

TARGETED CASE MANAGEMENT SYSTEM

The methodology for computing the reimbursement rate for Targeted Case Management (TCM) services is set forth below:

1. Each regional center will utilize an average TCM unit of service rate. A TCM unit is a 15-minute increment of service.
2. The computation of the base rate (before adjusting for the California Consumer Price Index (CCPI)) is prospective and is established on the basis of historical costs. Each fiscal year, defined as the year ending June 30, the Department of Health Services (DHS) will establish a rate based upon information received from the Department of Developmental Services (DDS).
3. DDS will calculate a per unit rate for TCM services for each regional center based on twelve (12) months of regional center actual expenditure data and case management utilization factors from the fiscal year ended June 30th of the year prior to the year of calculation. All costs (direct costs, regional center administrative staff costs, operating expenses and other staff costs) used to develop the TCM rate for each individual Regional Center will be in accordance with OMB Circular A-122. Each regional center will submit expenditure information for each direct case management service classification on a Rate of Reimbursement, Schedule B, Summary of Applicable Regional Center Costs of the TCM Rate Study Package. At least once every three years, a one-month time survey will be used to determine the allowable time spent on case management services. Regional centers will receive instructions delineating allowable and non-allowable time. For example, assessments of a consumer's functioning levels, needs and progress are allowable case management services. Intake services prior to the determination that the client is developmentally disabled are not allowable case management services. The TCM rate will be calculated as described in step 4, below.
4. Utilizing the DDS consumer and DHS Medi-Cal databases, the percentage of Medi-Cal recipients will be determined based on the ratio of consumers on Medi-Cal to the total number of consumers receiving case management at the regional centers. Using this percentage DDS will:
 - a. Multiply the percentage of Medi-Cal recipients by the case management costs for each direct service classification, using the expenditure information submitted pursuant to step 3, for the fiscal year ended June 30th of the year prior to the year of calculation.
 - b. Multiply the case management costs per Medi-Cal recipient determined in step 4 a by the percentage of allowable case management time determined in step 3.

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- c. DDS will determine the appropriate allocation of regional center administrative staff costs, operating expenses and other staff costs to case management services by multiplying these costs by the percentage taken from an annual time survey of administrative staff for the year ended June 30th of the year prior to the year of calculation.
 - d. The regional center administrative staff costs, operating expenses and other staff costs derived in step 4 c, above, will then be multiplied by the percentage of Medi-Cal recipients, derived in step 4 a, above, to arrive at the regional center administrative staff costs, operating expenses and other staff costs applicable to Medi-Cal recipients.
 - e. Total allowable direct service costs, regional center administrative staff costs, operating expenses and other staff costs for Medi-Cal recipients, derived pursuant to steps a through d above, will be divided by the TCM units recorded during the year ended June 30th of the year prior to the year of calculation to arrive at a per unit rate for TCM services and regional center administrative costs.
5. Regional centers will submit data that reflects Medi-Cal allowable costs that are determined in accordance with cost reimbursement principles identified in 42 C.F.R. Part 413, and to the extent not governed by Part 413, in accordance with Generally Accepted Accounting Principles and OMB Circular No. A-122.
 6. The new per unit rate will be effective July 1st of the fiscal year following the year of calculation, adjusted prospectively by the CCPI.
 7. For the period of May 3, 2003, through June 30, 2005, DDS will submit for DHS' approval, a one-time, twenty-six (26) month transitional per unit rate for TCM services for each regional center based on the regional center's expenditures and data for the fiscal year ending June 30, 2001, and adjusted for the CCPI. DDS will submit revised invoices for the transition period reflecting previous claims, revised claims using the transitional rate, and the difference between the two rates.
 8. Each year, DDS will submit to DHS the data and calculations that are developed, or were submitted, to respond to the requirements of steps 1 – 7, above.

MEDI-CAL CLAIMING PROCESS

1. TCM services will be documented by the case manager on a Medi-Cal eligible, client specific, activity log. (See page 5c of this supplement, which is an example of the documenting instrument to be employed by the regional centers.) The date of service, the case manager providing the service, the units of service (recorded in 15-minute increments of the service time), an explanation of the type of service, and the location of the service will be recorded on the activity logs. The total units of

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service provided to each Medi-Cal recipient eligible for TCM services will then be tallied at the end of each month by the regional center and submitted to DDS. The regional center will retain a copy of the activity log for auditing purposes.

