



**MENTAL HEALTH**

**MEDI-CAL ADMINISTRATIVE ACTIVITIES**

**IMPLEMENTATION PLAN**

**October 1, 2016**

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## I. INTRODUCTION

Title XIX of the Social Security Act created the Medicaid program in 1965. Medicaid is a joint federal/state entitlement program offering medical assistance for individuals and families with low incomes and resources. The Federal government establishes broad guidelines within which individual states implement the program.

The State of California's (State or California) Medicaid program is called Medi-Cal. Medi-Cal offers a broad array of physical health and mental health services to enrolled individuals. Most mental health services are provided through a Section 1915 (b) waiver called the Specialty Mental Health Waiver Program.

Under the 1915 (b) Specialty Mental Health Waiver Program, the State contracts with a mental health plan (MHP) to provide or arrange and pay for the provision of all Specialty Mental Health Services to all county Medi-Cal beneficiaries who meet medical-necessity criteria. Specialty Mental Health Services include:

- Rehabilitative mental health services<sup>1</sup>
- Psychiatric inpatient hospital services
- Targeted case management services
- Psychiatrist professional services
- Psychologist professional services
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) supplemental specialty mental health services

All MHPs are administered by county mental health departments.

MHPs may claim federal reimbursement for the cost of administrative activities that support the Medi-Cal program. The Code of Federal Regulations, 42 CFR Section 433.15 authorizes the Federal government to reimburse states for the cost of activities that the Secretary of Health and Human Services finds to be necessary for the proper and efficient administration of the State plan. California Statute (Welfare and Institutions Codes, Section 14132.47) authorizes the California Department of Health Care Services (DHCS) to contract with Local Governmental Agencies (LGA) or Local Educational Consortiums (LEC) to perform Medi-Cal Administrative Activities (MAA) that are necessary for the proper and efficient administration of the Medi-Cal program. The purpose of the Mental Health Medi-Cal Administrative Activities Implementation Plan (Implementation Plan) is to define those activities that are necessary for the proper and efficient administration of the Medi-Cal Specialty Mental Health Waiver program and to describe how MHPs appropriately claim federal reimbursement for the cost of those activities.

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<sup>1</sup> Rehabilitative mental health services include mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, crisis residential treatment, and adult residential treatment.

The Implementation Plan is divided into six sections. This introduction is Section I. Section II defines the activities that are necessary for the proper and efficient administration of the Medi-Cal Specialty Mental Health Waiver program. Section III describes the claiming plan that MHPs are to submit to DHCS and receive approval from DHCS before claiming reimbursement for its Mental Health Medi-Cal Administrative Activities (MH MAA). Section IV describes when an MHP is required to amend its claiming plan. Next, Section V discusses the various principles that MHPs will follow when claiming federal reimbursement for MH MAA. Furthermore, Section V describes the mental health cost report, which includes MH MAA. Finally, Section VI describes the MH MAA monitoring and oversight activities performed by the State. Appendices follow Section VI.

Appendices 1 through 12 describe the information that is required on the certification statement, the claiming unit functions grid, and the activity sheets. Appendix 13 is the quarterly claim for reimbursement template, and includes Schedules A through G.

## II. MENTAL HEALTH MEDI-CAL ADMINISTRATIVE ACTIVITIES

Title 42, United State Code, Section 1396b(a) and Title 42, Code of Federal Regulations, Section 433.15, provide for federal reimbursement of activities the Secretary of Health and Human Services finds necessary for the proper and efficient administration of the Medicaid State plan. This section of the Implementation Plan defines the activities that, when performed by employees of MHPs and their contract providers, are necessary for the proper and efficient administration of the Specialty Mental Health Waiver Program.

The following definitions and activity table explain the fully reimbursable and proportional Medi-Cal share designations.

### **Total Medi-Cal – TM**

Refers to an administrative activity that is one hundred percent allowable under the Medi-Cal program.

### **Proportional Medi-Cal – PM**

Refers to an administrative activity that is allowable under the Medi-Cal program but for which the allowable share of costs will be determined by applying the discounted or proportional Medi-Cal share (the Medi-Cal discount percentage). The Medi-Cal share is determined by calculating the ratio of Medi-Cal eligible clients to total clients.

### **Reallocated Activity – R**

Refers to activities that are to be reallocated across other activity codes on a proportional basis. The reallocated activity is reported under General Administration.

### **Unallowable Activities – U**

Refers to activities that are non-reimbursable under the MH MAA program.

**MH MAA Activity Codes**

Activity Code	Activity Description	FFP Rate
1	Other Activities	U
2	Direct Patient Care	U
3	Outreach to Non-Medi-Cal Programs	U
4	Medi-Cal Outreach – Not Discounted	TM
5	Eligibility Intake for Non-Medi-Cal Programs	U
6	Medi-Cal Eligibility Intake – Not Discounted	TM
7	Crisis Intervention	U
8	Referral in Crisis Situations for Non-Open Cases – Discounted	PM
9	Contract Administration for Non-Medi-Cal Programs	U
10	Medi-Cal Mental Health Service Contract Administration – Not Discounted	TM
11	Medi-Cal Mental Health Service Contract Administration – Discounted	PM

12	Program Planning and Policy Development for Non-Medi-Cal Programs	U
13	Program Planning and Policy Development – Discounted, Non-SPMP	PM
14	Program Planning and Policy Development – Discounted, SPMP	PM
15	Case Management of Open Cases	U
16	Case Management of Non-Open Cases – Discounted, SPMP	PM
17	MH MAA Coordination and Claims Administration – Not Discounted	TM
18	General Administration	R

**Activity 1: Other Activities – U**

**Description:** Other activities means performing an activity that is not mental health treatment or Medi-Cal related, including non-Medi-Cal health and wellness activities, social services, educational services, teaching services, employment, and job training.

**Examples:**

- Providing or administering a prevention and early intervention program that does not provide mental health treatment
- Placing a client into a board and care facility

**Activity 2: Direct Patient Care – U**

**Description:** Direct patient care means specialty mental health services as described in supplement 3 to Attachment 3.1A of the State’s Medicaid State Plan. This code includes administrative activities that are in integral part of or extension of a specialty mental health service.

**Examples:**

- Providing a mental health assessment
- Developing a mental health treatment plan
- Providing mental health therapy
- Providing targeted case management
- Providing medication management

**Activity 3: Outreach to Non-Medi-Cal Programs – U**

**Description:** Outreach to non-Medi-Cal programs means informing individuals about non-Medi-Cal services, such as employment training and income supports; assisting individuals to understand their need for services not covered by Medi-Cal; encouraging individuals to participate in services not covered by Medi-Cal; assisting individuals to access services not covered by Medi-Cal; and gathering information about an individual’s need for services not covered by Medi-Cal.

**Examples:**

- Educating individuals about job training programs available through the Department of Rehabilitation
- Referring individuals to the county welfare department to apply for food stamps or other income supports
- Gathering information about an individual's living situation to determine whether or not an individual is likely homeless and may qualify for housing services

**Activity 4: Medi-Cal Outreach – TM**

**Description:** Medi-Cal Outreach – Not Discounted means informing individuals who are eligible or potentially eligible for Medi-Cal about Medi-Cal services, including specialty mental health services; assisting individuals who are at-risk and eligible or potentially eligible for Medi-Cal to understand their need for mental health services covered by Medi-Cal; encouraging individuals who are reluctant to receive mental health services and are eligible or potentially eligible for Medi-Cal to apply and receive mental health services; assisting individuals with access to the Medi-Cal healthcare system by providing referrals, follow-up, and transportation, if needed, to engage them in needed care; and gathering information on the individual's health and mental health needs and Medi-Cal eligibility.

**Examples:**

- Educating individuals who are homeless about specialty mental health services available through the Medi-Cal program
- Educating children and guardians in the foster care program about specialty mental health services available through the Medi-Cal program
- Referring individuals who are homeless to a community-based provider for a mental health assessment
- Providing follow up contact to ensure that an individual received the services to which they were referred
- Encouraging individuals who do not follow through with a referral to seek mental health services

**Activity 5: Eligibility Intake for Non-Medi-Cal Programs – U**

**Description:** Eligibility intake for non-Medi-Cal programs means screening and assisting applicants for mental health services with the application for Non-Medi-Cal programs.

**Examples:**

- Assisting an individual with completing an application for the SNAP program
- Explaining the eligibility process for the TANF program
- Assisting an individual with completing the application for a housing voucher

### **Activity 6: Medi-Cal Eligibility Intake – TM**

**Description:** Screening and assisting applicants for mental health services with the application for Medi-Cal benefits.

**Examples:**

- Completing a financial screen to determine whether or not an individual requesting mental health services is likely eligible for the Medi-Cal program
- Explaining Medi-Cal eligibility rules and the enrollment process to individuals requesting mental health services
- Providing an individual with all of the forms that need to be completed and submitted in order to enroll in the Medi-Cal program
- Assisting individuals with gathering information needed to complete all of the required forms
- Assisting individuals with preparing the forms that need to be completed
- Assisting individuals with submitting the forms to the county welfare department to determine Medi-Cal eligibility

### **Activity 7: Crisis Intervention – U**

**Description:** Crisis intervention means a service lasting less than 24 hours, to or on behalf of an individual who is currently receiving mental health treatment from the county mental health plan for a condition that requires more timely response than a regularly scheduled visit. Service activities may include assessment, collateral, and therapy.

**Examples:**

- Meeting with individuals who walk into a clinic who may be experiencing a crisis situation for the purpose of making an assessment of the individual's mental health condition
- Providing therapeutic treatment for individuals experiencing a crisis
- Engaging an individual who calls a mental health clinic's access line who may be experiencing a crisis in order to assist the individual in de-escalating the situation

### **Activity 8: Referral in Crisis Situations for Non-Open Cases – PM**

**Description:** Referral in crisis situations for non-open cases means intervening in a crisis situation by referring an individual to mental health services when that individual is not currently receiving mental health services from the county mental health department.

**Examples:**

- Referring an individual who calls a mental health clinic and is experiencing a psychiatric crisis to an appropriate mental health provider
- Referring an individual who calls the mental health plan's access line and is experiencing a psychiatric crisis to an appropriate mental health provider

- Referring an individual who is experiencing a psychiatric crisis while in the community to an appropriate mental health provider
- Referring an individual who comes into a mental health clinic, is not a patient of that clinic, and is experiencing a psychiatric crisis to an appropriate mental health provider

### **Activity 9: Contract Administration for Non-Medi-Cal Programs – U**

**Description:** Contract administration for non-Medi-Cal programs means identifying and recruiting organizations to provide services not covered by Medi-Cal; negotiating and monitoring contracts with organizations that provide services not covered by Medi-Cal; and identifying and negotiating contracts with organizations that do not provide services, such as an alarm company.

#### **Examples:**

- Negotiating a master lease with an apartment complex that is used by the mental health plan to provide supported housing to individuals who have a serious mental illness
- Identifying and recruiting a developer who will build out housing that the mental health plan may use to provide supported housing to individuals who have a serious mental illness
- Negotiating a contract with a skilled nursing facility that is an institution for mental disease (IMD)
- Monitoring the quality of prevention services provided to individuals at risk of developing a serious mental illness or serious emotional disturbance

### **Activity 10: Medi-Cal Mental Health Services Contract Administration – TM**

**Description:** Medi-Cal mental health services contract administration means identifying and recruiting community agencies as mental health service providers exclusively serving Medi-Cal clients; developing and negotiating contracts with mental health service providers exclusively serving Medi-Cal clients; monitoring contracts with mental health service providers exclusively serving Medi-Cal clients; and providing technical assistance to mental health service providers exclusively serving Medi-Cal clients regarding county, state, and federal regulations.

#### **Examples:**

- Preparing and releasing a request for application (RFA) to identify potential community agencies able to provide specialty mental health services exclusively to Medi-Cal beneficiaries
- Reviewing applications received from providers and selecting those best able to provide specialty mental health services exclusively to Medi-Cal beneficiaries
- Negotiating the terms of a contract with a provider that exclusively serves Medi-Cal beneficiaries
- Monitoring the quality of specialty mental health services provided exclusively to Medi-Cal beneficiaries
- Monitoring payments made to a provider to ensure those payments do not exceed the terms of the contract

### **Activity 11: Mental Health Service Contract Administration – PM**

**Description:** Identifying and recruiting community agencies as mental health service providers serving Medi-Cal and non-Medi-Cal clients; developing and negotiating mental health service contracts serving Medi-Cal and non-Medi-Cal clients; monitoring mental health service contract providers serving Medi-Cal and non-Medi-Cal clients; and providing technical assistance to mental health service contract provider serving Medi-Cal and non-Medi-Cal clients regarding county, state, and federal regulations.

