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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

August 22, 2012

MHSD INFORMATION NOTICE NO.: 12-06

TO: LOCAL MENTAL HEALTH DIRECTOR'S
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICES
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: ELIMINATING THE SCHEDULE OF MAXIMUM ALLOWANCE PER ASSEMBLY BILL 1297

REFERENCE: Welfare and Institutions Code, Section 5720 and 5724, 42 CFR 447.362 and 42 CFR 433.51

EXPIRES: Retain until superseded

Effective July 1, 2012, Assembly Bill (AB) 1297 (Statutes of 2011) directs the Department of Health Care Services (DHCS) to reimburse county mental health plans (MHPs) based upon their certified public expenditures (CPEs) that do not exceed the non-risk contract upper payment limit (UPL) applied to each MHP. The intent of AB 1297 is for DHCS to claim federal reimbursement for each MHP based upon an approximation of its actual cost of providing the services without exceeding its UPL.

The purpose of this information notice is to briefly describe the CPE process, the UPL for each MHP, how the State will provide interim reimbursement to each MHP for specialty mental health services provided after June 30, 2012, and how the State will perform its interim and final cost settlement of specialty mental health services.

Certified Public Expenditures

The following overview of CPE requirements is provided to give MHPs a general understanding of the CPE requirements that are applicable to the specialty mental health services program.

Section 1903(a) of the Social Security Act provides, in part, that the Federal Government shall pay to the State a percentage "of the total amount expended" for

providing medical assistance (which includes specialty mental health services).[1] This percentage is referred to as the Federal Medical Assistance Percentage (FMAP).

States may use public funds expended by other units of government for purposes of claiming federal reimbursement for the cost of Medicaid services and activities. Section 433.51 of title 42 of the Code of Federal Regulations provides that the amount expended must be ". . . certified by the contributing public agency as representing expenditures eligible for FFP under this section." Public entities may not certify expenditures that have not yet been made, for example, where the certification is based, in whole or in part, on an invoice or other billing that has not yet been paid. Federal reimbursement with respect to the expenditure certified is paid to the state in accordance with the appropriate FMAP rate. For example, in a state with a 50 percent FMAP rate, if the amount certified is $100, then the claim would be for $50 in FFP (.50 x 100).

DHCS claims federal reimbursement for Medi-Cal specialty mental health services based on public expenditures certified by the MHPs. When a MHP submits an interim claim for reimbursement it should either reflect the MHP's actual cost or a reasonable approximation of the MHP's actual cost. When the claim for reimbursement is for a specialty mental health service rendered by a county owned and operated facility, the MHP is not expected to know its actual cost. The MHP will not know its actual cost until the fiscal year is over and it has completed its cost finding and cost allocation through the specialty mental health services cost report. Consequently, the interim claim for reimbursement of services rendered by county-owned and operated providers will be based upon a reasonable approximation of the MHP's actual cost. An example of a reasonable approximation is the determination of costs based upon the prior year's certified cost report. DHCS will settle these interim payments to actual cost when the MHP files its certified cost report.

When the claim for reimbursement is for a service provided by a contract provider, the MHP is expected to know its interim cost. After a contract provider renders a specialty mental health service to a Medi-Cal beneficiary, it will invoice the MHP for payment. The MHP must pay the provider before submitting a claim to DHCS for federal reimbursement. The interim cost to the MHP is equal to the amount it paid the provider for the service rendered. This cost to the county is the amount the county may certify as its public expenditures as long as the source(s) of funding used to pay the provider is eligible for federal reimbursement. DHCS expects the claim for reimbursement to equal the amount the MHP paid the provider for the service rendered less any funding sources not eligible for federal reimbursement.

[1] 42 U.S.C. § 1396b(a).

Mental Health Plan Upper Payment Limit

MHPs contract with DHCS to provide specialty mental health services to Medi-Cal beneficiaries under a section 1915(b) waiver. That section 1915(b) waiver identifies the contract between DHCS and the MHPs as a non-risk contract. Title 42, Chapter IV, Subchapter C, Part 447, Section 362 of the Code of Federal Regulations (42 CFR 447.362) establishes the UPL for non-risk contracts.

Under the provisions of 42 CFR 447.362, the federal reimbursement paid to MHPs may not exceed the amount that Medicaid would have paid providers under the State plan for the services furnished to Medi-Cal beneficiaries plus the net savings of administrative costs the Medicaid agency achieves by contracting with the MHPs.

DHCS is currently working with CMS to obtain approval of proposed State Plan Amendment (SPA) 09-004 that describes the methodology by which it will determine each MHP's non-risk contract UPL to be applied to reimbursement to each MHP for their expenditures in providing specialty mental health services. The purpose of SPA 09-004, which is expected to be approved for an effective date of January 1, 2009, is to establish the MHP UPL to allow reimbursement under the Specialty Mental Health Services Waiver up to the federal UPL, which will be equal to the sum of total allowable costs less third party revenue for all of the MHP's legal entities. Total allowable costs for each legal entity will likely be equal to the lower of allowable cost or usual and customary charges for the specialty mental health services provided, unless the legal entity qualifies as a nominal charge provider. Total allowable costs for a legal entity that qualifies as a nominal charge provider is equal to the legal entity's allowable cost for the specialty mental health services provided.