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**State Plan under Title XIX of the Social Security Act
Department/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

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

- 1) Providers participating in Targeted Case Management (TCM) will be required to submit an annual survey identifying:
 - a. labor costs of performing TCM services; and
 - b. overhead costs related to performing TCM.
- 2) The unit of service shall be a 15 minute case manager time increment on an individual beneficiary basis and billed through Electronic Data Systems (EDS).
- 3) Payments for TCM services will be issued by EDS directly to the providers of these services. The Department will work with EDS on:
 - a. establishing and implementing the reimbursement process; and
 - b. determining the appropriate edits and audits to ensure program integrity.
- 4) The department shall ensure “free care” and “third party liability” requirements are met.
- 5) The department shall conduct an annual survey of insurance carriers to determine whether TCM services, as described in this State Plan Amendment, are included and paid for as a covered benefit. The survey results will be used to determine the extent of Medicaid’s payment liability in accordance with federal regulations set forth in 42 CFR 433.139 (b).
- 6) Statewide hourly tiered rates will be established based on the annual survey submitted and will be grouped into low, medium, and high cost categories. Provider rates would be averaged for each of the 3 categories, providing the rate to be used by that grouping of providers.

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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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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

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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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

Case management services will be provided by licensed and certified Public Health Nurses (PHN) who are experienced in providing case management services and who are employed by a jurisdiction's local health department.

Reimbursement rates shall be established for a specific unit of service. The unit of service shall be an encounter with Title XIX eligible infants, children, and young adults to age 21.

An encounter is defined as a face-to-face contact or a significant telephone contact with the Title XIX eligible individual or with the individual or legal guardian designated to act on behalf of the Title XIX eligible individual.

The reimbursement process is as follows:

1. The Department of Health Services, Childhood Lead Poisoning Prevention Branch (CLPPB) budget for fiscal year 1996-97, includes State General Funds for the provision of Medi-Cal Lead Poisoning Case Management Services to lead poisoned Medi-Cal eligibles to age 21 by each jurisdiction's local health department.
2. For each jurisdiction's local health department, the CLPPB will calculate the estimated amount of per encounter costs based upon the statewide average cost of a Public Health Nurse (PHN) Medi-Cal Lead Poisoning Case Management encounter, the number of each jurisdiction's local health department's Medi-Cal eligibles to age 21 at risk for lead poisoning, and the number of each jurisdiction's local health department's lead poisoned Medi-Cal eligibles to age 21 currently receiving case management services.
3. The projected amount of State General Funds set aside for each jurisdiction's local health department will enable jurisdiction's local health departments to develop an annual Medi-Cal Lead Poisoning Case Management budget.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Case Management

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

Claims for federal financial participation reimbursement will be made retrospectively after Medi-Cal Lead Poisoning Case Management services have been provided and documented in each Medi-Cal eligible's chart and PHN personnel time is documented.

4. Each jurisdiction's local health department will conduct a regularly scheduled time study following federal OMB A-87 approved time study methodology. The time study will capture the PHN time spent providing case management services to both Medi-Cal and non-Medi-Cal eligibles in one or more components of case management services, such as assessment, plan development, referral, assistance in accessing services, follow-up crisis intervention planning, reevaluation, or on other activities that are directly related to the provision of case management services.
5. Each jurisdiction's local health department will establish a rate for case management services provided to Medi-Cal eligibles. The rate will be derived from the annual budget, which contains salary and benefits, and time studies that show time spent performing case management services, including travel. The total cost of providing case management services to Medi-Cal eligibles will be divided by the total number of Medi-Cal eligibles receiving case management services during the time-study period to arrive at a rate per Medi-Cal eligible.
5. Each jurisdiction's local health department will develop invoices for reimbursement of case management services provided to Medi-Cal eligibles. Invoices will be submitted quarterly to the Childhood Lead Poisoning Prevention Branch.
7. Each jurisdiction's local 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 Medi-Cal eligible,
 - 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 case manager.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

8. Fiscal monitoring will be conducted using an audit trail that includes a) the name, classification, duty statement, and amount of PHN time identified on the local health jurisdiction's budget submitted to and approved by the DHS/CLPPB; b) quarterly invoices submitted for reimbursement of PHN case management services; c) the time study identifying PHN time spent providing Medi-Cal Lead Poisoning Case Management services; and d) the PHN's field record documenting the recipient's Medi-Cal status, lab report documenting the Medi-Cal recipient's elevated blood lead level, the CLPPB Follow-up Form and PHN service plan that documents receipt of necessary follow-up activities.
9. The department shall ensure free care and third party liability requirements are met.
10. The department shall conduct an annual survey of insurance carriers to determine whether case management services, as described in this State Plan Amendment, are included and paid for as a covered benefit. The survey result will be used to determine the extent of Medicaid's payment liability in accordance with federal regulations set forth in 42 CFR 433.139(b).

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