State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

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Date: June 30, 2011

PPL No. 11-016

TO: Local Governmental Agency Targeted Case Management Coordinators

SUBJECT: **Implementation of Targeted Case Management State Plan Amendment for Individuals at Risk of Institutionalization**

This Policy and Procedure Letter announces the implementation of the new Targeted Case Management (TCM) State Plan Amendments (SPAs) for the target group of Individuals at Risk of Institutionalization. This SPA is one of five new TCM service SPAs effective with dates of service beginning July 1, 2011.

This SPA includes the new target group definitions, new program service definitions and requirements, as well as exclusions and limitations. LGAs must adhere to all aspects as provided in this PPL.

Additionally, this PPL identifies some of the common requirements below pertaining to the five SPAs and specific requirements for the target group of Individuals at Risk of Institutionalization.

1) The five new TCM service SPAs replace the current six TCM service SPAs, which are Public Health, Outpatient Clinic, Public Guardian, Linkages, Adult Probation, and Community target groups. Service provided under the current six SPAs will not be reimbursed for dates of service beyond June 30, 2011.

2) The five SPAs include four new service components that replace the current six service components. Most of the elements in the current six are contained in the new four.

   a) Crisis assistance planning is not explicitly identified in the four new service components, but much of the services a case manager might provide during a crisis are covered in the four components. Clients must have a TCM assessment and care plan developed before or concurrent with any referral or other TCM services provided to clients during a crisis to be reimbursable.

   b) All assessments and care plans must be an explicitly identifiable and distinct part of the client case notes so that any reviewer may be able to recognize them as such.

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3) The provider agency qualifications are the same for each of the five target groups.

4) This target group includes individuals transitioning to a community setting. This does not include individuals who are served in Institutions for Mental Disease or individuals who are inmates of public institutions.

5) SPAs contain requirements for client freedom of choice and access to services. LGAs must ensure that all freedom of choice and access to service requirements are met.

6) TCM cannot be claimed for any beneficiary receiving services through a Home and Community-Based Services Section 1915(c) waiver. Information on these waiver programs can be found at the following website:

   http://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp

7) LGAs participation in this SPA will be determined by the annual TCM participation survey, due to DHCS August 1, 2011.

8) TCM services do not include acting on behalf of the client during case conferences, arrangement and/or providing consent of placing clients into a licensed community care setting, or providing consent related to any medical treatments. Additionally, any activities related to the legal requirements for annual renewal of conservatorship or any investigations pertaining to the appropriateness and need for conservatorship cannot be claimed as TCM. TCM services do not include activities related to money management, property management or any legal requirements.

Existing TCM Program requirements not mentioned in this PPL remain in effect. For example, client care plans must still be reviewed and approved in writing by the case manager's supervisor; follow-up must still take place within 30 days of a referral, with documentation evident in client case notes.

The language of the newly approved SPA defining TCM services for Individuals at Risk of Institutionalization is as follows:

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):
Medi-Cal eligible individuals 18 years or older, who 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, or inability 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.

Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

For those individuals in this target group, who may receive case management services under a waiver program, case management services shall not be duplicated, in accordance with Section 1915(g) of the Social Security Act.

This target group excludes persons enrolled in a Section 1915(c) waiver program from receipt of Targeted Case Management (TCM) services.

There shall be a county-wide system to ensure coordination among TCM providers of case management services provided to Medi-Cal beneficiaries who are eligible to receive case management services from two or more programs.

<u>Areas of State in which services will be provided (§1915(g)(1) of the Act)</u>:
Only in the following geographic areas: Alameda, Amador, Butte, Contra Costa, El Dorado, Fresno, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Los Angeles, Madera, Marin, Mendocino, Merced, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Stanislaus, Sutter, Tulare, Tuolumne, Ventura, Yolo, and Yuba counties, City of Berkeley, City of Long Beach, and City of Pasadena.

