Standard Funding Questions
March 24, 2015

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1. Section 1903(a)(1). 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.)

The Mental Health Plans (MHPs) retain all Medicaid payments unless an overpayment is identified. Payments are settled annually through the cost report settlement process and are subject to final audit settlement. MHPs are required to return any overpayments during the cost settlement process and final audit settlement. Any overpayment of federal financial participation (FFP) is returned to the Centers for Medicare and Medicaid Services (CMS). Upon the discovery of an overpayment, the State recovers the overpayment in accordance with 42 CFR 433.316 and returns the overpayment to CMS as detailed below.

Current process for returning overpayments to CMS:

- **The State identifies overpayment information through their cost settlement process and Audit Reports.**
- **The State invoices the MHP to recoup the overpayment. The State returns the overpayment to CMS through the CMS 64 Expenditure Report. The payment information is reported in the CMS 64 Expenditure Report by:**
  - **the correct Medicaid Eligibility Group and Service Category for adjustments with a date of service July 1, 2005 and thereafter;**
  - **the line item; and**
  - **the fiscal year.**

The State performs fiscal audits of MHPs to ensure that the expenditures and other information reported on the cost report is true and correct in accordance with the certification on the cost report.

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. 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 (lGTs), 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 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 utilizes certified public expenditures (CPE) for the State-share of funding for each type of payment made to an MHP. The State does not use intergovernmental transfers, provider taxes, or similar mechanisms as the State share of the Medicaid payments for MHPs under the SMHS Waiver. All fifty-six MHPs are county government entities and have general taxing authority.

MHPs pay for the total cost of services using non-federal funding sources and then claim to the State for Federal Financial Participation (FFP) reimbursement using the CPE process. All CPE claims are verified using a billing system that verifies the claims are for eligible services from Medi-Cal certified providers for Medi-Cal eligible clients according to federal and state regulations. Below is information on the non-federal funding sources used to pay for the costs of Medi-Cal specialty mental health services.

FY 2015-2016 Non-Federal Funding

The FY 15-16 estimate of Non – Federal funding for Medi-Cal specialty mental health costs is $1,427,373,000. For FY 2015-2016, MHPs will receive funding from four sources.

- **1991 Realignment funds – Realignment funds are not subject to appropriation in the State Budget. In 1991, the Legislature enacted the Bronzan-McCorquodale Act in the areas of mental health, social services and health. 1991 Realignment shifted program responsibilities from the State to counties, adjusted cost sharing ratios and provided counties a dedicated revenue stream to pay for these changes. Realignment funds (which originate from a sales tax increase and a vehicle license fee increase) are collected by the State and allocated to various accounts and sub-accounts in a State Local Revenue Fund. Each county has three program accounts: mental health, social services and health. Counties receive deposits into their three accounts for spending on these programs. State law (W&I Code, Section 5777(g)) specifies that counties must fulfill their Medi-Cal contract obligations before funding other non-Medi-Cal programs with Realignment funds. These funds are distributed to counties on a monthly basis. The State estimates that counties will receive $1,188,051,000 in Fiscal Year 2015-2016 from 1991 realignment to provide mental health services.**

- **2011 Realignment funds: The 2011 Realignment legislation removed State General Funds as a non-federal funding source for Medi-Cal specialty mental health services and provided for revenues directly to the counties for the non-federal share of the funding.**

  It established a Local Revenue Fund 2011 into which a certain percentage of sales tax and vehicle license fee revenue is deposited. A certain percentage of sales tax revenue deposited into the Local Revenue Fund 2011 is allocated to a behavioral health subaccount and distributed to

counties to provide specialty mental health services, Drug Medical services, and other alcohol and other drug services. The State estimates that counties will receive $1,192,967,000 in Fiscal Year 2015-16 from the Behavioral Health Subaccount, and $140,885,000 from the Behavioral Health Services Growth Special Account to provide specialty mental health services, Drug Medi-Cal services and other alcohol and other drug services.

- **MHSA funds – Enactment of the MHSA in 2004, imposed a 1% income tax on personal income in excess of $1 million. To the extent that a county mental health system receives MHSA funds (intended for new and innovative programs), counties may provide services to Medi-Cal beneficiaries through these new or transformed programs. Medi-Cal reimbursable services provided to eligible beneficiaries may be funded with county MHSA funds, at county discretion. However, the funds may not be used to supplant existing state or county funds utilized to provide mental health services. The State estimates that counties will receive $1,713,500,000 in Fiscal Year 2014-2015 and $1,686, 800,000 in Fiscal Year 2015-2016 from the Mental Health Services Fund.**

- **Other County funds - At county discretion, other county funds may also be used for costs of administration of the SMHS waiver program and for the provision of specialty mental health services.**

FY 2016-2017; FY 2017-2018; FY 2018-2019; FY 2019-20120
The State anticipates that the same sources of funding will be used through waiver renewal period 8. These sources include 1991 Realignment Funds, 2011 Realignment Funds, MHSA funds and other county funds.

