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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

December 24, 2015

Ms. Henrietta Sam-Louie
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

STATE PLAN AMENDMENT 15-002

Dear Ms. Sam-Louie:

The Department of Health Care Services (DHCS) is submitting State Plan Amendment (SPA) 15-002 for your review and approval. SPA 15-002 updates the benefit and reimbursement pages for case management services for childhood lead poisoning prevention, as well as the description for case management in Limitations on Attachment 3.1-A and 3.1-B. SPA 15-002 responds to the companion letter DHCS received with the approval of SPA 11-019. The effective date for SPA 15-002 is December 11, 2015.

In the companion letter, the Centers for Medicare and Medicaid Services (CMS) asked the state to confirm the language for the payment methodologies in Attachment 4.19-B, pages 5g-5i, for individuals identified as lead poisoned. DHCS worked with the California Department of Public Health, Childhood Lead Poisoning Prevention Branch, to revise the payment methodologies in Attachment 4.19-B and to update benefit description in Supplement 1g to Attachment 3.1-A.

As part of the state's own same page review process, DHCS also updated the case management description on page 23 of Limitiations to Attachment 3.1-A and 3.1-B. The state is including page 8 of Attachment 3.1-A to add Supplement 1g to the list of supplements for case management, but 3.1-B is not included, because it lists Supplement 1g.

SPA 15-002 updates language to the provisions set forth in the following sections of the State Plan:

- Attachment 3.1-A, page 8;
- Limitations on Attachment 3.1-A, page 23;
- Limitations on Attachment 3.1-B, page 23;
- Attachment 4.19-B, pages 5g-5i.1; and
- Supplement G to Attachment 3.1-A, pages 1-5.

The state has used the rate methodology described in Attachment 4.19-B since the mid 1990s, so there is no financial impact for SPA 15-002. DHCS originally published a public notice on February 15, 2013. DHCS published a corrected public notice on December 11, 2015, for SPA 15-002 with the December 11, 2015, effective date. On November 16, 2015, CMS agreed a tribal notice was not required.

If you have any questions regarding the information provided, please contact Ms. Laurie Weaver, Assistant Deputy Director, Health Care Benefits and Eligibility, and Acting Chief, Benefits Division, by phone at (916) 552-9400 or by email at Laurie.Weaver@dhcs.ca.gov.

Sincerely,

ORIGINAL SIGNED

Mari Cantwell
Chief Deputy Director
Health Care Programs
State Medicaid Director

Enclosures

cc: Cynthia Nanes
Division of Medicaid and Children's Health Operations
Centers for Medicare and Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300(5W)
San Francisco, CA 94103-6707

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **15-002**

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 11, 2015

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Social Security Act, Sections 1905(a)(19), 1915(g)
42 CFR 441.18, 440.169

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $0
b. FFY 2017 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1-A, page 8,
Limitations on Attachment 3.1-A, page 23
Limitations on Attachment 3.1-B, page 23
Attachment 4.19-B, pages 5g through 5i.1
Supplement G to Attachment 3.1-A, pages 1-5

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A, page 8,
Limitations on Attachment 3.1-A, page 23
Limitations on Attachment 3.1-B, page 23
Attachment 4.19-B, pages 5g through 5i
Supplement G to Attachment 3.1-A, pages 1-5

10. SUBJECT OF AMENDMENT:
Update the rate methodology and description for case management for childhood lead poisoning prevention; update case management description.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
ORIGINAL SIGNED

13. TYPED NAME:
Mari Cantwell

14. TITLE:
Chief Deputy Director
Health Care Programs
State Medicaid Director

15. DATE SUBMITTED:

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, MS 4506
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory California

Case Management
Childhood Lead Poisoning Prevention

C. Comparability of Services

_____ Services are provided in accordance with Section 1902(a)(10)(B) of the Act.

__X__ Services are not comparable in amount, duration, and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(l0)(B) of the Act.

D. Definition of Services:

Medi-Cal Childhood Lead Poisoning Prevention Case Management Services include needs assessment, setting of objectives related to needs, individual service planning, service scheduling, and periodic evaluation of service effectiveness. Case management services ensure that the changing needs of the Medi-Cal eligible person are addressed on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs. Case management of lead poisoned individuals includes the following:

1. Assessment

Analyzing each lead poisoned client's need for medical, social, educational, and other services to determine appropriate resources and to develop a service plan.

2. Plan Development

Plan development includes the development of a written, comprehensive, individual service plan, based upon the assessment, which identifies the activities and assistance needed to accomplish the objectives developed between the client and the case manager. The service plan describes the nature, frequency, and duration of the activities and assistance that meet the individual's needs.

Specific client objectives are discussed and strategies for achieving the stated objectives are identified. This involves acquainting the client, parent, or legal guardian with the sources of services in the community and providing information for obtaining services through community programs.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory California

Case Management
Childhood Lead Poisoning Prevention

3. Linkages and Consultation

Implementing the service plan includes consultation with providers and interagency coordination on behalf of the client and referral of the client to needed medical, social, educational, and other services as well as follow-up to ensure services including, but not limited to, blood lead tests prescribed by providers are received by the client.

4. Assistance in Accessing Services

As necessary to facilitate communication between the client and the case manager and between the client and other providers of service, the case manager shall arrange for translation services. Facilitating access to services may also require arranging appointments and transportation to medical, social, educational, and other services.

5. Crisis Assistance Planning

The evaluation, coordination, and arranging of immediate services or treatment needed in those situations that appear to be emergent in nature or that require immediate attention or resolution in order to avoid, eliminate, or reduce a crisis situation for a specific client.

6. Periodic Review

Consistent with the client's needs, the case manager must periodically re-evaluate the client's progress toward achieving plan objectives. Based upon this review, it will be determined what changes to the client's plan should be made, if any, or if case management services are appropriate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory California

Case Management
Childhood Lead Poisoning Prevention

Medi-Cal Childhood Lead Poisoning Prevention Case Management services do not include:

- Program activities of the agency itself that do not meet the definition of case management defined by Medicaid.
- Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to case management services.
- Diagnostic and/or treatment services.
- Services that are an integral part of another service already reimbursed by Medicaid.
- 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.

E. Qualification of Providers:

1. Case Management Agencies:

   a. Must be a public health agency employing staff with case manager qualifications; and
   b. Have the ability to evaluate the effectiveness, accessibility, and quality of case management services on a community-wide basis; and
   c. Have established referral systems, demonstrated linkages, and referral ability with essential social and health services agencies; and
   d. Have a minimum of five years' experience in assisting high-risk or low income persons to obtain medical, social, educational, and/or other services; and
   e. Have an administrative capacity to ensure quality of services in accordance with state and federal requirements; and
   f. Have a financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles; and
   g. Have a capacity to document and maintain individual case records in accordance with state and federal requirements; and
   h. Have demonstrated the 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory California

Case Management
Childhood Lead Poisoning Prevention

2. Case managers employed by the case management agency must meet the following requirements for education and/or experience as defined below:

   a. A certified licensed Public Health Nurse (PHN) with a Bachelor's degree from an accredited college or university, and completion of agency-approved case management training.

   b. A Registered Nurse with training and experience in public health under the supervision of a licensed PHN.

F. The State assures that the provision of Medicaid/Medi-Cal Childhood Lead Poisoning Prevention 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 recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

3. Eligible clients will have the option to participate in the services offered under this plan.

STATE/TERRITORY: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A for Mentally Disabled (Short-Doyle) and Developmentally Disabled (Lantern), and Supplements 1a-1g to Attachment 3.1-A for Case Management Services (in accordance with section 1905 (a)(19) or section 1915 (g) of the Act).

__x_____Provided ____x_____With limitations _____ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act)

__x_____ Provided ____x_____ With limitations _____ Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th days falls.

_____ Additional coverage ++

b. Services for any other medical conditions that may complicate the pregnancy.

_____ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
19. Case Management Services (Pertains to Supplements 1a-1g to Attachment 3.1-A)	Services are limited to individuals who meet the target population criteria. Case management services means services which will assist eligible individuals in gaining access to needed medical, social, educational, and other services. Case management includes all of the following: • Assessment of an eligible individual • Development of a specific care plan • Referral to services • Monitoring activities	Prior authorization is not required. Case Management services do not include: • Program activities of the agency itself which do not meet the definition of targeted case management • Direct delivery of underlying medical, social, educational, or other services to which an eligible individual has been referred • Activities that are integral to the administration of foster care programs or most other non-medical program • Services which are an integral part of another service already reimbursed by Medicaid • 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

* Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory California

Case Management
Childhood Lead Poisoning Prevention

A. Target Group

Title XIX eligible children from birth to 21 years of age who are eligible for medical assistance in accordance with Sections 1902(a)(43), 1905(a)(4)(B) and 1905(r) of the Social Security Act and who have laboratory test results documenting:

1. One venous blood lead level equal to or greater than 20 micrograms of lead per deciliter of blood (mcg/dL), or

2. Two blood lead levels equal to or greater than 15 mcg/dL which are drawn at least 30 and no more than 600 calendar days apart. The first specimen is not required to be venous, but the second must be venous.

Individuals identified as lead poisoned require case management by public health nurses in order to access medical services to reduce elevated blood lead levels and to reduce and eliminate lead toxicity.

Payment for case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purposes.

Case management services provided in accordance with Section 1915 (g) of the Social Security Act will not duplicate case management services provided under any home and community-based services waiver.

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

B. Areas of State in which services will be provided:

_X_ Entire State

____ Only in the following geographic areas.

STATE/TERRITORY: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

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__x_____Provided ____x_____With limitations _____ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act)

__x_____ Provided ____x_____ With limitations _____ Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th days falls.

_____ Additional coverage ++

b. Services for any other medical conditions that may complicate the pregnancy.

_____ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

* Description provided on attachment

Enclosure A
Technical Assistance Tool
Optional State Plan Case Management
[CMS-2237-IFC]

BASIC PROVISIONS OF SECTION 6052 OF THE DRA

1) What is contained in section 6052 of the Deficit Reduction Act of 2005 (DRA), Reforms of Case Management and Targeted Case Management and the related rule, CMS-2237-IFC?

