

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: California

19. CASE MANAGEMENT SERVICES

A. Target Group: See Supplement 1 to Attachment 3.1-A.

A-1 Mentally Disabled (Short-Doyle), Page 3

A-2 Developmentally Disabled (Lanterman), Page 4

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

Entire State.

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

C. Comparability of Services

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

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)(10)(B) of the Act.

D. Definition of Services: See Supplement 1 to Attachment 3.1-A.

D-1 Mentally Disabled, Page 4

D-2 Developmentally Disabled, Page 6

E. Qualification of Providers: See Supplement 1 to Attachment 3.1-A.

E-1 Mentally Disabled, Page 10

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F. Assurances: See Supplement 1 to Attachment 3.1-A.

F-1 Mentally Disabled, Page 12

F-2 Developmentally Disabled, Page 14

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

1. Eligible 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 does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

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A. Target Group

A-1 Mentally Disabled

Short-Doyle mental health programs will provide case management services according to locally established priorities for mental health services and in a manner consistent with existing administration and service delivery structure. Services will be provided concurrently to clients who are Medi-Cal beneficiaries and to those who are not; services provided to clients who are not Medi-Cal eligible will be funded with State General Funds exclusively. Services provided to clients of the target population who are Medi-Cal beneficiaries will be reimbursed through SD/MC* Program. The target population for case management services include:

1. Individuals who are or have been hospitalized for psychiatric care in a state or local inpatient facility, including a psychiatric health facility, or admitted to a skilled nursing facility, and for whom a different level of care is appropriate.
2. Individuals who are perceived to be at risk of being admitted for psychiatric care to a state or local inpatient facility, psychiatric health facility, or a skilled nursing facility, but for whom care in a nonmedical facility is appropriate.
3. Mentally disabled individuals living with their families, significant others, or in independent or semi-independent living arrangements who need support services to maintain stability at this level.
4. Mentally disabled individuals who require care and supervision in a licensed nonmedical community care facility.
5. Severely emotional disabled children and adolescents who are at risk of needing out-of-home placement.
6. Mentally disabled children and youth who do not fall into the target groups previously cited but who are perceived to be in need of guidance and assistance to secure appropriate treatment and care.

* SD/MC means the Short/Doyle/Medi-Cal Program, which is that portion of the statewide mental health program which serves Medicaid-eligible persons.

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7. Mentally disabled homeless individuals.

A-2 Developmentally Disabled

The target population for which federal financial participation is requested is composed of those developmentally disabled persons who meet the following definition of developmental disability.

"Developmental disability" means a disability which originates before an individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial handicap for such individual. This term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include handicapping conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

Persons residing in those facilities designated as Intermediate Care Facilities/Mentally Retarded (ICF/MR) shall be excluded from the target group.

D. Definition of Services

D-1 Mentally Disabled

Client-specific services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational and other services. Defined services activities are:

1. Evaluation

Purpose: To determine the individual's strengths, needs, and resources. this activity would typically include assessment and periodic reassessment of the level of psychosocial impairment.

physical health problems, self-care potential, support network availability, adequacy of living arrangements, financial status, employment status, and potential and training needs. The case manager will review all available medical, psych-social, and other records; meet with the client as necessary; and consult with treatment staff and other agencies. Contacts may be face-to-face or by telephone with the client, family, or significant others.

2. Plan Development

Purpose: To develop a written, comprehensive, individual service plan (ISP), which specifies the treatment, services activities, and assistance needed to accomplish the objectives negotiated between the client and case manager. The service plan must describe the nature, frequency, and duration of services to be offered. Contacts may be face-to-face or by telephone with the client, family, or significant others.

3. Emergency Intervention

Purpose: To intervene with the client/others at the onset of a crisis to provide support and assistance in problem resolution and to coordinate or arrange for the provision of other needed services. Contacts may be face-to-face or by telephone with the client, family, or significant others.

4. Placement Services

Purpose: To assess the adequacy and appropriateness of the client's living arrangements and to assist in securing alternative living arrangements when needed. Services would typically include locating and coordinating the resources necessary to facilitate a successful and appropriate out-of-home placement, monitoring the client's progress, and consulting, as required, with the care provider. Contacts may be face-to-face or by telephone with the client's family, significant other, or service provider.

5. Assistance in Daily Living

Purpose: To monitor, support, and assist the client on a regular basis in developing or maintaining the skills needed to implement and achieve the goals of the ISP. Services would typically include support in the use of psychiatric, medical, and dental services; guidance in money management; and the use of educational, socialization, rehabilitation, and other social services.

6. Linkage and Consultation

Purpose: to identify, assess, and mobilize resources to meet the client's needs. Services would typically include consultation and intervention on behalf of the client with Social Security, welfare and health departments, and other community agencies, as appropriate. Although contact with the client, family, or significant others is not required, contacts must be on behalf of a specific client.

Client case records shall specify which case management service(s) has been provided, the date of the service(s), and the time spent providing the service(s).