**Examples:**

- Preparing and releasing a request for application (RFA) to identify potential community agencies able to provide mental health services for Medi-Cal and non-Medi-Cal clients
- Reviewing applications received from providers and selecting those best able to provide mental health services for Medi-Cal and non-Medi-Cal clients
- Negotiating the terms of a contract with a provider to render mental health services to Medi-Cal and non-Medi-Cal clients
- Monitoring the quality of mental health services provided to Medi-Cal and non-Medi-Cal clients
- Monitoring payments made to a provider to ensure those payments do not exceed the terms of the contract

### **Activity 12: Program Planning and Policy Development for Non-Medi-Cal Programs – U**

**Description:** Developing strategies to improve the delivery of non-Medi-Cal services and interagency coordination to improve the delivery of non-Medi-Cal services.

**Examples:**

- Working with a school district to develop a referral process to ensure that children who are at risk of developing a serious emotional disturbance are referred to a prevention program operated by the county department of mental health
- Developing a housing program for transition age youth who have a serious mental illness
- Developing strategies to improve coordination with an independent living program for transition age youth
- Developing strategies to improve coordination with a job training program for adults who have a serious mental illness

### **Activity 13: Program Planning and Policy Development – PM, Non-SPMP**

**Description:** Developing strategies to increase Medi-Cal system capacity and to close service gaps and interagency coordination to improve the delivery of mental health services to seriously mentally ill adults or seriously emotionally disturbed children or adolescents.

**Examples:**

- Developing a process for the county child welfare program to refer to the county mental health department children and youth who may need mental health services
- Analyzing utilization data to determine groups of individuals who may not be accessing mental health services
- Developing strategies to ensure that transition-age youth continue to receive mental health treatment after turning age twenty-one
- Performing a cost benefit analysis on whether or not to open a mental health clinic in the community
- Working with Medi-Cal providers in the community with the goal of developing stronger relationships in an effort to improve the provision of needed mental health services
- Planning and developing resources and referral guides to be used by clients when accessing county based mental health services
- Preparing for a board of supervisors hearing at which the expansion and/or improvement of existing mental health services are discussed and potentially voted on
- Developing and implementing a telephone hot line for Spanish speaking clients in need of referrals to mental health services

**Activity 14: Program Planning and Policy Development – PM, SPMP**

**Description:** Developing clinical strategies to increase Medi-Cal system capacity and to close service gaps and interagency clinical coordination to improve delivery of mental health services to seriously mentally ill adults or seriously emotionally disturbed children or adolescents.

**Examples:**

- A licensed psychologist develops a clinical protocol for all clinicians to implement an evidence-based intervention, such as cognitive behavioral therapy, for Medi-Cal beneficiaries
- A Licensed Clinical Social Worker writes a program plan to implement an evidence-based program, such as assertive community treatment (ACT), to meet the clinical needs of individuals who have a serious mental illness 24 hours a day, seven days a week
- A licensed psychologist evaluates the academic literature supporting various interventions designed to meet the needs of transition age youth who are experiencing their first episode of psychosis and develops an evidence-based program to meet the needs of those youth
- A licensed psychiatrist spends time analyzing clinical outcomes of clients using different pharmaceutical interventions to determine those that are most cost effective for different diagnoses and functional impairments
- A Licensed Clinical Social Worker attends an interagency task force meeting to work on a protocol for screening young adults who may need mental health services
- A licensed Marriage and Family Therapist contributes his/her clinical expertise to the development of an interagency referral and tracking system to expedite access to Medi-Cal

covered services for individuals who have a serious mental illness throughout the county health system. The clinical expertise provided includes a clinical understanding of motivational interviewing, the impact of an individual's willingness to change, and their choice to follow through on a referral

- A licensed psychologist contributes his/her clinical expertise to the development and review of policies and procedures for coordinating mental health services for recently discharged inmates with severe mental health issues. The licensed psychologist has knowledge and experience providing mental health services and is best able to design procedures for coordinating the delivery of those services with a probation officer.
- A psychiatrist spends time analyzing data related to the cost effectiveness of multiple drug treatments for clients suffering from different diagnoses and then summarizing the results with the ultimate goal of disseminating the findings to other county mental health departments. The psychiatrist's knowledge of and experience prescribing medication for psychiatric illnesses and interpreting clinical assessment data is critical to successfully completing this kind of task.
- The Medical Director spends time analyzing the department's patient billing data with the intention of improving the delivery of services
- Monitoring the effectiveness of the delivery of mental health services to the local community through the collection and analysis of medical data
- A registered nurse (RN) consults with a group of mental health providers about caring for children with schizophrenia and the appropriate responses to medical emergencies they may experience
- Identify, recruit, and provide specialty mental health program support to new clinical providers to expand access to mental health services for clients

### **Activity 15: Case Management of Open Cases – U**

**Description:** Assisting individuals who are currently receiving mental health treatment from the county mental health plan to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Service activities may include communication, coordination, and referral; monitoring service delivery to ensure the individual's access to service and the service delivery system; monitoring of the individual's progress; placement services; and plan development.

#### **Examples:**

- A case manager calls a child's probation officer to discuss how to best coordinate the delivery of services for the child
- A case manager refers an adult to a job training program
- A case manager calls a client to determine whether or not the client followed through on a referral and to identify whether the referral met the client's needs

### **Activity 16: Case Management of Non-Open Cases – PM, SPMP**

**Description:** Gathering information about an individual's health and mental health needs; assessing the likelihood an individual meets the medical necessity criteria to access specialty mental health services; and screen individuals for access to Medi-Cal covered physical health and mental health services, including specialty mental health services, by providing referrals, following-up, and arranging transportation for mental health care.

#### **Examples:**

- A Clinical Psychologist provides case management of non-open cases; conducts clinical interviews with clients to gather information regarding psychologically relevant material, assesses patient health and mental needs; assists individuals to access Medi-Cal covered physical health and specialty mental health services by providing referrals to appropriate county mental health services or other appropriate agencies.
- A Mental Health Clinician conducts clinical interviews to gather information, assess patient needs related to specialty mental health services, determine level of hazard to self or others, determine need for hospitalization, develop diagnostic information for non-open cases.

### **Activity 17: MH MAA Coordination and Claims Administration – TM**

**Description:** Drafting, revising, and submitting MH MAA claiming plans; serving as a liaison to claiming programs within the county mental health plan and with the state and federal governments on MH MAA; monitoring the performance of claiming programs; administering the mental health plan's claiming, including overseeing, preparing, compiling, revising, and submitting MH MAA claims to the State; attending training sessions, meetings, and conferences related to MH MAA; training mental health plan program staff and subcontractors on state, federal, and mental health plan requirements for MH MAA claiming; and, ensuring MH MAA claims do not duplicate Medi-Cal claims for the same activities from other providers.

#### **Examples:**

- The MH MAA Coordinator works with a claiming unit and the State to draft and finalize a claiming plan amendment for the claiming unit
- The MH MAA Coordinator provides training to claiming unit staff regarding the time survey process
- The MH MAA Coordinator attends a training sponsored by the State regarding the preparation of claiming plans and claiming plan amendments
- An employee in the accounting section prepares a quarterly invoice for federal reimbursement

### **Activity 18: General Administration – R**

**Description:** Reviewing departmental procedures and rules; performing administrative or clerical activities related to general building or county functions or operations; reviewing technical and research literature; filling out the time survey; developing and monitoring program budgets; participating in staff meetings; and researching and evaluating activities.

**Examples:**

- An employee who performs MH MAA attends a staff meeting to discuss general operational issues not related to MH MAA
- An employee provides clerical support to an employee who performs MH MAA
- An employee participates in training regarding how to perform a particular MH MAA code, such as case management of non-open cases
- An employee who performs MH MAA is out sick or on vacation
- When not included in the indirect rate, the general operation of the MH MAA program such as accounting, budgeting, payroll, purchasing, and data processing. (Certain functions, such as payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead; therefore, they are ONLY allowable through the approved indirect cost rate.)
- General supervision of staff or facilities, including staff performance reviews and personnel management
- Reviewing non-instructional MH MAA policies, procedures, or rules
- Attending or facilitating program or unit staff meetings, board meetings, or required in-service trainings and events
- Review of professional and inter-program correspondence
- Completing personal mileage and expense claims

<b>Parallel Activities</b>	
<b>Non-Reimbursable</b>	<b>Reimbursable</b>
<u>Activity 1</u> Other Activities – U	N.A.
<u>Activity 2</u> Direct Patient Care – U	N.A.
<u>Activity 3</u> Outreach to Non-Medi-Cal Programs – U	<u>Activity 4</u> Medi-Cal Outreach – TM
<u>Activity 5</u> Eligibility Intake for Non-Medi-Cal Programs – U	<u>Activity 6</u> Medi-Cal Eligibility Intake – TM
<u>Activity 7</u> Crisis Intervention – U	<u>Activity 8</u> Referral in Crisis Situations for Non-Open Cases, PM
<u>Activity 9</u> Contract Administration for Non-Med-Cal Programs – U	<u>Activity 10</u> Medi-Cal Mental Health Services Contract Administration – TM
	<u>Activity 11</u> Medi-Cal Mental Health Services Contract Administration – PM
<u>Activity 12</u> Program Planning and Policy Development for Non-Medi-Cal Programs – U	<u>Activity 13</u> Program Planning and Policy Development – PM, Non-SPMP
	<u>Activity 14</u> Program Planning and Policy Development – PM, SPMP
<u>Activity 15</u> Case Management of Open Cases – U	<u>Activity 16</u> Case Management of Non-Open Cases – PM, SPMP
N.A.	<u>Activity 17</u> MAA Coordination and Claims Administration – TM
N.A.	<u>Activity 18</u> General Administration – R

### **III. MENTAL HEALTH MEDICAL ADMINISTRATIVE ACTIVITIES CLAIMING PLAN**

An MHP will submit a comprehensive claiming plan package to DHCS and have that claiming plan approved by DHCS in order to participate in the MH MAA claiming process. This section of the Implementation Plan describes the information that the State will require each MHP to include in the claiming plan and the documents that the State will require each MHP to complete to provide the necessary information.

The State will require that each claiming plan include, at a minimum, information that:

- Identifies the claiming units that will be submitting claims for MH MAA
- Describes the nature of the work that each claiming unit does
- Identifies the specific MH MAA each claiming unit plans to perform
- Identifies the types of employees within each claiming unit that will be performing each type of MH MAA the claiming unit plans to perform
- Describes the documentation each claiming unit will maintain to support its claim
- Describes how each claiming unit will develop and document the costs related to each MH MAA

To comply with these requirements, the State will require each MHP to submit the following documents in its MH MAA claiming plan:

- Cover page
- Certification Statement
- Claiming Unit Functions Grid
- Activity Sheet for each MH MAA
- Duty Statements for each classification performing MH MAA
- Other documents identified on each activity sheet

The following sub-section of the Implementation Plan describes the information that the State will require each MHP to include in each document listed above, including the other documents that are to be submitted with each activity sheet.

## **A. Certification Statement**

The Certification Statement is intended to ensure that the information contained in the claiming plan package is true, correct, and accurately reflects the performance of the MH MAA described in the claiming plan. The Certification Statement must be signed by the mental health plan's MH MAA Coordinator. The Certification Statement can be found in Appendix 1.

## **B. Claiming Unit Functions Grid**

The State will require each MHP to submit a completed Claiming Unit Functions Grid (CUFG) for each claiming unit performing MH MAA. The purpose of the CUFG is to provide detailed information about each claiming unit. The following identifies the information that the State will require each MHP to include on the CUFG for each claiming unit:

1. The name of the MHP that is submitting the MH MAA claiming plan.
2. The date the CUFG was first submitted for the claiming unit.
3. The date that the CUFG is being submitted.
4. The name of the claiming unit.
5. The number of full time equivalent (FTE) employees who work in the claiming unit, including those who perform MH MAA and those who do not.
6. The physical address of the claiming unit, including the street, city, state, and zip code.
7. The name of the person who should be contacted regarding the claiming unit (contact person).
8. The phone number for the contact person.
9. The mailing address for the contact person, including the street address, city, state, and zip code.
10. A description of the claiming unit's functions. The description should relate to the proper and efficient administration of the Medi-Cal Specialty Mental Health program.
11. The title of each staff job classification that will be performing MH MAA.
12. The number of FTE employees within each staff job classification who are not Skilled Professional Medical Personnel (Non-SPMP) or are Skilled Professional Medical Personnel (SPMP) and will be performing MH MAA.
13. The number of FTE employees who will be performing each particular activity.

Please see Appendix 2 for the Claiming Unit Functions Grid.