Answer:

Section 6052 refined the definition of Medicaid case management and targeted case management (TCM). Part of that definition consisted of examples of Medicaid case management activities, as well as excluded activities. The interim final rule with comment period (IFC) implements and interprets the provisions of section 6052. The rule contains further guidance pertaining to the coverage of Medicaid case management and targeted case management services.

2) What are Medicaid case management and targeted case management services?

Answer:

Case management includes services that assist eligible individuals to gain access to needed medical, social, educational, and other services. Targeted case management are case management services provided only to specific classes of individuals, or to individuals who reside in specified areas of the State (or both). Case management does not include the underlying medical, social, educational and other services themselves, integral components of covered Medicaid services, nor does it include activities integral to foster care programs or other non-medical programs (with a few exceptions discussed below).

3) What are the components of case management?

Answer:

Case management services are comprehensive and must include all of the following: assessment of an eligible individual (42 CFR 440.169(d)(1)); development of a specific care plan (42 CFR 440.169(d)(2)); referral to services (42 CFR 440.169(d)(3)); and monitoring activities (42 CFR 440.169(d)(4)).

4) What services and activities do the statute and regulation exclude from Medicaid reimbursement as case management services?

Answer:

Medicaid reimbursement is not available as case management services for services or activities that do not comport with the definition of Medicaid case management. Nor is Medicaid reimbursement available as case management when any of the following conditions exist: 1) Case management activities are an integral component of another covered Medicaid service; 2) 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, but not limited to, services under parole and probation programs, public guardianship programs, special education programs, child welfare/child protective services, and foster care programs; 3) The activities are integral to the administration of

foster care programs; and, 4) The activities, for which an individual may be eligible, are integral to the administration of another non-medical program, such as a guardianship, child welfare/child protective services, parole, probation, or special education program except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Act.

There might be some confusion because there are administrative activities that have been previously referred to as "case management" such as prior authorization or referral to Medicaid services but that do not meet the definition of case management. States can continue to claim the costs of such activities as administrative costs. Services that meet the definition of case management services must be covered under the approved State plan cannot be claimed as administrative activities. (See Administrative Activities section below for further clarification).

5) What are some examples of activities that are not within the scope of Medicaid case management and would be excluded from Medicaid reimbursement?

Answer:

The DRA provided examples of activities that are not included within the scope of Medicaid case management that are related to the administration of foster care programs, such as home investigations and providing transportation. We have interpreted this statutory language to represent the types of activities which are excluded from the definition of case management, rather than as isolated exclusions. The listed activities in the statute represent instances where there could be cost shifting from the foster care program to Medicaid; we have interpreted the language to apply to similar activities where there could be cost shifting from other programs to Medicaid. Thus the exclusions define types of non-Medicaid costs for which Medicaid cannot pay, rather than the sole instance of inappropriate cost-shifting. The rule applies these same payment principles to all Medicaid case management services including special education programs (under the Individuals with Disabilities Education Act), parole and probation functions, legal services, child welfare/child protective services and guardianship.

6) What is the effective date of this rule? What steps are States expected to take to come into compliance with the new rule? Are SPAs or waiver program revisions necessary? If so by when?

Answer:

Section 6052 of the Deficit Reduction Act of 2005 was effective on January 1, 2006. This legislation provides a specific definition of Medicaid case-management and details the types of activities that should not be funded by the Medicaid program. This section of statute also authorized the Secretary to promulgate an Interim Final Rule with Comment Period (IFC), which appeared in the Federal Register on December 4, 2007. The provisions of the IFC became effective 90 days thereafter, March 3, 2008.

We recognize that there are certain provisions of the IFC that may pose significant implementation challenges to States; specifically the single case manager provision and the applicability of the IFC provisions to the 1915 (c) home and community-based waiver program. As such, additional time has been granted to implement these two provisions. The IFC states that States have up to one year after their next legislative sessions to adopt

practices to comply with the single case manager provision. Question 29 of this guidance document addresses the compliance timeframes for the 1915 (c) program. Also, please be advised that as CMS drafts the final rule, we intend to propose modifications of the 15-minute increment provision of the IFC. Specifically, we intend to recommend that the final regulation permit an extended timeframe for implementation as well as additional flexibility with respect to units of service.

We recommend that States submit State Plan Amendments (SPAs) no later than June 30, 2008 to revise the reimbursement, coverage, and eligibility provisions of their approved Medicaid State plans that will be affected by the regulation. CMS is developing additional guidance regarding SPA submittals. We further recommend States to engage their appropriate Regional Office staff in discussions regarding their current compliance status and potential SPA submittals.

7) **Does the rule address who may provide case management services? Is there an exception to this rule?**

Answer:

Individuals must be free to choose their case management provider from among those that have qualified to participate in Medicaid and are willing to provide the services. However, while the freedom of choice requirement is beneficial to the Medicaid population as a whole, Congress recognized that this requirement might not adequately protect the interests of persons with a developmental disability or chronic mental illness. When a target group consists solely of individuals with developmental disabilities or chronic mental illness, States may limit provider participation to specific persons or entities by setting forth qualifying criteria that assure the ability of the case managers to connect individuals with needed services.

8) **Can a participant choose his or her individual case manager?**

Answer:

Yes. Individuals may choose freely among those case managers or entities that the State has found qualified to provide case management services. Absent a waiver to the contrary, such individuals also maintain their right to choose qualified providers of all other Medicaid services they receive.

9) **Are States subject to public notice requirements prior to implementing the provisions in this regulation?**

Answer:

Yes. We expect that most States will need to do public notice because of changes to the reimbursement methodologies necessary to come into compliance with the provisions of this regulation. Such proposed changes qualify as a significant change in methods or standards of setting payment rates that meet the requirement for public notice as described in section 42 CFR 447.205 of the Medicaid regulation.

10) **What assistance will CMS provide to States (particularly those moving from a system where there were limited providers) as they open their systems to all willing and qualified providers?**

Answer:

The CMS will provide ongoing technical assistance to States as they explore options available for the delivery of case management for home and community based waiver populations. Specifically, CMS can assist States as they develop provider qualifications (for those States previously offering case management as an administrative component) and make necessary system modifications to accommodate the change. For those States interested in continuing to limit the providers of services for case management, CMS is available to provide technical assistance on section 1915(b)(4) or other authorities. States continue to have the ability to set provider qualifications for any Medicaid provider including providers of case management as long as they are reasonably related to the ability to effectively serve the targeted population. Furthermore, because the rule applies in total to Home and Community-Based Services (HCBS) waivers, States may, as described above, limit provider participation to specific persons or entities by setting forth qualifying criteria that assure the ability of the case managers to connect individuals with needed services when the target populations are individuals with developmental disabilities or individuals with chronic mental illness.

11) Are there options available to States who wish to restrict the providers of case management (for populations other than persons with developmental disabilities and those with mental illness)?

Answer:

To the extent the Secretary finds it cost effective and efficient and not inconsistent with the purposes of title XIX, section 1902(a)(23) may be waived through 1915(b)(4) or other authorities to restrict the provider from (or through) whom an individual can obtain services.

12) What is the applicability of TCM Reg for Disease Management?

Answer:

There is no impact on disease management. Disease management is typically a direct service offered either through a managed care organization, a primary care case manager, or individual practitioners. It is a coordinated package of care comprised of preventive, diagnostic and/or therapeutic services to a specific group of individuals who have, or are at risk for, a chronic illness or condition and does not include the same components to meet the definition of case management. In contrast, case management or targeted case management providers may not provide direct services such as disease education, medical monitoring, or instruction in health self-management. Please refer to the State Medicaid Directors letter #04-002 for disease management guidance.

13) Is it possible for individuals to have more than one case manager and what determines who is the single case manager for Medicaid?

Answer:

Medicaid case management facilitates access to needed services through a comprehensive assessment, care planning, referral to services and monitoring. Individuals may receive non-comprehensive services including some components of case management through other resources, but Federal Financial Participation (FFP) is available for case management services that meet the definition of Medicaid case management and targeted case management services as defined in the rule only from a single case manager rather than from multiple providers or under multiple TCM target groups. Before submitting claims for Medicaid payment, a qualified case manager will need to ascertain from the State Medicaid

agency whether the individual is already obtaining Medicaid case management services from another provider. If so, additional Medicaid payment will be available only when the prior case management assessment and plan is outdated, the Medicaid-eligible individual has agreed to receive case management services, and has chosen the provider.

This provision is based on the principles of: one accountable provider who has ultimate responsibility for the delivery of all components of the case management service; and the existence of a system that ensures there is no duplication of service and payment for case-management services. We recognize that in order to accomplish the goal of coordinating and developing a comprehensive, integrated plan of care, the single case manager may need to consult with other providers with specialized expertise. Further, it is important to recognize the distinct differences between case management and other reimbursable Medicaid services. Case management as a service should function to promote access to the direct delivery of other services.

CMS also recognizes that for supervisory purposes or during absences it may be practical for States to have structures in place that ensure continuity of care. In these instances, we would not view this as a violation of the one case manager provision. CMS is interested in working with States to ensure that the principles related to accountability and non-duplication of services are met in the delivery of quality case management services.

14) May a State provide TCM that is specific to only limited services (e.g., IEP services) as long as the individual is not enrolled in any other case management program?

Answer:

No. The definition of case management specifies that these services assist Medicaid eligible individuals to access needed services including medical, social, educational, and other services. This list is broad and does not provide for limiting the needed services.

Please note that per section 1903(a) of the Social Security Act (the Act), nothing in the rule would prohibit or restrict payment for medical assistance for covered Medicaid services furnished to a child with a disability because such services are included in the child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). Likewise, payment for those services that are included in the IEP or IFSP would not be available when those services are not covered Medicaid services.

15) Existing TCM services may include groups identified as Children with IEP's, Juvenile Justice Youth, or Foster Care Children. Can States continue to target these groups given that FFP is no longer available for case management services integral to the administration of another non-medical program including education, juvenile justice, and foster care?

