CHAPTER 9: Site Budget and Claims Reimbursement

Policy: Individual site contracts with CDA cover funding, budgets, slots, and billing. The language in the contract is controlling and should always be consulted regarding these issues.

Purpose: This chapter provides minimum standards for establishing a system to assure financial accountability of the program, and to ensure the appropriate utilization of fiscal resources.

References:

- CDA Standard Agreement (Site Contract).
- Home and Community-Based Services Waiver #0141.R07.00, Appendix I: Financial Accountability.

9.000 Budget

Each line-item budget is incorporated into their contract with CDA. The budget reflects the combination of Federal Title XIX funds matched with State general funds.

9.010 Budget Categories

MSSP site budgets are separated into three general types of expenditures:

- Care Management (CM): Line items listing each individual care management staff person, their full-time equivalency (FTE), and their salary and benefits.
- Care Management Support (CMS): Line items listing administrative staff information and detailed operating expenses that support care management functions.
- Waiver Services (WS): One line listing the total amount budgeted for the total Waiver Service funds.

It is the site's responsibility to monitor expenditures by category to make sure they do not overspend in any category unless it is their intent to supplement using local resources.

9.020 Budget Changes

Changes to a budget can be accomplished in one of two ways:

1. A formal amendment to the contract is required for any change (increase or decrease) to the total amount of the budget.
2. Submission of a revised budget. Subject to certain restrictions, funds can be moved between the categories of Care Management (CM), Care Management Support (CMS), and Waiver Services (WS).

   Budget revisions are necessary during the Fiscal Year to align program operations (CM & CMS) that have a variance greater than 5% from the anticipated expenditure categories on the approved budget. Budget revisions

should be submitted in a timely manner to allow for rate adjustments to be implemented thereby aligning expenditures and receivables by category.

Movement of funds out of Waiver Services is **not** permitted without approval from CDA. Formal procedures to request movement of funds out of WS must be followed. Movement of WS funds may be One Time Only (OTO) for unforeseen circumstances or as a permanent reduction in WS levels. Sites should contact CDA to confirm required criteria.

OTO requests may be submitted during the 4th Quarter of the fiscal year and must provide the following:

- Detail as to the nature of the unforeseen circumstance;
- The specific amount of WS to be moved;
- Description of other cost savings being implemented; and
- Proposed method for leveraging the cost in the next FY.

The OTO request must be accompanied by a revised budget and include the projected new maximum threshold for CM and CMS.

A Request for Permanent Reduction for WS level can be submitted at any time and must include description of other cost savings that have been implemented, new resources that are in place, and declaration that the level of services to the participants are not impacted. The request must be accompanied by a revised budget and include the projected new maximum threshold for CM and CMS. CDA will review the request using a three year 'look back' of the site's operational performance prior to providing a response. Additional information may be requested by CDA.

A site may submit a budget revision at any time to align the CM and CMS categories. Requests to move funding between CM and CMS categories **must** be in writing and align with MSSP procedural requirements.

9.030 Reimbursement Process

MSSP is a reimbursement program with defined budget categories. The site submits claims to capture the allocated funds by category each year. There are three categories for claims reimbursement:

- Care Management (CM)
- Care Management Support (CMS)
- Waiver Services (WS)

Care Management (CM) and Care Management Support (CMS)

CDA sends formal correspondence to the site at the beginning of the fiscal year advising of the **maximum threshold** for both CM and CMS. These are calculated by CDA using figures from the site's approved budget and the contracted caseload level.

Each site submits claims electronically and utilizes a software system of their choosing. The site sets the billing levels (rates) in their system and should enter the amount to align with the actual enrollment levels, without exceeding the maximum threshold. **During the year, sites must continue to monitor enrollment levels, tracking expenditures and receivables to ensure they align by category.**

If the site needs to increase the CM and/or CMS rates **above** the maximum threshold, a request must be submitted to CDA. In some instances a budget revision may be indicated.

CM and CMS are billed monthly on each active eligible participant over the twelve months of the fiscal year. CM and CMS may be billed upon the close of the month and separately from WS purchases. Sites are responsible to monitor billing to make sure the billed CM and CMS does not exceed funding by category.