### **C. Activity Sheets**

The State will require each MHP to submit for each claiming unit an activity sheet for each MH MAA each claiming unit will be performing. The following pages include:

- An overview of each MH MAA
- The activity sheet for each MH MAA
- A description of the information that must be contained in each activity sheet

#### **Activity 4: Medi-Cal Outreach – TM**

Medi-Cal Outreach – Not discounted is intended to assist individuals who are eligible or potentially eligible for Medi-Cal. The following types of Medi-Cal Outreach – Not Discounted may be performed:

1. Informing individuals who are eligible or potentially eligible about Medi-Cal services, including specialty mental health services.
2. Assisting individuals who are at-risk and are eligible or potentially eligible for Medi-Cal to understand the need for mental health services covered by Medi-Cal.
3. Actively encouraging individuals who are reluctant and are eligible or potentially eligible for Medi-Cal to accept needed mental health and health services.
4. Assisting individuals with access to the Medi-Cal healthcare system by providing referrals, follow-up and transportation, if needed, to engage them in needed care.
5. Gathering information on the individual's health and mental health needs and Medi-Cal eligibility.

Outreach may consist of discrete campaigns or may be an ongoing activity such as:

- Sending teams of outreach workers into the community to contact homeless adults about available mental health services
- Establishing a telephone or walk-in service for referring persons to Medi-Cal covered services or eligibility offices
- Operating a drop-in community center for underserved populations, such as minority teenagers, where Medi-Cal eligibility and mental-health service information is disseminated

An MHP or a community-based organization (CBO) that contracts with an MHP may perform Medi-Cal Outreach. An MHP that submits a claiming plan for a claiming unit that is operated by a CBO will also submit a copy of the sections of the contract(s) with the CBO that clearly describe the Medi-Cal Outreach to be performed, how the time spent performing the Medi-Cal Outreach will be documented, and show the effective date of the contract.

A claiming unit that is operated by an MHP may direct charge the cost of performing Medi-Cal Outreach when performed by a subcontractor. If an MHP chooses to direct charge these costs, the State will require the MHP to submit the sections of the contract it has with the subcontractor that clearly describes the Medi-Cal Outreach to be performed, the method used for determining the direct charge claim, and the dollar amount to be paid to the subcontractor(s).

The State will require MHPs to submit an activity sheet and the following documents or information for each claiming unit that performs Medi-Cal Outreach, unless the materials are not available when the

MHP submits the claiming plan.

- Flyers
- Announcements
- Any materials describing the Medi-Cal Outreach campaign(s)

If materials are not available when the MHP submits the claiming plan, the MHP will identify the location where the materials will be maintained for future DHCS and Centers for Medicare and Medicaid Services (CMS) review.

The State will require each MHP to provide the following information on the activity sheet for each claiming unit that performs Medi-Cal Outreach – Not Discounted:

1. The name of the claiming unit that will be performing the activity.
2. The date the activity sheet was first submitted for this claiming unit.
3. The name of the mental health plan that is submitting the claiming plan or claiming plan amendment.
4. The date the activity sheet is being submitted for the claiming unit.
5. The types of Medi-Cal Outreach that the claiming unit will be performing.
6. A clear description of how each type of outreach will be performed to achieve its objective of informing, assisting, or encouraging individuals who are Medi-Cal eligible or potentially Medi-Cal eligible. The description should identify the staff classifications that will be performing each type of Medi-Cal Outreach, the tasks each classification will perform to achieve the objectives of each type of Medi-Cal Outreach, when and where the tasks will be performed, and how each tasks furthers the objectives of each type of Medi-Cal outreach.
7. A description of the population of individuals to whom each type of outreach will be provided.
8. The length of time that each type of outreach will be performed. For example, outreach may be performed every day or only on certain days of the week and may be performed during certain hours or on an ad hoc basis.
9. A list of locations where each type of outreach is conducted. For example, outreach may be conducted in one or more office (e.g., telephone calls or walk-in) or in one or more particular communities.
10. The number of times each of type of outreach is conducted during a fiscal year or whether outreach is an ongoing activity.
11. A Description of the methodology the claiming unit uses to develop and document the costs associated with the activity. The methodology must be consistent with the description provided in Section V: Claiming Principles in this Implementation Plan.
12. The name(s) of any subcontractor(s), if applicable. If the mental health plan chooses to direct charge the outreach performed by the subcontractor(s), the contract(s) should also

clearly describe the Medi-Cal Outreach to be performed, the method used to determine the direct charge claim, and the dollar amount to be paid to the subcontractor(s).

13. The location where flyers, announcements or other materials that describe the Medi-Cal Outreach may be viewed by DHCS and/or CMS if those materials are not included with the claiming plan.

Please see Appendix 3 for a copy of the activity sheet.

### **Activity 6: Medi-Cal Eligibility Intake – TM**

Medi-Cal Eligibility Intake is intended to assist individuals with the application for Medi-Cal benefits. This activity does **not** include the eligibility determination itself. The following type of Medi-Cal Eligibility Intake may be performed:

1. Screening and assisting applicants for mental health services with the application for Medi-Cal benefits.
2. Explaining eligibility rules and the Medi-Cal eligibility process to prospective applicants.
3. Assisting an applicant fill out a Medi-Cal eligibility application.
4. Gathering information related to the application and eligibility or redetermination from a client.
5. Providing necessary forms and packing all forms in preparation for the Medi-Cal determination.

The State will allow claiming units that are operated by a mental health plan or one of its subcontractors to perform Medi-Cal Eligibility Intake. If the claiming unit is one of the mental health plan's subcontractors, the mental health plan will be required to include in its claiming plan, a copy of the sections of contract(s) with the subcontractor that clearly describes the Medi-Cal Eligibility Intake to be performed, how the time performing the Medi-Cal Eligibility Intake will be documented, and showing the effective date of the contract.

If the mental health plan chooses to direct charge the costs of Medi-Cal Eligibility Intake performed by the subcontractor(s), the contract(s) should also clearly describe the products that the subcontractor will develop for Medi-Cal Eligibility Intake and/or the number of individuals who will be screened and/or receive assistance with completing the application process, and the amount the claiming unit will pay the subcontractor to produce the product, screen the identified number of people, and/or assist the identified number of people with their application for Medi-Cal.

Each claiming unit that performs Medi-Cal Eligibility Intake will submit an activity sheet for the activity. Each claiming unit is required to provide the following information on the activity sheet for Medi-Cal Eligibility Intake:

1. The name of the claiming unit that will be performing this activity.
2. The date this activity sheet was first submitted for this claiming unit.
3. The name of the mental health that is submitting the claiming plan or claiming plan amendment.
4. The date this activity sheet is being submitted for the claiming unit.
5. The type of Medi-Cal Eligibility Intake the claiming unit will perform.
6. A clear description of how the type of Medi-Cal Eligibility Intake will be performed to achieve its objective. The description should identify the staff performing the activity, the tasks performed, when and where the tasks are performed, and the purpose for performing the activity.

7. A description of the methodology this claiming unit will use to develop and document the costs associated with this activity. The methodology must be consistent with the description in Section V: Claiming Principles.
8. The names of any subcontractor(s), if applicable, that will be performing this activity. If the mental health plan chooses to direct charge the cost of Medi-Cal Eligibility Intake performed by subcontractor(s), the contract(s) should clearly describe the Medi-Cal Eligibility Intake to be performed, the method used to determine the direct charge claim, and the dollar amount to be paid to the subcontractor(s).

Please see Appendix 4 for a copy of the activity sheet.

### **Activity 8: Referral in Crisis Situations for Non-Open Cases – PM**

Referral in Crisis Situations for Non-Open Cases is intended to assist individuals who are experiencing a psychiatric crisis and do not currently have an open mental health case. The following type of Referral in Crisis Situations for Non-Open Cases may be performed:

1. Intervening in a crisis situation by referring an individual to mental health services.

The State will allow a claiming unit operated by a mental health plan or one of its subcontractors to perform this activity. If the claiming unit is one of the mental health plan's subcontractors, the mental health plan will submit, with its claiming plan, a copy of the sections of the contract(s) that clearly describe the Referral in Crisis Situations for Non-Open Cases performed, how the time performing this MH MAA will be documented, and showing the effective date of the contract. The methodology must be consistent with the description in Section V: Claiming Principles.

A claiming unit may subcontract with another entity to perform Referral in Crisis Situations for Non-Open Cases and may direct charge the costs of the subcontract. If the claiming unit chooses to direct charge the costs of the subcontract, the contract(s) should also clearly describe the product(s) the subcontractor will develop for the Referral in Crisis Situations for Non-Open Cases, and/or the type of Referral in Crisis Situations for Non-Open Cases, and/or the number of individuals who will receive each type of Referral in Crisis Situations for Non-Open Cases, and the amount to be paid to the subcontractor for producing the products and/or providing each type of Referral in Crisis Situations for Non-Open Cases to the identified number of people.

The State will require each claiming unit to discount the costs to be reimbursed for performing this activity by the Medi-Cal percentage.

Each claiming unit that performs Referral in Crisis Situations for Non-Open Cases will submit an activity sheet for that activity. Each claiming unit is required to provide the following information on the activity sheet for Referral in Crisis Situations for Non-Open Cases:

1. The name of the claiming unit that will be performing Referral in Crisis Situations for Non-Open Cases.
2. The date the activity sheet was first submitting for this claiming unit.
3. The name of the mental health plan that is submitting the claiming plan or claiming plan amendment.
4. The date the activity sheet is currently being submitted for the claiming unit.
5. The type of Referral in Crisis Situations for Non-Open Cases this claiming unit will perform.
6. A clear description of how each type of Referral in Crisis Situations for Non-Open Cases will be performed to achieve its objective. The description should include the staff classifications that will perform this activity, a clear description of the tasks each staff classification will perform, when and where each task will be performed, and how each task furthers the objective of the activity.

7. A description of the methodology that will be used to calculate the Medi-Cal discount percentage. The methodology used to calculate the Medi-Cal discount percentage must be consistent with the discussion in Section V, “Determining the Medi-Cal Discount Percentage,” of this Implementation Plan.
8. A description of the methodology that will be used to develop and document the costs associated with this activity. The methodology must be consistent with the description in Section V: Claiming Principles.
9. The names of any subcontractor(s), if applicable, that will perform Referral in Crisis Situations for Non-Open Cases. If the mental health plan chooses to direct charge the Referral in Crisis Situations for Non-Open Cases to be performed, the contract(s) should clearly describe the Referral in Crisis Situations for Non-Open Cases to be performed by the subcontractor(s), the method used to determine the direct charge claim, and the dollar amount to be paid to the subcontractor(s).

Please see Appendix 5 for a copy of the activity sheet.

### **Activity 10: Medi-Cal/Mental Health Services Contract Administration – TM**

Medi-Cal/Mental Health Services Contract Administration – Not Discounted is intended to reimburse mental health plans for costs associated with the administration of contracts with providers that render Medi-Cal covered services to Medi-Cal beneficiaries. The following four types of Medi-Cal/Mental Health Services Contract Administration – Not Discounted may be performed:

1. Identifying and recruiting community agencies as Medi-Cal providers.
2. Developing and negotiating contracts with Medi-Cal providers.
3. Monitoring contracts with Medi-Cal providers.
4. Providing technical assistance to contract agencies that are Medi-Cal providers regarding county, state, and federal regulations.

The mental health plan may **not** subcontract with governmental or non-governmental organizations to perform Medi-Cal/Mental Health Services Contract Administration – Not Discounted. This MH MAA must be performed by the mental health plan.

Each claiming unit that performs Medi-Cal/Mental Health Services Contract Administration – Not Discounted will submit an activity sheet for this activity. Each claiming unit is required to provide the following information on the activity sheet for Medi-Cal/Mental Health Services Contract Administration – Not Discounted:

1. The name of the claiming unit that will be performing the activity.
2. The date the activity sheet was first submitted for the claiming unit.
3. The name of the mental health plan that is submitting the claiming plan or claiming plan amendment.
4. The date this activity sheet is being submitted for the claiming unit.
5. The type of Medi-Cal/Mental Health Services Contract Administration – Not Discounted the claiming unit will perform.
6. A clear description of how each type of Medi-Cal/Mental Health Services Contract Administration – Not Discounted activity will be performed to achieve its objective. The description should identify the staff classification(s) that will be performing each type of Medi-Cal/Mental Health Services Contract Administration – Not Discounted, the tasks that each staff classification will perform, when and where those tasks will be performed, and how those tasks further the objective of the type of Medi-Cal/Mental Health Services Contract Administration – Not Discounted to be performed.
7. A description of the methodology the claiming unit will use to develop and document the costs associated with performing Medi-Cal/Mental Health Services Contract Administration – Not Discounted. The methodology must be consistent with the description in Section V: Claiming Principles.