Answer:

Section 1915(g)(2) states that targeted case management services may be offered to individuals in any defined location of the State or to individuals within target groups specified in the State Plan. This provision provides States the flexibility to target case management services to specific classes of individuals who represent special populations in need of case management services. The new rule retains this provision. However, the new rule includes several provisions (others may apply, as well) that may have an impact on TCM

services targeted to these particular groups. Please refer to the rule for an explanation of the following points:

- FFP is not available for activities integral to the administration of foster care programs. Examples of these activities are included in the rule and under 45 CFR 1340.14, 45 CFR 1355.33- 45 CFR 1357.16, and 45 CFR 1356.60. For example, since case management is an administrative activity under title IV-E foster care, it is likely that Medicaid TCM services targeted to a group comprised of children eligible for title IV-E would be considered integral to that program and thus FFP would not be available under Medicaid. Similarly, the title XX block grant includes services/administrative activities for "preventing and remedying neglect, abuse, or exploitation of children…or preserving rehabilitating or reuniting families."
- Case management may not be furnished by an employee or contractor of a juvenile justice, child welfare, or foster care program. For example, Medicaid may not pay for case management services furnished by contractors to the State child welfare/child protective services agency, even if they would otherwise be qualified Medicaid providers, because they are furnishing direct services of the programs of that agency.
- The State may not restrict participants' freedom of choice of Medicaid providers for Medicaid case management/targeted case management.
- The definition of the target group would include the need for services.
- Case management services included in an individual's IEP or IFSP are treated differently. Under section 1903(c), covered Medicaid services are furnished to a child with a disability even when such services are included in the child's Individualized Education Program IEP or Individualized IFSP. In this case Medicaid is the first payor for covered services in an IEP or IFSP. (See rule for further guidance.)

16) **Do you think the limitation on gate keeping applies only to State plan services? Or to all Medicaid services? Does it prevent a case manager (transition coordinator) from authorizing transition services?**

Answer:

Yes. We included section 441.18(a)(6) to prohibit providers of case management services from exercising the State Medicaid agency's authority to authorize or deny the provision of other services under the plan. Although a State Medicaid agency may place great weight on the informed recommendation of a case manager, it must not rely solely on case management recommendations in making decisions about the medical necessity of other Medicaid services that the individual may receive. Medical necessity and the decision to authorize the provision of a service must remain with the State Medicaid agency as required by section 431.10(e). Costs related to these activities, such as prior authorization or determination of medical necessity, which are necessary for the proper and efficient administration of the Medicaid State plan, must be claimed as a direct administrative expense by the Medicaid agency and may not be included in the development of a case management rate.

17) **One State contracts with a non-state agency to do an assessment, level of care and a care plan as an "authorized agent of the state." Notices to consumers are sent on department letterhead that states that the organization is functioning as the State's authorized agent. Will this arrangement still be allowed?**

Answer**:**

Yes. States may continue to enter into agreements with other entities to provide certain functions for the proper and efficient administration of the State plan or to provide services. However, the focus is whether the targeted case management services meet the definition described in the rule, are claimed as a service, and individuals maintain choice of qualified provider, with the exceptions of target groups including individuals with chronic mental illness or developmental disabilities.

18) **When an individual qualifies for more than one targeted case management group or waiver program, how will States determine the individual's case manager?**

Answer:

Consistent with a person-centered approach, when an individual could qualify for case management services under more than one benefit, the individual or the legal representative of the individual, would have a choice of the case management service and provider. In addition, the individual or legal representative would have a choice not to receive the service. With the case manager, the individual or legal representative can participate throughout all components of case management and direct who may participate in the care plan development process.

19) **Can States establish provider qualifications that would result in limiting individuals' choice of providers of targeted case management services to only a county agency or Tribal provider?**

Answer:

No. Other providers may qualify to provide these services because States must ensure freedom of choice of providers and establish provider qualifications that are reasonably related to the provision of the service. To restrict an individual's choice of willing and

qualified providers, a waiver of section 1902(a)(23) would be needed. The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of title XIX, may waive this requirement. States may wish to contact CMS for guidance on the statutory authorities that would waive the "freedom of choice of provider" provision.

20) If a State is providing TCM as a service under section 1115 authority as part of the benefit package, do these regulations apply?

Answer:

Yes. States providing TCM as a State plan service under section 1115 demonstrations would provide TCM as defined in the rule.

21) Do these regulations also apply to case management services offered under EPSDT?

Answer:

Yes. The EPSDT statutory language at section 1905(r)(5) mandates the provision of any medically necessary Medicaid coverable 1905(a) services to any eligible child. However, services provided under EPSDT must be provided in accordance with statutory and regulatory guidance governing the provision of those services under Medicaid. The description of case management in section 5310. D in Chapter 5 of the State Medicaid Manual does not supersede the definition of case management as defined in the rule. Therefore, the policies set forth in the rule apply to the definition of case management services as provided under EPSDT.

22) Do these regulations also apply to case management services offered under the State Children's Health Insurance Program (SCHIP)?

Answer:

Yes. To the extent an SCHIP program is offered as a Medicaid expansion program, the rule applies because these programs follow Medicaid rules.

23) If the State has a Money Follows the Person (MFP) grant, where the State is enrolling nursing facility transitionees into an established waiver, can the State utilize the full 6 months of pre-transition coordination and support as specified in that established waiver?

Answer:

Yes. The State can use the 6 months of case management before the waiver is renewed and has to come into compliance provided the waiver includes the services. MFP does not change current waiver policy.

IMPLEMENTATION

24) Will there be a preprint for states to use in amending their SPA? (Is there going to be an SMD letter with the preprint as an attachment?)

Answer:

A suggested State plan outline for sections 3.1A and B that would meet the requirements of the rule may be located in Enclosure B. CMS is available to provide technical assistance on an individual basis to States seeking to amend SPAs or other programs. A SMD letter will not be issued since CMS-2237-IFC provides needed guidance.

IMPACT ON 1915(c) WAIVER PROGRAMS

25) Do these regulations also apply to case management provided as a service under 1915(c) Home and Community Based Services waiver programs?

Answer:

Yes. CMS has determined that the policies set forth in CMS-2237-IFC will apply to the definition of case management services as provided under section 1915(c) Home and Community Based Services waiver programs.

26) Does the provision of the regulation that requires choice of providers except for those populations (persons with chronical mental ill/developmental disabilities) apply to case management provided as a service under 1915(c) Home and Community Based Services waiver programs?

Answer:

Yes. The choice of provider requirements will apply to case management services provided under section 1915(c) Home and Community Based Services waiver programs. However, as noted above, the State may choose to limit providers when the population served includes individuals with developmental disabilities or individuals with chronic mental illness.

27) What if a State has designed a service in a 1915(c) waiver under the "other" category that incorporates elements of case management but also includes other elements of scope?

Answer:

The CMS will analyze the service to determine its alignment with the case management definition in CMS-2237-IFC. To the extent that the service aligns with the regulatory definition of case management, the regulations will apply.

28) If a State has historically offered case management for their 1915(c) waiver program as an administrative activity to restrict the providers of the function (i.e., to State government staff or Area Agencies on Aging), will they be able to continue in this fashion under this new rule?

Answer:

States must identify the activities claimed as administration and compare the activities to the definition of case management services. If these activities are a case management service, then the service must be claimed as medical assistance. If the activities are for the proper and efficient administration of the State Plan, then reimbursement would be claimed as administration. See Question #29 for a discussion of administration.

Individuals' free choice of qualified Medicaid provider is an important beneficiary protection included in Statute that is also consistent with a person-centered approach to providing services. When a State chooses to include case management services as medical assistance, per section 1902(a)(23) of the Act and section 9508 of COBRA, individuals eligible to receive case management or targeted case management services must be free to choose a case management provider from among those qualified to participate in Medicaid and willing to provide the services. (Section 1915(g)(1) of the Act includes an exception that allows States to limit the providers of case management services available for individuals with

developmental disabilities or chronic mental illness.) To restrict an individual's choice of willing and qualified providers, a waiver of section 1902(a)(23) would be needed. The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of title XIX, may waive this requirement. States may wish to contact CMS for guidance on the statutory authorities that would waive the "freedom of choice of provider" provision.

When activities are administrative, the State Medicaid Agency may enter into interagency agreements with other governmental entities to perform certain administrative functions for the proper and efficient administration of the State plan such as identifying and enrolling potential eligibles into Medicaid. The interagency agreement would describe and define the activities each party to the agreement offers, under what circumstances, and the relationship between the State Medicaid agency and the participating agency.

29) What steps are States expected to take to regarding 1915(c) waiver programs to come into compliance with the new rule?

Answer:

For renewal waivers with an effective date between March 3, 2008, and March 3, 2010, States must be compliant with the regulation no later than March 3, 2010. All other waivers must be compliant by the time of their next waiver renewal. (Examples: A waiver with a renewal date of July 1, 2008, will be given until March 3, 2010, to be compliant; a waiver with a renewal of July 1, 2009, must be compliant by March 3, 2010; a waiver with a renewal date of January 1, 2011, must be compliant at the time of renewal). Note: All States will be advised of these timelines to ensure compliance by the appointed timeframes. Because the renewal cycle for waivers is no greater than 5 years, all waivers will be in compliance no later than March 3, 2013.

The CMS will not approve new waivers submitted after March 3, 2008 that are not compliant with CMS-2237-IFC.

No amendments to waivers that would render the State out of compliance with CMS-2237-IFC submitted after March 3, 2008 will be approved.

30) Can States continue to claim for assessment and development of an interim care plan under administration?

Answer:

Yes. Activities for the proper and efficient administration of the State Plan may continue to be claimed under administration as long as they are not duplicative of costs claimed through the rate paid for direct medical services.

31) Case managers in some States may perform some tasks (preadmission assessment, and prior authorization (of waiver services) that look like they can be covered as an administrative expense and others that fall under case management. Are these costs claimable under administration?

