The City TCM Program: a. Annually, the City TCM will provide L.A. Care with TCM target population listing. b. In collaboration with L.A. Care, develop a referral tracking system at no cost to promote coordination for Clients/Members receiving TCM services.	L.A. Care will: a. Share the TCM target population listing provided by City TCM with appropriate providers. b. In collaboration with City TCM, develop a referral tracking system at no cost to promote coordination of services for Clients/Members receiving TCM services. c. Receives from State a listing of L.A. Care Members enrolled in City TCM Program on a monthly basis, which assist L.A. Care in following up and coordinating TCM services and other activities with City TCM.
J. MEMBER OUTREACH AND EDUCATION	
a. The City TCM Case Managers will screen Medi-Cal Beneficiaries to identify if they are assigned to L.A. Care for their primary medical care. b. Ensure that all City TCM Case Managers are educated on how to make referrals to L.A. Care and/or other providers as designated by L.A. Care.	a. Inform L.A. Care Members about availability of City TCM Program. b. Ensure L.A. Care providers are educated on how to make TCM service referrals to City TCM Program.
K. QUALITY IMPROVEMENT AND ISSUE RESOLUTION	
a. Notify the L.A. Care liaison(s) when the Member's medical needs are not being addressed by the PCP as determined by the City TCM Case Manager's ongoing assessment of the Member's overall status. b. If the issue remains unresolved, the City TCM liaison can request involvement of appropriate L.A. Care Management staff to address and resolve quality, administrative or operational issues. c. As needed, the City TCM Case Managers may participate in ad-hoc meetings with L.A. Care.	a. Notify City TCM liaison(s) when mutual Member's non-medical issues are not being addressed effectively, as determined by the Member's PCP. b. If the issue remains unresolved, the L.A. Care liaison can request involvement of appropriate City TCM Management Team staff to address and resolve quality, administrative or operational issues. c. Convene ad hoc meetings with City TCM Case Managers, as needed.