



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



EDMUND G. BROWN JR.  
GOVERNOR

DATE: August 20, 2015

MHSUDS INFORMATION NOTICE NO.: 15-034

COUNTY BEHAVIORAL HEALTH PROGRAM DIRECTORS

COUNTY DRUG & ALCOHOL ADMINISTRATORS

COUNTY BEHAVIORAL HEALTH DIRECTOR'S ASSOCIATION

CALIFORNIA COUNCIL OF COMMUNITY MENTAL HEALTH AGENCIES

COALITION OF ALCOHOL AND DRUG ASSOCIATIONS

SUBJECT: DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM PILOT FISCAL PROVISIONS

**PURPOSE:**

This notice conveys the fiscal provisions for the Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot program. This includes expenditure authorities, sources of funding and reimbursement requirements, and annual reconciliation and reporting requirements.

**BACKGROUND:**

The DMC-ODS Pilot program is authorized and financed under the authority of the State's 1115 Bridge to Reform Demonstration Waiver. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP) programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible, providing services not typically covered by Medicaid, and using innovative service delivery systems that improve care, increase efficiency, and reduce costs. In general, section 1115 demonstrations are approved for a five-year period. Demonstrations must be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the Waiver.

**DISCUSSION:**

I. Expenditure Authorities

- a) *California Bridge to Reform DMC-ODS Waiver Standard Terms and Conditions.*  
For claiming Federal Financial Participation (FFP), counties will certify the total

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allowable expenditures incurred in providing the DMC-ODS Waiver services provided either through county-operated providers, contracted fee-for-service (FFS) providers or contracted managed care plans. Counties will propose county-specific interim rates for each covered mode of service, except for the Narcotic Treatment Program/Opioid Treatment Program (NTP/OTP) modality, and the State will approve or disapprove those rates. If during the State review process, the State denies the proposed interim rates for DMC-ODS services, the county will be provided the opportunity to adjust the rates and resubmit to the State. The State will retain all approval of the rates in order to assess that the rates are sufficient to ensure access to available DMC-ODS Waiver services. The approved interim rates will be specified in the State/County contract. If the county elects to contract for covered services through a State contracted managed care plan, the county will provide reimbursement for the services delivered by the managed care organization as a part of the contracted capitation rate.

NTP/OTP reimbursement shall be set pursuant to the process set forth in Welfare and Institutions Code Section 14021.51. All NTP/OTP providers contracting with counties shall provide their county with financial data on an annual basis. This data is to be collected for the purpose of setting the rates after the expiration of the Waiver. The Department of Health Care Services (DHCS) Rates Setting Workgroup shall propose a recommended format for this annual financial data and the State will approve a final format. Counties shall provide this financial data and the State will approve the final format. Counties shall provide this financial data to the DHCS Rates Setting Workgroup upon its request. The provision in the Welfare and Institutions Code Section 14124.24(h), remains in effect and NTPs/OTPs will not be required to submit cost reports to the counties for the purpose of cost settlement.

For county-operated services, the county will be reimbursed based on actual allowable costs. A Centers for Medicare and Medicaid Services (CMS) approved Certified Public Expenditure (CPE) protocol is required before FFP associated with Waiver services is made available to the State. This approved CPE protocol must explain the process the State will use to determine costs incurred by the counties under this demonstration.

Only State plan services will be provided prior to the DHCS and CMS approval of the State/County contract (managed care contract per Federal definition) and executed by the County Board of Supervisors. State plan DMC services will be reimbursed pursuant to the State plan reimbursement methodologies until a county is approved to begin DMC-ODS services.

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Senate Bill 1020 (Statutes of 2012) created the permanent structure for 2011 Realignment. It codified the Behavioral Health Subaccount, which funds programs including Drug Medi-Cal. Allocations of Realignment funds run on a fiscal year of October 1- September 30. The monthly allocations are dispersed to counties from the State Controller's Office. The Department of Finance develops schedules, in consultation with appropriate State agencies and the California State Association of Counties (CSAC), for the allocation of Behavioral Health Subaccount funds to the counties. The base has not yet been set, as the State assesses the expenditures by county for these programs. The State will continue to monitor the Behavioral Health Subaccount and counties to ensure that the Medi-Cal entitlement program obligations are met for all substance use disorder and mental health services.

