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

JENNIFER KENT
DIRECTOR

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DATE: February 23, 2018

MHSUDS INFORMATION NOTICE NO.: 18-012

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES
CALIFORNIA OPIOID MAINTENANCE PROVIDERS

SUBJECT: MENTAL HEALTH PLAN CLAIMING FOR ELIGIBLE COSTS RELATED TO NEW FEDERAL MEDICAID MANAGED CARE AND PARITY REQUIREMENTS

REFERENCE: TITLE 42, CODE OF FEDERAL REGULATIONS PART 438

EXPIRES: Retain until superseded

Purpose

This Mental Health and Substance Use Disorder Services Information Notice (MHSUDS IN) provides county Mental Health Plans (MHPs) instructions for claiming Federal Financial Participation (FFP) and State General Fund (SGF) reimbursement for increased administrative costs associated with implementing the Federal Medicaid Managed Care Final Rule (Final Rule) and the Federal Mental Health and Substance Use Disorder Services Parity Final Rule (Parity Rule) requirements.

Additionally, this MHSUDS IN includes the Department of Health Care Services' (DHCS) methodology MHPs must use to determine costs incurred to implement the new provisions of the federal regulations.

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Background

On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule[1], aimed at aligning the Medicaid managed care regulations with requirements for other major sources of coverage. MHPs are classified as Prepaid Inpatient Health Plans, and therefore, must comply with federal managed care requirements (with some exceptions). On March 30, 2016, CMS issued Final Rule CMS-2390-P in the Federal Register (81.Fed.Reg. 18390) to apply the Paul Wellstone Mental Health Parity and Addiction Equity Act to Medicaid benefits. The Parity Rule strengthens access to mental health and substance use disorder services for Medicaid beneficiaries. These regulations amend and expand the requirements of Title 42, Code of Federal Regulations (CFR) Part 438, pertaining to managed care.

The Budget Act of 2017 appropriated a total (SGF and FFP) of $37,056,000 for the Managed Care Final Rule. The non-federal share of costs is funded with fifty percent County Funds and fifty percent SGF.

Claiming Instructions

MHPs incurring increased Medi-Cal Administrative and Utilization Review/Quality Assurance (UR/QA) costs to implement new provisions of these federal regulations may claim FFP and SGF reimbursement consistent with federal and state guidance. MHPs should submit claims for these costs using the MC 1982 B and MC 1982 C claim forms, which have been amended accordingly. The amended MC 1982 B and MC 1982 C claim forms are available via the link below, under the title, *Certification Forms*.

http://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx

Increased costs may include costs incurred for the following:

1. Hiring new employees;
2. Redirecting existing staff time that has not been previously reimbursed by any state or federal source;
3. Procuring new contracts to conduct new administrative and UR/QA activities associated with the Final rule, translating written materials, modifying information technology systems and programming necessary to ensure compliance with federal regulations, and increased document retention costs.

[1] 81 FR 27497

This is not an exhaustive list, and MHPs must maintain adequate documentation that supports claiming for increased costs to implement Final Rule provisions. MHPs may submit claims for costs incurred retroactively to July 1, 2017.

Federal Requirements

MHPs must comply with all applicable federal requirements. However, MHPs may only claim SGF reimbursement for activities related to implementing ***new*** provisions, which result in increased costs to the MHP.

In an effort to assist MHPs in determining appropriate costs, DHCS identified provisions of the federal regulations that may result in increased costs. MHPs may document and claim the additional costs associated with implementing the new requirements outlined in the federal regulations based on the following eligible categories:

Rules effective July 1, 2017

Regulation	Regulation Impact
§438.3(h)	**Inspection and audit of records and access to facilities.** An MHP or its subcontractors must make available at any time for inspection and audit any records or documents of the premises, physical facilities, and equipment where Medi-Cal-related activities or work is conducted for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
§438.3(n)	**Parity in mental health and substance use disorder benefits.** MHPs must provide for services to be delivered in compliance with federal regulatory requirements related to parity (Subpart K of CFR Part 438).
§438.3(u)	**Record keeping requirements.** MHPs must retain, and require subcontractors to retain records, as applicable, for a period of no less than 10 years.
§438.10	**Information requirements.** Each MHP must provide all required information to beneficiaries in a manner and format that may be easily understood and is readily accessible. This includes making oral interpretation available in all languages and written translation available in each prevalent non-English language. Each MHP must comply with the language and formatting requirements of the Final Rule.
§438.208	**Care coordination.** Each MHP shall implement procedures to deliver care to and coordinate services for all of its beneficiaries.

