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

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

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Ms. Henrietta Sam-Louie
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

RESPONSE TO REQUEST FOR ADDITIONAL INFORMATION (RAI) –STATE PLAN AMENDMENT (SPA) 09-004 AND RESUBMISSION OF SPA 09-004

Dear Ms. Sam-Louie:

The Department of Health Care Services (DHCS) is resubmitting the enclosed State Plan Amendment (SPA) 09-004 for your review and approval as well as responses to the Centers for Medicare and Medicaid Services (CMS) RAI dated June 26, 2009 regarding SPA 09-004. The responses contained in this letter are for the RAIs regarding reimbursement. Responses to RAIs regarding coverage were submitted with SPA 10-012B and SPA 10-016.

SPA 09-004 is amending the reimbursement methodology for targeted case management, rehabilitative mental health, and psychiatric inpatient hospital services. The amendments describe a reimbursement methodology for targeted case management and rehabilitative mental health services that is based upon the lower of the providers reasonable and allowable costs or customary charge. The amendments identify a specific group of hospitals that will be reimbursed the lower of their reasonable and allowable costs or customary charge for psychiatric inpatient hospital services. The amendments clarify the existing methodology for reimbursing all other hospitals that provide psychiatric inpatient hospital services.

SPA 09-004 revises or adds language to the provisions set forth in the following sections of the State Plan:

- Attachment 4.19 A – pages 38-40
- Attachment 4.19 A – pages 41-45
- Attachment 4.19 B – pages 21-25

Mental Health and Substance Use Disorder Services Division
1501 Capitol Avenue, MS 4000, P.O. Box 997413
Sacramento, CA 95899-7413
Phone: (916) 440-7800 Fax (916) 319-8219
Internet Address: www.dhcs.ca.gov

Our responses to your **[bolded]** questions are as follows:

D. Attachment 4.19A, pages 38-40 and Appendix 3 to Attachment 4.19-A (Supplemental Payment)

1. **Please confirm that the changes to Attachment 4.I 9A, as proposed by this SPA, are limited to *hospital* inpatient reimbursement and do not impact any other institutional providers.**

   The changes to Attachment 4.19A, as proposed by SPA 09-004, are limited to hospital inpatient reimbursement and do not impact any other institutional providers other than psychiatric health facilities approved to provide hospital inpatient services

2. **Assuming that the inpatient hospital supplemental payment provided for in Appendix 3 of Attachment 4.19A is only for inpatient hospital specialty mental health services (see Section A, #3.c above), is the supplemental payment only for the unmet inpatient hospital cost related to hospitals' furnishing of specialty mental health services that are billed through county MHPs? Does the supplemental payment apply to unmet inpatient hospital cost related to hospitals' furnishing of inpatient hospital specialty mental health services that are billed to EDS? Presumably, only private hospitals' specialty mental health services are billed to EDS and therefore, would not eligible for these CPE-funded supplemental payments. Please confirm.**

   SPA 09-004 has been revised and no longer describes an inpatient hospital supplemental payment because the supplemental payment methodology only applies for services provided through the county MHPs. As such, the supplemental payment methodology is described in the State's Certified Public Expenditure (CPE) protocol for specialty mental health services delivered under the state's 1915b waiver. The supplemental payment for unmet hospital costs described in the CPE protocol only applies to specialty mental health services billed through the county MHPs. The supplemental payment for unmet hospital costs does not apply to specialty mental health services billed to the state's Fiscal Intermediary (FI).

3. **Appendix 3 to Attachment 4.19A: Please clarify whether the supplemental payment is reimbursable to the county MHP as a PIHP payment or reimbursable directly to the hospitals providing**

inpatient hospital specialty mental health services.

The supplemental payment will be reimbursable to the county MHP as a PIHP payment and therefore SP 09-004 has been revised to no longer describe a supplemental payment methodology. The state has described the methodology for this supplemental PIHP payment in its CPE protocol for specialty mental health services delivered under the state's 1915b waiver.

4. **If the supplemental payment is reimbursable directly to hospitals for providing inpatient hospital specialty mental health services that are exclusively billed through the MHPs as PIHPs, this would appear to violate 42 CFR 438.60, which prohibits a direct payment to providers for services available through a PIHP contract. If the State disagrees, please explain.**

   The state will not be making supplemental payments directly to hospitals for providing inpatient hospital specialty mental health services that are exclusively billed through the MHPs as PIHPs. The methodology for this additional PIHP payment is in the CPE protocol approved by CMS through the 1915b waiver.

5. **If the supplemental payment is reimbursable to the PIHPs for hospitals' furnishing of inpatient hospital specialty mental health services, then the supplemental payment is to be considered as an additional PIHP payment. Therefore, the supplemental PIHP payment does not need to be provided for through the State plan, because this payment will be available as a PIHP contract payment subject to the limit of the non-risk PIHP upper payment limit (UPL) per 42 CFR 447.362.**

   Attachment 4.I 9A of the State plan needs to provide for a reimbursement methodology for inpatient hospital specialty mental health services which I) serves as the basis for reimbursement in the absence of a PIHP and also 2) serves as an upper payment limit when/if the specialty mental health services are delivered through a non-risk PIHP. The State plan methodology for inpatient hospital specialty mental health services should encompass a reimbursement methodology that covers both the reimbursement to 1) county hospitals and other hospitals that are now providing inpatient hospital specialty mental health services as legal entities under the county

MHP, and 2) hospitals that, under current system, bill to EDS for the inpatient hospital specialty mental health services and are reimbursed at a rate either as a contracting or non-contracting hospital. (Please explain if there are other methods for the delivery of inpatient hospital specialty mental health services.) It would appear reasonable for the State plan reimbursement for the first group of hospitals to be cost reimbursement, as this would result in an adequate non-risk PIHP UPL for inpatient hospital specialty mental health services – the State's PHIP payments for inpatient hospital specialty mental health services furnished by the county hospital legal entities, including the supplemental payment, must not exceed these hospitals' actual costs. Please refer to question #7 of this section for further comment on this first group of hospitals. The State plan reimbursement for the second group of hospitals should reflect the actual current reimbursement, since the inpatient hospital specialty mental health services provided by these other hospitals are billed through EDS, and not through the county mental health plan PIHPs. Please refer to question #8 of this section for further comment on this second group of hospitals.

The supplemental payment is an additional PIHP payment and is therefore no longer described in SPA 09-004 but is instead set forth in the CPE protocol approved by CMS in the 1915b waiver. Attachment 4.19A pages 38 – 40 now describes a reimbursement methodology for inpatient hospital specialty mental health services provided by hospitals that are legal entities under the county MHP. The reimbursement methodology described on pages 38-40 is based upon the lower of allowable costs or customary charges. Attachment 4.19A pages 41-45 has also been revised for inpatient hospital specialty mental health services that are billed to the State's Fiscal Intermediary. The reimbursement methodology described on pages 41-45 reflects the actual current reimbursement methodology.

6. **Given the discussion above as to what the State plan needs to provide, please respond to the following questions on Attachment 4.19-A, page 38-40: 1) Is the limitation of the Statewide maximum allowances (SMAs) necessary? 2) Do the definitions of providers and legal entities apply? Legal entities as providers appear to only be a concept under the county mental health plan model; in Attachment 4.19A, hospitals must be the providers who furnish inpatient hospital specialty mental health services.**

The statewide maximum allowance rate is necessary for administrative day services, but it is not necessary for acute psychiatric inpatient hospital services. Definitions of providers and legal entities no longer apply to Attachment 4.19A. Attachment 4.19A – pages 38-40 has been revised to list those specific hospitals in California for which the reimbursement methodology described on pages 38-40 apply and to refer to hospitals generally as state owned and operated, county owned and operated, and privately owned and operated.

7. **Cost reimbursement for inpatient hospital specialty mental health services: Where the State plan needs to be revised to provide for a cost reimbursement for inpatient hospital specialty mental health services, the State should incorporate in its State plan a detailed description of the cost determination methodology. The State plan language, similar to other SPAs and protocols on hospital inpatient cost reimbursement, should include: the cost principles and the cost reporting tool (the CMS-2552) in use to identify allowable costs; the process by which allowable costs are apportioned to Medicaid beneficiaries; the scope of the Medicaid services that are included in the SPA (i.e., describing specialty mental health services and, for the purposes of Attachment 4.19A, inpatient hospital specialty mental health services); the eligibility of providers (i.e., establishing which hospitals are subject to the cost reimbursement); any interim/final payments and reconciliations; State cost report audit/settlement processes; the source of the Medicaid days and charges used; and payments offsets needed to arrive at the unmet costs.**

   Attachment 4.19A – pages 38-40 has been revised to describe a reimbursement methodology that is based upon the lower of allowable cost or customary charge. The methodology identifies the cost principles and cost reporting tool in use to identify allowable costs; the process by which allowable costs are apportioned to Medicaid beneficiaries; the scope of the Medicaid services that are reimbursed through the methodology described on pages 38-40; identifies the specific hospitals that are eligible for reimbursement through the methodology described on pages 38-40; the interim cost settlement process; the final audit and cost settlement process; the source of Medicaid days and charges. It does not describe payment offsets needed to arrive at unmet costs, because supplemental payments will not be made through the State plan. The payments offsets needed to arrive at unmet costs will be described in the states CPE protocol for Specialty Mental Health Services.

8. **Reimbursement for hospitals that are currently billing through EDS for inpatient hospital specialty mental health services: Please review current pages 41-45 of Attachment 4.19A, for payments to**

hospitals that are billing through EDS for inpatient hospital specialty mental health services to ensure that these pages are reflective of current practice. If they are not, CMS suggests that the State revise these pages accordingly through the SPA process. For example, paragraph B.9 on page 43 appears to indicate that the reimbursement method described is no longer applicable, given the associated Section 1915(b) waiver.

Attachment 4.19A, pages 41-45, has been revised to reflect current practice.

9. **If the inpatient supplemental payment provided for in Appendix 3 of Attachment 4.19A is for mental health services other than those specialty mental health services (see Section A, #3.c above), please explain how the supplemental payment interplays/overlaps with other 4.19A inpatient hospital reimbursement as well as any inpatient hospital reimbursement provided for through California's Medi-Cal Hospital/Uninsured Care 1115 waiver. Additionally, for any inpatient hospital non- specialty mental health services, please incorporate into the State plan a detailed methodology that discusses: the cost principles and the cost reporting tool (the CMS-2552) in use to identify allowable costs; the process by which allowable costs are apportioned to the Medicaid populations; which Medicaid services are subject to the cost reimbursement (in this case, describing inpatient hospital non-specialty mental health services); the eligibility of providers (i.e., establishing which hospitals are subject to the cost reimbursement for inpatient hospital non-specialty mental health services); any interim/final payments and reconciliations; State cost report audit/settlement processes; the source of the Medicaid days and charges used; and the payments offsets needed to arrive at the unmet costs.**

   The supplemental payment that California is contemplating is only for the unmet cost of inpatient hospital specialty mental health services. The state will describe the methodology for making this additional PIHP payment in its CPE protocol for specialty mental health services.

10. **Please remove all State plan reimbursement references to "certified public expenditure." The approved State plan should use "cost reimbursement" or similar language.**

Attachment 4.19A – pages 38-40E do not make reference to certified public expenditures.

E. Standard Funding Questions - Attachment 4.19A

The following questions are being asked and should be answered in relation to all payments made to all providers under Attachment 4.19A of your State plan.

1. **Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

   Payments for services provided under Attachment 4.19A, pages 38-40 are made to the county MHP based on the county MHPs Certified Public Expenditure (CPE). The MHP retains the full federal Medicaid payment it receives for hospital inpatient specialty mental health services provider under Attachment 4.19A, pages 38-40. Payments for services provided under Attachment 4.19A, pages 41-45 are made to the hospital. The hospital retains 100% of the payment received under Attachment 4.19A, pages 41-45.