Waiver Services (WS)
Waiver Service funds are used for services and products purchased for participants. At the start of the budget process, CDA sends formal correspondence to each site confirming full contract amount and the specific amount that has been designated for Waiver Services. In preparing the budget, the site enters the Waiver Service amount on the corresponding line. These funds are accessed on a reimbursement cycle as purchases are completed. The billed amount must match the purchase price and be supported by an invoice or bill of sale that links the service/item to the participant.

Specific costs for services and/or items are established by each site through their vendor contracting process and **maximum** billable amounts are listed on the **Site Rate Sheet** (Chapter 8, Section 8.400, Vendor Rates, and Appendix 44). The amounts on the Site Rate Sheet for a service or item should be equal to or greater than the **maximum** contract vendor rate.

It is the responsibility of the site to monitor the expenditures and receivables by category to make sure the CM and CMS billed claims and receivables are drawing down the funds appropriately. Likewise, it is the responsibility of the site to have a system in place to monitor the WS category for even distribution of expenditures over the fiscal year while maximizing use of the available funding for the participants.

Historically, all participants have been Fee for Service (FFS) with claims submitted for reimbursement following the month of service. With the advent of the Coordinated Care Initiative (CCI), there were different requirements for payment and data reporting that were detailed within the contracts between sites and health plans for health plan members that are MSSP participants. Effective January 1, 2022, all MSSP sites are FFS.

9.030.1 Threshold Rate Change Requests

Requests to increase the rate threshold must be made in writing to MSSPService@aging.ca.gov and should include the following:

- HCPCS Code;
- Service Code;
- Service Description;
- Unit Type;
- New threshold amount; and
- Effective date for billing.

Changes for CM & CMS may necessitate an explanation and revised budget.

The process for rate adjustments may take several weeks. The site must **not** commence billing at the new rate until formal confirmation is received from CDA.

Sites do not need to request reductions to the amounts listed on the Site Rate Sheet as those are **maximum thresholds.** At any time the site can reduce the amount billed to align with the enrollment levels and the amount of funding available for the month for the categories of CM and CMS.

9.040 Slot Allocations and Enrollment Levels

A participant slot means a position, whether vacant or filled, which is funded according to a site's budget and allocated for a participant during a given month. CDA provides funding and participant slot allocation amounts to individual sites at the beginning of the contract cycle. The number of slots allocated to a site determines the contracted funding amount, grant uploads, and advance amounts.

Sites shall maintain a caseload of no less than 95 percent and no more than 105 percent of the specified number of participant slots for the 12-month fiscal year. CDA will track this through monthly and quarterly reporting. If the site's active participant count falls below the ninety-five percent (95%) of the contracted caseload for three (3) consecutive months, the site shall be required to submit an enrollment plan for review, approval, and monitoring by CDA. If the site is unable to demonstrate improvement and make progress to the required enrollment level, CDA may, upon written notice, decrease the site's total caseload, and return the excess slots to the State for redistribution to other sites and communities of need. Nothing in this section shall be read to prohibit the site, upon a subsequent change in circumstances and demonstration of a legitimate business need, from requesting an adjustment to their slot allocation amounts as set for in section 9.040.1 below.

9.040.1 Slot Allocation Change Requests by Sites

CDA has the authority to adjust slot allotments for individual sites during the contract cycle process. Sites with a legitimate business need may request adjustments to their slot allocation amounts.

1. Voluntarily Relinquishing Slots:
   At any time and for any reason, a site may voluntarily request to return slots in increments of 10, preferably 40 (full caseload).

2. Request for Additional Slots:
   A site operating at 95% enrollment or higher may request additional slots. The site may request slots in increments of 40 (full caseload).

A site may initiate the slot change request process by notifying CDA in writing. The written request must include:

- The requested change amount;
- The reason for the request including explanation of community needs; and
- An explanation with timeline of how the site will reach and maintain compliance of 95% enrollment or above while meeting the need for MSSP services in their community.

In the event of waiver or legislative geographic expansion, any site considering assisting with serving an additional county will be required to provide details about how they will serve the expanded county and community as part of their request for additional slots. Geographic consideration for cross-county expansion will include:

- Existing business presence in the identified county, including staffing, office space and/or established footprint and existing provider relationships
- Contiguous proximity to the identified county preferred

If slots are available, CDA will notify the site of its determination within 60 days. CDA's decision is final. A site may submit a total of two requests for additional slots in a single calendar year.

