Specialty Mental Health Services Certified Public Expenditure Protocol
Effective July 1, 2012

Under California's Specialty Mental Health Services Waiver, the State contracts with a mental health plan (MHP) in each county. All MHPs are currently county mental health departments. Each MHP assumes responsibility for providing or arranging for the provision of specialty mental health services to all eligible Medicaid beneficiaries who meet the services' medical necessity criteria. MHPs may provide specialty mental health hospital and/or non-hospital services through county-operated facilities and providers and/or through contracts with governmentally-operated and privately operated providers (hereafter referred to as contract providers). Contract providers include governmentally-operated and privately operated hospitals, privately-operated organizational providers, privately-operated group providers, privately-operated individual providers, privately-operated administrative service organizations, and privately-operated non-organizational providers that deliver only therapeutic behavioral services.

The State makes interim payments of federal financial participation (FFP) to the MHPs based upon expenditures submitted by the mental health plans. For services provided by a contract provider, the MHP pays the provider before submitting a claim to the State for the payment of FFP. When submitting a claim for FFP for services provided by a county-operated or contract provider, the MHP is required to certify that it has made expenditures on which the claim for FFP is based, that the expenditures are no greater than the actual cost of providing services, and that the expenditures meet all federal and State requirements for claiming FFP.

The State uses a State-developed cost report for its specialty mental health services waiver program. All MHPs are required to submit a cost report package by December 31st following the close of each fiscal year. The MHPs cost report package includes a detail cost report for county-operated providers, as well as all governmentally-operated hospitals, privately-operated hospitals, and the privately-operated organizational providers that contract with the MHP.[1] The State will use the protocol outlined below to determine allowable Medicaid costs to be certified as public expenditures.

I. Definitions

In this protocol, the following terms have the following meaning:

Blended FMAP means a federal medical assistance percentage (FMAP) that is equal to a weighted average of multiple FMAPs.

[1] Privately-operated individual providers, group providers, administrative service organizations, privately operated hospitals that provide acute psychiatric inpatient hospital services to Healthy Families beneficiaries, and non-organizational providers that deliver only therapeutic behavioral services do not submit cost reports. They are considered Program 2 providers. An MHP that contracts with one of those providers reports its actual expenditures for services provided under the contract with each provider.

Control rate means a rate calculated by the State that is used to monitor interim payments of federal financial participation made to mental health plans for services provided by contract providers. The rate is calculated using the contract provider's most recently filed cost report increased by a cost of living index.

Federal Medical Assistance Percentage (FMAP) means the percentage used to determine federal financial participation for the total allowable costs apportioned to a particular Medicaid program. Allowable costs apportioned to some programs are reimbursed at an enhanced rate.

Governmentally-operated hospital means a hospital that is owned and operated by a unit of government.

Healthy Families beneficiary means an individual who is enrolled in a health plan under the State's Children's Health Insurance Program.

Licensed mental health professional means a licensed physician, licensed psychologist, licensed clinical social worker, licensed marriage and family therapist, registered nurse, licensed vocational nurse, and licensed psychiatric technician.

Privately-operated administrative service organization means an organization that is owned and operated by a private entity and contracts with a mental health plan to coordinate the delivery of rehabilitative mental health and/or case management services to beneficiaries residing in another county.

Privately-operated group provider means an organization that is owned and operated by private entities and that provides rehabilitative mental health and/or case management services through two or more individual providers.

Privately operated hospital means a hospital that is owned and operated by a private entity.

Privately-operated individual provider means a licensed mental health professional whose scope of practice permits the practice of psychotherapy without supervision who provides rehabilitative mental health and/or case management services.

Privately operated organizational provider means a provider of rehabilitative mental health and/or case management services that is owned and operated by a private entity and that provides the services through employed or contracting licensed mental health professionals and other staff.

Schedule of Maximum Allowance (SMA) for administrative day services means the maximum per diem rate administrative day services. The maximum rate for administrative day services is calculated annually and is based upon the prospective class median rate for nursing facilities that are distinct parts of acute care hospitals and offer skilled nursing services.