2. **Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that,**

if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.SI(b). For any payment funded by CPEs or IGTs, please provide the following:

- **(i) a complete list of the names of entities transferring or certifying funds;**
- **(ii) the operational nature of the entity (state, county, city, other);**
- **(iii) the total amounts transferred or certified by each entity;**
- **(iv) clarify whether the certifying or transferring entity has general taxing authority; and,**
- **(v) whether the certifying or transferring entity received appropriations (identify level of appropriations).**

The state share of payments for inpatient hospital specialty mental health services provided under Attachment 4.19A, pages 38-40, comes from the county MHP's CPE. The state share of payments for inpatient hospital specialty mental health services provided under Attachment 4.19A, pages 41-45, is transferred from counties to the state on a monthly basis.

Attachment 4.19A, Pages 38-40

The state share of Medicaid payments for psychiatric inpatient hospital services made pursuant to Attachment 4.19A, pages 38-40 is funded through the county mental health department's CPE. The enclosed table (Enclosure 1) displays the entities that certified public expenditures for specialty mental health services reimbursed pursuant to Attachment 4.19A, pages 38-40, the operational nature of each entity, the total amounts certified by each entity in Fiscal Year 2012-13, identifies whether the entity certifying has taxing authority, and identify the level of funding appropriated to each entity for Fiscal Year 2012-13.

Attachment 4.19A, Pages 41-45

The state share of Medicaid payments for psychiatric inpatient hospital services made pursuant to Attachment 4.19A, pages 41-45, is funded with transfers from the monthly distribution to each county from the local revenue fund.

3. **Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.**

   Supplemental or enhanced payments are not currently made to hospitals reimbursed for psychiatric inpatient hospital services under Attachment 4.19A – pages 38 – 40 or Attachment 4.19A – pages 41-45.

4. **Please provide a detailed description of the methodology used by the state to estimate the UPL for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e. applicable to the current rate year) UPL demonstration.**

   Payments for specialty mental health inpatient hospital services are made under the 1915(b) specialty mental health waiver. The payments made to the mental health plan are subject to the non-risk upper payment limit described in 42 CFR 447.362, which is equal to what Medicaid would have been paid for the services rendered on a fee-for-service basis plus any net savings on administrative costs realized by the Medicaid agency.

   The State estimates the UPL after settling each mental health plan's cost report. The most recent fiscal year for which the state has completely settled county cost reports if FY 2009-10. Attachment 2 contains a detailed UPL demonstration for FY 2009-10.

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

   The State does not reimburse providers directly. The State reimburses mental health plans under the 1915(b) specialty mental health waiver. The payments made to mental health plans do not exceed the lower of the

mental health plan's certified public expenditures or non-risk upper payment limit determined in accordance with 42 CFR 447.362. If interim payments exceed the lower of the mental health plan's certified public expenditures or non-risk upper payment limit, the State recoups the overpayments and returns the Federal share to CMS on the quarterly expenditure report.

F. Attachment 4.198, pages 21 -26 and Supplement 11 to Attachment 4.19-B (Supplemental Reimbursement)

1. Please itemize the non-institutional specialty mental health services that are eligible for the proposed supplemental reimbursement as described in a revised Attachment 3.1 A and B. (See Section F #4.b. below for further details.)

SPA 09-004 has been revised and is no longer proposing a supplemental reimbursement within the state plan. After further discussions with CMS, the State is amending Attachment 4.19B, pages 21-25 to describe a reimbursement methodology that is based upon allowable cost. The State has described the supplemental payment methodology in a Certified Public Expenditure protocol for the 1915(b) specialty mental health waiver program.

2. a. Assuming that this SPA, as it pertains to Attachment 4.19-B, is only for non-institutional specialty mental health services that are currently delivered and billed through the county MHPs as PIHPs (see Section A, #3.c), please clarify if the supplemental payment as proposed under Supplement 11 of Attachment 4.19-B, is paid to the county MHPs or is reimbursed directly to hands-on providers of these services. If the payment is directly paid to hands-on providers, this would violate 42 CFR 438.60, which prohibits a direct payment to providers for services available through a PIHP contract. If the State disagrees, please explain.

The state has revised SPA 09-004. The state does not make supplemental payments directly to hospitals for providing inpatient hospital specialty mental health services that are exclusively billed through the MHPs as PIHPs. The state described the additional PIHP payment in the CPE protocol approved by CMS through the 1915b waiver.

b. **According to the "Chart for Specialty Mental Health Services" provided to CMS on May 26, 2009, some of the services are currently receiving a supplemental payment under SPA 02-018 (outpatient hospitals) and 05-023 (governmental-operated providers for professional services). Since these services are provided through a PIHP delivery system, please explain why non- institutional specialty mental health services are eligible for the supplemental payment under SPAs 02-018 and 05-023.**

Supplemental Reimbursement For Public Outpatient Hospital Services (TN 02-018):

The providers that participate in the Public Hospital Outpatient (OP) Services Supplemental Reimbursement Program (AB 915) do **NOT** receive reimbursement for OP specialty mental health (MH) services. OP specialty MH services are billed through the Short Doyle system only, not the FI. The providers that receive supplemental reimbursement for AB 915 report only the OP services billed directly through the FI, therefore, their supplemental claims do not contain any specialty MH data.

Reimbursement to Specified Government-Operated Providers for Costs of Professional Services (TN 05-023):
Medi-Cal Psych Physician and Non-Physician costs and revenues are captured in the P14 workbook and flow through to Step 8: Medi-Cal Claiming Under the Physician SPA, on Schedule 2.1-A, which is the data used to calculate supplemental reimbursement for the program. The costs captured in Schedule 1B, Medi-Cal Psych Columns 9b and 9d, which flow into schedule 2.1-A, are Specialty MH costs. The Medi-Cal Psych costs reported in the P14 for Physician SPA can either be carved out of Schedule 2.1-A Step 8, or offset with the base and SPA payments reported in Schedule 3.1 to ensure that those costs are not being reimbursed under both the MH SPA and PNPP.

3. **If the supplemental payment is reimbursable to the PIHPs for non-institutional specialty mental health services, then the supplemental payment is to be considered as an additional PIHP payment. Therefore the supplemental PIHP payment does not need to be provided for through the State plan, because this payment will be available as a PIHP contract payment subject to the limit of the non-risk PIHP UPL per 42 CFR 447.362.**

   Instead, the State needs to describe a State plan reimbursement methodology to be used to a) pay the non-institutional specialty mental health services in absence of the PIHP delivery system and b)

serve as an UPL when the non-institutional specialty mental health services are delivered through a PIHP, i.e. the non-risk PIHP UPL.

The current State plan methodology does not reflect what the State would be paying providers in absence of the Section I9I 5(b) waiver, and it does not adequately serve as an UPL for the non-risk PIHP structure. Please update the definitions and State plan methodology accordingly. See question #4 below for further comments.

SPA 09-004 has been revised accordingly. Attachment 4.19B, pages 21-25 has been revised to describe a reimbursement methodology to be used to pay providers of non-institutional specialty mental health services in absence of the PIHP delivery system and that will serve as a UPL when the non-institutional specialty mental health services are delivered through a PIHP delivery system.

4. **State Plan Methodology for Specialty Mental Health Services**

A. The current State plan methodology as described on page 22, #8 - Reimbursement Limits, i.e. the lowest of published charges, allowable cost or SMAs, may not be able to achieve the limit that would at least be equal to the total PIHP payments, i.e. regular payments and the supplemental payment to the county MHPs. From the information provided to date, we believe the State plan methodology for non-institutional specialty mental health services should contemplate an actual cost reimbursement methodology. Please review the proposed State plan pages 21 -26 and revise the methodology accordingly.

To be in compliance with current CMS policy, the State needs to provide details regarding how the cost reimbursement for these non-institutional specialty mental health services is determined. Specifically, the State needs to include the procedures and methodologies used to determine actual costs for the non-institutional specialty mental health services. In addition, the following information must be included in the State plan:

a. **Please revise the heading of this reimbursement section of the State plan. We suggest "Reimbursement of Specialty Mental Health Services".**

b. **Page 26, #E -Allowable Services, include the services covered and units of services definitions. Please confirm that these services are the same individual Section 1905(a)**

services that are identified and approved in Attachments 3.1A and B for specialty mental health.

c. Identify the providers/entities eligible to be reimbursed using the proposed cost methodology.

d. Specify the sources of the cost and revenue data used in the determination.

e. Include details on interim payments. On page 25, Item D, the State indicated that providers approved rates as established through this section for each procedure code. It is unclear where, in this section, these rates are being described. Please clarify.

f. Page 25, Item D, includes purpose of the cost reports. Please specify the time frame for submitting the cost report from the county MHPs to the Department. Please include details regarding how costs are determined. This will include, but not limited to, the source of the data and the cost principles and steps used to determine allowable medical costs, the methodologies (e.g. time study) used to apportion cost to the Medicaid program and the timeline for submitting the cost report. (See Section F #4.h. below for further details on Medicaid non-institutional reimbursement policy.)

g. Page 26 - SD/MC Reconciliation and Final Cost Settlement Process – Please describe the purpose of the reconciliation and settlement process. Please include details of the process and data used to reconcile the total interim payments to the as-filed and final audited cost, the process and the data used to validate the units of service and interim payment and, who is responsible for the process. The State should also provide a timeline for these processes. Please eliminate references to the Short- Doyle program.

h. In addition, the following policies, when applicable, should be followed and factored into the details of reimbursement methodology:

    i. Where mental health services are provided in facilities that are used for multiple purposes and the provision of medical services is not the sole purpose, the allowable costs recognized include costs related to direct practitioners, medical equipment, medical supplies and overhead

expenses calculated based on an approved indirect cost rate. When there is no approved indirect rate, only those overhead costs that are directly attributable to the provision of the medical services are permitted using a CMS approved allocation methodology. Overhead costs incurred that "benefit" multiple purposes, but would generally be incurred at the same level if the medical services did not occur, are not allowable.

ii. For mental health services provided through outpatient hospitals and hospital-based clinics, please provide details on how costs of services are determined using the 2552-96 Medi-Cal cost report.

The above information, principles, and policies are applicable to the providers who, under the presently approved PIHP delivery system stemming from the State's Section 1915(b) waiver, are recognized as legal entities and whose actual provider costs for the furnishing of non-institutional specialty mental health services are recognized as part of the allowable costs under the county MHP cost settlement process.

B. For non-institutional specialty mental health services provided in the absence of a PIHP delivery system, the State also needs to incorporate into the State plan a detailed methodology for providers other than those discussed in the above Section F, #4.A. that are to be subject to cost reimbursement. The State plan should specify the following:

a. itemize the services being reimbursed using the methodology. Please confirm that these services are the same individual Section 1905(a) services that are identified and approved in Attachments 3.1A and B for specialty mental health.
b. define the providers eligible for the specific methodology.
c. the details of the method -if it is based on a fee schedule, the State needs to include the effective date and where the fee schedule can be located. If another methodology is used, the details of the cost principles and the cost reporting tool used to identify allowable costs, the process by which allowable costs are apportioned to the Medicaid populations, any interim/final payments and reconciliations, state cost report audit/settlement process and the source of program and cost data must be included. (See Section F, #4.A. for more

specifics.)

Attachment 4.19B, pages 21-25 has been revised to describe an actual cost reimbursement methodology for non-institutional specialty mental health services.

