

ATTACHMENT 5

ALLOWABILITY OF COST CATEGORIES--RESOLUTION PERIOD

Key principles in determining the allowability of, and making payments for, costs as Medi-Cal administrative activities according to HCFA interpretations are:

1. The activities must be necessary for the proper and efficient administration of the State Plan;
2. The activities must be performed with respect to medical assistance services in the State plan, a Medi-Cal waiver, or expanded early and periodic screening, diagnostic and treatment services (EPSDT);
3. The activities must be performed with respect to Medi-Cal eligible individuals;
4. Those activities related to eligibility outreach and intake may be performed for all persons potentially eligible for Medi-Cal. Activities related to facilitating access to services, however, may only be claimed as administrative costs for persons determined to be eligible. Once these individuals are determined eligible, activities related to facilitating access to Medi-Cal services are allowable;
5. Only those portions of allowable activities specifically related to the Medi-Cal program, as indicated in the previous points, are allowable.

The following clarify a number of issues only for the purposes of resolving the retroactive MAC claims through this resolution process. The following clarifications relate specifically to the Medi-Cal program, the retroactive MAC claims, and the resolution process. They are not intended to set precedent for any other claims or issues, past, present or future, Medi-Cal or otherwise.

Eligibility Intake--Medi-Cal eligibility intake, an allowable administrative activity, is defined as taking a Medi-Cal application and gathering information related to the application and eligibility determination from a client, including resource information and third party liability information, as a prelude to submitting a formal Medi-Cal application to the county welfare department. If translation is part of the intake activity, the actual costs paid for translation services may be claimed as eligibility intake or separately as translation, but not both. In either case, the costs are allowable administrative costs of the Medicaid program.

Prior Authorization--Prior authorization of certain Medi-Cal services for Medi-Cal eligibles, a traditionally allowable administrative activity known as approval of Treatment Authorization Requests (TARs) in the State of California, is a legally required and binding pre-requisite to the State's payment for those medical services and is generally performed by the State. However, in certain local jurisdictions the prior authorization (or TARs) function has been delegated by the State Medi-Cal program to public entities and may be allowable, if not already otherwise paid for through some other source. The State will provide acceptable written agreements for any local TAR activity to HCFA for HCFA's review and determination of appropriate payment, if any.

Translation—Translation services may be allowable either as part of a medical assistance service, or as a separate administrative activity. Where the medical assistance provider receives a rate for a medical service, translation by facility employees who are performing a billable Medi-Cal service which is contemporaneous with receipt of that service is considered by HCFA to be included in the rate for that service. In that case, costs of the translation activities cannot be unbundled and claimed again as Medi-Cal administration.

Translation may be allowable as an administrative activity, if it is not included and paid for as part of a medical assistance service. However, it must be provided by separate units or by separate employees performing solely translation functions for a health facility, such as at Highland Hospital in Alameda County, and it must facilitate access to Medi-Cal services. The State will provide documentation acceptable to HCFA for review and determination that the translation unit's activity is not already included in the medical services rates, as applicable.

Administrative Case Management (ACM)—Case management is only allowable as an administrative activity, according to HCFA's interpretation, when it involves the facilitation of access and coordination for a Medi-Cal eligible client for services which are covered under the State's approved Medi-Cal Plan. To assure that ACM activities being performed are allowable, that is, that they are being performed with respect to facilitating access to Medi-Cal services, a complete list of Medi-Cal State Plan covered services for the period of the retroactive MAC claim was distributed to each program or claiming unit in an LGA participating in MAC claiming for the purposes of implementing this resolution process.

However, in designing the surveys to make them unbiased and readily understandable to employees, HCFA and the State agreed that the words "medical services" will be a surrogate for "Medi-Cal services" as the scope of coverage of the State Plan is broad enough to encompass all direct medical services. Likewise, by applying the Medi-Cal percentage as determined in Section I-Step 3 above in discounting reported costs as described in Section I-Step 4 above, the State is assuring that the facilitation of access and coordination of these services is to a Medi-Cal eligible client. (NOTE: It is the position of the State, which HCFA does not agree with, that the scope of allowable Medi-Cal administrative case management is broader than HCFA's definition.)

Referral and Follow-up—Referral of Medi-Cal eligibles to Medi-Cal services and follow-up are allowable administrative activities so long as they are not performed in connection with a medical visit. This means that this activity when performed by nurses and others in the clinic setting incident to a medical encounter were not allowable as Medi-Cal administrative costs for the purposes of resolving these claims.

Referral and follow-up for medical services are allowable administrative activities which are part of case management when performed by staff who are not in a setting where there is a billable Medi-Cal rate. For example, the referral and follow-up activities of public health field nurses performed for clients with regard to medical issues would be allowable Medi-Cal administrative case management activities except for referral services provided as part of investigating and tracking communicable diseases.

