Medi-Cal

Targeted Case Management

Provider Manual

SECTION 9

TCM Documentation and Oversight

Table of Contents

I. OVERVIEW

Local Governmental Agencies (LGAs) can participate in the Targeted Case Management (TCM) program in California in which program oversight is provided by the Department of Health Care Services (DHCS). Based on the existing federal laws and regulations, and the Medicaid State Plan, DHCS developed state laws and regulations to manage the TCM program. The program is offered statewide and does not require mandatory participation for each LGA. Oversight responsibility of TCM resides with the LGA and DHCS in order to safeguard the provision of TCM services and ensure the proper federal reimbursement for Medi-Cal beneficiaries.

II. TCM PROGRAM DOCUMENT REQUIREMENTS

1. TCM Service Provider Documentation Requirements

a. Beneficiary Case Record Documentation

An individual beneficiary case record must be kept for each beneficiary receiving TCM services. For billable TCM encounters, the beneficiary case records must at minimum, contain the following information:

- The name of the recipient and his/her Medi-Cal number (i.e. Medi-Cal Eligibility Data Systems (MEDS) ID number, Social Security Number (SSN), Client ID Number (CIN), Benefits Identification Card (BIC) Number, etc.)
- The date of service
- The name of the TCM Provider agency
- The name, title, and signature of the TCM Case Manager providing the TCM services
- A description of the specific nature and extent of the TCM service provided, in relation to the four TCM service components described in section 2 and below in this section
- The location of where the TCM service was provided (e.g. home, office, or other)
- The name, title, and signature of the TCM Case Manager's supervisor where deemed necessary by TCM requirements
- Documentation noting that the TCM service meets the definition of an encounter with the beneficiary

2. TCM Service Component Documentation

According to 42 Code of Federal Regulations (CFR) part 440.169(d), case management services are comprehensive and must include at least one of the following four service components:

1. Comprehensive Assessment and Periodic Reassessment
2. Development of a Specific Care Plan

3. Referral and Related Activities
4. Monitoring and Follow-Up Activities

Below are the documentation requirements for the four TCM service components:

1) Comprehensive Assessment and Periodic Reassessment

The TCM program conducts a comprehensive assessment and periodic reassessment of individual's needs to determine the need for any medical, educational, social, or other services. The comprehensive assessment must be wide-ranging and not solely focusing on a single assessment area, such as housing or medical needs. These assessment activities include:

- Taking beneficiary history
- Identifying the individual's needs and completing related documentation
- 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 periodic reassessment is to be conducted at a minimum of six months to determine if an individual's needs, conditions, and/or preferences have changed

The documented needs and problems based on a comprehensive assessment must be identified in agreement with the beneficiary.

There may be occasions where a TCM Case Manager may perform a comprehensive assessment on a beneficiary and no needs or problems are identified, or the beneficiary does not wish to continue to receive services. If the beneficiary has no needs or problems identified in an area of the comprehensive assessment, then a statement or checkbox stating "No needs identified" is sufficient documentation. If the TCM service component of a comprehensive assessment was performed during an encounter with the beneficiary, it would be considered a claimable TCM encounter. The case would then be closed and the beneficiary case record should state that no further TCM services would be provided.

Note: Documentation of this activity must describe the specifics of the comprehensive assessment or the periodic re-assessment performed. This documentation must demonstrate that the TCM service "Comprehensive Assessment and Periodic Reassessment" was performed during a specific face-to-face encounter. When documentation is requested by DHCS during a site or desk review this documentation must be submitted to DHCS as part of requested encounter documentation.

If the comprehensive assessment occurs over multiple visits, the TCM Case Manager should document in the beneficiary case record the following information:

- Reasons why the comprehensive assessment was not completed in one encounter and
- The specific areas addressed in each part of the comprehensive assessment performed at each encounter.

2) Development of a Specific Care Plan

A specific care plan is developed by the TCM Case Manager based on the information collected through the comprehensive assessment that:

- Specifies the goals and actions to address the medical, social, educational, and other services needed by the individual; and
- 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.

