Medi-Cal

Targeted Case Management

Provider Manual

SECTION 6

TCM Program Reimbursement Methodology Requirements

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I. OVERVIEW

For the Target Case Management (TCM) program, the federal share received by the Local Government Agency (LGA) for providing TCM services is defined as Federal Financial Participation (FFP). To be qualified to receive FFP, the expenditures incurred for the TCM program must meet the certified public expenditure (CPE) requirements.

II. ELEMENTS OF ALLOWABLE CLAIMS FOR FEDERAL FINANCIAL PARTICIPATION

Title 42 of the Code of Federal Regulations (CFR) 433.51, which entitled public funds as the state share of Financial Participation, states:

(a) Public funds may be considered as the state's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.
(b) The public funds are appropriated directly to the state or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the state or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.
(c) The public funds are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds.

1. Certified Public Expenditure (CPE) Fund Requirements

TCM is a reimbursement program, not a matching or grant program. Federal claiming by the state is based on actual expenditures by the state or by another public agency authorized to certify expenditures to the state for Medicaid (Medi-Cal) services. As a result of the state's claim, federal funding is subsequently provided to the state.

The amount that can be CPE is the actual Medicaid (Medi-Cal) expenditures that have been made by the public agency for which supporting documentation is available at the time the claim is made. It is improper and insufficient for a public entity to certify expenditures that they have not incurred, for example, where the certification is based, in whole or in part, on an invoice or other billing that has not yet been paid. Since FFP is reimbursement for expenditures that have been made, DHCS or another public agency is required to certify that those expenditures have actually incurred before it can be claimed as FFP.

CPE as actual Medi-Cal expenditures can be defined in the following references:

Per CMS Publication 45-2, section 2560.4F, State Agency. For the purpose of expenditures for financial assistance under Title XIX, "State Agency" is defined as any agency of the state, including the State Medicaid Agency, its fiscal agents, a State Health Agency, or any other state or local organization which incurs equivalent

expenses; for purposes of expenditures under all other titles, see the definitions in the appropriate program's regulations (45 CFR 95.4).

Per CMS Publication 45-2, section 2560.4 G(1)a, expenditures for services are made in the quarter in which any state agency made a payment to the service provider (45 CFR 95.13(b):

(1) **Public Facility or Provider**: this expenditure is made when it is paid or recorded, whichever is earlier, by any state agency. Public providers are those that are owned or operated by a state, county, city, or other local government agency or instrumentality.
(2) **Non-public Facility or provider**: this expenditure is incurred when paid by any state agency.

It is the LGAs responsibility to ensure that the attested CPE is made and recognized in a timely manner as stated in the above references to draw down FFP. If a TCM Provider has a question regarding eligible CPE or actual costs at the claiming or Community-Based Organization (CBO) level, they should contact DHCS.

2. Federal Medical Assistance Percentages

Any federal funding an LGA receives is dependent on California's Federal Medical Assistance Percentage (FMAP) per Section 1905(b) of Title XIX of the Social Security Act.

Federal funding with respect to the CPE is paid to the state in accordance with the appropriate FMAP rate. TCM Medi-Cal interim payments are made as follows: The TCM interim Medi-Cal payment rate multiplied by the number of Medi-Cal encounters multiplied by the FMAP.

For example: the interim Medi-Cal payment rate is $100, the number of Medi-Cal encounters is 100, and the current FMAP rate for the State of California is 50%, the total interim payment for FFP is equal to $5,000 ($100 x 100 x .50 = $5,000).

3. Non-Duplication of FFP

LGAs are paid FFP for actual expenditures claimed by the state or by another public agency authorized to certify expenditures to the state for Medi-Cal services. An LGA may not draw down FFP for costs that are duplicative. In cases where federal grants are allowed for CPE reimbursement, LGAs are required to maintain documents to support the claim(s) for TCM services.

Claims must not be duplicated in whole or in part. Receiving duplicate reimbursement of Medi-Cal program activities or services that have been, or should have been paid through another/alternate funding source is prohibited. LGAs are required to verify that

claims for Medi-Cal program expenditures have not previously been, or shall not subsequently be, used for federal match through an alternate funding source. Payments for TCM shall not be duplicated by any public or private entity under other program authorities for the same purpose. LGAs are required to submit claims to the appropriate FFP programs and maintain sufficient documentation.

