# MENTAL HEALTH AND SUD FINANCING PART II

INTERIM PAYMENTS AND COST SETTLEMENT

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## MEDI-CAL FEDERAL FINANCIAL PARTICIPATION

- Types of Costs Eligible for Reimbursement
  - Medical assistance
  - Utilization review and quality assurance
  - Mental health plan administration
- Reimbursement Cycle
  - Interim Payments
  - Interim Cost Settlement
  - Final Cost Settlement

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# Medical Assistance – Interim Payments

- Mental health plans may claim federal reimbursement for the cost of providing covered specialty mental health services to Medi-Cal beneficiaries who meet medical necessity criteria by providers eligible to provide the covered service rendered.
- Mental health plans must submit an electronic claim file (837) to the Short-Doyle Medi-Cal Phase II claiming system.
- The claiming system adjudicates the claim and issues an electronic remittance advice to the mental health plan with the outcome of the adjudication.
- The claiming system limits reimbursement for services rendered by county operated providers to an interim rate that DHCS sets.
- The claiming system does not limit reimbursement for services rendered by contract providers unless the county voluntarily chooses to set a limit.

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# UTILIZATION REVIEW AND QUALITY ASSURANCE – INTERIM PAYMENTS

- Mental health plans may claim interim federal reimbursement for the cost of performing utilization review and quality assurance functions required under the mental health plan contract.
- Complete the MH 1982 C manual claim form to request interim federal reimbursement for utilization review and quality assurance costs.
- The manual claim must be based upon actual costs.

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# OTHER ADMINISTRATION – INTERIM PAYMENTS

- Mental health plans may claim federal interim reimbursement for costs incurred to implement administrative requirements, other than utilization review and quality assurance activities, contained in the mental health plan contract.
- Complete the MH 1982 B manual claim form to request interim federal reimbursement for other administrative costs.
- The manual claim must be based upon actual costs.

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# INTERIM COST SETTLEMENT

- Interim cost settlement process and time frames
- Cost determination policies

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# INTERIM COST SETTLEMENT PROCESS AND TIME FRAMES

- Initial Submission – Mental health plans must submit a cost report package by December 31st following the close of the fiscal year.
- Reconciliation – Mental health plans must clear all errors and reconcile the Medi-Cal units of service to final adjudicated interim claims by the October 31st following the initial submission.
- Interim Settlement – DHCS must settle the reconciled cost report by January 31st following submission of the reconciled cost report.

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# MEDI-CAL COST DETERMINATION POLICIES

- Eligible Direct Costs
- Eligible Indirect Costs

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# ELIGIBLE DIRECT COSTS

- Direct costs are those costs that can be identified specifically with a particular final cost objective or can be directly assigned to such activities relatively easily with a high degree of accuracy (2CFR200.413)
- Final cost objective is a cost objective that has allocated to it both direct and indirect costs and is one of the final cost accumulation points (2CFR200.45).
  - Medical Assistance
  - Utilization Review/Quality Assurance
  - Other Administration

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# MEDICAL ASSISTANCE – OUTPATIENT SERVICES

- Mental Health Services (Title 9, CCR, Section 1810.227)
- Medication Support Services (Title 9, CCR, Section 1810.225)
- Crisis Intervention Services (Title 9, CCR, Section 1810.209)
- Therapeutic Behavioral Services
- Targeted Case Management (Title 9, CCR, Section 1810.249)

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## MEDICAL ASSISTANCE – DAY SERVICES

- Crisis Stabilization
- Day Treatment Intensive
- Day Rehabilitation

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## MEDICAL ASSISTANCE – 24 HOUR SERVICES

- Psychiatric Health Facility
- Crisis Residential Treatment
- Adult Residential Treatment
- Children's Crisis Residential Program

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# ELIGIBLE DIRECT COSTS OUTPATIENT SERVICES

- Outpatient medical assistance is typically provided through individual organizational units in the county (e.g., clinics) or through individual provider sites under contract with the county.
- If the sole purpose of the organizational unit or provider site is to provide outpatient medical assistance, all costs accumulated within that organizational unit or provider site may be directly assigned to the medical assistance final cost objective.
- If the sole purpose of the organizational unit or provider site is **not** to provide medical assistance, the costs accumulated within the organizational unit or provider site may not be directly assigned to the medical assistance final cost objective.

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# ELIGIBLE DIRECT COSTS DAY SERVICES

- All day services are provided at a specific site that is required to meet specific staffing requirements. Those sites do not also provide other services.
  - For example, there must be a clearly established site for day treatment intensive services and that site must meet specific staffing requirements.
- All costs accumulated within that site may be directly assigned to the cost of providing that day service.

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# ELIGIBLE DIRECT COSTS
# 24 HOUR SERVICES

- All 24 hour services are provided at a specific site that is required to meet specific staffing requirements.
  - For example, a crisis residential facility is required to have a specific site and it must meet certain staffing requirements to be certified.
  - The rate paid to these facilities covers the cost to provide all services except for targeted case management and medication support services.
- All costs accumulated in these sites, except for room and board, may be directly assigned to the Medical Assistance Final Cost Objective.
- The Mental Health Plan should use a time study, or similar methodology, to allocate costs to targeted case management and medication support services that are not included within the rate paid for the 24 hour service.

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# UTILIZATION REVIEW/QUALITY ASSURANCE
# MHP CONTRACT PROVISIONS

- Exhibit A – Attachment 5 – Quality Improvement System
- Exhibit A – Attachment 6 – Utilization Management Program
- Exhibit A – Attachment 9 – Documentation Requirements
- Exhibit A – Attachment 10 – Coordination of Care

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# ELIGIBLE DIRECT COSTS
# UTILIZATION REVIEW/QUALITY ASSURANCE

- If the county has designated one or more discrete organizational units within the county responsible to perform UR/QA activities required in the MHP contract, all costs accumulated within that organizational unit may be directly assigned to the UR/QA final cost objective.
- If UR/QA activities are performed in one or more organizational units that also perform activities in other final cost objectives, the mental health plan must allocate the costs accumulated in the unit among those final cost objectives.
- If the county can allocate those costs accurately and with relative ease, they may be directly assigned.