For a specific care plan, the following items need to be documented:

- Referrals must be linked to the needs or problems identified in the comprehensive assessment.
- Follow up on referrals must indicate if the referral met the need or problem, and achieved the goal.
- Goals must be consistent with meeting the needs and problems of the beneficiary that are identified in the comprehensive assessment.
- If a new need or problem is assessed during the course of providing TCM services to a beneficiary, the care plan must be updated.
- The Care Plan must be signed by:
    - The TCM Case Manager and the TCM Case Manager's supervisor.
    - The client does not need to sign the Care Plan.
- A plan for the frequency and duration of providing TCM services for each beneficiary.
    - The frequency and duration is how often the TCM Case Manager will visit the beneficiary and for what period of time.
        - Example: The TCM Case Manager plans to visit the beneficiary 2 times a week for 1 week, and then 1 time a week for 5 weeks.
- The TCM Case Manager has developed and discussed the care plan with the beneficiary or the beneficiary's authorized health care decision maker.

The TCM Case Manager's supervisor must sign the care plan, certifying the care plan is true and correct for federal reimbursement.

Note: Documentation of this activity must describe the specifics of the development of a specific care plan. The documentation must demonstrate that the TCM service

"Development of a Specific Care Plan" was performed during a specific encounter. When documentation is requested by DHCS during a site visit or desk review documentation must be submitted to DHCS as part of the requested encounter documentation.

3) Referral and Related Activities

TCM provides referral and related activities to help the eligible individual obtain needed services.

- These are activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing interventions to address identified needs and problems specified in the care plan.

Referrals must be linked to the needs and problems identified in the care plan. Examples of referrals:

- A beneficiary has an identified need of not having a primary health care provider. The TCM Case Manager would then refer the beneficiary to a primary health care provider and make an appointment for the beneficiary.
- A beneficiary has an identified need of lack of food. The TCM Case Manager would then refer the beneficiary to the local food bank.

Multiple referrals for an identified need or problem are allowed, particularly when the initial referral does not remedy the beneficiary's need or problem. The TCM Case Manager must document why additional referrals are needed and how the TCM Case Manager plans to address any barriers that prevent the beneficiary from using referrals. If the beneficiary is facing barriers in utilizing the referrals, the TCM Case Manager must document those barriers and describe any related activities that the TCM Case Manager must perform to eliminate those barriers in order to meet the needs of the beneficiary, and to attain the desired goals.

Family referrals are referrals that meet the needs of multiple family members, and can only be billed to one TCM beneficiary. For example, if a mother with four children needs housing; a housing referral encounter can only be billed to the mother and not to each of the children.

4) Monitoring and Follow-Up Activities

Monitoring and follow-up activities are required to effectively assess whether the beneficiary's identified needs or problems are being adequately met by the referrals and resources that have been provided to the beneficiary by the TCM Case Manager. Monitoring and follow-up should be done in a reasonable time period. For referrals with a designated appointment date, the follow-up must be done within 30 days of the appointment date.

Follow-up and monitoring documentation should describe whether the beneficiary's need(s) or problem(s) has been met or not. For referrals not meeting the beneficiary's needs or problems, documentation should include a description of why the referral sources did not meet the beneficiary's need(s) or problem(s), and plans for further intervention. The documentation must be written to reflect if:

- Services are being furnished in accordance with the beneficiary's care plan.
- Services in the care plan are meeting the identified need(s) or problem(s) of the beneficiary.
- Changes in the needs of status of the individual are reflected in the care plan.
- Monitoring and follow-up activities include making necessary adjustments in the beneficiary care plan and/or service arrangements with providers.
- Further actions are needed to meet the beneficiary's needs or problems.

For example:

- A beneficiary who was referred to an appointment with their primary care provider; the TCM Case Manager should document whether the appointment was kept and the outcome of the appointment.
- A beneficiary was referred to the local food bank; the TCM Case Manager should document whether the beneficiary utilized the food bank, and if this resource will meet the ongoing needs of the beneficiary, or if there is a need for additional referrals.

Follow-up and monitoring may be done with the beneficiary, family members, service providers, or other entities, and may be conducted as frequently as necessary to assess whether the referral met the need or problem of the beneficiary.

Monitoring does not include ongoing evaluations, assessments, or check-ins of a beneficiary when all care plan goals have been met; there should be no continuous monitoring.

At least once annually, monitoring must be documented to determine whether services are being furnished in accordance with the beneficiary's care plan. Annual monitoring must include documentation of a reassessment of whether the beneficiary is progressing to meet the goals established in the care plan. The annual monitoring may be performed in conjunction with the periodic review.

The periodic review must be completed at least every six months. Documentation of the periodic review must include all of the following:

- Reassessment of the target population.
- Reassessment of the beneficiary.
- The current care plan must be reviewed with the beneficiary or caregiver.