Outreach--Outreach is traditionally an allowable Medicaid administrative function. However, according to HCFA, the only allowable outreach for purposes of Medi-Cal administrative claiming is to groups or individuals targeted to two goals:

- (1) bringing potential eligibles into the Medi-Cal system for the purpose of determining Medi-Cal eligibility; and
- (2) bringing Medi-Cal eligible people into Medi-Cal services.

Outreach campaigns directed to the entire population to encourage potential Medi-Cal eligibles to apply for Medi-Cal are allowable and the costs do not have to be discounted by the Medi-Cal percentage. Similarly, outreach campaigns directed toward bringing Medi-Cal eligibles into Medi-Cal covered services are allowable and the costs do not have to be discounted by the Medi-Cal percentage.

Outreach campaigns directed toward bringing specific populations, for example, pregnant women or substance abusers, into services, are only allowable to the extent they bring Medi-Cal eligibles into Medi-Cal covered services. The cost of these activities are allowable, but discounted by the Medi-Cal percentage.

Outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medi-Cal are not allowable.

Health Education--(1) General preventive health education programs or lifestyle campaigns addressed to the general population (e.g. SANE, DARE, dental prevention, anti-smoking, alcohol reduction, etc.) are not allowable Medi-Cal administrative activities, according to HCFA. However, a health education program or campaign may be allowable as an administrative cost if it is targeted specifically to Medicaid services and for Medi-Cal eligible individuals. Additionally, if a specific Medi-Cal health education program is included as part of a broader general health education program, the Medicaid portion may be allowable if the general health education program is pro-rated according to the Medi-Cal percentage. (2) General health education is not allowable as part of a clinic service. In a clinic setting, if the health education occurs with individual patients incident to the nature of the clinic visit, according to HCFA, it is not separately claimable as an administrative activity, but is considered to be reimbursed as part of the clinic service rate.

Non-Emergency Non-Medical Transportation--California pays for emergency medical transportation for Medi-Cal eligibles as a Medi-Cal service. California also pays for non-emergency medical transportation by ambulance, litter van, and wheelchair van, when supported by a TAR, as a Medi-Cal service. Neither of these forms of medical transportation are claimable as Medi-Cal administration.

However, California must also assure access to Medi-Cal services for Medi-Cal eligibles, in accordance with 42 CFR 431.53, by providing what California calls non-emergency "non-medical" transportation. California refers to this transportation as "non-medical" even though the transportation is for Medi-Cal eligibles to Medi-Cal covered medical services. California has historically relied on the local jurisdictions and local non-profit agencies (e.g.

Easter Seals) to arrange for and/or provide this non-emergency "non-medical" transportation of Medi-Cal eligibles to Medi-Cal services by such means as private/public vehicles, bus, light rail, etc.

The actual costs of arranging and providing this non-emergency "non-medical" transportation of Medi-Cal eligibles to Medi-Cal services is allowable as a Medi-Cal administrative cost to the extent that such costs are actually borne by the local jurisdiction. The costs of arranging and providing for non-emergency "non-medical" transportation for which no actual cost is borne by the State or local jurisdiction is not an allowable Medi-Cal administrative cost.

Directly Observed Therapy—Directly observed therapy (DOT) is a medical service, if provided for in the approved State plan, and not Medi-Cal administration. However, California has submitted a Medicaid State plan amendment to include directly observed therapy (DOT) for tuberculosis (TB) as a medical service with a proposed effective date of October 1, 1994. The HCFA Regional Office is currently awaiting further information from the State on this State plan amendment. Therefore, when the State plan amendment is approved, DOT may be claimed as a medical service as of the effective date of the State plan amendment. DOT applies to a medical professional observing a Medi-Cal eligible individual taking a prescribed regimen of TB medication. Since the activity is considered part of a service, not an administrative cost, the activity only may be claimed under TB Services, which is a State Plan covered service.

Inter-agency Coordination/Development of County-wide Initiatives—Inter-agency coordination and development of county-wide health initiatives may be allowable as administrative activities, so long as the coordination and services involve Medi-Cal services for Medi-Cal eligible individuals. The costs of this activity will be pro-rated according to the Medi-Cal percentage in the county, i.e., the county-wide average. The up-front development costs of local managed care initiatives are not allowable under this resolution process as \$10 million has already been allocated to this initiative for these development costs.

Provider Coordination—Provider coordination is an allowable administrative activity, so long as the providers are Medi-Cal providers.

