

Information Item D - MH
INSTRUCTIONS for MH REPORT III

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I. Purpose of MH Report III

MH Report III represents the primary source of financial data for mental health services that is used by DSHS. It forms the basis for the Legislative Appropriation Request by strategy, is utilized for quarterly reporting to the Legislative Budget Board, and is often used for open records requests and various ad hoc reports and/or requests by advocacy organizations, Legislators, and DSHS staff.

Contractors will use MH Report III to report all expenses and their method of finance. DSHS will use MH Report III to monitor compliance with this contract's provisions regarding administrative costs.

Expenditures by Strategy/Substrategy

MH Report III is intended to mirror as closely as possible the appropriation structure for the DSHS. On an annual basis, the data reported by the Contractor is utilized to determine the percentage of services provided by strategy. Allocations paid out to the Contractor are booked in DSHS's accounting system by strategy and substrategy. Based on the system-wide use of funds by strategy/substrategy, we then book DSHS amount of funding by strategy/substrategy that is requested through the Legislative Appropriation Request.

Open Records Requests/Ad Hoc Reporting

It is not uncommon for DSHS to receive requests for financial and other data relating to a specific Contractor and/or for the system of Local Mental Health Authorities (Contractors) as a whole. The primary source of data for responding to these requests is MH Report III.

Quarterly Reporting to the Legislative Budget Board – Output and Efficiency Measure Reporting

CARE financial (MH Report III) and CARE output data is the basis for all reporting of output and efficiency measures to the LBB. It is used to derive the efficiency (cost) measures that are reported quarterly to the LBB. Basically, efficiency measure calculations **must reflect the cost to the state** of services provided with funds appropriated by the Legislature. Funds included in the State's bill pattern and appropriated by the Legislature are called **the State Appropriation Authority Funds**. These funds consist of the following:

- All Allocated Funds - State and Federal (this is all the funds shown on the allocation tables published each year)
- Title XIX - Rehabilitation Services
- Title XIX - Target Case Management

The State Appropriation Authority Funds exclude local funds earned by the Contractor and exclude funds used by Contractors to meet local match. In addition, they exclude funds contracted between the Contractor and another State Agency such as the Department of Assistive and Rehabilitative Services (DARS) and the Department of Aging and Disability Services (DADS).

In order to calculate the cost to DSHS of services provided with funds appropriated by the Legislature, it is necessary to determine what percentage of the total expenditures reported by Contractors were funded with the State Appropriation Authority Funds. That percentage

is then applied to the number of persons served as reported in CARE to determine the output measure funded through the State Appropriation Authority Funds.

II. Output and Efficiency Measure Calculations

a	The State Appropriation Authority Funds Reported as Expended for a given measure
b	Total Expenditures Reported by Community MHMR Centers for a given measure
a/b	= State Funded Percentage

a	Sum of Total Assignments for a given measure
b	X State Funded Percentage (see above calculation)
c	Divided by Number of Months in period
(aXb)/c	= Output Measure Funded through the State Appropriation Authority

a	The State Appropriation Authority Funds Reported as Expended for a given measure
b	Divided by Output Measure Funded through the State Appropriation Authority
a/b	= Efficiency Measure for the State Appropriation Authority Funds

The State Appropriation Authority Funds:
 All Allocated Funds – State and Federal
 Title XIX - Rehab Services
 Title XIX - Targeted Case Management

If persons are not entered in CARE but the funding associated with them is shown on MH Report III, it will skew the calculation of the percentage of services funded by the State Appropriation Authority funds. Accordingly, persons served with funds reported in all strategies (columns/categories) on MH Report III EXCEPT Other Services should be reported in CARE.

III. Instructions for Completion

Refer to the DSHS Community Mental Health Service Array to map Encounter and Procedure Codes to Report III Substrategies.

The current version of the Texas Department of State Health Services (DSHS) Community Mental Health Service Array (File Name: Info_Mental_Health_Service_Array_Combined) can be found in the Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW), in the CA General Warehouse Information folder.

If the rounding for calculation of Administration allocation causes a \$1 error, make necessary adjustment (add or subtract \$1) in Additional Local Funds to allow funds to balance.