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# OTHER ADMINISTRATION

- Exhibit A – Attachment 3 – Financial Requirements
- Exhibit A – Attachment 4 – Management Information Systems
- Exhibit A – Attachment 7 – Access and Availability of Services
- Exhibit A – Attachment 8 – Provider Network
- Exhibit A – Attachment 11 – Information Requirements
- Exhibit A – Attachment 12 – Beneficiary Problem Resolution
- Exhibit A – Attachment 13 – Program Integrity
- Exhibit A – Attachment 14 – Reporting Requirements

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# ELIGIBLE DIRECT COSTS OTHER ADMINISTRATION

- If the county has designated one or more organizational units that are solely responsible for one or more other administrative functions required in the MHP contract, the county may directly assign those costs to this final cost objective.
- If these other administrative activities are performed in organizational units that also perform activities related to another final cost objective, the county must allocate the costs accumulated in the organizational unit among those final cost objectives.
- If the county is able to allocate costs accurately and with relative ease, the county may directly assign the allocated costs to the final cost objectives.

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# ALLOCATING COSTS BETWEEN MEDI-CAL AND NON MEDI-CAL PROGRAMS

- Utilization Review and Quality Assurance
- Other Administration
- Medical Assistance

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# UTILIZATION REVIEW AND QUALITY ASSURANCE

- Costs allocated to the UR/QA cost center need to be allocated between the Medi-Cal program and Non Medi-Cal programs.
- The county needs to identify appropriate statistics to allocate these costs to the Medi-Cal program and Non-Medi-Cal program.
- The county must maintain work papers showing how it allocated these costs for audit.

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# OTHER ADMINISTRATION

- Costs allocated to Other Administration must be allocated to the Medi-Cal program, MCHIP program, and Non Medi-Cal programs.
- The cost report instruction manual allows counties to choose from among three methods to perform this allocation.
  - Gross costs
  - Program beneficiaries
  - Relative value
- Counties must maintain their work papers demonstrating how it allocated these costs.

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# GROSS COSTS

- Identify the total service costs apportioned to each program (Medi-Cal, MCHIP, and Non Medi-Cal).
- Divide the service costs apportioned to each program by the sum of all service costs to calculate the allocation percentage for each program.
- Multiply the total costs allocated to the Other Administration cost center by each program's allocation percentage.

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# PROGRAM BENEFICIARIES

- Identify the number of encounters with a beneficiary in each program (Medi-Cal, MCHIP, and Non Medi-Cal).
- Divide the number of encounters in each program by the sum of all encounters to calculate the allocation percentage for each program.
- Multiply the total costs allocated to Other Administration by each program's allocation percentage.
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# RELATIVE VALUE

- Identify the total units of service, by service type, provided to beneficiaries in each program (Medi-Cal, MCHIP, and Non Medi-Cal).
- Multiply the total units of service for each service type by its usual and customary charge.
- Calculate the sum of the usual and customary charge across all service types for each program.
- Divide the sum of the usual and customary charges for each program by the sum of the usual and customary charge for all programs to calculate the allocation percentage.
- Multiply the total costs allocated to Other Administration by each program's allocation percentage.

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# MEDICAL ASSISTANCE

- Counties must allocate medical assistance costs to the mode of service and then the service type.
- The cost report apportions costs allocated to the service to specific Medi-Cal programs and all non Medi-Cal programs.
- Counties can directly assign costs to the mode level. Services at the mode level are provided at a designated site. For the most part, each site only provides one mode of services.
- The cost report instruction manual allows counties to choose from among three methodologies to allocate medical assistance costs from the mode level to the service type.
  - Cost determined at the service type level
  - Time study
  - Relative value

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# COSTS DETERMINED AT THE SERVICE TYPE

- Some counties may be able to directly assign costs to each individual service type.
- For example, day services and other 24 hour services are provided at a designated site, which makes it relatively easy to directly assign costs to those service types.
- However, all outpatient services may be provided at the same site, which makes it difficult to directly assign costs to each service type.

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# TIME STUDY

- Counties may use the results of a time study to allocate medical assistance costs to specific service types.
- For the mode of service (e.g., outpatient services) divide the hours identified with each service type by the hours identified across all service types within the organizational unit to calculate the allocation percentage for each service type.
- Multiply the total costs allocated to the mode of service by allocation percentage for each service type to allocate the costs.

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# RELATIVE VALUE

- **Step One**: Identify the total units of service for each service type within a mode of service.
- **Step Two:** Multiply the total units of service for each service type by the usual and customary charge for each service type.
- **Step Three:** Calculate the sum of the result in step two for each service type.
- **Step Four:** Divide the result in step two for each service type by the result of step three to calculate the allocation percentage for each service type.
- **Step Five:** Multiply the allocation percentage for each service type from step four by the total costs allocated to the mode of service.

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# APPORTIONING COSTS

- The cost report uses units of service to apportion costs allocated to each service type to specific Medi-Cal programs and to all Non Medi-Cal programs.
- The cost report calculates a cost per unit of service for each service type (Total Costs/Total Units of Service).
- The cost report multiplies the cost per unit by the total units reported with each Medi-Cal program (aka, eligibility group) to apportion costs to those Medi-Cal programs.
- The cost report multiplied the cost per unit by the total units reported as Non Medi-Cal units to apportion costs to Non Medi-Cal programs.

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