Comparability of Services (§§1902(a)(10)(B) and 1915(g)(1))
Services are not comparable in amount, duration, and scope (§1915(g)(1)).

Definition of Services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
   - Taking client history;
   - Identifying the individual'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 individual;
   - Assessment and/or periodic reassessment to be conducted at a minimum of once every 6 months to determine if an individual'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 individual;
   - Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's 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 individual;

3. Referral and related activities (such as scheduling appointments for the individual) 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 individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
     - Services are being furnished in accordance with the individual's care plan;
     - Services in the care plan are adequate; and

- Changes in the needs or status of the individual 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 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 an individual when all care plan goals have been met.

Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
(42 CFR 440.169(e))

<u>Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b))</u>:
TCM Provider Agency Qualifications:

- Establish a system to coordinate services for individuals who may be covered under another program which offers components of case management or coordination similar to TCM including, but not limited to, the coordination of services with Managed Care providers, California Children's Services, as well as State waiver programs (e.g. HIV/AIDS, etc.); and
- Demonstrated programmatic and administrative experience in providing comprehensive case management services and the ability to increase their capability to provide their services to the target group; and
- Must be an agency employing staff with case management qualifications; and
- Establish referral systems and demonstrated linkages and referral ability with essential social and health service agencies; and
- Have a minimum of five years providing comprehensive case management services to the target group; and
- Administrative capacity to ensure quality of services in accordance with state and federal requirements; and
- Financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles; and
- Capacity to document and maintain individual case records in accordance with state and federal requirements; and
- Demonstrated ability to meet state and federal requirements for documentation, billing and audits; and
- Ability to evaluate the effectiveness, accessibility, and quality of TCM services on a community-wide basis.

TCM Case Manager Qualifications: Case managers employed by the case management agency must meet the requirements for education and/or experience as defined below:

- A Registered Nurse, or a Public Health Nurse with a license in active status to practice as a registered nurse in California; individual shall have met the educational and clinical experience requirements as defined by the California Board of Registered Nursing, or
- An individual with at least a Bachelor's degree from an accredited college or university, who has completed an agency-approved case management training course, or
- An individual with at least an Associate of Arts degree from an accredited college, who has completed an agency-approved case management training course and has two years of experience performing case management duties in the health or human services field, or
- An individual who has completed an agency-approved case management training course and has four years of experience performing case management duties in a health or human services field.

Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):
The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):
Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i) The name of the individual; (ii) The dates of the case management services; (iii) The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in § 440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and FFP is not available in expenditures for, services defined in § 440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Limitations on translation: Arranging for translation activities and/or providing translation as part of the TCM service, including the costs of purchasing translation services from a vendor to enable communication between the client and case manager, is included in the TCM rate. When a case manager provides translation that is unrelated to providing the TCM service, the translation is not claimable as TCM.

Case Management Services Do Not Include:

- Case management activities do not include activities that are the direct delivery of another service such as, but not limited to, acting on behalf of the client during case conferences, arrangement and/or providing consent of placing clients into a licensed community care setting, or providing consent related to any medical treatments. Additionally, any activities related to, the legal requirements for annual renewal of conservatorship or any investigations pertaining to the appropriateness and need for conservatorship cannot be claimed as TCM,
- Program activities of the agency itself that do not meet the definition of TCM,
- Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to the targeted case management,
- Diagnostic and/or treatment services,
- Restricting or limiting access to services, such as through prior authorization,
- Activities that are an essential part of Medicaid administration, such as outreach, intake processing, eligibility determination, or claims processing,
- Services that are an integral part of another service already reimbursed by Medicaid,
- Activities related to money management, property management or any legal requirements.

If you have any questions regarding this PPL, please contact Tracy Albano, TCM Chief at (916) 552-9538 or Tracy.Albano@dhcs.ca.gov.

Sincerely,

ORIGINAL SIGNED BY GERI BAUCOM

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