Section 1

Funding Summary - Page 1 of MH Report III represents a listing of all funds earned by the Contractor, without regard to the type of service funded or whether the funds were fully utilized to fund the services provided. In other words, this schedule is intended to represent all funds recognized as “earned” by the Contractor and would include funds that were earned over and above what was necessary to fully fund services. The total funds earned in each row may not equal the total for that row shown in the method of finance by strategy section of MH Report III.

Funding Summary amounts may be greater than Expenditure amounts in Section 2 but cannot be less than Expenditure amounts in Section 2.

Section 2

Expenditures and Method of Finance by Strategy – This section of the report shows General Administrative and Authority Administrative expenses, the allocation of the administrative costs to the various strategies, the expenses by strategy/substrategy, and how these expenses were funded. In this section of the report, expenditures and revenues should balance and expenditures should tie to the general ledger. Expenditures could include items unallowable under A-87 which were funded with local funds or some other non- State source.

Strategy/Substrategy Structure – (Column Headings)

Refer to DSHS Performance Contract Program Attachments for Adult Mental Health Services and Child & Adolescent Mental Health Services for a description of services.

ADMINISTRATIVE COSTS

General Administrative

Includes expenditures classified as General Administrative, in accordance with Attachment V of the CAM Manual. This category refers to activities that support both Local Authority functions and provider functions. These systems are integrated in practice without defining lines between that associated with the local authority and the provider network. General Administrative expenses will be allocated to Authority Administrative, as well as the strategies, based on total expenditures. The allocation will be made by the system, as part of the CARE calculations. Exception: General Administrative expenses are not allocated to the column for Medications.

Authority Administrative

Includes expenditures classified as Authority Administrative, in accordance with Attachment V of the CAM Manual. Authority Administrative expenses, including its share of General Administrative expenses, are allocated to all of the strategies,

except “Other Services, Non-Priority Population”, and Medications. The allocation will be made by the system, as part of the CARE calculations.

Authority Administrative functions will likely include activities related to the non-State funded programs (e.g., contract management of addiction services and ECI contracts). Report the expenses for the activities in the Authority Administrative column, rather than allocating a portion of the expense to “Other Services”. Offset the expense of the additional activities with the funding reflected in the method of finance. However, if Authority Administrative includes an activity that is funded 100% by a single, the non- State funded source, then report the expense and associated method of finance in the “Other Services” strategy (e.g., a contract manager whose sole duty is to manage an HIV clinic contract, and whose expenses are paid by the contract).

Report the method of finance for the General Administrative and Authority Administrative expenditures, including its portion of the General Administrative expenditures.

The Performance Contract limits use of allocated state funds to 10% for General Administrative and Authority Administrative. The total funds (state and federal) allocated as per the allocation tables times 10% determines the maximum amount of state funds that can be utilized. MH funds and MR funds provide separate sources for General Administrative and Authority Administrative funding. Although the Center may have expense in these categories that exceed the 10% limit, the excess must be funded with other sources. The allowed 10% should be funded from General Revenue. MHA’s are also allowed the use of up to 5% of their Mental Health Block Grant funds for General Administration and Authority Administration costs that would be allocated to MH community programs.

The method of finance portion of the “Allocate General Administrative and Authority Administrative” column will show a system calculated negative amount equal to the sum of the General Administrative and Authority Administrative amounts for each code line. The three columns become, in effect, memorandum entries. For example:

Code No. / Method of Finance	General & Administrative	Authority Administrative	Allocate General Administrative and Authority Administrative
750 Gen Rev - MH	\$100	\$100	(\$200)

MENTAL HEALTH REPORTING CATEGORIES - DEFINITIONS

B.2.1 Adult MH Services

Medications (Meds only)

The intent of this column is to capture the pure pharmaceutical costs that are incurred for Medications. Accordingly, report ALL expenditures for Medications that are related to the pharmaceutical expense (and script processing fee if applicable) in this column on Row 108a. Do not include salaries to administer the program or pharmacist salaries. Exception: Exclude allocation of indirect costs to this column. For the method of finance section of this column, include funds that were utilized to fund the expenditures you report. This would include dedicated funding for medications, and any other general revenue or local funding utilized for this purpose.

