Medi-Cal

Targeted Case Management

Provider Manual

SECTION 3

Participation and Program Requirement

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I. OVERVIEW

A Local Government Agency (LGA) must meet all of the following requirements to participate in the Targeted Case Management (TCM) program:

- Have a fully executed TCM Provider Participation Agreement (PPA),
- Complete a TCM Annual Participation Prerequisite (APP),
- Participate in TCM Time Survey Training and Documentation (refer to Section 4),
- Complete an annual TCM Cost Report (refer to Section 5), and
- Maintain supporting documentation to substantiate the TCM services provided (refer to Section 9).
- Maintain Memorandums of Understanding (MOU) with their Medi-Cal managed care health plans (MCP).

II. PROGRAM REQUIREMENTS

1. Freedom of Choice

Federal law requires that beneficiaries have freedom of choice to receive TCM services from any qualified Medicaid provider, unless the state obtained a waiver. (42 USC § 1396a(23), 42 CFR §§ 431.51(a)(1), 441.18(a)(1).) The LGA must document that the eligible individual is aware of and understands their freedom of choice options. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in the California State Medicaid Plan (State Plan). (Supplements 1a, 1b, 1d, 1e and 1f to Attachment 3.1-A of the State Plan).

2. Fee Mechanism

Because Medi-Cal is the payer of last resort, a fee mechanism must be in place to ensure that all other possible payment sources have been considered prior to using Medi-Cal as a payment source for TCM services.

Payment for TCM services under 42 CFR part 441.18(a)(4) must not be duplicate payments made to public agencies or private entities under other program authorities for the same purposes. In general, payment may not be made for services which another payer is liable or for which no payment liability is incurred. Similarly, separate payment cannot be made for similar services, which are an integral and inseparable part of another Medicaid covered service.

3. Third Party Liability

Because Medi-Cal is the payer of last resort, LGAs must determine if beneficiaries have health insurance coverage other than Medi-Cal for comprehensive case management

services. LGAs may only provide and claim reimbursement for TCM services to the extent that those services are not covered by any other insurance that the beneficiary may have. If a beneficiary does have other insurance coverage, the insurance information and the extent of the coverage for case management services must be documented in beneficiary case notes.

4. Care Coordination to Prevent Duplication with Other Programs

Prior to and during the course of providing TCM services, the TCM case manager must be vigilant and coordinate with other providers to prevent duplication of services.

i. 1915(c) Home and Community-Based Services (HCBS) Waiver

LGAs cannot claim encounters for TCM services provided to beneficiaries enrolled in any Section 1915(c) HCBS Waiver program. However, once a beneficiary is dis-enrolled from a Section1915(c) HCBS Waiver program, TCM services may be claimed. In these cases, evidence of beneficiary Section 1915(c) HCBS Waiver status contemporaneous with the provision of TCM service must be documented in the beneficiary case notes.

For more information regarding the 1915(c) HCBS Waiver please visit Medicaid.gov.

ii. Medi-Cal Managed Care

MCP and LGAs are responsible for care coordination and case management services for beneficiaries. This includes coordination and referral of resources for beneficiary social support issues.

To facilitate collaboration between the TCM program and MCPs, LGAs are required to enter into a MOU with each MCP. Participation in the TCM program is contingent upon signing an MOU. These MOUs will serve to define the responsibilities and coordination requirements between the TCM program and MCPs.

iii. Other Programs

A case manager is expected to coordinate with all agencies and programs that provide case management services to the beneficiary to ensure non-duplication of services. Other programs that provide case management include, but are not limited to, the following:

- California Children's Services (CCS)
- AIDS Program
- Mental Health TCM
- Maternal Child Health Program

- Enhanced Care Management
- Employment and Human Services Program
- Adult and Aging Services Program

5. TCM Encounter

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 TCM service components by a case manager.

