DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

DEC 19 2013

Toby Douglas, Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) 10-010. CA-10-010 was submitted to my office on September 30, 2010 to revise the process through which cost is determined and Certified Public Expenditures (CPEs) are claimed for California's county-based Targeted Case Management (TCM) program

The effective date of this SPA is October 16, 2010. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Attachment 4.19-B: pages 5d-5k

If you have any questions, please contact Tom Schenck by phone at (415) 744-3589 or by email at Schenck@cms.hhs.gov.

Sincerely,

Original Signed

Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Kathyryn Waje, California Department of Health Care Services
Jennifer Brooks, California Department of Health Care Services

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: **10-010**

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
July 1, 2010

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:
Section 1915(g) Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2010-2011 $48,655,737
b. FFY 2011-2012 $48,655,737
c. FFY 2012-2013 $48,655,737

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, pages 5d, 5d (i)(ii)(iii)(iv)(v)(vi), 5e, 5f, 5j and 5k

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B, pages 5d, 5e, 5f, 5j and 5k

10. SUBJECT OF AMENDMENT:

Reimbursement Methodology for Targeted Case Management Services

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:

13. TYPED NAME:
Toby Douglas

14. TITLE:
Director

15. DATE SUBMITTED:
9/30/2010

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.3.26
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
9/30/2010

18. DATE APPROVED:
Dec 19 2013

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/16/2010

20. SIGNATURE OF REGIONAL OFFICIAL:
Originally Signed By

21. TYPED NAME:
Gloria Nagle, Ph.D, MPA

22. TITLE:
Associate Regional Administrator

23. REMARKS:
At CMS' request, CA made pen and ink changes to the original HCFA 179 in the following places: Boxes 4, 7 & 8.

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TARGETED CASE MANAGEMENT REIMBURSEMENT METHODOLOGY
Reimbursement methodology for Case Management Services as described in Supplement 1a, 1b, 1d, 1e, 1f, and 1h to Attachment 3.1-A

This segment of the State Plan sets forth reimbursement for Targeted Case Management (TCM) services provided to eligible Medi-Cal beneficiary target populations identified in Supplements 1a, 1b, 1d, 1e, 1f, and 1h of Attachment 3.1-A.

A. General Applicability

(1) Definitions

(a) The "unit of service" will be an encounter.

(b) An "encounter" is defined as a face-to-face contact or a telephone contact in lieu of a face-to-face contact when environmental considerations preclude a face-to-face encounter for the purpose of rendering one or more targeted case management service components by a case manager.

(c) The "Department" means the California Department of Health Care Services.

(d) "Target population" means those Medi-Cal beneficiaries described in Supplements 1a, 1b, 1d, 1e, 1f, and 1h of Attachment 3.1-A.

(e) "A&I" means the Department's Audits & Investigations Division.

(f) "CMS" means the Centers for Medicare & Medicaid Services.

(g) "LGA" means Local Governmental Agency.

(h) "CPE" means Certified Public Expenditure as defined in 42 C.F.R. 433.51.

(i) "TCM provider" means public and private entities contracted with an LGA to provide TCM services on behalf of the LGA under a CMS-approved contractual arrangement.

(j) "Contributing public agency" means the LGA or another State or local governmental entity which provides funding for TCM services provided to target populations.

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(2) Cost Report

(a) Cost Report. Each eligible LGA will complete an annual cost report in the format approved by CMS and as required by the Department, which will include a certification that the costs included in the cost report are public expenditures that have been made and that the public expenditures are eligible for federal financial participation (FFP) pursuant to 42 C.F.R. 433.51. Cost reports are to be filed with the Department by eligible LGAs no later than November 1 after the close of the State fiscal year (FY).

(b) Accepted Cost Report. Annually, the Department will perform reviews of each filed cost report to ensure their completeness. The Department will contact LGAs to resolve omissions. Upon resolution the Department will issue an Acceptance Letter to the LGA, which notifies the LGA that their filed cost report was accepted by the Department.

(c) Cost Reports will be finalized by A&I three (3) years from the date of submission of the original or amended cost report by the LGA, whichever is later.

(d) TCM providers contracting with the LGA will submit to the LGA a subcontractor time survey, which is a time survey based on a CMS approved methodology. The LGA will submit to the Department the subcontractor time survey with the cost report. The time survey percentages will be used to determine either the funding payments to subcontractors in providing TCM services or the TCM program costs incurred by the LGA-contracted provider participating in TCM.

(e) LGAs are required to conduct time surveys to account for staff time spent providing TCM and non-TCM eligible services using the Time Study Methodology for the County Based Medi-Cal Administrative Activities and Targeted Case Management Programs approved by CMS. The time survey results will be used to calculate labor costs of providing TCM services, and overhead costs related to providing TCM services in the cost report. The time survey results will be filed with the LGA's cost report.

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B. Cost-Based Reimbursement Methodology

(1) LGAs will be reimbursed for their allowable costs incurred from providing TCM services rendered to target populations. Allowable costs will be determined in accordance with applicable cost-based reimbursement requirements set forth below or otherwise approved by CMS. The allowable costs will be certified as public expenditures (CPEs).

(2) Allowable costs will be determined in accordance with all of the following: (a) the reimbursement methodology for cost-based entities outlined in 42 CFR Part 413; (b) the Provider Reimbursement Manual (CMS Pub. 15-1); (c) OMB Circular A-87; (d) Medi-Cal Administrative Claiming System (MAC) Agreement; (e) California Welfare and Institutions (W&I) Code; (f) State issued policy directives, including Policy and Procedure Letters; and (g) all applicable federal and State directives as periodically amended, which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medi-Cal program, except as expressly modified herein.