Answer:

Costs related to activities such as prior authorization or determination of medical necessity, which are necessary for the proper and efficient administration of the Medicaid State plan,

may be claimable as a direct administrative expense by the Medicaid agency and must not be included in the development of a case management rate. These activities are administrative and do not comport with the definition of Medicaid case management.

32) How will States ensure health and welfare of waiver participants under this rule ?

Answer:

Any activities that the State pursues to ensure health and welfare that are consistent with the definition of case management and its required components would be allowable under case management. For all activities that fall outside the definition of case management, e.g. quality assurance and improvement activities, States may claim them as administrative activities. For individuals who refuse case management services, the State may carry out the functions necessary to assure health and welfare through the use of State staff or contractors. This may be claimed administratively. An example of such an arrangement may include a State Quality Assurance staff person who, in addition to broad-based system-related quality assurance activities, will undertake person-specific monitoring in instances when the individual refuses case management. This activity may include monitoring the plan of care, or providing service referrals, along with other actions necessary to meet the statutory health and welfare assurance.

33) Will States that currently cover case management as an administrative activity rather than a waiver service, continue to do so until the date of which the 1915(c) waiver is expected to be in compliance?

Answer:

Yes. Please see the timeframes in #29.

34) How does the 15 minute unit relate to the waivers?

Answer:

Because the entirety of the rule applies to 1915(c) waivers, the State must utilize reimbursement methodologies that are consistent with the rule. CMS has prepared technical guidance with regard to rate determination that may be useful to States as they construct their rates. Also, please be advised that as CMS drafts the final rule, we intend to propose modifications of the 15-minute increment provision of the IFC.

ADMINISTRATIVE CLAIMING

35) Are administrative activities that include elements of, but are less comprehensive than, case management or targeted case management services able to continue to be billed under administration?

Answer:

Administrative activities for the proper and efficient administration of the State plan can continue to be claimed under administration. For example, an administrative activity may include assisting an individual, who has not yet been determined eligible for Medicaid, to apply for or obtain this eligibility. The following activities are allowable:

- Medicaid eligibility determinations and redeterminations;
- Medicaid intake processing;
- Medicaid preadmission screening for inpatient care;

- Prior authorization for Medicaid services;
- Utilization review; and
- Outreach activities to inform or persuade beneficiaries or potential beneficiaries to enter into care through the Medicaid system.

36) What happens if a State submits a cost allocation plan but won't be in compliance with the regulation by the time the cost allocation needs to be approved?

Answer:

Federal regulations at 42 CFR 433.34 require that the State Medicaid agency have an approved public assistance Cost Allocation Plan (CAP) on file with the Department of Health and Human Services that meets regulatory requirements specified at Subpart E of 45 CFR Part 95. The State Medicaid agency is at risk for any claims submitted prior to approval of an amendment to the public assistance CAP.

However, approval of a CAP amendment, or lack thereof, does not dictate when a State must be in compliance with the CM/TCM regulation. CMS works directly with the Division of Cost Allocation in the CAP amendment review and approval process. Therefore, if CMS has reached agreement with a State regarding a plan for compliance with the CM/TCM regulation, that agreement can be factored into the CAP review and approval process.

37) When will States have to stop claiming for school-based administration?

Answer:

On December 28, 2007, CMS issued a regulation in the Federal Register which eliminates reimbursement under the Medicaid program for costs of school-based administration and of transportation from home to school and back (CMS-2287-F). However, there's a six-month moratorium on CMS' ability to enforce the school-based rule, due to Public Law 110-173. This moratorium is scheduled to end June 30, 2008. For practical purposes, CMS intends to begin enforcing CMS-2287-F on the earliest date after June 30, 3008 that the school district begins a new school year or semester (but no later than September 30, 2008). After that date, school-based administrative activities will no longer be reimbursable.

The effective date for the TCM regulation (CMS-2237-IFC) is March 3, 2008. Section 441.18(c)(5)) of the TCM regulation (CMS-2237-IFC) states that activities meeting the definition in Sec. 440.169 for case management services and under the approved State plan cannot be claimed as administrative activities. Therefore, States do not have the option to claim any activities meeting the definition of case management services under the TCM rule as Medicaid administration. States will need to bring their school-based claiming programs into compliance with the TCM rule irrespective of the current moratorium on the school-based administrative claiming rule.

The relevant effective date is that of the TCM rule, March 3, 2008, rather than the implementation date associated with the school-based rule. States have to make changes to their Medicaid State plan to comply with the TCM rule for all populations, including school-based populations. So, to the extent activities formerly considered school-based administrative case management meet the definition of TCM under the final rule, the implementation dates and compliance requirements associated with the TCM rule would apply.

SERVICES FOR TRANSITIONING FROM MEDICAL INSTITUTIONS

38) What was the basis for the decision to go from 180 to 60 days for transitional case management?

Answer:

Due to an overwhelming number of comments on the time limits for transitioning an individual to the community, CMS is actively considering the impact of this provision.

39) Can the same case manager performing the transition to the community continue as case manager when the person leaves the institution?

Answer:

When an individual chooses to receive targeted case management services to assist with transitioning from a medical institution to the community, the case manager who serves the individual while in the institution may continue to serve the individual when he or she returns to the community. Please note that case management can only be provided by and reimbursed to community case management providers.

40) Can States claim for transitional TCM if the individual never leaves the institution, i.e. case management time was spent trying to secure an appropriate community placement but for a various reasons, the transition was not accomplished?

Answer:

Due to an overwhelming number of comments on the time limits for transitioning an individual to the community, CMS is actively considering the impact of this provision.

41) Are States that already have individuals transitioning to the community prior to the effective date of the regulation, subject to the 60 and 14 day timeframes?

Answer:

No. Those States that already have individuals transitioning to the community prior to the effective date of the regulation will have 180 days and will not be subject to the 60 and 14 day timeframes.

MANAGED CARE

42) Does this rule apply to Primary Care Case Management (PCCM) services?

Answer:

No. PCCM remains unchanged and is defined in section 42 CFR 440.168 of the Medicaid regulation.

43) If an individual is enrolled in a Managed Care Organization (MCO) which is paid a capitated rate that includes primary care coordination, can the individual receive targeted case management services outside of the MCO plan?

Answer:

Yes. A beneficiary enrolled in a MCO may receive services to coordinate his or her primary health care under the plan and also receive targeted case management services, as described

in the regulation, outside of the managed care plan. Receipt of targeted case management outside of the managed care plan may require adjustment of the managed care rate if it affects the actuarial value of services furnished by the managed care plan.

44) If an individual is enrolled in a Managed Care Organization (MCO) that is paid a capitated rate that includes primary care coordination, can the individual receive targeted case management services through a 1915(c) home and community based services waiver program?

Answer:

Yes. A beneficiary enrolled in a MCO may receive services to coordinate his or her primary health care under the plan and also receive targeted case management services, as described in the regulation, outside of the plan. Receipt of targeted case management outside of the managed care plan may require adjustment of the managed care rate if it affects the actuarial value of services furnished by the managed care plan.

45) Targeted case management typically has fee-schedule rates and the regulation does not address payment methodologies. Therefore, is it correct that the impact to managed care programs at the State level extends to ensuring any targeted case management services within managed care contracts are appropriately defined and priced?

Answer:

Yes. Managed care rates must reflect the cost of covered State plan case management services as defined in this regulation.

46) What changes will be required in capitation rates that include the State plan costs of case management services?

Answer:

As with other services, States may only include the cost of State-plan covered services, including HCBS, in developing the capitation rate for risk contracts. A State's actuary must use the state plan reimbursement methodology in determining the State plan cost of case management. If this adjustment results in a change in the portion of the rate intended to cover case management services, the rate should be revised accordingly.

47) What steps are States expected to take regarding capitated managed care programs to come into compliance with the new rule?

Answer:

All managed care contracts approved after the effective date of March 3, 2008, must be in compliance with the case management regulations.

48) Do the CM/TCM requirements apply to additional services provided through cost savings under 1915(b)(3) that result from more cost effective medical care?

Answer:

Section 1915(b)(3) services are provided out of the savings derived from managing the recipient's care and are not considered to be section 1905(a) services. Therefore, the requirements of the rule do not apply to these services. However, CMS will look at the specifics of each proposal to ensure that the approach is consistent with the rule.

CASE MANAGEMENT UNDER 1915(i) HCBS AS STATE PLAN OPTION

49) Does the regulation for Targeted Case Management apply to the 1915(i) State plan option?

Answer:

Yes. The policies set forth in CMS-2237-IFC will apply to the definition of case management services as included under section 1915(i) Home and Community Based Services as a State Plan Option.

50) Section 1915(i) requires an independent assessment. Please describe how States will ensure the independence of the assessor when the function is performed by any qualified provider (as assessment appears to meet the definition of case management under 42 CFR 440.169, and is therefore ineligible for administrative reimbursement).

Answer:

The independent assessment required pursuant to Section 1915(i) of the Social Security Act, is a stand-alone function that does not meet the requirements to be case management. Instead, it is a cost of administering the home and community-based benefit described in 1915(i), and the cost of the assessment may be claimed by the State as an administrative cost. This element, which is critical to the determination of eligibility for the 1915(i) benefit shall not be considered case management for the purposes of this regulation.

51) Are the following activities included in case management services, under 1915(i)? How should a State claim FFP for these activities? Plan development – service authorization Referral – account for costs for care coordinator

Answer:

When a State chooses to include case management services within a 1915(i) State plan HCBS benefit, the definition of the service must comport with section 42 CFR 440.169. Case management services are distinct from independent evaluation functions, described under section 1915(i)(1)(E)(i) and 1915(i)(1)(D)(i), which determine individuals' eligibility for the State Plan HCBS benefit. Reimbursement for case management services would be included under the section 1915(i) State plan HCBS benefit and be reimbursed as a service. A State may request reimbursement for independent evaluation, HCBS service plan development, eligibility determination and service authorization functions as administration.