- The resolved need(s) and problem(s) must be reviewed with the beneficiary or caregiver.
- The unresolved need(s) and problem(s) must be reviewed with the beneficiary or caregiver.
- The continued need(s) and problem(s) must be reviewed with the beneficiary or caregiver.
- The beneficiary or caregiver understands and agrees with the ongoing care plan.
- Determination if TCM services should be continued, modified, or discontinued.
- The frequency and duration of ongoing TCM services by the TCM Case Manager.

During the biannual periodic review, the supervisor must sign the care plan certifying that the services provided in the care plan are true and correct. Additionally, the supervisor must certify that the care plan is appropriate for providing TCM services until the beneficiary's case is closed.

3. Providing Multiple TCM Services during an Encounter:

When multiple TCM services are provided during the same visit, only one encounter may be billed.

- TCM Case Managers can only bill for one encounter, no matter how many TCM services were provided during the visit.

4. Transitional TCM Documentation

Medi-Cal enrolled 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.

States cannot furnish Transitional TCM services for longer than 180 consecutive days to a Medicaid eligible individual:

> [Targeted Case Management]…may be furnished as a service to institutionalized persons who are about to leave the institution in order to facilitate their transition to community services and enable them to gain access to needed medical, social and other services in the community. [Targeted Case Management] may be furnished during the last 180 consecutive days of a Medicaid eligible person's institutional stay for the purposes of community transition. States may specify a shorter time period or other conditions under which Targeted Case Management may be provided. (See, 74 Fed.Reg. 31190.)

5. Special Documentation Requirements and Risks When Providing Transitional TCM

TCM services provided to Transitional TCM beneficiary must be documented in the beneficiary's case records. Specifically, the items that need to be documented for Transitional TCM in the beneficiary case records are:

- The name and location of the facility the beneficiary is residing in.
- The discharge date from the facility to a community setting.

In addition, TCM encounters provided to Transitional TCM beneficiaries must be recorded on the encounter log.

If a beneficiary does not get discharged from the institution, encounters are not claimable and must not be billed.

6. General Documentation Requirements

TCM Case Managers must maintain beneficiary case records that capture telephone calls, encounter documentation, communication with other parties providing TCM services to the beneficiary, case conferences, and any other circumstances where the TCM Case Manager is communicating regarding the beneficiary. The beneficiary case record documentation serves as the primary support for billable TCM encounters.

An LGA must be able to specify the location where beneficiary case records are stored. It is not necessary to maintain duplicate records. All original documentation, in addition to beneficiary case records, must be available and easily accessible during a state or federal program review or audit.

All records in support of allowable TCM services must be maintained for the greater of (a) three fiscal years after the end of the quarter the LGA receives reimbursement from DHCS for the expenditures incurred, or (b) three fiscal years after the date of submission of the original or amended TCM cost report, whichever is later [per Welfare and Institutions Code (WIC) section 14170]. If an audit is in progress, or is identified as forthcoming, all records relevant to the audit shall be retained throughout the audit's duration or the final resolution of all audit exceptions, deferrals, and/or disallowances.

DHCS has the right to timely and unrestricted access to any books, documents, papers, or other beneficiary records (electronic or paper) that are pertinent. In the case of any pending litigation, documentation must be retained until the case is completely closed. In the case of other issues and potential litigation, it is advisable to retain all documentation until the matters are fully resolved. Each LGA should reevaluate their local procedures and or guidelines on record retention to maximize their protection. Each LGA may find it beneficial to retain records beyond the minimum records retention period.

In addition to the documentation described in the previous section, the LGA must maintain beneficiary case records, which document the following information:

- The first and last name of the beneficiary. In case of a newborn, the mother's name should be included in the newborn's case record. If the newborn's case record is electronic then the newborn's case record should be linked with the mother's case record.
- Beneficiary's Medi-Cal number such as Medi-Cal Beneficiary Identification Number (BIN), MEDS number, CIN or SSN. In the case of a newborn include the mother's beneficiary Medi-Cal number in the newborn's case record. If the case record is electronic, link the newborn's case record with the mother's case record.
- Beneficiary's date of birth. Be aware that the beneficiary's date of birth may be incorrect in the MEDS and such information must be documented in the beneficiary case record. If the date of birth is found to be wrong in the MEDS system, document the wrong date of birth in the beneficiary's case record until it is corrected. In the case of a newborn include the mother's date of birth in the newborn's case record. If the case record is electronic, link the newborn's record with the mother's record.
- Location where the service(s) were provided such as home, office or other. If the location is "Other", then the location must be specifically documented. For example – Library, lobby of police department, skilled nursing facility.
- Type of TCM service component provided as described in the prior section.
- Date the TCM service was provided.
- Name of the provider agency.
- Name of the TCM Case Manager.
- Description of the specific nature and content of the TCM case management services provided to the beneficiary and the outcome of those services.
- Whether the beneficiary declined services or not.
- Coordination with others who provide case management and other services to the beneficiary.
- Frequency and duration of providing TCM case management services to the beneficiary.
- Signed case records by the TCM Case Manager.

