Drug Medi-Cal Claim for Reimbursement of Quality Assurance – Utilization Review Costs

County:_____ County Code: ___ Date: _____

Fiscal Year: _____ Quarter:_____

DMC: _____ ☐ Replacement Claim

Total Individuals Served:_____ Medi-Cal Individuals Served:_____

Individuals not Eligible for Federal Financial Participation:_____

		A	B
		Skilled Professional Medical Professional (SPMP)	Other Medi-Cal Program
1	*Salary		
2	*Benefits		
3	*Training		
4	*Travel		
5	*General Expense		
6	*Communication		
7	*Facility Operation		
8	TOTAL (1 thru 7)	0	0
9	*Percent of Time Spent on QA/UR	1	1
10	*Percent of Time Spent on QA/UR for Medi-Cal	1	1
11	Claimable Amount (8) x (9) x (10)	0	0
12	FFP – 75% Amount (11A) x (0.75)	0	
13	FFP – 50% Amount (11B) x (0.50)		0
14	County Match to FFP (11A minus 12A) and (11B minus 13B)	0	0
15	*Prop 30 State		
	Prop 30 State unused		
	Prop 30 State unused		

	Prop 30 State unused		
16	*Prop 30 Federal		
	Prop 30 Federal unused		
	Prop 30 Federal unused		
	Prop 30 Federal unused		
17	Medi-Cal Discount Percentage		
18	Non - Eligible Medi-Cal		
19	Prop 30 FFP Amount Claimable		
20	Prop 30 SGF Amount Claimable	0	
21	Total SGF Amount Claimable		[redacted]
22	Total FFP Amount Claimable (12A + 13B)		

County:_____ County Code: ___ Date: _____

Fiscal Year: _____ Quarter:_____

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Drug Medi-Cal services in and for said claimant; that I am authorized to sign this certification on behalf of the County; that I have not violated any of the provisions of Sections 1090-1099 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Welfare and Institutions Code Section 14124.24; that the claim is based on actual, total-fund expenditures for services to eligible beneficiaries; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with the law. The County further certifies under penalty of perjury that: all claims for services provided to county clients have been provided to the clients by the County or County-contracted provider; the services were, to the best of the County's knowledge, provided in accordance with the client's written treatment plan; and that all information submitted to the Department of Health Care Services (DHCS) is accurate and complete. The County understands that payment of these claims from federal and/or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. Pursuant to the Code of Federal Regulations (CFR) Title 42, Section 433.32, the County agrees to keep for a minimum of three years after final determination of costs is made through the DHCS cost report settlement process and retained beyond the three-year period if audit findings have not been resolved, a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The County agrees to furnish these records and any information regarding payments claimed for providing services, on request, within the State of California to DHCS, the Medi-Cal Fraud Unit, California Department of Justice, Office of the State Controller, U.S. Department of Health and Human Services, or their duly authorized representatives. The County also certified under penalty of perjury that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, gender, or physical or mental disability.

Print name:_____ Executed At:_____, California

County Alcohol and Other Drug Programs Administrator

Signature:_____ Date:_____

County:_____ County Code: ___ Date: _____

Fiscal Year: _____ Quarter:_____

I CERTIFY under penalty of perjury that I am a duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts; that I am authorized to sign this certification on behalf of the County, and that the information is to be used for filing a claim with the federal government for federal funds pursuant to CFR Title 42, Section 430.30. I understand that misrepresentation of any information provided herein constitutes a violation of state and federal law. I further certify under penalty of perjury that the claim is based on actual, total-funds expenditures made by the County of public funds that meet the requirements for claiming federal financial participation (FFP) pursuant to all applicable requirements of state and federal law, including, but not limited to CFR Title 42, Section 430.30 and 433.51, and the Federal Office of Management and Budget Circular A-87, and that the expenditures claimed have not previously been, nor will they be claimed at any other time as claims to receive FFP funds under Medicaid or any other program. I understand that DHCS must deny any payment if it determines that the certification is not adequately supported for purposes of claiming FFP. I understand that all records of funds expended are subject to review and audit by DHCS and/or the federal government and that, pursuant to CFR Title 42 Section 433.32, all records necessary to fully disclose the extent of services furnished to clients must be kept for a minimum of three years after the final determination of costs is made through the DHCS cost report settlement process and retained beyond the three year period if audit findings have not been resolved.