An LGA must certify that it has confirmed non-duplication of its claims. Public agencies may not make a profit by claiming estimated costs which could exceed actual costs incurred during a State Fiscal Year (SFY). An LGA may not claim more than the actual costs incurred during the SFY. Public agencies may not receive duplicate payments for public expenditures. Any misrepresentation relating to the filing of claims for federal funds constitutes a violation of the Federal False Claims Act.

4. FFP Exclusions

Per Section 1905(a) of the Social Security Act and 42 CFR Section 435.1009, when a person is an inmate of a public institution, FFP is not available until the inmate is released from the public institution. Once the inmate has been released, Medi-Cal program activities or services can be performed and FFP is available. However, if an inmate is in a medical institution, such as an Institution for Mental Diseases (IMD), the FFP exclusion may not apply.

There are requirements for LGAs that claim for TCM encounters conducted with clients who reside in institutions, such as clients who are identified as being part of the TCM target populations. These requirements include:

- Limitations on claiming for TCM services provided to clients who reside in an institution.
- Confirming whether a facility is an IMD.
- Documenting the client's date of discharge from an institution.
- Documenting the client's actual location in the community. When TCM clients reside in nursing facilities, hospitals, convalescent homes, or other facilities that are not their residence, TCM case managers must make a good faith effort, as specified in their Performance Monitoring Plan, not to claim for services that have already been provided as part of the institution's all-inclusive clinic services rate. CMS has determined that case management services are provided to clients in Skilled Nursing Facilities (SNFs) by medical staff.

Pursuant to the Olmstead Decision (U.S. Supreme Court, June 1999), CMS states that TCM:

> May be furnished as a service to institutionalized persons who are about to leave the institution, to facilitate the process of transition to community services and to enable the person to gain access to needed medical, social, educational, and other services in the community. TCM may be furnished during the last 180

> consecutive days of a Medicaid eligible person's institutional stay, if TCM is provided for the purpose of community transition (Olmstead Update 3, July 25, 2000).

Note: Refer to Section 2 for further transitional TCM information.

TCM case managers face further limitations on claims for services provided to clients who reside in psychiatric facilities that are IMDs. TCM case managers must verify with staff in such facilities whether or not the facilities are IMDs. Title 42 of CFR section 435.1010 defines IMD as:

> …a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for Individuals with Intellectual Disabilities is not an institution for mental diseases.

TCM case managers must ensure that they do not claim for case management services they provide to clients who reside in an IMD who are under age 65 or over age 21. 42 CFR Section 435.1009 states:

> FFP is not available in expenditures for services provided to…individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under Section 440.160 of this subchapter.

For IMD clients who are under age 65 and over age 21, 9 CCR Section 1840.374 states:

(a) TCM services are not reimbursable on days when the following services are reimbursed, except for day of admission or for placement services as provided in subsection (b):

> (1) Psychiatric Inpatient Hospital Services.
> (2) Psychiatric Health Facility Services.
> (3) Psychiatric Nursing Facility Services.

(b) TCM services, solely for the purpose of coordinating placement of the beneficiary on discharge from the hospital, psychiatric health facility or psychiatric nursing facility, may be provided during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per continuous stay in the facility.

TCM services are not claimable for IMD patients, except on the day of admission and within 30 days prior to the day of discharge. Because the day of discharge can only be confirmed after the client has been discharged, it is essential that the client's actual date of discharge be clearly identified in the client case records. When claiming for TCM services, the case manager must make a good faith effort to determine the client's expected date of discharge and to claim only for those encounters that meet the criteria for clients who reside in institutions, as described above.

TCM case records and encounter logs must include the following items:

- Recipient's name, date of birth, and Medi-Cal number.
- Date of service
- Names of the provider agency and the person providing the service.
- Type of TCM service provided.
- Location of the service (home, office, or type of institution).
- Date of the recipient's admission and discharge from an institution, if any TCM encounters are provided.

Note: If the above items cannot be provided as backup for the encounter, TCM services will not be reimbursed.

III. TCM PROGRAM REIMBURSEMENT METHODOLOGY

According to the State Plan (Attachment 4.19-B, pages 5d (ii)-(v)), LGAs will receive reimbursement for their allowable costs incurred in providing TCM services rendered to target populations. The allowable costs are CPEs.