5. **If the supplemental payment is for all mental health services and not limited to specialty mental health services (see question A.3.c above):**

   a. **The State must separately address non-institutional, non-specialty mental health services, and specify that non-institutional specialty mental health services are not eligible for this proposed supplemental payment. (See Section F, #2. above for details.)**

   b. **Since the governmental providers may already be eligible to receive a supplemental payment for non-institutional, non-specialty mental health services under SPA 02-018 (outpatient hospitals), 05-023 (governmental- operated providers for professional services), and the pending 06-016 (free-standing governmental clinics), please explain how the State can assure the same services would be excluded from this proposed supplemental payment.**

   c. **The State plan must include details of the methodology used to determine uncompensated mental health care costs. Specifically, the State needs to include:**

      i. **Steps and methodology used to determine actual costs for these mental health services. (See comment Section F, #4 above for details that need to be included in description.)**

      ii. **The State indicated in Supplement I, page 2 #6 that the revenue data are from the governmental entity. However, it is CMS policy that the Medicaid payments should be extracted from the Medicaid Agency MMIS system. Please revise accordingly.**

      iii. **The timeline on when the governmental entity will submit the cost report, the reconciliation process, and when supplemental payment will be determined and paid.**

d. **Please provide a copy of the cost report that is submitted by the governmental entity to the DHCS to be used for determining the supplemental reimbursement.**

The State has revised SPA 09-004 and is no longer proposing to make supplemental payments through the State plan. Attachment 4.19B has been revised to describe a reimbursement methodology that is based upon allowable costs. The State described a supplemental reimbursement process in a Certified Public Expenditure protocol submitted to CMS as part of its 1915(b) waiver.

G. Standard Funding Questions - Attachment 4.19B

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4. I 9- B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the State plan for such service.

1. **Section I903(a)(I) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)**

   Payments for services provided under Attachment 4.19B, pages 21-25 are made to the county MHP based on the county MHPs Certified Public Expenditure (CPE). The MHP retains the full federal Medicaid payment it receives for hospital inpatient specialty mental health services provider under Attachment 4.19B, pages 21-25.

2. **Section I902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:**

   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

   The state share of payments for outpatient specialty mental health services provided under Attachment 4.19B, pages 21-25 comes from the county MHP's CPE. The enclosed table (Enclosure 1) displays the entities that certified public expenditures for specialty mental health services reimbursed pursuant to Attachment 4.19B, pages 21-25, the operational nature of each entity, the total amounts certified by each entity in Fiscal Year 2012-13, identifies whether the entity certifying has taxing authority, and identifies the level of funding appropriated to each entity for Fiscal Year 2012-13.

3. **Section I 902(a)(30) requires that payments for services be consistent**

with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Supplemental or enhanced payments are not currently made to hospitals reimbursed for psychiatric inpatient hospital services under Attachment 4.19B – pages 21–25.

4. **For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the UPL for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.**

   Payments for specialty mental health inpatient hospital services are made under the 1915(b) specialty mental health waiver. The payments made to the mental health plan are subject to the non-risk upper payment limit described in 42 CFR 447.362, which is equal to what Medicaid would have been paid for the services rendered on a fee-for-service basis plus any net savings on administrative costs realized by the Medicaid agency.

   The State estimates the UPL after settling each mental health plan's cost report. The most recent fiscal year for which the state has completely settled county cost reports if FY 2009-10. Attachment 2 contains a detailed UPL demonstration for FY 2009-10.

5. **Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?**

   The State does not reimburse providers directly. The State reimburses mental health plans under the 1915(b) specialty mental health waiver. The payments made to mental health plans do not exceed the lower of the mental health plan's certified public expenditures or non-risk upper payment limit determined in accordance with 42 CFR 447.362. If interim payments exceed the lower of the mental health plan's certified public expenditures or non-risk upper payment limit, the State recoups the overpayments and returns the Federal share to CMS on the quarterly expenditure report.

Please review the State's resubmission of the latest draft of SPA 09-004 included with this letter. The State requests that CMS disregard previously submitted versions of SPA 09-004. For questions or comments please contact Charles Anders, Chief, Fiscal Management and Outcomes Reporting Branch, at (916) 319-8166 or by e-mail at Charles.Anders@dhcs.ca.gov. Thank you for your assistance.

Sincerely,

ORIGINAL SIGNED

Mari Cantwell
State Medicaid Director
Health Care Programs

Enclosures

cc: See next page

cc: Tyler Sadwith, CMS San Francisco Regional Office
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health
90th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Cheryl Young, CMS San Francisco Regional Office
Centers for Medicare and Medicaid Services
Division of Medicaid and Children's Health
90th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

SPA_Waivers_SanFrancisco_R09@cms.hhs.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 0 9 — 0 0 4

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 9, 2009

5. TYPE OF PLAN MATERIAL *(Check One)*

- ☐ NEW STATE PLAN
- ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN
- ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447.252 of the Act 1902 (a) (13) of the Act
42 CFR 447.201 42 CFR 447.302 1902 (a) (30)

7. FEDERAL BUDGET IMPACT
a. FFY 2008-09 $ 64,187
b. FFY 2009-10 $ 110,886

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19A - Pages 38-40
Attachment 4.19A Pages 41-45
Attachment 4.19B Pages 21-25

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

10. SUBJECT OF AMENDMENT
SPA 09-004 is amending the reimbursement methodology for targeted case management, rehabilitative mental health, and psychiatric inpatient hospital services. The amendments describe a reimbursement methodology for targeted case management and rehabilitative mental health services that is based upon the lower of the providers reasonable and allowable costs or customary charge. The amendments identify a specific group of hospitals that will be reimbursed the lower of their reasonable and allowable costs or customary charge for psychiatric inpatient hospital services. The amendments clarify the existing methodology for reimbursing all other hospitals that provide psychiatric inpatient hospital services.

11. GOVERNOR'S REVIEW *(Check One)*

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
- ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- ☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED

16. RETURN TO

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME

22. TITLE

23. REMARKS

Instructions on Back

Citation Condition or Requirement

REIMBURSEMENT OF PSYCHIATRIC INPATIENT HOSPITAL SERVICES PROVIDED BY FEE-FOR-SERVICE/MEDI-CAL (FFS/MC) HOSPITALS

A. GENERAL APPLICABILITY

Reimbursement of FFS/MC Psychiatric Inpatient Hospital Services shall be as established below.

B. DEFINITIONS

"Acute psychiatric inpatient hospital service" means a service provided by a hospital to a Medi-Cal beneficiary for whom the facilities, services, and equipment are medically necessary for diagnosis or treatment of a mental disorder.

"Administrative day service" means inpatient hospital services provided to a Medi-Cal beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the Medi-Cal beneficiary's stay at the hospital must be continued beyond the individuals' need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options and non-acute residential treatment facilities that meet the needs of the Medi-Cal beneficiary.

"Allowable psychiatric accommodation code" means a reimbursable hospital billing code, based on room size and type of service that may be used by Fee-for-Service/Medi-Cal providers to claim payment for psychiatric inpatient hospital services provided to beneficiaries.

"Border community" means a community located outside, but in close proximity to, the California border. A border community is not considered to be out of state for the purpose of excluding coverage because of its proximity to California and historical usage of providers in the community by Medi-Cal beneficiaries.

"Disproportionate share hospital" means a FFS/MC hospital that serves a disproportionate share of low-income people as defined at page 18 and following of this Attachment 4.19-A.

"FFS/MC contract hospital" means a Fee-for-Service/Medi-Cal Hospital that is a disproportionate share hospital, a traditional hospital, or a hospital listed on page 45C. FFS/MC contract hospitals contract with the negotiating entity to provide psychiatric inpatient hospital services.

"Fee-for-Service/Medi-Cal hospital" means a hospital that submits claims for reimbursement of psychiatric inpatient hospital services to the State's fiscal intermediary and include all hospitals, except for those hospitals identified as SD/MC hospitals in Attachment 4.19-A, pages 38-40.

"Hospital-based ancillary services" means services other than routine hospital services and psychiatric inpatient hospital professional services that are received by a beneficiary admitted to a psychiatric inpatient hospital. .

"Negotiating Entity" means an entity which authorizes services and negotiates rates with the FFS/MC Hospitals. A negotiating entity may be a county, counties acting jointly, or another governmental entity.

"Per diem rate" means a daily rate, for each allowable psychiatric accommodation code, for reimbursable psychiatric inpatient hospital services for a beneficiary for the day of admission and each day that services are provided excluding the day of discharge.

"Psychiatric inpatient hospital professional services" means services provided to a beneficiary by a licensed mental health professional with hospital admitting privileges while the beneficiary is in a hospital receiving psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include all services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include routine hospital services or hospital-based ancillary services.

"Psychiatric inpatient hospital service" means an acute psychiatric inpatient hospital service or an administrative day service.

"Routine Hospital services" means bed, board, and all medical, nursing, and support services usually provided to an inpatient by a hospital. Routine hospital services do not include hospital-based ancillary services, psychiatrist or other physician services, or psychologist services.

"Traditional Hospital" means a FFS/MC hospital that, according to historical Medi-Cal payment data for the fiscal year that is two years prior to the fiscal year

which rates are being developed, provided services to beneficiaries of the negotiating entity that account for five percent or twenty thousand dollars, whichever is more, of the total fiscal year Medi-Cal psychiatric inpatient hospital service payments made to FFS/MC hospitals for beneficiaries of the negotiating entity.

C. REIMBURSEMENT METHODOLOGIES AND PROCEDURES

1. RATE SETTING FOR PSYCHIATRIC INPATIENT HOSPITAL SERVICES PROVIDED BY FEE-FOR-SERVICE/MEDI-CAL CONTRACT HOSPITALS

a. Reimbursement (a per diem rate) for acute psychiatric inpatient hospital services for each Fee-for-Service/Medi-Cal contract hospital will be based on a negotiated per diem rate negotiated between the negotiating entity and the hospital on an annual basis. The starting point for this negotiation will be the hospital's routine and ancillary costs of providing psychiatric inpatient hospital services as reported in its most recently filed CMS 2552 cost report. The negotiating entity and hospital will also consider the trend of the hospital's routine costs, the trend of the hospital's ancillary costs, and the hospital's usual and customary charge for psychiatric inpatient hospital services in negotiating the rate. The negotiated per diem rate negotiated between the negotiating entity and a hospital will not exceed the lower of the hospital's usual and customary charge or the maximum per diem rate for each accommodation code as calculated pursuant to the methodology described in Section C.1.d of this segment of the State plan.

When a hospital is owned or operated by the same organizational entity as the negotiating entity, the per diem rate will be submitted by the negotiating entity and is subject to approval by the State. The State will approve the per diem rate submitted by the negotiating entity if it is not greater than the lower of the following:

- Highest per diem rate within the State, negotiated by a different negotiating entity for a different hospital.
- The hospitals customary charge.
- The maximum rate calculated pursuant to C.1.d. of this segment.

b. The negotiated per diem rate includes routine hospital services and all hospital-based ancillary services.

c. Only one negotiated per diem rate for each allowable psychiatric accommodation code for each negotiated rate Fee-for-Service/Medi-Cal

hospital may be established. The negotiated per diem rate will not be subject to retrospective adjustment to cost.

d. The Maximum negotiated reimbursement rate for each allowable accommodation code and rate region will be determined by the State on an annual basis pursuant to the following methodology:
    i. The State will identify all Fee-for-Service/Medi-Cal Contract Hospitals in Fiscal Year 2013-14.
    ii. The State will obtain the number of days and direct expenses within the psychiatric acute inpatient cost center plus costs allocated to the psychiatric acute inpatient cost center from non-revenue producing cost centers for each hospital identified in (i) above from each hospital's audited 2013 Hospital Annual Disclosure Report filed with the Office of Statewide Health Planning and Development. Direct expenses may include salaries and wages, employee benefits, professional fees, supplies, purchased services, depreciation expense, leases and rentals, and other direct expenses within the psychiatric acute inpatient cost center. Direct expenses do not include professional costs and ancillary costs.
    iii. The State will calculate a weighted average direct expense per day using the data obtained in (ii) above. The weighted average will be equal to the total expenses within the psychiatric acute inpatient cost center summed across all hospitals identified in (i) above divided by the total patient days within the psychiatric acute inpatient cost center summed across all hospitals identified in (i) above.
    iv. The State will increase the weighted average direct expense per day as calculated in (iii) by 16 percent to incorporate the cost of ancillary services.
    v. The State will annually increase the rates calculated in (iv) by the percentage increase from quarter 4 in the current year to quarter 4 in the rate year from the Global Insight Inpatient Market Basket Index.

e. The per-diem rate for administrative day services will be based upon the prospective class median rate for nursing facilities that are distinct parts of acute care hospitals and offer skilled nursing services, plus an allowance for the cost of ancillary services equal to 16 percent of the prospective class median rate. The state will calculate one statewide interim rate for administrative day services that is applied to all FFS/MC contract hospitals that provide administrative day services. The statewide interim rate for administrative day services will be calculated using the following steps.
    - Enter into a spreadsheet the skilled nursing facility reimbursement rates calculated under Attachment 4.19-D for each hospital that

operates a distinct part nursing facility in the prospective fiscal year, which runs from August 1st through July 31st.