Please see Appendix 6 for a copy of the activity sheet.

### **Activity 11: Medi-Cal/Mental Health Services Contract Administration – PM**

Medi-Cal/Mental Health Services Contract Administration – Discounted is intended to reimburse mental health plans for costs associated with the administration of contracts with providers that render Medi-Cal covered services to individuals who are either Medi-Cal or non-Medi-Cal beneficiaries. The following four types of Medi-Cal/Mental Health Services Contract Administration – Discounted may be performed:

1. Identifying and recruiting community agencies as mental health service providers serving individuals who are Medi-Cal beneficiaries and individuals who are not Medi-Cal beneficiaries.
2. Developing and negotiating contracts with community agencies to provide mental health services to individuals who are Medi-Cal beneficiaries and individuals who are not Medi-Cal beneficiaries.
3. Monitoring contracts with community agencies providing mental health services to individuals who are Medi-Cal beneficiaries and individuals who are not Medi-Cal beneficiaries.
4. Providing technical assistance to community agencies under contract with the mental health plan to provide mental health services to individuals who are Medi-Cal beneficiaries and individuals who are not Medi-Cal beneficiaries regarding county, state, and federal regulations.

The mental health plan may **not** subcontract with governmental or non-governmental organizations to perform Medi-Cal/Mental Health Services Contract Administration – Discounted. This MH MAA must be performed by a claiming unit that is operated by the mental health plan.

The State will require claiming units to discount the reimbursable costs for Medi-Cal/Mental Health Services Contract Administration – Discounted by the Medi-Cal percentage. The Medi-Cal discount percentage must be calculated in a manner consistent with the discussion in item Section V, “Determining The Medi-Cal Discount Percentage” of this Implementation Plan. The State will require that each claiming unit performing Medi-Cal/Mental Health Services Contract Administration – Discounted submit an activity sheet for that activity. Each claiming unit will be required to provide the following information on the activity sheet for Medi-Cal/Mental Health Services Contract Administration – Discounted:

1. The name of the claiming unit that will be performing the activity.
2. The date the activity sheet was first submitted for the claiming unit.
3. The name of the mental health plan that is submitting the claiming plan or claiming plan amendment.
4. The date this activity sheet is being submitted for the claiming unit.
5. The type of Medi-Cal/Mental Health Services Contract Administration – Discounted the claiming unit will perform.
6. A clear description of how each type of Medi-Cal/Mental Health Services Contract Administration – Discounted activity will be performed to achieve its objective. The description should identify the staff classification(s) that will be performing each type of

Medi-Cal/Mental Health Services Contract Administration – Discounted, the tasks that each staff classification will perform, when and where those tasks will be performed, and how those tasks further the objective of the type of Medi-Cal/Mental Health Services Contract Administration – Discounted to be performed.

7. A description of the methodology the claiming unit will use to develop and document the costs associated with performing Medi-Cal/Mental Health Services Contract Administration – Discounted. The methodology must be consistent with the description in Section V: Claiming Principles.
8. A description of the methodology the claiming unit will use to calculate the Medi-Cal discount percentage. The methodology used to calculate the discount percentage must be consistent with the discussion in Section V, “Determining The Medi-Cal Discount Percentage,” in this Implementation Plan.

Please see Appendix 7 for a copy of the activity sheet.

### **Activity 13: Program Planning and Policy Development – PM, Non-SPMP**

Program Planning and Policy Development is intended to reimburse mental health plans for costs associated with program planning and policy development designed to improve the mental health system for Medi-Cal beneficiaries. The following three types of Program Planning and Policy Development may be performed:

1. Developing strategies to increase Medi-Cal system capacity and to close Medi-Cal service gaps, including the analysis of Medi-Cal data related to a specific program or specific group.
2. Interagency coordination to improve the delivery of Medi-Cal mental health services to adults and older adults with a serious mental illness and/or children and adolescents with a serious emotional disturbance.
3. Developing resource directories of Medi-Cal services and/or providers.

These activities include “support activities.” Examples of support activities include developing resource directories, preparing Medi-Cal data reports, conducting needs assessments, and preparing proposals for expanding Medi-Cal services. These activities may be performed by a mental health plan or a subcontractor. If the mental health plan subcontracts with a CBO, a copy of the sections of the contract(s) clearly describing the support activities to be performed, how the time performing the activities will be documented, and the effective date of the contract will be included with the claiming plan. If the mental health plan chooses to direct charge the costs of support activities performed by the subcontractor(s), the contract(s) should also clearly describe the method used for determining the direct charge claim and the dollar amount to be paid to the subcontractor(s).

The State will require claiming units performing Program Planning and Policy Development to discount its reimbursable costs by the Medi-Cal discount percentage. The Medi-Cal discount percentage must be calculated in a manner consistent with the discussion in item Section V, “Determining The Medi-Cal Discount Percentage” of this Implementation Plan.

Each claiming unit that performs Non-SPMP Program Planning and Policy Development will submit an activity sheet for this activity. Each claiming unit is required to provide the following information on the activity sheet for Program Planning and Policy Development:

1. The name of the claiming unit that will be performing Program Planning and Policy Development (PP&PD).
2. The date the activity sheet was first submitted.
3. The name of the mental health plan that is submitting the claiming plan or claiming plan amendment.
4. The date this activity is currently being submitted for the claiming unit.
5. The type of PP&PD this claiming unit will perform.
6. A clear description of how each type of activity will be performed to achieve its objective. The description will identify the staff classification that will be performing each type of PP&PD, a clear description of the tasks to be performed in each type of PP&PD, when and

where those tasks will be performed, and a clear description of how the tasks further the objectives of each type of PP&PD.

7. A description of the methodology that will be used to develop and document costs associated with this activity. The methodology must be consistent with the description in Section V: Claiming Principles.
8. A description of the methodology that will be used to calculate the Medi-Cal discount percentage. The methodology used to calculate the Medi-Cal discount percentage must be consistent with the discussion contained in Section V, "Determining The Medi-Cal Discount Percentage," of this Implementation Plan.
9. The names of subcontractors, if applicable. If the mental health plan chooses to direct charge the support activities performed by one or more subcontractors, the contracts should also clearly describe the method used to determine the direct charge claim and the dollar amount paid to the subcontractors.

Please see Appendix 8 for a copy of the activity sheet.

### **Activity 14: Program Planning and Policy Development – PM, SPMP**

SPMP Program Planning and Policy Development is intended to reimburse mental health plans for costs associated with program planning and policy development designed to improve the mental health system for Medi-Cal beneficiaries. The following three types of SPMP Program Planning and Policy Development may be performed:

1. Developing strategies to increase Medi-Cal system capacity and to close Medi-Cal service gaps, including the analysis of Medi-Cal data related to a specific program or specific group.
2. Interagency coordination to improve the delivery of Medi-Cal mental health services to adults and older adults with a serious mental illness and/or children and adolescents with a serious emotional disturbance.
3. Developing resource directories of Medi-Cal services and/or providers.

Program Planning and Policy Development activities performed by subcontractors are not eligible for enhanced reimbursement when performed by an SPMP. Only PP&PD activities performed by employees of the mental health plan are eligible for enhanced reimbursement when performed by an SPMP.

The State will require claiming units performing SPMP Program Planning and Policy Development to discount its reimbursable costs by the Medi-Cal discount percentage. The Medi-Cal discount percentage must be calculated in a manner consistent with the discussion in Section V, “Determining The Medi-Cal Discount Percentage” of this Implementation Plan.

Each claiming unit that performs SPMP Program Planning and Policy Development will submit an activity sheet for this activity. Each claiming unit is required to provide the following information on the activity sheet for Program Planning and Policy Development:

1. The name of the claiming unit that will be performing PP&PD.
2. The date the activity sheet was first submitted.
3. The name of the mental health plan that is submitting the claiming plan or claiming plan amendment.
4. The date this activity is currently being submitted for the claiming unit.
5. The type of PP&PD this claiming unit will perform.
6. A clear description of how each type of activity will be performed to achieve its objective. The description should identify the staff classification that will be performing each type of PP&PD, a clear description of the tasks to be performed in each type of PP&PD, when and where those tasks will be performed, and a clear description of how the tasks further the objectives of each type of PP&PD.
7. A description of the methodology that will be used to develop and document costs associated with this activity. The methodology must be consistent with the description in Section V: Claiming Principles.

8. A description of the methodology that will be used to calculate the Medi-Cal discount percentage. The methodology used to calculate the Medi-Cal discount percentage must be consistent with the discussion contained in Section V, “Determining The Medi-Cal Discount Percentage,” of this Implementation Plan.

Please see Appendix 9 for a copy of the activity sheet.

### **Activity 16: Case Management of Non-Open Cases – PM, SPMP**

SPMP Case Management of Non-Open Cases is intended to assist Medi-Cal beneficiaries without an open mental health case to access Medi-Cal covered mental health services. The following three types of Case Management of Non-Open Cases may be performed:

1. Gathering information about an individual's health and mental health needs to determine whether or not the individual is likely to meet the medical necessity criteria to access specialty mental health services.
2. Assisting individuals who likely meet medical necessity criteria with access covered specialty mental health services by providing referrals to Medi-Cal specialty mental health providers.
3. Assisting individuals who likely do not meet medical necessity criteria with accessing covered Medi-Cal mental health services by providing referrals to Medi-Cal Fee-For-Service providers or managed care organizations that provide mental health services.

Case Management of Non-Open Cases may not be performed by subcontractors. Activities performed by subcontractors are not eligible for enhanced reimbursement. Only Case Management of Non-Open Cases activities performed by employees of the mental health plan are eligible for enhanced reimbursement when performed by an SPMP.

The State will require claiming units that perform this activity to discount its reimbursable costs by the Medi-Cal discount percentage. The Medi-Cal discount percentage must be calculated in a manner that is consistent with the discussion in Section V, "Determining The Medi-Cal Discount Percentage," of this Implementation Plan.

Each claiming unit that performs SPMP Case Management of Non-Open Cases will submit an activity sheet for this activity. Each claiming unit is required to provide the following information on the activity sheet for SPMP Case Management of Non-Open Cases:

1. The name of the claiming unit that will be performing the activity.
2. The date this activity sheet was first submitted for the claiming unit.
3. The name of the mental health plan that is submitting the claiming plan or claiming plan amendment.
4. The date the current activity sheet is being submitted for this claiming unit.
5. The type of case management of non-open cases the claiming unit will perform.
6. A clear description of how each type of activity will be performed to achieve its objective.
7. A description of the methodology the claiming unit will use to develop and document the costs associated with this activity. The methodology must be consistent with the description in Section V: Claiming Principles.
8. A description of the methodology that will be used to calculate the Medi-Cal discount percentage. The State will require the methodology used to calculate the Medi-Cal

discount percentage to be consistent with the discussion in Section V, “Determining The Medi-Cal Discount Percentage,” of this Implementation Plan.

Please see Appendix 10 for a copy of this activity sheet.

### **Activity 17: MH MAA Coordination and Claims Administration – TM**

MH MAA Coordination and Claims Administration is intended to reimburse mental health plans for costs associated with administration of the MH MAA program. The following seven types of MH MAA Coordination and Claims Administration may be performed:

1. Drafting, revising, and submitting MH MAA claiming plans.
2. Serving as liaison with claiming programs within the LGA and with the state and federal governments on MH MAA.
3. Monitoring the performance of claiming plans.
4. Administering the mental health plan claiming, including overseeing, preparing, compiling, revising, and submitting MH MAA claims to the State.
5. Attending training sessions, meetings, and conferences involving MH MAA.
6. Training mental health plan program and subcontractor staff members on state, federal, and local requirements for MH MAA claiming.
7. Ensuring that MH MAA claims do not duplicate Medi-Cal Specialty Mental Health claims for the same activities from other providers.

A mental health plan may subcontract with governmental and non-governmental organizations to perform MH MAA Coordination and Claims Administration when the subcontracting entity performs this activity as part of the mental health plan's claiming unit. However, the mental health plan may **not** subcontract with governmental and non-governmental organizations to perform MH MAA Coordination and Claims Administration if the subcontractor is a claiming unit. This activity must be performed by the mental health plan, since the activity will be performed on a LGA-wide basis.

Each claiming unit that will perform MH MAA Coordination and Claims Administration must submit an activity sheet. Each claiming unit is required to provide the following information on the activity sheet for MH MAA Coordination and Claims Administration:

1. The name of the claiming unit that will be performing this activity.
2. The date the claiming unit was first approved to perform this activity.
3. The name of the mental health plan that is submitting the claiming plan or claiming plan amendment.
4. The date this activity sheet is being submitted for the claiming unit.
5. A list of the type of MH MAA Coordination and Claims Administration that the claiming unit will perform.
6. A clear description of how the claiming unit will implement each type of MH MAA Coordination and Claims Administration to meet its objective. The description should identify the staff classifications that will perform each type of MH MAA Coordination and Claims Administration, include a clear description of the tasks to be performed under each type of MH MAA

Coordination and Claims Administration, and how each task furthers the objective of each type of MH MAA Coordination and Claims Administration.