6. TCM Encounter Log

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

- Medi-Cal eligibility of TCM encounters through the Medi-Cal Eligibility Data System (MEDS)
- Duplicative encounters
- Invoices submitted within the 12 month claiming deadline
- Valid case manager National Provider Identifier (NPI)

After the TCM System completes all appropriate verifications on the encounter information, Department of Health Care Services (DHCS) staff then verifies the claims (invoices submitted by the LGAs) to either approve or deny the invoices. The payment information reported in the TCM System is used by the DHCS TCM program to develop the paid claim summary reports that are given to DHCS Audits & Investigations (A&I), for use in auditing the TCM Cost Reports submitted by the LGAs.

i. 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.)

ii. Required Information for the TCM Encounter Log

The information required on the TCM encounter log includes:

- The beneficiary’s first and last name

- The beneficiary's date of birth (Refer to Section 8 for more information)
- The beneficiary's Medi-Cal number, Beneficiary Identification Number, or Social Security number
- The date of the TCM service (encounter)
- The name of the provider agency
- The name and NPI number of the case manager
- The location of the encounter

For beneficiaries residing in institutions, the TCM encounter log must include the following additional requirements:[1]

- The location of the service (home, office, other, 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 log 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.

iii. Reconciling the TCM Encounter Log to the TCM System

LGAs must 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.

- Claimable TCM Medi-Cal Only Encounters: Encounters include all TCM Medi-Cal encounters with a claimable status.

- Non-claimable TCM Medi-Cal Only Encounters: Encounters consist of TCM Medi-Cal encounters that are not claimable through the TCM program. For example: a TCM Medi-Cal encounter that is reimbursed through a 1915(c) HCBS Waiver would not be a claimable TCM encounter due to duplication of services. Include this encounter in the TCM encounter log.

[1] When TCM clients reside in nursing facilities, hospitals, convalescent homes, or other facilities that are not their private residence, TCM case managers must make good faith effort, as specified in their Performance Monitoring Plan, not to claim for services that have already been provided.

- TCM Non-Medi-Cal Encounters: Encounters received a non-eligible status due to Medi-Cal ineligibility.

Note: To ensure accuracy, all TCM encounters classified above must be included in the TCM encounter log. The encounter log should be reconciled and updated once payments are received.

7. TCM Encounter Rate

For more information about how the TCM encounter rate is created, refer to Section 5 of this Manual.

8. Quality Assurance

Each LGA participating in the TCM program must have a Quality Assurance (QA) process. QA refers to administrative and procedural activities implemented systematically to assure that the requirements and goals of the TCM program are met. It is the systematic measurement, comparison with a standard, monitoring of processes or an associated feedback loop that promotes programmatic compliance.

9. Non-Claimable Operating Costs

Reimbursement is not available for non-claimable operating costs on the TCM Cost Report, therefore the LGA must reclassify those costs as Non-TCM costs. Examples of non-claimable operating costs are listed below but are not limited to the following:

- Malpractice insurance
- Equipment used for providing direct services
- Medical supplies (excluding Personal Protective Equipment (PPE)) such as blood pressure devices, scales, thermometers, etc.
- Drugs and medications
- Costs of elected officials and their related costs
- Costs for lobbying activities

Note: The repair and maintenance of lab equipment such as an x-ray machine are not valid claimable costs.

Claimable operating costs are costs other than salaries, benefits, travel, and training that are necessary for the proper and efficient administration of the TCM program. Reimbursement is available for claimable operating costs including PPE.

10. Subcontractors

An LGA may subcontract with public or private entities to provide TCM services on behalf of the LGA, typically a Community Based Organization (CBO) or Local Public Entity (LPE). The subcontractor must agree that it will perform TCM services and will ensure that expenditures are allowable and meet all federal requirements for the provision of TCM services. The subcontract must contain language that the subcontractor will comply with the same requirements applicable to LGAs as described in the TCM PPA between the LGA and DHCS, including those contained in the State Plan and this Manual.

III. HOST COUNTY

Per California Code of Regulations (CCR), title 22, Section 51185(c), the "Host County" is the LGA designated by all TCM program participants to be the administrative and fiscal intermediary between DHCS and all participating LGAs. According to WIC Sections 14132.44 and 14132.47, the Host County and DHCS execute a contract enabling the Host County to reimburse DHCS its costs for administering the TCM and County-Based Medi-Cal Administrative Activities (CMAA) programs on behalf of all participating LGAs.

