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

## TARGETED CASE MANAGEMENT SERVICES

A. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9))

The target population is composed of those individuals diagnosed with a 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 disability 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.

B. __X__ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions (State Medicaid Directors Letter (SMDL), July 25, 2000).

C. Areas of State in which services will be provided (§1915(g)(1) of the Act):
__X__ Entire State
_____ Only in the following geographic areas:

D. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
_____ Services are provided in accordance with §1902(a)(10)(B) of the Act.
__X__ Services are not comparable in amount duration and scope (§1915(g)(1)).

E. Background

California's developmental disabilities service system is administered by the Department of Developmental Services (DDS). DDS directly administers four state developmental centers, one smaller state-operated community facility 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 contracts 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 (Lanterman Act) (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 seven areas, each served by a regional center.

F. Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
   - taking client history;
   - identifying the individual's needs and completing related documentation; and
   - gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual.

   Assessment includes activities that provide data (e.g. client history, needs identification, information obtained from the client, family members, service providers, and educators, if needed) necessary to develop a plan for current and future client services. This involves gathering 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 program plan.

In conjunction with the "Monitoring and follow-up activities" described below, assessment information is reviewed, and updated as needed, at least annually. 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.

2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
    - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
    - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
    - identifies a course of action to respond to the assessed needs of the eligible individual.

    An individual program plan (IPP) is developed for each client. This is a process in which goals, objectives and plans are formulated to meet the unique needs of the client. The IPP represents the cooperative effort and agreement of the planning team which is composed of the regional center Client Service Coordinator (CSC), the client and/or legal representative, and other parties involved, as appropriate. The IPP, using the information gained from the assessment of the client's specific capabilities and needs, includes; a statement of goals based on the needs preferences and life choices of the individual; objectives for achieving the stated goals and addressing the client's needs; and a schedule of services and supports to meet the objectives.

3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
    - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

    This involves the CSC acquainting and educating the client, parent, or legal representative with sources of services in the community and providing procedures for obtaining services through the regional center or other sources. This includes activities, such as making referrals to service providers and scheduling appointments that link the client to providers capable of delivering services identified in the IPP.

4. Monitoring and follow-up activities:
   - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
     i. services are being furnished in accordance with the individual's care plan;
     ii. services in the care plan are adequate; and
     iii. changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

   This includes activities and contacts that are necessary to ensure the IPP is effectively implemented and adequately addresses the needs of the client. The contacts may be with the client, family members, service providers, or others involved in implementing the IPP. At least on an annual basis, the CSC will review client progress in achieving IPP objectives and assess the client's current status. Based on this assessment, the regional center CSC and the client or legal representative shall determine if reasonable progress has been made and shall decide 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.

G. __X__ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

H. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)): The CSC, employed by the regional center, will be designated as the provider of TCM services. The minimum requirement is either 1) a degree in social sciences or a related field; or 2) case management experience in the developmental disabilities field or a related field which may be substituted for education on a year-for-year basis.

I. Freedom of choice (42 CFR 441.18(a)(1)):
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 individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

J. Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
__X__ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

The target group consists of eligible individuals with developmental disabilities, as defined previously. Providers of case management services through this state plan amendment are limited to Client Service Coordinators (CSCs) employed by regional centers. As indicated previously, DDS contracts with 21 boards of directors of private, nonprofit corporations to operate regional centers. Regional centers, as established by the Lanterman Act, provide fixed points of contact in the community for persons with developmental disabilities and their families. Regional centers coordinate and/or provide community-based services to eligible individuals. Due to this service delivery structure, regional center CSCs are uniquely qualified to provide case management services to individuals with developmental disabilities.

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

A fair hearing opportunity will be provided in compliance with Chapter 7, 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.

K. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

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.

L. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted 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.

M. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Regional centers (case management provider agencies) are required to maintain case records for all case management recipients that document the information identified in (i) – (viii) above.

N. Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when 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 for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

No additional limitations.