Medication Related Services

Supplemental services provided by a Registered Nurse, Licensed Vocational Nurse or other appropriately licensed/credentialed professional to assist an individual to manage and adhere to their prescribed medication regimen. This excludes all physician services, nursing services incidental to a physician's office visit, pharmacological management services, case management services, medication training and other rehabilitative services. This includes such activities as checking an individual's vital signs during a home visit, refilling pill packs, monitoring self administration of medications, pill pack counts, and evaluating the severity of side effects of medications during a home visit.

Flexible Funds

Non-clinical supports that assist in community integration, reduce symptomatology, and maintain quality of life. Allowable expenses per the [Texas Resilience and Recovery Utilization Management Guidelines – Adult Services](#) include: rental assistance, transportation, utilities, emergency food, house wares, residential services, clothing. This is an allowable expense for any adult authorized for LOC 1-4.

Medicaid Type Mental Health Services

All physician, counseling and other allowable Medicaid Card mental health services, as well as rehabilitative and targeted case management services provided to a Medicaid eligible person or a medically indigent person.

Value Added Services

Non-clinical and other services provided to enhance the array of services and meet legislative requirements.

Voter registration and information referral.

Non-clinical services to support the Patient Assistance Program (acquisition of free medications from the pharmaceutical companies).

Non-clinical services that support Representative Payee Activities.

Community Critical Incident Reporting and Disaster Assistance.

Primary care services to address physical health issues.

Screening and Eligibility

Includes Program Description Definitions of Screening and Preadmission Assessment (Diagnostic Eligibility Assessment and Pre-Admission QMHP-CS Assessment) in the Performance Contract Program Attachment for Adult Mental Health Services. Excludes Crisis Screening and Eligibility.

All Other Outpatient Services

Includes all other outpatient services in the service array not defined as Medicaid Type Services or Screening and Eligibility. Examples include: vocational specific training, assisting people with finding housing.

Crisis Residential/Inpatient

Includes services such as Inpatient Services, Crisis Stabilization Units, Extended Observation, Crisis Residential Services and Crisis Respite Services (bed days).

Crisis Outpatient Services

Includes services such as Mobile Crisis Outreach, Crisis Intervention Team (CIT)/Mental Health Deputy Program, Crisis Respite (hourly services), and all other services not Medicaid billable.

Crisis Screening and Eligibility

Includes services such as Crisis Hotline

Crisis Other

Includes services such as Crisis Transportation, Crisis Flexible Benefits, and other services not associated with Residential/Inpatient, Outpatient and Crisis Screening and Eligibility.

NOTE: LMHAs should continue maintenance of effort for crisis services in Strategy B.2.1 in accordance with Section 4.06 of the General Provisions.

B.2.2 Children's MH Services

Medications (Meds only)

The intent of this column is to capture the pure pharmaceutical costs that are incurred for Medications. Accordingly, report ALL expenditures for Medications that are related to the pharmaceutical expense (and script processing fee if applicable) in this column on Row 108a. Do not include salaries to administer the program or pharmacist salaries. Exception: Exclude allocation of indirect costs to this column. For the method of finance section of this column, include funds that were utilized to fund the expenditures you report. This would include dedicated funding for medications, and any other general revenue or local funding utilized for this purpose.

Medication Related Services

Supplemental services provided by a Registered Nurse, Licensed Vocational Nurse or other appropriately licensed/credentialed professional to assist an individual to manage and adhere to their prescribed medication regimen. This excludes all physician services, nursing services incidental to a physician's office visit, pharmacological management services, case management services, medication

training and other rehabilitative services. This includes such activities as checking an individual's vital signs during a home visit, refilling pill packs, monitoring self administration of medications, pill pack counts, and evaluating the severity of side effects of medications during a home visit.

Family Support Services

Support and informational meetings for parents of children receiving services that are facilitated and routinely scheduled. Non-clinical supports that assist in community integration, reduce symptomatology, and maintain quality of life. Allowable expenses per the [Texas Resilience and Recovery Utilization Management Guidelines – Child and Adolescent Services](#) include: respite, mentors, childcare, and transportation assistance. This is an allowable expense only for children enrolled in LOC2 and LOC 3 and their families.