To ensure the proper program reimbursement, TCM reimbursement includes two steps:

- **Interim payment**: Each SFY an interim rate will be established for each LGA in claiming the interim Medi-Cal payment or encounter rate during the period when TCM services are provided. The LGAs will invoice DHCS for interim payments.
- **Payment reconciliation**: DHCS' Audits and Investigation Division will review the accepted cost report annually to perform Interim and Final Reconciliation to ensure only eligible CPEs can be drawn down for FFP.

Below is an excerpt from the State Plan, Attachment 4.19-B, subsections B, C, and G regarding the TCM program reimbursement methodology:

> 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 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) 2 CFR, Part 200 as implemented by HHS at 45 CFR, Part 75.
(d) Section G below regarding TCM Rate Content.
(e) California Welfare and Institutions Code (WIC).
(f) State issued policy directives, including Policy and Procedure Letters.
(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) When calculating CPEs or performing any reconciliation required by this segment of the State Plan, any payments made by or on behalf of a Medi-Cal beneficiary for services reimbursed under this segment of the State Plan will be used to reduce the amount submitted for purposes of federal reimbursement.

(4) The Department will ensure "free care" and "third party liability" requirements are met. For purposes of this paragraph, "free care" is defined as 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" is defined as 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 amount that will approximate the Medi-Cal TCM program 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 SFY. This accepted cost report will be used to establish the interim Medi-Cal TCM program payment rate for the current SFY.

Note: To review (c) refer to Attachment 4.19-B, page 5d (iii)

(d) 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.

(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 SFY. 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 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) LGAs enrolling or re-enrolling in the TCM program are required to have an interim Medi-Cal payment rate to begin claiming federal reimbursement for providing TCM services. The TCM program will use an Industry Average methodology to provide LGAs with a standardized method to compute and establish an interim Medi-Cal payment rate. The computation for the Industry Average Interim Encounter Rate (Industry Average Medi-Cal payment rate) will be established by dividing the sum of all LGAs interim Medi-Cal payment rates by the number of LGAs participating in the TCM program for the prior SFY.

(g) The interim payments will be subject to interim and final reconciliation processes described below.

(1) Interim Reconciliation

Each LGA's interim Medi-Cal payments will be reconciled with the accepted TCM cost report for the SFY 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.

(2) Final Reconciliation

(a) Each LGA's total interim payments and interim reconciliation adjustments for a SFY will also be subsequently reconciled to the allowable cost in the accepted cost report for that same SFY.

(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.

G. TCM Rate Contents

For purposes of clarifying the claiming of various costs, the costs of performing the following activities are included in the TCM service rate:

(1) Staffing cases through team meetings and interagency coordination time.

(2) Case manager travel time and costs when performing TCM duties.

(3) Case manager time to arrange client transportation and appointments.

(4) Preparing/documenting case records.

(5) Arranging for translation activities and/or providing translation as part of the TCM service, including the costs of purchasing translation services from a vendor to enable communication between the client and case manager. When a case manager provides translation that is unrelated to providing the TCM service, the translation is not claimable as TCM.

(6) Supervision of case managers.

(7) Case manager non-SPMP training.

(8) TCM subcontract administration when performed by an identifiable unit or one or more employees not otherwise claimed or funded through established rates or other programs, to:

(a) Identify and recruit community agencies as TCM contract providers.
(b) Develop and negotiate TCM provider subcontractor performance to ensure appropriate delivery of TCM services to eligible beneficiaries.
(c) Monitor TCM provider subcontracts to ensure compliance with Medi-Cal regulations.
(d) Provide technical assistance to TCM subcontractors regarding county, Federal, and state regulations.

(9) TCM data systems and claiming coordination, including:

(a) Input of Medi-Cal data from the Encounter Log into the data collection system,
(b) Reconciliation of TCM Medi-Cal encounter claims reported as rejected by the state,
(c) Maintaining and analyzing Medi-Cal TCM management information systems, and
(d) Preparing, reviewing, and revising TCM claims.

(10) TCM quality assurance/performance monitoring, including:

(a) TCM case documentation compliance,
(b) TCM "free care" and TPL compliance,
(c) Preventing duplication of services and ensuring continuity of care when a Medi-Cal recipient receives TCM services from two or more programs, and
(d) Monitoring Medi-Cal TCM provider agency capacity and availability.

Activities "8", "9" and "10" cannot be performed by a case manager or other service provider.

(11) TCM program planning and policy development, including:

(a) Planning to increase TCM system capacity and close gaps,
(b) interagency coordination to improve TCM service delivery,
(c) Developing policies and protocols for TCM, and
(d) Developing TCM resource directories.