Information and Referral—Information and referral may be an allowable administrative activity so long as the encounters are with Medi-Cal eligible individuals and involves discussion of Medi-Cal issues and the referrals relate to Medi-Cal services. For example, the part of the telephone encounter on a suicide prevention hotline provided by the county which involves the personal problems of the caller would not be allowable, while the time spent in facilitating access and making referrals for a Medi-Cal eligible individual to Medi-Cal mental health counseling/facilities would be allowable, according to HCFA. Discounting costs by the Medi-Cal percentage is a surrogate for ensuring the Medi-Cal status of callers.

Inmates of Public Institutions—Medical assistance services provided to inmates of public institutions are not eligible for Medicaid payment. However, Medi-Cal eligibility intake administrative activities provided to such inmates may be allowable under certain limited

circumstances. For example, an eligibility intake process has been established for inmates by their home counties in the month of their release in order to facilitate transition to Medi-Cal services in their communities. This Medi-Cal eligibility intake activity is allowable. No other administrative activities or direct Medi-Cal services are allowable for inmates of public institutions.

Public Guardians—The activities of public guardians are allowable administrative activities if they involve case management of Medi-Cal services and Medi-Cal eligibility intake for clients. The coordination and provision of legal, financial, and property management services by the public guardian's office are not allowable.

SSI Advocacy—The costs of SSI advocacy are not allowable as Medi-Cal administration.

Administrative Case Management (ACM) in Institutions for Mental Diseases (IMD)—In California individuals can be legally detained without cause for a 72-hour assessment period in an IMD facility observation unit. If a Medi-Cal eligible individual stays in an IMD facility observation unit for less than 24 hours, the service costs may be claimed as medical assistance costs. However, if the individual remains in the IMD facility for 24 hours or more, the individual is considered to be an inpatient institutionalized in an IMD for purposes of Federal regulations at 42 CFR 441.13, for the entire length of stay.

Since by law, no Medicaid payment may be made for individuals who are inpatients institutionalized in IMDs, no payment may be made for any part of the stay in an IMD for any individuals who stay in an IMD for 24 hours or more.

Short-Doyle Mental Health—Payments for claims under this resolution process must not duplicate payments for activities and services payable under the "Short-Doyle" Medi-Cal mental health program.

San Diego County ceased billing for Short-Doyle Medi-Cal mental health services and opted to claim administratively under MAC for activities which might have been claimed under Short-Doyle Medi-Cal. San Diego County will be allowed in the resolution process to claim legitimate allowable administrative costs which might have been, but were not claimed under Short-Doyle Medi-Cal.

Capitated Counties—Payments for claims for administrative activities and medical assistance services must not duplicate administrative activities and services which are paid for under a capitation rate. This is especially significant in counties that have county-wide Medi-Cal managed care programs.

As the State has made assurances and submitted documentary evidence of non-duplication of payment during the resolution period, HCFA agrees to pay counties with managed care programs according to the procedures detailed in this Agreement for resolving MAC claims. To ensure that such duplication does not occur in the future, particularly with the expansion of county-wide Medi-Cal managed care programs, the State agrees to incorporate non-duplication language into existing and future Medi-Cal managed care agreements. This language would exclude targeted case management provided

under the State Plan Amendments referenced in this agreement from the range of services to be covered by managed care plans and would require coordination between managed care plans and providers of TCM services under the approved TCM State Plan Amendments.

Public Health Programs/Claiming Units for Which Activities 11 and 12 Are Not Allowable—Activities 11 and 12 under the Public Health Program, indicated below, are generally considered approvable Medi-Cal activities. However in health education claiming units, activities 11 and 12 are NOT allowable, since general preventive public health education services performed by these programs are not allowable as administration of the Medi-Cal program.

Activities 11 and 12 are as follows:

11. Teach and counsel individuals and families regarding specific diseases or health conditions including the identification of health problems, conditions, and injuries that require medical intervention.
12. Provide information to individuals and/or their caretakers about normal development of children, ways to enhance normal development and about the importance of preventive health practices such as immunizations.

Activities 11 and 12 are NOT allowable with respect to the following local jurisdictions and/or claiming units:

PROGRAM: PUBLIC HEALTH - SKILLED PROFESSIONAL MEDICAL PERSONNEL (SPMP)

Programs/Claiming Units for which SPMP activities 11/12 are not allowable:

Alameda - Dental Disease Prevention
Alameda - School Based Tobacco
Alameda - Tobacco Control
Alameda - Pregnancy Prevention
San Francisco - Health Education
San Mateo - Public Health Education

PROGRAM: PUBLIC HEALTH - NON-SKILLED PROFESSIONAL MEDICAL PERSONNEL (NON-SPMP)

Programs/Claiming Units for which activities 11/12 are not allowable:

Alameda - Dental Disease Prevention
Alameda - School Based Tobacco
Alameda - PEAS Injury Prevention
Alameda - Tobacco Control

Alameda - American Lung Association
Alameda - Girls Inc.
Alameda - Road
San Francisco - Health Education
San Mateo - Public Health Education

Public Health Programs/Claiming Units Which are Not Allowable--HCFA and the State agree that the following Public Health programs/claiming units in their entirety are not allowable, as the activities performed under these programs/claiming units are not related to the administration of the Medi-Cal program.