9.100 Claims Billing/Reimbursement

Claims are to be coded and submitted for payment in accordance with the reimbursement methodology and processes set forth in the Waiver including:

1. All MSSP participants are Medi-Cal eligible.

2. Claims submitted for each participant are run through the California Medi-Cal Management Information System (CA-MMIS) to check for Medi-Cal eligibility prior to payment.

3. Individuals served by MSSP may either reside in the community, or be in their last 180 days of stay in a hospital or nursing facility and pending discharge into the community. For those in an institution, program eligibility is not finalized, and billing cannot occur until the discharge action is implemented.

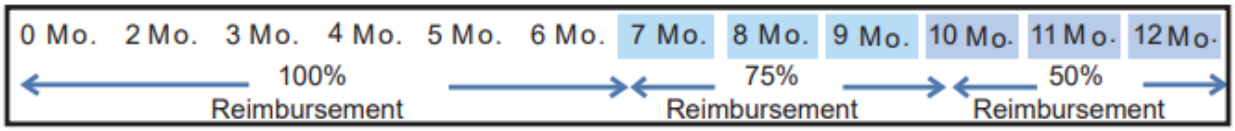
4. All billed services are identified in an approved care plan.

5. Vendor claims must be verified by the primary care manager against the care plan prior to payment to vendors by the site.

9.110 Billing Process

Billing is completed electronically. Sites select software for electronic billing and contract directly with the software provider. Reimbursement for Fee for Service participants is provided through the fiscal intermediary contracted by Medi-Cal.

Sites must follow current Medi-Cal billing procedures. Claims must be received by the fiscal intermediary within six months following the month in which services were rendered, in order to receive 100% reimbursement.



For non-institutionalized participants (home one day during the month), each site prepares a monthly billing for services provided to each participant. The bill is submitted electronically to the Medi-Cal fiscal intermediary that edits the claim, pays it under the HCBS Federal Financial Participation (FFP) rate, and includes the participant, service and payment data in CA-MMIS.

Services for **institutionalized individuals** are billed as follows:

For those individuals who are discharged into the community as planned, the cumulative total of care management and care management support services received while in the institution is billed and paid as a special single unit of Deinstitutional Care Management (DCM) under the HCBS FFP rate. This billing cannot occur before the person leaves the institution and is enrolled in the Waiver.

Sites can bill for Care Management (CM) and Care Management Support (CMS) services once in each month for each individual. **Do not** bill these services to **both** DCM **and** the Waiver in the same month. For individuals receiving DCM services that subsequently qualify for and are enrolled in the MSSP Waiver, the CM and CMS services the month in which enrollment occurs should be billed under the Waiver as a regular MSSP participant and not included in the DCM billing.

For example:
The participant began receiving DCM services July 7, 2025. The participant was discharged from the nursing facility on September 18, 2025. The participant was enrolled in MSSP on September 18, 2025.

- DCM Billing: CM and CM Support services for the months of July and August are billed under DCM, along with any Waiver Services purchased (billed separately) prior to discharge.

- MSSP Billing: CM and CM Support services for September are billed to MSSP as a regular MSSP participant and not included in the DCM billing.

9.120 Reimbursement & Remittance Advice Details (RADs)

The fiscal intermediary provides Remittance Advice Details (RADs) to sites with payment for services billed. RADs can be downloaded in an online PDF format from the Provider Portal. RADs document the reimbursements itemizing the billed services by participant. If any service(s) submitted to the fiscal intermediary for payment is reduced or denied, there will be an entry providing a denial code. Explanations for the denial codes are listed on the RAD. It is the responsibility of the site to reconcile the RADs to the billed services.

All denials should be reviewed to ascertain the reason for the denial. If the RADs are maintained by the fiscal department, the Site Director or SCM should be provided copies to evaluate the nature of the denials and assess if any of the denials require further evaluation.

The fiscal intermediary does **not** monitor reimbursements by category. It is the site's responsibility to monitor expenditures and receivables by category to ensure the approved budget amounts are not exceeded. This is especially critical for CM and CMS due to fluctuations in enrollment levels. In the event the site overbills by category, it may be necessary to return the funding through the Medi-Cal CIF (claims information form) process or following the CDA fiscal audit.

Reimbursements must be supported by expenditures and should align with the approved budget by category. This provides the foundation for the Closeout process for the Fiscal Year.