Medicaid Type Mental Health Services

All physician, counseling and other allowable Medicaid Card, rehabilitative, and targeted case management services provided to a Medicaid eligible person or a medically indigent person.

Value Added Services

Non-clinical and other services provided to enhance the array of services and meet legislative requirements as applicable such as information referral.

Non-clinical services to support the Patient Assistance Program (acquisition of free medications from the pharmaceutical companies).

Non-clinical services that support Representative Payee Activities.

Community Critical Incident Reporting and Disaster Assistance.

Primary care services to address physical health issues.

Screening and Eligibility

Includes Program Description Definitions of Screening and Preadmission Assessment (Diagnostic Eligibility Assessment and Pre-Admission QMHP-CS Assessment) in the Performance Contract Program Attachment for Children's Mental Health Services. Excludes Crisis Screening and Eligibility.

All Other Outpatient Services

Includes all other outpatient services in the service array not defined as Medicaid Type Services or Screening and Eligibility. Examples include: vocational specific training, assisting people with finding housing.

Crisis Residential/Inpatient

Includes services such as Inpatient Services, Crisis Stabilization Units, Extended Observation, Crisis Residential Services and Crisis Respite Services (bed days).

Crisis Outpatient Services

Includes services such as Mobile Crisis Outreach, Crisis Intervention Team (CIT)/Mental Health Deputy Program, Crisis Respite (hourly services), and all other services not Medicaid billable.

Crisis Screening and Eligibility

Includes services such as Crisis Hotline

Crisis Other

Includes services such as Crisis Transportation, Crisis Flexible Benefits, and other services not associated with Residential/Inpatient, Outpatient and Crisis Screening and Eligibility.

NOTE: LMHAs should continue maintenance of effort for crisis services in Strategy B.2.2 in accordance with Section 4.06 of the General Provisions.

B.2.3 Crisis, Transitional, and Intensive Ongoing Services

Report expenditure of Strategy B.2.3 funding on Lines 759 – 763 only. Crisis funding must not be used to supplant funds historically expended on crisis services (see notes under Strategies B.2.1, and B.2.2 above).

Residential/Inpatient

Includes both crisis and non-crisis residential services provided using funding allocated to strategy B.2.3 (e.g., Residential Treatment, Crisis Stabilization Unit, Extended Observation, etc).

Outpatient Services

Includes both crisis and non-crisis outpatient services provided using funding allocated to strategy B.2.3 (e.g., Crisis Intervention Services, Crisis Respite Services (hourly), physician services, Case Management services.

Screening and Eligibility

Includes both crisis and non-crisis screening and eligibility services provided using funding allocated to strategy B.2.3 (e.g., Screening, Pre-Admission QMHP-CS Assessment, Crisis Hotline, etc).

Other

Includes both crisis and non-crisis other services provided using funding allocated to strategy B.2.3 (e.g., Crisis Flexible Benefits, Flexible Funds, Flexible Community Supports, Crisis Transportation, etc).

C.2.1 Community Hospitals

Reported by the four Contractors who receive specific funding for a Community Hospital: Lubbock Regional MHMR Center, Gulf Coast Center, Hill Country Community MHMR, and MHMRA of Harris County. This column should reflect Inpatient expenditures only. Any Community Hospital funding that is utilized for outpatient services and associated expenses should be reported in the applicable B.2.1.1 or B.2.2.1 strategies.

Also reported by Contractors who have a separate contract attachment for the purchase of private inpatient beds at the local level.

Report only expenditures and method of finance that flow through the Contractor accounting records. Do not include expenditures/funds in support of the hospital that are earned by a contractor in support of the community hospital operations.

OTHER SERVICES (BOTH General and Authority Administration Allocation)

Includes all MR Services except In-Home and Family Support.

The expenditures and revenues reported in this column as well as persons served will be excluded for output and efficiency measure reporting to the LBB.

OTHER SERVICES (NO Administration Allocation)

Includes MR Services for In-Home and Family Support.