Subject to the participation standards and process to be established by the State, counties may also pilot an alternative reimbursement structure for a DMC-ODS modality if both the provider of that modality and the county mutually and contractually agree to participate. This may include use of case rates. The State and the CMS will have the final approval of any alternative reimbursement structure pilot proposed by the county, and such pilot structure must continue to meet the terms and conditions expressed herein, including but not limited to, the rate approval process described above.

- b) *Federal Certified Public Expenditure Requirements.* Pursuant to 42 CFR §433.51, public funds may be considered as the State's share in claiming FFP if the public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP. The public funds must not be Federal funds unless authorized by Federal law to be used to match other Federal funds. In accordance with 42 CFR §447.206, all health care providers that are operated by units of government are limited to reimbursement not in excess of the individual health care provider's cost of providing covered Medicaid services to eligible Medicaid recipients. Reasonable methods of identifying and allocating costs to Medicaid are determined by the Secretary in accordance with § 1902, 1903, and 1905 of the Social Security Act, as well as 45 CFR §92.22 and Medicare cost principles when applicable. Medicaid costs for non-institutional governmentally-operated health care providers must be supported by auditable documentation in a form approved by the Secretary that is consistent with 42 CFR §433.51 (b)(1) through (b)(4).

Each provider must submit annually a cost report to the Medicaid agency that reflects the individual provider's cost of serving Medicaid recipients during the year. States may utilize most recently filed cost reports to develop interim rates and may trend those interim rates by an applicable health care-related index. Interim reconciliations must be performed by reconciling the interim Medicaid payment rates to the filed cost report for the spending year in which interim payment rates were made. Final reconciliation must be performed annually by reconciling any interim payments to the finalized cost report for the spending year in which any interim payment rates were made. If it is determined that a governmentally-operated health care provider received an overpayment, amounts related to the overpayment will be properly credited to the Federal government. State review of Medicaid payments made to governmentally operated health care providers must be performed annually and completed by the last day of the Federal fiscal year ending two years from the Medicaid State plan rate year under review. Each State must submit a summary report to the CMS demonstrating the results of the State's review of Medicaid payments to ensure compliance with the Medicaid cost limit applicable to governmentally operated health care providers by the last day of the calendar year ending two years from the Medicaid State Plan rate year under review.

- c) *California County Certified Public Expenditure Protocol.* DHCS is currently in the process of implementing changes as required by CMS to the cost report forms with the approval of State Plan Amendment #09-022. The changes will be implemented starting with Fiscal Year 2015-16. Upon approval of the DMC-ODS Waiver, further changes, if applicable, will be made to the cost report forms for the certification of public expenditures. The State will also identify if changes are needed within any DMC-ODS Waiver State/County contracts regarding the certification of public expenditures. Changes will reflect all Standard Terms and Conditions, each county's submitted and approved Implementation Plan, and other conditions suggested by CMS.

## II. Sources of Funding and Reimbursement Requirements

FFP will be provided through the adjudication of claims certified by the contracting county to meet all Federal Medi-Cal CPE, full funds expenditure, and claims integrity requirements. Annual interim rates for each covered service will be developed by the county and approved by the State. These interim rates must conform to 42 CFR §433.51 and 42 CFR §447.207, and all certified public expenditures will be subject to annual reconciliation and cost settlement consistent with Federal and State requirements.

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State funding (non-Federal match) will be provided subject to the provisions of 2011 Realignment. The county will make all required full funds CPE using the local 2011 behavioral health subaccount consistent with current Federal and State requirements. Federal funds will be claimed by the county and adjudicated through the Short Doyle 2 system based on the approved interim rates throughout the fiscal year. Federal reimbursements will be provided to contracting counties subject to the expenditure authorities and requirements cited above.

Annual State share funding will be provided subject to the appropriation established in the State budget. Additional State general funds will be made available by DHCS to contracting counties participating in the DMC-ODS based on a schedule to be determined, similar to the distribution of block grant funds. These funds are to be expended consistent with the requirements outlined in the annual State budget and those established by DHCS and the Department of Finance. These funds are intended to provide support for the expansion of DMC coverage required under the Waiver in order to increase beneficiary access and improve program quality and integrity.

**III. Annual Reconciliation and Reporting Requirements**

FFP will be subject to annual cost report, reconciliation and settlement requirements as outlined in Section (I)(b) and (c) of this notice.

Sincerely,

Original signed by

Karen Baylor, Ph.D., LMFT, Deputy Director  
Mental Health & Substance Use Disorder Services