REIMBURSEMENT

52) How much time will States have to redesign their MMIS system to accommodate the 15 minute units of case management?

Answer:

As CMS drafts the final rule, we intend to propose modifications of the 15-minute increment provision of the IFC. Specifically, we intend to recommend that the final regulation permit an extended timeframe for implementation as well as additional flexibility with respect to units of service. Please note that the 15-minute increment is not applicable for those States that opt to certify expenditures.

53) Are billable units only for face-to-face meetings?

Answer:

Billable units are for time spent delivering a case management service. That service may occur face-to-face with the beneficiary or may consist of telephone contacts or mail or e-mail contacts necessary to ensure that the beneficiary is served. Billable units may not be billed for such things as time spent traveling to a beneficiary to provide a case management service. However, the case management rate can factor in the cost of non-productive time associated with such things as case manager travel time and costs associated with mileage (in a cost-based payment methodology, by allocating such costs among all of the productive time increments). It may also include the actual writing of case notes, time documenting social history and writing the information gathered for the case file for the development of a specific care plan; and the gathering of information and the actual documentation. The state may also document non-productive time by providing evidence of State or private agency policies regarding sick leave, vacation leave, paid holidays and training requirements. Any other non-productive time must be documented via use of a CMS approved time study.

Several States have inquired as to what practices should be employed to ensure that no TCM provider is paid for more 15 minute units then they can feasibly deliver. One state intends to require documentation from each Target Case Manager and signed by his/her supervisor certifying the number of hours each day that a TCM was available to provide TCM services. The monthly summary of this data will be compared to the number of 15 minute units of service that were billed and paid. Billing units must be equal to or less than the number of available 15 minute units of time. This is an acceptable practice and States should also consider whether the rate has been developed to account for non-productive time, the number of billable units per case manager cannot be greater than the amount of productive time identified through the rate setting methodology. For example, if the rate is adjusted to account for one hour a day of non-productive time, the case manager (assuming an 8 hour day) could only bill for 28, 15 minute units which is equal to the 7 hours of productive time identified by the state in constructing the rate.

54) What constitutes an approved, statistically valid time study?

Answer

Recognizing the necessity of using a sample to develop claims, OMB Circular A-87 permits the use of "substitute systems" for allocating costs to federal awards in place of activity reports. Any such sampling methodology, or time study, must be approved by the funding agency (CMS). These time studies may utilize random moment sampling, case counts, or other quantifiable measures of employee effort, as long as they are deemed by CMS to be statistically valid and capture all paid time, even if it is not allowable to Medicaid. Required elements for a time study include the following: defining the sample universe, developing the activity codes, designing the sampling methodology, retaining required documentation, conducting training, ongoing oversight and monitoring, and developing a validation protocol. Surveys will not be sufficient. For private providers, states may wish to consider developing market-based rates as an alternative to documenting nonproductive time. Any such time study would be approved by CMS outside of the State plan amendment review process, and reference therein. The State's public assistance Cost Allocation Plan must also reference the CMS approved time study by way of amendment.

55) With respect to 441.18(a)(7) and "units of case management received", does there have to be a note in the file for every 15 minute code billed or can the documentation

requirements be met for 441.18(a)(7) by listing all the required information for a number of units, like a 2 hour service?

Answer: If a case management service lasts for 2 hours, the supporting documentation would indicate a service duration of 2 hours and a description of the activities that took place during that 2 hour period. Eight, 15 minute units would be billed.

56) What compliance activities will CMS initiate for States that have not implemented 15-minute increment payment methodology by June 30?

Answer:

It is our intent to modify this provision due to an overwhelming number of comments indicating the challenges for States to adopt this methodology and the time frame in which to do so.

57) Can CMS explain the 10 percent threshold in establishing overhead rates, and whether States may submit overhead rates larger than 10 percent?

Answer:

The CMS will entertain indirect rates higher than 10 percent, but the State will need to provide detailed documentation of the costs that are included in that rate and how it was developed.

58) What "additional documentation" will be necessary to support TCM claims when States submit their May budget estimates?

Answer:

The CMS is in the process of developing a format for States to use to provide documentation in support of their claims for TCM services for quarter ending June 30 documentation, conducting training, ongoing oversight and monitoring, and developing a validation protocol. Any such time study would be approved by CMS outside of the State plan amendment review process, and referenced therein. The State's public assistance Cost Allocation Plan must also reference the CMS approved time study by way of amendment.

TRIBAL ORGANIZATIONS

59) Are States subject to Tribal notice requirements prior to implementing the provisions in this regulation and do tribes need to be involved in and informed of the changes the State will need to make to apply the new case management requirements?

Presidential Executive order 13175 (November 6, 2000), states a federal requirement "…to establish regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have tribal implications, to strengthen the United State's government-to-government relationships with Indian tribes, and to reduce the imposition of unfunded mandates upon Indian tribes."

Tribal entities have indicated that they are unfamiliar with the significant changes that will be enacted in the new TCM regulation and have concerns regarding the impact of this policy on the tribes. CMS has shared information on the rule with tribal organizations and will host a call with tribal organizations in order to provide an update on the implementation of the IFC. We will notify the State professional organizations of the time and logistics for this call.

In keeping with the requirements of the Executive Order, States should engage in discussions and notify in writing, all Federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State. States are strongly encouraged to provide for Tribal participation in the implementation of the substantive changes to the State case management policies and include Tribal organizations in discussions with CMS.

4302. OPTIONAL TARGETED CASE MANAGEMENT SERVICES - BASIS, SCOPE AND PURPOSE

The Consolidated Omnibus Budget Reconciliation Act (P.L. 99-272, COBRA) added §§1915(g)(1) and (g)(2) to the Act. These sections add optional targeted case management services to the list of services that may be provided under Medicaid. Section 1895(c)(3) of the Tax Reform Act of 1986 (P.L. 99-514) added case management services to the list of services in §1905 of the Act. Section 4118(i) of OBRA 1987 (P.L. 100-203) added a section discussing the qualifications of case managers for individuals with developmental disabilities or chronic mental illness. Both the Tax Reform Act and OBRA 1987 amendments are effective as if included in COBRA and are considered effective on April 7, 1986.

A. Background.--Case management is an activity which assists individuals eligible for Medicaid in gaining and coordinating access to necessary care and services appropriate to the needs of an individual. Prior to the enactment of P.L. 99-272, States could not provide case management as a distinct service under Medicaid without the use of waiver authority. However, aspects of case management have been an integral part of the Medicaid program since its inception. The law has always required interagency agreements under which Medicaid patients may be assisted in locating and receiving services they need when these services are provided by others. Prior to the enactment of P.L. 99-272, Federal financial participation (FFP) for case management activities may be claimed in any of four basic areas:

1. Component of Another Service.--Case management may be provided as an integral and inseparable part of another covered Medicaid service. An example of this type of case management is the preparation of treatment plans by home health agencies. Since plan preparation is required as a part of home health services, separate payment for the case management component cannot be made, but is included in the payment made for the service at the Federal Medical Assistance Percentage (FMAP) rate.

2. Administration.--Case management may be provided as a function necessary for the proper and efficient operation of the Medicaid State plan, as provided in §1903(a) of the Act. Activities such as utilization review, prior authorization and nursing home preadmission screening may be paid as an administrative expense. The payment rate is either the 50 percent matching rate or the 75 percent FFP rate for skilled professional medical personnel, when the criteria in 42 CFR 432.50 are met.

3. Section 1915(b) Waivers.--Case management may be provided in a waiver granted under §1915(b) of the Act. Section 1915(b) provides that a State may request that the Secretary waive the requirements of §1902 of the Act, including the freedom of choice requirements in §1902(a)(23), if necessary to implement a primary care case management system as described in 42 CFR 431.55(c).

To qualify for such a waiver, the case management project must be cost effective, efficient, and consistent with the objectives of the Medicaid program. The waiver is needed to restrict the provider from (or through) whom an eligible individual can obtain medical care services (other than in emergency circumstances), provided the restriction does not substantially impair access to services of adequate quality, and that the statutory and regulatory requirements for waiver approvals are met. Upon the written request of the State, case management services furnished on or after April 7, 1986 pursuant to a waiver granted under §1915(b)(1) may be reimbursed at the FMAP rate when these services are performed by a vendor. Because of the nature of case management services under a §1915(b)(1) waiver, this activity, when performed by an employee of the Medicaid agency, is construed as necessary for the proper and efficient administration of the State plan and is therefore an administrative expense.

4. Section 1915(c) Waivers.--Case management may be provided as a service in a waiver granted pursuant to §1915(c) of the Act. Section 1915(c)(4)(B) specifically enumerates case management as a service which may be provided as part of a home and community-based services waiver. In order to provide this service, you must define it as part of a waiver request, and identify the qualifications of the providers. Under such a waiver, case management services must be provided under a written plan of care which is subject to the approval of the State Medicaid agency. Services provided in this fashion are reimbursed at the FMAP rate. Section 4440 supplies additional information concerning home and community-based services waivers.

NOTE: The enactment of P.L. 99-272 and P.L. 99-514 has not altered your authority to provide any of the previous categories of case management.

B. Legislation.--P.L. 99-272 adds case management to the list of optional services which may be provided under Medicaid. Section 9508 of P.L. 99-272 adds a new subsection (g) to §1915 of the Act. This subsection, as amended by P.L. 100-203, provides that:

> "(g)(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B). The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23). A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS); or with AIDS-related conditions, or with either, and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness. The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.

(2) For purposes of this subsection, the term 'case management services' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services."

In authorizing States to offer case management services, Congress recognized that there was some potential for duplicate payments because the same or similar services have often been provided by other programs or under the Medicaid program itself. H. Rep. No. 453, 99th Cong., 1st Session 546 (1985), which accompanies this portion of P.L. 99-272, emphasizes that payment for case management services under §1915(g) must not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

FFP is available at the FMAP rate for targeted case management services rendered on or after April 7, 1986, when these services are included in the State plan.