IV. CLAIMABLE PORTION OF PARTICIPATION FEE

On an annual basis, the Host County calculates the overall participation fee for all LGAs, then calculates each LGA's portion of the participation fee, then invoices and collects each participating LGA's portion of participation costs, which include costs such as DHCS' administrative costs.

An LGA that meets TCM program requirements may receive federal reimbursement for a portion of its participation fee. Reimbursable expenditures cannot include costs that will be or have been claimed for federal reimbursement such as DHCS' program administration costs, compensation related to the LGA Executive Committee (EC), or compensation for being the Host County during a SFY. To calculate the claimable participation fee percentage, the sum of claimable expenses is divided by the participation fee of the prior SFY.

$$Claimable\ Participation\ Fee\ \% = \frac{Sum\ of\ Claimable\ Expenses}{Prior\ SFY\ Participation\ Fee}$$

To calculate any particular LGA's claimable participation fee for the current SFY, an LGA multiplies its total claimed expenses by the Claimable Participation Fee Percentage. An LGA's claimable amount must be claimed during the quarter that the LGA made a payment to the Host County. This entry should be on the Cost Worksheet, in the Direct Charge Other Cost Section under Cost Pool #5, in the CMAA invoice.

V. PARTICIPATION REQUIREMENTS

1. Provider Participation Agreement

For an LGA to participate in the TCM program and to claim reimbursement for Medicaid TCM services, federal regulations require that an agreement be in place between the single state agency (DHCS) responsible for administering the Medicaid program (Medi-Cal) and the LGA to whom any administrative responsibilities have been delegated. In California, the agreement between DHCS and the LGA is referred to as the TCM PPA. The PPA establishes the responsibilities of the LGA and DHCS for providing TCM services.

i. Ensuring Non-Duplication of Services

Methods for delivering TCM services vary from program to program; therefore, it is the responsibility of the LGA to design and implement a countywide system to prevent duplication of services and ensure coordination and continuity of care among all providers of case management under all programs or waivers, including 1915(c) HCBS Waivers. Each LGA will be required to certify each year, in a manner prescribed by DHCS (the TCM Performance Monitoring Plan (PMP)), that it has a care coordination plan in place (refer to the PMP subsection).

ii. Medi-Cal Disclosure Statement – Form 6207

Every TCM provider must submit a completed and current Medi-Cal Disclosure Statement (DHCS 6207) as part of its enrollment application package, for continued enrollment, or certification as a Medi-Cal provider. This document must be completed and signed by an authorized signer and must be submitted to DHCS upon enrolling, re-enrolling, or revalidating every five years.

iii. Medi-Cal Provider Enrollment Agreement – Form 6208

The Medi-Cal Provider Enrollment Agreement (Form 6208) serves as an agreement between the LGA and the DHCS to provide Medi-Cal services within the county. This document must be completed, notarized, and signed by an authorized signer and must be submitted to DHCS upon enrolling, re-enrolling, or revalidating every five years.

2. Memorandum Of Understanding

LGAs are required to implement a MOU with MCPs serving beneficiaries in the same county per federal and DHCS policy directives, including Policy and Procedure Letters (PPL). The MOU defines the care coordination responsibilities of LGAs and MCPs, including coordination protocols to ensure non-duplication of services provided to beneficiaries in common. Although the PMP includes similar non-duplication of services

responsibilities as the MOU, the MOU contains additional and unique requirements not contained in the PMP. Please refer to the DHCS TCM and Managed Care Plan Memorandum of Understanding Protocol for further information regarding necessary components of the MOU.