- Identify the median rate among all hospitals that operate a distinct part nursing facility.
- The rate for administrative day services is equal to the median skilled nursing facility rate for hospitals that operate a distinct part nursing facility.

f. Reimbursement for acute psychiatric inpatient hospital services provided by FFS/MC contract hospitals will be based on the negotiated per diem rate, less third party liability and patient share of cost.

g. Reimbursement for administrative day services provided by FFS/MC contract hospitals will be based on the per diem rate for administrative day services less third party liability and patient share of cost.

h. The negotiated per diem rate less third party liability and patient share of cost shall be considered to be payment in full for psychiatric inpatient hospital services provided to a beneficiary.

2. RATE SETTING FOR PSYCHIATRIC INPATIENT HOSPITAL SERVICES FOR NON-NEGOTIATED RATE, FEE-FOR-SERVICE/MEDI-CAL HOSPITALS

a. Reimbursement rates (a per diem rate) for acute psychiatric inpatient hospital services for all FFS/MC hospitals except FFS/MC contract hospitals shall be determined by the State.

i. The per diem rate will be calculated by the State prior to the beginning of each fiscal year and will not be modified for subsequent rate changes among Fee-for-Service/Medi-Cal negotiated rate hospitals or the addition of new Fee-for-Service/Medi-Cal negotiated rate hospitals.

ii. One per diem rate for each allowable psychiatric accommodation code per non-negotiated rate, Fee-for-Service/Medi-Cal hospital per Rate Region listed in (7) will be established and used.

iii. The per diem rate will not be subject to retrospective adjustment to cost.

b. The per diem rate will include routine hospital services and all hospital-based ancillary services

c. The per diem rate will equal the weighted average per diem rates negotiated for all Fee-for-Service/Medi-Cal hospitals within the Rate Region where the non-negotiated rate Fee-for-Service/Medi-Cal hospital is located. The per diem rate, when there are no Fee-for-Service/Medi-Cal hospitals with a negotiated rate within the Rate Region, will equal the weighted average per diem rate negotiated for all Fee-for Service/Medi-Cal hospitals statewide. The weighted average per diem rate, whether regional or statewide, will be calculated as follows:

   i. The Fee-for-Service/Medi-Cal acute psychiatric inpatient hospital services patient days by accommodation code and by Fee-for-Service/Medi-Cal contract hospital from two fiscal years prior to the fiscal year for the rate is being computed will be multiplied by the negotiated per diem rate by accommodation code and by Fee-for-Service/Medi-Cal contract hospital for the fiscal year for which the rate is being computed.

   ii. The sum of the products from (a) by accommodation code for all Fee-for-Service/Medi-Cal contract hospitals within a Rate Region (or statewide when developing a statewide weighted average) will be divided by the Fee-for-Service/Medi-Cal acute psychiatric inpatient hospital services patient days by accommodation code for FFS/MC contract hospitals within the Rate Region (or statewide) that have a negotiated rate to compute the weighted average per diem rate for each accommodation code within the Rate Region (or statewide).

Reimbursement for administrative day services will be the rate based on the prospective class median rate for nursing facilities that are distinct parts of acute care hospitals and offer skilled nursing services, plus an allowance for the costs of ancillary service equal to 16 percent of the prospective class median rate. The state will calculate one statewide rate for administrative day services that is applied to all FFS/MC hospitals, excluding FFS/MC contract hospitals that provide administrative day services. The Statewide rate for administrative day services will be calculated using the following steps:

- Enter into a spreadsheet the skilled nursing facility rates calculated under Attachment 4.19 – D for each hospital that operates a distinct part nursing facility in the prospective fiscal year, which runs August 1st through July 31st.

- Identify the median rate among all hospitals that operate a distinct part nursing facility.

- The rate for administrative day services is equal to the median skilled nursing facility rate for hospitals that operate a distinct part nursing facility.

d. For both acute psychiatric inpatient hospital services and administrative day services, reimbursement to the non-negotiated, Fee-for-Service/Medi-Cal hospital will be based on the lower of the hospitals customary charge or calculated per diem rate less third party liability and patient share of cost.

e. The Rate Regions, including specified border communities, are:

i. Superior – Butte, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, Tehama and Trinity Counties and the border communities of Ashland, Brookings, Cave Junction, Jacksonville, Grants Pass, Klamath Falls, Lakeview, Medford, and Merrill Oregon.

ii. Central Valley – Alpine, Amador, Calaveras, El Dorado, Fresno, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter, Tulare, Tuolumne, Yolo and Yuba Counties and the border communities of Carson City, Incline Village, Minden, Reno, Sparks, and Zephyr Cove, Nevada.

iii. Bay Area – Alameda, Contra Costa, Marin, Monterey, Napa, San Benito, San Francisco, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma Counties.

iv. Southern California – Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara and Ventura Counties and the border communities of Las Vegas, and Henderson, Nevada, and Kingman, Lake Havasu City, Parker and Yuma Arizona.

v. Los Angeles County

The following is a list of FFS/MC contract hospitals that are not disproportionate share hospitals or traditional hospitals as those terms are defined in Attachment 4.19-A, pages 41-45.

1. Eden Medical Center
2. Aurora Las Encinas Hospital
3. BHC Alhambra Hospital
4. Citrus Valley Medical Center
5. College Hospital Cerritos
6. Community Hospital Long Beach
7. East Valley Glendora
8. Encino Hospital Medical Center
9. Glendale Adventist Medical Center
10. Grancel Village
11. Henry Mayo Newhall
12. Huntington Memorial Hospital
13. Northridge Medical Center
14. Sherman Oaks Hospital
15. Southern CA Hospital at Culver City
16. Verdugo Hills Hospital
17. Los Alamitos Medical Center
18. St. Joseph Hospital
19. Corona Regional Medical Center
20. Redlands Community Hospital
21. Alvarado Parkway Institute
22. St. Mary's Medical Center
23. Catholic Healthcare West
24. Good Samaritan Hospital
25. Aurora Vista Del Mar

Citation Condition or Requirement

REIMBURSEMENT OF PSYCHIATRIC INPATIENT HOSPITAL SERVICES PROVIDED BY SHORT-DOYLE/MEDI-CAL HOSPITALS

Psychiatric inpatient hospital services will be provided as part of a comprehensive program that provides rehabilitative mental health and targeted case management services to Medicaid (Medi-Cal) beneficiaries that meet medical necessity criteria established by the State.

A. GENERAL APPLICABILITY

Short-Doyle Medi-Cal (SD/MC) Hospitals will be eligible to be reimbursed under this segment for the provision of Psychiatric Inpatient Hospital Services. Reimbursement will be based upon each hospital's reasonable and allowable cost as determined in the CMS 2552 hospital cost report and supplemental schedules or its usual and customary charge, whichever is lower, unless the hospital is a nominal charge hospital. Reimbursement of Psychiatric Inpatient Hospital Services provided by SD/MC hospitals that are nominal charge hospitals is based upon each hospital's reasonable and allowable cost as determined in the CMS 2552 hospital cost report and supplemental schedules.

B. DEFINITIONS

"Acute psychiatric inpatient hospital services" means those services provided by a hospital to beneficiaries for whom the facilities, services, and equipment are medically necessary for diagnosis or treatment of a mental disorder.

"Administrative Day services" means psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's needs for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options at non-inpatient hospital services due to a temporary lack of residential placement options at non-acute residential treatment facilities that meet the needs of the beneficiary.

"Hospital-based ancillary services" means services other than routine hospital services and psychiatric inpatient hospital professional services that are received by a beneficiary admitted to a SD/MC hospital

"Nominal charge hospital" means a hospital with charges that are less than or equal to sixty percent of the reasonable and allowable cost of psychiatric inpatient hospital services.

"Psychiatric inpatient hospital services" means acute psychiatric inpatient hospital services and administrative day services provided by a SD/MC hospital, which are reimbursed a per diem rate that includes the cost of routine hospital services and all hospital based ancillary services.

"Reconciled cost report" mean the amended cost report filed by a hospital no later than eighteen months after the close of the fiscal year, which reconciles the days and charges reported in the cost report with the State's records pursuant to Section D.d of this segment.

"Reasonable and allowable cost means cost based on year-end CMS 2552 hospital cost reports and supplemental schedules; and Medicare principles of reimbursement as described at 42 CFR 413; the CMS Provider Reimbursement Manual, Publication 15-1; and other applicable federal directives that establish principles and standards for determining allowable costs and the methodology for allocating and apportioning those expenses to the Medicaid program.

"Routine hospital services" means bed, board, and all medical, nursing, and support services usually provided to an inpatient by a hospital. Routine services do not include hospital-based ancillary services, psychiatrist or other physician services, or psychologist services.

"Schedule of Maximum Interim Rates" means a statewide schedule of maximum rates per day that will be paid on an interim basis for acute psychiatric inpatient hospital services and administrative day services. These rates are updated and published annually.

"SD/MC hospitals" means hospitals that claim reimbursement for psychiatric inpatient hospital services through the SD/MC claiming system and are the hospitals listed on page 40E of this segment.

"Usual and Customary Charge" means the regular rates that providers charge both Medi-Cal beneficiaries and other paying patients for the services furnished to them (42 CFR 413.13).

C. PSYCHIATRIC INPATIENT HOSPITAL SERVICES

Psychiatric Inpatient Hospital Services provided by SD/MC hospitals are both acute psychiatric inpatient hospital services and administrative day services provided in a SD/MC hospital and are reimbursed a per diem rate that includes the cost of routine hospital services and all hospital based ancillary services.

a. Acute psychiatric inpatient hospital services are those services provided by a hospital to beneficiaries for whom the facilities, services, and equipment are medically necessary for diagnosis or treatment of a mental disorder.

b. Administrative day services are psychiatric inpatient hospital services provided to a beneficiary who has been admitted to the hospital for acute psychiatric inpatient hospital services, and the beneficiary's stay at the hospital must be continued beyond the beneficiary's need for acute psychiatric inpatient hospital services due to a temporary lack of residential placement options and non-acute residential treatment facilities that meet the needs of the beneficiary.

D. REIMBURSEMENT METHODOLOGY AND PROCEDURES

The following steps will be taken to determine reasonable and allowable Medicaid costs and associated reimbursements.

a. Interim Rates
The State calculates an interim rate for acute psychiatric inpatient hospital services for each hospital and one statewide interim rate for administrative day services on an annual basis using the methodologies described below.

1. Administrative Day Services
The state calculates one statewide interim rate for administrative day services that is applied to all SD/MC hospitals that provide administrative day services. The statewide interim rate for administrative day services is calculated, to be effective from August 1st to July 31st of each rate year, using the following steps.

- Enter into a spreadsheet the skilled nursing facility rates calculated for each hospital that operates a distinct part nursing facility for the prospective nursing facility rate year, which runs from August 1st through July 31st.
- Identify the median rate among all hospitals that operate a distinct part nursing facility.
- The interim rate for administrative day services is equal to the median skilled nursing facility rate for hospitals that operate a distinct part nursing facility.