PROGRAM: PUBLIC HEALTH - SKILLED PROFESSIONAL MEDICAL PERSONNEL (SPMP)

Programs/Claiming Units for which the SPMP Public Health Program is not allowable:

San Diego - EMS
Santa Cruz - EMS

PROGRAM: PUBLIC HEALTH - NON-SKILLED PROFESSIONAL MEDICAL PERSONNEL (NON-SPMP)

Programs/Claiming Units for which the Non-SPMP Public Health Program is not allowable:

Alameda - EMS Injury Prevention
Alameda - Information Systems
San Diego - EMS
Santa Cruz - Sheriff's Office
Santa Cruz - Fenix Services Incorporated (Note, Fenix Services Incorporated's public health claim has been withdrawn and the LGA intends to resubmit the claim as a drug and alcohol claiming unit).

Drug and Alcohol Programs--Drug and Alcohol Program claiming units may not submit claims for the resolution period or the transition period until; (1) the State submits a claiming proposal for claiming Drug and Alcohol Programs and such proposal is approved by HCFA, (2) the State and HCFA agree on an activity survey form for such programs and, (3) the results of such activity surveys are compiled and tabulated by the State and approved by HCFA.

ATTACHMENT 6



HEALTH CARE FINANCING ADMINISTRATION
Medicaid Bureau—Office of Financial Services

July 26, 1995

Ms. Roberta Ward
Staff Counsel
Department of Health Services
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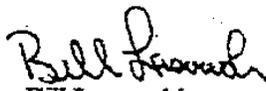
Dear Roberta:

We have reviewed your July 19, 1995 proposal for mental health administrative claiming and we approve the proposal as modified by your letter. This approval is contingent upon each mental health claiming unit including a comprehensive Medi-Cal administrative mental health claiming plan as part of the LGA comprehensive Medi-Cal administrative claiming plan being submitted for State and HCFA approval.

Additionally, whenever a mental health claiming unit intends to claim at the enhanced skilled professional medical personnel (SPMP) matching rate of 75 percent, the claiming plan must specifically explain how the personnel and activities meet the requirements of 42 CFR 432.50 applicable to SPMP.

Please give me a call on 410-786-2003 if you have any questions.

Sincerely,


Bill Lasowski
Director

cc:
Donna Eden
Tom Coupar
Richard Iniguez
Terry Jordan

DEPARTMENT OF HEALTH SERVICES

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July 19, 1995

William Lasowski, Director
Division of Financial Management
Health Care Financing Administration
Room 281 EHR
P.O. Box 26678
Baltimore, Maryland 21207-0278

Dear Bill:

On June 13, 1995, I sent you for review and approval the enclosed proposal for Medi-Cal administrative claiming for mental health for the period after June 30, 1995.

Since that time, we have had several conversations regarding the mental health administrative claiming proposal. In addition, the definitions of allowable Medi-Cal administrative claiming categories have been clarified. As we have not received a written response to the proposal for administrative claiming for mental health, I am summarizing below my understanding of what the Health Care Financing Administration (HCFA) considers approvable.

The "Proposed Format for MAC Mode and Service Function Codes" includes four service function codes which represent allowable Medi-Cal administrative activities. As you represented to me, HCFA will not accept the "extended outreach" category under service function code 01, because this is a non-discounted category. Rather, HCFA would like these activities listed under discounted service function codes. My proposal is to include "gathering information about an individual's health and mental health needs" and "assisting individuals to access Medi-Cal covered physical health and mental health services by providing referrals, follow-up, and arranging transportation for mental health care" when provided to non-open cases, in service function code 03, if performed by a SPMP, and in service function code 04, if provided by a non-SPMP. Both of these codes are discounted by the Medi-Cal percentage.

Based on the detailed description of allowable SPMP training which you developed for the document on residual administrative claiming, I believe that the description of training in service function code 03 must be changed, as follows: "SPMP training, given or received, which improves the skill levels of SPMP staff members in performing allowable SPMP administrative activities, specifically program planning and development and case management of non-open cases." Clinical training, given or received, should be deleted from service function code 04, and instead, general training should be included under general administration for cost allocation.

William Lasowski, Director
Page 2
July 19, 1995

I would appreciate your informing me as soon as possible if HCFA is in agreement with the service function codes, as revised above. County mental health staff need to begin recording time under these categories immediately, as the administrative claiming system under the resolution and transition periods has lapsed.