C. Technical Statutory Change.--Section 1895(c)(3) of the Tax Reform Act of 1986 adds case management services to §1905(a)(19) of the Act. In so doing, it defines §1905(a)(19) in terms of §1915(g)(2).

D. Purpose.--The purpose of these instructions is to implement these sections of the statute, and to provide clarification regarding the requirements of the statute and how they may be met.

4302.1 Case Management Services - Process.--

A. Applicability.--The process described in this section applies to case management services, as described in §1905(a)(19) and §1915(g) of the Act.

B. Submission and Timeframes.--Case management under either §1905(a)(19) or §1915(g) is an optional service under Medicaid. To provide the service, incorporate it into your Medicaid State Plan by means of a State plan amendment submitted to your servicing regional office. As with all State plan amendments that provide additional services, the effective date may be no earlier than the first day of the calendar quarter in which the amendment is submitted. In no case may FFP be claimed for case management services under §1915(g) provided prior to April 7, 1986.

In order to provide services under §1915(g), submit a separate amendment for each target group. There is no limit to the number or size of target groups to whom you may provide case management services. The target group may be the State's entire Medicaid population.

4302.2 State Plan Amendment Requirements.--Any State plan amendment request to provide optional case management services must address all of the requirements of this section.

A. Target Group.--Identify the target group to whom case management services will be provided. This targeting may be done by age, type or degree of disability, illness or condition (e.g., Acquired Immune Deficiency Syndrome (AIDS) or Chronic Mental Illness), or any other identifiable characteristic or combination thereof. The following examples are target groups currently receiving case management services under §1915(g) of the Act:

- Developmentally disabled persons (as defined by the State);
- Children between the ages of birth and up to age 3 who are experiencing developmental delays or disorder behaviors as measured and verified by diagnostic instruments and procedures;
- Pregnant women and infants up to age 1;
- Individuals with hemophilia;
- Individuals 60 years of age or older who have two or more physical or mental diagnoses which result in a need for two or more services; and
- Individuals with AIDS or HIV related disorders.

In defining the target group, you must be specific and delineate all characteristics of the population.

B. Comparability.--Unless you intend to provide case management services in the same amount, duration and scope to all eligible recipients, indicate that §1915(g)(1) of the Act is invoked to provide these services without regard to the requirements of §1902(a)(10)(B) of the Act. (See 42 CFR 440.240.) The exception to comparability requirements applies only to case management services under §1915(g) of the Act. Comparability requirements relating to all other Medicaid services are unaffected by this section.

C. Statewide Availability.--Indicate whether case management services are available to the target group statewide or whether the authority of §1915(g)(1) of the Act is invoked to provide case management services to the target group on a less than statewide basis. If case management services are not to be provided on a statewide basis, indicate the geographic areas or political subdivisions to be served. The provision of targeted case management services on a less than statewide basis does not excuse you from the requirements of §1902(a)(1) of the Act (see 42 CFR 431.50) in regard to the statewide availability of other Medicaid services.

D. Freedom of Choice.--Section 1915(g)(1) of the Act specifies that there shall be no restriction on free choice of qualified providers, in violation of §1902(a)(23) of the Act. Assure that there will be no restriction on a recipient's free choice of qualified providers of case management services. In addition, assure that case management services will not restrict an individual's free choice of providers of other Medicaid services.

In order to meet the freedom of choice requirements, you must provide for the following:

1. Option to Receive Services.--The receipt of case management services must be at the option of the individual included in the target population. A recipient cannot be forced to receive case management services for which he or she might be eligible.

2. Free Choice of Providers.--Except as indicated for individuals with developmental disabilities or chronic mental illness, an eligible individual must be free to receive case management services from any qualified provider of these services. The recipient may not be limited to case management providers in a clinic, even if the individual receives all other Medicaid services through that clinic. However, in situations where the State has chosen to provide case management services on a less than statewide basis, free choice of the qualified providers is limited to those providers located within all of the identified geographic areas or political subdivisions, as specified in the State plan.

When providing case management services to individuals with developmental disabilities or with chronic mental illness, you may limit the case managers available. This ensures that the case managers for these individuals are capable of providing the full range of needed services to these targeted recipients. This limitation is permissible only with regard to the target groups of developmentally disabled or chronically mentally ill, or any subgroups that you choose to define. If you choose to target a subgroup of individuals who are developmentally disabled or chronically mentally ill, the targeted group (e.g., based on age, degree of impairment) must continue to fit the definition of chronic mental illness or developmental disability. The requirements discussed in items D.1, D.3, and D.4 continue to apply to all target groups.

3. Provider Participation.--Any person or entity meeting State standards for the provision of case management services who wishes to become a Medicaid provider of those services must be given the opportunity to do so. However, the State is not required to extend provider participation to providers located outside the geographic areas in which case management is targeted.

4. Unrestricted Access.--Case management services under §1915(g) of the Act may not be used to restrict the access of the client to other services available under the State plan. This option is, however, available through waivers granted pursuant to §1915(b) of the Act. (See §2100.)

E. Qualifications of Providers.--The statute does not set minimum standards for the provision of case management services. Therefore, establish the minimum qualifications for the providers of case management services. The qualifications set must be reasonably related to the case management functions that a provider is expected to perform. While reasonable provider qualifications are necessary to assure that case managers are capable of rendering services of acceptable quality, use caution in determining the acceptable degree of such qualifications. With the exception of providers of case management services to individuals with developmental disabilities or chronic mental illness, provider qualifications must not restrict the potential providers of case management services to only those viewed as most qualified. Individuals within the specified target group must be free to receive case management services from any qualified provider.

Except as discussed in item D.2, you may not limit the provision of these services to State or other public agencies, but must permit any person or entity that meets the established qualifications in accordance with 42 CFR 431.51(b) to become a Medicaid provider.

F. Nonduplication of Payments.--Payment for case management services under §1915(g) of the Act may not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

In general, payment may not be made for services for which another payer is liable. Exceptions to this general rule include payments for prenatal or preventive pediatric care, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services; payments for services covered under a plan for an individual for whom child support enforcement is being carried out; or any payments made through a waiver granted under the cost effectiveness provisions of 42 CFR 433.139(e). Another major exception is that payments may be made to State education agencies to cover the costs of services provided under a recipient's Individualized Education Program.

Payment may not be made for services for which no payment liability is incurred. Similarly, separate payment cannot be made for similar services which are an integral and inseparable part of another Medicaid covered service.

G. Differentiation Between Targeted Case Management Services and Case Management Type Activities for Which Administrative Federal Match May Be Claimed.--You must differentiate between case management services which may properly be claimed at the service match under §1915(g) and case management activities which are appropriate for FFP at the administrative match under the State plan, based upon the appropriate criteria. These two payment authorities do not result in mutually exclusive types of services.

There are certain case management activities which may appropriately be eligible for FFP at either the administrative or the service match rate. Examples of case management activities that may be claimed at either the administrative or the service match rate entail providing assistance to individuals to gain access to services listed in the State plan, including medical care and transportation. In cases where an activity may qualify as either a Medicaid service or an administrative activity, you may classify the function in either category. This decision must be made prior to claiming FFP because of the different rules which apply to each type of function under the Medicaid program.

1. Case Management as a Service Under §1915(g).--FFP is available at the FMAP rate for allowable case management services under §1915(g) when the following requirements are met:

- Expenditures are made on behalf of eligible recipients included in the target group (i.e. there must be an identifiable charge related to an identifiable service provided to a recipient);

- Case management services are provided as they are defined in the approved State plan;

- Case management services are furnished by individuals or entities with whom the Medicaid agency has in effect a provider agreement;

o Case management services are furnished to assist an individual in gaining or coordinating access to needed services; and

o Payment for services is made following the receipt of a valid provider claim. Providers must maintain case records which indicate all contacts with and on behalf of recipients. The case records must document name of recipient, the date of service, name of provider agency and person providing the service, nature, extent, or units of service, and the place of service delivery. In addition, providers must develop a billing system to appropriately identify and bill all liable third parties.

Because §1915(g) of the Act defines case management services as services which assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services, recipients may obtain access to services not included in the Medicaid State plan. The costs of case management services provided under §1915(g) that involve gaining access to non-Medicaid services are eligible for FFP at the service match rate.

Examples of case management services provided under §1915(g) of the Act may include assistance in obtaining Food Stamps, energy assistance, emergency housing, or legal services. All case management services provided as medical assistance pursuant to §1915(g) of the Act must be described in the State plan. In addition, they must be provided by a qualified provider as defined in the State plan.

When case management is provided pursuant to §1915(g) of the Act, the service is subject to the rules pertaining to all Medicaid services. If you choose to cover targeted case management services under your State plan, as defined in §1915(g) of the Act, you cannot claim FFP at the administrative rate for the same types of services furnished to the same target group.

NOTE: Although FFP may be available for case management activities that identify the specific services needed by an individual, assist recipients in gaining access to these services, and monitor to assure that needed services are received, FFP is not available for the cost of these specific services unless they are separately reimbursable under Medicaid. Also, FFP is not available for the cost of the administration of the services or programs to which recipients are referred.

2. Case Management as an Administrative Activity.--Case management activities may be considered allowable administrative costs of the Medicaid program when the following requirements are met:

o They are provided in a manner consistent with simplicity of administration and the best interest of the recipient, as prescribed by §1902(a)(19) of the Act; and

o Documentation maintained in support of the claim is sufficiently detailed to permit HCFA to determine whether the activities are necessary for the proper and efficient administration of the State plan, as provided by §1903(a) of the Act.

The following list of functions provides examples of activities which may properly be claimed as administrative case management activities, but not as targeted case management services. The omission of any particular function from this list does not represent a determination on HCFA's part that the function is not necessary for the administration of the plan.

- Medicaid eligibility determinations and redeterminations;
- Medicaid intake processing;
- Medicaid preadmission screening for inpatient care;
- Prior authorization for Medicaid services and utilization review; and
- Medicaid outreach (methods to inform or persuade recipients or potential recipients to enter into care through the Medicaid system).