D. Definition of Service

D-2 Developmentally Disabled

Regional center case management, as provided to eligible developmentally disabled clients, via contract with the Department of Developmental Services (DDS) and authorized by the Lanterman Act, are those individual services that will assist beneficiaries in gaining access to needed medical, social, educational, and other services.

1. Background

California's developmental disabilities service system is administered by DDS which, as of January 1988, was serving 88,314 Clients and has expenditures of \$911 million. DDS directly administers 7 state developmental centers (formerly called state hospitals) and contracts on an annual basis with 21 boards of directors of private, nonprofit corporations to operate regional centers (case management provider agency). It is through these contacts that DDS ensures program and financial accountability for regional center case management services.

The regional center system is governed by the Lanterman Developmental Disabilities Services Act of 1977 (Division 4.5 of the California Welfare and Institutions Code). Under the Act, DDS is responsible for coordinating the services of many state departments and community agencies to ensure that no gaps occur in communication or the provision of services to persons with developmental disabilities.

The catchment area boundaries for the regional centers conform to county boundaries or groups of counties, except for Los Angeles County which is divided into 7 areas, each served by a regional center.

2. Core Elements of Case Management

For purposes of the Medicaid Targeted Case Management Services program, the provision of services will be limited to case management services provided by the regional centers (case management provider agency). Case management is the process of needs assessment, setting of objectives related to needs, service scheduling, program planning, and evaluating program effectiveness.

The regional center provides services which ensure that the changing needs of the person and the family are recognized on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs. Case management includes the following:

a. Assessment

Assessment includes those case management services available to the developmentally disabled client in order to provide data necessary to develop a plan for current and future client services. This involves acquainting and educating the client, parent, or legal guardian with sources of services in the community; providing procedures for obtaining services through the regional center; analyzing each client's medical, social, and psychological evaluations, and any other evaluations necessary to determine appropriate resources to meet each client's needs and completing a treatment plan. (While physical and psychological examinations and evaluations are essential components of case management, these services fall within the scope of regular Medi-Cal benefits. As such, these services will not be billed as Targeted Case Management Services). Specific client objectives are discussed and strategies for achieving the stated objectives are identified.

b. Individual Program Plan (IPP)

An IPP is created for each client who is determined, through the above described assessment, to be in need of such a plan. This is a process in which a client's abilities and needs are identified and goals, objectives and plans are formulated by the case manager to meet the unique needs of the clients. The regional center case manager, the Client Service Coordinator (CSC), is responsible for the development of the IPP. The IPP includes an assessment of the client's specific capabilities and problems; time-limited objectives for improving capabilities and resolving problems; a schedule of services to meet objectives; and a schedule of regular, periodic review and reassessment to ascertain that planned services have been provided and that objectives have been reached within times specified.

The IPP represents the cooperative effort and agreement of an interdisciplinary team which is composed of the regional center CSC, the client and/or legal representative, and other parties involved, as appropriate.

c. Annual/Periodic Review

At least on an annual basis, CSC will complete a summation of client progress in achieving IPP objectives and an assessment of the client's current status. Based on this assessment, the regional center CSC and the person with developmental disabilities, or the conservator shall determine if reasonable progress has been made and shall be free to choose whether current services should be continued, modified, or discontinued. Periodic reviews will be conducted when it is determined that the implementation of the client's IPP needs to be reviewed more frequently than once a year or where state/federal law requires more frequent reviews.

d. Discharge Planning

Discharge planning to assist the individual in transitioning from inpatient to outpatient status, and arranging for appropriate services for the person being discharged. This work needs to begin prior to the actual date of discharge, and for this reason, targeted case management services for discharge planning activities performed by the regional center for up to 180 days prior to an individual's actual discharge from an institutional setting are included.

Individuals requesting case management services may receive these services from the regional center responsible for the catchment area in which the individual resides. Catchment area boundaries have been established in order to assure individuals access to services within a reasonable distance for their residence. The individual's freedom of choice of providers is not, however, restricted to any particular regional center in that the individual may seek case management services from any regional center in the state.

The Lanterman Act requires that the performance of the CSC be reviewed at least annually by the regional center, the client, and the client's parents or guardian or conservator. The CSC may not continue to serve as a case manager for the client unless there is agreement by all parties that the CSC should do so. All parties shall be free to choose whether the CSC's services should be continued, modified, or discontinued. If the client is dissatisfied with a particular CSC, the regional center works with the client and the CSC in an attempt to resolve the problem. If the situation cannot be resolved, the client may transfer to another case manager.

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Clients are not required to accept case management services. Should a client refuse to accept these services, this refusal shall not be used as a basis to restrict the client's access to other Medicaid-funded services. Further, the provision of case management services will in no way restrict the individual's free choice of providers of other Medicaid-funded services.

A fair hearing opportunity will be provided in compliance with Article 3 of the Lanterman Act for beneficiaries who believe they were not given the choice of case management services or who believe they are denied the service of their choice by the regional center.