Sincerely,

Roberta M. Ward

Roberta M. Ward
Staff Counsel

Enclosures

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COUNTY OF SANTA CRUZ

HEALTH SERVICES AGENCY COMMUNITY MENTAL HEALTH

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June 12, 1995

Roberta Ward
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Dear Roberta,

I am writing on behalf of the California Mental Health Directors Association (CMDA) to confirm the agreement which was reached, Thursday, June 8th, with Health Care Financing Administration (HCFA), California Department of Health Services (CDHS), and the California Department of Mental Health (CDMH), regarding continued claiming of certain Medi-Cal administrative costs (formerly known as MAC), by public mental health agencies.

The following is an outline of the agreement:

- 1) Effective July 1, 1995, Medi-Cal administrative activities will be added to the existing Short-Doyle Medi-Cal program.
- 2) The Medi-Cal administrative activities to be claimed are:

Eligibility Intake (No discount, 50% FFP)
Referral in Crisis Situations (M/C discount, 50% FFP)
Extended Medi-Cal Outreach (No discount, 50% FFP)
Medi-Cal Contract Administration (No discount, 50% FFP)
Program Planning/Development (M/C discount, 50% & 75% FFP)
Clinical Training (M/C discount, 50% & 75% FFP)

This list includes the allowable activities from the Mental Health Retroactive Resolution Survey, with the exception of Case Management of Medi-Cal Covered Services - Non-Open Cases. As discussed at the June 8th meeting, many of the functions which had been included under this category on the Survey are more appropriately included in "Extended Medi-Cal Outreach".

- 3) A computer assisted direct time recording system will be used to

capture the actual costs of performing Medi-Cal administrative activities and all other direct and indirect functions. Under this system, staff will be required to account for 100% of their time in one minute increments.

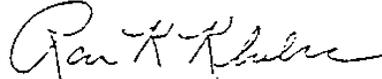
- 4) Federal Financial Participation (FFP) will be claimed on an actual cost reimbursement basis using the methodology which is currently used for Short-Doyle/Medi-Cal Quality Assurance claiming. This methodology includes a provision for discounting the actual costs by the agency Medi-Cal percentage where, applicable.

Attached is a revised version of the Discussion Paper describing the mental health plan, which was distributed June 1st. The paper has been revised to further clarify the plan as well as to reflect modifications suggested during the June 8th meeting. It is my understanding that Bill Lasowski plans to obtain final ECFA approval of the proposed allowable administrative activities listed above, by June 15th. At that time it is our intention to proceed with development of the necessary infrastructure and procedures to implement the plan.

With regard to the Transition Period (January 1, 1995 through June 30, 1995), it is our understanding that local jurisdictions will be permitted to submit MAC invoices using the claiming percentages which were approved for the Retroactive Resolution Process. In the case of Mental Health, there will be no splitting of the survey percentaged into targeted case management and administrative costs categories; the entire allowable percentage will be claimed as administrative costs.

If you have any questions, please contact:
Linda Powell (DME) or Stan Johnson (DMH) at 916-634-3060

Sincerely,



Rama Khalsa, Ph.D
Mental Health Director

Rk:tm
Attachments

cc: Richard Iniguez, Chief, Medical Services Section, Medi-Cal Policy Division, CDHS
Linda Powell, Deputy Director Administrative Services, CDMH
Cathleen Gentry, MAC Host County Liaison

STAFF RECOMMENDATION

AMEND STATE PLAN FOR MEDICAL MENTAL HEALTH SERVICES TO CHANGE MAC TO A DIRECTLY CLAIMED SERVICE ACTIVITY

Background

Senate Bill 910 enabled California local governing agencies to request Federal reimbursement for certain Medi-Cal Administrative costs, effective July 1, 1992. This reimbursement process later became known as Medi-Cal Administrative Claiming (MAC).

A MAC claiming plan was developed and implemented statewide; however, on March 1, 1995 the Federal government denied all submitted claims.

Effective January 1, 1995 Federal reimbursement will be limited to certain activities detailed under Targeted Case Management (TCM) and allowable administrative activities (MAC). County Mental Health programs were already claiming for case management through an existing state plan amendment for TCM. County Mental Health programs had been claiming for the administrative activities using the processes required by DHS. County programs working with DMH and DHS recommend utilizing the existing computer tracking structure and cost report methodology to claim for the administrative activities as described below from July 1, 1995 onward.

Recommendation

Define specific units for MAC as outlined in Attachment I and assign unique Mode and Service Function Codes (SFC) to them. Develop a direct time-based, computerized claiming system for the allowable service components. Enter the units of time for appropriate services into the County Mental Health computer system as required by the State for client data system (CDS) reporting and the CRDC cost report.

Invoice total monthly MAC units (minutes) of service in the manner presently used to bill the SD/MC Utilization Review costs. A MH 1982 D form would be developed to accommodate this methodology.