(12) County Overhead, which includes:

(a) Operating expenses and equipment,
(b) Accounting,

(c) Budgets,
(d) Personnel,
(e) Business Services,
(f) Clerical Support,
(g) Management, and
(h) County Indirect Costs.

(13) County Based Medi-Cal Administrative Activities (CMAA)/TCM Coordination and Claims Administration:

LGA employees whose position description/duty statement includes the administration of CMAA and TCM on an LGA service region-wide basis, may claim for the costs of these activities on the CMAA detailed invoice as a direct charge. Cost incurred in the preparation and submission of CMAA claims at any level, including staff time, supplies, and computer time, may be direct charged on the CMAA invoice. If the CMAA/TCM Coordinator and/or claims administration staff are performing this function part-time, along with other duties, they must certify the percentage of total time spent performing each of the activities. The percentage certified for the CMAA/TCM Coordinator and/or claims administration staff activities will be used as the basis for federal claiming.

The CMAA/TCM Coordinator and claims administration staff may claim the costs of the following activities, as well as any other reasonable activities directly related to the LGA's administration of TCM services and CMAA at the LGA-wide level:

(a) Drafting, revising, and submitting CMAA Claiming Plans, and TCM performance monitoring plans.
(b) Serving as liaison with and monitoring the performance of claiming programs within the LGA and with the state and federal governments on CMAA and TCM.
(c) Administering LGA claiming, including overseeing, preparing, compiling, revising, and submitting CMAA and TCM invoices on an LGA-wide basis to the state.
(d) Attending training sessions, meetings, and conferences involving CMAA and/or TCM.
(e) Training LGA program and subcontractor staff on state, federal, and local requirements for CMAA and/or TCM claiming.
(f) Ensuring that CMAA and/or TCM invoices do not duplicate Medi-Cal invoices for the same services or activities from other providers. This includes ensuring that services are not duplicated when a Medi-Cal beneficiary receives TCM services from more than one case manager.

The costs of the CMAA/TCM Coordinator's time and claims administration staff time must not be included in the CMAA claiming or in the TCM rate, since the costs associated with the time are to be direct charged on the CMAA invoice. The costs of TCM claiming activity at the TCM provider level are to be included in the TCM rate.

IV. TCM PROGRAM REIMBURSEMENT REQUIREMENTS

1. CPE Certification

FFP claiming is based on actual expenditures made by the State or another public agency authorized to certify expenditures for Medi-Cal services. Based on the State's claim, federal funds are provided to DHCS for reimbursement to the LGAs. DHCS or another public agency is required to certify the expenditures before the LGA can claim FFP. LGAs certify their actual costs incurred in a CPE certification to claim FFP. The source of all expenditures must meet the requirements of 42 CFR Section 433.51, 45 CFR 95.13(b), CMS Pub. 45-2, Section 2560.4F & G1a, and other existing laws regulations. and program policies. DHCS CPE certification requirements for the TCM program are administered at two levels:

(1) Encounter invoicing
(2) Cost report filing

When an LGA submits a TCM invoice to the State, a certification needs to be signed by the LGA designated representative to indicate costs have been reviewed and verified to the best of their knowledge, are allowable, and meet all federal requirements for seeking FFP.

Annually, each LGA will report the total-funds expenditures incurred by the LGA and/or other governmental entities in providing TCM services using the TCM cost report. Along with the cost report submission, the LGA will submit the LGA Certification Statement for the TCM cost report, the Non-LGA Local Public Entity (CPE) Certification, and the LGA Attestation Statements for the TCM cost report. The LGA will certify all total-fund expenditures, which will include certifications signed by other contributing public agencies certifying their expenditures. LGAs will ensure and certify that all total-funds expenditures are allowable and meet all federal requirements for the provision of TCM services.

For TCM services provided by an LGA contractor, the allowable costs incurred in providing TCM services can be reimbursed only if the funding to the contractors meets the requirements for 42 CFR Section 433.51. The LGAs will follow the above instructions to ensure the CPE certification requirements are met in order to claim FFP. When an LGA is contracted with a private non-for-profit entity, and the contractor only utilized its own funds for supporting TCM services, DHCS cannot claim FFP because the private funds do not meet the requirements for 42 CFR Section 433.51. For more

detailed information, please refer to the State Plan (Attachment 4.19-B, page 5d (v)) and Section 5 of this manual.