The expenditures and revenues reported in this column as well as persons served will be excluded for output and efficiency measure reporting to the LBB.

OTHER SERVICES (General Administration Allocation ONLY)

Includes services to the MH non-priority population through programs such as DSHS- Substance Abuse, HUD, TDCJ, Americorps, TCOOMMI, TRC, ECI and/or other contractual arrangements that provide services for private entities. **The expenditures and revenues reported in these columns as well as persons served will be excluded for output and efficiency measure reporting to the LBB.**

Funding associated with the Federal Emergency Management Agency (FEMA – CFDA 83.539 and/or Department of Health and Human Services, Mental Health Disaster Assistance (MHDA) 93.892) should be reported in this column. Persons served with this funding are reported separately to the program coordinator at DSHS.

The expenditures and revenues reported in this column as well as persons served will be excluded for output and efficiency measure reporting to the LBB.

GENERAL GUIDELINES FOR REPORTING PERSONS SERVED

All persons in the priority population should be reported in CARE and the corresponding funding that supports these individuals should be reported in the various categories (columns) on MH Report III. As a general rule, services to the priority population would not be reported in the Other Services – Non-Priority Population column. **Exceptions: ECI (see below); special contractual arrangements to provide a set of services that are primarily for the non-priority population but which in theory might also include priority population persons.**

Children served through contract with DARS who are receiving only ECI services should not be reported in CARE. Report ECI funding and expenditures in the column for Other Services, Non-Priority Population. If a child is receiving Center services in addition to ECI funded services, report them in CARE. Corresponding expenditures for them should be reported in the MH Report III column that applies to the Center services they are receiving.

IV. Definitions of Object of Expense

Definitions are consistent with Cost Accounting Methodology

Code Object

- 102 Salaries** - Includes all full time, part time and temporary staff. This category also includes shift differential, overtime, merit increases, performance bonuses, compensatory time pay off, and car allowances associated with classified positions. Includes paid leave and severance pay associated with this salary classification.
- 103 Employee Benefits** - Includes FICA, Unemployment, Worker's Compensation, Group Health/Dental Insurance, Employee Retirement including 457 contributions, expenses paid by the Center for Section 125 (Cafeteria Plan) services, and expenses associated with Employee Assistance Programs.
- 104 Professional, Consultant and Contracted Client Services** – Expenses for activities directly associated with carrying out the Statement of Work that are delegated to a third party, including all contracts for client services. Third party activities for general and administrative services (i.e., accounting, audit, payroll, temporary staffing, etc...) are not included in this category; they are properly classified in the "Other Operating Expenses."
- 105 Training and Travel** – Includes registration and other fees associated with training expenses along with all travel costs.
- 106 Debt Service** - Principal and interest payments on property, computer and equipment. Debt issuance costs are included. Also includes furniture and equipment capital lease contracts over \$5,000 where the intent is to own the items at the end of the contract period.
- 107a Capital Outlay** - Expenses associated with the purchase of buildings, land, construction in progress, building user fees, capital improvements, and leasehold improvements over \$5,000; purchase of furniture and equipment and vehicles with a purchase price of over \$5,000. Operating and capital leases associated with vehicles is also included in this category. Also includes computer hardware, software and related equipment with a cost of over \$5,000.
- 107b Non-Capitalized Equipment** - Expenses associated with the purchase of furniture, equipment and vehicles with a purchase price under \$5,000. Also includes computer hardware, software and related equipment with a cost under \$5,000.
- 108a Pharmaceutical Expense – (Medications and Script Process Fee Only)** - Pharmaceuticals used in client treatment that are purchased for distribution through an in-house pharmacy or through arrangement with a pharmacy in the area. Contracted pharmaceutical is included in this category.
- 108b Pharmaceuticals** – This row is used to report pharmaceuticals donated through PAP for Medications. The total amounts reported on this line 108b should equal the amounts shown as revenue on line 707