The State uses the following methodology to verify that the total expenditures being certified are eligible for FFP in accordance with 42 CFR 433.15(b). Each MHP must submit a State developed cost report by December 31 following the close of the fiscal year. The State requires the MHP and each of its contract providers to complete a cost report. The MHP's cost report contains the costs it incurred to provide Medi-Cal services through its own employees. Each MHP also reports the amount it paid each provider to provide Medi-Cal services. State staff completes a desk review to verify that the MHP paid each provider an amount that is equal to or greater than the costs incurred by the provider that are eligible for reimbursement. If the MHP paid the provider an amount that is less than the costs incurred by the provider that are eligible for reimbursement, the MHP is required to make an adjustment to FFP.

When MHPs submit claims to the State for Medicaid reimbursement, the MHP certifies that the expenditures reported on the claim meet all Federal and State statutory and regulatory provisions, including 42 CFR 433.51. By signing the claim certification form, the MHP is certifying that claim is based on actual, total expenditures of public funds as necessary for claiming FFP.

The State verifies that the expenditures being certified by the MHPs are in compliance with the requirements established in the MHP contract, that the beneficiaries were Medi-Cal eligible at the time of services and that the expenditures for the services provided are eligible for FFP reimbursement. The MHPs must also certify under penalty of perjury that the claim is based on actual, total expenditures of public funds as necessary for claiming FFP pursuant to all applicable requirements of federal law, including Section 1903(a) of the Social Security Act and in accordance with 42 CFR 433.51(b). The State requires that funding sources be identified on the year-end cost report submitted by each MHP, and conducts formal audits of the cost reports after the cost settlement process and all related adjustments have been completed.

Further, the public funds used as the State's share are certified by the MHP as representing expenditures eligible for FFP under 42 CFR 433.51 because (1) MHPs are required to report actual expenditures from their county auditor controller's report on the cost report used to determine total computable expenditures and (2) MHPs are required to follow Medicare principles of reimbursement prescribed in CMS' Provider Reimbursement Manual in determining actual expenditures used to determine the total computable expenditures.

The certification statement signed by the mental health director and auditor controller includes language that complies with the requirements of 42 CFR 433.51. Both the county mental health director and county auditor controller certify that the claim is based on actual total funds expenditures for services provided to eligible beneficiaries. Furthermore, the auditor controller certifies that the expenditures being claimed have not previously been, nor will they be, claimed at any other time as claims to receive FFP funds under Medicaid or any other program. When the county mental health director and county auditor controller sign the claim certification form, both are certifying that the county has incurred the expenditures on the claim and that those expenditures have not previously been reimbursed nor will be submitted for reimbursement in the future under the Medicaid program or any other federal program.

The State is currently working with CMS on a CPE protocol. The State expects the CPE protocol to be approved before the beginning of the 2016-17 Fiscal Year.

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. 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.

No enhanced payments have been ~~are~~ made to MHPs. The State is in the process of amending its Medicaid State Plan (through State Plan Amendment (SPA) #09-004) to remove language pertaining to incentive payments to negotiated rate providers.

The State is in the process of establishing a supplemental payment program. The supplemental payment process is described in the CPE protocol currently under review with CMS. SPA 09-004, once approved, will establish a non-risk upper payment limit that will allow the State to make supplemental payments to MHPs

4. Please explain how the State is in compliance with the non-risk UPL specified in 42 CFR 447.362. Under a nonrisk contract, Medicaid payments to the contractor may not exceed—(a) What Medicaid would have paid, on a fee-for-service basis, for the services actually furnished to recipients: plus (b) The net savings of administrative costs the Medicaid agency achieves by contracting with the plan instead of purchasing the services on a fee-for-service basis.

The State continues to work with CMS on SPA #09-004 which addresses the non-risk UPL. This SPA proposes to remove negotiated rates; set a non-risk UPL in the State Plan creating a reimbursement methodology to accommodate for the Prepaid Inpatient Health Plan (PIHP) contract payments outside of the State Plan (inclusive of the supplemental payments); include cost settlement and cost reporting information/descriptions in the SPA; and describe the general payment methodology which must reflect current and appropriate payment processes. The effective date of SPA #09-004 will be January 1, 2009.

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?

Governmental providers do not receive payments that in aggregate exceed their reasonable costs of providing services. The State limits reimbursement to the MHPs to the upper payment limit for non-risk contract pursuant to 42CFR 447.362. This limit is applied at the interim cost settlement and the final settlement. If the State determines that it has paid an MHP in excess of the upper payment limit for non-risk contracts, the State recoups the over payment and returns it to CMS in accordance with 42 CFR 433.316.