Federal guidance and the State law that implements CPE programs require that the public agency using the CPE process submit a certification to the State attesting that the total-funds (total computable) amount of its claimed expenditures are eligible for FFP, in accordance with the State Plan and the provisions of 42 CFR Section 433.51. The CPE certification must be submitted to DHCS, and is used as the basis for DHCS to claim FFP within two years from the date of the expenditure.

2. CPE Requirements as Applied to LGAs

There are two situations in which a public agency can certify expenditures: (1) The public agency is the provider of the service, or (2) the public agency has paid other providers for the services. Each of these situations is discussed below:

1. The Public Agency is the TCM Provider:

If the public agency is itself the TCM provider, then it may certify its own costs (subject to applicable payment limitations). If this is the case, the public agency may certify the costs actually incurred in providing covered services to eligible TCM clients. LGAs, being counties and chartered cities, are public agencies and are authorized by state and federal law to certify their expenditures.

Accordingly, LGAs may certify their actual costs incurred in providing TCM services to eligible TCM clients. DHCS then uses the LGA's certification to claim FFP from CMS. CMS then provides federal funding to DHCS at the FMAP rate for California.

2. The Public Agency Contracts with TCM Providers:

An LGA that elects to contract to provide TCM services, for each SFY, for the purpose of obtaining Medicaid reimbursement, must submit an annual cost report that certifies the actual expenditure of costs incurred for the provision of TCM services. (WIC Section 14132.44, sub. (f)). The amount paid for the TCM services must be in compliance with any payment limitations set forth in State law, in the Medicaid State Plan, in the provisions of a federal waiver or demonstration, or in a contract between DHCS and the LGA, as may be applicable. The certification must reflect the payment by the public agency to the contracted provider for TCM services provided to eligible TCM clients. An LGA may only certify its total expenditures for TCM services provided by private CBOs in the amount the LGA has actually paid by the LGA to the CBOs for TCM services, and that the CBOs can appropriately document as having been provided.

Furthermore, expenditures made directly to a CBO by state or other local agencies may not be certified by an LGA for the purpose of claiming FFP. LGAs may only certify

expenditures that have actually incurred for the period that the TCM services are provided, not expenditures that others have made.

Any federal grant that is not authorized by federal law cannot be used as certified public expenditure.

3. Certification by Other State Agencies (and Related Local Entities)

Pursuant to state law, County Proposition 10 Commissions that participants in the California Children and Families Program (First 5 California) may be established as either a legal entity separate from the county or, as an agency of the county, with independent authority over the county's strategic plan and the local trust fund. (See Health & Safety Code §§ 130140 and 130140.1.) Similarly, Area Agencies on Aging (AAAs) may be established as a part of the county (or counties) or as some other type of agency or organization.

A county (as LGA) may certify expenditures made by the county First 5 Commissions that are established as agencies of the county. County First 5 Commissions that are established as legal entities separate from the county would normally qualify as "public agencies" eligible to certify their expenditures under current federal law and regulations. Under current state law, the only public agencies that can directly certify their expenditures for TCM are LGAs (counties or chartered cities). Such First 5 Commissions need to submit certification to their respective LGAs, who in turn will attest the certification made by such First 5 Commissions and submit it to DHCS.

To the extent that a county (LGA) provides funding to a First 5 Commission, the LGA may certify that expenditure. DHCS understands that county First 5 Commissions that were established as legal entities separate from the county were established as such by a decision of the county Board of Supervisors for administrative purposes, but that the Proposition 10 tax revenues, allocated to the county pursuant to Health and Safety Code Sections 130105 and 130140, are considered county funds. As long as a county First 5 Commission is administering funds that are county funds, and expenditures of those funds for TCM services is certified by the LGA, the expenditures may be eligible for federal reimbursement.

In the case of the TCM services provided by AAAs, some of the AAAs are private and some are public (part of the county), but they all receive their funding from California Department of Aging (CDA). The county, as a public agency, can certify the expenditures made by AAAs that are part of the county (or that otherwise could be classified as public agencies), but the private AAAs are not public agencies and therefore, in most cases, cannot certify directly to DHCS. However, because CDA is a governmental entity, it can certify the funding that it has provided to the private AAAs. Based on the CDA certification and LGA attestation taken together with the required documentation as to how the funds were used, federal reimbursement may be available.