- 109 Other Operating Expenses** - Includes all other expense items not reported in the above objects of expense categories.
- 201 General Administrative Charged to/Paid by Authority Administrative** – Portion of the General Administrative associated with the Contractor’s Authority Administrative function. The allocation is based on total expenditures.
- 202 Subtotal** – Lines 202 and 800, Method of Finance should be equal for the General and Authority Administration columns.
- 203 Allocation of General Administrative to Strategies** – System calculated allocation to non-administrative strategies and “Other Services”. The allocation is based on total expenditures reported on Line 110 of each column. General Administrative is not allocated to IHFS and Community Hospital.
- 204 Allocation of Authority Administrative** – System calculated allocation to each non-administrative strategy. “Other Services”, IHFS, and Community Hospital are excluded from the allocation. The allocation is based on total expenditures reported on Line 110 of each applicable column.
- 210 Expenditures after Allocation of General Administrative and Authority Administrative Expenditures** – Lines 210 and 800, Method of Finance should equal.

V. Classification of Funding Sources

GENERAL REVENUE ALLOCATED FROM DSHS

Includes all non-federal funds allocated through the Performance Contract as shown on the annual allocation tables.

Code Type Fund/Definition

- 750 General Revenue - DSHS** - As allocated
Existing funding used for crisis services should be distributed in Strategies B.2.1 and B.2.2 in the appropriate Crisis substrategy.
- 750.1 General Revenue - DSHS** – State Match for Medicaid Rehab Services paid by TMHP. Do not include in 750.
- 750.2 General Revenue – DSHS** – State Match for Medicaid Targeted Case Management paid by TMHP. Do not include in line 750.
- 755 OBRA/PASRR** - OBRA/PASRR funds cannot be used to fund General Administrative and/or Authority Administrative expenses.
- 757 Community Hospitals** - As allocated. Funding for Outpatient services should be reported in strategies B.2.1 and B.2.2. Funding for Inpatient services should be reported in Strategy C.2.1.

- 758 Other General Revenue - DSHS** - As allocated. This row is used when specifically instructed by DSHS, including Mental Health First Aid.
- 759 Crisis Services - General** - This line should include B.2.3 crisis funding. These Crisis Funds should be distributed in Strategy B.2.3 in the appropriate substrategy.
- 760 Crisis Services - Outpatient Competency Restoration (OCR)** - Reported only by Contractors who receive specific funding for OCR. This line should include B.2.3 OCR funding. These Funds should be distributed in Strategy B.2.3 in the appropriate substrategy.
- 761 Crisis Services - Psychiatric Emergency Service Centers (PESC)** - Reported only by Contractors who receive specific funding for PESC. This line should include B.2.3 PESC funding. These Funds should be distributed in Strategy B.2.3 in the appropriate substrategy.
- 762 Transitional Services** - This line should include B.2.3 Transitional Services funding. These Funds should be distributed in Strategy B.2.3 in the appropriate substrategy. This line should include any funds related to services provided to a child or adult with an LOC-A = 5. All services in the current MH Service Array are allowable. This may include outpatient, residential or other.
- 763 Intensive Ongoing Services** - This line should include B.2.3 Intensive Ongoing Services funding. These Funds should be distributed in Strategy B.2.3 in the appropriate substrategy. This line should include funding related to children with an LOC-A = 2.1, 2.2, 2.3, or 2.4. This line should include funding related to adults with an LOC-A = 3 or 4.
- 764 Project Private Beds** - This line should include all funding used for the purchase of private inpatient beds at the local level, and should only be used by Local Mental Health Authorities that have a separate contract attachment specific to the purchase of these beds. These funds should be distributed among General Admin, Authority Admin and Strategy C.2.1.

MEDICAID WAIVER AND ICF EARNINGS

Code Type Fund/Definition

- 770 HCS** – Funds earned as a result of the provision of HCS services. Include both the state and federal portion on this line. All HCS-funded services should be reported in the non-priority population column. Service Coordination activities are part of the HCS rate structure effective 9/1/03 and should be reported in this revenue code.
- 771 ICF-MR** - Funds earned as a result of the provision of ICF-MR services. Include both the state and federal portion on this line. All ICF-MR-funded services should be reported in the non-priority population column.

772 TxHmL Waiver - Funds earned as a result of the provision of HCS services. Include both the state and federal portion on this line. All TxHmL-funded services should be reported in the non-priority population column.

