Medi-Cal

Targeted Case Management

Provider Manual

SECTION 1

TCM Program Overview

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I. PROGRAM OVERVIEW

Pursuant to the Welfare and Institutions Code (WIC) section 14132.44, Targeted Case Management (TCM) became a covered Medi-Cal benefit effective January 1, 1995. The TCM program provides comprehensive case management services to eligible Medi-Cal beneficiaries of defined targeted populations to gain access to needed medical, social, educational, and other services. Case management services ensure that the changing needs of the beneficiaries are addressed and that appropriate TCM service components are provided to meet the beneficiaries needs.

The TCM program is a voluntary Medi-Cal program funded in part by federal Title XIX funds and local funds. Reimbursable TCM services are limited to allowable services provided to Medi-Cal beneficiaries eligible for Federal Financial Participation (FFP).[1] The TCM program is authorized under WIC section 14132.44 and governed by regulations contained in Title 22 of the California Code of Regulations (CCR), Division 3, Chapter 3, and the California Medicaid State Plan (State Plan).

The TCM program reimburses participating local governmental agencies (LGAs) the federal share of costs (typically 50%) for case management services provided to FFP qualified Medi-Cal beneficiaries in specific target populations based on the LGAs' certified public expenditures (CPEs). Through interim encounter rates established in the annual cost reports, LGAs claim FFP for these case management services. Actual reimbursement costs are settled via interim and final reconciliation of the cost report.

The Department of Health Care Services (DHCS) is the single state agency administering the federal Medicaid program in California. The State Plan is a comprehensive written document describing the nature and scope of California's Medicaid program, which includes TCM as a covered service. The Centers for Medicare and Medicaid Services (CMS) must approve any State Plan Amendment (SPA) before FFP is provided to the state.

The State Plan specifies the target populations that are eligible to receive TCM services, the geographic area(s) to be served, comparability of services, types of covered services and their limitations, provider and case manager qualifications, documentation requirements, methodology by which payments and rates are made, and assures beneficiary's freedom of choice of provider. The State Plan also requires that LGAs ensure non-duplication of services.

Annually by July 1, participating LGAs are listed in the Approved State Plan Amendments and posted to the TCM website under the Policies & Legislation section.

[1] Unless otherwise stated, all references in this Manual to beneficiaries receiving case management services under the TCM program are FFP qualified Medi-Cal beneficiaries.

TCM services are case management services furnished without regard to the requirements of 42 Code of Federal Regulations (CFR) part 431.50(b) (related to statewide provision of services) and part 440.240 (related to comparability). As such, TCM services do not need to meet the requirements of "state wideness" or "comparability." TCM may be provided to a broad segment of the population, or may be limited to a certain group within a geographic area or political subdivision.

Per 42 CFR part 440.169(a), case management services mean services furnished to assist individuals, eligible under the State Plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services.

II. TARGET POPULATIONS

TCM services are provided to five defined TCM target populations. These target populations are defined in Supplement 1a, 1b, 1d, 1e, and 1f to Attachment 3.1-A of the State Plan by age, type or degree of disability, illness or conditions, or any other identifiable characteristic or combination thereof.

The five distinct TCM target populations are:

- Children Under the Age of 21 (14),
- Medically Fragile Individuals (15),
- Individuals at Risk of Institutionalization (16),
- Individuals in Jeopardy of Negative Health or Psycho-Social Outcomes (17), and
- Individuals with a Communicable Disease (18).

Note: For purposes of the TCM System, the target populations are referred to by the above numbers 14 through 18. For more information on the TCM System, refer to Section 2.

The individuals in these five target populations must be:

- At high risk for medical compromise due to condition(s) specified in the State Plan,
- In need of assistance in accessing necessary medical, social, educational, or other services, and
- Without comprehensive case management provided by any other publicly funded program.

III. TCM SERVICE COMPONENTS

Under the TCM program, services are provided during an encounter. An encounter is a "face-to-face contact or significant telephone contact in lieu of a face-to-face contact

when environmental considerations preclude a face-to-face encounter, for the purpose of rendering one or more targeted case management service components by a case manager."