DHCS will separately calculate the UPL for each MHP and apply it to the total certified public expenditures at interim settlement and final settlement. At interim and final settlement, the MHP's total CPEs reimbursed must not exceed its UPL.

Interim Claims for Reimbursement

Interim claims for payment of federal reimbursement for specialty mental health services provided after June 30, 2012, will not be limited by the Schedule of Maximum Allowances (SMA). Interim claims for reimbursement of specialty mental health services provided by county owned and operated providers will be limited by an interim rate established for each county. MHPs must submit claims for reimbursement of services provided by contract providers that are equal to the lowest of the amount the county paid the provider, an estimate of the provider's reasonable and allowable cost to provide the service, or the provider's usual and customary charge for the service. MHPs will have the option to establish a countywide maximum allowance to limit interim

claims for reimbursement of specialty mental health services provided by contract providers.

Because the MHPs know their interim cost of services provided by their contract providers, they may claim reimbursement based upon the amount they paid the providers without a maximum rate. Some MHPs may not have the capacity to submit claims for reimbursement based upon their actual costs due to various claiming rules established by the Health Insurance Portability and Accountability Act (HIPAA). To prevent over claiming in these situations, some MHPs may want to limit their interim reimbursement for services provided by contract providers to some maximum rate. The State will be seeking additional information from MHPs to determine which MHPs intend to limit their interim reimbursement for services provided by contract providers and the maximum rates they will establish for services provided by contract providers.

Because the MHP does not immediately know the actual cost of services provided by its county-owned and operated providers, DHCS must establish interim rates that approximate the MHP's cost of providing the service. DHCS will calculate interim rates for each MHP for each Medi-Cal mode and service function that the MHP is certified to provide.[2] DHCS will base the interim rate on the most recently filed cost report trended forward using a cost of living index. All interim claims submitted by a MHP for services provided by its county owned and operated providers will be limited by this interim rate.

To calculate appropriate interim rates for county owned and operated providers for Fiscal Year 2012-13, DHCS will be requesting additional cost information from the MHPs. DHCS will base the Fiscal Year 2012-13 interim rates on the most recently filed Fiscal Year 2009-10 cost report for the county legal entity. DHCS's methodology to reimburse indirect costs in the Fiscal Year 2009-10 cost report is different from the methodology it will use to reimburse indirect costs in Fiscal Year 2012-13. In Fiscal Year 2009-10, indirect costs would have been largely allocated to administration. In Fiscal Year 2012-13, indirect costs will be distributed among administration, utilization review/quality assurance, Medi-Cal Administrative Activities, and direct services. DHCS will be requesting MHPs to provide it with the amount of indirect costs that would have been allocated to each mode and service function reported in the Fiscal Year 2009-10 cost report had the county allocated costs using the same methodology described in DMH Letter 11-01.

Interim Settlement

DHCS will base the settlement of all interim payments on the MHP's CPEs that do not exceed its UPL. The MHP's CPEs for services provided by its county legal entity is

[2] The terms "Medi-Cal mode" and "Medi-Cal service function" are defined in the Specialty Mental Health Services billing and cost reporting protocol.

equal to the county legal entity's reasonable and allowable costs as determined in the county legal entity's specialty mental health services cost report. The MHP's CPEs for specialty mental health services provided by its contract owned and operated providers is equal to the amount it paid its contract providers for the specialty mental health services.

Each MHP's UPL will be equal to the total amount that DHCS would have paid the provider if the provider was reimbursed pursuant to the State Plan. The reimbursement methodology in the State Plan is likely to be limited to the lower of the provider's usual and customary charge or allowable cost for the specialty mental health services provided. The UPL for each MHP will likely be equal to the sum of each provider's usual and customary charge or allowable cost for the services provided, whichever is lower.[3] DHCS will calculate the federal reimbursement due to each MHP based on its CPEs that do not exceed its UPL.

The amount of federal reimbursement due to a MHP as determined in its cost report will continue to be compared to all interim payments made to the MHP. If the interim payments are less than the amount of federal reimbursement determined in the cost report, the MHP will receive a payment for the amount due. If the interim payments made to the MHP are greater than the federal reimbursement determined in the cost report, DHCS will require the MHP to repay the overpayment.

Final Settlement

Within three years after the MHP submits the reconciled cost report, DHCS will settle all payments to the MHP's finalized, audited spending year cost report. If at the final settlement, DHCS determines that the MHP has been underpaid, the MHP will receive a payment for the amount due. If at the end of the final settlement, DHCS determines that it overpaid the MHP, it will require the MHP to repay the overpayment. DHCS will follow federal Medicaid procedures for managing overpayments.

Please contact Charles Anders at (916) 650-6684 or Charles.Anders@dhcs.ca.gov if you have any questions about this information notice.

Sincerely,

Original signed by

Vanessa Baird
Deputy Director

[3] The State will inform MHPs how the UPL will be calculated once CMS approves SPA 09-004.