Because activities related to services which Medicaid does not cover are not considered necessary for the administration of the Medicaid plan, the accompanying costs are not eligible for Medicaid FFP at the administrative rate. For example, case management related to obtaining social services, Food Stamps, energy assistance, or housing cannot be considered a legitimate Medicaid administrative expense even though it may produce results which are in the best interest of the recipient. These services can be provided as medical assistance if described in the State plan.

Similarly, setting up an appointment with a Medicaid participating physician and arranging for transportation for a recipient may be considered case management administrative activities necessary for the proper and efficient administration of the Medicaid plan. However, arranging for baby sitting for a recipient's child, although beneficial to the recipient, is not an activity for which administrative FFP can be claimed.

In addition, when a caseworker suspects that physical abuse of a recipient has occurred, the referral to medical care could be considered a reimbursable administrative activity under the Medicaid program. However, assisting the victim in obtaining emergency housing and legal services, although in the best interest of the recipient, is not an activity for which administrative FFP may be claimed. In cases where workers perform activities funded under multiple auspices, careful records must be kept to document the State§s claims for Federal funds under the appropriate authorities.

Administrative case management activities may be performed by an entity other than the single State agency. However, there must be an interagency agreement in effect.

When a State expects to claim FFP for Medicaid administrative case management activities, the costs for these activities must be included in a cost allocation plan submitted to and approved by your HCFA RO. HCFA reserves the right to evaluate the activities for which FFP is claimed to determine whether they meet the requirements (either administrative or service match) for payment. When FFP is claimed for any functions performed as case management administrative activities under §1903(a) of the Act, documentation must clearly demonstrate that the activities were provided to Medicaid applicants or eligibles, and were in some way connected with determining eligibility or administering services covered under the State plan.

H. Case Management Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program.--Care coordination, including aspects of case management, has always been an integral component of the EPSDT program, as described in 42 CFR 441.61. OBRA 1989 (P.L. 101-239) modified the EPSDT program by adding §1905(r) to the Act. Section 1905(r) requires that States provide any services included in §1905(a) of the Act, when medical necessity for the service is shown by an EPSDT screen, whether such services are covered under the State plan. While case management is required under the expanded EPSDT program when the need for the activity is found medically necessary, this does not mean §1915(g) targeted case management services. Therefore, when the need for case management activities is found to be medically necessary, the State has several options to pursue:

1. Component of an Existing Service.--Case management services may be provided to persons participating in the EPSDT program by an existing service provider such as a physician or clinic referring the child to a specialist.

2. Administration.--Case management services may be provided to EPSDT participants by the Medicaid agency or another State agency such as title V, the Health Department or an entity with which the Medicaid agency has an interagency agreement. Administrative case management activities must be found necessary for the proper and efficient administration of the State plan and therefore must be limited to those activities necessary for the proper and efficient administration of Medicaid covered services. FFP is available at the administrative rate.

3. Medical Assistance.--Case management services may be provided under the authority of §1905(a)(19) of the Act. The service must meet the statutory definition of case management services, as defined by §1915(g) of the Act. Therefore, FFP is available for assisting recipients in gaining access to both Medicaid and non-Medicaid services. FFP for case management services furnished under §1905(a)(19) of the Act is available at the FMAP rate.

Any combination of two or more of the above is possible, as long as FFP is not available for duplication of services.

I. Service Limitations.--The following are not allowable targeted case management services as defined in §1915(g)(2) of the Act.

1. Other Medicaid Services.--When assessing an individual's need for services includes a physical or psychological examination or evaluation, bill for the examination or evaluation under the appropriate medical service category. Referral for such services may be considered a component of case management services, but the actual provision of the service does not constitute case management.

2. Referral for Treatment.--When an assessment indicates the need for medical treatment, referral or arrangements for such treatment may be included as case management services, but the actual treatment may not be considered.

3. Institutional Discharge Planning.--Discharge planning is required as a condition for payment of hospital, NF and ICF/MR services. Therefore, this cannot be billed separately as a targeted case management service.

4. Client Outreach.--Outreach activities in which a State agency or a provider attempts to contact potential recipients of a service do not constitute case management services. The statute defines case management services as, "services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational and other services" (emphasis added). The attempt to contact individuals who may or may not be eligible for case management services does not fall under this definition. However, such outreach activities may be considered necessary for the proper and efficient administration of the Medicaid State plan. When this is the case, FFP is available at the administrative rate.

J. Coordination With Home and Community-Based Services Waivers.--Case management services continue to be available under home and community-based services waivers approved pursuant to §1915(c) of the Act. However, since approval for §1915(c) waiver services may only be granted for services not otherwise available under the State plan, the addition of case management services under the State plan may necessitate the modification of a home and community-based services waiver. In order to comply with the nonduplication of services requirements discussed in §4302B, the following elements apply to waivers under §1915(c).

1. Service Not Included in Waiver.--Home and community-based services waivers (and requests for waivers) which do not contain case management as a waiver service are not affected by this section.

2. Different Target Population.--Home and community-based services waivers (and requests for waivers) which are targeted at a population different from the group(s) to whom targeted case management services are provided are not affected by this section.

3. Duplication of State Plan Service.--When a home and community-based services waiver contains case management as a waiver service and the State adds case management services to the State plan, the following apply:

a. Same Target Population and Service Definition.--If the target population and the service definitions are the same, delete the case management services from the waiver through an amendment request, and make appropriate cost and utilization adjustments to the waiver cost effectiveness formula.

b. Same Service Definition.--If the definition of services is the same, but only a portion of waiver recipients (who receive waiver case management) are now eligible for the State plan service, the service may remain in the waiver. Adjustments must be made to the cost effectiveness formula to reflect the fact that a number of recipients now receive the State plan service.

4. Same Target Population.--If you have targeted case management services in your State plan for a particular group, and you submit a waiver request for the same targeted group, the request for waiver may not include case management services through the waiver under the same definition used in the State plan. If the case management is provided under an identical definition, it must be provided under the State plan and not under the waiver.

K. Payment Methodology.--The amendment must specify the methodology by which payments and rates are made. Indicate the payment methodology for public as well as private providers. Enter this information on attachment 4.19-B of the State plan.

L. Documentation of Claims for Case Management Services.--In order to receive payment for case management services under the plan (i.e., at the FMAP rate), fully document your claim as you do for any other Medicaid service. If you pay for case management services through capitation or prepaid health plans, the requirements of 42 CFR Part 434 must be met. With the exception of claims paid under capitation or prepaid health plan arrangements, you must document the following:

- o date of service,
- o name of recipient,
- o name of provider agency and person providing the service,
- o nature, extent, or units of service, and
- o place of service.

NOTE: While forms of documentation such as time studies, random moment sampling and cost allocation plans may be appropriate for claiming administrative FFP for activities in support of the State plan, these modes of documentation are not acceptable as a basis for Federal participation in the costs of Medicaid services. There must be an identifiable charge related to an identifiable service provided to a recipient.

4302.3 Instructions For Completing Preprint Supplement.--

A. State Plan Amendment.--To include case management services in your State plan, indicate your intentions on Attachment 3.1-A and 3.1-B of the State plan preprint. In addition, complete one preprint supplement for each target group to whom the services will be provided. (OMB approval is required under the Paper Work Reduction Act of 1980 and will be obtained.)

B. Supplement 1 to Attachment 3.1-A.--Exhibit 1 is a copy of supplement 1 to Attachment 3.1-A. Each item must be completed for the amendment to be approved.

Item 1. Define the target group. Indicate any limitations of disease or condition, age, institutional or noninstitutional status or other characteristic(s) by which the target group is identified.

Item 2. Check one category. If services are provided on a less than statewide basis, specify the geographic areas or political subdivisions to which the services will be provided.

Item 3. Check one category.

Item 4. Define case management services as they apply to the target population. Specify any limitations that apply. Indicate the unit(s) of service. Identify any coordination with non-Medicaid programs or agencies.

Item 5. Specify the qualifications of the providers. These qualifications must be reasonably related to the case management function(s) that the providers are expected to perform.

Item 6. No information necessary.

Item 7. No information necessary.

EXHIBIT I

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

CASE MANAGEMENT SERVICES

A. Target Group:

B. Areas of State in Which Services Will Be Provided:

Entire State

Only in the following geographic areas (authority of §1915(g)(1) of the Act is invoked to provide services less than statewide):

C. Comparability of Services:

Services are provided in accordance with §1902(a)(10)(B) of the Act.

Services are not comparable in amount, duration and scope. Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B).

D. Definition of Services:

E. Qualifications of Providers:

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

SPA Impact Form

State/Title/Plan Number: California/15-002

Federal Fiscal Impact: $0

Number of People Affected by Enhanced Coverage, Benefits or Retained Eligibility: _zero_____

Number of Potential Newly Eligible People: __zero_____
or
Eligibility Simplification: Yes/No

Number of People Losing Medicaid Eligibility: ___none_____

Reduces Benefits: No

Provider Payment Increase: No

Delivery System Innovation: No

Comments/Remarks: SPA 15-002 will update the reimbursement pages to past practice since the mid 1990s and the benefit pages to current practice. It will also update the description of case management services to reflect current federal requirements

DHS Contact: Jim Elliott, 445-8325

Date: December 11, 2015

EDMUND G. BROWN, JR., GOVERNOR

OFFICE OF ADMINISTRATIVE LAW

California Regulatory Notice Register

REGISTER 2015, NO. 50–Z PUBLISHED WEEKLY BY THE OFFICE OF ADMINISTRATIVE LAW DECEMBER 11, 2015

PROPOSED ACTION ON REGULATIONS

(Continued on next page)

Time-Dated Material

GENERAL PUBLIC INTEREST

SUSPENSION OF ACTION REGARDING UNDERGROUND REGULATIONS

DISAPPROVAL DECISIONS

SUMMARY OF REGULATORY ACTIONS

The *California Regulatory Notice Register* is an official state publication of the Office of Administrative Law containing notices of proposed regulatory actions by state regulatory agencies to adopt, amend or repeal regulations contained in the California Code of Regulations. The effective period of a notice of proposed regulatory action by a state agency in the *California Regulatory Notice Register* shall not exceed one year [Government Code § 11346.4(b)]. It is suggested, therefore, that issues of the *California Regulatory Notice Register* be retained for a minimum of 18 months.