Regulation	Regulation Impact
§438.210	**Coverage and authorization of services.** Each MHP must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services. This includes having mechanisms in effect to ensure consistent application of review criteria for authorization decisions and processes for notifying providers and beneficiaries of decisions. Each MHP must comply with specified timeframes for authorizing services.
§438.214	**Provider selection.** Each MHP must implement policies and procedures for selection and retention of network providers that meet the requirements specified in the Final Rule.
§438.230	**Sub-contractual relationships and delegation.** Each MHP must ensure that it subcontracts with network providers comply with the content requirements specified in the Final Rule. Each subcontract shall be in writing and shall include a requirement that the MHP monitor the subcontractor's compliance with the provisions of the subcontract and the MHP contract and a requirement that the subcontractor provide a corrective action plan if deficiencies are identified. Each MHP shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the DHCS, notwithstanding any relationship(s) that the MHP may have with any subcontractor.
§438.242	**Health Information Systems.** Each MHP must maintain a health information system that includes the basic elements specified in the Final Rule to effectively collect, analyze, integrate, and report data. The MHP shall submit encounter data to DHCS at a frequency and level specified by the DHCS and CMS. The MHP shall ensure collection and maintenance of sufficient beneficiary encounter data to identify the provider who delivers service(s) to the beneficiary.
Subpart F §438.400-438.424	**Grievance and appeal systems.** Each MHP must have a grievance and appeal system in place for beneficiaries. This includes giving beneficiaries timely and adequate notice of adverse benefit determination in writing consistent with the requirements specified in the Final Rule; handling of grievances and appeals; resolution of appeals; and recordkeeping.
§438.608	**Program integrity requirements.** Each MHP must implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. This includes a compliance program that contains all of the elements specified in the Final Rule.

Rules effective July 1, 2018 and beyond

Regulation	Regulation Impact
§438.62	**Continued services to enrollees.** Each MHP must implement a transition of care policy consistent with the requirements in the Final Rule that meets the State defined transition of care policy.
§438.68	**Network Adequacy.** MHPs must comply with the network adequacy standards developed by DHCS, including time and distance standards.
§438.206	**Availability of Services.** MHPs must comply with timely access, and cultural and accessibility considerations to ensure that all services covered under the State plan are available and accessible to MHP beneficiaries in a timely manner.
§438.207	**Assurances of adequate capacity and services.** Each MHP must give assurances to DHCS and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the state standards and reporting requirements.
§438.334	**Quality rating system.** Each MHP must submit to DHCS the data necessary for DHCS to issue a quality rating, using the quality rating system adopted under this section.
§438.602(b) §438.608(b)	**Screening and enrollment of providers.** Each MHP shall ensure that all network providers are enrolled with DHCS as Medi-Cal providers consistent with the provider disclosure, screening, and enrollment requirements of 42 CFR Part 455, subparts B and E. This includes the MHP screening and periodically revalidating all network providers in accordance with federal requirements and promptly notifying DHCS of any excluded parties found. The MHP may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon determination that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider, and notify affected beneficiaries.

Interim Reimbursement

For Fiscal Year (FY) 2017-18, county MHPs will receive interim federal and state general fund reimbursement for the eligible activities subject to the total amount

appropriated in the State budget. DHCS will reimburse county MHPs based on the information provided and certified on the MC 1982 B and MC 1982 C forms.

Cost Settlement

Each MHP will be required to provide documentation of the actual increased cost incurred in FY 2017-18. The MHP must use an appropriate cost allocation methodology, such as staff time study, contractor invoices, or other generally accepted methods. MHPs must also report that amount on their FY 2017-18 cost report, which will determine the reconciled final amount of FFP and SGF paid to or recovered from each MHP based upon the MHP's actual eligible costs. The final cost report and the supporting documentation will be subject to audit as required by federal and state regulation.

For any questions regarding this MHSUDS IN, please contact Moses Ndungu, Chief, Fiscal Policy Section, Mental Health Management and Outcomes Reporting Branch, Mental Health Services Division, at Moses.Ndungu@dhcs.ca.gov.

Sincerely,

Original signed by

Brenda Grealish, Acting Deputy Director
Mental Health & Substance Use Disorder Services