Therapeutic behavioral health services provider means an individual that contracts with the mental health plan to only provide therapeutic behavioral services.

II. Summary of State-Developed Cost Report

The State-developed cost report package includes a “detail cost report” that is submitted by the MHP for the services provided by the county-operated providers and for each of the privately-operated organizational providers, governmentally-operated hospitals, and privately-operated hospitals with which the MHP contracts, as well as a summary cost report. In its detail cost report the MHP includes the costs it incurred for services that it provided as well as services that were provided under contract with an administrative services organization, individual providers, group providers, and non-organizational providers that deliver only therapeutic behavioral services. Each privately-operated organizational provider, governmentally-operated hospital, and privately-operated hospital includes the costs it incurred for the services it provided.

The following includes a brief summary of the forms and schedules contained in the detail cost report for the county-operated providers, and the privately-operated organizational providers, governmentally-operated hospitals, and privately-operated hospitals with which the MHP contracts.

<u>MH 1900 Info</u>
The MH 1900 fulfills a number of purposes: Section I is completed by all providers and captures identifying information about the provider that is repeated in all forms, such as the provider’s name. Section II is completed by the MHP only. The MHP provides information that is used in the cost settlement process, such as total payments to privately-operated organizational providers, governmentally operated hospitals, and privately-operated hospitals with which the MHP contracts, and Fee-for-Service hospitals for specialty mental health inpatient and outpatient services and adjustments to Federal Financial Participation (FFP) that account for costs of non-county hospitals and organizational providers that have not been incurred by the MHP.

<u>MH 1960</u>
The purpose of the MH 1960 is to adjust the provider’s total expenditures for Medi-Cal principles of reimbursement and determine costs allocated to direct cost centers. MHPs may allocate allowable costs to waiver administration, utilization review/quality assurance, and direct services, which includes Medi-Cal Administrative Activities and medical assistance. All other providers may allocate allowable costs to direct services, which includes Medi-Cal Administrative Activities and medical assistance. Indirect costs are allocated to waiver administration utilization review/quality assurance, and direct service cost centers on an equitable basis that is consistent with the Office of Management and Budget (OMB) Circular A-87 (and its superseding OMB Super-Circular at 2 CFR 200), including an indirect cost rate plan developed in accordance with OMB A-87 (and its superseding OMB Super-Circular at 2 CFR 200).

Each provider reports total costs from its financial records. County-operated providers report total expenditures from the County Auditor Controller's financial statement for the county Department of Mental Health or the county agency within which the Department of Mental Health is located. All other providers report total expenditures from their trial balance. State auditors must be able to reconcile this amount to the organization's general ledger.

The cost report contains additional schedules that are intended to adjust total expenditures for Medicaid principles of reimbursement contained in CMS Publication 15-1 and Title 42, Code of Federal Regulations, Part 413, OMB Circular A-87 (and its superseding OMB Super-Circular at 2 CFR 200) and Medicaid non-institutional reimbursement policy. The MH 1960 captures data from the form MH 1965 to reclassify costs that were not properly classified in the entity's accounting system, captures adjustments from the MH 1961 to adjust costs for Medicaid principles of reimbursement contained in CMS Publication 15-1 and Title 42, Code of Federal Regulations, Part 413, OMB Circular A-87 (and its superseding OMB Super-Circular at 2 CFR 200) and Medicaid non-institutional reimbursement policy, captures adjustments from the form MH 1962 for non-mental health costs, and captures adjustments from the form MH 1963 for MHP payments to privately-operated hospitals, governmentally-operated hospitals, and privately-operated organizational providers with which the MHP contracts. The MH 1963 is completed by the MHP only.