Therefore, it is essential to ascertain the nature of each entity established in a county (or counties) in order to confirm to what extent the LGA, a First 5 Commission, or AAA may certify TCM expenditures, and to what extent that the LGA needs to attest the certification made by other state agencies and related local entities.

In the cases that CPE is made by other state agencies and related local entities, an LPE certification and LGA attestation statement needs to be utilized and submitted via the annual cost report submission.

4. Required Documentation of Certified Public Expenditures

CPEs must be supported by auditable documentation that identifies the relevant category of expenditure under the TCM program guidelines, and demonstrates the actual expenditures incurred by the LGA in providing services to eligible TCM clients.

5. Examples of Unacceptable CPE Certification

CPE certification needs to be justified by fiscal records. Below are examples of situations that are **not** in compliance with current federal regulations governing CPEs:

- A certification that funds are available at a state or local level.
    - The "availability" of funds does not meet the federal requirement that state or local dollars have actually been expended to provide covered health care services to eligible TCM clients.
- A certification based on an estimate of Medicaid costs derived from surveys of health care providers.
    - An estimate does not meet federal requirements that state or local dollars have actually been expended to provide health care services to eligible TCM clients.
- A certification that is higher than the actual cost or expenditure of the governmental unit that has generated the CPE (based on its provision of, or payment for, services to eligible TCM clients).
- A certification that is anything less than 100 percent of the total-funds (total computable) expenditure.
    - Federal funding is available only as a percentage of the total-funds (total computable) Medicaid expenditure that has been certified. For example, a certification that certifies only the amount of the non-federal share of the total-funds expenditure is not acceptable.

6. Examples of Unacceptable Claims

The following is an example with several variations provided to clarify what will not be permitted by DHCS, based on federal law and policy:

An LGA submits an invoice to DHCS on which it has certified a total-funds expenditure of $100 for TCM provided to clients of its contracted CBO. The LGA expects DHCS to reimburse it at the FMAP rate of 50 percent, or $50. However, after DHCS reviews the LGA's supporting documentation, DHCS determines that the LGA:

1. Has paid the CBO only $80. Even though the CBO's costs were actually $100, as stated on the invoice, DHCS will only reimburse the LGA based on the amount spent by the LGA. Because the LGA paid the CBO $80, DHCS may provide the LGA with $40 in FFP, and not $50. If an LGA does not pay a CBO, the LGA may not submit invoices to DHCS for work the CBO has performed.

2. Has paid the CBO $80. However, upon review of the CBO's cost report (best practice, not required) and supporting documentation, it is determined that the actual cost to provide TCM services was only $60 and that the remaining $20 was used for non-TCM services. DHCS will only reimburse the LGA the amount spent for providing TCM services. The LGA only incurred TCM costs of $60, which means the remaining $20 paid for non-TCM services. Therefore, DHCS will provide the LGA with $30 in FFP, and not $40. If an LGA does not pay a CBO, the LGA cannot certify the CPE funding. Instead, only the unit of government that provides the CPE to the CBO may certify the funds. Thereafter, the LGA may only attest to the certification and then submit the invoice and Cost Report.

3. Does not have supporting documentation to demonstrate that it made expenditure to its CBO specifically for the provision of TCM services. DHCS will not reimburse the LGA the federal share of the invoice because all payments for Medi-Cal services must be supported by adequate documentation (e.g., LGA warrants to the CBO and remittance advices that specify the amount shown on the TCM invoice submitted to DHCS, or specify the portion of the LGA payment to the CBO that was for the provision of TCM services). For example, an LGA's payments to its CBO(s) for TCM services could be identified as such in the LGA's general ledger or documented pursuant to an agreement between the LGA and the CBO.

4. Based its certification solely on payments made directly to the CBO by other state agencies. DHCS will not claim FFP or pay the LGA for this invoice because it does not reflect LGA expenditures; therefore, the LGA has no basis on which to certify that it has made an expenditure. Even though the CBO used state funds for the provision of TCM services, the LGA cannot certify as its own, a total-funds expenditure that was expended by another entity.

5. Based its certification on expenditures made by another state or local agency within its geographical region, such as state departments, Proposition 10 Commissions, and non-chartered cities. DHCS cannot claim federal funds based on an LGA's certification when the LGA did not itself make the expenditure.

Nothing, however, would prevent an LGA from collecting certification and expenditure detail from other entities, and submitting this information to DHCS.