7. A clear description of the methodology the claiming unit will use to develop and document the costs associated with this activity. The methodology must be consistent with the description in Section V: Claiming Principles.
8. An indication of whether or not employees, who perform this activity, perform it on a part-time basis in addition to other duties.

Please see Appendix 11 for a copy of the activity sheet.

**Activity 18: General Administration – R**

The purpose of this code is to capture job duties that support time for your primary job. Time recorded under this code will be apportioned appropriately to MAA and non-MAA. Paid time off is when you are being paid, but you're not at work. This includes such time as paid vacation days, jury duty, and sick leave. If you are not paid for your time off, you cannot record that time here. Unpaid time off should be left blank on your time survey.

Each claiming unit that will perform MH MAA General Administration – Reallocated will submit an activity sheet. Each claiming unit is required to provide the following information on the activity sheet for MH MAA General Administration – Reallocated:

1. The name of the claiming unit that will be performing this activity.
2. The date the claiming unit was first approved to perform this activity.
3. The name of the mental health plan that is submitting the claiming plan or claiming plan amendment.
4. The date this activity sheet is being submitted for the claiming unit.
5. Identify staff for whom some of their time will be coded to General Administration – Reallocated.
6. Describe the kinds of activities for each staff for which they will be recording time to General Administration – Reallocated.

Please see Appendix 12 for a copy of the activity sheet.

## **D. Duty Statements/Position Descriptions**

Each claiming unit must submit a duty statement/position description for each job classification listed in Box 11 of its Claiming Unit Functions Grid (CUFG). The duty statement/position description does not need to be an official county document for the particular county job classification. To ensure the duty statement/position description is not returned by DHCS, Mental Health Plans will adhere to the following guidelines when preparing duty statements/position descriptions for the MH MAA claiming plan:

- Include the name of the mental health plan
- Include the name of the claiming unit
- Include the date the duty statement is being submitted
- Clearly distinguish MH MAA duties from duties that are not MH MAA
- Clearly identify the MH MAA to which each MH MAA duty relates. For example, duties associated with Medi-Cal Outreach – Not Discounted would be identified with “Activity 4” in parentheses at the end of the description of the duty.
- Clearly indicate for duties related to Referral in Crisis Situations for Non-Open Cases (Activity 8) and Case Management of Non-Open Cases (Activity 16) that these duties are performed only for individuals who do not have an open case with the mental health plan. For example, a duty statement might state which job classification refers individuals who do not have an open mental health case and are experiencing a psychiatric crisis to appropriate mental health services.
- Include the title of the job classification. The title of the job classification must match the title in Box 11 of the Claiming Unit Functions Grid.

#### **IV. MENTAL HEALTH MEDI-CAL ADMINISTRATIVE ACTIVITIES CLAIMING PLAN AMENDMENTS**

A mental health plan's MH MAA claiming plan will remain in effect from year to year until it is amended. The State will require that a mental health plan amend its MH MAA claiming plan when one of the following changes occur:

1. Adding a new claiming unit.
2. Adding a new MH MAA code to an existing claiming unit.
3. Adding a new subcontractor to an existing claiming unit.
4. Changing the type of activities and/or services in a contract for which MH MAA are performed.
5. Changing any of the MH MAA claiming plan documents.

When a mental health plan submits a MH MAA claiming plan amendment for one of the reasons described above, copies of the following documents will be submitted to DHCS:

- Cover letter
- Signed certification statement
- Mental Health Medi-Cal Administrative Activities Claiming Plan Amendment Checklist; and,
- Amended documents<sup>2</sup>

All MH MAA claiming plan amendments will be reviewed and approved by DHCS. The claiming plan amendment becomes effective on the first day of the quarter in which it is submitted. However, claiming plans may be submitted up to and through November 1st to be effective on the first day of the first quarter (i.e., July 1st). Once approved by DHCS, the claiming plan amendment remains in effect until amended again.

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<sup>2</sup> MHPs will **not** submit the entire claiming plan. Only the amended documents will be submitted, such as a duty statement or the Claiming Unit Functions Grid.

## V. **CLAIMING PRINCIPLES**

Mental Health Plans will adhere to certain principles for determining allowable administrative activity costs, apportioning the costs to the Medi-Cal program, preparing invoices, and determining if an activity is eligible for enhanced reimbursement when performed by Skilled Professional Medical Personnel. In part, achievement of these claiming principles will be facilitated by a proper time survey system.

## A. Time Tracking

The State will require claiming units to claim reimbursement for MH MAA on a minute-by-minute basis throughout the time-tracking period. The time-tracking period is equivalent to the claiming period for the mental health plan, which begins July 1st and ends June 30th to comply with the quarterly claiming of the following calendar year. Staff performing allowable MH MAA during the time-tracking period for claiming units will track their time by individual MH MAA on a per-minute basis.

Claiming units performing MH MAA will be required to utilize a time-tracking system where staff members perpetually record the number of minutes spent performing specific MH MAA. Claiming units that provide mental health treatment in a clinical setting for which Medi-Cal reimburses the claiming unit a prospective payment system (PPS) rate per encounter will be required to complete the CMS approved clinician log. This section describes the basic criteria for a proper time-recording system and use of the CMS approved clinician log.

The time tracking system should be designed so staff members are able to record their time in actual minutes. Claiming units will be required to claim reimbursement for MH MAA activities on a per-minute basis. Some computerized time tracking software is designed to track time by larger increments, such as fifteen minutes. In these instances, staff members would not be able to record 39 minutes performing case management of non-open cases. The system would accept 30 minutes or 45 minutes, but not the actual number of minutes. Therefore, the system would not accurately record the time in minutes staff members spent performing MH MAA.

Claiming units will be required to use a time-tracking system that is designed so staff members will be able to record 100 percent of their time to specific reimbursable and non-reimbursable activities. Eighteen activities have been defined for employees to record their time. Four activities are reimbursed at the non-enhanced rate and are not discounted, three activities are reimbursed at the non-enhanced rate and are discounted, and two activities are reimbursed at the enhanced rate and are discounted. One activity is reallocated across other activity codes on a proportional basis. The reallocated activity is reported under General Administration. The remaining eight activities are not reimbursable.

Mental health plans must be able to document the amount of time authorized staff members spend performing specific MH MAA. Furthermore, the system will record dates, instances, and times performing treatment services, if applicable, as well. Claiming units will be required to use a time-tracking system that is designed so staff members are able to record multiple instances of performing a MH MAA during each day of the week. For example, a staff member authorized to perform Case Management of Non-Open Cases may perform the activity separate times throughout the day for varying amounts of time.<sup>3</sup> The system will be designed to allow a staff member to record the number of minutes he/she spent performing Case Management of Non-Open Cases during each instance.

The State will provide training to mental health plans regarding time-tracking requirements. Mental health plans will also provide training to staff members who are authorized to perform MH MAA, enabling staff members to accurately recognize when they are performing an allowable activity and

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<sup>3</sup> For example, the activity may be performed in one day by a single-staff member five separate times for increments of nine, 18, seven, 23, and 33 minutes.

how to appropriately record their time for that activity. To assist staff members with accurately recognizing when they are performing a MH MAA, the training will inform participants of the general requirements to be met to qualify as an MH MAA. Furthermore, the training will incorporate a series of hypothetical situations to assist staff members with applying the general requirements to real-life situations. To assist staff members with appropriately recording their time, the training should include an overview of the time-tracking system, a written procedure describing the time-recording process, and a series of hypothetical scenarios allowing staff to apply the procedure.

The mental health plan will maintain documentation of time authorized staff members spent performing MH MAA in its audit file. The time-recording system will be able to generate monthly reports demonstrating how individual employees spent 100 percent of their time. This report will include MH MAA time, time spent in General Administrative activities, as well as time spent on other services including treatment. The monthly reports will reflect employee's total time worked, thus preventing double charging of time and claiming for duplicative activities. Furthermore, the Office of Management and Budget (OMB) Circular A-87 contains a number of criteria that must be met to support salaries and wages charged to federal awards.

1. Charges to federal awards for salaries and wages, whether treated as direct or indirect costs, will be based on payroll documentation in accordance with generally accepted practice of the governmental unit and approved by one or more responsible officials of the governmental unit.
2. Payroll documentation is all that is required for salaries and wages of employees who work in a single indirect cost activity.
3. Where employees are expected to work solely on a single federal award or cost objective, charges for their salaries and wages should be supported by periodic certifications that the employees worked solely on that program for the period covered by the certification; and the certifications should be prepared at least semi-annually and will be signed by the employee or supervisory official who has first-hand knowledge of the work performed by the employee.
4. Where employees work on multiple activities or cost objectives, a distribution of their salaries and wages will be supported by personnel activity reports or equivalent documentation that meets the following standards:
  - Reflects an after-the-fact distribution of the actual activity of each employee
  - Accounts for the total activity for which each employee is compensated
  - Is prepared at least monthly and coincides with one or more pay periods
  - Is signed by the employee<sup>4</sup>

The following information in this documentation will also match the information in the claiming unit's claiming plan and Schedule G of the Quarterly Claim form (Appendix 13):

1. The claiming unit and/or cost center will match the name of the claiming unit on the CUFG and the Schedule G.
2. The staff member's job title will match the job classification listed on the CUFG.

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<sup>4</sup> The employee's signature indicates the employee has reviewed the monthly time-reports and verified its accuracy.

3. The total minutes spent performing particular MH MAA will match the total units reported on the quarterly invoices and in the mental health cost report.<sup>5</sup>

Finally, claiming units that provide mental health treatment in a clinic setting for which Medi-Cal reimburses the claiming unit a PPS rate should have the clinician complete the CMS-approved clinician log when the clinician performs a MH MAA in conjunction with a clinical service.

Claiming units will be required to maintain information in the audit file for three years from the time the final signed certification of the mental health cost report (MH 1940) is submitted to the DHCS. Mental health plans are required to submit a cost report by December 31st following the close of each fiscal year. This original submission includes a signed certification. Staff from the DHCS work with staff of the mental health plans to address any edits. Once all edits have been addressed, the mental health plan will be given 90 days to reconcile the cost report against their own records. Once the mental health plan has completed its reconciliation, it will submit a final cost report, which includes a signed certification (MH 1940). The DHCS has three years from the date this final signed certification was submitted to audit the claims associated with the cost report.

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<sup>5</sup> Time spent completing the time study is not 100 percent MAA and should be charged to General and Administrative expenses.

## **B. Determining the Medi-Cal Discount Percentage**

The Mental Health Medi-Cal Administrative Activities claiming process will reimburse mental health plans only for costs associated with the Medi-Cal program. Some of the MH MAA activity codes will benefit the Medi-Cal program, as well as non-Medi-Cal programs. The Medi-Cal percentage will be used to reduce, or discount, the costs of those activities to determine the costs associated only with the Medi-Cal program. This section identifies the MH MAA activity codes which will be discounted by the Medi-Cal percentage, and describes the method by which mental health plans will calculate the discount percentage.

Five MH MAA codes benefit Medi-Cal clients as well as non-Medi-Cal clients. The costs associated with the following activities will be discounted by the Medi-Cal percentage:

- Activity 8: Referral in Crisis Situations for Non-Open Cases
- Activity 11: Medi-Cal Mental Health Services Contract Administration
- Activity 13: Non-SPMP Program Planning and Policy Development
- Activity 14: SPMP Program Planning and Policy Development
- Activity 16: SPMP Case Management of Non-Open Cases

County mental health departments and their contract providers provide services to individuals who are Medi-Cal eligible, as well as individuals who are not Medi-Cal eligible. The Medi-Cal discount percentage for a county mental health department or one of its contract providers is equal to the ratio of Medi-Cal individuals who received a mental health service to all individuals who received a service. These data are extracted directly from the county's clinical health records, which may include the county's clinical-billing system. The numerator is equal to the total number of individuals enrolled in the Medi-Cal program that received a mental health service and are included in the claiming unit's clinical health records and are an open case. The denominator is equal to the total number of individuals who received a mental health service who both reside in the claiming unit's clinical health records and are an open case. The number of individuals in the numerator and denominator must be an unduplicated count. The most typical approach to gathering these data will be for a County mental health department to extract the data directly from their own mental health clinical records. The Medi-Cal discount percentage is then applied to all of the MH MAA discounted-activity codes.