The Medicaid non-institutional reimbursement policy in determining allowable costs includes:

a) Facilities that are primarily providing medical services - Allowable direct costs will be limited to the costs related to direct practitioners, medical equipment, medical supplies and other costs, such as professional service contract, that can be directly charged to covered medical services. Indirect costs are determined by either applying the agency specific approved indirect cost rate to its net direct costs. When there is not an approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These allocated indirect costs are reduced by any unallowable amount based on Medicaid non-institutional reimbursement policy.
b) Rehabilitative mental health services provided in Adult Residential Treatment Services, Crisis Residential Treatment Services, and Psychiatric Health Facility Services –Allowable costs will be limited to the costs related to direct practitioners, medical equipment, medical supplies and overhead costs determined using one of the following methods. The provider may allocate overhead costs based upon a cognizant agency approved indirect cost rate. When there is not an approved indirect cost rate, the provider will derive the indirect cost from the allocation process through the provider's approved cost allocation plan. These indirect costs are reduced by any unallowable amount. For those facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes and would be incurred at the same level

if the medical services did not occur are not allowed (e.g. room and board, allocated cost from other related organizations). "

MH 1960_HOSP_COSTS

The purpose of the MH 1960_HOSP_COST is to calculate a hospital's cost per day and cost to charge ratio for hospital costs and physician and other professional costs. The MH 1960_HOSP_Costs captures hospital costs for routine, ancillary, outpatient, other reimbursable, and special purpose cost centers from Worksheet B, Part I, Column 27 of the CMS 2552-96; and adds back direct graduate medical education (GME) costs adjusted out on Worksheet B, Part I, Column 26 of the CMS 2552-96. The MH 1960_HOSP_COSTS captures physician costs from worksheet A-8-2, Column 4 and non-physician professional costs from worksheet A-8.

MH 1960_HOSP_05, MH 1960_HOSP_10, MH_1960_HOSP_15

The MH 1960_HOSP is designed to apportion hospital costs entered on the MH 1960_HOSP_COSTS to the Medi-Cal and Healthy Families Program. The cost per day for routine cost centers and the cost to charge ratio for ancillary and outpatient cost centers calculated on the MH 1960_HOSP_COSTS automatically populates column 1 of the MH 1960_HOSP for each mode of service. For each settlement group, the hospital enters its total days for routine cost centers and total charges for ancillary cost centers to apportion hospital costs to each settlement group. The total cost for administrative day services is limited to the schedule of maximum allowance (SMA) rate established for administrative day services. The total costs for each settlement group and mode of service is transferred to the MH 1968.

MH 1960_PHYS_05, MH 1960_PHYS_10, MH 1960_PHYS_15

The MH 1960_PHYS is designed to apportion hospital-based physician and non-physician professional costs entered on the MH 1960_HOSP_Costs to the Medi-Cal and Healthy Families Program. The cost to charge ratio for ancillary, outpatient, and non-physician practitioner cost centers as calculated in column 11 of the MH 1960_HOSP_COSTS is transferred to column 1 of the MH 1960_PHYS for each mode of service. The hospital enters its physician and professional component charges for each ancillary, outpatient, and non-physician practitioner cost centers to apportion total costs to each settlement group. The total physician and non-physician professional component costs for each settlement group and mode and service is transferred to the MH 1968.

Schedule A

The purpose of Schedule A is to allow each provider to report its normal and customary charge to the public for each type of service it provided during the cost reporting fiscal year. At the interim and final settlement, the MHP is not reimbursed in excess of the provider's customary charge to the public unless it meets criteria for exemption.

Schedule B

The purpose of Schedule B is to capture, for each type of service that the provider delivered during the cost reporting fiscal year, the total units of service provided to

Medicaid beneficiaries eligible for non-enhanced and enhanced (i.e., M-CHIP, Refugee, BCCTP) Federal reimbursement, SCHIP beneficiaries, and Non Medi-Cal program beneficiaries; as well as third party revenue collected for those units of service. Units of service provided by hospitals are separately identified from units of service provided by non-hospitals using a specific settlement type.

Schedule C

The purpose of Schedule C is to allocate direct service costs to individual types of service. The MHPs are allowed to use one of three approved methods to allocate direct costs to individual types of services, The three methods are Direct Allocation, Time Study, and Relative Value.

Under the Direct Allocation Method, a MHP can capture its direct costs at the service function level if the MHP has the technology and the reporting means to capture the costs at the service function level.

