



DAVID MAXWELL-JOLLY
Director

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



ARNOLD SCHWARZENEGGER
Governor

SEP 30 2010

Ms. Gloria Nagle
Associate Regional Administrator
Division of Medicaid & Children's Health Operations, Region IX
Centers for Medicare and Medicaid Services
San Francisco Regional Office
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

STATE PLAN AMENDMENT No. 10-010

Dear Ms. Nagle:

The Department of Health Care Services is submitting the enclosed State Plan Amendment (SPA) 10-010 to revise the reimbursement methodology under which the Targeted Case Management Program reimburses services provided by government agencies. The basis for the revisions is to adopt a more specific certified public expenditure methodology. This SPA, Attachment 4.19-B for Reimbursement Methodology for Targeted Case Management Services, will make changes to California's Medicaid State Plan under Title XIX of the Social Security Act.

This SPA conforms to CMS 2237-Final which revised Title 42, Code of Federal Regulations, Parts 431, 440 and 441. The effective date of the SPA will be July 1, 2010.

If you have any questions or concerns regarding the proposed provisions, please contact Ms. Jalyne Callori, Assistant Division Chief, Safety Net Financing Division at (916) 552-9215.

Sincerely,

Toby Douglas
Chief Deputy Director
Health Care Programs

Enclosures

cc: See Next Page

Ms. Gloria Nagle
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cc: Mr. Robert O'Neill, Deputy Director
Audits and Investigations Division
Department of Health Care Services
MS 2000
P.O. Box 997413
Sacramento, CA 95899-7413

Ms. Jalyne Callori
Assistant Division Chief
Safety Net Financing Division
Department of Health Care Services
MS 4504
P.O. Box 997413
Sacramento, CA 95899-7436

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER: 10-010	2. STATE California
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE July 1, 2010	

FOR: HEALTH CARE FINANCING ADMINISTRATION

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

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
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19-B, pages 5d, 5d.1, 5d.2 and 5d.3	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): Attachment 4.19-B, pages 5d, 5e, 5f, 5j and 5k

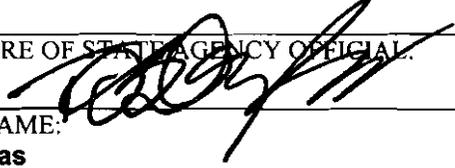
10. SUBJECT OF AMENDMENT:

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: 	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
13. TYPED NAME: Toby Douglas	
14. TITLE: Chief Deputy Director	
15. DATE SUBMITTED:	

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:	

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

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

General Applicability

Notwithstanding any other provisions of the State Plan, this segment of the Plan sets forth special payment rules that apply to the categories of services listed below only when those services are provided to eligible beneficiaries. These provisions apply to the targeted case management services set forth in Supplement 1a, 1b, 1d, 1e, 1f, and 1h to Attachment 3.1-A:

1. Assessment
2. Plan Development
3. Linkage and Consultation
4. Assistance in Accessing Services
5. Crisis Assistance Planning
6. Periodic Review

Reimbursement rates will be established for a specific unit of service. The unit of service will be an encounter.

An encounter is defined as a face-to-face contact or a telephone contact for the purpose of rendering one or more Targeted Case Management (TCM) service components by a case manager. A telephone contact may be reimbursed in lieu of a face-to-face contact only when services are provided and when environmental considerations preclude a face-to-face encounter.

Cost-Based Reimbursement Methodology

The following general provisions apply to all services identified above. Reimbursement to Local Governmental Agencies (LGAs) will be for 100 percent of reasonable and allowable costs for Medi-Cal services rendered to Medi-Cal beneficiaries at the applicable Federal Medicaid Assistance Percentage (FMAP) rate. Reasonable and allowable costs will be determined in accordance with applicable cost-based reimbursement requirements set forth below, including those in the regulations and publications noted below (except for modifications described in this segment of the State Plan or otherwise approved by the Centers for Medicare & Medicaid Services (CMS)):

1. LGAs will identify the funding sources for all expenditures submitted as Certified Public Expenditures (CPEs) for billable TCM services provided to Medi-Cal beneficiaries described in Supplement 1a, 1b, 1d, 1e, 1f, and 1h to Attachment 3.1-A. A determination will be made as to whether any of the expenditures, on the basis of the funding sources identified, cannot be used for claiming federal reimbursement pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations (CFR).

