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State/Territory Name: California

State Plan Amendment (SPA) #: 10-012A

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DEC 2 0 2010

Toby Douglas
Chief Deputy Director
Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) Number 10-012A, effective July 1, 2010. This SPA updates the Developmentally Disabled target group language to align with Federal regulations and allows the provision of targeted case management services to beneficiaries of the Developmentally Disabled target group who reside in facilities designated as Intermediate Care Facilities/Mentally Retarded.

During the review of this SPA, CMS performed an analysis of the coverage and reimbursement provisions. This analysis revealed issues that will require additional information and/or possible revision through a corrective action plan. Under separate cover, CMS will release a letter detailing those issues and providing guidance on timeframes for correction.

If you have any questions, please contact Kristin Curran at (415) 744-3579 or at kristin.curran@cms.hhs.gov.

Sincerely,

[redacted]

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Dina Kokkos-Gonzales, California Department of Health Care Services
Vickie Orlich, CA Department of Health Care Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **10-012A**

2. STATE: **CA**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2010

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Social Security Act 1905(a)(19)
42 USC Section 1396 n(g)/Social Security Act 1915(g)
42 CFR 431.51, 440.169 and 441.18

7. FEDERAL BUDGET IMPACT:
a. FFY 2009-2010 $ 1.5 million
b. FFY 2010-2011 $ 6.0 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Supplement 1 to Attachment 3.1-A, Page ~~1-14~~ 1-7

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Supplement 1 to Attachment 3.1-A, Page ~~1-14~~ 1-7

10. SUBJECT OF AMENDMENT:
Targeted Case Management for the Developmentally Disabled Target Group

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Toby Douglas

14. TITLE:
Chief Deputy Director

15. DATE SUBMITTED: 11/14/10

16. RETURN TO:
Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.3.26
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/30/10

18. DATE APPROVED: DEC 20 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 7/1/10

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted] for

21. TYPED NAME: Gloria Nagle

22. TITLE: Associate Regional Administrator

23. REMARKS:

Pen and ink change made to Box 8 confirmed by email on 12/21/10

Pen and ink change made to Box 9 confirmed by email on 12/21/10

FORM HCFA-179 (07-92)

State Plan under Title XIX of the Social Security Act
State/Territory: CALIFORNIA

TARGETED CASE MANAGEMENT SERVICES

A. Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9))

The target population is composed of those individuals diagnosed with a developmental disability.

"Developmental disability" means a disability which originates before an individual attains age 18, continues, or can be expected to continue indefinitely, and constitutes a substantial disability for such individual. This term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include handicapping conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

B. __X__ Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions (State Medicaid Directors Letter (SMDL), July 25, 2000).

C. Areas of State in which services will be provided (§1915(g)(1) of the Act):
__X__ Entire State
_____ Only in the following geographic areas:

D. Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))
_____ Services are provided in accordance with §1902(a)(10)(B) of the Act.
__X__ Services are not comparable in amount duration and scope (§1915(g)(1)).

E. Background

California's developmental disabilities service system is administered by the Department of Developmental Services (DDS). DDS directly administers four state developmental centers, one smaller state-operated community facility and contracts on an annual basis with 21 boards of directors of private, nonprofit corporations to operate regional centers (case management provider agency). It is through these contracts that DDS ensures program and financial accountability for regional center case management services.

The regional center system is governed by the Lanterman Developmental Disabilities Services Act of 1977 (Lanterman Act) (Division 4.5 of the California Welfare and Institutions Code). Under the Act, DDS is responsible for coordinating the services of many state departments and community agencies to ensure that no gaps occur in communication or the provision of services to persons with developmental disabilities.

The catchment area boundaries for the regional centers conform to county boundaries or groups of counties, except for Los Angeles County which is divided into seven areas, each served by a regional center.

F. Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:
   - taking client history;
   - identifying the individual's needs and completing related documentation; and
   - 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 includes activities that provide data (e.g. client history, needs identification, information obtained from the client, family members, service providers, and educators, if needed) necessary to develop a plan for current and future client services. This involves gathering each client's medical, social, and psychological evaluations and any other evaluations necessary to determine appropriate resources to meet each client's needs and completing a program plan.