The Medi-Cal discount percentage will be calculated on a quarterly basis by the county mental health department and each of its contract providers that participate in the MH MAA claiming process. After the close of each quarter of the fiscal year (July – September, October – December, January – March, and April – June), the county mental health department and/or contract provider will determine the unduplicated number of individuals who were enrolled in the Medi-Cal program and received a mental health service during the quarter; and the unduplicated number of all individuals (Medi-Cal and non-Medi-Cal) who received a mental health service during the quarter.

### **C. Skilled Professional Medical Personnel**

Skilled Professional Medical Personnel (SPMP) employed by the mental health plan and their directly supporting staff may claim Federal Financial Participation (FFP) at a rate of 75% of eligible expenditures related to two particular Mental Health Medi-Cal Administrative Activities. Federal regulations identify five criteria that must be met to claim 75% reimbursement for SPMP staff. This section identifies those criteria and how they will be implemented in California's Mental Health Medi-Cal Administrative Claiming process.

The first criterion is that the expenditures are for activities that are directly related to the administration of the Medicaid program, and as such do not include expenditures for medical assistance. The Implementation Plan identifies two administrative activities that are eligible for 75% reimbursement: Program Planning and Policy Development and Case Management of Non-Open Cases. The first criterion will be met only when one of these two activities is being performed.

The second criterion is that the individual performing the activity has professional education and training in the field of medical care or appropriate medical practice. Professional education and training means the completion of a 2-year or longer program leading to an academic degree or certificate in a medically related profession, which is demonstrated by possession of a medical license, certificate, or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. The second criterion will be met when the individual performing the activity has completed a 2-year or longer program of academic study in a medically related profession and has an active license issued by a State of California licensing body to practice in that medically related profession. Such licensed professionals include, but are not limited to, the following:

- Psychiatrist
- Physician
- Psychologist
- Registered Nurse
- Licensed Clinical Social Worker (LCSW)
- Marriage and Family Therapist (MFT)

The third criterion is that the individual is in a position that has duties and responsibilities that require their professional medical knowledge and skills. The third criterion is met when the individual is performing an allowable MH MAA activity that requires the specialized knowledge and/or skill of an SPMP. The duty statement for those classifications that require a license will identify the MH MAA activities required to be performed in the position. Some Case Management and PP&PD activities require the knowledge and skill of an SPMP and will be eligible for enhanced reimbursement. When coding time, SPMP staff will assess whether or not the activity performed required the use of their specialized knowledge and skill.

The fourth criterion is that the individual be employed by the Medicaid agency or by a public agency that has a written agreement with the Medicaid agency to verify that these requirements are met. To be eligible to claim 75% reimbursement, the staff must also be employed by the county mental health department, which meets the first part of the fourth criterion. The agreement between the county mental health department and the Medicaid agency will be contained in the mental health plan contract between the county mental health department and the State. Therefore, only individuals who are employed by county mental health departments that have executed a mental health plan contract with the State are eligible to claim 75% reimbursement when the other three criteria have also been met.

Finally, the employee costs for those directly supporting SPMP staff are also eligible for 75% reimbursement. Directly supporting employees include secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that are directly necessary for the completion of the professional medical responsibilities and functions of the skilled professional medical staff. The skilled professional medical employees must directly supervise the supporting employees and the performance of the supporting employees.

## D. Quarterly Claim for Reimbursement

DHCS will provide interim federal reimbursement to mental health plans on a quarterly basis. Interim reimbursement will be determined on a quarterly invoice submitted by the mental health plan. Interim payments will be settled to actual cost through the annual cost report. This section describes the seven schedules in the invoice and how MHPs are to complete the invoice. The quarterly invoice contains four cost pools. The first cost pool includes salary and benefit costs for all activities reimbursed at 50% that are not discounted. This cost pool includes the following activities:

- Activity 4 – Medi-Cal Outreach – Not Discounted
- Activity 6 – Medi-Cal Eligibility Intake – Not Discounted
- Activity 10 – Mental Health Services Contract Administration – Not Discounted
- Activity 17 – MH MAA Coordination and Claims Administration – Not Discounted

The second cost pool includes the salary and benefit costs for all activities reimbursed at 50% that are discounted by the Medi-Cal discount percentage. This cost pool includes the following activities:

- Activity 8 – Referral in Crisis Situations for Non-Open Cases – Discounted
- Activity 11 – Mental Health Services Contract Administration – Discounted
- Activity 13 – Program Planning and Policy Development – Discounted, Non-SPMP

Column D includes the cost pool for activities performed by an SPMP which are reimbursed at the enhanced rate of 75% and are discounted by the Medi-Cal discount percentage. The activities in this cost pool will be performed by a SPMP. The allowable activities associated with the cost pool captured in Column D include:

- Activity 14 – Program Planning and Policy Development – Discounted, SPMP
- Activity 16 – Case Management of Non-Open Cases – Discounted, SPMP

The fourth cost pool includes general and administrative costs. General and administrative costs include salary and benefit costs allocated to Activity 18. General and administrative costs also include other operating expenses, which are non-salary costs.

The following is an example of how to fill out the invoice as it relates to the above-discussed cost pools. The fourth cost pool, Line 2 “General and Administrative Costs,” will be discussed with a following example of how to fill out this cost pool and the remainder of the invoice schedules.

## **Schedule A – MH MAA Time Study Results**

The purpose of Schedule A is to capture the claiming unit's time study results, including time for direct charges.

**Column A – Staff Classifications:** Please enter the classification for each individual that the claiming unit identifies as performing MH MAA on the CUGF from the claiming plan that was in effect during the quarter for which the invoice is being submitted. For example, if the CUGF identifies three individuals in the classification of Accountant I, Accountant I should appear three times whether or not each of those individuals performed MH MAA during the quarter.

**Column B – Medi-Cal Outreach (Not Discounted):** Please enter the number of minutes each staff classification listed on Column A spent performing Medi-Cal Outreach (Not Discounted). The amount of time reported in Column B should be supported by personnel activity reports that are prepared at least once a month and are signed by the employee.

**Column C – Medi-Cal Eligibility Intake (Not Discounted):** Please enter the number of minutes each staff classification listed on Column A spent performing Medi-Cal Eligibility Intake (Not-Discounted). The amount of time reported in Column C should be supported by personnel activity reports that are prepared at least once a month and are signed by the employee.

**Column D – Referral in Crisis Situations for Non-Open Cases (Discounted):** Please enter the number of minutes each staff classification listed on Column A spent performing Referral in Crisis Situations for Non-Open Cases (Discounted). The amount of time reported in Column D should be supported by personnel activity reports that are prepared at least once a month and are signed by the employee.

**Column E – Mental Health Services Contract Administration (Not Discounted):** Please enter the number of minutes each staff classification listed on Column A spent performing Mental Health Services Contract Administration (Discounted). The amount of time reported in Column E should be supported by personnel activity reports that are prepared at least once a month and are signed by the employee.

**Column F – Mental Health Services Contract Administration (Discounted):** Please enter the number of minutes each staff classification listed on Column A spent performing Mental Health Services Contract Administration (Discounted). The amount of time reported in Column F should be supported by personnel activity reports that are prepared at least once a month and are signed by the employee.

**Column G – SPMP Program Planning and Policy Development (Discounted):** Please enter the number of minutes each staff classification listed on Column A spent performing SPMP Program Planning and Policy Development (Discounted). The amount of time reported in Column G should be supported by personnel activity reports that are prepared at least once a month and are signed by the employee.

**Column H – Non-SPMP Program Planning and Policy Development (Discounted):** Please enter the number of minutes each staff classification listed on Column A spent performing Non-SPMP Program

Planning and Policy Development (Discounted). The amount of time reported in Column H should be supported by personnel activity reports that are prepared at least once a month and are signed by the employee.

Column I – SPMP Case Management of Non-Open Cases (Discounted): Please enter the number of minutes each staff classification listed on Column A spent performing SPMP Case Management of Non-Open Cases (Discounted). The amount of time reported in Column I should be supported by personnel activity reports that are prepared at least once a month and are signed by the employee.

Column J – MH MAA Coordination and Claims Administration (Not Discounted): Please enter the number of minutes each staff classification listed on Column A spent performing MH MAA Coordination and Claims Administration (Not Discounted). The amount of time reported in Column J should be supported by personnel activity reports that are prepared at least once a month and are signed by the employee.

Column K – General Administration: Please enter the number of minutes each staff classification listed on Column A spent performing general administration activities. The amount of time reported in Column K should be supported by personnel activity reports that are prepared at least once a month and are signed by the employee.

Within the administrative category certain operating costs may be allowable. These costs are allowable to the extent they are (1) necessary for the proper and efficient administration of the Medi-Cal program, (2) reasonable, (3) related to and needed for the provision of Medi-Cal services and allocated on an acceptable basis, and (4) in accordance with the Mental Health Medi-Cal Administrative Activities Implementation Plan.

Column L – Non-Reimbursable: This is the number of minutes each staff classification listed on Column A spent performing non-reimbursable activities. Column L is formula-driven: The total minutes in Column M minus the sum of columns B through K. The amount of time reported in Column L should be supported by personnel activity reports that are prepared at least once a month and are signed by the employee.

Column M: Total Minutes: Column M is equal to the sum of Columns B through L. Employees are expected to record 100 percent of their time. Column M should reconcile with time sheets used to process payroll for each individual listed in Column A.

## **Schedule B – Salaries and Benefits**

The purpose of Schedule B is to determine the quarterly salary and benefit costs for each Staff Classification listed in Schedule A.

Column A – Staff Classification: Column A is automatically populated from Schedule A, Column A.

Column B – Salary: Please enter the annual salary paid to each individual listed in Column A that was in effect during the quarter for which the invoice is being prepared. The amount entered in Column B must be supported with official payroll documents.

Column C – Benefits: Please enter the cost of benefits provided to each individual listed in Column B. Benefits are often estimated as a percentage of the individual's salary. The amount reported in Column C must be supported by official payroll or budget documents.

Column D – Salary and Benefits: Column D is equal to the sum of Columns B and C. Column D represents the total annual salary and benefit costs incurred for each employee listed in Column A.

## **Schedule C – Salary and Benefit Allocation Percentages**

The purpose of Schedule C is to determine the percentage of total time worked each classification spent reimbursable and non-reimbursable activities.

Column A – Staff Classification: Column A is automatically populated from Schedule A, Column A.

Column B – Medi-Cal Outreach (Not Discounted): Column B is equal to the total minutes entered in Schedule A, Column B divided by the total minutes calculated in Schedule A, Column M.

Column C – Medi-Cal Eligibility Intake (Not Discounted): Column C is equal to the total minutes entered in Schedule A, Column C divided by the total minutes calculated in Schedule A, Column M.

Column D – Referral in Crisis Situations for Non-Open Cases (Discounted): Column D is equal to the total minutes entered in Schedule A, Column D divided by the total minutes calculated in Schedule A, Column M.

Column E – Mental Health Services Contract Administration (Not Discounted): Column E is equal to the total minutes entered in Schedule A, Column E divided by the total minutes calculated in Schedule A, Column M.

Column F – Mental Health Services Contract Administration (Discounted): Column F is equal to the total minutes entered in Schedule A, Column F divided by the total minutes calculated in Schedule A, Column M.

Column G – SPMP Program Planning and Policy Development (Discounted): Column G is equal to the total minutes entered in Schedule A, Column G divided by the total minutes calculated in Schedule A, Column M.

Column H – Non-SPMP Program Planning and Policy Development (Discounted): Column H is equal to the total minutes entered in Schedule A, Column H divided by the total minutes calculated in Schedule A, Column M.

Column I – SPMP Case Management of Non-Open Cases (Discounted): Column I is equal to the total minutes entered in Schedule A, Column I divided by the total minutes calculated in Schedule A, Column M.

Column J – MH MAA Coordination and Claims Administration (Not Discounted): Column J is equal to the total minutes entered in Schedule A, Column J divided by the total minutes calculated in Schedule A, Column M.

Column K – General Administration: Column K is equal to the total minutes entered in Schedule A, Column K divided by the total minutes calculated in Schedule A, Column M.

Column L – Non-Reimbursable: Column L is equal to the total minutes entered in Schedule A, Column L divided by the total minutes calculated in Schedule A, Column M.

Column M – Total: Column M is equal to the sums of Columns B through L.

## **Schedule D – Allocation of Salary and Benefit Costs**

The purpose of Schedule D is to allocate the total salary and benefit costs to reimbursable and non-reimbursable activities.

**Column A – Staff Classification:** Column A is automatically populated from Schedule A, Column A.

**Column B – Medi-Cal Outreach (Not Discounted):** Column B is equal to the allocation percentage calculated in Schedule C, Column B multiplied by the total salary and benefit costs calculated in Schedule B, Column D for each staff classification listed in Column A.

