January 5, 2022

To Whom it May Concern:

There are a few questions and concerns regarding the Intergovernmental Transfer (IGT) process identified to fund CSCT.  Please accept this letter as an attempt to answer these questions.

IGT’s are expressly approved as a means for states to leverage federal funding.  It is true that they have been questioned, however except for cases where they have been used to fund Supplemental Payments (payments to providers not tied directly to services provided to individuals), the strategy remains viable.  For reference, I’d point to the report Medicaid: Primer on Financing Arrangements (<https://www.gao.gov/assets/710/708283.pdf>), submitted in July of 2020, by the U.S. Government Accountability Office (GAO). On page 9, Figure 4 (below) the report identifies the use of the IGT for County Hospitals, resulting in a funding mechanism identical to the one being used for CSCT.

The only rule cited controlling these transactions is that the IGT transfer cannot be greater than nonfederal share of the Medicaid payment amount, i.e., the transfer from the OPI to DPHHS cannot be more than 35%.  **As clearly laid out by the GAO, these types of mechanisms are not fraudulent.**  The approval of our State Plan Amendment (SPA) identifying the IGT for CSCT is in accordance with precedent.  Please note that, even in the states that used the IGT’s for Supplemental Payments, the response from CMS was phase these payments out, rather than cut them off.

There was some discussion of Medicaid payments resulting in Federal Single Audits because of being over the $750,000 expenditure threshold, or that they may be treated differently by state auditors.  **Medicaid payments are exempted under the Single Audit Act**:

The Single Audit Act at 31 U.S.C. § 7501(a)(5) exempts from the definition of “Federal financial assistance” amounts “received as reimbursement for services rendered to individuals in accordance with guidance issued by the Director [of the Office of Management and Budget (OMB)].” The definitions in Circular A-133 at § \_\_\_\_.105 recognize this exception by also excluding from the definition of “Federal financial assistance” “amounts received as reimbursement for services rendered to individuals as described in §\_\_\_.205(h) and §\_\_\_.205(i).” Sections \_\_\_\_.205(h) and (i), in turn, state as follows:

(h) Medicare. Medicare payments to a non-Federal entity for providing patient care services to Medicare eligible individuals are not considered Federal awards expended under this part.

(i) Medicaid. Medicaid payments to a subrecipient for providing patient care services to *Medicaid eligible individuals are not considered Federal awards expended under this part unless a State requires the funds to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis.* (italics mine)

**Districts have historically received Medicaid dollars for services well over $750,000 with no additional audit requirements.**  For example, in FY2020, the Billings Public School District received nearly 3.5 million dollars in Medicaid services (<https://resources.finalsite.net/images/v1616002598/billingsschoolsorg/v0obnyhrh7xqowiitvuz/BillingsPublicSchools2020FinalReport.pdf>, pg 156).  Notice that the funds were classified as “State Medicaid Funds”, not Federal.  In the Missoula Public School District, their FY2020 audit identified Medicaid revenues as dropping by nearly 2 million, or 43%, suggesting that the amount of Medicaid dollars they brought in the previous year was also over 3 million (<https://www.mcpsmt.org/cms/lib/MT01001940/Centricity/Domain/3972/Final%2006%2030%2020%20FS.pdf>, pg 10).

Presumably, the largest proportion of this was for CSCT services, however Medicaid may pay a district directly for a variety of services, including the following:

* Therapy services (physical therapy, occupational therapy, speech language pathology)
* Audiology
* Private duty nursing
* School psychology and mental health services (including clinical social work and clinical professional counseling)
* Comprehensive School and Community Treatment (CSCT)
* Personal care (provided by paraprofessionals)
* Other diagnostic, preventative and rehabilitative services
* Specialized transportation
* Orientation and Mobility Specialist services (for blind and low vision)

Each of the services above have overhead costs.  It seems to be a stretch that suddenly the dollars directly related to CSCT, due to the IGT, would be treated differently.  In the audit of the Billings School district, there are no footnotes or comments on how these dollars were allocated or spent.  The Missoula audit only notes the decrease in Medicaid revenue and their impact on Program Revenues overall.

**Districts have been attesting to 35% overhead costs since the inception of the CSCT program, with no questions raised by either the OPI or any auditor.**  Identifying these costs as questionable today, means that districts have been misrepresenting their overhead for several decades.  **I do not believe this to be the case.**

To our knowledge, there has also been no additional auditing of costs and revenues associated with the County Ambulance Services that are currently funded via an IGT in Montana.  While a County Hospital (GAO example), County Ambulances (MT IGT example) and a School District are distinct entities, both receive state and federal funding for services, and both are publicly owned.  Neither can make a “profit”.  However, both can generate reserves for operating or to use revenues from different sources to meet their needs.  **Past audits have identified the ability for districts to retain these dollars for future use.** As an example, in the 2019 Missoula Public School Audit, conducted by Anderson Zuhrmuelen (AZ), page 8, 4th paragraph, AZ specifically states “These other revenue streams include items like indirect cost revenues, Medicaid Administrative Claiming and Medicaid Direct Billing revenues which can be preserved and utilized in future years when needed.” (<https://www.mcpsmt.org/cms/lib/MT01001940/Centricity/Domain/3972/Final%2006%2030%2019%20FS.pdf>, pg 8)

In the end, despite the Montana Legislature assigning to the OPI the authority to fund the IGT, the ultimate responsibility for the IGT process lies with the Medicaid authority.  DPHHS is obligated to follow CMS rules regarding the use of the IGT.  They have laid out the process in our SPA, and the process was approved**.  DPHHS holds the risk if the IGT process does not follow the rules, not the OPI.**  Montana is not the only state using the IGT process in schools.  According to our information, Florida and Louisiana use the strategy in the schools, and possibly Indiana.

In response to the suggestion that the OPI would like to push towards a Certified Public Expenditure (CPE) model to fund CSCT**, a CPE model has significantly more risks than the IGT model we are using.**  Under a CPE, a statistically valid time study, periodic cost reporting and reconciliation of interim payments would be required.  This results in much more work, and more risk.  The CPE model could be disastrous and burdensome, to the point that it may kill the entire program or result in significant payback to CMS.  Rather than working towards a CPE model, it may be beneficial for stakeholders to work together to have the CSCT match funded through the same mechanism as nearly every other Medicaid service, via the General Revenue Fund (GRF).  Short of that, keeping the IGT for as long as possible is the most viable funding option available.

BHAM and the Mental Health Centers providing CSCT services are committed to working with stakeholders, including DPHHS, the OPI, Districts and the Legislature. We implore all parties to work together to ensure sustainability of this vital program.

Respectfully,

Mike Chavers, CEO, Yellowstone Boys and Girls Ranch

Chair, Behavioral Health Association of Montana (BHAM)