(3) In calculating CPEs or in performing any reconciliation required by this segment of the State Medicaid Plan, any payments made by or on behalf of a Medi-Cal beneficiary for services reimbursed under this segment of the State Medicaid Plan will be used to reduce the amount submitted for purposes of federal reimbursement.

(4) The Department will ensure “free care” and “third party liability” requirements are met. For purposes of this paragraph, “free care” means services that are available without charge to all persons in the community, where there is no beneficiary liability, and where Medi-Cal claiming is not authorized. “Third party liability” means the federal requirements for excluding third party claims from being reimbursed by Medicaid.

C. Certified Public Expenditure Protocol

(1) Interim rate establishment & Interim payment

(a) The purpose of an interim payment is to provide a per encounter interim payment that will approximate the Medi-Cal TCM program

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cost per encounter eligible for FFP claimed through the CPE process. Computation for establishing an interim Medi-Cal TCM encounter payment claimed by CPEs must be performed on an annual basis and in a manner consistent with the instructions below.

(b) The process of determining the allowable Medi-Cal TCM program costs eligible for FFP begins with each LGA's most recently filed and accepted cost report covering the LGA's TCM costs from the previous State FY. This accepted cost report will be used to establish the interim Medi-Cal TCM program payment rate for the current State FY.

(c) For services provided beginning October 16, 2010, until June 30, 2011, the interim Medi-Cal payment rate for the submission of CPEs by the LGA for reimbursement by the Department will be based on the accepted cost reports that were due to be filed by November 1, 2010.

(d) For services provided beginning July 1, 2011, and lasting until a new interim rate is established, the interim Medi-Cal payment rate for the submission of CPEs by the LGA for reimbursement by the Department for services beginning July 1, 2011, will be based on the accepted cost reports that were due to be filed by November 1, 2011. The interim Medi-Cal payment rate for each LGA will be based on a weighted average of what the interim Medi-Cal payments would be for each target population. The interim Medi-Cal payment will be calculated for each target population by dividing the total allowable costs of providing eligible TCM services for the target population by total encounters with the target population from the accepted cost reports containing 100 percent of each target population's cost.

(e) Beginning with cost reports due to be filed by November 1, 2013, and continuing for subsequent payment periods, the Department will establish a new interim Medi-Cal payment rate for each LGA using the accepted cost reports that are due to be filed by November 1 of each State FY. The interim Medi-Cal payment rates for the time periods listed in this paragraph will be calculated by dividing the total allowable costs by total encounters from the same report. The interim Medi-Cal payment rate will be used until a new interim rate is established in order to allow an interim payment to exist between July

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1 and November 1 of each payment period. The Department will adjust the rate downward on an annual basis if requested by the LGA.

(f) The interim payments will be subject to interim and final reconciliation processes described below.

(2) Interim Reconciliation

Each LGA's interim Medi-Cal payments will be reconciled to its accepted TCM cost report for the State FY for which interim payments were made for services on and after the effective date of this SPA. If at the end of the interim reconciliation process, it is determined that an LGA received an overpayment, the overpayment will be collected from the LGA and returned to the federal government. Conversely, if at the end of the interim reconciliation process it is determined that an LGA received an underpayment; the underpayment will be paid to the LGA.

(3) Final Reconciliation

(a) Each LGA's total interim payments and interim reconciliation adjustments for a fiscal year will also be subsequently reconciled to the allowable cost in the accepted Cost Report for that same fiscal year.

(b) The final reconciliation will be finalized upon a review by A&I for purposes of Medi-Cal reimbursement for services on and after the effective date of this SPA.

(c) If at the end of the final reconciliation process, it is determined that an LGA received an overpayment, the overpayment will be collected from the LGA and returned to the federal government. Conversely, if at the end of the final reconciliation process, it is determined that an LGA received an underpayment, the underpayment will be paid to the LGA.

D. CPE Certification

(1) The source of all expenditures will meet the requirements of 42 C.F.R. 433.51.

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(2) Each LGA will report the total-funds expenditures incurred by itself and other governmental entities. The LGA will certify its total-funds expenditures in providing TCM services, and will include a certification signed by the other Contributing public agency's designated representative certifying its total-funds expenditures. LGA will ensure the total-funds expenditures are allowable and meet all federal requirements for the provision of TCM services.

(3) Each LGA will submit a claim to DHCS that is accompanied by an attestation signed by the LGA's designated representative that it has reviewed such costs, that to the best of its knowledge such costs are allowable and meet all federal requirements in seeking FFP.

E. LGA Responsibilities

(1) The LGA will be responsible for the TCM services received by target populations it oversees.

(2) The LGA will ensure public funds were used in providing TCM services and will meet all federal and state requirements seeking FFP.

(3) The LGA will file its cost reports with the Department annually.

F. Department Responsibilities

(1) DHCS will submit claims for FFP for the expenditures as specified in this segment of the State Plan for TCM services provided to target populations as allowable under federal law.

(2) DHCS will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for FFP will include only those expenditures that are allowable under federal law.

(3) DHCS has in place a public process, which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

(4) DHCS will audit and settle the cost reports filed by the LGA in determining the actual Medi-Cal expenditures eligible for reimbursement.

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