3. Annual Participation Prerequisite

The APP provides DHCS with TCM participation information to ensure compliance with regulations and develop TCM program encounter and cost projections. The APP provides the following information and forms:

- LGA's intent to participate in TCM
- LGA's target population(s) participation for the SFY
- LGA's beneficiary notice of target population(s) discontinuation where applicable: The discontinuation notice must include the Notice Log and notice to each impacted beneficiary of the target population(s) discontinuation.
- LGA's target population program estimates
- Time Survey Frequency
- Supplemental information for each CBO and LPE subcontracted for the provision of TCM services
- Subprogram codes assigned to participating provider agencies
- TCM System LGA Profile Request Form: used to update and verify the accuracy of the information on file for each LGA within the TCM System
- TCM System LGA Signature Authority Request Form: used to update and accurately verify the validity of authorized signers for invoices submitted for reimbursement claiming.
- New form(s) must be submitted for all authorized signers for each SFY.
- PMP: The PMP must specifically address how the LGA ensures non-duplication of services. The PMP must include specific protocols and procedures to ensure coordination and continuity of care that is provided to eligible beneficiaries. Also, the PMP must identify all other Medi-Cal programs or waivers that provide case management services to beneficiaries in their LGA (e.g., California Children's Services, Mental Health TCM, Childhood Lead Team, etc.). The PMP must include, at a minimum, procedures explaining how TCM Case Managers coordinate with MCPs.
- Fee Mechanism and instructions for use: LGAs must have an established fee mechanism specific to TCM services that may include a sliding fee schedule based on income. The fee mechanism may vary by program.
- Contract/Memorandum of Understanding (if applicable): If an LGA subcontracts TCM services to a private non-profit CBO/LPE, a copy of the subcontract between the LGA and the CBO/LPE must be submitted.

- Proof (screenshots) displaying verification that case managers do not appear on the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE).

i. APP Submission

Submit a completed APP using the instructions found within the "instructions" tab along with the required additional documentation to DHCS-TCM@dhcs.ca.gov by the end of February each SFY*. There is an ability to save information submitted under each tab while in progress before submitting the APP to the DHCS.

If a LGA would like to add a target population not previously participated in prior to the SFY, the LGA must list the target population on the Participation Tab worksheet in the APP document.

Because the LGA Coordinator is required to submit the APP to DHCS via e-mail, the transmitted e-mail will function as the LGA Coordinator's signature.

The DHCS TCM inbox limits e-mail size to 30 MB. Compression software such as WinZip must be used to e-mail the APP and the required documentation to DHCS. LGAs unable to do so should contact the TCM Unit at DHCS-TCM@dhcs.ca.gov. For further direction, please review the information under the header of "Adding a New Target Population".

ii. APP Impact on State Plan

LGAs will not be able to participate in the TCM Program for the SFY if the required documentation is not received by the deadline stated above.

Once the APP has been submitted, DHCS will update Supplements 1a, 1b, 1d, 1e, and 1f to Attachment 3.1-A of the State Plan to include the LGA in the list of geographic regions for each target population that the LGA will serve.

If an LGA is not included in a geographic region in which TCM services are provided in the State Plan for a particular target population served, then the LGA may not claim FFP for that particular target population.

4. PMP

The TCM PMP is required under CCR, title 22, Section 51271(a). The PMP helps ensure statewide non-duplication of payments and efficient use of agency resources to meet beneficiary needs. The PMP must include protocols and procedures for coordination and continuity of care among providers for Medi-Cal beneficiaries who are eligible to receive TCM services from two or more programs/providers.

i. Non-Duplication of Services

There is risk of duplicating case management services provided by third parties when providing targeted case management services under the TCM program. To prevent against duplication of services and claims, LGAs are required to maintain a PMP, which must include a description of the following systematic controls in place that ensure non-duplication of TCM services:

- LGAs will communicate with MCPs at least once every six months for beneficiaries with open medical issues needing case management.
    - LGA TCM case managers will contact the beneficiary's MCP case manager or other appropriate contact to discuss the beneficiary medical issues and/or related social support issues.
    - Coordination will include, at a minimum, all medical issues and all social support related issues identified by the MCP and/or by the LGA TCM program.
- LGA case managers will obtain and review the MCP's member care plan.
- LGA case managers will notify the MCP that the beneficiary is receiving TCM services and has identified a social support issue(s) that may impede the implementation of the MCP care plan.
- List all other Medi-Cal programs and waivers that provide case management services to beneficiaries in their LGA (e.g., California Children's Services, Mental Health TCM, Childhood Lead Team, etc.).
- List all 1915(c) HCBS Waivers (e.g., AIDs Waiver, In-Home Operations Waiver, Developmentally Disabled Waiver, etc.).
- Provide the procedures and steps used to identify TCM beneficiaries receiving services through other Medi-Cal programs or Waiver by verbally asking beneficiaries if other case management services are being received.
- It is strongly recommended that TCM programs identify contacts within their counties for any other Medi-Cal programs or waiver programs with whom to check beneficiary participation. Evidence of beneficiary status in regard to other programs or waivers must be documented in the beneficiary case notes. This may include provider agency directives to case managers or other such internal documents.
- If a beneficiary participates in other programs or a waiver is identified, LGAs must follow the detailed specific methods to coordinate which should be specified in the procedures in their existing PMP. These procedures may include such elements as specific program contacts for other specific programs, frequency of contacts, protocols for coordination, etc. All such coordination must be documented in beneficiary case notes.
- Identify specific procedures to ensure non-duplication of services.

ii. Managed Care Non-Duplication of Services

To prevent duplication of services, an LGA must have coordination of care between the TCM program and the MCPs. The PMP must include, at a minimum, procedures for LGAs to coordinate with MCPs to ensure non-duplication of services:

- Annually provide MCPs with the TCM target populations in which the LGA participates, including the TCM target population definition(s).
- Identify TCM beneficiaries who are assigned to MCPs to assist TCM programs and MCPs in meeting coordination requirements by querying TCM beneficiaries.
- Refer any beneficiary with an open TCM case to the client's MCP care coordinator when the TCM case manager identifies beneficiary medical needs.
- Coordinate with the beneficiary's MCP when the beneficiary's medical needs are not being addressed in a timely or effective manner as determined by the TCM case manager from monitoring the beneficiary's condition and/or progress.
- Provide MCPs with beneficiary status updates when a TCM assessment is performed.
- Provide direction to MCPs when referring beneficiaries to TCM if the beneficiary meets the definition of the target populations the LGA participates in and when the MCP identifies a non-medical need and/or other issue where TCM may be beneficial.
- The MCPs shall collaborate with the TCM program for referrals when the beneficiary requires services not covered by the MCP. All such coordination must be described and documented in each TCM beneficiary's case notes.

iii. Lead Case Manager Non-Duplication of Services

When there are multiple case managers, one must assume the role of the lead case manager in order to avoid duplication of services. The lead case manager will be responsible for communicating with the other case managers when developing, implementing, and monitoring a beneficiary's care plan. The TCM case managers must communicate regularly relative to the needs of their mutual TCM beneficiary.

5. Office of Inspector General (OIG) Reviews

To verify that each case manager is not on the OIG LEIE database exclusion list, annually the LGAs must search the LEIE online database. LGAs must search for each case manager by first and last name and take a screenshot of the page verifying that each case manager is not an excluded provider, and therefore, has passed the OIG LEIE database check.

Annually, to be eligible to claim for TCM services, LGAs are required to submit and perform the following items either with their APP submission and/or when any new

providers and/or case managers enroll to provide TCM services.

1. Search the LEIE online database, located at: https://exclusions.oig.hhs.gov, and verify that each TCM case manager is not on the OIG LEIE database exclusion list.
2. Search the LEIE online database for each case manager by first and last name and take a screenshot of the page, verifying that each TCM case manager is not an excluded provider and thereby passing the OIG LEIE database check.
3. Submit a list of TCM case managers and OIG screen shots to DHCS.

Pursuant to 42 CFR part 433.32, DHCS will maintain copies of the above verifications. LGAs will not be able to participate in the TCM program for the SFY if the required documentation is not received annually.