Discussion

County Mental Health programs did not bill for case management through the MAC process as they already have a targeted case management plan amendment and claim process. The existing data system bills for all allowable case management activities on open cases with current MediCal benefits.

Other activities associated with MediCal administration cannot however be claimed through the current TCM plan (benefits intake, evaluation and assistance; outreach/intensive informing, crisis evaluation and referral to MediCal services for non-open cases, MediCal contract administration, clinical training for MediCal services, and program planning for MediCal services. These MAC

activities can be identified and tracked in Mode 50, a component of the existing computer architecture which is no longer being used. Program and client activities in Mental Health are tracked by service "mode" or type and service function (for each specific service).

When the Federal government issued its denial of all MAC claims in March 1995, one of their concerns regarded the inability of the time study tool to effectively separate all claimable activity from non-claimable activity. The Federal concern was that a number of the activity codes were too broad in scope. They subsequently agreed to a replacement activity list for mental health activities. That list includes:

1. Three activities that are reimbursable at full non-enhanced (50% FFP/50% match) rate;
2. One activity that is reimbursable at the non-enhanced rate (50% FFP/50% match) and is discounted on a pro rata basis linked to the percentage of Medi-Cal eligible clients;
3. Three activities that are reimbursable at either the non-enhanced rate (50% FFP/50% match) for non-SPMP staff or at the enhanced rate (75% FFP/25% match) for SPMP staff, and which are also discounted on a pro rata basis linked to the percentage of Medi-Cal eligible clients;
4. Three administrative activities that are reimbursable on a pro rata basis linked to both the Medi-Cal eligible percentage and the percentage of MAC activities to total non-administrative activities; and,
5. Non-claimable activities.

Attachment 1 shows the activities and proposed computer structure for future claiming for the first four categories.

The activities in the first category above are not discounted by the Medi-Cal eligibility percentage and are only reimbursable at the non-enhanced 50% FFP rate. These activities must be individually identified and documented based on staff time by service function code. A monthly claiming process must be established, based upon verifiable cost data similar to the existing Utilization Review claim for Short-Doyie MediCal.

The one activity in the second category above is discounted by the Medi-Cal eligibility percentage and is only reimbursable at the non-enhanced 50% FFP rate. This activity must be individually identified and documented. A claim must be developed, based upon verifiable cost data and activity data.

The activities in the third category above are reimbursable on a pro rata basis discounted by the Medi-Cal eligible percentage of the client base. These activities are eligible for enhanced 75% reimbursement when performed by SPMP qualified staff. Non-SPMP staff will be reimbursed at the non-enhanced 50% rate. These activities must be individually identified and documented. A claim must be developed based upon verifiable cost data. The percentage of the provider's units which are paid by MediCal as a function of the total units must be developed.

The activities in the fourth category above are partially reimbursable, however claiming them individually is not practical. The documentation requirements alone would be daunting. Claiming the activities in this category require the provider to meet all the conditions of the second category, described above, as well as development of a verifiable mechanism to

determine what percentage of each staff's time is spent in all three categories. This mechanism is likely to be some form of time study or staff survey. A more practical solution is to identify the costs associated with these activities and incorporate those costs into the rates for category one and two activities. This eliminates the need to track category three activities while still allowing for recovery of the associated costs. If necessary an annual staff survey or time study may be accomplished to support the distribution of costs, although the annual SD/MC cost report should be sufficient.

Adoption of a unit of time direct claiming system for all appropriate personnel to claim Federal reimbursement of direct clinical services and the MAC services will resolve many of the Federal and State concerns as to the validity of the claiming process. The MAC claiming process originally implemented was not readily understood, which probably contributed to the level of scrutiny and the eventual denial of the claims. Direct claiming for clinical services and MAC is consistent with the claiming methodology for Medi-Cal and Medicare, raising the level of understanding and the verifiability of the claims, with a corresponding increase in comfort level for all involved parties. The existing computer and cost report system can track all staff time by minutes of service or activity.

Required Elements:

The MAC Documentation Form

Forms already exist in all County Mental Health program to claim for all direct service activities and time. These forms will be changed to add on the specific service functions for Medi-Cal administrative activities as identified on Attachment 1. This form will be input into the computer system for cost reports and claims. This form would double as an input document for counties who claim Medi-Cal electronically. Some of the elements that would be required to be added on this form are:

1. The identity of the staff member providing the direct service or MAC activity.
2. Date and time when activity was performed.
3. Length of time in actual minutes spent performing the activity.
4. The specific direct service or MAC activity which was being performed, the Mode and SFC for that activity, and the activity code.

(Additional information on the form should provide staff with instructions for completing the form, and clearly identify whether an activity was claimable by SPMP staff only, or was claimable by SPMP and non-SPMP staff both, and include a table showing the complete list of approved direct service and MAC activities with the correct definitions, codes, Modes, and SFC.)

