
# Medi-Cal

# Targeted Case Management

# Provider Manual

# SECTION 2

# TCM Program Descriptions

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# I. TARGETED CASE MANAGEMENT (TCM) TARGET POPULATION DESCRIPTIONS

Pursuant to Code of Federal Regulations (CFR) sections 441.18(a)(8)(i) and 441.18(a)(9), persons who are eligible to receive TCM services shall consist of the following Medi-Cal beneficiary groups.

## 1. Children Under the Age of 21 (14)

Medi-Cal eligible children, under the age of 21 years old, who are:

a) At risk for medical compromise due to one of the following conditions:

(i) Failure to take advantage of necessary health care services, or
(ii) Non-compliance with their prescribed medical regime, or
(iii) An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, or
(iv) An inability to understand medical directions because of comprehension barriers, or
(v) A lack of community support system to assist in appropriate follow-up care at home, or
(vi) Substance abuse, or
(vii) A victim of abuse, neglect, or violence, and

b) In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

## 2. Medically Fragile Individuals (15)

Medi-Cal eligible individuals, 18 years or older, who are medically fragile, and have multiple diagnoses. Such individuals must also be:

a) At risk for medical compromise due to one of the following conditions:

(i) Failure to take advantage of necessary health care services, or
(ii) Non-compliance with their prescribed medical regime, or
(iii) An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, or
(iv) An inability to understand medical directions because of comprehension barriers, or

(v) A lack of community support system to assist in appropriate follow-up care at home, or
(vi) Substance abuse, or
(vii) A victim of abuse, neglect, or violence, and

b) In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

### 3. Individuals at Risk of Institutionalization (16)

Medi-Cal eligible individuals 18 years or older, are in frail health, and meet the following criteria:

a) Have been identified as needing assistance due to one of the following reasons:

(i) Are in need of assistance to access services in order to prevent medical institutionalization, or
(ii) Exhibits an inability to independently handle personal, medical or other affairs, or
(iii) Are transitioning to a community setting, who due to socioeconomic status, substance abuse, neglect, or violence have failed to take advantage of necessary health care services, and

b) At high risk for medical compromise due to one of the following conditions:

(i) Failure to take advantage of necessary health care services, or
(ii) Noncompliance with their prescribed medical regime, or
(iii) An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, or
(iv) An inability to understand medical directions because of comprehension barriers, or
(v) A lack of community support system to assist in appropriate follow-up care at home, or
(vi) Substance abuse, or
(vii) A victim of abuse, neglect, or violence, and

c) In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

**4. Individuals in Jeopardy of Negative Health or Psycho-Social Outcomes (17)**

Medi-Cal eligible individuals who have been determined to be in jeopardy of negative health or psycho-social outcomes and meet the following criteria:

a) At risk due to one of the following disparity factors:

i. Substance abuse in the immediate environment, or
ii. History of, or in danger of family violence, or
iii. History of, or in danger of physical, sexual or emotional abuse.
iv. Experiencing substandard housing, or
v. Illiteracy, and

b) In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

**5. Individuals with a Communicable Disease (18)**

Medi-Cal-eligible individuals infected with a communicable disease, including tuberculosis, HIV/AIDS, etc.; or individuals who have been exposed to communicable diseases, until the risk of exposure has passed. Such individuals must also be:

a) At risk for medical compromise due to one of the following conditions:

(i) Failure to take advantage of necessary health care services, or
(ii) Noncompliance with their prescribed medical regime, or
(iii) An inability to coordinate multiple medical, social, and other services due to the existence of an unstable medical condition in need of stabilization, or
(iv) An inability to understand medical directions because of comprehension barriers, or
(v) A lack of community support system to assist in appropriate follow-up care at home, or
(vi) Substance abuse, or
(vii) A victim of abuse, neglect, or violence, and

b) In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

## II. TCM SERVICE COMPONENTS

TCM services are defined in 42 CFR Section 440.169 as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. TCM includes the following service components.

### 1. Comprehensive Assessment and Periodic Reassessment

Comprehensive assessment and periodic reassessment of individual needs are used 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 and/or periodic reassessment is to be conducted at a minimum of once every six months to determine if an individual's needs, conditions, and/or preferences have changed.

### 2. Development of a Specific Care Plan

Development (and periodic revision) of a specific care plan 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.

### 3. Referral and Related Activities

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.

### 4. Monitoring and Follow Up Activities

Monitoring and follow-up activities and contact that is necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs. This can be accomplished with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary. In addition, this shall include at least one annual monitoring encounter to determine whether the following conditions are met:

- Services are being furnished in accordance with the individual's care plan, or
- Services in the care plan are adequate, or
- Changes in the needs or status of the individual are reflected in the care plan, or
- Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Periodic Reviews will be completed at least every six months. These activities may be conducted as specified in the care plan, or as frequently as necessary to ensure proper implementation of the care plan.

The Case Manager shall follow up with the beneficiary and/or service provider to determine whether services were received and if the services met the beneficiary's needs. The follow-up shall occur as quickly as indicated by the assessed need, not to exceed thirty (30) days from the scheduled date of the referral service.

If a 30-day follow-up cannot be made with the client due to an unexpected circumstance, the reason must be documented in the client's file. Additionally, if a 30-day follow-up cannot be made due to the referral being set to take place more than 30-days out from the initial referral, it must be documented in the client's case notes.

Monitoring does not include ongoing evaluation or check-in of an eligible individual when all care plan goals have been met.

## III. LOCAL GOVERNMENTAL AGENCIES (LGA) AS TCM PROVIDERS

The LGA is the TCM Provider and must assure that the client is provided access to a qualified TCM Case Manager.

