State of California—Health and Human Services Agency
Department of Health Care Services

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Behavioral Health Information Notice No: 21-027

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Cost Allocation Policy for Mental Health Plans (MHP)

PURPOSE: To clarify how MHPs shall determine costs eligible for federal reimbursement when incurred to provide mental health and targeted case management services, perform utilization review and quality assurance (UR/QA) activities, and administer the mental health plan.

BACKGROUND:
MHPs submit claims for interim reimbursement of costs incurred to provide mental health and targeted case management services, to perform UR/QA activities, and to administer the mental health plan. DHCS makes interim payments of Federal Financial Participation (FFP) and, when applicable, State General Funds (SGF) to MHPs based upon their interim claims. Six months after the close of the fiscal year, MHPs submit an annual cost report that determines the reasonable and allowable cost incurred by the county and its contract providers to render mental health and targeted case management services, perform UR/QA activities, and to administer the mental health plan. DHCS reconciles all interim payments of FFP and SGF to actual costs as determined in the annual cost report.

POLICY:

Cost Principles

MHPs must determine costs eligible for federal reimbursement consistent with cost principles described in Title 2, Code of Federal Regulations, Part 200, Subpart E. Total costs of a federal award are equal to the sum of allowable direct costs and allocable indirect costs.[1] Direct costs include those costs that can be identified specifically with a particular cost objective[2] relatively easily with a high degree of accuracy.[3] Indirect costs include those costs incurred for a common or joint purpose benefiting more than one cost objective and not readily assignable to the specific cost objectives benefited without effort disproportionate to the results achieved.

The Medi-Cal specialty mental health services waiver program has three cost objectives that include medical assistance (i.e, direct client services), UR/QA activities, and administration of the mental health plan.[4] DHCS reimburses MHPs the federal share and, when required by Proposition 30, the non-federal share for allowable direct costs incurred to provide medical assistance, perform UR/QA activities, and administer the mental health plan plus an appropriate allocation of indirect costs among those three cost objectives. Enclosure 1 defines terms used in this Information Notice; Enclosure 2 provides examples of indirect costs and of methodologies that may be used to allocate indirect costs.

Mental Health and Targeted Case Management Services – Allowable Direct Costs

DHCS must reimburse MHPs that have certified public expenditures consistent with federal Medicaid requirements for calculating federal upper payment limits as specified in the approved Medicaid state plan and waivers.[5] The federal upper payment limit for non-risk contractors is equal to the amount DHCS would have paid on a fee-for-service basis for the services actually furnished to beneficiaries plus the net savings of administrative costs achieved by contracting with the mental health plan.[6] The amount that DHCS would have paid on a fee-for-service basis for mental health and targeted case management services is equal to allowable cost for county operated providers and to the lower of allowable cost or usual and customary charge for privately operated providers.[7] Allowable costs include both direct and indirect costs.[8] Allowable direct costs

[1] 2 C.F.R. § 200.402.
[2] 2 C.F.R. § 200.28.
[3] 2 C.F.R. § 200.413.
[4] Welfare and Institutions Code (W&I) § 14711.
[5] W&I § 14708.
[6] 42 C.F.R. § 447.362.
[7] California State Medicaid Plan (State Plan) Attachment 4.19-B, page 25, para. A.
[8] Id. at page 25, para. C.3.

are limited to the costs for direct practitioners, medical equipment, medical supplies, psychiatric inpatient hospital services, and other costs that can be directly charged to the service or services rendered.[9]