The Monthly Claiming Format

Replace the present quarterly MAC claiming format with a monthly direct claim format similar to the 1982 form used by the State Department of Mental Health for Utilization Review. Bill monthly using the computer assisted direct time recording system based on verifiable costs. These costs will also

be included in a specific section of the CRDC cost report to reconfirm the actual costs for the program

Using this proposed mechanism, MAC could be claimed monthly by including it with the Department of Mental Health (SDMH) MH 1982 series of forms, as revised November 1994 (refer to SDMH Letter 94-20) to include separate forms for Treatment (MH 1982 A), Administrative Costs (MH 1982 B), and Quality Assurance (MH 1982 C). MAC could be billed using a newly developed form MH 1982 D.

Billing may be accomplished electronically or manually, upon the claimant's preference, subject to the use of sound generally accepted accounting principles. Enhanced reimbursement verification for SPMP staff may be also be conducted in an electronic or manual format, as preferred by the claimant agency. However, hard copy documentation of the actual delivery of each claimed activity (MAC form and SPMP licensure) will be required to be available for audit purposes.

Claim Reimbursement Determination

As stated previously, costs and rates per minute for direct services and MAC activities must be verifiable. The best available tool for developing these rates is the SD/MC cost report, as it is designed to ensure there is no occurrence of double-reporting costs. Prevention of potential double-reporting of costs has been a principal theme in all Federal reviews of the present MAC process. MAC is certain to be closely reviewed in this area, and counties need to be very proactive in ensuring that the claim development process is clear and auditable.

Assigned Mode and Service Function Codes

Incorporating MAC into the Short-Doyie MediCal claim and cost report system will require assigning unique Mode and SFC to the reimbursable activities. Attachment 1 shows a proposed format discussed and revised in our June 8th meeting. This was subject to final approval from HCFA in Baltimore for some of the specific activities. For purposes of illustration, we have chosen to use Mode 50 for MAC. This was done because Mode 50 has been used in the past to claim SD/MC reimbursement but is not currently in use. The State may wish to develop a new Mode or expand existing SFC's in another Mode to accommodate MAC claim process. For consistency with our other direct claiming activities, we recommend using minutes as the claiming unit.

SPMP Determination

The SPMP determination process as it presently exists is administratively cumbersome and an area of potential audit concern. It is also duplicative effort in that staff licensure information is available through their personnel files. We recommend that it be replaced with the requirement that SPMP staff must be California licensed psychiatrists, physicians, psychologists, registered nurses, licensed clinical social workers with an Masters in Social Work (MSW), or staff who are Marriage, Family and Child Counselors (MFCC). This requirement is slightly more restrictive than the existing SPMP standard, but the required data is readily available for audit review in personnel records.

Contract Provider Participation

Because California Health Care systems are large and seek to be as cost effective and community responsive as possible, many of our administrative and direct service activities are done by sub-contractors. To be clear about the conditions of their participation, however, is extremely important for claiming and audits. They must comply with all direct claiming requirements as identified in this paper. County contracts and the state MAC plan should also be explicit that "Contract providers may

claim reimbursement for MAC activities which they perform. These activities must be specifically identified within their contract, with approved claim processes and rates. Contractors are never eligible for enhanced reimbursement.*

Summary

We recommend integrating MAC into the State Short-Doyle MediCal claim process using a direct claiming methodology based on specific services/activities and staff time. This direct claiming system will utilize the existing computer system for tracking and claiming direct services and utilization review. It will also utilize the CRDC cost report to insure all appropriate costs are tracked and properly allocated and there is no double billing.

• = Simplify the claiming process by using a direct claiming methodology. Each claimed unit will be individually documented. Services will be reimbursed up to actual costs based on the appropriate formulas for MAC activities.

This methodology is consistent with current Medi-Cal and Medicare claiming procedures, and lends the benefit of a familiar and accepted process.

Increase accountability by replacing a complex and unwieldy claiming methodology with a system that identifies specific units of service and that applies a verifiable cost to each unit.

Integrating MAC into the State Short-Doyle MediCal system consolidates an unsuccessful reimbursement process (MAC) into an existing and accepted billing process (SD/MC).

Eliminate multiple claiming formats by utilizing the SDMH MH 1982 series of forms.

Integrating TCM/MAC into the State CRDC Cost report would tie all related costs to the annual SD/MC cost report, providing fiscal and auditable assurance that all costs are accounted for and no costs were used more than once.