2. Acute Psychiatric Inpatient Hospital Services
   Each hospital's interim rate for acute psychiatric inpatient hospital services is calculated using the following steps.
   - Enter into a spreadsheet the allowable Medi-Cal acute psychiatric inpatient hospital service costs and total allowable Medi-Cal acute psychiatric inpatient days as determined and reported in the most recently filed CMS 2552 hospital cost report and supplemental schedules for each hospital.
   - Divide gross costs by total patient days to calculate a cost per day for each hospital.
   - The interim rate is equal to the lower of the cost per day multiplied by one plus the percentage increase from the midpoint (calendar year quarter 4) of the last updated rate year to the midpoint (calendar quarter 4) of the year for which the rates are being calculated from the Global Insight Market Basket Index or the Schedule of Maximum Interim Rate (SMIR) for acute psychiatric inpatient hospital services.

b. Interim Payments
   Interim payments of FFP are based upon an approximation of the Medicaid (Medi-Cal) costs that are eligible for Federal Financial Participation (FFP) without exceeding the Schedule of Maximum Interim Rate (SMIR). Interim payments for SD/MC hospitals will be based upon interim per diem rates that are established by the State on an annual basis as described in this segment of the State plan.

c. Cost Report Submission
   Each SD/MC hospital will be required to file a CMS 2552 hospital cost report and supplemental schedules by December 31st following the close of the State Fiscal Year (i.e., June 30th).

d. Reconciliation
No later than fifteen months after the close of the State Fiscal Year, each SD/MC hospital will be provided an opportunity to reconcile its approved Medi-Cal days and charges to the State's records. Each hospital will be given ninety days to file an amended cost report that reconciles its Medi-Cal days and charges with the State's records. This amended cost report is called the reconciled cost report.

e. Interim Settlement
No later than twenty-four months after the close of the State Fiscal Year, the State will complete the interim settlement of each SD/MC hospital's most recently amended cost report. The interim settlement will compare interim payments made to each SD/MC hospital with the amount determined in the CMS 2552 cost report and supplemental schedules. The CMS 2552 hospital cost report and supplemental schedules will limit reimbursement to the lower of the SD/MC hospital's allowable costs or usual and customary charge for the acute psychiatric inpatient hospital services provided. The CMS 2552 hospital cost report and supplemental schedules will limit reimbursement to the lower of the SD/MC hospitals allowable costs, usual and customary charge, or SMIR for administrative day services. The State will pay the SD/MC hospital additional amounts due if the total reimbursement calculated in the cost report is more than the interim payments made to the hospital. Any overpayments are recouped, and the federal share of the overpayments is returned to the federal government in accordance with 42 CFR 433.316.

f. Final Settlement Process
The State will complete the audit of the interim settled CMS 2552 hospital cost report and supplemental schedules within three years of the date the reconciled CMS 2552 hospital cost report and supplemental schedules are submitted and certified. The audit performed by the State will determine whether the income, expenses, and statistical data reported on the CMS 2552 hospital cost report and supplemental schedules are reasonable, allowable, and in accordance with State and Federal rules, regulations, and Medicare principles of reimbursement issued by the Centers for Medicare and Medicaid Services (CMS). The audit will also determine that the SD/MC hospital's CMS 2552 hospital cost report and supplemental schedules represent the actual cost of providing Psychiatric Inpatient Hospital Services in accordance with the Specialty Mental Health Program's Cost and Financial Reporting System (CFRS), Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR),

Office of Management and Budget (OMB) Circular A-87, Generally Accepted Governmental Auditing Standards as published by the Comptroller General of the United State and other State and Federal regulatory authorities. The State will pay the SD/MC hospital additional amounts due if the total reimbursement calculated in the cost report is more than the interim payments made to the hospital. Any overpayments are recouped, and the federal share of the overpayments is returned to the federal government in accordance with 42 CFR 433.316.

g. Cost Principles
For the purposes of paragraphs e and f, allowable costs will be determined using the CMS 2552 hospital cost report and the cost principles described in 42 CFR 413 and the Provider Reimbursement Manual, CMS Publication 15-1.

h. Apportioning Costs to Medicaid (Medi-Cal)
Total inpatient costs will be determined in the CMS 2552 hospital cost report and supplemental schedules. Total inpatient hospital costs will be apportioned to the Medi-Cal program using a cost per day for each routine hospital cost center and a cost-to-charge ratio for each ancillary and other hospital cost centers. Intern and resident costs will be included in the total costs determined on the CMS 2552 and apportioned to the Medi-Cal program. The State does not reimburse these costs separately using a per resident amount methodology.

E. PROVIDERS OF PSYCHIATRIC INPATIENT HOSPITAL SERVICES

Short-Doyle/Medi-Cal (SD/MC) hospitals are eligible to provide services under this segment.

F. SCHEDULE OF MAXIMUM INTERIM RATES METHODOLOGY

The State Calculates the Schedule of Maximum Interim Rates on an annual basis and publishes those rates through an information notice that is posted to its website. The following describes the methodology used to calculate the statewide maximum interim rate for acute psychiatric inpatient hospital services and administrative day services provided by SD/MC hospitals.

a. Acute Psychiatric Inpatient Hospital Services
The Maximum Interim Rate for acute psychiatric inpatient hospital services was initially developed using cost reports filed for Fiscal Year 1989-90 (July 1, 1989 through June 30, 1990) using the following methodology.

1. Enter into a spreadsheet all hospitals, their reported gross costs for all patients' acute psychiatric inpatient services, and all reported days for all patients' acute psychiatric inpatient hospital services.
2. Divide gross costs by total of days for all patients' acute psychiatric inpatient hospital services to calculate a cost per day for each hospital.
3. Remove from the data set those hospitals that have a cost per day that is one standard deviation above the mean.
4. After completing step 3, remove those hospitals that have a cost per day in the top ten percent of the remaining hospitals.
5. From the remaining hospitals, calculate the sum of gross costs reported for acute psychiatric inpatient hospital services.
6. From the remaining hospitals, calculate the sum of patient days reported for acute psychiatric inpatient hospital services.
7. Divide the sum of gross costs determined in step 5 by the sum of patient days determined in step 6 to calculate the statewide average cost per day.
8. The statewide average cost per day calculated in step 7 is increased on an annual basis by the increase from the midpoint (calendar year quarter 4) of the last updated rate year to the midpoint (calendar year quarter 4) of the year for which the rates are being calculated from the Global Insight Market Basket Index.

b. Administrative Day Services

The maximum interim rate for administrative day services is equal to the prospective class median rate for nursing facilities that are distinct parts of acute care hospitals and offer skilled nursing services. The rate is updated and published on an annual basis (for each rate year from August 1st to July 31st consistent with the nursing facility rate year described in Attachment 4.19-D of the state plan).

Short Doyle/Medi-Cal Hospitals

1. Santa Barbara County Psychiatric Health Facility
2. San Mateo County Medical Center
3. Gateways Hospital and Community Mental Health Center
4. Kern County Medical Center
5. Riverside County Regional Medical Center
6. Kedren Hospital and Community Mental Health Center
7. Natividad Medical Center
8. LAC/USC Medical Center
9. Contra Costa Regional Medical Center
10. Harbor/UCLA Medical Center
11. Olive View/UCLA Medical Center
12. San Francisco General Hospital
13. Sempervirens Psychiatric Health Facility
14. Ventura County Medical Center
15. Santa Clara Valley Medical Center
16. Alameda County Medical Center
17. Arrowhead Regional Medical Center
18. Rady Children Adolescent Psychiatric Services
19. Mills Peninsula Hospital
20. Stanford University
21. Shasta Psychiatric Hospital

Citation Condition or Requirement

REIMBURSEMENT OF REHABILITATIVE MENTAL HEALTH AND TARGETED CASE MANAGEMENT SERVICES

A. GENERAL APPLICABILITY

Reimbursement of rehabilitative mental health and targeted case management services provided by eligible private providers will be limited to the lower of the provider's reasonable and allowable cost, as determined in the CMS approved State-developed cost report, or usual and customary charge for the type of service provided for the reporting period. Reimbursement of rehabilitative mental health and targeted case management services provided by county owned and operated providers and county owned and operated hospital-based providers will be based upon the provider's certified public expenditures pursuant to Section 433.51 of Title 42 Code of Federal Regulations.

B. DEFINITIONS

"Service coordinating organization" means a privately operated entity that contracts with eligible providers and arranges with those providers for the delivery of rehabilitative mental health services and/or targeted case management services provided to Medi-Cal beneficiaries. A service coordination organization does not provide rehabilitative mental health services and/or targeted case management services.

"Cognizant agency" for county owned and operated providers means the California State Controller's Office. The Cognizant agency for other providers means the single federal agency that represents all other federal agencies in dealing with a grantee within common areas, such as the development of an indirect cost rate.

"County owned and operated hospital-based outpatient provider" means a hospital that is owned and operated by a county government and that provides rehabilitative mental health or targeted case management services to Medi-Cal beneficiaries on an outpatient basis.

"County owned and operated provider" means a provider of rehabilitative mental health and targeted case management services that is owned and operated by a

county government, which provides services through employed or contracted licensed mental health professionals, waivered/registered professionals and other qualified providers as those providers are defined in Supplement 1 and Supplement 3 to Attachment 3.1-A of the State plan. County government provider does not include a county government hospital-based outpatient provider, individual provider, group provider, or service coordinating organization.

"Eligible provider" means a county owned and operated hospital-based outpatient provider, state owned and operated hospital-based outpatient provider, private hospital-based outpatient provider, county owned and operated provider, state owned and operated provider, private organizational provider, individual provider, group provider, or other qualified provider.

"Group provider" means an organization that provides rehabilitative mental health services through two or more individual providers, such as independent practice associations. Group providers do not include hospital-based outpatient providers, county owned and operated providers, private organizational providers, or administrative service organizations.

"Individual provider" means a licensed mental health professional whose scope of practice permits the practice of psychotherapy without supervision. Individual provider includes licensed physicians, licensed psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional clinical counselors, and registered nurses with a master's degree.

"Private hospital-based outpatient provider" means a hospital that is owned and operated by a private entity that provides rehabilitative mental health or targeted case management services to Medi-Cal beneficiaries on an outpatient basis.

"Private organizational provider" means a provider of rehabilitative mental health services and/or targeted case management that is owned and operated by a private entity, which provides services through employed or contracted licensed mental health professionals, waivered/registered professionals and other staff who are qualified to provide rehabilitative mental health and/or targeted case management services as described in Supplement 1, pages 8 through 17, and Supplement 3 to Attachment 3.1-A of the State Plan.

"Professional service contract" means a contract between a county owned and operated provider and an individual provider, group provider, service coordinating

organization, or other qualified provider of rehabilitative mental health and/or targeted case management services.

"Psychiatric inpatient hospital professional services" means services provided to a beneficiary by a licensed mental health professional with hospital admitting privileges while the beneficiary is in a hospital receiving psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include all services that may be provided in an inpatient setting. Psychiatric inpatient hospital professional services include only those services provided for the purpose of evaluating and managing the mental disorder that resulted in the need for psychiatric inpatient hospital services. Psychiatric inpatient hospital professional services do not include routine hospital services or hospital-based ancillary services.

"Rehabilitative Mental Health Services" means any of the following: mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, and psychiatric health facility services provided to individuals who meet medical necessity criteria as defined in Supplement 3 to Attachment 3.1-A of the State plan; and services provided in a treatment foster home.

"Relative value statistic" means a statistic that has been developed from dissimilar elements that acts as a common basis for the purpose of allocating a pool of costs.

"Schedule of Maximum Rates (SMR)" means a schedule of maximum rates per unit of service, as defined in Section G of this Segment, that will be paid for each type of service.

"SD/MC hospital" means a hospital as defined in Attachment 3.19-A, Pages 38-40 of the State Plan. A SD/MC hospital may be a UC hospital, may be owned and operated by a county government, or may be owned and operated by a private entity.

"State Owned and Operated Provider" means a provider that is owned and operated by the Regents of the University of California.

"Targeted Case Management" has the meaning defined in supplement 1 to attachment 3.1-A, pages 8-17 of the State Plan.