Direct Practitioners

Direct practitioners include those individuals who provide mental health services or targeted case management services. Mental health services include mental health services, medication support services, crisis intervention services, day treatment intensive, day rehabilitation, crisis stabilization, adult residential treatment, crisis residential treatment and psychiatric health facility services.[10] Mental health services also include the following Early and Periodic Screening, Diagnosis and Treatment services that are not defined in the Medi-Cal State Plan: Intensive Home-Based Services, Therapeutic Behavioral Services, Intensive Care Coordination, and Therapeutic Foster Care. Qualified providers include physicians, psychologists, licensed clinical social workers, licensed professional clinical counselors, marriage and family therapists, registered nurses, certified nurse specialists, nurse practitioners, licensed vocational nurses, psychiatric technicians, mental health rehabilitation specialists, physician assistants, pharmacists, occupational therapists, and other qualified providers.[11] The cost of salaries, wages, and benefits paid to qualified providers to render covered mental health and targeted case management services are an allowable direct cost.[12] Qualified providers also include those staff necessary to meet staffing requirements for day treatment intensive[13], day rehabilitation[14], crisis stabilization[15], adult residential treatment[16], crisis residential treatment[17], and psychiatric health facility services.[18] [19]

Medical Equipment

Medical equipment includes any equipment necessary to render a covered mental health or targeted case management service. Examples include the cost of telehealth

[9] Id.
[10] Supplement 3 to Attachment 3.1-A of the State Plan, pages 2c-2m.
[11] Id. at pages 2m-2p and Supplement 1 to Attachment 3.1-A, pages 11-15.
[12] 2 C.F.R. § 200.413(b).
[13] 9 Cal. Code of Regs. § 1840.350.
[14] Id. at 1840.352.
[15] Id. at 1840.348.
[16] Id. at 1840.354.
[17] Id. at 1840.356.
[18] Id. at 1840.358.
[19] Id. at 1840.344.

equipment and medical equipment purchased for and necessary to administer convulsive therapy.

Medical Supplies

Medical supplies include supplies of a medical nature that are necessary to render a covered mental health or targeted case management service. For example, syringes and needles purchased for and used to administer an injectable medication are medical supplies and the cost of those supplies is an allowable direct cost. Hand sanitizer, masks and gowns, plastic barriers, or other supplies used to allow safe patient care and prevent infection spread are medical costs. However, paper used to document services in a client's chart is not a medical supply.

Other Costs – Direct Charges

Other costs specifically incurred for the covered service or services rendered are also allowable direct costs of medical assistance. A cost that can be identified specifically with a covered service or services rendered may be directly charged.[20] All costs incurred that are necessary to run a direct service program may be directly charged to the provision of those services. This could include, but is not limited to, the cost of support staff, office supplies and furnishing, leased equipment, utilities and facility related costs. If staff within a direct service program also provide UR/QA activities, costs within that program with a joint purpose benefiting both direct service and UR/QA activities must be allocated between these two cost centers with a reasonable documented basis.

County-operated or county-contracted providers may use technology to improve care and support the delivery of mental health services. Examples include software programs to support case management (identifying needed services and connecting beneficiaries to them), apps to facilitate assessment, apps that collect patient-reported outcomes as part of clinical care or case management (such as administering patient surveys to measure response to treatment or other clinical outcomes), and apps that administer supplemental counseling or educational modules, such as app-based cognitive behavioral therapy. Software used for quality improvement purposes or evaluation is not considered a direct Medi-Cal reimbursement cost.

[20] 2 C.F.R. § 200.413.

Utilization Review and Quality Assurance – Direct Costs

DHCS must reimburse MHPs for the costs incurred to perform utilization review and quality assurance activities separately from the costs incurred to provide medical assistance and to administer the mental health plan.[21] Direct costs for utilization review and quality assurance include those costs that the mental health plan can relatively easily identify with performing utilization review and quality assurance activities with a high degree of accuracy.

Utilization review and quality assurance activities include those tasks a mental health plan must perform in order to implement the requirements contained in Exhibit A, Attachments 5 (Quality Improvement System), 6 (Utilization Management Program), 9 (Documentation Requirements), and 10 (Coordination and Continuity of Care) to the 2017-2022 mental health plan contract for monitoring and measuring performance, designing and implementing quality standards, developing policies and procedures for UR/QA, reporting and disseminating guidance, authorizing and coordinating service delivery.

