State Plan under Title XIX of the Social Security Act
State/Territory: CALIFORNIA

TARGETED CASE MANAGEMENT SERVICES
CHILDREN WITH AN IEP/IFSP

Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)
Children with an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP), when Targeted Case Management (TCM) is included in the plan.

Areas of state in which services will be provided (§1915(g)(1) of the Act):
_X_ Entire State
___ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
___ Services are provided in accordance with §1902(a)(10)(B) of the Act.
_X_ Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): TCM 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. TCM 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:
   - Reviewing individual's records, such as cumulative files, health history, and/or medical records;
   - Interviewing the individual and/or parent/guardian;
   - Observing the individual in the classroom and other appropriate settings; and
   - Writing a report to summarize assessment results and recommendations for additional LEA services;

Assessment and/or periodic reassessment to be conducted on an annual, triennial and as needed basis (one amended assessment allowed to be reimbursed for each service type every 30 days) 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 meeting with the individual and parent(s) or guardian(s) to establish needs;
   - 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:

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- 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.

_X_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))"

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

- Must be an agency employing staff or contracting with qualified practitioners with case management qualifications; and
- Have demonstrated the ability to collaborate with public and private service providers; and
- Have demonstrated direct experience in the coordination of educational support services (e.g. Early Periodic Screening, Diagnosis, and Treatment, Social Services; Counseling Services; Psychological Services; Student Assistance; Special Education; and Nutritional Services); and
- Have an administrative capacity to ensure quality of services in accordance with state and federal requirements; and
- Have a financial management capacity and system that provides documentation of services and costs. For entities that also furnish services by another federally funded program, costs must be in accordance with OMB A-87 principles; and
- Have a capacity to document and maintain individual case records in accordance with state and federal requirements; and

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- Have demonstrated ability to meet all state and federal laws governing the participation of providers in the state Medicaid program, including, but not limited to, the ability to meet federal and state requirements for documentation, billing and audits.

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 will ensure the provision of TCM 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.
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 will ensure the following:

- TCM services will not be used to restrict an individual's access to other services under the plan;
- Individuals will not be compelled to receive TCM services, condition receipt of TCM services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of TCM services; and
- Providers of TCM 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 TCM 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)):
Each encounter of TCM services, with an eligible individual, must include the date of service; name of the individual; Medi-Cal identification number; name of the agency or provider

rendering the service; nature, extent, or units of service; place of service, whether goals specified in the plan have been achieved, if the individual has declined any services in the care plan, the need for and occurrences of coordination with other case managers, and a timeline for obtaining needed services and revaluation of the plan.

Individuals may receive TCM services from more than one agency or provider. To avoid duplication of services and billing LEAs must clearly document the LEA and TCM services rendered by each TCM agency or provider, and where necessary, develop written agreements to define the TCM service(s) each agency or provider will be responsible for rendering.

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 Federal Financial Participation (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))

TCM services authorized in the individual's IEP or IFSP may be billed up to 32 units per individual per day. A unit is defined as 15 minutes of continuous treatment (any time over seven continuous treatment minutes can be billed as a 15-minute increment).

Services not covered under TCM include assessment costs to determine the individual's needs, provision of medical treatment or services, discharge planning from an institution, administrative activities (eligibility determination, screening, intake, outreach, and utilization review), formal advocacy and development of new provider resources, payment for administration costs of other services or programs to which the child is referred, general Medicaid administrative expenses, and prior authorization of services. Additionally, TCM does not include diagnostic or treatment services, educational activities that may be reasonably expected in the school system, administrative activities or program activities that do not meet the definition of TCM, and services that are an integral part of another service already reimbursed by Medicaid.

Federal Financial Participation only is available for TCM 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 TCM that is included in an IEP or IFSP consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c)).

Reimbursement Methodology for Case Management Services as described in Supplement 1c to Attachment 3.1-A will sunset on June 30, 2015.

1) Providers participating in Targeted Case Management (TCM) will be required to submit an annual survey identifying:

    a. labor costs of performing TCM services; and
    b. overhead costs related to performing TCM.

2) The unit of service shall be a 15 minute case manager time increment on an individual beneficiary basis and billed through Electronic Data Systems (EDS).

3) Payments for TCM services will be issued by EDS directly to the providers of these services. The Department will work with EDS on:

    a. establishing and implementing the reimbursement process; and
    b. determining the appropriate edits and audits to ensure program integrity.

4) The department shall ensure “free care” and “third party liability” requirements are met.

5) The department shall conduct an annual survey of insurance carriers to determine whether TCM services, as described in this State Plan Amendment, are included and paid for as a covered benefit. The survey results will be used to determine the extent of Medicaid’s payment liability in accordance with federal regulations set forth in 42 CFR 433.139 (b).

6) Statewide hourly tiered rates will be established based on the annual survey submitted and will be grouped into low, medium, and high cost categories. Provider rates would be averaged for each of the 3 categories, providing the rate to be used by that grouping of providers.