For the Relative Value Method, a MHP can conduct a time study to capture and accumulate hours at the service function level. A percentage of the hours for each service function is calculated by the dividing the total hours of the service function by total hours of all service functions. The percentage of each service function is multiplied by the total direct costs to determine the direct costs for each service function.

Under the Relative Value Method, first the total units of service for each service function is multiplied by the legal entity's published charge for the service function to arrive at the relative value for the service function. The relative value for each service function is then divided by the sum of all the relative values for all service functions to determine the percentage for the service function. The percentage is then multiplied by the total direct costs to determine the direct cost for each service function.
Total costs allocated on schedule C must reconcile with total costs allocated to direct services on the MH 1960.

MH 1963

The purpose of form MH 1963 is to allow the MHP to report payments made to each governmentally-operated hospital, privately-operated hospital, and privately-operated organizational provider with which the county contracted to provide mental health services during the cost report fiscal year. The county reports total payments made to each provider during the cost report fiscal year as well as all payments made to each non-county hospital and organizational provider for Medi-Cal reimbursable services provided during the cost report fiscal year by settlement and period of time.

MH 1966

The purpose of form MH 1966 is to apportion non-hospital costs allocated to particular types of service on Schedule C among the Medicaid program, State Children's Health Insurance Program (SCHIP), and non-Medicaid/SCHIP programs. The cost report includes a separate form MH 1966 for acute psychiatric inpatient hospital services (including administrative days), other 24-hour services, day services, program 1

outpatient services, and program 2[2] outpatient services. The only purpose of the form MH 1966 for acute psychiatric inpatient hospital services (including administrative days) is to calculate the gross published charge for comparison with allowable costs. The form MH 1966 for Program 1 outpatient services apportions costs for outpatient services provided by a county or a non-county organizational provider. The form MH 1966 for Program 2 outpatient services apportions costs for services provided by an administrative service organization, individual provider, group provider, or non-organizational provider that delivers only therapeutic behavioral services under contract with the MHP.

Each form MH 1966 calculates a cost per unit for each type of service based upon the total costs allocated to the service on the Schedule C and total units reported on the Schedule B. The cost per unit is multiplied by the total units provided to Medicaid beneficiaries, SCHIP beneficiaries, and non-Medicaid/SCHIP beneficiaries to determine the costs apportioned to each program.

Each form MH 1966, except the form MH 1966 for program 2 outpatient services, also calculates the total published charge attributable to the Medicaid program, State Children's Health Insurance Program, and Non-Medicaid/SCHIP programs. The published charge for each type of service entered on Schedule A is transferred to each form MH 1966. Each form MH 1966 multiplies the published charge for each type of service by the total units provided to Medicaid beneficiaries, SCHIP beneficiaries, and non-Medicaid/SCHIP beneficiaries to determine the published charge attributable to each program.

MH 1969 – INST

The purpose of form MH 1969-INST is for the provider to document whether or not it meets certain criteria necessary to be considered a nominal fee provider. Federal reimbursement for a nominal fee provider is not limited by the provider's published charge. To qualify as a nominal fee provider, the provider must have a published schedule of its full (non-discounted) charges, base patient care revenue on application of the published charge schedule, maintain written policies for its process of making patient indigence determinations, and maintain sufficient documentation to support the amount of "indigence allowances" written off in accordance with those procedures. An entity that does not meet all four criteria does not qualify as a nominal fee provider.

MH 1969

The purpose of the form MH 1969 is to determine whether a provider that meets the four criteria in the MH 1969-INST has Medi-Cal adjusted customary charges that are equal to or less than 60 percent of its Medi-Cal costs. If a provider's Medi-Cal adjusted customary charges are equal to or less than 60% of its Medi-Cal costs, it qualifies as a

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[2] Privately-operated individual providers, group providers, administrative service organizations, privately operated hospitals that provide acute psychiatric inpatient hospital services to Healthy Families beneficiaries, and non-organizational providers that deliver only therapeutic behavioral services do not submit cost reports. They are considered Program 2 providers. An MHP that contracts with one of those providers reports its actual expenditures for services provided under the contract with each provider.

nominal fee provider. Reimbursement for a nominal fee provider is limited to cost. The provider's published charge is not considered.