**Column C –Medi-Cal Eligibility Intake (Not Discounted):** Column C is equal to the allocation percentage calculated in Schedule C, Column C multiplied by the total salary and benefit costs calculated in Schedule B, Column D for each staff classification listed in Column A.

**Column D – Referral in Crisis Situations for Non-Open Cases (Discounted):** Column D is equal to the allocation percentage calculated in Schedule C, Column D multiplied by the total salary and benefit costs calculated in Schedule B, Column D for each staff classification listed in Column A.

**Column E – Mental Health Services Contract Administration (Not Discounted):** Column E is equal to the allocation percentage calculated in Schedule C, Column E multiplied by the total salary and benefit costs calculated in Schedule B, Column D for each staff classification listed in Column A.

**Column F – Mental Health Services Contract Administration (Discounted):** Column F is equal to the allocation percentage calculated in Schedule C, Column F multiplied by the total salary and benefit costs calculated in Schedule B, Column D for each staff classification listed in Column A.

**Column G – SPMP Program Planning and Policy Development (Discounted):** Column G is equal to the allocation percentage calculated in Schedule C, Column G multiplied by the total salary and benefit costs calculated in Schedule B, Column D for each staff classification listed in Column A.

**Column H – Non-SPMP Program Planning and Policy Development (Discounted):** Column H is equal to the allocation percentage calculated in Schedule C, Column H multiplied by the total salary and benefit costs calculated in Schedule B, Column D for each staff classification listed in Column A.

**Column I – SPMP Case Management of Non-Open Cases (Discounted):** Column I is equal to the allocation percentage calculated in Schedule C, Column I multiplied by the total salary and benefit costs calculated in Schedule B, Column D for each staff classification listed in Column A.

**Column J – MH MAA Coordination and Claims Administration (Not Discounted):** Column J is equal to the allocation percentage calculated in Schedule C, Column J multiplied by the total salary and benefit costs calculated in Schedule B, Column D for each staff classification listed in Column A.

**Column K – General Administration:** Column K is equal to the allocation percentage calculated in Schedule C, Column K multiplied by the total salary and benefit costs calculated in Schedule B, Column D for each staff classification listed in Column A.

Column L – Non-Reimbursable Activities: Column L is equal to the allocation percentage calculated in Schedule C, Column L multiplied by the total salary and benefit costs calculated in Schedule B, Column D for each staff classification listed in Column A.

Column M – Total Salary and Benefits: Column M sums Columns B through Column L.

## **Schedule E – Total General and Administrative Costs**

The purpose of Schedule E is to determine the general and administrative costs to be allocated among the cost pools.

Line 1, Column B: Line 1 is automatically populated from Schedule D, Column K. Line 1 is equal to the total salary and benefit costs that were allocated to the general and administrative cost pool.

Line 2, Column B: Please enter the total other operating expenses incurred for the MH MAA program during the quarter for which this invoice is being prepared.

In general, operating costs are those costs other than salary and benefits which are needed for staff to perform their daily work on the administration of the Medi-Cal program. For example, this would include items needed by the office, such as paper, pencils, desks, chairs, and other office supplies and furnishings. MH MAA operating expenses must not be duplicated or confused with other kinds of administrative costs, such as those outlined under Section 5724 of the Welfare and Institutions Code and associated with service costs claimed through the Short-Doyle/Medi-Cal system.

The following is a list of claimable non-salary costs and a list of non-claimable non-salary costs. Both lists are examples and are not comprehensive. These costs are claimable costs only if they do not relate to non-claimable categories of cost. As part of the invoice submission, LGAs are required to provide a detailed list of all non-salary costs that are included in the invoice.

### **Claimable Non-Salary Costs:**

- Office supplies
- Office furniture
- Computers and software
- Data processing costs
- Purchased clerical support
- Office maintenance costs
- Utility costs
- Building/space costs (with capitalization limits)
- Repair and maintenance of office equipment
- Vehicle rental/amortization and fuel
- Facility security services
- Printing and duplication costs
- Agency publication and advertising costs
- Personnel and payroll services costs
- Travel
- Property and liability insurance (excluding malpractice insurance)
- Professional association/affiliation dues
- Legal representation for the agency
- Indirect costs when determined to be in accordance with OMB Circular A-87

**Non-Claimable Non-Salary Costs:**

- Malpractice insurance
- Equipment used for providing medical treatment
- Medical supplies
- Drugs and medications
- Payments made to resolve audits
- Costs of elected officials and their related costs
- Costs for lobbying activities
- Fund Raising

Line 3, Column B: Please enter the total Internal Indirect Costs incurred by the claiming unit during the quarter for which the invoice is being prepared.

Line 4, Column B: Please enter an estimate of the total OMB A-87 external indirect costs that will be allocated to the claiming unit after the close of the fiscal year.

Line 5, Column B: Line 5 is equal to the sum of lines 1 through 4. Line 5 is equal to the total general and administrative costs for the claiming unit.

Line 6, Total MAA Minutes Worked, is automatically populated from Schedule A and is the total of columns B through J.

Line 7, Total Claiming Unit Minutes Worked, is automatically populated from Schedule A, Column M.

Line 8 is formula-driven and is the percentage of the MAA minutes worked (Line 6 divided by Line 7).

Line 9, MAA General and Administrative Costs, is formula-driven: Line 5 multiplied by Line 8.

Line 10 is the Total Salary and Benefits Allocated to General and Administrative Cost Pool and is populated from Schedule D, Column K.

Line 11, Total General and Administrative Costs, is formula-driven and is the sum of the MAA General and Administrative Costs, and Total Salary and Benefits Allocated to General and Administrative Cost Pool.

## **Schedule F – Allocation of Total General and Administrative Costs**

The purpose of Schedule F is to allocate the total general and administrative costs calculated on Schedule E to the cost pools.

Line 1 – Allocated Salary and Benefit Costs: Line 1 is automatically populated from the Totals line on Schedule D for each cost pool.

Line 2 – Overhead Allocation Percentages: Line 2 is equal to Line 1 for each cost pool divided by Line 1, Column L. Line 2 calculates each cost pool's percentage of the total cost incurred by the claiming unit.

Line 3 – Overhead Allocated Costs: Line 3 is equal to Line 2 for each cost pool multiplied by Line 11 from Schedule E.

## **Schedule G – Claim for Federal Financial Participation**

Line 1 – Allocated Salary and Benefit Costs: Line 1 is automatically populated from the Totals line on Schedule D for each cost pool. The cost pools created by summing the activity totals from Schedule D are:

- Non-SPMP, Not-Discounted
- Non-SPMP, Discounted
- SPMP, Discounted

Line 2 – General and Administrative Costs: Line 2 is equal to the sum of Schedule F, Line 3 for each cost pool.

Line 3 - Direct Charge (Contractor Fees): Input any direct charges or contractor fees in Line 3. Keep any contractor invoices or related backup for the audit file. These documents should tie to the totals entered into Line 3.

Line 4 – Total MH MAA Expenditures: Line 4 sums the values of the Lines 1, 2, and 3.

Line 5 – Medi-Cal Discount Percentage: Line 5 reflects the calculated Medi-Cal discount percentage to be applied to the two discounted cost pools, Non-SPMP – Discounted (Column B) and SPMP – Discounted (Column D).

Line 6 – Total Eligible MH MAA Expenditures: Line 6 multiplies Line 4 by the discount percentage in Line 5.

Line 7 – Offsetting Revenue: Any offsetting revenue applicable to Columns A, B, and D should be input into Line 7.

Line 8 – Total Allowable Expenditures: Line 8 subtracts Line 7 from Line 6.

Line 9 – FMAP: Line 9 reflects the appropriate FMAP for the cost pools in Columns A, B, and D.

Line 10 – Total FFP: Line 10 multiplies Line 8 by Line 9 to derive the total FFP the MHP is claiming for the quarter.

Once the invoice has been created it must be certified by the mental health director and the county auditor controller or the mental health plan's chief financial officer. The mental health director certifies the accuracy of the program information and the auditor controller or the chief financial officer certifies that the costs contained in the invoice are eligible for federal reimbursement pursuant to Title 42, Code of Federal Regulations Section 433.

## **E. Settlement to Interim Mental Health Cost Report**

All interim payments made to the mental health plan will be settled to cost annually in the mental health cost report. The county mental health plans and each of their contract providers are required to submit a comprehensive cost report on an annual basis. The cost report captures each provider's total cost of providing mental health services and activities, including MH MAA, and allocates those costs to services and activities that are Medi-Cal reimbursable and services and activities that are not Medi-Cal reimbursable. This section of the Implementation Plan discusses the type of information collected in the cost report and how it will be used to determine the costs that are eligible for federal reimbursement.

The cost report begins with each provider's total costs for the fiscal year as reported in the organization's financial statements. Total costs for the county mental health plan are taken from the county department's financial statement prepared by the county auditor-controller. The total costs for a contract provider are taken from its trial balance.

Each service provider will adjust its total costs as well. The adjustments will be made to comply with Medicaid principles of reimbursement. For example, an organization that fully recognizes the cost of an asset used to deliver Medi-Cal services in the year it was purchased will need to adjust its costs so it recognizes the depreciation expense only for that particular fiscal year. Adjustments also will be made to remove non-mental health costs. For example, a county mental health department part of a behavioral health department would adjust its total costs to remove the alcohol and other drug costs.

Each provider will allocate its adjusted costs to reimbursable-cost centers. The county mental health plan allocates its adjusted costs among administration, utilization review/quality assurance, and services, which includes MH MAA. Contract providers will allocate their adjusted costs to services, which includes MH MAA. Costs allocated to administration and utilization review/quality assurance are further distributed to Medi-Cal and non-Medi-Cal reimbursable administration and utilization review/quality assurance. Costs allocated to services will be further distributed among various types of services and activities. These services and activities are either Medi-Cal reimbursable or not Medi-Cal reimbursable.

The cost report captures one hundred percent of each provider's costs and allocates them to reimbursable and non-reimbursable services and activities. The cost report is an auditable document that allows the State to verify costs allocated to particular services and activities are allowable and have not been allocated to more than one service and/or activity.

## **F. Certified Public Expenditures**

County mental health plans must meet federal Certified Public Expenditure (CPE) requirements to receive FFP for MH MAA. MHPs should obtain and maintain supporting documentation to verify the following:

- 100 percent of the expenditures eligible for reimbursement are specifically related to performing the Medi-Cal specialty mental health program administrative activities and services
- The expenditures eligible for reimbursement are restricted to the actual costs incurred
- The funds expended to account for the actual costs are from revenue sources allowable under all applicable state and federal laws and regulations
- The administrative activity and service expenditures of the Medi-Cal specialty mental health program are incurred prior to requesting FFP reimbursement

MHPs must certify to their allowable expenditures for the actual costs of providing MH MAA. MHPs may not use private funds and contract providers may not certify their own expenditures. MHP's must first pay contract providers for the MH MAA performed before submitting a claim to the State for federal reimbursement. The claim to the State must be based upon the costs incurred by the MHP for the services provided by the contract provider.

The State will provide training to the MHPs and will provide ongoing technical assistance to MHPs that have questions regarding these CPE requirements.

## **VI. MONITORING AND OVERSIGHT**

The State will provide comprehensive monitoring and oversight related to the MH MAA program. The monitoring and oversight to ensure program quality and compliance will take place in a variety of contexts:

- Training
- Information dissemination
- Program Auditing
- Fiscal Auditing

These activities, described in the following subsections, will support program compliance with all Federal and State regulations and guidelines for the MH MAA program.

## **A. Training**

The State will conduct annual training for all MHPs with an approved MH MAA program. These training sessions will be focused on three topics:

1. Claiming Plan Training will focus on the requirements of a complete Claiming Plan and will adhere to the methodology described in Section III: Mental Health Medi-Cal Administrative Activities Claiming Plan.
2. Time Study Training will focus on the protocol and procedures for claiming plan employees conducting time studies. This training will adhere to the requirements described in Section V-A: Time Tracking.
3. Invoice Training will focus on the protocol and procedures for MHPs' quarterly claiming for reimbursement via the seven schedules of the Quarterly Claim form (Appendix 13). This training will adhere to the requirements described in Section V-D: Quarterly Claim for Reimbursement, Schedule G

Furthermore, the State may conduct additional training sessions going forward as determined to be necessary via program and financial-audit findings on an ad hoc basis.

## **B. Information Dissemination**

The State will periodically issue Mental Health Information Notices to key organization leaders, including the Mental Health Directors, of the MHPs. Initial Information Notices will focus on publishing the Implementation Plan, as well as communicating the process which the State will review existing plans to ensure compliance with the revised Implementation Plan. Additional Information Notices will publish updated forms and invoices, as well as instructions for completion. In the future, additional Information Notices will announce training sessions, as well as any program changes, including monitoring and oversight activities.