7. TCM Beneficiary Documentation Requirements

a. Target Population Documentation

Before TCM services progress beyond the initial comprehensive assessment, the TCM Case Manager must document, in the beneficiary record, the beneficiary's unique characteristics that meet one of the defined target populations. Should the beneficiary's characteristics have changed, the TCM Case Manager must document it in the beneficiary case record and reassign the beneficiary to a new target population. This

process may be completed every 6 months with the periodic reassessment and periodic review.

b. Location of Beneficiary

For an encounter, the TCM Case Manager must document the location where TCM services are being provided.

There are rare circumstances due to environmental factors where the TCM Case Manager cannot physically deliver face-to-face TCM services to the beneficiary, and can only provide TCM services via the telephone or internet. In these rare and infrequent circumstances, the TCM Case Manager must document with specific detail the environmental factors that preclude a face-to-face visit. For example, if the beneficiary lived in a rural area and the only bridge to their home was washed out.

8. Freedom of Choice Documentation

Before TCM services progress beyond the initial comprehensive assessment the TCM Case Manager must document in the beneficiary's case record that the beneficiary is informed of and understands their Freedom of Choice.

The beneficiary must be informed of their Freedom of Choice to:

- Select their provider of TCM case management services.
- Choose which TCM Case Manager provides TCM services to them.
- Refuse TCM case management services.

9. Fee Mechanism Documentation

Before TCM services progress beyond the initial comprehensive assessment, the TCM Case Manager must screen the beneficiary for health coverage, and document the established fee mechanism of the TCM Provider in the beneficiary's case records.

As part of the fee mechanism, a TCM Provider may waive fees in the following circumstances:

- The beneficiary has no health coverage and qualifies to apply for Medi-Cal.
- The beneficiary has submitted a Medi-Cal application and the beneficiary's Medi-Cal status is pending.
- The beneficiary has an unmet share of cost for Medi-Cal.
- The health and welfare of the beneficiary is at risk without TCM services. The TCM Case Manager must document the risk if the beneficiary would be without TCM.
- The health and welfare of the public is at risk without TCM services. The TCM Case Manager must document the risk if the public would be without the beneficiary receiving TCM.

- The beneficiary would refuse TCM services if the beneficiary has to pay a fee. In the TCM Case Manager's judgment the beneficiary would fail to seek necessary health or social services without TCM assistance. The TCM Case Manager must document the negative impact to the beneficiary if they were not to receive TCM services.

10. Non Duplication of Services and Care Coordination Documentation

Prior to providing TCM services, before progressing beyond the initial comprehensive assessment, and during the course of providing TCM services, the TCM Case Manager must be vigilant in assuring that they are not duplicating services already being provided. The TCM Case Manager must coordinate with other providers to assure duplication of services does not occur.

The coordination of care between agencies providing services to the beneficiary must be documented in the beneficiary case records by the TCM Case Manager. This information shall be described in the TCM Performance Monitoring Plan (PMP).

Specific questions should be asked and documented in the beneficiary's case record if services by the following are being provided to the beneficiary:

- 1915(c) Home and Community-Based Services (HCBS) Waiver.
- Managed Care Plan
- Other programs (refer to Section 3 for further information).

As part of the initial comprehensive assessment and the periodic review, the TCM Case Manager should ask the beneficiary "Is anyone else helping you with _____, (the specific need(s) identified through the TCM assessments)?" The TCM Case Manager should not solely rely on the beneficiary's declaration, but also do their due diligence in investigating the possibility that other programs are providing services to the beneficiary based on the TCM Case Manager's initial comprehensive assessment.

For example, if a severely disabled child is receiving private duty care through a home health agency, the TCM Case Manager should investigate if these services are being provided through a local regional center via a 1915(c) HCBS Waiver, because often beneficiaries are unaware of how these services are being provided.

Duplication does not exist if the issues identified during the TCM comprehensive assessment and ongoing assessment are not being addressed by other providers. The TCM Case Manager will document in the beneficiary's file "Beneficiary states no other provider is addressing the identified needs."