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## TARGETED CASE MANAGEMENT SERVICES

A. Target Group (42 Code of Federal Regulations (CFR) 441.18(a)(8)(i) and 441.18(a)(9))

Targeted case management services are provided as part of a comprehensive specialty mental health services program available to Medi-Cal beneficiaries that meet medical necessity criteria established by the State, based on the beneficiary's need for targeted case management established by an assessment and documented in the client plan.

1. For members of the target group who are transitioning to a community setting targeted case management services will be made available for up to 30 calendar days for a maximum of three non-consecutive periods of 30 calendar days or less per hospitalization or inpatient stay prior to the discharge of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions (State Medicaid Directors Letter (SMDL), July 25, 2000).

B. Areas of State in which services will be provided (Section 1915 (g)(1) of the Act)

X Entire State
_____ Only in the following geographic areas

C. Comparability of services (Sections 1902(a)(10)(B) and 1915(g)(1)

_____ Services are provided in accordance with Section 1902(a)(10)(B) of the Act
X Services are not comparable in amount duration and scope (Section 1915(g)(1))

D. Definition of Services (42 CFR 440.169)

Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, alcohol and drug treatment, social, educational and other services.

Targeted case management may be provided face-to-face, by telephone, or by telemedicine with the beneficiary or significant support person and may be provided anywhere in the community. Targeted case management contacts with significant support persons may include helping the eligible beneficiary access services, identifying needs and supports to assist the eligible beneficiary in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible beneficiary's needs (42 CFR 440.169(e)).

Targeted case management means services that assist a beneficiary to access needed medical, alcohol and drug treatment, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities include (dependent upon the practitioner's judgment regarding the activities needed to assess and/or treat the beneficiary): communication, coordination, and referral; monitoring service delivery to ensure beneficiary access to service and the service delivery system; monitoring of the beneficiary's progress; placement services; and plan development.

Targeted case management includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for establishment or continuation of targeted case management services to access any medical, educational, social, or other services. These assessment activities include:
   a. Taking client history;
   b. Identifying the individual's needs and completing related documentation, reviewing all available medical, psychosocial, and other records, and gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary) to form a complete assessment of the individual; and
   c. Assessing support network availability, adequacy of living arrangements, financial status, employment status, and potential and training needs.

   Assessments are conducted on an annual basis or at a shorter interval as appropriate.

2. Development and Periodic Revision of a Client Plan that is:
   a. Based on the information collected through the assessment;
   b. Specifies the goals, treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical, social, educational, and other services needed by the individual;

c. Includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals;
d. Identifies a course of action to respond to the assessed needs of the eligible individual; and
e. Develops a transition plan when a beneficiary has achieved the goals of the Client Plan.

3. Referral and Related Activities:
   a. To help an eligible individual obtain needed services including activities that help link an individual with medical, alcohol and drug treatment, social, educational providers or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual;
   b. To intervene with the client/others at the onset of a crisis to provide assistance in problem resolution and to coordinate or arrange for the provision of other needed services;
   c. 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, schools, social services and health departments, and other community agencies, as appropriate; and
   d. Placement coordination services when necessary to address the identified mental health condition, including assessing the adequacy and appropriateness of the client's living arrangements when needed. Services would typically include locating and coordinating the resources necessary to facilitate a successful and appropriate placement in the least restrictive setting and consulting, as required, with the care provider.

4. Monitoring and Follow-Up Activities:
   a. Activities and contacts that are necessary to ensure the Client Plan is implemented and adequately addresses the individual's needs, and which may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
      - Services are being furnished in accordance with the individual's Client Plan;
      - Services in the Client Plan are adequate; and
      - There are changes in the needs or status of the individual, and if so, making necessary adjustments in the Client Plan and service arrangements with providers.

b. Activities 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 Client Plan. Services would typically include support in the use of psychiatric, medical, educational, socialization, rehabilitation, and other social services.

Monitoring and update of the Client Plan is conducted on an annual basis or at a shorter interval as appropriate.

E. Qualification of Providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b))

Targeted Case Management services are provided by certified mental health organizations or agencies and by mental health professionals who are credentialed according to state requirements or non-licensed providers who agree to abide by the definitions, rules, and requirements for Targeted Case Management services established by the Department of Health Care Services to the extent authorized under state law.