TN# 10-010 Approval Date _____ Effective Date July 1, 2010
Supersedes
TN# 00-013

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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 A-87, and (d) all applicable federal directives, 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 Plan, any payments made by or on behalf of a Medi-Cal beneficiary for services reimbursed under this segment of the State Plan will be used to reduce the amount submitted for purposes of federal reimbursement.
4. The allowable costs which may be certified under this methodology include TCM and overhead costs, determined pursuant to paragraph 6, which are incurred providing covered services to Medi-Cal beneficiaries described in Supplement 1a, 1b, 1d, 1e, 1f, and 1h to Attachment 3.1-A.
5. Each eligible LGA will complete an annual cost report in the format prescribed by DHCS which will include a certification that the costs included in the report have been expended and that the expenditures are eligible for federal reimbursement pursuant to 42 CFR 433.51.

Notwithstanding any regulation to the contrary, cost reports are to be submitted by eligible LGAs no later than November 1 after the close of the fiscal year.

6. When applicable, LGAs, or subcontracted providers, participating in TCM will be required by the department to submit a time survey based on a CMS approved methodology. The time survey percentage will be applied to time spent on direct TCM services and directly related activities, time spent on non-TCM services and related activities, and general and administrative time allowable for reallocation. For the cost report, the time survey results will be used to calculate labor costs of performing TCM services, and overhead costs related to performing TCM services.
7. 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 Medicaid claiming is not authorized.
8. The department will conduct an annual survey of insurance carriers to determine whether TCM services, as described in this State Plan, are included and paid for as a covered benefit. The survey results will be used in determining the extent of Medicaid's payment liability in accordance with federal regulations set forth in 42 CFR 433.139(b).

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Interim Claiming Methodology

1. Annually, for each LGA, the Department will establish an interim, all-inclusive reimbursement rate (interim rate) for each target population by dividing the total allowable costs from the most recently filed cost report by total encounters from the same report. The interim rate will be used for the initial submission of CPEs by the LGAs. Where an LGA files more than one cost report for a specific target population, the cost report that contains 100 percent of the target population's costs and encounters will be used for the purpose of establishing the interim rate. The State may periodically adjust such rates for inflation or to take into consideration increases or decreases in costs not reflected in the most recently filed cost report to ensure that CPEs based on the interim rates approximate actual allowable costs; however, in no event will the interim all-inclusive payment rates exceed 95 percent of approximated actual allowable costs per encounter.
2. CPEs submitted by each LGA for TCM services to which this segment of the State Plan applies will be based on the interim rate per encounter.

Interim Reconciliation

1. After receipt of the filed cost report, due November 1, the Department will perform an interim reconciliation of interim claims for federal reimbursement to allowable costs (as reported on the filed cost report(s)) multiplied by the FMAP beginning July 1 of the following fiscal year. Final rates based on the filed cost report(s) will be applied at this time.

In performing this interim reconciliation, the Department may, if appropriate, make adjustments to costs reported on the filed cost(s) reports based on the results of the most recent audit of a prior year's cost report. The Department will follow federal Medicaid procedures for managing overpayments of federal Medicaid funds. If it is determined that an eligible TCM provider has been underpaid, the eligible provider will receive an adjusted payment amount.

2. Where an LGA files more than one cost report for a specific target population, the cost report that contains 100 percent of the target population's costs and encounters will be used for interim reconciliation.

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Final Reconciliation

1. Interim claims based on CPEs submitted by LGAs (as adjusted during interim reconciliation process) will be reconciled to audited allowable costs multiplied by the FMAP. If it is determined that the LGA has been overpaid, the LGA will repay the Medi-Cal program. The Department will follow federal Medicaid procedures for managing overpayments of federal Medicaid funds. If it is determined that an LGA has been underpaid, the LGA will receive an adjusted reimbursement amount.
2. A final reconciliation will be performed by the Department only if there is an audit of the TCM cost report. The final reconciliation will be performed based on the audited costs.