Print name:_____ Executed At:_____, California

Title:_____

County Auditor-Controller, City Finance Officer, or County Alcohol and Other Drug Programs Accounting Officer

Signature:_____ Date:_____

Instructions for Completing the DMC Quarterly Claim for Reimbursement of QA/UR Costs

Complete the following fields marked with an asterisk (*) in the form:

1. County: From dropdown selection, select County Name
2. County Code: will populate.
3. Date: Select the date claim form is submitted.
4. Fiscal Year: From dropdown selection, select Fiscal Year in which costs were incurred.
5. Quarter: Select applicable quarter (Q1, Q2, Q3, Q4 or Total Fiscal Year).
6. DMC: From dropdown selection, select DMC-ODS or DMC State Plan.
7. Replacement Claim: If submitting a replacement claim form, mark an “X”.
8. Total Individuals Served: Enter total individuals served.
9. Medi-Cal Individuals Served: Enter Medi-Cal Individuals Served.
10. Individuals not Eligible for Federal Financial Participation: Enter individuals not eligible for FFP.
11. Lines 1-7, Columns A & B
    a. Column A - Enter the amounts expended for skilled professional medical personnel and their direct support staff.
    b. Column B – Enter the amounts expended for non-medical professionals and non-enhanced clerical staff.
12. Line 9, – Enter the percentage of time staff spent on QA/UR activities.
13. Line 10, – Enter the percentage of time spent on Medi-Cal QA/UR. If your county only provided QA/UR only for Medi-Cal patients, then enter 100 percent. If your county provides quality assurance activities for all patients, then the percentage of Medi-Cal patients will be used here.
14. Line 15, Columns A & B – Enter the amounts expended for Prop 30 State. No current available claiming.
15. Line 16, Columns A & B – Enter the amounts expended for Prop 30 Federal. Beginning in July1, 2022, claiming for expenses related to Parity, Provider credentialing is allowable for State Plan Counties.
16. Lines 8, 11, 12, 13, 14, 17, 18, 19, 20, 21 and 22 – are formula driven with no data entry required by the county.
17. Send a signed claim form in a PDF format to BHFSOps @dhcs.ca.gov

Please use the Time Survey - Method to report all salary for the two main categories of expenses to be reported for the quarter, Skill Professional Medical Personnel (SPMP) and Other (Non SPMP salaries). Salaries bundled together and calculations are done in the reporting form allocating out QA/UR expenses. Example for quarter: 2 employees salaries are $50k, combined total $100k, for 1 quarter that would amount to $25k.

Certifications:
Each claim form must include the signed certification of the County Alcohol and Other Drug Programs Administrator and either County Auditor-Controller, Finance Officer, or County Alcohol and Other Drug Programs Accounting Officer.

Completed form is due within 60 calendar days following the end of the service quarter. Scan and email as an attachment to BHFSOps@dhcs.ca.gov.

SPMP Expenses

SPMP means physicians, nurses, and other specialized personnel who have professional education and training in the field of medical care or appropriate medical practice. This 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 medical field issued by a college or university certified by a professional medical organization (see 42 CFR 432.50(d)). In California, licensure organizations include the Board of Behavioral Sciences, Board of Registered Nursing, Medical Board of California, Board of Pharmacy, and the Board of Psychology.

SPMP must be in positions that have duties and responsibilities that require the application of their professional medical knowledge and skills.

The direct supporting staff are secretarial, copying personnel, file clerks, and records clerks who provide clerical services that are directly necessary for the completion of the responsibilities of the SPMP. The SPMP must directly supervise the supporting staff and the performance of the supporting staff's work.

Costs incurred must be attributable to the performance of medical QA/UR review by a quality improvement organization as defined in Title XI, Section 1152 of the SSA.

Other Expenses

Persons other than SPMP personnel that performed QA/UR activities.