MH 1968

The purpose of form MH 1968 is to determine the lower of the provider's actual costs for inpatient services and outpatient services that are subject to reimbursement or published charge. The form MH 1968 subtracts third party revenue collected for services provided to Medi-Cal beneficiaries and State Children's Health Insurance Program beneficiaries as reported on the MH 1901 Schedule B from the lower of actual cost to determine the expenditures eligible for federal reimbursement (i.e., net costs). The net costs eligible for federal reimbursement are transferred to form MH 1979. The summary cost report for each mental health plan summarizes the data in the MH 1968 across all providers that file a cost report.

MH 1979

The purpose of form MH 1979 is to calculate total federal financial participation due to the MHP for the specialty mental health services provided to Medicaid and SCHIP beneficiaries. Form MH 1979 multiplies total expenditures eligible for federal reimbursement by the appropriate Federal Medical Assistance Percentage (FMAP) to calculate federal reimbursement. At the time the State does its desk edit, the FFP calculated is adjusted down if the hospital's or organizational provider's expenditures are greater than county payments. The summary cost report for each mental health plan summarizes the data in the MH 1979 across all providers that file a cost report.

MH 1992

The purpose of the MH 1992 is to capture the sources of revenue used to make the expenditures reported on the MH 1960. The summary cost report for each mental health plan summarizes the data in the MH 1992 across all providers that file a cost report.

III. Certified Public Expenditures – Determination of Allowable Medicaid Costs

The following steps are taken to determine a MHP's allowable Medicaid expenditures and associated Medicaid reimbursements when such expenditures are used for claiming FFP through the certified public expenditure (CPE) process.

Interim Medicaid Payments

Interim payments of FFP are based on approximate Medicaid (Medi-Cal) expenditures that are eligible for FFP claimed through the CPE process. Interim payments of FFP to MHPs for services delivered by county-operated facilities are based upon interim rates established by the State for those providers on an annual basis. Interim payments of FFP to MHPs for services delivered by privately operated hospitals, governmentally operated hospitals, privately-operated organizational providers, privately operated group providers, privately-operated individual providers, privately operated Administrative Service Organizations, and therapeutic behavioral services providers are based upon the payments the MHP makes to those providers.

Interim rates for county-operated providers are established by the State on an annual basis using the following procedure. The State extracts from each county operated provider's cost report, the total costs for each type of service as reported on the MH 1901 Schedule C and the total units for each type of service as reported on the MH 1901 Schedule B. The State calculates a cost per unit for each type of services as the ratio of total costs divided by total units. The cost per unit for inpatient services is inflated by the change in the medical component of the national consumer price index and the cost per unit for all outpatient services is inflated by the change in the home health agency market basket unless CMS approves the use of some other cost of living index.

The State's interim payment of FFP to the MHP for the services provided by a contract provider is based upon the amount the MHP certifies to the State as a public expenditure. Except for privately-operated individual providers, privately-operated group providers, privately-operated administrative service organizations, and therapeutic behavioral services providers, the amount the MHP certifies to the State as a public expenditure may not exceed the lowest of (1) the amount the MHP actually paid the provider for the service rendered, (2) a reasonable approximation of the provider's allowable cost to render the service based upon its most recently filed cost report, or (3) the provider's usual and customary charge for rendering the service. The amount the MHP certifies to the State as a public expenditure for individual providers, group provider, administrative service organizations, and therapeutic behavioral service providers must equal the amount the MHP paid the provider. The MHP may adjust the interim rates established with its contract providers throughout the fiscal year, depending upon the MHP's agreement with the contract provider. MHPs may also settle with their contract providers after the close of the fiscal year and claim FFP for additional expenditures through the interim settlement process.