"Services Provided in a Treatment Foster Home" means a bundle of rehabilitative mental health services provided to children and youth up to 21 years of age who have been placed in a Residential Treatment Foster Home and who meet medical necessity criteria for this service as established by the State. The bundle of rehabilitative mental health services includes plan development, rehabilitation, collateral, and crisis intervention, as those services are defined in Supplement 3 to Attachment 3.1-A of the State Plan. The bundle of services are provided by an other qualified provider under the direction of a licensed mental health professional as those provider types are defined in Supplement 3 to Attachment 3.1-A of the State Plan.

"Third party revenue" means revenue collected from an entity other than the Medi-Cal program for a service rendered.

"UC Hospital" means a hospital that is owned and operated by the University of California Regents.

C. REIMBURSEMENT METHODOLOGY AND PROCEDURES – COUNTY OWNED AND OPERATED PROVIDERS AND PRIVATE ORGANIZATIONAL PROVIDERS

The following steps will be taken to determine reasonable and allowable Medicaid costs and associated reimbursements for rehabilitative mental health and targeted case management services provided by county owned and operated providers and private organizational providers.

1. Interim payments to county owned and operated providers and private organizational providers are intended to approximate the allowable Medicaid (Medi-Cal) costs incurred by the provider for services rendered to Medi-Cal beneficiaries. Interim payments for rehabilitative mental health and targeted case management services provided by county government providers and private organizational providers will be based upon interim rates that are established by the State on an annual basis. The State will follow the process described below to calculate an interim rate for each rehabilitative mental health service and targeted case management for each county government and private organizational provider when cost report data is available.

- Include the gross costs allocated to each type of service from the most recently filed CMS-approved State-developed cost report.
- Include the total units of service for each type of service from the most recently filed CMS-approved State-developed cost report.
- Divide the gross costs by the total units of service to calculate the cost per unit for each type of service.
- Multiply the cost per unit by one plus the percentage change in the a CMS approved cost of living index.

When cost report data is not available for a rehabilitative mental health service or targeted case management, the State will set the interim rate at the SMIR calculated for the service as described in Section G of this segment.

2. Cost Report Submission
Each county owned and operated provider and private organizational provider that receives reimbursement for rehabilitative mental health and targeted case management services pursuant to this section is required to file a CMS-approved State-developed cost report by December 31st following the close of the State Fiscal Year (i.e., June 30th). Each county owned and operated provider must certify that it's cost report is based on actual, total expenditures as necessary for claiming Federal Financial Participation pursuant to all applicable requirements of state and federal law including Sections 430.30 and 433.51 of Title 42 Code of Federal Regulations.

3. Cost Determination
The reasonable and allowable cost of providing rehabilitative mental health and targeted case management services for each county owned and operated provider and private organizational provider will be determined in the CMS-approved State-developed cost report pursuant to the following methodology.

- Total allowable costs include direct and indirect costs that are determined in accordance with the reimbursement principles in Part 413 of Title 42 of the Code of Federal Regulations, OMB Circular A-87 and CMS Medicaid non-institutional reimbursement policy.
- Allowable direct costs will be limited to the costs related to direct practitioners, medical equipment, medical supplies, and other costs, such as professional service contracts, that can be directly charged to rehabilitative mental health and targeted case management services.
- Indirect costs may be determined by applying the cognizant agency specific approved indirect cost rate to its net direct costs, allocating indirect costs

based upon the allocation process in the agency's approved cost allocation plan, or allocating indirect costs based upon direct program costs.

- Indirect costs allocated pursuant to an approved cost allocation plan will be reduced by any unallowable amount based on CMS' Medicaid non-institutional reimbursement policy.

For the following subset of rehabilitative mental health services – Adult Residential Treatment Services, Crisis Residential Treatment Services, services provided in a treatment foster home and Psychiatric Health Facility Services – allowable costs are determined in accordance to the reimbursement principle in title 42 CFR 413, OMB Circular A-87 and CMS Medicaid non-institutional reimbursement policy. Allowable direct 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 an approved indirect cost rate.
- When there is not an approved indirect cost rate, the provider may allocate those overhead costs that are "directly attributable" to the professional component of providing the medical services using a CMS approved allocation methodology.
  Overhead costs that are not directly attributable to the provision of medical services but would "benefit" multiple purposes and generally be incurred at the same level if the medical service did not occur, will not be allowable (e.g. room and board, allocated cost from other related organizations).

4. Allocating Costs to Services
   Allowable direct and indirect costs will be allocated to each type of rehabilitative mental health service and targeted case management using one or more of the following three methods;

   - Direct assignment: Providers with the ability to determine costs at the service level may directly assign allowable direct and indirect costs.
   - Time study: Providers may allocate allowable direct and indirect costs among services based upon the results of a CMS-approved time study.
   - Relative value: Providers that render multiple types of service may allocate allowable direct and indirect costs among services based upon relative value statistics.

5. Apportioning Costs to Medicaid (Medi-Cal)

Total allowable direct and indirect costs allocated to a type of service will be apportioned to the Medi-Cal program based upon units of service. For each type of rehabilitative mental health and targeted case management service, the provider will report on the CMS-approved State-developed cost report, the total units of service it provided to all individuals. Units of service will be measured in increments of time as defined in Section H below. The total direct and indirect costs allocated to a particular type of rehabilitative mental health service or to targeted case management will be divided by the total units of service reported for the same type of service to determine the cost per unit of service.

For each type of rehabilitative mental health and targeted case management service, the provider will report the total units of service provided to Medi-Cal beneficiaries. The cost per unit calculated for each rehabilitative mental health service and for targeted case management will be multiplied by the total units of that service provided to Medi-Cal beneficiaries to apportion costs to the Medi-Cal program.

For each type of rehabilitative mental health service and for targeted case management, the provider will also report all third party revenue and patient share of cost collected for the services rendered to Medi-Cal beneficiaries. The costs apportioned to the Medi-Cal program for each type of rehabilitative mental health service and for targeted case management will be reduced by the total third party revenue and patient share of cost the provider collected for each type of service rendered to determine the cost eligible for reimbursement.

6. Reconciliation
   No later than eighteen months after the close of the State Fiscal Year, each county government provider and private organizational provider will reconcile the units of service that were provided to Medi-Cal beneficiaries as reported in its filed CMS-approved state-developed cost report with the provider's records received from the State regarding the result of the State's claims adjudication.

7. Interim Settlement
   Not later than twenty-four months after the close of the State Fiscal Year, the State will complete the interim settlement of each county government provider's and private organizational provider's reconciled cost report. The interim settlement will compare interim payments made to each provider with the total reimbursable costs as determined in the CMS-approved State-developed cost report. Total reimbursable costs for private organizational providers are equal to

the lower of the provider's reasonable and allowable costs or usual and customary charge for the services provided for the reporting period. Total reimbursable costs for county government providers are equal to the provider's reasonable and allowable costs for the services provided for the reporting period. If the total reimbursable costs are greater than the total interim payments, the State will pay the provider the difference. If the total interim payments are greater than the total reimbursable costs, the State will recoup the difference and return the Federal share to the Federal government in accordance with 42 CFR 433.316.

8. Final Settlement Process
   The State will complete the audit process of the interim settled state-developed cost report, as described in Section C.7, within three years of the date the certified reconciled state-developed cost report is submitted. The audit performed by the State will determine whether the income, expenses, and statistical data reported on the CMS-approved state-developed cost report are reasonable, allowable, and in accordance with State and Federal rules and regulations, including Medicare principles of reimbursement issued by CMS and CMS' Medicaid non-institutional reimbursement policy. The audit will also determine that the provider's CMS-approved state-developed cost report represents the actual cost of providing rehabilitative mental health and targeted case management services in accordance with the program's Cost and Financial Reporting System (CFRS), Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR), Office of Management and Budget (OMB) Circular A-87, CMS' Medicaid non-institutional reimbursement policy, Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United State and other State and Federal regulatory authorities. The State will recoup any overpayments and return the Federal share to the Federal government in accordance with 42 CFR 433.316. If the total reimbursable costs are greater than the total interim payments, the state will pay the provider the difference.

D. REIMBURSEMENT METHODOLOGY AND PROCEDURES – COUNTY OWNED AND OPERATED HOSPITAL-BASED OUTPATIENT PROVIDERS, STATE OWNED AND OPERATED HOSPITAL-BASED OUTPATIENT PROVIDERS AND PRIVATE HOSPITAL-BASED OUTPATIENT PROVIDERS

The following steps will be taken to determine reasonable and allowable Medicaid costs and associated reimbursements for rehabilitative mental health and targeted

case management services provided by county owned and operated hospital-based outpatient providers, state owned and operated hospital-based outpatient providers and private hospital-based outpatient providers.

1. Interim Payments
   Interim payments to county owned and operated hospital-based outpatient providers, state owned and operated hospital-based outpatient providers and private hospital-based outpatient providers are intended to approximate the Medicaid (Medi-Cal) costs incurred by the provider for services rendered to Medi-Cal beneficiaries. Interim payments for rehabilitative mental health and targeted case management services provided by county owned and operated hospital-based outpatient providers, state owned and operated hospital-based outpatient providers and private hospital-based outpatient providers will be based upon interim rates that are established by the State on an annual basis. The State will follow the process described below to calculate an interim rate for each rehabilitative mental health service and targeted case management for each county owned and operated and private hospital-based outpatient provider.

   - Include the gross costs allocated to each type of service from the most recently filed CMS 2552 and supplemental schedules.
   - Include the total units of service for each type of service from the most recently filed CMS 2552 and supplemental schedules.
   - Divide the gross costs by the total units of service to calculate the cost per unit for each type of service.
   - Multiply the cost per unit by one plus the percentage change in a CMS approved cost of living index.

   When cost report data is not available for a rehabilitative mental health service or targeted case management, the State will set the interim rate at the SMIR calculated for the service as described in Section G of this segment.

2. Cost Report Submission
   Each county owned and operated hospital-based outpatient provider, state owned and operated hospital-based outpatient provider and private hospital-based outpatient provider that receives reimbursement for rehabilitative mental health and targeted case management services pursuant Section D will be required to file a CMS 2552 hospital cost report and supplemental schedules by December 31st following the close of the State Fiscal Year (i.e., June 30th). Each county owned and operated hospital-based outpatient

provider must certify that it's cost report is based on actual, total expenditures as necessary for claiming Federal Financial Participation pursuant to all applicable requirements of state and federal law including Sections 430.30 and 433.51 of Title 42 Code of Federal Regulations.

3. Cost Determination
The reasonable and allowable cost of providing outpatient services for each county owned and operated hospital-based outpatient provider and private hospital-based outpatient provider will be determined on the CMS 2552 hospital cost report and supplemental schedules.

4. Apportioning Costs to Medicaid (Medi-Cal)
The reasonable and allowable cost of providing outpatient services as determined on the CMS 2552 hospital cost report will be apportioned to rehabilitative mental health services (except for adult residential treatment, crisis residential treatment, services provided in a treatment foster home, and psychiatric health facilities) and targeted case management, as described under Section H, provided to Medi-Cal beneficiaries based upon a cost-to-charge ratio. Each hospital-based outpatient provider will transfer the total costs for each outpatient cost center as determined on the CMS 2552 hospital cost report to a supplemental schedule. Each hospital will report its total charges for outpatient services provided in each outpatient cost center on the supplemental schedule. The supplemental schedule will divide the total costs by the total charges for each outpatient cost center to calculate the cost-to-charge ratio. Each hospital based outpatient provider will report on the supplemental schedules, the total charges for rehabilitative mental health and targeted case management services provided in each outpatient cost center to Medi-Cal beneficiaries. The supplemental schedules will multiply the Medi-Cal charges for rehabilitative mental health and targeted case management services by the cost-to-charge ratio for each outpatient cost center to calculate the outpatient costs apportioned to the Medi-Cal program for each outpatient cost center.

5. Reconciliation
No later than eighteen months after the close of the State Fiscal Year, each hospital-based outpatient provider will reconcile the Medi-Cal charges it reported on the supplemental schedules for rehabilitative mental health and targeted case management services. Each hospital-based outpatient

provider will reconcile the Medi-Cal charges it reported with records it received from the State regarding the results of claims adjudication.