If issues are identified as being addressed by other providers and agencies, then those needs should not be addressed by the TCM Case Manager, and should not be included in the care plan. The TCM Case Manager should document in the beneficiary's case

record those needs or problems that are being taken care of, and document the name of the agency and interventions.

11. TCM Time Frames

To substantiate compliance with the TCM program requirements, beneficiary case record documentation must demonstrate that the following required TCM time frames have been met:

- TCM Case Managers must provide follow-up within 30 days of a scheduled service to which a beneficiary was referred.
    - Example: The beneficiary is referred to their primary care provider and the TCM Case Manager makes the beneficiary an appointment for February 1. The TCM Case Manager must follow-up on the outcomes of that appointment with the beneficiary or caregiver by March 2.
    - If the TCM Case Manager is unable to follow-up with the beneficiary within the 30-day time frame, the TCM Case Manager must document why, and must reasonably continue attempting to follow-up with the beneficiary.

For further information, reference California Code of Regulations (CCR), title 22, section 51351(a)(3).

- Periodic reassessment and periodic review of the beneficiary is to be conducted, at a minimum, once every six months to determine if a beneficiary's needs, conditions, and/or preferences have changed.
    - If the TCM Case Manager is unable to conduct the periodic reassessment before the sixth month date, the barriers to performing the reassessment must be documented and performed in a reasonable time frame, or TCM services should be discontinued.

Note: LGA's TCM programs should also determine and have internal policies and procedures in place regarding reasonable timeframes for completion of documentation, supervisor signatures, and follow-up on non-scheduled services based on TCM program requirements.

12. Confidentiality

The state and federal confidentiality laws apply to all TCM case records. Both DHCS and Centers for Medicaid and Medicare Services (CMS) have legal access to all information germane to the administration of the federal Medicaid (Medi-Cal) program. All staff with access to such information are bound by the federal laws of confidentiality. The state and federal program reviewers/auditors have access to all information and

documentation that support a TCM claim. For more information, refer to WIC section 14132.275 and the Health and Safety Code section 121025, subdivisions (d) and (e).

13. Encounter Log

An "encounter" is defined as a face-to-face contact or a 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.

To accurately report costs in the TCM Cost Report, LGAs must properly maintain their TCM encounter log and correctly submit information in the TCM System. The TCM System is an online web-based system that the LGAs use to claim for reimbursement for providing TCM services.

LGAs are required to maintain a TCM encounter log to keep a listing of all the encounters (claimable and un-claimable beneficiary interactions) in their jurisdiction. The LGA Coordinator uses the encounter log information to enter encounters into the TCM System and submit invoices based on the date of service and target population. The TCM System verifies the following information:

a. Medi-Cal eligibility of TCM encounters through the Medi-Cal Eligibility Data System (MEDS)
b. Duplicative encounters
c. Invoices submitted within the 12 month claiming deadline
d. Valid TCM Case Manager National Provider Identifier (NPI)

After the TCM System completes all appropriate verifications on the encounter information, DHCS staff further verifies the claims (invoices submitted by the LGAs) to either approve or deny them. The information reported in the TCM System is used to develop the TCM Cost Report.

a. TCM Encounter Log Requirements

The TCM encounter log is used by the LGA to record the necessary information required to compile the LGA's claim for federal reimbursement. Note that the TCM encounter log does not supplant the need for detailed beneficiary case records.

b. Required Information for the TCM Encounter Log

The information required on the TCM encounter log includes:

- The beneficiary's name
- The beneficiary's date of birth and the mother's date of birth in the case of newborns.
- The beneficiary's Medi-Cal number, BIN, or SSN.

- The date of the TCM service (encounter).
- The name of the provider agency.
- The TCM Case Manager ID and NPI number.

For beneficiaries residing in institutions, the TCM encounter log must include the following in addition to the above stated requirements:

- The location of the service (home, office, or type of institution; for example: Board and Care, Intermediate Care Facility, Hospital, Nursing Facility, Psychiatric Facility, Institutions for Mental Diseases, etc.)
- The beneficiary's admission and discharge date from an institution

For the purpose of developing the TCM Cost Report accurately, it is necessary to maintain a list of all TCM encounters for both Medi-Cal and non-Medi-Cal beneficiaries. A separate log may be maintained to record encounters for beneficiaries for whom reimbursement will not be claimed through the TCM program.

c. Reconciling TCM Encounter Log to the TCM System

LGAs are expected to reconcile their TCM encounter log to the data in the TCM System for the following three encounter categories. Encounters will be identified in these three categories after they have been entered into the TCM System. This is a necessary step to accurately complete the TCM Cost Report.