773 Other Waivers (Consumer Directed Services) - Funds expended as the administrative agent for consumer directed services.

ALLOCATED FEDERAL FUNDS

Includes all federal funds allocated through the Performance Contract as shown on the annual allocation table.

Code Type Fund/Definition

781 TANF to Title XX Block Grant - CFDA 93.558 - As Allocated. Funds are used to assist needy families with children. TANF to Title XX Block Grant funds cannot be used to fund General Administrative and/or Authority Administrative expenses.

782 Title XX, Social Services Block Grant - CFDA 93.667 - As Allocated. Funds may be used for the proper and efficient operation of social service programs. Title XX, Social Services Block Grant funds cannot be used to fund General Administrative and/or Authority Administrative expenses.

783 Mental Health Block Grant - CFDA 93.958 - Funds are used to provide comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance; at least 10% of these funds must be used for services to seriously emotionally disturbed children and youth. A maximum of 5% of the Mental Health Block Grant funds can be used to fund General Administrative and/or Authority Administrative expenses.

784 TANF Transfer to Title XX Block Grant - CFDA 93.558.667 – As allocated. Funds are used to help meet specified social services needs of defined low income and at risk populations. This will reflect funding effective 2012 for TANF Transfer to Title XX. Funds cannot be used to fund General Administrative and/or Authority Administrative expenses.

OTHER FEDERAL FUNDS

Medical Assistance Program, CFDA 93.778:

Code Type Fund/Definition

730 Medicaid Rehabilitation Services from TMHP (federal only) - Used to report earnings paid by TMHP as a result of claims submitted for services rendered.

Title XIX Rehabilitation Funds earned (federal portion) should be reported in the categories (columns) for which the funds were earned. This would exclude reporting in the MH Other Services Non Priority Population column, the Crisis Residential columns and the Community Hospital column.

731a Medicaid Service Coordination from TMHP-DADS (federal and state share) - Used to report earnings paid by TMHP directly to the Center as a result of claims submitted for services rendered.

All expenditures related to MR Service Coordination should be reported in non-priority population. Thus, Title XIX Service Coordination Funds earned (federal portion) should be reported only in this category (column).

731b Medicaid Targeted Case Management from TMHP (federal only) - Used to report earnings paid by TMHP directly to the Center as a result of claims submitted for services rendered.

All expenditures related to Targeted Case Management should be reported in Assessment and Coordination (Targeted Case Management Adult, Targeted Case Management Child). Thus, Title XIX Targeted Case Management Funds earned (federal portion) should be reported only in these categories (columns).

732 Medicaid Service Coordination/Case Management from TMHP-ECI- (federal and state share) (MR only) - Used to report earnings paid by TMHP directly to the Center as a result of claims submitted for services rendered to ECI clients. Payment by TMHP represents the federal portion only. Reported only in MR Other Services – Non-Priority.

733 Medicaid Administrative Claiming - Used to report earnings as a result of the quarterly reporting for administration of the Medicaid program.

735 Medicaid Card Services - Used to report earnings paid by TMHP as a result of claims submitted for physician and other allowable card services.

736 Vendor Drug

ALL OTHER FEDERAL FUNDS

Code Type Fund/Definition

737 MH Disaster Assistance - Represents award to DSHS for the purpose of provision of services in areas of the state where a natural disaster has occurred. Funds are in turn contracted with the Contractor.

738 Federal Emergency Management Agency (FEMA) Crisis Counseling CFDA 97.032 - Represents award to DSHS for the purpose of provision of services in areas of the state where a natural disaster has occurred. Funds are in turn contracted with the Contractor.

739 Americorps, CFDA 94.006

740-742 Other Federal - Any other federal awards not specifically identified above.

743 PATH - CFDA 93.150 - Projects for Assistance in Transition from Homelessness – Includes Federal Funds that are used to provide services to individuals with serious mental illness and substance abuse disorders who are homeless or at imminent risk

of becoming homeless. Refer to program regulations for future information and limitation/uses of funds.