6. Interim Settlement

No later than twenty-four months after the close of the State Fiscal Year, the State will complete the interim settlement of the CMS 2552 hospital cost report and supplemental schedules submitted by each county owned and operated hospital-based outpatient provider, state owned and operated hospital-based outpatient provider and private hospital-based outpatient provider. The interim settlement will compare interim payments made to each county owned and operated hospital-based outpatient provider and private hospital-based outpatient provider with the total reimbursable costs. The CMS 2552 and supplemental schedules is used to calculate total reimbursable costs. Total reimbursable costs for private hospital-based outpatient providers and state-owned and operated hospital-based outpatient providers are equal to the lower of the provider's allowable costs determined in the CMS 2552 hospital cost report and supplemental schedules or usual and customary charge for the services provided. Total reimbursable costs for county owned and operated hospital-based outpatient providers are equal to the provider's reasonable and allowable costs determined in the CMS 2552 hospital cost report and supplemental schedules for the services provided for the reporting period. The State will pay the provider an additional amount if the total reimbursable cost is more than the interim payments made to the provider. Any overpayments will be recouped and returned to the Federal government in accordance with 42 CFR 433.316.

7. Final Settlement Process

The State will complete its audit of the interim settled CMS 2552 hospital cost report and supplemental schedules within three years of the date the certified reconciled CMS 2552 hospital cost report and supplemental schedules are submitted. The audit performed by the State will determine whether the income, expenses, and statistical data reported on the CMS 2552 hospital cost report and supplemental schedules are reasonable, allowable, and in accordance with State and Federal rules, regulations, and Medicare principles of reimbursement issued by the CMS. The audit will also determine that the provider's CMS 2552 hospital cost report and supplemental schedules represent the actual cost of providing rehabilitative mental health and targeted case management services in accordance with the program's Cost and Financial Reporting System (CFRS), Generally Accepted Accounting

Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR), Office of Management and Budget (OMB) Circular A-87, Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United State and other State and Federal regulatory authorities. The State will pay the provider an additional amount if the total reimbursable cost is more than the interim payments made to the provider. Any overpayments will be recouped and returned to the Federal government in accordance with 42 CFR 433.316.

E. REIMBURSEMENT METHODOLOGY AND PROCEDURES – PSYCHIATRIC INPATIENT HOSPITAL PROFESSIONAL SERVICES PROVIDED IN SD/MC HOSPITALS

The following steps will be taken to determine reasonable and allowable Medicaid costs and associated reimbursements for psychiatric inpatient hospital professional services provided in SD/MC hospitals.

Interim Payments

Interim payments for psychiatric inpatient hospital professional services provided in SD/MC hospitals are intended to approximate the Medicaid (Medi-Cal) costs incurred by the SD/MC hospital for the services rendered to Medi-Cal beneficiaries. Interim payments for psychiatric inpatient hospital services provided in SD/MC hospitals will be based upon interim rates that are established by the State on an annual basis. The State will follow the process described below to calculate an interim rate for psychiatric inpatient hospital professional services provided in each SD/MC hospital.

- Include the gross costs allocated to each type of service from the most recently filed CMS 2552 and supplemental schedules.
- Include the total units of service for each type of service from the most recently filed CMS 2552 and supplemental schedules.
- Divide the gross costs by the total units of service to calculate the cost per unit for each type of service.
- Multiply the cost per unit by one plus the percentage change in a CMS approved cost of living index.
-

Cost Report Submission

Each SD/MC hospital that receives reimbursement for psychiatric inpatient hospital professional services pursuant to this section will be required to file a CMS 2552 hospital cost report and supplemental schedules by December 31st following the

close of the State Fiscal Year (i.e., June 30th). Each SD/MC hospital that is owned and operated by a county government must certify that it's cost report is based on actual, total expenditures as necessary for claiming Federal Financial Participation pursuant to all applicable requirements of state and federal law including Sections 430.30 and 433.51 of Title 42 Code of Federal Regulations.

Cost Determination

The reasonable and allowable cost of providing psychiatric inpatient hospital professional services for each SD/MC hospital will be determined on the CMS 2552 hospital cost report and supplemental schedules.

Apportioning Costs to Medicaid (Medi-Cal)

The reasonable and allowable cost of providing psychiatric inpatient hospital professional services as determined on the SD/MC hospital's CMS 2552 hospital cost report will be apportioned to the Medi-Cal program based upon a cost-to-charge ratio. Each SD/MC hospital will transfer the total costs for inpatient hospital professional services as determined on the CMS 2552 hospital cost report to a supplemental schedule. Each hospital will report its total charges for each cost center containing inpatient hospital service costs on the supplemental schedule. The supplemental schedule will divide the total costs by the total charges for each cost center containing inpatient hospital professional service costs and charges. Each SD/MC hospital will report, on another supplemental schedule, the total charges for psychiatric inpatient hospital services provided to Medi-Cal beneficiaries in each cost center. The supplemental schedule will multiply the Medi-Cal charges for psychiatric inpatient hospital services by the cost-to-charge ratio for each cost center to calculate the inpatient hospital professional service costs apportioned to the Medi-Cal program for psychiatric inpatient hospital services.

Reconciliation

No later than eighteen months after the close of the State Fiscal Year, each SD/MC hospital will reconcile the Medi-Cal charges it reported on the supplemental schedules for psychiatric inpatient hospital professional services. Each SD/MC hospital will reconcile the Medi-Cal charges it reported with records it received from the State regarding the results of claims adjudication.

Interim Settlement

No later than twenty-four months after the close of the State Fiscal Year, the State will complete the interim settlement of the CMS 2552 hospital cost report and supplemental schedules submitted by each SD/MC hospital. The interim settlement

will compare interim payments made to each SD/MC hospital with the total reimbursable cost. The CMS-approved state developed cost report is used to calculate the total reimbursable costs. Total reimbursable costs for SD/MC hospitals that are owned and operated by a private entity are equal to the lower of the SD/MC hospital's allowable costs determined in the CMS 2552 hospital cost report and supplemental schedules or usual and customary charge for the psychiatric inpatient hospital professional services provided. Total reimbursable costs for SD/MC hospitals that are a UC hospital or owned and operated by a county government are equal to the provider's reasonable and allowable costs determined in the CMS 2552 hospital cost report and supplemental schedules. The State will pay the SD/MC hospital an additional amount if the total reimbursable costs are more than the interim payments made to the provider. Any overpayments will be recouped and returned to the Federal government in accordance with 42 CFR 433.316.

Final Settlement Process

The State will complete its audit of the interim settled CMS 2552 hospital cost report and supplemental schedules within three years of the date the certified reconciled CMS 2552 hospital cost report and supplemental schedules are submitted. The audit performed by the State will determine whether the income, expenses, and statistical data reported on the CMS 2552 hospital cost report and supplemental schedules are reasonable, allowable, and in accordance with State and Federal rules, regulations, and Medicare principles of reimbursement issued by the Centers for Medicare and Medicaid Services (CMS). The audit will also determine that the provider's CMS 2552 hospital cost report and supplemental schedules represent the actual cost of providing rehabilitative and targeted case management services in accordance with the program's Cost and Financial Reporting System (CFRS), Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR), Office of Management and Budget (OMB) Circular A-87, Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United State and other State and Federal regulatory authorities. The State will pay the provider an additional amount if the total reimbursable costs is more than the interim payments made to the provider. Any overpayments will be recouped and returned to the Federal government in accordance with 42 CFR 433.316.

F. REIMBURSEMENT METHODOLOGY AND PROCEDURES – INDIVIDUAL AND GROUP PROVIDERS AND OTHER QUALIFIED PROVIDERS

Individual and group providers and other eligible providers that render rehabilitative mental health services and/or targeted case management services will be reimbursed based upon the SMIR.

D. SCHEDULE OF MAXIMUM RATES

The State originally calculated the Schedule of Maximum Interim Rates (SMIR) for targeted case management services and rehabilitative mental health services, except crisis stabilization, crisis residential treatment, and adult residential treatment, using data from state fiscal year 1998-99 cost reports. These rates are updated on an annual basis and published in an information notice that is posted to the single state agency's website. The following describes the methodology the State used to calculate the original SMIR and the methodology the state will use to annually update those rates.

1. Extract from each provider's cost report the reported gross costs for each type of service and reported units of service for each type of service. Gross costs do not include county administrative and utilization review costs.
2. Divide gross costs by units of service for each type of service.
3. Remove from the data set those providers that have a cost per unit that is one standard deviation above the mean.
4. After completing step 3, remove those providers that have a cost per day in the top ten percent of the remaining providers.
5. From the remaining providers, calculate the sum of gross costs reported for each type of service.
6. From the remaining providers, calculate the sum of the units of service reported for each type of service.
7. Divide the sum of gross costs determined in step 5 by the sum of the units of service as determined in step 6 to calculate the statewide average cost per unit for each type of service.
8. The statewide average cost per unit calculated in step 7 will be increased on an annual basis, effective the first day of each state fiscal year, using the change in the home health agency market basket index.

The State originally calculated the SMIR for crisis stabilization using a cost survey of fourteen county programs that provided services for up to 24 hours in an emergency room setting. The statewide average cost per unit for crisis stabilization services will be increased on an annual basis, effective the first day of each fiscal year, using the change in the home health agency market basket index. The annually updated cost

per unit for crisis stabilization services will be published in an annual information notice that is posted to the single state agency's website.

The State originally calculated the SMIR for crisis residential treatment and adult residential treatment services based on a cost survey from approximately sixty facilities. The survey distinguished between the cost of treatment from the cost for room and board, which is excluded from the SMIR for crisis residential treatment and adult residential treatment. The statewide average cost per unit for crisis residential treatment and adult residential treatment will be increased on an annual basis, effective the first day of each fiscal year, using the change in the home health agency market basket index. The annually updated cost per unit for crisis residential treatment and adult residential treatment will be published in an annual information notice that is posted to the single state agency's website.

The SMIR for services provided in a treatment foster home will initially be set at $87.40 per day and the State will annually increase this SMIR based upon the change in the home health agency market basket index. The $87.40 daily rate is based upon the existing rate the State pays providers for a similar service called intensive treatment foster care. The treatment component of these rates are based upon an hourly rate of $23 for an in-home support counselor multiplied by the number of hours the in-home support counselor is likely to provide treatment to the child. The most intensive level of treatment expects the in-home support counselor to provide 114 hours of treatment per month, which is 3.8 hours per day. The hourly rate of $23 multiplied by 3.8 hours per day of treatment equals the daily rate of $87.40.

