STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: CALIFORNIA

TARGETED CASE MANAGEMENT REIMBURSEMENT METHODOLOGY

Reimbursement Methodology for Case Management Services as Described in Supplements 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” means the rendering of one or more targeted case management service components by a case manager to beneficiaries of target populations. Targeted case management services can be appropriately provided face-to-face, as well as through video synchronous and audio-only synchronous telehealth interactions.

(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.

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

(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.

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

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) 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 (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.

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

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

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

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

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 fiscal year (FY).

(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 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.

(2) 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.

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

(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.

(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.

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

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.

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;

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

(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

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

(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) lnteragency 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) Medi-Cal Administrative Activities (MAA)/TCM Coordination and Claims Administration:

LGA employees whose position description/duty statement includes the administration of County-based Medi-Cal Administrative Activities (CMAA) and TCM on an LGA service region-wide basis, may claim for the costs of these

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

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.

State Medicaid 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

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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

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