A process of client fair hearings is described in the California Administrative Code, Title 17, Section 50540.

E. Qualification of Providers

E-1 Mentally Disabled

SD/MC reimbursement for hospital and clinic services is provider-specific, based upon costs (to a maximum) that are unique to that provider. The provider, moreover, must be certified by DHS to be eligible for the SD/MC Program, and certification is dependent upon compliance with established staffing standards. For case management services, the same basic principles will apply. County mental health programs will have two options:

1. Case management services may be added as a mode of service to be provided by certified SD/MC clinics. This option may be the more appropriate and cost-effective one for small county programs with a limited number of staff and/or service providers and relatively few clients who require case management services. The designated case manager(s) may be required to perform other duties in addition to case management services, but a clear audit trail for case management services will be assured by requiring counties to maintain a unique cost center for case management services and to document case management activities separately; i.e., a separate case record or a separate section of the clinical record.

2. A distinct program unit, or more than one, may be established by the county and certified by DHS to provide and be reimbursed FFP for the case management mode of service. The identified unit(s) will be required (1) to have a unique provider number, (2) to meet staffing standard requirements, and (3) to have in place a utilization review system.

Case management services, whether provided by a certified SD/MC clinic or by a distinct program unit which provide case management services exclusively, shall be provided by or under the direction of Title 9, CCR, Sections 623, 624, 625, 627, 628, and 629 (minimum qualifications which apply to the head or chief of a particular service).

Case managers who will function under the supervision of the licensed professional noted above will include staff who are social workers (licensed and nonlicensed), nurses, marriage, family and child counselors, and, in some instances, staff with mental health experience but varied backgrounds who have been hired into job classifications of a generic nature, i.e., mental health specialists.

The State will require that supervisor/supervisees ratios for case management services be commensurate to the professionalism and experience of the case management staff. The local mental health director is held responsible to assure the quality of services provided subject to DMH and DHS oversight.

E. Qualification of Providers

The CSC, employed by the regional center, will be designated as the provider of TCM services. The minimum requirement is a degree in social sciences or a related field. Case management experience in the developmental disabilities field or a related field may be substituted for education on a year-for-year basis. Case aides will do basic duties such as working by telephone with consumers and families. They assist in screening calls for services and frequently resolve requests for services. The case aides are employed by the regional center and work under the direct supervision of the CSC.

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F. Additional Assurances

F-1 Mentally Disabled

County mental health programs which claim SD/MC reimbursement for case management services shall be required to provide and abide by the following assurances. DMH and DHS, as the single state agency, shall monitor to assure that:

1. Reimbursement

SD/MC reimbursement for case management services provided to residents of an inpatient hospital or skilled nursing/intermediate care (SNF/ICF) facility will be claimed only for evaluation and placement services. Those case management services, as defined in Attachment to Supplement 1 to Attachment 3.1-A, will not be allowed as a substitute for or as a part of the screening and other requirements of Public Law 100-203 (Nursing Home Reform).

FFP for case management evaluation and placement services provided to residents of an inpatient hospital or an SNF/ICF will be limited to a period of 30 days immediately prior to the eligible individual's discharge from the facility to noninstitutional care. Moreover, while acknowledging that, for a variety of possible reasons, discharge may not always materialize as planned; the State, nevertheless, will limit reimbursement for such case management services to a maximum of 3 nonconsecutive episodes of 30 days or less per institutional stay.

2. Record Keeping/Utilization Review

Record keeping/utilization review requirements are fully implemented.

DMH utilization review standards for case management services will be similar to those which have been developed and implemented for hospital inpatient and outpatient clinic services. DMH will develop an appropriate utilization review protocol which will be submitted to DHS for review and concurrence prior to implementation.

DMH shall require local mental health programs and providers of case management services to utilize existing systems, or establish necessary additional systems, to review the quality and appropriateness of case management services funded by Medi-Cal and shall audit for compliance. County or provider utilization review committees should anticipate that DMH utilization review audits shall:

- a. Verify that providers of case management services have a continuous operational program of utilization review in effect under which the admission of each client for case management services is reviewed for approval.
- b. Verify that the client meets the criteria established for the target population.
- c. Verify that the county/provider has established criteria, and applied that criteria, to evaluate the need for case management services and for termination of case management services.
- d. Verify that the need for case management services has been established and clearly documented. The initial review by the county or provider's utilization review committee shall be within 60 days of the client's admission for case management service; subsequent reviews shall be scheduled, at a minimum, every 6 months.
- e. Verify that the case management service plan (goals, objectives, time frame) are appropriate to the identified need(s) and that the interventions of the case manager are appropriate to the goals, objectives, and projected time frame.
- f. Identify and recoup inappropriate payments of FFP.
- g. Provide an administrative mechanism for providers who wish to appeal a review finding.

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SUPPLEMENT 1 TO ATTACHMENT 3.1-A
Page 14

F. Additional Assurances

F-2 Developmentally Disabled

No assurances.

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