To claim Federal Financial Participation (FFP) for providing TCM services, the LGA must meet all of the following:

- Meet the TCM Provider qualifications (listed below),
- Have a signed Provider Participation Agreement (PPA) with Department of Health Care Services (DHCS), and

- Be an authorized provider of TCM services as listed in the State Plan Amendment.

The LGA must meet the following minimum qualifications:
(Qualifications of Providers, 42 CFR sections 441.18(a)(8)(v) and 441.18(b))

- Establish a system to coordinate services for individuals who may be covered under another program which offers components of case management or coordination similar to TCM including, but not limited to, the coordination of services with Managed Care providers, California Children's Services, as well as state waiver programs (e.g., HIV/AIDS, etc.),
- Demonstrate programmatic and administrative experience in providing comprehensive case management services and the ability to increase their capability to provide their services to the target group,
- Must be an agency employing staff with case management qualifications.
- Establish referral systems and demonstrated linkages and referral ability with essential social and health service agencies,
- Have a minimum of five years providing comprehensive case management services to the target group,
- Administrative capacity to ensure quality of services in accordance with state and federal requirements,
- Financial management capacity and system that provides documentation of services and costs in accordance with cost principles established under 2 CFR part 200,
- Capacity to document and maintain individual case records in accordance with state and federal requirements,
- Demonstrate ability to meet state and federal requirements for documentation, billing, and audits,
- Ability to evaluate the effectiveness, accessibility, and quality of TCM services on a community-wide basis.

Note**:** For the TCM subcontractor agencies minimum qualifications see Section 7.

## IV. TCM CASE MANAGER QUALIFICATIONS

A TCM Case Manager employed by the case management agencies (LGA or LGA subcontractor who are providing TCM services) must meet any of the following minimum requirements for education, training, and experience as defined in the State Plan.

- A Registered Nurse, or Public Health Nurse with a license in active status to practice as a registered nurse in California (the individual shall have met the educational and clinical experience requirements as defined by the California Board of Registered Nursing),

- An individual with a Bachelor's degree from an accredited college or university, who has completed an agency-approved case management training course,
- An individual with an Associate of Arts degree from an accredited college, who has completed an agency-approved case management training course and has two years of experience performing case management duties in a health and human services field,
- An individual who has completed an agency-approved case management training course and has four years of experience performing case management duties in a health and human services field.

Note: The agency that is to oversee the agency-approved case management training is the LGA.

## V. LIMITATIONS OF TCM CASE MANAGEMENT SERVICES

Case management does not include and FFP is not available for expenditures for services defined in 42 CFR Section 440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual 4302.F).

Case management does not include and FFP is not available for expenditures for services defined in Section 440.169 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. This includes foster care programs, and services such as, but not limited to, the following (per 42 CFR Section 441.18(c)):

- 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.

FFP is available for TCM services if there are no other third parties liable to pay for such services, including 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 Social Security Act. (Section 1902(a)(25) and 1905(c)).

Limitations on translation: Arranging for translation activities and/or providing translation as part of the TCM service, including the costs of purchasing translation services from

vendors to enable communication between the eligible individual and case manager, is included in the TCM rate. When a case manager provides translation that is unrelated to providing the TCM service, the translation is not claimable as TCM.

TCM services do not include:

- Program activities of the agency itself that do not meet the definition of TCM.
- Administrative activities necessary for the operation of the agency providing case management services rather than the overhead costs directly attributable to TCM.
- Diagnostic and/or treatment services.
- Restricting or limiting access to services, such as through prior authorization.
- Activities that are an essential part of Medicaid administration (such as outreach, intake processing, eligibility determination, or claims processing).
- Services that are an integral part of another service already reimbursed by Medicaid.

## VI. TRANSITIONAL TCM

Medi-Cal eligible individuals must be discharged to a community setting for transitional TCM claims to be eligible for reimbursement. A discharge date is necessary as payment criteria for the encounters that occur during the last 180 days of a stay. Any transfer or discharge to another institution of higher care shall be considered a transfer rather than a discharge for these billing purposes, as the individual was not discharged to a community setting. For more detailed information, refer to Section 9 of this manual.

## VII. CONFLICT OF INTEREST

Per the TCM PPA 8.F.:

> DHCS intends to avoid any real or apparent conflict of interest on the part of the Provider (LGA), subcontractors, or employees, officers and directors of the Provider or subcontractors. Thus, DHCS reserves the right to determine, at its sole discretion, whether any information, assertion or claim received from any source indicates the existence of a real or apparent conflict of interest; and, if a conflict is found to exist, to require the LGA to submit additional information or a plan for resolving the conflict, subject to DHCS' review and prior approval.
>
> 1) Conflicts of interest include, but are not limited to:
>
> a) An instance where the Provider or any of its subcontractors, or any employee, officer, or director of the Provider or any subcontractor has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under the contract would

allow for private or personal benefit or for any purpose that is contrary to the goals and objectives of the PPA.

b) An instance where the Provider's or any subcontractor's employees, officers, or directors use their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business or other ties.

If DHCS is or becomes aware of a known or suspected conflict of interest, the Provider will be given an opportunity to submit additional information or to resolve the conflict. A Provider with a suspected conflict of interest will have five (5) working days from the date of notification of the conflict by DHCS to provide complete information regarding the suspected conflict. If a conflict of interest is determined to exist by DHCS and cannot be resolved to the satisfaction of DHCS, the conflict will be grounds for terminating the contract. DHCS may, at its discretion upon receipt of a written request from the Provider, authorize an extension of the timeline indicated herein.