



**OFFICE OF MENTAL HEALTH AND SUBSTANCE  
ABUSE SERVICES BULLETIN  
OFFICE OF MENTAL RETARDATION BULLETIN**

COMMONWEALTH OF PENNSYLVANIA \* DEPARTMENT OF PUBLIC WELFARE

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SUBJECT

Cost Settlement Policy and Procedures for Community-Based Medicaid Initiatives

BY

Joan L. Erney, J.D.

Deputy Secretary for Mental Health and Substance Abuse Services

BY

Kevin Casey

Deputy Secretary for Mental Retardation

**SCOPE:**

**County Mental Health & Substance Abuse/Mental Retardation Administrators  
County Mental Health & Substance Abuse/Mental Retardation Fiscal Officers**

**PURPOSE:**

**To set forth policy and procedures for cost settlement activity associated with Medicaid initiatives for mental health & substance abuse services and mental retardation community-based services.**

During Fiscal Year 2002-2003, OMHSAS approved rate exceptions of the Department established fees. OMHSAS policy did not allow rate exceptions to continue in 2003-2004. If the county elected to reimburse the provider at a higher rate than the Department's established fee, the county was responsible for the difference. Ms. Erney's letter of May 16, 2003 describes these requirements.

**BACKGROUND:**

To date, the Office of Mental Health and Substance Abuse Services (OMHSAS) and the Office of Mental Retardation (OMR) have received Federal approval of an amendment to the State Medicaid Plan allowing payments on behalf of persons eligible for Medicaid for the following services:

- o MH – Intensive Case Management (ICM)
- o MH – Family-Based Mental Health Services (FBMH)
- o MH – Mental Health Crisis Intervention Services (CI)
- o MH – Resource Coordination (RC)
- o MR – Targeted Services Management (TSM)

Information specific to those counties under HealthChoices for Mental Health and Substance Abuse Services is contained in Attachment 4.

This Bulletin obsoletes Bulletin Numbers OMH-94-06, OMH-95-10, OMH-96-03, OMH-97-04, OMHSAS-99-03, OMHSAS-99-07, OMHSAS-00-02, OMHSAS-01-05, OMHSAS-02-03 and OMHSAS 03-02.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Bureau of Financial Operations, Financial Reporting & Payments Section, Mental Health and Mental Retardation Unit (717) 787-3760

As of July 1, 1995, the Office of Mental Health and Substance Abuse Services made Mental Health Crisis Intervention a Department established fee.

As of July 1, 2000, the Office of Mental Health and Substance Abuse Services made the following services Department established fees:

- Intensive Case Management
- Family-Based Mental Health Services
- Resource Coordination

Therefore, as indicated in the PA Code Title 55 Chapter 4300, these services will no longer be subject to the cost settlement requirement that previously existed. During Fiscal Year 2003-2004, no rate exceptions were approved that would allow a provider of service or a county acting as a provider to bill PROMISE for a rate higher than the Department established fee. Although the cost settlement process no longer applies, prior year audit adjustments should still be made following the procedures described here for OMHSAS programs and for OMR's Targeted Services Management. In the event your county has an exception, cost settlement would then be necessary. This would not apply if your county is funding the difference out of county funds or the OMHSAS grant allocation as defined in Ms. Joan Erney's May 16, 2003 correspondence. Please contact your regional OMHSAS representative if you have questions.

The county program determines service delivery systems as county-operated or contracted with independent providers. Providers and/or counties are required to adhere to all productivity standards and governing regulations as applicable to each service activity. With contracted services, the county program negotiates rates eligible for Federal Financial Participation (FFP) for each specific service to be funded as per the county's annual plan. All rates are based upon estimated costs for each service; therefore, subject to cost settlement. Since cost settlement impacts on two (2) distinct funding mechanisms supporting these services, the reconciliation process uniformly captures adjustments specific to advanced State Grant funding and Federal reimbursements accrued through direct invoicing of PROMISE. **In order for cost settlement to work properly, reporting of Federal Medicaid revenues must be on the accrual basis reflective of billable units of service rendered during the fiscal reporting period.**

#### PROCEDURE:

The **Cost Settlement Report (CSR)** implemented in this Bulletin serves as the vehicle to capture the interim reconciliation to actual costs for community-based Medicaid initiatives based upon accrued expenditures and accrued Medicaid revenues for each service activity. **CSRs** must be completed by the county program operating as the provider of service and by all independent contractors for each service activity within each fiscal reporting period. The CSR must be completed when a reimbursement rate has been negotiated and approved and when FFP has been received. The **CSR** is designed to compare overall accrued expenditures eligible for DPW State/Federal participation to combined DPW State/Medicaid accrued revenues. This approach eliminates the need to cost settle to multiple interim rates negotiated for a particular service activity within any given fiscal reporting period. This **CSR** should be incorporated as an essential component of the county program's existing fiscal year closing activity, with results ultimately represented on the Annual Income and Expenditure (I&E) Report for the preceding fiscal reporting period.

The county MH/MR program is responsible for the following:

1. Completion of **CSRs** for community-based Medicaid initiative service activities that are county-operated;
2. Review and approval of **CSRs** for community-based Medicaid initiative service activities that are contracted with independent providers;
3. Completion of the **Cost Settlement Summary**;
4. Submission of the **Cost Settlement Summary** and supporting **CSR** documents for service activity to the Department of Public Welfare, Bureau of Financial Operations for the preceding fiscal reporting period;
5. Reporting of expenditures, Medical Assistance revenues and DPW participation on the Income and Expenditure Report Schedule MH/MR 16 that is reflective of interim settlements for both service delivery systems;
6. Authorization in writing of the state matching funds available to satisfy underpayment settlements;
7. Collection of State grant fund overpayments and payment of additional State grant funds when available to satisfy settlements as necessary with contracted providers; and
8. Comparison of the budgeted units identified in the rate setting process to the actual units provided and reported on the **CSR**. **If the actual units reported are less than the estimated budgeted units, a narrative must be submitted as part of the cost settlement package which details the reasons why the productivity standard was not met.** This information will be supplied to the appropriate Program Office for their review. Assistance may be offered by the Program Office when indicated.