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2015, 48–Z, November 27, 2015. The Notice incorrectly stated that the deadline to submit written comments was "January 11, 2015."

The correct deadline is "January 11, 2016."

If you have any questions, please contact Ivy Branaman at 916.323.7162 or ibranaman@ fppc.ca.gov.

DEPARTMENT OF HEALTH CARE SERVICES

CORRECTION TO NOTICE OF GENERAL PUBLIC INTEREST

THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES CORRECTS THE NUMBER OF THE STATE PLAN AMENDMENT ASSOCIATED WITH THE PROPOSED UPDATE TO THE REIMBURSEMENT METHODOLOGY FOR MEDI–CAL CHILDHOOD LEAD POISONING PREVENTION CASE MANAGEMENT

This notice corrects the State Plan Amendment (SPA) number referenced in the public notice published by Department of Health Care Services (DHCS) on February 15, 2013, which is associated with a proposed change in the reimbursement methodology for case management services to Medi–Cal beneficiaries under the Childhood Lead Poisoning Prevention Program benefit established in chapter 5 of part 5 of division 103 of the Health and Safety (H&S) Code (commencing with section 105275) and, specifically, section 105290. While the initial public notice stated that DHCS would submit SPA 12–015, the updated SPA number will now be 15–002 and the proposed effective date will be December 11, 2015. There are no other changes to the proposed SPA content. For more information, please contact Laurie Weaver, Assistant Deputy Director, Health Care Benefits and Eligibility; Department of Health Care Services; MS 4600; P.O. Box 997417; Sacramento, CA 95899–7417.

SUSPENSION OF ACTION REGARDING UNDERGROUND REGULATIONS

VETERINARY MEDICAL BOARD

OFFICE OF ADMINISTRATIVE LAW SUSPENSION OF ACTION REGARDING UNDERGROUND REGULATIONS

(Pursuant to Title 1, section 280, of the California Code of Regulations)

On September 30, 2015, the Office of Administrative Law (OAL) received a petition challenging Continuing Education Waivers for Undue Hardship issued by the Veterinary Medical Board (VMB) as an alleged underground regulation.

On November 20, 2015, VMB certified to OAL that the VMB's Frequently Asked Question No. 29 on the VMB website has been rescinded; therefore, pursuant to title 1, section 280 of the California Code of Regulations, OAL must suspend all action on this petition. On November 30, 2015, OAL filed the certification with the Secretary of State.

DISAPPROVAL DECISIONS

DECISIONS OF DISAPPROVAL OF REGULATORY ACTIONS

Printed below are the summaries of Office of Administrative Law disapproval decisions. The full text of disapproval decisions is available at www.oal.ca.gov under the "Publications" tab. You may also request a copy of a decision by contacting the Office of Administrative Law, 300 Capitol Mall, Suite 1250, Sacramento, CA 95814–4339, (916) 323–6225 — FAX (916) 323–6826. Please request by OAL file number.

BOARD OF OPTOMETRY

State of California
Office of Administrative Law

In re:
Board of Optometry
Regulatory Action:

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
19. Case Management Services (Pertains to Supplements 1a-1g to Attachment 3.1-A)	Services are limited to individuals who meet the target population criteria. Case management services means services which will assist eligible individuals in gaining access to needed medical, social, educational, and other services. Case management includes all of the following: • Assessment of an eligible individual • Development of a specific care plan • Referral to services • Monitoring activities	Prior authorization is not required. Case Management services do not include: • Program activities of the agency itself which do not meet the definition of targeted case management • Direct delivery of underlying medical, social, educational, or other services to which an eligible individual has been referred • Activities that are integral to the administration of foster care programs or most other non-medical program • Services which are an integral part of another service already reimbursed by Medicaid • 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

* Prior authorization is not required for emergency services.
**Coverage is limited to medically necessary services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: California

Case Management
Childhood Lead Poisoning Prevention

Reimbursement Methodology for Case Management Services as described in Supplement 1g to Attachment 3.1-A (continued)

Case management services will be provided by licensed and certified Public Health Nurses (PHN) who are experienced in providing case management services. If a local government agency's health department (which has been approved by the California Department of Public Health [CDPH] Childhood Lead Poisoning Prevention [CLPP] Branch) cannot identify PHNs to perform the necessary case management services, a supervised Registered Nurse (RN) may be used with prior approval by the CLPP Branch.

As used in this portion of the State Plan, a "supervised RN" is a defined as a registered nurse with training and experience in public health whose practice is supervised by a licensed PHN and who is employed by a local government agency's health department.

Reimbursement rates will be established for a specific unit of service. The unit of service will be an encounter with Medi-Cal eligible individuals under 21 years of age.

An encounter is defined as a "face-to-face" contact by a PHN or supervised RN or a significant telephone contact in lieu of a "face-to-face" contact when considerations preclude, for the purpose of rendering one or more case management service components. An encounter is also defined to include a follow-up with Medi-Cal eligible individual or with the individual or legal guardian designated to act on behalf of the Medi-Cal eligible individual.

The reimbursement process is as follows:

1. Pursuant to Health and Safety Code sections 105305 and 105310 in effect as of December 11, 2015, the CLPPB State Treasury contains a special fund into which CLPP fees, levied on industries responsible for having contributed to environmental lead contamination are deposited. The fees from this special fund are used as the nonfederal share for purposes of obtaining federal financial participation (FFP). The fees are for the provision of Medi-Cal CLPP Case Management Services provided to eligible Medi-Cal individuals under 21 years of age. The projected amount of State CLPP fees set aside each year enables the local government agency health departments to develop an annual Medi-Cal CLPP Management budget.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: California

Case Management
Childhood Lead Poisoning Prevention

Reimbursement Methodology for Case Management Services as described in Supplement 1g to Attachment 3.1-A (continued)

2. Costs for CLPP case management for eligible Medi-Cal individuals is based on cost reports which are to include all of the following: each local government agency health department's average cost for a PHN or supervised RN Medi-Cal CLPP Case Management encounter; the number of each local government agency health department's eligible Medi-Cal individuals under 21 years of age at risk for lead poisoning; and the number of each local government agency health department's lead poisoned, eligible Medi-Cal individuals under 21 years of age currently receiving case management services.

   Claims for FFP reimbursement will be made retrospectively after Medi-Cal CLPP Case Management services have been provided and documented in each eligible Medi-Cal individual's chart, and PHN or supervised RN personnel time is documented.

3. Each local government agency health department will conduct regularly scheduled time studies pursuant to the federally approved Time Survey Methodology for the County Based Medi-Cal Administrative Activities and Targeted Case Management Programs, and consistent with the federal Office of Management and Budget (OMB) Circular A-87 Revised approved time study methodology. The time study will capture the PHN and supervised RN time providing case management services to both Medi-Cal and non-Medi-Cal eligible in one or more components of case management services, such as assessment, plan development, referral, assistance in accessing services, follow-up crisis intervention planning, re-evaluation, or on other activities that are directly related to the provision of case management services.

4. Each local government agency health department will establish an annual budget with CDPH approval based upon actual expenses for CLPP case management services provided to eligible Medi-Cal individuals in the previous fiscal year. The annual budget will be derived from the salaries, benefits, and time studies that document time spent performing case management services, including travel. The total cost of providing case management services to eligible Medi-Cal individuals will be divided by the total number of eligible Medi-Cal individuals receiving case management services during the time-study period, resulting in an average expense per each eligible Medi-Cal individual.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: California

Case Management
Childhood Lead Poisoning Prevention

Reimbursement Methodology for Case Management Services as described in Supplement 1g to Attachment 3.1-A (continued)

5. Each local government agency health department will prepare invoices, time studies and supporting documentation for reimbursement of lead case management services provided to eligible Medi-Cal individuals. Invoices will be submitted quarterly to the CDPH CLPP Branch, and upon quarterly submission, CDPH CLPP will submit invoices to the Department of Health Care Services (DHCS) in accordance with the executed interagency agreement for purposes of claiming applicable FFP.

6. CDPH, in accordance with the interagency agreement with DHCS, is responsible for ensuring that each local government agency health department will maintain documentation in support of invoices submitted for case management services. The documentation will include:

   a. Date of service,
   b. Name of eligible Medi-Cal recipient,
   c. Name of provider agency and person providing the case management service,
   d. Nature, extent, or units of service,
   e. Place of service, and
   f. Completed time-study for each PHN or supervised RN providing case management services.

7. An audit of each participating local government agency will be conducted pursuant to federal compliance audit and review requirements. The audited time studies will form the basis of a reconcillation and will determine if there were any over or under payments. Overpayments will be collected from the local government agency and applicable FFP will be returned to the federal government. Underpayments will result in a corrective payment and associated claims for FFP.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: California

Case Management
Childhood Lead Poisoning Prevention

Reimbursement Methodology for Case Management Services as described in Supplement 1g to Attachment 3.1-A (continued)

8. Fiscal monitoring will be conducted by CDPH as outlined in the interagency agreement. Fiscal monitorning will include, but is not limited to, the following: using an audit trail that includes a) the name, classification, duty statement, and amount of PHN and supervised RN time identified on the local government agency health department budget submitted to and approved by the CDPH/CLPPB; b) quarterly invoices submitted for reimbursement of PHN and supervised RN case management services; c) the time-study identifying PHN or supervised RN time spent providing Medi-Cal CLPP Case Management services; and d) the PHN's or supervised RN's field record documenting the recipient's Medi-Cal status, lab report documenting the Medi-Cal recipient's elevated blood level, the CLPP Branch Follow-up Form and PHN and supervised RN service plan that documents receipt of necessary follow-up activities.

9. DHCS and CDPH will ensure third party liability requirements are met.