When the activity requires the knowledge and skill of a skilled professional medical personnel to be completed, the staffing/training costs incurred to complete that activity is eligible for enhanced federal reimbursement at seventy-five percent.[22] Otherwise, the costs incurred to perform the activity is eligible for reimbursement at 50%.[23] Enclosure 1 provides definitions of utilization review and quality assurance activities.

A mental health plan may directly charge the costs accumulated within a specified organizational unit that only performs one or more utilization review and quality assurance activities. A mental health plan may directly charge to utilization review and quality assurance a portion of the costs accumulated within a specified organizational unit that performs activities related to multiple final cost objectives (i.e., medical assistance, utilization review and quality assurance, and mental health plan administration) if the mental health plan is able to relatively easily identify the portion of costs with performance of the utilization review and quality assurance activity with a high degree of accuracy. For example, staff who perform activities related to multiple final cost objectives may complete a time study or direct time tracking to identify the portion of the salary and benefit costs directly charged to the utilization review and quality assurance final cost objective.

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[21] W&I § 14711(d).
[22] 42 C.F.R. § 432.50.
[23] Id. at 456.2; 431.15; 433.15(b)(7).

Mental Health Plan Administration – Direct Costs

DHCS must reimburse MHPs for the direct and indirect costs incurred to administer the mental health plan separately from the costs incurred to provide medical assistance and to perform utilization review and quality assurance activities.[24] Indirect costs are the general costs associated with organization-wide activities.[25] By contrast, direct costs assignable to mental health plan administration include those costs that the mental health plan can identify as costs incurred for performing those activities necessary to administer the mental health plan with a high degree of accuracy.[26]

Activities necessary to administer the mental health plan are activities necessary to implement requirements contained in Exhibit A, Attachments 4 (Management Information Systems), 7 (Access and Availability of Services), 8 (Provider Network), 11 (Information Requirements), 12 (Beneficiary Problem Resolution), 13 (Program Integrity), and 14 (Reporting Requirements) to the mental health plan contract for developing policies and procedures, implementing and managing processes, and monitoring compliance to administrative requirements. A mental health plan may directly charge to the mental health plan administration final cost objective those costs accumulated within a specific organizational unit that performs one or more activities necessary to implement requirements contained in one of the attachments listed above. A mental health plan may directly charge to the mental health plan administration final cost objective a portion of the costs accumulated in a specific organizational unit that performs activities related to more than one final cost objective if the mental health plan can relatively easily identify the costs with one or more activities necessary to implement one or more of the attachments listed above with a high degree of accuracy. For example, staff who perform activities related to ensuring mental health network adequacy and contract administration for various departments, including mental health, may complete a time study to identify the portion of the salary and benefit costs directly charged to the mental health plan administration.

Refer to Enclosure 1 for further further definition of administrative activities.

Indirect Cost Allocation

As discussed above, an indirect cost is a cost incurred for a common or joint purpose benefiting more than one final cost objective and not readily assignable to the specific final cost objectives benefited without effort disproportionate to the results achieved.[27] Indirect costs for county operated MHPs include indirect costs incurred within the county

[24] W&I § 14711.
[25] OMB FAQ .56-1, Indirect Costs v. Administrative Costs.
[26] 2 C.F.R. § 200.413.
[27] 2 C.F.R. § Pt. 200, App. VII., ¶ A.1.

agency administering the mental health plan (i.e., internal indirect costs) as well as the portion of the countywide indirect costs allocated to the county agency administering the mental health plan (i.e., external indirect costs).[28] MHPs must allocate indirect costs to each final cost objective using a reasonable documented basis.[29]

Enclosure 2 provides examples of indirect costs and of how those costs may be reasonably allocated.

Cost Apportionment

After assigning direct costs and allocating indirect costs to each final cost objective, a mental health plan must apportion those costs to the Medi-Cal program and non-Medi-Cal programs. The methodology by which a mental health may apportion costs varies by each final cost objective.