Specific instructions for completion of the **CSR** and the **Cost Settlement Summary** are provided in this Bulletin. Also provided is a document flow chart to illustrate the process.

Upon receipt of the county program's **CSR** report package, the Bureau of Financial Operations will verify the information. If a discrepancy is identified, immediate contact will be made with the county program. The Bureau of Financial Operations will provide written notification to the county program of all PROMISE adjustments initiated. This information will be provided simultaneously to the Office of Mental Health and Substance Abuse Services and/or the Office of Mental Retardation, whichever program office is applicable.

#### INTERIM SETTLEMENTS:

The interim settlement will be based upon accrued expenditures and revenues. The results are ultimately represented on the Annual Income and Expenditure Report for the corresponding fiscal period in which services were rendered. **NOTE: MR Targeted Services Management rate setting does not contain a Non-MA (Non-FFP) component. Therefore, TSM costs, not overall Case Management costs, should be utilized for Cost Settlement. (Please refer to CSR Instructions, Attachment 2, Page 6 for specific instructions.)**

### Overpayments

Federal Portion: The service provider will have a credit (negative balance) applied to the PROMISe provider file to satisfy the Federal portion of the claim. This is accomplished through a Gross Adjustment request initiated by the Bureau of Financial Operations to the Office of Medical Assistance Programs. The overpayment credit will be offset against active invoices in PROMISe.

State Portion: The county program is responsible to collect State overpayments from the contracted providers. State overpayments may be represented as those State match funds utilized for Federal Financial Participation (FFP) and/or 100% State funds ineligible for Federal Financial Participation (Non-FFP).

### Underpayments

Each individual county administrative unit will determine through fiscal year closing activity if additional State funds are available within their **existing** allocations to meet (full or partial) actual costs for providing services. In this instance, all units subject to retroactive settlement **(both MA eligible (FFP) and Non-MA eligible (Non-FFP) must be reimbursed at the same level for any given period of time within the fiscal year.)** Reimbursement cannot discriminate between federally funded and non-federally funded services. Federal funds utilized for the reimbursement of an underpayment for MA eligible services require verification of (and are limited by the availability of) a lump sum State match. **A State Match Verification (SMV) must accompany the CSR.** If no State dollars are available from the county program, no additional Federal dollars may be obtained. If the adjustment to FFP is due to productivity not meeting the established standard, the justification should be reviewed and incorporated into the county's decision. The County must determine if they can support the adjustment with available state match.

Federal Portion: The service provider will have a debit (positive balance) applied to the PROMISe file, via gross adjustment, to generate the Federal portion due in a lump sum. This payment will be identified on a future Remittance Advice. For gross adjustments, the appropriate state match must be reported to provide for an adjustment to federal payments.

State Portion: The provider is reimbursed in a lump sum by the county with State funds, as determined available within the county program's existing allocation.

**Restriction:** Requests for additional payments to support MR TSM services, which are MA reimbursable, will be subject to the OMR review and approval.

### FINAL SETTLEMENTS:

All documentation supporting the information reported by the county programs should be held for a minimum of four (4) years after the close of the fiscal reporting period, or until all related settlement issues have been resolved by the Department, whichever is later. Community-based Medicaid initiative cost settlement procedures as described in this Bulletin will be referenced in the Department of Public Welfare's Single Audit Supplement. The county program is responsible for (1) determining any variances between interim and final schedules, (2) reporting changes to State grant funding and (3) requesting PROMISe gross adjustments. All of these are processed through the next available Annual Income and Expenditure Report submitted to the Department.

To facilitate these determinations, the Department requires that county programs include the CSR as a required supplemental schedule for independent audits received from contracted service providers. The county programs are now required to submit the final CSR (based on audited information) to the Department when processing final actions. If requesting an underpayment be sure to include the SMV section, found on the second page of the CSR.

### Criteria for Satisfying Final Settlements

#### Overpayments

Any variance between the interim and final CSR, which results in an overpayment, must be satisfied. The corresponding Federal and State portions will be collected in the same manner as described for interim settlements.

#### Underpayments

In accordance with Title 55, Chapter 4300.147, Deficits, current year Department allocated funds may not be utilized to pay for a deficit incurred during a prior period without the approval of the Secretary of Public Welfare. Therefore, variances between the interim and final CSR reflecting an underpayment can be satisfied; however, **only up to the maximum amount of available State grant funds that were reported as unexpended in that prior period and budgeted for within the current fiscal reporting period.**

### Procedure for Reporting Prior-Year Adjustments

When the county program operates as the provider of service, reporting of final State grant funding and Federal participation adjustments must occur through the County Single Audit.

When the county program contracts with independent providers, the county administrative unit is responsible to report State grant funding and Federal participation adjustments resulting from service provider audits as prior-year adjustments on the next available Annual Income and Expenditure Report. **Funding of Program Services Schedules, MH 15 and MR 15, Columns 6a and 6b, has been revised to isolate all prior-year audit adjustments related to cost settlement of Medicaid-initiative services.** Detailed instructions on the reporting of prior year adjustments will be contained in the I&E instruction package.

**Attachment 1. Cost Settlement Document Flow**

**Attachment 2. CSR Form and Instructions**

**Attachment 3. Cost Settlement Summary**

**Attachment 4. Instructions pertaining to counties operating under Health Choices**