1. Claimable Medi-Cal Encounters
2. Non-Claimable Medi-Cal Encounters
3. Non-Medi-Cal Encounters

d. Newborn Date of Birth

Pursuant to CCR, title 22, section 50733, subdivision (c), a mother's Medi-Cal BIC shall be authorization for services for her newborn child during the month of birth and the month following the month of birth. However, subsequent to the month following the month of birth, TCM services provided to the infant must be claimed using the infants own Medi-Cal BIC and the infant's date of birth.

> Example: If a baby is born on July 15, 2013, starting September 1, 2013, the baby's Medi-Cal number must be used for billing, instead of the mother's Medi-Cal number.

Therefore, a beneficiary is considered a newborn only from the time of birth until the end of the month following the month of birth, referred to as Newborn Date-Range. In accordance with the above regulation, newborn encounters beyond the Newborn Date-Range will be marked as "Expired" in the TCM System and will not be reimbursed until the newborn's Medi-Cal number is entered in the TCM System for invoicing.

e. TCM Encounter Log Issues

Below is a list of issues identified by DHCS during site visits where LGA TCM encounter logs did not meet program requirements:

1. Missing beneficiary Date of Birth
2. Missing Client ID
3. Billing the encounter under the wrong TCM Case Manager name and NPI number
4. Not having a continuous/all-inclusive TCM encounter log. The TCM encounter log must be continuous/all-inclusive and include all encounters provided during the entire fiscal year

f. TCM Encounter Log Best Practices

In addition to the TCM encounter log requirements, DHCS recommends adding the information below to the TCM encounter log as best practices for the TCM program:

1. Program Type (Target Population):
    a. For example: 14, 15, 16, 17, and/or 18.
2. Location of the Encounter:
    a. For example: Home, Office, Other (specify other)
3. Encounter log versus beneficiary file:
    a. Procedures need to be in place to ensure that the encounters listed on the TCM encounter log match the beneficiary case files (for all requirements listed above), prior to billing for the encounter through the TCM System.
    b. Beneficiary's full name must be spelled correctly within both the TCM encounter log and beneficiary case file.

The LGA and its subcontractor are required to maintain an up-to-date TCM encounter log to support the provided services. The TCM encounter log helps to support the LGA in claiming Federal Financial Participation (FFP). LGA TCM billing staff need to ensure:

- All claimable encounters entered into the TCM System must be consistent with the records in the TCM encounter log.
- The TCM encounter log is updated per information from the TCM System.
- TCM payments received from the state must reconcile to invoices submitted.
- The TCM System is updated for paid encounters once the payment is received.

14. Position Descriptions / Duty Statements

A position description and/or duty statement for each classification of individuals performing TCM must be retained. Duty statements need to be specific to staff member job classifications designated to perform TCM on behalf of the claiming unit. The duty statement must include a description of all job functions, duties, tasks, and responsibilities the staff members in the specific classification must perform. The

functions, duties, tasks, and responsibilities specific to the performance of TCM must be clearly identified. The activities performed for the TCM program must be identified by placing the appropriate activity code number next to each TCM activity. The duty statement must also be signed by the employee to ensure understanding of the TCM specific performance expectations.

15. Organizational Chart

An organizational chart is a diagram that outlines the internal structure of a program. It is a common visual depiction of how an organization is structured and outlines the roles, responsibilities, and relationships between individuals within an organization. An organizational chart can be used to depict the structure of an organization as a whole, or categorized by department and/or unit.

For TCM purposes, a Budget Unit (BU) is a readily identifiable organizational component and an accounting structure on the LGA's organizational chart and general ledger. BU staff provide both TCM and Non-TCM services. (Refer to Section 5 for further information).

16. Contracts / Memorandum of Understanding (MOU)

Copies of all originally signed contracts, MOUs, lateral agreements, including exhibits with the LGA, et al, for the TCM period of the claim must be retained on site. These contracts must include the TCM Evergreen Provider Participation Agreement (PPA) and the Provider Agreement with DHCS.

17. Performance Monitoring Plans

The TCM PMP is required by CCR, title 22, section 51271(a). The PMP establishes a countywide system that helps ensure non-duplication of payments, non-duplication of services, and a more efficient use of agency resources in meeting beneficiary's needs. The PMP must include protocols and procedures for coordination and continuity of care among providers for Medi-Cal beneficiaries whom are eligible to receive TCM services from two or more providers. LGAs that participate in and claim through the TCM program and other programs providing TCM services must include in their PMP a description of the systematic controls that are in place to ensure non-duplication of services (refer to Section 3 for further information).