6. LGA Signature Authority Request

The LGA Signature Authority Request form provides the names of all individuals authorized to review, approve, and sign on behalf of the LGA when submitting TCM program invoices, forms, etc.

Note: This form must be included with the electronic submission of the APP package (this form must be submitted annually). The Signature Authority Request form can be found on the TCM website in the TCM Forms section under the Tools & Templates section.

7. LGA Profile Request

The LGA Profile Request form is used to obtain, update, and verify a LGA's pertinent information (such as name, address, etc.) on file for each of the participating LGAs in the automated TCM System.

Note: This form must be included with the electronic submission of the APP package (this form must be submitted annually).The LGA Profile Request can be found on the TCM website in then TCM Forms section under the Tools & Templates section.

8. Fee Mechanism

LGAs must have an established fee mechanism specific to TCM services that may include a sliding fee schedule based on income. The fee mechanism may vary by program and must include instructions as to how it will be used.

For more details on Fee Mechanisms please see program requirements at Section II. above.

9. Subprogram Codes

All TCM encounters entered into the TCM System require a subprogram code associated with the LGA, including CBOs, subcontracted public agencies, etc.

The Subprogram Codes tab of the APP worksheet lists the required information that TCM analysts use to update LGA Profiles in the TCM System for the next SFY. Each of the columns listed below must be completed:

- Provider Agency - For each target population used by the LGA, list the provider agency names in the provider agency column on the left side of the worksheet.
    - For example: County Health Care Services.
- Name of Subdivision Providing Services – For example: Public Health Department.
- Subprogram code – LGAs will create their own subprogram codes (DHCS does not create them). The subprogram codes must be four characters long (numbers, letters, or a mixture of both numbers and letters).
    - For Example: 1234 or CH01.
- Target Population – List the target populations in which your county participates in, per each of the provider agencies:
    - For example: List 14, 15, and 17, if your county only participates within those three target populations.
    - List all of the provider agencies for each of the target populations.
- Agency Type – CBO, LPE, LGA.

LGAs can add subprogram codes to their LGA profile in the TCM System by completing the subprogram codes tab in the APP worksheet and submit it to DHCS with their APP submission.

LGAs that exceed the space provided in their subprogram codes tab in the APP worksheet can use the Subprogram Codes worksheet that can be found on the TCM website. This Subprogram Codes worksheet is also used to submit additional subprogram codes throughout the year. To update subprogram codes after the submission of the APP, LGAs must submit the Subprogram Codes worksheet through e-mail to dhcs-tcm@dhcs.ca.gov.

10. The American Rescue Plan Act (ARPA)

Section 9817 of the ARPA provides a temporary enhanced Federal Medical Assistance Percentage (FMAP) for certain Medicaid expenditures for Medicaid HCBS programs during the Public Health Emergency as a result of COVID-19, beginning April 1, 2021.

DHCS is required to preserve all existing HCBS in amount, duration, and scope, which were in effect as of April 1, 2021, in order to receive the increased FMAP from CMS.

i. LGAs are currently not allowed to withdraw from the TCM Program

In order for DHCS to qualify for the enhanced FMAP under ARPA, the TCM program must comply with ARPA's Maintenance of Effort requirements, which means that TCM services must continue in the same amount, duration, and scope, of services established as of April 1, 2021 by the State Plan until March 31, 2025 (subject to change). Therefore, LGAs will not be permitted to withdraw from the TCM Program for SFY 2022-23 and SFY 2023-2024, 2024-2025, nor remove target populations from its service populations.

Per ARPA, LGAs are only required to provide services to the target populations that were in effect on April 1, 2021. ARPA does not require LGAs to provide additional TCM services. LGAs are also not required to expand their target populations, and are only required to provide services to beneficiaries that request services. LGAs can choose to add new target populations. However, LGAs are required to continue providing TCM services to beneficiaries in all of their existing target populations until March 31, 2025.

Note: This is a temporary policy that is subject to change, but is expected to end no later than March 31, 2025. Upon expiration, DHCS will notify TCM LGAs and will instruct LGAs to please proceed with the standard TCM withdrawal process.