In conjunction with the "Monitoring and follow-up activities" described below, assessment information is reviewed, and updated as needed, at least annually. While physical and psychological examinations and evaluations are essential components of case management, these services fall within the scope of regular Medi-Cal benefits. As such, these services will not be billed as Targeted Case Management Services.

2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:
    - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
    - 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.

    An individual program plan (IPP) is developed for each client. This is a process in which goals, objectives and plans are formulated to meet the unique needs of the client. The IPP represents the cooperative effort and agreement of the planning team which is composed of the regional center Client Service Coordinator (CSC), the client and/or legal representative, and other parties involved, as appropriate. The IPP, using the information gained from the assessment of the client's specific capabilities and needs, includes; a statement of goals based on the needs preferences and life choices of the individual; objectives for achieving the stated goals and addressing the client's needs; and a schedule of services and supports to meet the objectives.

3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:
    - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

    This involves the CSC acquainting and educating the client, parent, or legal representative with sources of services in the community and providing procedures for obtaining services through the regional center or other sources. This includes activities, such as making referrals to service providers and scheduling appointments that link the client to providers capable of delivering services identified in the IPP.

4. Monitoring and follow-up activities:
   - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
     i. services are being furnished in accordance with the individual's care plan;
     ii. services in the care plan are adequate; and
     iii. changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

   This includes activities and contacts that are necessary to ensure the IPP is effectively implemented and adequately addresses the needs of the client. The contacts may be with the client, family members, service providers, or others involved in implementing the IPP. At least on an annual basis, the CSC will review client progress in achieving IPP objectives and assess the client's current status. Based on this assessment, the regional center CSC and the client or legal representative shall determine if reasonable progress has been made and shall decide whether current services should be continued, modified, or discontinued. Periodic reviews will be conducted when it is determined that the implementation of the client's IPP needs to be reviewed more frequently than once a year or where state/federal law requires more frequent reviews.

G. __X__ Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

H. Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)): The CSC, employed by the regional center, will be designated as the provider of TCM services. The minimum requirement is either 1) a degree in social sciences or a related field; or 2) case management experience in the developmental disabilities field or a related field which may be substituted for education on a year-for-year basis.

I. Freedom of choice (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

J. Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
__X__ Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

The target group consists of eligible individuals with developmental disabilities, as defined previously. Providers of case management services through this state plan amendment are limited to Client Service Coordinators (CSCs) employed by regional centers. As indicated previously, DDS contracts with 21 boards of directors of private, nonprofit corporations to operate regional centers. Regional centers, as established by the Lanterman Act, provide fixed points of contact in the community for persons with developmental disabilities and their families. Regional centers coordinate and/or provide community-based services to eligible individuals. Due to this service delivery structure, regional center CSCs are uniquely qualified to provide case management services to individuals with developmental disabilities.

Clients requesting case management services may receive these services from the regional center responsible for the catchment area in which the client resides. Catchment area boundaries have been established in order to assure clients access to services within a reasonable distance from their residence. The client's freedom of choice of providers is not, however, restricted to any particular regional center in that the client may seek case management services from any regional center in the state.

The Lanterman Act requires that the performance of the CSC be reviewed at least annually by the regional center, the client, and the client's parents or legal representative. The CSC may not continue to serve as a case manager for the client unless there is agreement by all parties that the CSC should do so.

All parties shall be free to choose whether the CSC's services should be continued, modified, or discontinued. If the client is dissatisfied with a particular CSC, the regional center works with the client and the CSC in an attempt to resolve the problem. If the situation cannot be resolved, the client may transfer to another case manager.

A fair hearing opportunity will be provided in compliance with Chapter 7, Article 3 of the Lanterman Act for beneficiaries who believe they were not given the choice of case management services or who believe they are denied the service of their choice by the regional center.

K. Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.
- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Clients are not required to accept case management services. Should a client refuse to accept these services, this refusal shall not be used as a basis to restrict the client's access to other Medicaid-funded services. Further, the provision of case management services will in no way restrict the individual's free choice of providers of other Medicaid-funded services.

L. Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

M. Case Records (42 CFR 441.18(a)(7)):

Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Regional centers (case management provider agencies) are required to maintain case records for all case management recipients that document the information identified in (i) – (viii) above.

N. Limitations:

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

No additional limitations.