18. Time Surveys

A listing of employees participating in each time survey must be maintained in the review/audit file. The original time survey must be included in the file to support the TCM services. The time survey must be signed and dated by the TCM time survey participants and their supervisor.

Internal time tracking records that substantiate the time survey period must be available during the record retention period or when an audit is in process.

The total number of hours a participant records on the Worker Log Time Survey document must match the participant's time card and BU payroll records. (Refer to Section 4 for further information).

19. Cost Report and Supporting Source Documentation

For cost report required documentation, refer to Section 5 of this manual.

To request federal reimbursement, LGAs must fully document their activities to validate the service provided and the cost incurred in providing those services. When an auditing agency is conducting an audit, all supporting documentation or related records must be made available upon request. Any pending litigations/deferrals, documentation must be retained until the case is completely closed. In instances of other issues and potential litigation/deferral, it is advisable to retain all documentation until the matters are fully resolved.

DHCS highly recommends that an audit file be created for future audit and review of the filed TCM Cost Report.

III. TCM OVERSIGHT

1. LGA Oversight

Federal guidelines require the oversight and monitoring of TCM programs. LGA and BU (program) obligations for oversight are:

- Ensuring the processing of TCM-related agreements and subcontractor agreements.
- Ensuring a PMP is in place to prevent the duplication of TCM services.
- Ensuring MOUs are in place with Medi-Cal Managed Care Health Plans (MCP) to prevent duplication of TCM services.

a. Training Requirements and Compliance with Oversight Obligations:

- Ensuring TCM program participants including TCM Case Managers, support staff to TCM Case Managers, and TCM Case Manager supervisors, are trained how to time survey when first employed and annually thereafter.
- Ensuring the TCM Case Managers, support staff to TCM Case Managers and TCM Case Manager Supervisors participate in the required time survey.
- Ensuring program staff, involved with preparing the TCM Cost Report understand how to prepare the TCM Cost Report.
- Reviewing all statistically valid time surveys to ensure that the BU meets the 85% compliance rate.

- Ensuring the BU complies with time survey requirements, and that the BU (program) is aware of non-compliance consequences.
- Providing and/or coordinate technical assistance for the TCM BU to receive training regarding the TCM program when necessary.
- Training TCM Case Managers, support staff to TCM Case Managers, and TCM Case Manager Supervisors regarding TCM program documentation requirements.

b. TCM Program and Financial Monitoring includes:

- Participating in periodic DHCS oversight reviews including site visits and TCM audits.
- Coordinating a quality assurance program to ensure that TCM program requirements are met, including the review of beneficiary case records to ensure billable encounters are compliant with TCM requirements.
- Maintaining encounter logs and having a reconciliation process between the TCM System and data on the encounter log to ensure consistency.
- Developing, initiating, and maintaining internal TCM program procedures to ensure compliance with TCM program requirements.
- Assisting in the development and oversight the TCM, program beneficiary case records documentation.
- Performing internal TCM program reviews to ensure compliance with state and federal regulations.
- Conducting financial training with the BU.
- Maintaining all source documents to support filed TCM cost reports.
- Ensuring that appropriate documentation is maintained to support the time study.
- Maintaining and establishing an audit file.
- Ensuring expenditures are charged to the appropriate BU as reflected on the general ledger.
- Ensuring that revenues are appropriately credited to the BU as reflected on the general ledger.

c. Check Submission Form

In the event the LGA discovers, through a self-audit, an overpayment or payment of unallowable TCM claim(s) is made from DHCS, the LGA shall use the Check Submission Form when submitting refund checks to DHCS. LGAs must also include the fiscal year, invoice number, and the encounter number(s) associated with the refund check. Once the form is complete, sign in blue ink, attach to the refund check, and email it to DHCS.

Note: If additional space is needed, be sure to include the fiscal year, invoice number(s), and encounter number(s) on Page 2 of the form. Please use one form per

Check Number. Submit the completed Check Submission Form to the address on the form.

d. TCM System Monitoring

- Updating and maintaining the LGA's profile.
- Ensuring claimable encounters are invoiced for accurate claiming. Researching non-invoiced encounters before the 12-month expiration date. (For more information on how to update non-invoiced encounters, refer to Section 8.)
- Ensuring that invoices are marked "Paid" when payments are received by the LGA.
- Monitoring access to the TCM System at the User level.