E. ALLOWABLE SERVICES

Allowable Rehabilitative Mental Health and Targeted Case Management Services and units of service are as follows:

Service	Units of Service
Mental Health Services	One Minute Increments
Medication Support Services	One Minute Increments
Day Treatment Intensive	Half-Day or Full-Day

Day Rehabilitation	Half-Day or Full-Day
Crisis Intervention	One Minute Increments
Crisis Stabilization	One-Hour Blocks
Adult Residential Treatment Services	Day (Excluding room and board)
Crisis Residential Treatment Services	Day (Excluding room and board)
Psychiatric Health Facility Services	Day (Excluding room and board)
Targeted Case Management	One Minute Increments
Services provided in a treatment foster home	Day (Excluding room and board)

ATTACHMENT 41.9 A, PAGES 38-40			
FISCAL YEAR 2012-13 HOSPITAL INPATIENT PAYMENTS FUNDED WITH CERTIFIED PUBLIC EXPENDITURES			
ENTITIES CERTIFYING PUBLIC EXPENDITURES	OPERATIONAL NATURE	ENTITY HAS GENERAL TAXING AUTHORITY	AMOUNTS CERTIFIED
ALAMEDA	County Government	Yes	$14,964,424.23
CONTRA COSTA	County Government	Yes	$6,925,385.99
HUMBOLDT	County Government	Yes	$1,516,185.44
KERN	County Government	Yes	$3,854,236.56
LOS ANGELES	County Government	Yes	$15,421,404.41
MONTEREY	County Government	Yes	$1,388,569.08
RIVERSIDE	County Government	Yes	$13,817,000.31
SAN BENITO	County Government	Yes	$2,259.56
SAN BERNARDINO	County Government	Yes	$10,172,950.93
SAN DIEGO	County Government	Yes	$1,075,358.98
SAN FRANCISCO	County Government	Yes	$3,299,663.26
SAN MATEO	County Government	Yes	$3,461,496.79
SANTA BARBARA	County Government	Yes	$2,890,344.98
SANTA CLARA	County Government	Yes	$9,279,392.50
VENTURA	County Government	Yes	$1,876,206.58
TOTAL			$89,944,879.60

ATTACHMENT 41.9 B, PAGES 21-25			
FISCAL YEAR 2012-13 OUTPATIENT PAYMENTS FUNDED WITH CERTIFIED PUBLIC EXPENDITURES			
ENTITIES CERTIFYING PUBLIC EXPENDITURES	OPERATIONAL NATURE	ENTITY HAS GENERAL TAXING AUTHORITY	AMOUNTS CERTIFIED
ALAMEDA	County Government	Yes	$145,174,183.76
ALPINE	County Government	Yes	$128,195.94
AMADOR	County Government	Yes	$847,781.39
BUTTE	County Government	Yes	$30,639,463.49
CALAVERAS	County Government	Yes	$1,649,033.62
COLUSA	County Government	Yes	$1,853,703.84
CONTRA COSTA	County Government	Yes	$64,404,350.54
DEL NORTE	County Government	Yes	$2,399,365.05
EL DORADO	County Government	Yes	$5,654,205.63
FRESNO	County Government	Yes	$44,756,240.29
GLENN	County Government	Yes	$2,267,799.63
HUMBOLDT	County Government	Yes	$12,915,512.72
IMPERIAL	County Government	Yes	$18,560,156.54
INYO	County Government	Yes	$1,046,743.30
KERN	County Government	Yes	$44,825,706.70
KINGS	County Government	Yes	$4,391,601.49
LAKE	County Government	Yes	$4,771,742.66
LASSEN	County Government	Yes	$1,653,870.98
LOS ANGELES	County Government	Yes	$864,501,074.57
MADERA	County Government	Yes	$4,106,675.86
MARIN	County Government	Yes	$10,630,100.72
MARIPOSA	County Government	Yes	$2,224,371.82
MENDOCINO	County Government	Yes	$8,338,669.04
MERCED	County Government	Yes	$8,045,282.61
MODOC	County Government	Yes	$657,556.70
MONO	County Government	Yes	$356,724.48
MONTEREY	County Government	Yes	$33,014,938.09

NAPA	County Government	Yes	$7,131,780.13
NEVADA	County Government	Yes	$9,796,344.95
ORANGE	County Government	Yes	$59,392,015.54
PLACER	County Government	Yes	$9,742,066.71
PLUMAS	County Government	Yes	$1,422,945.79
RIVERSIDE	County Government	Yes	$54,203,676.14
SACRAMENTO	County Government	Yes	$84,094,271.96
SAN BENITO	County Government	Yes	$1,780,443.54
SAN BERNARDINO	County Government	Yes	$70,897,206.43
SAN DIEGO	County Government	Yes	$111,420,430.01
SAN FRANCISCO	County Government	Yes	$97,521,025.20
SAN JOAQUIN	County Government	Yes	$38,278,624.26
SAN LUIS OBISPO	County Government	Yes	$18,300,889.93
SAN MATEO	County Government	Yes	$31,063,342.58
SANTA BARBARA	County Government	Yes	$28,632,412.09
SANTA CLARA	County Government	Yes	$217,178,482.60
SANTA CRUZ	County Government	Yes	$27,220,004.69
SHASTA	County Government	Yes	$10,891,501.11
SIERRA	County Government	Yes	
SISKIYOU	County Government	Yes	$3,105,593.47
SOLANO	County Government	Yes	$19,630,085.99
SONOMA	County Government	Yes	$20,036,712.19
STANISLAUS	County Government	Yes	$26,184,596.54
SUTTER/YUBA	County Government	Yes	$13,662,942.34
TEHAMA	County Government	Yes	$3,339,109.51
TRINITY	County Government	Yes	$1,863,380.80
TULARE	County Government	Yes	$29,266,739.52
TUOLUMNE	County Government	Yes	$2,014,098.55
VENTURA	County Government	Yes	$33,756,608.87
YOLO	County Government	Yes	$5,755,953.44
TOTAL			$2,357,398,336.34

ATTACHMENT 41.9 A, PAGES 38-40 AND ATTACHMENT 41.9 B PAGES 21-25						
FISCAL YEAR 2012-13 HOSPITAL INPATIENT & OUTPATIENT PAYMENTS FUNDED WITH CERTIFIED PUBLIC EXPENDITURES						
ENTITIES CERTIFYING PUBLIC EXPENDITURES	OPERATIONAL NATURE	ENTITY HAS GENERAL TAXING AUTHORITY	OUTPATIENT AMOUNTS CERTIFIED	INPATIENT AMOUNTS CERTIFIED	TOTAL AMOUNTS CERTIFIED	APPROPRIATIONS TO THE CERTIFYING ENTITY[1]
ALAMEDA	County Government	Yes	$145,174,183.76	$14,964,424.23	$160,138,607.99	$163,790,053.85
ALPINE	County Government	Yes	$128,195.94		$128,195.94	$1,758,823.65
AMADOR	County Government	Yes	$847,781.39		$847,781.39	$3,943,231.48
BUTTE	County Government	Yes	$30,639,463.49		$30,639,463.49	$27,776,319.42
CALAVERAS	County Government	Yes	$1,649,033.62		$1,649,033.62	$4,765,341.13
COLUSA	County Government	Yes	$1,853,703.84		$1,853,703.84	$4,346,107.73
CONTRA COSTA	County Government	Yes	$64,404,350.54	$6,925,385.99	$71,329,736.53	$85,848,500.60
DEL NORTE	County Government	Yes	$2,399,365.05		$2,399,365.05	$4,744,603.05
EL DORADO	County Government	Yes	$5,654,205.63		$5,654,205.63	$13,075,164.42
FRESNO	County Government	Yes	$44,756,240.29		$44,756,240.29	$102,684,144.46
GLENN	County Government	Yes	$2,267,799.63		$2,267,799.63	$4,536,958.70
HUMBOLDT	County Government	Yes	$12,915,512.72	$1,516,185.44	$14,431,698.16	$16,154,350.12
IMPERIAL	County Government	Yes	$18,560,156.54		$18,560,156.54	$19,972,360.86
INYO	County Government	Yes	$1,046,743.30		$1,046,743.30	$3,351,637.84
KERN	County Government	Yes	$44,825,706.70	$3,854,236.56	$48,679,943.26	$79,902,981.57
KINGS	County Government	Yes	$4,391,601.49		$4,391,601.49	$12,306,392.86
LAKE	County Government	Yes	$4,771,742.66		$4,771,742.66	$8,051,458.20
LASSEN	County Government	Yes	$1,653,870.98		$1,653,870.98	$4,765,302.18
LOS ANGELES	County Government	Yes	$864,501,074.57	$15,421,404.41	$879,922,478.98	$1,170,066,487.79
MADERA	County Government	Yes	$4,106,675.86		$4,106,675.86	$13,399,037.40
MARIN	County Government	Yes	$10,630,100.72		$10,630,100.72	$24,242,554.18
MARIPOSA	County Government	Yes	$2,224,371.82		$2,224,371.82	$3,135,930.17
MENDOCINO	County Government	Yes	$8,338,669.04		$8,338,669.04	$14,340,083.32
MERCED	County Government	Yes	$8,045,282.61		$8,045,282.61	$26,099,083.06

MODOC	County Government	Yes	$657,556.70		$657,556.70	$2,682,822.31
MONO	County Government	Yes	$356,724.48		$356,724.48	$747,064.86
MONTEREY	County Government	Yes	$33,014,938.09	$1,388,569.08	$34,403,507.17	$38,111,720.48
NAPA	County Government	Yes	$7,131,780.13		$7,131,780.13	$14,941,234.70
NEVADA	County Government	Yes	$9,796,344.95		$9,796,344.95	$10,442,929.30
ORANGE	County Government	Yes	$59,392,015.54		$59,392,015.54	$230,410,991.43
PLACER	County Government	Yes	$9,742,066.71		$9,742,066.71	$19,587,136.51
PLUMAS	County Government	Yes	$1,422,945.79		$1,422,945.79	$4,004,072.40
RIVERSIDE	County Government	Yes	$54,203,676.14	$13,817,000.31	$68,020,676.45	$153,388,123.84
SACRAMENTO	County Government	Yes	$84,094,271.96		$84,094,271.96	$152,019,756.70
SAN BENITO	County Government	Yes	$1,780,443.54	$2,259.56	$1,782,703.10	$5,234,274.36
SAN BERNARDINO	County Government	Yes	$70,897,206.43	$10,172,950.93	$81,070,157.36	$174,812,873.66
SAN DIEGO	County Government	Yes	$111,420,430.01	$1,075,358.98	$112,495,788.99	$264,187,089.35
SAN FRANCISCO	County Government	Yes	$97,521,025.20	$3,299,663.26	$100,820,688.46	$116,829,247.31
SAN JOAQUIN	County Government	Yes	$38,278,624.26		$38,278,624.26	$64,950,602.47
SAN LUIS OBISPO	County Government	Yes	$18,300,889.93		$18,300,889.93	$25,145,230.57
SAN MATEO	County Government	Yes	$31,063,342.58	$3,461,496.79	$34,524,839.37	$61,681,807.33
SANTA BARBARA	County Government	Yes	$28,632,412.09	$2,890,344.98	$31,522,757.07	$40,060,971.54
SANTA CLARA	County Government	Yes	$217,178,482.60	$9,279,392.50	$226,457,875.10	$161,439,754.03
SANTA CRUZ	County Government	Yes	$27,220,004.69		$27,220,004.69	$28,644,911.89
SHASTA	County Government	Yes	$10,891,501.11		$10,891,501.11	$18,635,537.15
SIERRA	County Government	Yes			$0.00	$1,933,201.85
SISKIYOU	County Government	Yes	$3,105,593.47		$3,105,593.47	$6,225,717.53
SOLANO	County Government	Yes	$19,630,085.99		$19,630,085.99	$37,969,013.41
SONOMA	County Government	Yes	$20,036,712.19		$20,036,712.19	$37,910,400.02
STANISLAUS	County Government	Yes	$26,184,596.54		$26,184,596.54	$46,786,575.24
SUTTER/YUBA	County Government	Yes	$13,662,942.34		$13,662,942.34	$20,296,275.44
TEHAMA	County Government	Yes	$3,339,109.51		$3,339,109.51	$7,424,887.81
TRINITY	County Government	Yes	$1,863,380.80		$1,863,380.80	$2,969,004.32
TULARE	County Government	Yes	$29,266,739.52		$29,266,739.52	$50,380,287.38

TUOLUMNE	County Government	Yes	$2,014,098.55		$2,014,098.55	$5,554,255.98
VENTURA	County Government	Yes	$33,756,608.87	$1,876,206.58	$35,632,815.45	$64,660,584.68
YOLO	County Government	Yes	$5,755,953.44		$5,755,953.44	$17,662,726.14
TOTAL						$3,700,787,990.03

[1] Funds deposited into the Local Revenue Fund, Mental Health Services Fund, and Local Revenue Fund 2011 and are continuously appropriated to counties and are distributed on a monthly basis. The amounts reported in this column reflect the amount of money distributed to counties from the Local Revenue Fund, Mental Health Services Fund, and Local Revenue Fund 2011 for mental health services in Fiscal Year 2012-13.