The State monitors interim payments of FFP to MHP's for services provided by contract providers on a quarterly basis. At the beginning of the fiscal year, the State prepares a set of "control rates" for each governmentally-operated hospital, privately operated hospital, and privately-operated organizational provider, as well as individual and group providers, ASO providers, and TBS providers with which each MHP contracts. The control rates for organizational providers, governmentally operated hospitals, and privately operated hospitals with which an MHP contracts are based upon the lower of the provider's cost per unit or usual and customary charge as reported in its most recently filed cost report trended to the current year using the home health agency market basket for outpatient services, the medical component of the national consumer price index for inpatient services, or another cost of living index approved by CMS. The control rates for individual and group providers, ASO providers, and TBS providers are based upon the average cost per unit for each type of provider as reported in the MHP's annual cost report. On a quarterly basis, the State prepares a report from its claiming system that shows the rate per unit of service the MHP submitted in its claims for services provided by each contract provider. The State compares the rate per unit from

the claiming system with the control rate. The State contacts each MHP when the rate used to claim reimbursement exceeds the control rate by ten percent or more. When the MHP submits claims for services provided by both county-operated and contract providers, it certifies that the expenditures meet all federal and State statutory and regulatory provisions, including 42 CFR 433.51. By signing the claim, the MHP is certifying that it made expenditures for the amount included in the claim.

Interim Reconciliation of Interim Medicaid Payments

Each MHP's expenditures that are used to claim interim FFP payments are reconciled to its State-developed cost report package for the State fiscal year in which services were provided. If, at the end of the interim reconciliation process, it is determined that a MHP received an overpayment, the overpayment is properly credited to the federal government in accordance with 42 CFR 433.316. If, at the end of the interim reconciliation process, it is determined that a MHP received an underpayment, an additional payment is made to the MHP. The State uses the following process to complete its interim reconciliation of interim Medicaid payments of FFP no later than 24 months after the close of the state fiscal year.

Each MHP is required to submit a State-developed cost report package to the State by December 31st following the close of the State fiscal year, which is June 30th. The State-developed cost report package includes a "detail cost report" for the MHP's county operated providers and all privately-operated hospitals, governmentally-operated hospitals, and privately-operated organizational providers with which the MHP contracts to provide specialty mental health services to its beneficiaries and a summary cost report. The county mental health director and county auditor controller sign a statement certifying the accuracy of the initial cost report submitted. Typically, beginning in the October following cost report submission, MHPs are given 90 days to reconcile their Medi-Cal reimbursable units of service with the State's record of claims adjudication. While reconciling Medi-Cal reimbursable units of service, the MHP may also update the Medi-Cal payments made to governmentally-operated hospitals, privately-operated hospitals and organizational providers as reported on the MH 1963. During the time between initial submission of the cost report and reconciliation of Medi-Cal units, the MHP may settle with their contract providers. This settlement process may result in additional payments to contract providers for Medi-Cal specialty mental health services provided during the cost report fiscal year. Medi-Cal payments reported on the MH 1963 may be updated to reflect these additional payments made to governmentally-operated hospitals, privately-operated hospitals, and organizational providers. MHP's submit the cost report to the State after making adjustments for Medi-Cal reimbursable units of service and Medi-Cal payments to governmentally-operated hospitals, privately-operated hospitals, and organizational providers.

When the State receives the reconciled cost report, staff completes a desk review of all detail cost reports to verify that the county has made payments for the costs that have been reported by privately-operated hospitals, governmentally-operated hospitals, and privately-operated organizational providers with which the MHP contracts; or

appropriate adjustments have been made to FFP calculated on the form MH 1979 to ensure that the county is not receiving federal reimbursement for expenditures that it did not make. The desk review compares the total Medi-Cal payments that the county MHP reported it paid each privately-operated hospital, governmentally-operated hospital, and privately-operated organizational provider with which it contracts on the form MH 1963 with the total expenditures eligible for federal reimbursement for each settlement group and period of time. If the total Medi-Cal payments made by the county are greater than or equal to the total expenditures eligible for federal reimbursement, the county has incurred the costs that are being reimbursed. If the total Medi-Cal payments made by the county are less than the total expenditures eligible for federal reimbursement, the State requires that the privately-operated hospital, governmentally operated hospital, or privately-operated organizational provider cost report reduce the total FFP by the amount of FFP that is based on costs that have not been incurred by the county.
The county may not compute the excess FFP based on blended FMAPs, but rather the total computable of excess CPE should be attributed to the particular claiming quarters for CMS-64 reporting purposes. The State requires the county to use the following method to calculate the adjustment to FFP if its Medi-Cal payments are less than the net reimbursement used to calculate FFP on the MH 1979. For each settlement group and period of time, subtract the total Medi-Cal payments reported on the MH 1963 from the net reimbursement calculated on the MH 1979 to identify expenditures that are not properly classified as certified public expenditures. Multiply the expenditures that cannot be properly classified as certified public expenditure by the FMAP applicable to the settlement group and period of time to determine the adjustment to FFP.

