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State/Territory Name: California

State Plan Amendment (SPA) #: 18-036

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

October 18, 2018

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

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-0036, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on August 7, 2018. SPA 18-0036 makes updates to the state plan section describing reimbursement for Targeted Case Management (TCM) services, including incorporating language from the 1995 Medi-Cal Administrative Claiming (MAC) agreement with CMS (then the Health Care Financing Administration) and replacing an outdated reference to the Office of Management & Budget (OMB) A-87 memo with a reference to the current cost principles under Title 2 Code of Federal Regulations (CFR) Part 200.

The MAC agreement language incorporated in the TCM reimbursement methodology references "free care" compliance on page 5d(vii), item 10(b). This language is a direct citation from the 1995 MAC agreement entered by the Department of Health Care Services and Health Care Financing Administration (now CMS). Per State Medicaid Director Letter (SMDL) #14-006, CMS has clarified that Medicaid payment is allowed for any covered services for Medicaid-eligible beneficiaries when delivered by Medicaid-qualified providers, regardless whether the services are available without charge to the community or otherwise known as "free care." CMS is approving SPA 18-0036 with the understanding that "free care" compliance will not result in restrictions of Medicaid payment for any covered services for Medicaid-eligible beneficiaries when delivered by Medicaid-qualified providers, regardless whether the services are available without charge to the community.

The effective date of this SPA is July 1, 2018. Enclosed is the following approved SPA page that should be incorporated into your approved state plan:

- Attachment 4.19-B, pages 5d(ii), 5d(vi), 5d(vii), 5d(viii) and 5d(ix)

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

/s/

Dzung Hoang
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: John Mendoza, DHCS
Shelly Taunk, DHCS
Betty Lai, DHCS
Nathaniel Emery, DHCS
Angeli Lee, DHCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 0036

2. STATE: California

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2018

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
Section 1915(g)(1) Social Security Act
42 CFR 447, Subpart F

7. FEDERAL BUDGET IMPACT
a. FFY 2017/18 $ 0
b. FFY 2018/19 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-B Page 5d (ii), 5d(vi), 5d(vii), 5d(viii) & 5d(ix).

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-B Page 5d (ii) & 5d(vi)

10. SUBJECT OF AMENDMENT
Removing the Medi-Cal Administrative Claiming (MAC) Agreement reference and also updating the Office of Management and Budget (OMB) A-87 to Title 2 Code of Federal Regulations (CFR) Part 200 reference.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
August 7, 2018

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
August 7, 2018

18. DATE APPROVED
October 18, 2018

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/s/

21. TYPED NAME
Dzung Hoang

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

For Box 11 "OTHER, As Specified" : Please note: The Governor's Office does not wish to review the State Plan Amendment.
Box 2: CMS corrected DHCS typo using redaction function on 10/18/18.
Box 6: CMS added regulatory citation per CMS email dated 10/12/18.
Box 8: CMS added new pages per DHCS email dated 10/4/18.
Box 9: CMS added add'l superseded page on 10/18/18.

Instructions on Back

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

TARGETED CASE MANAGEMENT REIMBURSEMENT METHODOLOGY
Reimbursement methodology for Case Management Services as described in Supplement 1a, 1b, 1d, 1e, 1f, and 1h to Attachment 3.1-A

B. Cost-Based Reimbursement Methodology

(1) LGAs will be reimbursed for their allowable costs incurred from providing TCM services rendered to target populations. Allowable costs will be determined in accordance with applicable cost-based reimbursement requirements set forth below or otherwise approved by CMS. The allowable costs will be certified as public expenditures (CPEs).

(2) Allowable costs will be determined in accordance with all of the following: (a) the reimbursement methodology for cost-based entities outlined in 42 CFR Part 413; (b) the Provider Reimbursement Manual (CMS Pub. 15-1); (c) 2 CFR, Part 200 as implemented by HHS at 45 CFR, Part 75; (d) Section G below regarding TCM Rate Content; (e) California Welfare and Institutions (W&I) Code; (f) State issued policy directives, including Policy and Procedure Letters; and (g) all applicable federal and State directives as periodically amended, which establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medi-Cal program, except as expressly modified herein.

(3) In calculating CPEs or in performing any reconciliation required by this segment of the State Medicaid Plan, any payments made by or on behalf of a Medi-Cal beneficiary for services reimbursed under this segment of the State Medicaid Plan will be used to reduce the amount submitted for purposes of federal reimbursement.

C. Certified Public Expenditure Protocol

(1) Interim rate establishment & Interim payment

(a) The purpose of an interim payment is to provide a per encounter interim payment that will approximate the Medi-Cal TCM program

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F. Department Responsibilities

(1) DHCS will submit claims for FFP for the expenditures as specified in this segment of the State Plan for TCM services provided to target populations as allowable under federal law.