11. TCM Program Withdrawal and Enrollment and/or Re-enrollment

i. LGA Participation Withdrawal from The TCM Program Form

This form is to be used by LGAs to initiate withdrawal from the TCM program. LGAs must also meet the termination notice requirements outlined in the PPA and must submit a final TCM Cost Report with their withdrawal requests. The LGA Coordinator must sign the form in blue ink and return it to the address provided on the PPA and must submit a final Cost form or e-mail it to dhcs-tcm@dhcs.ca.gov before July 1 of each year, if applicable.

Note: LGAs who withdraw from the TCM program must submit a Cost Report.

ii. Beneficiary Notification Requirements

CMS requires each LGA to provide a written notice to beneficiaries when LGAs opt out of participating in a specific TCM target population prior to the start of the new SFY. When an LGA elects to discontinue participation in a TCM target population, the LGA's beneficiaries must receive a written notification from the LGA at least 30 days before the LGA's discontinuation.

The notification to the beneficiaries must inform the beneficiaries that the LGA will no longer receive federal reimbursements for TCM services provided to the beneficiaries by the LGA. If the decision to discontinue providing services to a target population is reported to DHCS during the annual APP submission process, which occurs in February, the LGA must notify beneficiaries by June 1 of that SFY.

Upon notifying the beneficiaries, LGAs are required to submit 1) a copy of the notification letter(s) and 2) the notice log to DHCS via electronic mail at DHCS-TCM@dhcs.ca.gov.

iii. Providing Notification Documentation to DHCS

In accordance with federal guidelines, the LGA may use DHCS' Uniform Notification Template (UNT) or an equal substitute when providing written notification to the beneficiaries. The LGA must submit electronic copies of the notification letters to DHCS within 30 days of the date the notification letters were sent to the beneficiaries, or by June 1 of the SFY (whichever occurs first).The LGA may use the DHCS-provided UNT or an equal substitute when providing written notification to the beneficiaries. The language in the UNT informs beneficiaries of the termination, reduction, or suspension of a previously covered Medi-Cal TCM service.

If the LGA elects to use a different form of notification to the beneficiary other than the UNT, per 42 CFR part 431.210, the written notice must at least contain:

a) A statement of what action the LGA intends to take and the effective date of such action;
b) A clear statement of the specific reasons supporting the intended action;
c) The specific regulations that support, or the change in Federal or State law that requires, the action;
d) An explanation of:
    i. The individual's right to request a local evidentiary hearing if one is available, or a State agency hearing; or
    ii. In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and
e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

Please note that the notification letter contains Protected Health Information (PHI) andthe electronic submission must be sent via secured means to DHCS' TCM inbox: dhcs-tcm@dhcs.ca.gov .

Samples of the UNT and Notice Log along with PPL 20-018 (Beneficiary Notification when LGAs Discontinue Participation in a Target Population), is located on the DHCS TCM website in the Policy and Procedures section under the Policies & Legislation section.

iv. No Appeal Rights

Discontinuation of services under the TCM program does not trigger an administrative hearing or appeal under 42 CFR part 431.206(c) because TCM services continue to be available to the beneficiary under Medi-Cal. As such, the notices are not required to include hearing information per 42 CFR part 210(d)(1). Nevertheless, LGAs are responsible for ensuring that they comply with all applicable state and federal requirements, including tendering this notice.

v. LGA Participation Enrollment and/or Re-Enrollment In The TCM Program Form

The LGA will use this form to formally enroll or re-enroll in the TCM program. The LGA Coordinator must sign the form and e-mail it to dhcs-tcm@dhcs.ca.gov before December 31. The LGA Enrollment and/or Re-Enrollment Form can be found on the TCM website.

Note: DHCS must be contacted for additional information concerning new provider enrollment. The LGA does not need to complete this form if continuing TCM participation.

