Mental Health Financial Reporting

California Institute for Behavioral Health Solutions (CIBHS)
Small County Fiscal Technical Assistance

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Medi-Cal Specialty Mental Health Reimbursement

• Counties contract with the State as the providers of specialty mental health services
  • Mental Health Plans (MHPs)

• Counties are responsible for providing or contracting to provide all Medi-Cal specialty mental health services
  • All Medi-Cal claims and cost reporting run through the county MHP
Medi-Cal Specialty Mental Health Reimbursement

• County Mental Health Plans (MHP) are reimbursed a percentage of their actual expenditures (Certified Public Expenditures-CPE) based on the Federal Medical Assistance Percentage (FMAP)
  • Same for all Medi-Cal Specialty Mental Health services except FFS/MC inpatient hospital services
• County MHPs are reimbursed an interim amount throughout the fiscal year based on approved Medi-Cal services and interim billing rates
  • Interim rates for contract providers represent amount paid by MHP to provider
  • Interim rates for county-operated providers should approximate actual costs
Medi-Cal Specialty Mental Health Reimbursement

- County MHPs and DHCS reconcile the interim amounts to actual expenditures through the year end cost report settlement process
- DHCS audits the cost reports to determine final Medi-Cal entitlement
  - Within three years after settlement
Purpose of Medi-Cal Specialty Mental Health Cost Report

• Primary purpose is to determine the net Medi-Cal entitlement (Federal Financial Participation-FFP) for each County Mental Health Plan

• Additional objectives are to:
  • Compute the cost per unit for each Service Function
    • Used to apportion costs between Medi-Cal and non-Medi-Cal services
  • Identify sources of funding
  • Serve as the basis for the local mental health agency’s year-end cost settlement, focused reviews and subsequent Medi-Cal Specialty Mental Health fiscal audit

• Should reflect cost of providing the services identified on the cost report
Overview of Medi-Cal Specialty Mental Health Cost Report

• County Mental Health Plan cost report consists of one summary cost report and detailed cost reports for each legal entity

• Summary Cost Report
  • Compiles data from all detailed cost reports
  • Report use of Mental Health Services Act funding
  • In prior years, report use of State General Fund monies

• Detail Cost Report
  • Contract providers and County providers
  • Used to determine FFP by legal entity
Medi-Cal Specialty Mental Health Detail Cost Report

- Report costs and revenues directly from County’s financial system
  - Make adjustments to reflect actual costs during fiscal year
  - Depends on structure of cost centers
- County excludes payments to contractors
- Adjustments based on Medicare principles of reimbursement
  - CBHDA Lobbying
  - Depreciation
  - Self-Insured Workers Compensation
  - CMS.GOV / Regulations & Guidance / Manuals / Paper Based Manuals/ PRM 15-1
- Report units of service directly from claims processing system
  - Total units and Medi-Cal units
  - Medi-Cal units should reconcile with State 835 file
Direct versus Indirect Costs

- Federal OMB Circular A-87 defines direct and indirect costs
  - DHCS Policy Letter 11-01
- Direct Costs
  - Costs that can be directly identified with a specific cost objective
    - Mental Health Services
    - Administration of the Mental Health Plan
    - Utilization Review
  - Direct costs are not necessarily the same as direct service costs
- Indirect Costs
  - Costs that are incurred for a common or joint purpose benefiting more than one cost objective
  - Often costs incurred because of being the County versus being the County Mental Health Plan
    - Legal
    - Human Resources
    - Procurement
Medi-Cal Specialty Mental Health Detail Cost Report

- County identifies direct costs by cost center
  - Mental Health Services (Non-Hospital Mode Costs)
    - Costs of clinics
  - Administration of the Mental Health Plan (Administrative Costs)
    - Outreach
    - Eligibility intake
    - Contract administration
    - Program planning and policy development
    - Administrative case management
    - Claims administration
    - Medicaid management information system development and operation
  - Utilization Review Costs
Medi-Cal Specialty Mental Health Detail Cost Report

• Administrative costs are separated into Medi-Cal, Healthy Families, MCHIP, non-Medi-Cal and Continuum of Care Reform based on one of three methods:
  • Percentage of program beneficiaries of the population served by the county
  • Relative values based on units and charges
  • Gross costs of each program
• Utilization review costs are separated into SPMP, non-SPMP Medi-Cal and non-Medi-Cal
• Direct service costs are allocated to modes and then service functions
Medi-Cal Specialty Mental Health
Detail Cost Report

- Costs are apportioned between Medi-Cal and non-Medi-Cal based on units of service
- Total Medi-Cal costs are compared to charges to determine gross Medi-Cal reimbursement
  - Aggregate comparison
  - Inpatient reimbursement computed separately from non-Inpatient reimbursement
  - County legal entities are entitled to actual costs
Medi-Cal Specialty Mental Health Detail Cost Report

- Medi-Cal administrative costs limited to no more than 15% of Medi-Cal direct service costs
  - Direct service costs include contract provider Medi-Cal direct service costs
  - Inpatient direct service costs include gross payments to FFS/MC hospitals
- Total costs and total funding are reported on MH1992
Medi-Cal Specialty Mental Health Summary Cost Report

• Provides roll up of county and contract provider data
  • Make sure all files follow the naming convention listed in the instructions.
  • Keep all Cost Reports from County and Contractors together in the same file – Clear of any other files to ensure a clean run.
  • Compute Summary – Auto populates the data from all the other cost reports