According to 42 CFR part 440.169(d), case management services are comprehensive and include the following four service components:

1. Comprehensive assessment and periodic reassessment of individual needs, or
2. Development of a specific care plan, or
3. Referral and related activities, or
4. Monitoring and follow-up activities.

IV. LGA REQUIREMENTS

WIC section 14132.44(d) states that each LGA that provides TCM services shall have all of the following:

- Established procedures for performance monitoring,
- A countywide system to prevent duplication of services and to ensure coordination and continuity of care among providers of case management services, and
- A fee mechanism, specific to TCM services.

Additionally, per title 42 United States Code (USC) section 1396a(a)(23), LGAs must have established procedures to ensure freedom of choice of provider.

The State Plan requires LGAs to sign a Provider Participation Agreement (PPA) with DHCS in order to provide TCM services. Under the conditions specified by WIC section 14132.44(c) and 42 CFR part 433.51, an LGA may contract with any private or public entity to provide TCM services to target populations on its behalf.

V. PROVIDER PARTICIPATION AGREEMENT

In California, the contract between DHCS and the LGA is the TCM PPA. LGAs must have a current signed TCM PPA on file with DHCS in order to submit a TCM claim. The PPA includes instructions on processes to ensure non-duplication of services and payments. For more detailed information, refer to Section 3 of this manual.

VI. ANNUAL PARTICIPATION PREREQUISITE

Prior to the end of each State Fiscal Year (SFY), DHCS disseminates an Annual Participation Prerequisite (APP) to the LGAs. DHCS uses the APP to gather information about each LGA, including the target populations they plan to serve in the following fiscal year. Each LGA must submit a completed APP to DHCS prior to the end of

February of each SFY in order to participate in the TCM program. For more detailed information, refer to Section 3 of this manual.

VII. TIME SURVEY

LGA staff that participate in the TCM program must track all paid time spent during a workday. All LGAs and LGA subcontractors must follow and utilize the CMS approved County-Based Medi-Cal Administrative Activities (CMAA)/TCM Time Survey Methodology. The time survey result is a key element in determining the TCM program cost of a TCM budget unit. For more detailed information, refer to Section 4 of this manual.

VIII. COST REPORT

Pursuant to WIC section 14132.44, each LGA participating in the TCM program must annually submit a completed cost report to DHCS for the SFY (ending June 30). The cost report must be prepared in a format specified by DHCS and submitted to DHCS by November 1 of each year. The purpose of a cost report is to:

- Determine the TCM program cost and total encounters for each SFY,
- Determine the maximum TCM program Medi-Cal reimbursement,
- Summarize the TCM reimbursement settlement for the service period covered by the filed cost report, and
- Establish a new interim rate for interim payment for the provision of TCM services for the following SFY.

The TCM Medi-Cal Reimbursable Cost in the cost report reflects the reimbursable direct and indirect costs of providing TCM services as described in 45 CFR part 75. For more detailed information, refer to Section 5 of this manual.

IX. FEDERAL FINANCIAL PARTICIPATION

TCM services are eligible for FFP if the program expenditures meet the Certified Public Expenditures (CPE) requirements of 42 CFR part 433.51. To ensure proper federal funding, an LGA's claim for CPE will be settled through an audit by DHCS Audits and Investigations (A&I) Division, for each SFY's TCM Cost Report submitted. For more detailed information, refer to Section 5 and 6 of this manual.

X. LGA WITHDRAWAL AND RE-ENROLLMENT TO THE TCM PROGRAM

LGAs may choose to withdraw or re-enroll in the TCM program when permitted to do so according to DHCS TCM program policies and procedures. For more detailed information, refer to Section 3 of this manual.

XI. TCM MEDI-CAL INVOICE SUBMITTAL

TCM encounters must be invoiced and submitted electronically via email to DHCS for reimbursement within 12 months from the end of the month in which the service was provided. TCM encounters invoiced and submitted after the 12-month limit will not be reimbursed. For more detailed information, refer to Section 8 of this manual.