Information dissemination will also be conducted via the Mental Health Medi-Cal Administrative Activities webpage at <http://www.dhcs.ca.gov/services/Pages/MH-MAA.aspx>. The MH MAA webpage will be the source for updated forms and invoices as well as instructions for completion. Additionally, the webpage will be updated for announcements of training sessions, program changes, monitoring and oversight activities.

## **C. MH MAA Program Compliance Responsibilities**

Each entity within the MH MAA program claiming process has a responsibility to ensure MH MAA program claiming compliance. The first level of review is done at the claiming unit or 'local' level. The local level review includes a review of the MH MAA claiming plan documents, the time survey and/or direct charge documents, and the quarterly invoice documents to ensure they are accurate and complete. The local level review should also ensure that all training guidelines are met.

The second level of review is done at the MH MAA Coordinator level. Review at this level includes a secondary review of all local level responsibilities; however, the MH MAA Coordinator also has primary responsibility to comply with all training, site visit, desk review, and claiming plan requirements to ensure accuracy and completeness regarding MH MAA claiming. The MH MAA Coordinator is responsible for ensuring accuracy and completeness regarding all MH MAA program related documents and guidelines. The MH MAA Coordinator is also responsible for the submission of MH MAA claiming invoices to DHCS.

The third and final level of review is performed by DHCS. Review at this level includes a final review of all local and MHP level responsibilities. DHCS will conduct ongoing reviews of all MH MAA claiming documents, processes, procedures, and guidelines. In the event deficiencies are discovered, DHCS will take whatever steps necessary to ensure the integrity of the MH MAA program and its funding. If a review identifies an invoice overpayment, DHCS will recover the overpayment amount from the MHP. If warranted, DHCS may also conduct additional training, implement procedural changes, and/or perform provider audits and reviews. In the event an audit or review is necessary, DHCS will, upon conclusion of the audit or review, issue a written report reflecting findings and required corrective actions and identify any required recovery amounts, if applicable.

### **a. MH MAA Program Site Review**

DHCS will conduct program site reviews of each MHP participating in the MH MAA program at least once every four years. The purpose of the site visit is to verify that the MH MAA claiming by the MHPs for the approved claiming units are in compliance with State and federal laws, rules, and regulations. The claiming units included in the review will be a representative sample of all of the claiming units within each MHP. DHCS will analyze the following documents during the review:

#### **Time Survey Documentation**

- Copies of time cards or time sheets for the time survey period
- Staff Certification of All Staff Time forms

#### **Invoice Documentation**

- Copies of salaries and benefits information used for those costs associated with the invoices (such as payroll registers, general ledgers, budget reports, etc.)
- Non-salary costs backup documentation
- Supporting documentation for CPE (if applicable)
- Supporting documentation for Actual Client Count (if applicable)

- Supporting documentation for Direct Charge (if applicable)

**Claiming Plan Documentation (as applicable)**

- Flyers, announcements, or other materials
- Materials unique to, or designed by, the claiming unit
- Copies of contracts/MOUs between the MHP and the Claiming Unit
- Copies of contracts/MOUs between the Claiming Unit and any subcontractors
- Documentation that supports Claiming Plan Methodology for determining direct charge claiming and the dollar amount to be paid to the subcontractor and/or MHP staff
- Sample(s) of Resource Directories
- Full and complete duty statements
- Time Survey Training Presentation and sign-in sheets
- SPMP Designation Documentation
- Copies of SPMP supporting documentation (e.g. copies of the SPMP license)
- List of staff in each classification
- Copies of training curriculum and materials

On the day of the site review, DHCS staff will arrive at the designated address. The site review will begin with DHCS staff conducting an entrance conference with the MH MAA Coordinator and any pertinent MHP or claiming unit staff that wish to be present. The entrance conference will explain the DHCS site review process and provide an opportunity for the staff in attendance to ask questions prior to the review.

Upon conclusion of the entrance conference, DHCS staff typically begin the interview process with the selected participating staff. However, the interviews are conducted in consideration of the claiming unit's staff schedules; therefore, the interviews may be conducted sporadically throughout the site review. The interview will assess the job responsibilities of staff, whether these responsibilities are appropriate, and whether these responsibilities match with the MHP's approved claiming plan. Either after the interviews or immediately following the entrance conference, DHCS staff will begin review of the MHP claiming unit documentation. The MH MAA Coordinator is permitted to be present during the documentation review; although, it is not a requirement. However, the MH MAA Coordinator should be available to DHCS staff to answer any questions regarding the documentation.

DHCS staff will utilize a standardized worksheet to conduct the documentation review. The MH MAA worksheet provides a series of questions that DHCS staff intend to obtain answers in relation to the areas of documentation under review. As part of this process, DHCS will request copies of staff licenses. All MHP documentation, processes, procedures, and guidelines should be reasonable and appropriate for billing and/or reimbursement.

Once the on-site review has been concluded, the DHCS staff will conduct an exit conference with the MH MAA Coordinator and any pertinent MHP or claiming unit staff that wish to be present. The exit conference will explain the results of the DHCS site review, detail the corrective measures that may be needed, if any, and provide an opportunity for the staff in attendance to ask questions regarding the site review findings.

Within 60 days following the site review, the MH MAA Coordinator will receive a written summary of findings report from DHCS. The report will provide an analysis of the site review, and will either indicate that the MHP is in compliance with the MH MAA claiming standards, or will indicate that the MHP is required to develop a corrective action plan to correct any issues that were discovered during the site review. The summary of findings report will also give the MHP a deadline for submitting the corrective action plan to DHCS. DHCS will review and approve the corrective action plan prior to the MHP submitting any corrections and/or revisions. Once the plan is approved by DHCS, the MHP will be sent an approval letter and a DHCS MH MAA analyst will work with the MHP to ensure all identified corrections and/or revisions are resolved. In the event the corrective action plan is not approved, the DHCS MH MAA analyst will provide technical assistance to the MHP to ensure the plan meets the standards for MH MAA claiming.

DHCS will maintain copies of any monitoring tools, the summary of findings, all corrective action plan responses, and technical assistance documents (if applicable).

#### **b. Recurring Compliance Issues**

Repetitive deficiencies or compliance issues within an MHP may be cause for DHCS to conduct more frequent site visits, desk reviews, or technical assistance visits. DHCS will also require the MHP to regularly submit more thorough and complete supporting documentation for invoices. In extreme cases, DHCS will conduct site reviews, desk reviews, or technical assistance visits every two years instead of every four years to ensure adequate oversight and monitoring.

## **D. Financial Audits and Audit Files**

The State will audit each mental health plan's annual cost report, including costs allocated to administrative activities. Mental health plans will maintain documentation allowing the State to verify that the costs allocated to MH MAA on the cost report were appropriately allocated. The purpose of this chapter is to provide mental health plans with guidance regarding the type of documentation that should be maintained in an audit file to facilitate an audit of its MH MAA claims.

Generally, a mental health plan's audit file will maintain documentation allowing an auditor to verify the following information:

1. A claiming unit that submitted one or more claims for reimbursement had a claiming plan in effect during the quarter(s) for which the claim(s) were submitted.
2. A claiming unit's claiming plan authorized it to perform the MH MAA for which it is claiming reimbursement.
3. A claiming unit performed the number of MH MAA units for which it is claiming reimbursement.
4. The staff members who performed the MH MAA units were identified in an approved claiming plan to perform the particular MH MAA units.
5. The costs included in the MH MAA salaries and benefits rates for which the claiming unit is claiming reimbursement were appropriately claimed as salaries and benefits costs.
6. The costs included in the direct charge amount, if any, were appropriately claimed as a direct charge.
7. The costs included in the calculation of the operating expense percentage were appropriately claimed as operating expenses and appropriately allocated to the MH MAA units.
8. The Medi-Cal percentage, if any, used to discount MH MAA expenditures must be calculated appropriately and is consistent with the method identified in the claiming plan.
9. A claiming unit that submitted one or more claims for reimbursement used appropriate sources of revenue to make the expenditures for which reimbursement is being claimed.

MHPs are required to submit a comprehensive claiming plan identifying all the claiming units for which claims will be submitted. The MHP must keep a copy of all the claiming plans. Claims submitted to the State without an approved claiming plan will be rejected.

The Claiming Unit Functions Grid (CUFG) of each claiming unit should identify the categories of MH MAA for which the MHP intends to claim reimbursement. The activity codes entered on Schedule A of the Quarterly Claiming form must correspond with the activity codes on the CUFG.

MHPs are required to document performance of MH MAA on a minute-by-minute basis. Each minute spent performing a particular MH MAA is equivalent to one MH MAA unit.

MHPs will maintain documentation that meets the standards described in the Office of Management and Budget (OMB) Circular A-87, which provides guidance for documenting staff time allocated to

federal awards. When employees work solely on a single federal award or cost objective (i.e., a single MH MAA), charges for their salaries and wages may be supported by periodic certifications (at least semi-annually) that the employee(s) worked solely on that cost-objective for the period covered by the certification. These certifications will be signed by the employee or a supervisor who has firsthand knowledge of the work the employee performs. When employees work on multiple activities or cost objectives (i.e., multiple MH MAA), a distribution of their time will be supported by personnel activity reports or equivalent documentation, which meets the following standards:

- Reflects an after-the-fact distribution of the actual activity of the employee;
- Accounts for the total activity for which each employee is compensated;
- Prepared at least monthly and coincides with one or more pay periods; and,
- Signed by the employee.

The claiming plan will identify on the CUFG the staff job classifications and the number of employees within each classification who will perform particular MH MAA. The staff job classifications identified on the CUFG must correspond with the staff job classifications identified on the certifications and/or personnel activity reports used to document the distribution of staff time. Furthermore, the MH MAA to which each staff job classification distributed his/her time must correspond with the MH MAA identified for that staff job classification on the CUFG.

MHPs will maintain documentation that allows an auditor to verify that the salaries and benefits costs included in the salaries and benefits rates on the Quarterly Claiming form were appropriately allocated. In addition to maintaining documentation of time spent performing particular MH MAA, the MHP will maintain payroll documentation that is in accordance with generally accepted practices of the mental health plan and are approved by a responsible official of the governmental unit, such as time sheets that are signed by the employee and the employee's supervisor. Documentation of the actual expenditures (e.g., payroll summaries) on salaries and benefits for those employees whose salaries and benefits are allocated to the salaries and benefits rates will also be maintained. In addition, the MHP will maintain work papers that clearly show how the actual expenditures on salaries and benefits were allocated to particular MH MAA and how the salaries and benefits rates were finally calculated. The job titles on the payroll documentation must match the job titles on the CUFG and the corresponding duty statements.

Documentation will be maintained to verify direct charge amount, if any, that is claimed on the Quarterly Claiming form. Mental health plans may direct charge certain types of costs. These costs include salaries and benefits of individuals charging time to any one activity code, and expenditures made to subcontractors with MH MAA specific contracts. Individuals direct charging their time to one allowable MH MAA activity code will maintain documentation of the time charged to the code. The mental health plan will maintain documentation of time worked that is consistent with the OMB Circular A-87, the MH MAA specific contracts for which a direct charge amount is claimed, and the actual salaries and benefits expenditures or expenditures made to the subcontractors with MH MAA

specific contracts. The supporting documentation must reconcile with the direct charge amount on Schedule G of the Quarterly Claiming form.

Operating expenses and percentages used to allocate those expenses are to be entered into the Quarterly Claiming form. For daily and monthly operating expenses, the mental health plan will maintain a list of items purchased (e.g., paper, pencils, furniture, and equipment), the expenditures made for those items, and the basis for allocating those costs among the various activities of the claiming unit. For internal and external indirect costs, the mental health plan will maintain a copy of the internal and external indirect cost plans and documentation that those costs were allocated in a manner consistent with the plan.

The MHP will maintain documentation that verifies that the sources of revenue used to make the expenditures for which reimbursement is being claimed are eligible for FFP. This documentation will include work papers that clearly show:

- All sources of revenue available to the claiming unit during a particular quarter
- The sources of revenue that are and are not eligible for FFP
- The total amount of each revenue source that was expended
- The total amount of revenue sources eligible for FFP that were expended
- The total MH MAA costs for which reimbursement is being claimed
- The total amount of expenditures that were supported by sources of revenue not eligible for FFP, which is the amount that needs to be offset

MHPs will complete the CMS-approved clinician log when a clinician performs a MH MAA in conjunction with a clinical service.

The mental health plan will maintain documentation that allows an auditor to verify that the staff members who performed MH MAA for which enhanced reimbursement is being claimed are actually SPMP. In addition, the mental health plan will maintain a copy of the employee's professional license or certification.