Mental Health and Targeted Case Management Services

Counties provide a variety of mental health and targeted case management services. Some of these services are covered under the Medi-Cal program and some are not. Some of the individuals receiving Medi-Cal covered services are enrolled in the Medi-Cal program and some are not. DHCS requires counties to first allocate costs to specific mental health and targeted case management services and to then apportion those costs to the Medi-Cal program and non-Medi-Cal programs. DHCS requires counties to use one or more of the following three methods to allocate costs to each service:[30]

1. **Direct Assignment**: Counties may directly assign costs to a specific service. Directly assigning costs to a specific service is easiest when one organizational unit provides one type of service.
2. **Time Study**: Counties may allocate direct and indirect costs among services based upon the results of a time study.
3. **Relative Value**: Counties may allocate direct and indirect costs among services based upon relative value statistics.

The state-developed cost report uses units of service to apportion the cost of mental health and targeted case management services to the Medi-Cal program and non-Medi-Cal programs. The cost report first calculates the cost per unit for each mental health service and targeted case management service. Then the cost report multiplies the cost per unit of service by the total units of service provided to Medi-Cal

[28] 2 C.F.R. § 200.416(b).
[29] Id. at 200.405(d).
[30] State Plan Attachment 4.19-B, page 25.1, para. C.4.

beneficiaries to determine the costs apportioned to the Medi-Cal program. Costs not apportioned to the Medi-Cal program are apportioned to non-Medi-Cal programs.

Mental Health Plan Administration

Counties must apportion the total direct and indirect costs assigned and allocated to mental health plan administration to the Medi-Cal program and non-Medi-Cal programs using one of the following three methods:[31]

- **Percentage of Program Beneficiaries:** Divide the number of service encounters for Medi-Cal beneficiaries by the number of service encounters for all service recipients. (Service encounters include direct care provided to a beneficiary that is reimbursable as a component of a covered SMH service; service encounters do not include client outreach or other activities that are not explicitly included within existing SMH service definitions.) Multiply this percentage by the total direct and indirect costs for mental health plan administration to determine the amount apportioned to the Medi-Cal program. Reference Section V, Subsection B, "Determining the Medi-Cal Discount Percentage" in the CMS approved Mental Health Medi-Cal Administrative Activities Implementation Plan for a more complete description of how to calculate the percentage of program beneficiaries.
- **Percentage of Gross Costs:** Divide the total medical assistance costs apportioned to the Medi-Cal program by the total medical assistance costs to determine the Medi-Cal percentage of medical assistance costs. (Medical assistance costs include treatment costs for covered SMH benefits and do not include modes 45 and 60.) Multiply the Medi-Cal percentage of medical assistance costs by the total direct and indirect cost for mental health plan administration to determine the amount apportioned to the Medi-Cal program.
- **Percentage of Relative Value Costs:** For each service, multiply the published charge by the total units of service to determine the total relative value cost. For each service, multiply the published charge by the total Medi-Cal units of service to determine the Medi-Cal relative value cost. Divide the Medi-Cal relative value cost by the total relative value cost to determine the Medi-Cal relative value percentage. Multiply the Medi-Cal relative value percentage by the total direct and indirect costs for mental health plan administration to determine the amount apportioned to the Medi-Cal program.

[31] Cost and Financial Reporting System, Instruction Manual, Fiscal Year 2017-18, page 21.

Utilization Review and Quality Assurance

Counties must apportion total direct and indirect costs assigned and allocated to utilization review and quality assurance among the Medi-Cal program and non Medi-Cal programs. Refer to Enclosure 1 for a definition of utilization review and quality assurance.

Please e-mail MedCCC@dhcs.ca.gov with any questions regarding this IN.

Sincerely,

Original signed by

Lindy Harrington
Deputy Director
Health Care Financing

Attachments