GSK:SZ:LC

Attachment

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ATTACHMENT 1

PROPOSED FORMAT FOR MAC MODE AND SERVICE FUNCTION CODES

<u>Mode</u>	<u>Service Function Code</u>	<u>Description</u>
50	01	TCMMAC Activities, all staff, not discounted by Medi-Cal eligibility %. Reimbursed at the 50% non-enhanced rate.
<u>Includes the following activities:</u>		
All Medi-Cal eligibility intake:		
Screening and assisting applicants for mental health services with the application for Medi-Cal benefits.		
All Medi-Cal outreach:		
*Informing Medi-Cal recipients or potential eligible about Medi-Cal services, including SD/M-C services.		
*Gathering information on the individual's health and mental health needs and Medi-Cal eligibility.		
*Assisting at-risk Medi-Cal recipients or potential eligibles to understand the need for mental health services.		
*Actively encouraging reluctant and difficult Medi-Cal recipients or potential eligible to accept needed mental health and health services.		
*Assisting individuals with access to the Medi-Cal health care system by providing referrals, follow-up and transportation if needed to engage them in needed care		
Medi-Cal contract administration:		
*Identifying and recruiting community agencies as Medi-Cal contract providers.		
*Developing and negotiating Medi-Cal provider contracts.		
*Monitoring Medi-Cal provider contracts.		
*Providing technical assistance to Medi-Cal contract agencies regarding County, State and Federal regulations.		

<u>Mode</u>	<u>Service Function Code</u>	<u>Description</u>
50	02	MAC Activity, all staff, discounted by Medi-Cal eligibility %. Reimbursed at the 50% non-enhanced rate.
<u>Includes the following activities:</u>		
Referral in crisis situations to non-open cases:		
Intervening in a crisis situation by referring to mental health services.		

<u>Mode</u>	<u>Service Function Code</u>	<u>Description</u>
50	03	MAC Activities, SPMP staff only, discounted by the Medi-Cal eligibility %. Reimbursed at the 75% enhanced rate.
<u>Includes the following activities:</u>		
Program planning and development:		
*Developing strategies to increase system capacity and to close service gaps.		
*Interagency coordination to improve delivery of mental health services to seriously mentally ill adults or seriously emotionally disturbed children or adolescents.		
Clinical training, given or received:		
Clinical training, given or received, which improves the skill levels of staff members in assessing and serving the mental health needs of clients.		

ATTACHMENT 1

<u>Mode</u>	<u>Service Function Code</u>	<u>Description</u>
50	04	MAC Activities, non-SPMP staff and all contract provider staff, discounted by the Medi-Cal eligibility %, Reimbursed at the 50% non-annanced rate.

Includes the following activities:

Program planning and development:

Developing strategies to increase system capacity and to close service gaps.

Interagency coordination to improve delivery of mental health services to seriously mentally ill adults or seriously emotionally disturbed children or adolescents.

Clinical training, given or received:

Clinical training, given or received, which improves the skill levels of staff members in assessing and serving the mental health needs of clients.

The following activities are eligible for cost distribution to MAC on a rational and systematic cost allocation basis. These costs should be distributed to all units of service, including the four MAC service function codes cited above as Mode 50, SFC 01 through 04.

Non-clinical training

- Other non-clinical training

General Administration

- Participating in staff meetings
- Reviewing and studying professional and technical written materials such as journal articles which enhance skills
- Developing and monitoring program budgets
- Supervising staff
- Researching and evaluating activities
- Contract management
- Developing and reviewing program policies, procedures, and standard protocols related to mental health services
- Other administrative activities

Paid-Time-Off

- Vacation, Paid Sick Time, any other employee time off that is paid

mac2.wp

ATTACHMENT 2

PROPOSED FORMAT FOR MAC MODE AND
SERVICE FUNCTION CODES

<u>Mode</u>	<u>Service Function Code</u>	<u>Description</u>
50	01	MAC Activities, all staff, not discounted by Medi-Cal eligibility %. Reimbursed at the 50% non-enhanced rate.
		Includes the following activities: <ol style="list-style-type: none"> 1. All Medi-Cal eligibility intake; 2. All Medi-Cal outreach; 3. Medi-Cal contract administration.
50	02	MAC Activity, all staff, discounted by Medi-Cal eligibility %. Reimbursed at the 50% non-enhanced rate.
		Includes the following activities: <ol style="list-style-type: none"> 4. Referral in crisis situations - non-open cases only;
50	03	MAC Activities, SPMP staff only, discounted by the Medi-Cal eligibility %. Reimbursed at the 75% enhanced rate.
		Includes the following activities: <ol style="list-style-type: none"> 1. Program planning and development; 2. Clinical training, given or received.
50	04	MAC Activities, non-SPMP staff and all contract provider staff, discounted by the Medi-Cal eligibility %, Reimbursed at the 50% non-enhanced rate.
		Includes the following activities: <ol style="list-style-type: none"> 1. Program planning and development; 2. Clinical training, given or received.

See Attachment 1 for complete description of specific activities, as presently defined by
SDMH and HCFA.