Targeted case management services may be provided by or under the direction (for those providers that may direct services) of the following Licensed Mental Health Professional providers or teams of providers determined to be qualified to provide the service, consistent with state law.

"Licensed Mental Health Professional" means licensed physicians, licensed psychologists, licensed clinical social workers, licensed professional clinical counselors, licensed marriage and family therapists, registered nurses (includes certified nurse specialists and nurse practitioners), licensed vocational nurses, and licensed psychiatric technicians.

"Under the direction of" means that the individual directing service is either directly providing the service, or acting as a clinical team leader, providing direct or functional supervision of service delivery, or review, approval, and signing client plans. An individual directing a service is not required to be physically present at the service site to exercise direction. The licensed professional directing a service assumes ultimate responsibility for the targeted case management service provided. Services are provided under the direction of: a physician; a licensed or waivered psychologist; a licensed, waivered or registered social worker; a licensed, waivered or registered marriage and family therapist; a licensed, waivered or registered professional clinical counselor, or a registered nurse (including a certified nurse specialist, or a nurse practitioner).

"Waivered/Registered Professional" means:

(1) For a psychologist candidate, "waivered" means an individual who either (1) is gaining the experience required for licensure or (2) was recruited for employment from outside California, has sufficient experience to gain admission to a licensing examination, and has been granted a professional licensing waiver approved by the Department of Health Care Services to the extent authorized under state law.
(2) For a social worker candidate, a marriage and family therapist candidate, or a professional counselor candidate, "registered" means a candidate for licensure who is registered with the corresponding state licensing authority for the purpose of acquiring the experience required for licensure, in accordance with applicable statutes and regulations, and "waivered" means a candidate who was recruited for employment from outside California, whose experience is sufficient to gain admission to the appropriate licensing examination and who has been granted a professional licensing waiver approved by the Department of Health Care Services to the extent authorized under state law.

The following specific minimum provider qualifications apply for each individual delivering or directing services.

1) Physicians

Physicians must be licensed in accordance with applicable State of California licensure requirements. Physicians may direct services.

2) Psychologists

Psychologists must be licensed in accordance with applicable State of California licensure requirements. Psychologists may direct services.

A psychologist may also be a Waivered Professional who has a waiver of psychologist licensure to the extent authorized under State law. Waivered Psychologists may also direct services under the supervision of a Licensed Mental Health Professional in accordance with laws and regulations governing the waiver.

3) Licensed Clinical Social Workers (LCSW)

Licensed clinical social workers must be licensed in accordance with applicable State of California licensure requirements. Licensed clinical social workers may direct services.

A clinical social worker may also be a Waivered/Registered Professional who has (1) registered with the State licensing authority for clinical

social workers for the purpose of acquiring the experience required for clinical social work licensure in accordance with applicable statutes and regulations or (2) been waivered by the Department of Health Care Services as a candidate who was recruited for employment from outside California and whose experience is sufficient to gain admission to the appropriate licensing examination but who requires time in which to make arrangements for and take the appropriate licensing examination.

4) Licensed Professional Clinical Counselors (LPCC)

Licensed professional clinical counselors must be licensed in accordance with applicable State of California licensure requirements. Licensed professional clinical counselors may direct services.

A professional clinical counselor may also be a Waivered/Registered Professional who has (1) registered with the State's licensing authority for professional clinical counselors for the purpose of acquiring the experience required for licensure, in accordance with applicable statutes and regulations, or (2) been waivered by the Department of Health Care Services as a candidate who was recruited for employment from outside California and whose experience is sufficient to gain admission to the appropriate licensing examination but who requires time in which to make arrangements for and take the appropriate licensing examination.

5) Marriage and Family Therapists (MFT)

Marriage and family therapists must be licensed in accordance with applicable State of California licensure requirements. Marriage and family therapists may direct services.

A marriage and family therapist may also be a Waivered/Registered Professional who has (1) registered with the State licensing authority for marriage and family therapists for the purpose of acquiring the experience required for marriage and family therapist licensure, in accordance with applicable statutes and regulations, or (2) been waivered by the Department of Health Care Services as a candidate who was recruited for employment from outside California and whose experience is sufficient to gain admission to the appropriate licensing examination but who requires time in which to make arrangements for and take the appropriate licensing examination.