• Additional data
  • MHSA funding

• County certification
Medi-Cal Specialty Mental Health Cost Report Settlement

• Submit initial cost report ("B" file) by December 31 following the close of the fiscal year
  • Total costs and total units need to be accurate
  • Does not result in any settlement payments
• Counties clear cost reports of all errors and DHCS provides the County with an "F" file that starts the reconciliation/settlement process
• Counties have 90 days to make changes to the “F” file
  • Medi-Cal units of service
  • Revenues
• Amount paid by DHCS for services provided during the fiscal year as well as administration and utilization review activities is compared to amount determined through cost report “F” file to compute balance owed or due county
  • Does not compare State units of service to County units of service
Medi-Cal Specialty Mental Health Cost Report Settlement

- Counties receive settlement payment when:
  - Cost per unit exceeds the interim rate per unit
  - County includes more Medi-Cal units than DHCS has paid
  - County did not fully claim for Medi-Cal Administration and/or Utilization Review

- DHCS has indicated the following settlement dates (Information Notice 18-026):
  - 1/31/19 – FY11/12 and FY12/13
  - 6/28/19 – FY13/14 and FY14/15
  - 12/13/19 – FY15/16 and FY16/17
  - 2/28/20 – FY17/18
Medi-Cal Specialty Mental Health Cost Report Audit

• DHCS audits cost report within three years of submission of the “F” file cost report (i.e., amended cost report)
  • Welfare and Institutions Code Section 14170(a)(1)

• Units of Service
  • Must be supported with County records
  • DHCS uses lowest of County records or State records for each service function and Medi-Cal program (Medi-Cal, MCHIP, ACA, etc.)
Medi-Cal Specialty Mental Health Cost Report Audit

• Allocation of administrative costs between Medi-Cal and non-Medi-Cal
• Allocation of indirect costs to SPMP utilization review
  • DHCS Policy Letter 05-11
• Allocation of direct service costs to modes and service functions
  • Costs identified as treatment mode of service costs must generally have a correlation with treatment units of service
• No off-setting revenue when reporting Medi-Medi units of service
MHSA Revenue and Expenditure Report

- Counties are required to submit an Annual MHSA Revenue and Expenditure Report (ARER) by December 31 following the close of the fiscal year
  - California Code of Regulations Title 9, Section 3510
- DHCS has issued the template and instructions on an annual basis
  - Proposed DHCS regulations would reference in regulations the forms for the MHSA ARER
- DHCS withholds 25 percent of future distributions if county doesn’t submit a complete and accurate ARER by December 31
  - Included in proposed DHCS regulations
MHSA Revenue and Expenditure Report Purpose

• Identify the expenditures of MHSA funds provided to each County
• Quantify additional funds generated as a result of MHSA programs
• Identify unexpended funds, and interest earned on MHSA funds
• Determine reversion amounts, if applicable, from prior fiscal year distributions
• Allows for the evaluation of all of the following:
  • Children’s systems of care
  • Prevention and early intervention strategies
  • Innovative projects
  • Workforce education and training
  • Adults and older adults systems of care
  • Capital facilities and technology needs
• Report expenditures on veterans beginning in FY18/19
MHSA Revenue and Expenditure Report

• All MHSA expenditures must be consistent with the County’s approved MHSA Three-Year Program and Expenditure Plan, Annual Update or other update
• Report total cost for each program/project within each component
  • Including costs reimbursed with non-MHSA revenues
• Generally want to complete Medi-Cal Specialty Mental Health cost report first in order to determine Medi-Cal associated with MHSA programs and activities
MHSA Revenue and Expenditure Report

• For each component, costs are reported separately for planning, evaluation and administration
  • For Innovation, costs are reported for each project’s administration and evaluation
• Transfers to a Joint Powers Authority (JPA) are reported as well as expenditures incurred by the JPA
  • Funds are not considered expended until the JPA incurs an expenditure
• Report transfers between CSS and other components
• Report transfers from CSS to the prudent reserve
• Costs are reported by program/project/funding category
MHSA Revenue and Expenditure Report

• Allows for adjustments to prior year MHSA expenditures and/or Medi-Cal reimbursement

• Do not report MHSA distributions
  • No longer identify unspent funds on the ARER

• DHCS calculates reversion based on expenditures and interest reported on ARER and distributions reported by State Controller’s Office on a case basis
  • [https://www.sco.ca.gov/ard_payments_mentalhealthservicefund.html](https://www.sco.ca.gov/ard_payments_mentalhealthservicefund.html)
MHSA Reversion Process

• DHCS proposed regulations specify the reversion process associated with the MHSA ARER
  • https://www.dhcs.ca.gov/formsandpubs/laws/regs/Pages/DHCS-16-009.aspx
  • DHCS determines amount of reverted funds within 30 days of receipt of a complete and accurate ARER
  • County has 30 days to appeal
  • DHCS notifies county within 45 days either approval or disapproval of the appeal and the reason(s) for the decision
MHSA Audit Issues

• Non-Supplant (CCR Section 3410)
  • Expand services beyond what was in existence on November 2, 2004
  • Cannot supplant funding required to be used for services and supports in FY 2004-05
  • Cannot be used for costs associated with inflation for programs and/or services in existence on November 2, 2004

• Show how expenditures relates to approved MHSA Plan
  • Should not be limited to budget amounts in approved MHSA Plan except for Innovation projects

• Be cognizant of reversion

• Identification of other revenues