Once the cost report has passed the desk review, the State notifies the MHP that its cost report has been accepted by the State and requests that the MHP submit the appropriate certification within 10 days. The county mental health director and county auditor controller sign a statement certifying the accuracy of the reconciled cost report submitted. By signing the certification, the mental health director and auditor controller are certifying that the expenditures meet all federal and State statutory and regulatory provisions, including 42 CFR 433.51.

All of the detail cost reports submitted by a MHP are summarized into a summary cost report that shows the federal financial participation (FFP) due to the MHP for the services provided by the county MHP and all of the privately-operated hospitals, governmentally-operated hospitals, and privately-operated organizational providers with which it contracts. The total FFP calculated on the summary cost report is compared to total interim payments made to the MHP in the applicable State fiscal year to determine whether the MHP received more or less FFP than it is due for the cost report fiscal year. MHPs that received FFP in excess of the amount due to them are invoiced and the money is promptly returned to the federal government in accordance with 42 CFR 433.316. MHPs that received FFP in an amount that is less than the amount due to them receive an additional payment.

Final Reconciliation of Interim Medicaid Payments

The State will complete its audit of the reconciled cost report within three years of the date the certified reconciled State-developed cost report is submitted. The audit performed by the State determines whether the income, expenses, and statistical data reported on the mental health cost report are reasonable, allowable, and in accordance with State and federal rules, regulations, and Medicare principles of reimbursement issued by the Department of Health and Human Services and Centers for Medicare and Medicaid Services (CMS). The audit also determines that the county's mental health cost report accurately represents the actual cost of operating the Medi-Cal Specialty Mental Health program in accordance with the program's Cost and Financial Reporting System (CFRS), Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42CFR), Office of Management and Budget (OMB) Circular A-87 (and its superseding OMB Super-Circular at 2 CFR 200), Medicaid non-institutional reimbursement policy, Generally Accepted Auditing Standards (GAAS), Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United States and other State and federal regulatory authorities. The State audit staff compares the FFP due to the MHP in the audited cost report with all interim payments, including the interim settlement and supplemental payments to eligible entities, and applies the upper payment limit pursuant to 42 CFR 447.362. The purpose of this comparison or review is for the State to determine if an overpayment or underpayment exists, and ensure that any overpayment of FFP is promptly returned to the federal government per 42 CFR 433.316 and 433.320. If the State determines that the MHP received an underpayment, the State makes an additional payment to the MHP.

COVID-19 Public Health Emergency

Notwithstanding any other provisions in this Attachment, the following modified requirements will apply for covered inpatient and outpatient services provided on or after March 1, 2020, until the COVID-19 public health emergency ends:

- Interim payments of FFP to MHPs for services delivered by county-operated facilities are at the lower of the county's billed amount or interim rates established by the State for those providers on an annual basis increased by 100 percent.
- The State's interim payment of FFP to the MHP for the services provided by a contract provider is based upon the amount the MHP certifies to the State as a public expenditure. The amount the MHP certifies to the State as a public expenditure must equal the amount the MHP actually paid the provider for the service rendered. Except for covered inpatient services, the limitations of a reasonable approximation of the provider's allowable cost to render the service based upon its most recently filed cost report, and of the provider's usual and customary charge for rendering the service, are suspended.
- For purposes of interim and final reconciliation of covered outpatient services, net costs eligible for federal reimbursement will be equal the provider's actual allowable cost. The limitation of the provider's customary charge to the public for covered outpatient services is suspended.

To the extent necessary to implement these modified requirements, all conflicting provisions in this Attachment are suspended.