VI. LGA COORDINATOR RESPONSIBILITIES

DHCS and LGAs work in partnership to safeguard proper administration of the CMAA and TCM programs. To aid communication between program participants and DHCS, each LGA designates an LGA Coordinator(s) to collaborate with DHCS' CMAA and TCM program staff. Each LGA can designate multiple coordinators known as primary and alternate LGA Coordinators. It is essential for LGA Coordinators to possess a thorough operational and financial understanding of the CMAA and TCM programs to operate in compliance with federal and state laws and regulations.

The primary LGA Coordinator often works as the lead in a team model to accomplish the required functions of the CMAA and TCM programs. The LGA Coordinators are responsible for organizing these programs at the LGA level and ensuring compliance with the applicable state and federal laws and regulations, even though other LGA staff may perform some duties. Furthermore, it is the LGA Coordinators' responsibility to inform DHCS of programmatic issues or concerns that impact DHCS' administration of the CMAA and TCM programs.

Separately, CMAA and TCM LGAs elect five LGA Coordinators from within the LGA consortium to represent their interests and collaborate with DHCS on both programs.

These five members are known as the LGA Executive Committee (EC). The LGA EC supports LGA Coordinators and program participants with CMAA and TCM program operations and compliance.

i. CMAA and TCM LGA Coordinator Responsibilities

Below are general requirements for CMAA and TCM LGA Coordinators. LGA Coordinators must:

1. Review the following program materials:
    - CMAA/TCM Time Survey Methodology
    - CMAA Operational Plan
    - CMAA and TCM PPLs and related DHCS policies
    - TCM Provider Manual
    - TCM Cost Report Instructions
    - State Plan (Section 4.19, p. 58; Attachment 4.19-B, pp. 5d-5k; Section 3.1, p. 19; Limitations on Attachment 3.1-A, p. 23; and Supplements 1a, 1b, 1d, 1e, and 1f to Attachment 3.1-A.)
2. Regularly communicate with DHCS staff to ensure that the LGA Coordinator roster is current and the CMAA and TCM programs operate timely and efficiently. Additionally, train a successive coordinator(s), when possible.
3. Ensure that all CMAA and TCM program participants receive the mandated time survey training and any additional CMAA and/or TCM training.
4. Communicate with and inform DHCS CMAA/TCM program staff of any programmatic issues or concerns regarding DHCS' administration of the programs.

ii. TCM Specific LGA Coordinator Responsibilities

Per the TCM Provider Manual, CMAA/TCM Time Survey Methodology and State Plan, LGA Coordinators participating in the TCM program must:

1. Ensure each encounter is reviewed for TCM components.
2. Ensure all encounters are entered into the TCM Online System prior to the 12-month from the date of service invoice submission deadline.
3. Ensure encounters are valid prior to billing.
4. Maintain a LGA encounter log and ensure no duplication of encounters.
5. Submit complete and accurate invoices to DHCS with correct signatures per the Signature Authority Form that comply with all applicable TCM program guidance, laws, and regulations.
6. Submit invoices prior to the 12-month invoice submission deadline.
7. Ensure case notes for each encounter are complete and accurate.
8. Ensure all encounter related data is handled in compliance with the Health Insurance Portability and Accountability Act (HIPAA).

9. Continue coordination with Managed Care Plans (MCP) per the LGA/MCP Memorandum of Understanding to ensure non-duplication of services.
10. Review MCP care coordination data received from DHCS to ensure non-duplication of services.
11. Ensure LGA staff are available for desk reviews and site visits, and provide all requested documentation prior to review.
12. Fully implement corrective action plans per DHCS' guidelines.
13. Ensure interim and final reconciliation guidelines are followed.
14. Review TCM case managers' NPIs quarterly to confirm each participant has and maintains a valid NPI.
15. Submit a TCM Cost Report annually by November 1.

LGA Coordinators must ensure they are familiar with all essential functions of the TCM program by undergoing all relevant trainings, and maintaining a working knowledge of the TCM Provider Manual, PPLs, and other related TCM guidance. Failure to meet the abovementioned responsibilities may result in disallowance or recoupment of LGA payments by DHCS.