- 744 Medicaid 1115 Transformation Waiver** – Federal funds received through the 1115 Transformation Waiver DSRIP incentive payments.

OTHER STATE FUNDING

Used to report grants, contracts or other arrangement between state agencies and the Center for specified services.

Code Type Fund/Definition

710 Department Aging & Disability Services

711 Texas Department of Criminal Justice

712 Telecommunications Infrastructure Fund Board

713 Department State Health Service - Substance Abuse

714 Department Assistive & Rehabilitative Services - Rehab

715 Department Assistive & Rehabilitative Services – ECI - Children who are receiving only ECI services should not be reported in CARE. Report ECI funding and expenditures in the column for Other Services, Non-Priority Population. If a child is receiving Center services in addition to ECI funded services, report them in CARE and in the MH Report III column which applies to the Center services they are receiving.

716 Texas Department of Transportation

717 Texas Correctional Office on Offenders with Medical or Mental Impairments

718 Other State Agencies

719 DSHS - PATH (Projects for Assistance in Transition from Homelessness). - Includes State Funds that are used to provide services to individuals with serious mental illness and substance abuse disorders who are homeless or at imminent risk of becoming homeless. Refer to program regulations for future information and limitation/uses of funds.

LOCAL FUNDS

In Section 1 of MH Report III, Funding Summary, the amounts recognized as earned in each of the categories below should be reported regardless of whether it was used to fund expenditures. For Section 2 of MH Report III, Expenditures and Method of Finance by Strategy, Rows 701-707 are not reported at this level of detail.

Code Type Fund/Definition

701 City Government Tax Funds

702 County Government Tax Funds

703 Other Taxing Authority Funds

704 Patient Fees, Insurance, Reimbursements

705 Transfers from Reserves

706 Miscellaneous Income & Contributions

707 PAP Contributions

709.1.a Program Income used as Required Local Match

709.1.b Non-Program Income used as Required Local Match

709.2.a Program Income as Additional Local Funds

709.2.b Non-Program Income used as Additional Local Funds

Required Local Match is calculated as a percent of the funds allocated for rows 750, 750.1, 750.2, 759, 762, 763, 781, 782, 783, and 784. Lines 709.1.a and 709.1.b, plus the total of Report IV (CARE Screen B33), must be equal to or greater than the required local match total of the contract. The percentage to be applied may be different for each Contractor and is included in the annual Performance Contract. To satisfy the required local match requirement, the Contractor cannot use local funds reported in Other Services Non Priority Population- **All funds reported in 701-707 are available for matching purposes except for Workshop/Production Income.**

Program Income

Program income is defined as:

- All income generated by “programs” funded by the Performance Contract;
- Income earned as a result of the provision of the defined services to MH priority population (DSHS) and the MR priority population (DADS) as defined in the respective performance contracts; or
- Income earned as a result of the provision of services in the local service area as defined in the DSHS and DADS performance contracts.

The following programs and their revenue are not recognized as program income:

- Fee for service contracts
- Medicaid Funded contracts
- Miscellaneous Contracts with other state agencies or providers to perform services outside the scope of the Performance Contracts
- Government Revenues such as taxes, (e.g. city, county, other taxing, special assessments and levies are excluded if they are not used to meet matching requirements of the Performance Contracts).

VI. Miscellaneous Reporting Guidelines

Recoupment and Liquidated Damages Payments

Payments of this nature should be expensed to the year to which they apply.

Year End Reconciliation of CARE & External Audits to Allocations / Return of Funds At Year End

At the same time that the external audit is sent to DSHS, funds allocated and paid which were not recognized as earned by the Contractor should be remitted to DSHS. DSHS will review the audit report, CARE and payment data to determine agreement with the amount remitted. Although the preliminary CARE report following year end continues to be due in September, CARE will not be frozen until December 31 to allow each Contractor to make changes to MH Report III as a result of external audit activity. If CARE data shown on the December 31 frozen CARE report does not match the audit report, the Contractor should submit a reconciliation with submission of the audit report. The Schedule of Revenue and Expenditures by Source of Funds included in the Audit Report shall reflect excess revenues over expenditures and reconciliation to CARE notes, if applicable.