2. Oversight At State Level

DHCS is the single state agency that oversees the TCM program. Two divisions within DHCS, Local Governmental Financing Division, and Audits and Investigations (A&I) Division are the main units monitoring the program.

a. Local Governmental Financing Division (LGFD) Oversight

LGFD's County-Based Claiming and Inmate Services Section (CBISS), TCM Unit, is the policy group that manages the DHCS TCM program. The TCM Unit develops state policies concerning the TCM program and monitors the program by conducting periodic reviews of the TCM participants.

b. Site Visit

For site visits, DHCS staff visit the LGA's office in person. Approximately six weeks prior to the site visit, DHCS will contact the LGA to establish a date for the site visit. The site visit involves the review of case records, encounter logs, and interviews with the LGA staff. Pre-selected TCM Case Managers, supervisors, and other staff who support TCM will be interviewed to ensure program compliance.

LGA staff selected by DHCS must be available for interviews during site visits. DHCS will request randomly selected and necessary documentation in order to conduct the site visit. Prior to a site visit, DHCS will inform the LGA Coordinator of the documentation needed to be available for the site visit.

Following the site visit, DHCS will provide the LGA with a summary of its findings. Findings from the TCM program site visits will be forwarded to DHCS A&I.

c. Desk Review

DHCS may conduct a desk review in lieu of a site visit. DHCS will request from the LGA a copy of the TCM program beneficiary's' record(s) and encounter logs. The LGA Coordinator must ensure the documents do not include confidential Personal Health

Information such as beneficiary name or Medi-Cal ID numbers, as required by Health Insurance Portability and Accountability Act. After confidential information is redacted, the LGA Coordinator must identify the requested documents by their encounter ID number and mail/e-mail them to DHCS. DHCS will evaluate the documentation and contact the LGA Coordinator for clarification, if needed. DHCS will determine if the billed encounters meet TCM program requirements.

Following the desk review, DHCS will provide the LGA with a summary of findings. Findings from the TCM program reviews will be forwarded to DHCS A&I.

d. DHCS A&I Oversight

DHCS A&I conducts an annual TCM Cost Report audit. Per WIC section 14170, and the California Medicaid State Plan, Attachment 4.19-B, all accepted TCM Cost Reports will be audited within three years from the date of submission of the original or amended report by the provider, whichever is later. A&I's audit can be performed as either a desk or a field audit. A&I issues an audit report once the audit is completed.

The blue-cover audit report identifies the total TCM program cost incurred by a TCM BU for a specific State Fiscal Year (SFY). It determines an LGA's final Medi-Cal reimbursable cost which can draw down FFP. It also calculates the final federal reimbursement settlement for an LGA participating in the TCM program for that SFY. If an overpayment is identified through the blue-cover audit report, DHCS will recover the overpayment on behalf of the federal government. Conversely, DHCS will draw down additional FFP for the LGA for the underpayment identified on the blue-cover audit report.

All records in support of allowable TCM services must be maintained for the greater of (a) three fiscal years after the end of the quarter the LGA receives reimbursement from the DHCS for the expenditures incurred, or (b) three fiscal years after the date of submission of the original or amended TCM Cost Report, whichever is later, per WIC section 14170.

e. Other Audits

DHCS will notify LGAs if they are selected for other audits, such as audits by CMS.

3. Oversight Funding Reimbursements

During the oversight process, DHCS or the LGA may discover an overpayment to the LGA whereby the LGA owes DHCS for funds received in excess of what was reimbursable or an underpayment whereby funds are owed to the LGA for funds received less than what was reimbursable. DHCS will notify the LGA for any over/under payment discovered.

a. Overpayment

DHCS will send a letter with the overpayment amount to the LGA and notify the LGA that the overpayment amount is due to DHCS within 60 days of the notice. The LGA has two options for fund repayment to DHCS; a lump sum payment submitted as a check or DHCS offsetting future invoices until the balance repayment is complete.

b. Withhold

An LGA that does not remit to DHCS the full balance of the overpayment within 60 days of the notice will go on withhold status. While the LGA is on withhold status, DHCS will not process any current or future invoices and will begin the process of offsetting invoices. DHCS at its discretion may grant an extension to the 60 days or enter into another agreement with the LGA. Any such agreements must be completed in writing. An LGA will remain on withhold until the balance owed to DHCS is repaid in full.

c. Underpayment

DHCS will send a letter with the underpayment amount to the LGA notifying the LGA that the underpayment amount will be paid to the LGA. Underpayments follow the regular invoice timeline, which can or may vary. The underpayment will show on the Activity Report as a Not in TCM System invoice.