6) Registered Nurses (RN)

Registered nurses must be licensed in accordance with applicable State of California licensure requirements. Registered nurses may direct services.

7) Certified Nurse Specialists (CNS)

Certified nurse specialists must be licensed in accordance with applicable State of California license requirements. Certified nurse specialists may direct services.

8) Nurse Practitioners

Nurse practitioners may be licensed in accordance with applicable State of California licensure requirements. Nurse practitioners may direct services.

The following providers may provide services under the direction of those Licensed Mental Health Professionals (listed above) who may direct a service.

9) Licensed Vocational Nurses (LVN)

Licensed vocational nurses must be licensed in accordance with applicable State of California licensure requirements.

10) Psychiatric Technicians (PT)

Psychiatric technicians must be licensed in accordance with applicable State of California licensure requirements.

11) Mental Health Rehabilitation Specialists (MHRS)

A mental health rehabilitation specialist shall be an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education may be substituted for the experience requirement on a year-for-year basis; up to two years of post associate arts clinical experience may be substituted for the required educational experience in addition to the requirement of four years' experience in a mental health setting.

12) Physician Assistants (PA)

Physician assistants must be licensed in accordance with applicable State of California licensure requirements.

13) Pharmacists

Pharmacists must be licensed in accordance with applicable State of California licensure requirements.

14) Occupational Therapists (OT)

Occupational therapists must be licensed in accordance with applicable State of California licensure requirements.

15) Other Qualified Provider

An individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service by the county mental health department.

F. Freedom of Choice (42 CFR 441.18(A)(1))

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 individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

G. Freedom of Choice Exception (Section 1915(g)(1) and 42 CFR 441.18(b))

__X__ Target group consists of eligible individuals who meet medical necessity criteria for specialty mental health services. Providers are limited to qualified Medicaid providers of case management services employed by or contracted with the county mental health department who are capable of ensuring that individuals receive needed services.

H. Access to Services (42 CFR 441.18(A)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)

The State assures the following:

- Targeted case management services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of targeted case management on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of targeted case management services; and

- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

I. Payment (42 CFR 441.18(a)(4))

Payment for targeted 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.

J. Case Records (42 CFR 441.18(a)(7)

Providers maintain case records that document for all individuals receiving targeted case management as follows:

1. The name of the individual
2. The dates of the targeted case management services
3. The name of the provider agency (if relevant) and the person providing the case management service
4. The nature, content, units of the targeted case management services received and whether goals specified in the client plan have been achieved
5. Whether the individual has declined services in the client plan
6. The need for, and occurrences of, coordination with other case managers
7. A timeline for obtaining needed services
8. A timeline for reevaluation of the client plan

K. Limitations

Targeted case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in 42 CFR section 440.169 when the targeted case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Targeted case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in 42 CFR section 440.169 when the targeted case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; and making placement arrangements. (42 CFR 441.18(c))

FFP only is available for targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other 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. (Sections 1902(a)(25) and 1905(c))

Targeted Case Management Services are not reimbursable on days when Psychiatric Inpatient Hospital Services; Psychiatric Health Facility Services; or Psychiatric Nursing Facility Services are reimbursed, except for on the days of admission to and discharge from these services. TCM services provided to a beneficiary in a psychiatric inpatient hospital, a psychiatric health facility, or a psychiatric nursing facility solely for the purpose of transitioning a beneficiary into the community are reimbursable for a maximum of three non-consecutive periods of 30 calendar days or less per hospitalization or inpatient stay. Claims are not submitted for reimbursement until after the beneficiary has transitioned to the community. Reimbursement for TCM will be made only to providers in the community and not to institutions. TCM services are not reimbursable when provided to a beneficiary who is receiving services in an Institution for Mental Diseases except for beneficiaries aged 21 and younger receiving services as described in 42 CFR 440.160 and beneficiaries aged 65 and older receiving services described in 42 CFR 440.140.