(2) DHCS will, on an annual basis, submit any necessary materials to the federal government to provide assurances that claims for FFP will include only those expenditures that are allowable under federal law.

(3) DHCS has in place a public process, which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

(4) DHCS will audit and settle the cost reports filed by the LGA in determining the actual Medi-Cal expenditures eligible for reimbursement.

G. TCM Rate Contents

For purposes of clarifying the claiming of various costs, the costs of performing the following activities are included in the TCM service rate:

(1) Staffing cases through team meetings and interagency coordination time;

(2) Case manager travel time and costs when performing TCM duties;

(3) Case manager time to arrange client transportation and appointments;

(4) Preparing/documenting case records;

(5) Arranging for translation activities and/or providing translation as part of the TCM service, including the costs of purchasing translation services from a vendor to enable communication between the client and case manager. When a case manager provides translation that is unrelated to providing the TCM service, the translation is not claimable as TCM.

(6) Supervision of case managers;

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(7) Case manager non-SPMP training;

(8) TCM subcontract administration when performed by an identifiable unit or one or more employees not otherwise claimed or funded through established rates or other programs, to:

(a) Identify and recruit community agencies as TCM contract providers;

(b) Develop and negotiate TCM provider subcontractor performance to ensure appropriate delivery of TCM services to eligible beneficiaries;

(c) Monitor TCM provider subcontracts to ensure compliance with Medi-Cal regulations;

(d) Provide technical assistance to TCM subcontractors regarding county, Federal, and State regulations;

(9) TCM data systems and claiming coordination, including:

(a) Input of Medi-Cal data from the Encounter Log into the data collection system;

(b) Reconciliation of TCM Medi-Cal encounter claims reported as rejected by the State;

(c) Maintaining and analyzing Medi-Cal TCM management information systems; and

(d) Preparing, reviewing, and revising TCM claims.

(10) TCM quality assurance/performance monitoring, including:

(a) TCM case documentation compliance;

(b) TCM "free care" and TPL compliance;

(c) Preventing duplication of services and ensuring continuity of care when a Medi-Cal recipient receives TCM services from two or more programs; and

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(d) Monitoring Medi-Cal TCM provider agency capacity and availability.

Activities "8", "9" and "10" cannot be performed by a case manager or other service provider.

(11) TCM program planning and policy development, including:

(a) Planning to increase TCM system capacity and close gaps;

(b) lnteragency coordination to improve TCM service delivery;

(c) Developing policies and protocols for TCM; and

(d) Developing TCM resource directories.

(12) County Overhead, which includes:

(a) Operating expenses and equipment;

(b) Accounting;

(c) Budgets;

(d) Personnel;

(e) Business Services;

(f) Clerical Support;

(g) Management; and

(h) County Indirect Costs

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

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

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activities on the CMAA detailed invoice as a direct charge. Cost incurred in the preparation and submission of CMAA claims at any level, including staff time, supplies, and computer time, may be direct charged on the CMAA invoice. If the CMAA/TCM Coordinator and/or claims administration staff are performing this function part-time, along with other duties, they must certify the percentage of total time spent performing each of the activities. The percentage certified for the CMAA/TCM Coordinator and/or claims administration staff activities will be used as the basis for federal claiming.

The CMAA/TCM Coordinator and claims administration staff may claim the costs of the following activities, as well as any other reasonable activities directly related to the LGA's administration of TCM services and CMAA at the LGA-wide level:

(a) Drafting, revising, and submitting CMAA Claiming Plans, and TCM performance monitoring plans.

(b) Serving as liaison with and monitoring the performance of claiming programs within the LGA and with the State and Federal Governments on CMAA and TCM.

(c) Administering LGA claiming, including overseeing, preparing, compiling, revising and submitting CMAA and TCM invoices on an LGA-wide basis to the State.

(d) Attending training sessions, meetings, and conferences involving CMAA and/or TCM.

(e) Training LGA program and subcontractor staff on State, Federal, and Local requirements for CMAA and/or TCM claiming.

(f) Ensuring that CMAA and/or TCM invoices do not duplicate Medi-Cal invoices for the same services or activities from other providers. This includes ensuring that services are not duplicated when a Medi-Cal beneficiary receives TCM services from more than one case manager.

The costs of the CMAA/TCM Coordinator's time and claims administration staff time must not be included in the CMAA claiming or in the TCM rate, since the costs associated with the time are to be direct charged on the CMAA invoice. The costs of TCM claiming activity at the TCM provider level are to be included in the TCM rate.