Friday, September 29, 2025

VIA CERTIFIED MAIL

Michelle Baass, Director
California Department of Health Care Services (DHCS)
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413

Re: August 15, 2025, Recoupment Notice – ** Dispute of SMHS Inpatient & Unsatisfactory Immigration Status Recoupments

Dear Director Baass:

Lake County Behavioral Health Department (LCBH), in conjunction with the County Counsel's Office, writes to formally dispute the recoupment notice dated August 15, 2025, which is based on Regular Policy Change Number 199. This notice seeks to recover funds from LCBH for two categories of claimed Federal Financial Participation (FFP): (1) Specialty Mental Health Services (SMHS) – Inpatient disallowances, and (2) services provided to beneficiaries with Unsatisfactory Immigration Status (UIS). LCBH respectfully objects to both recoupment amounts assigned to our county. LCBH requests that DHCS rescind these recoupments in full or, at a minimum, provide a formal appeals process through which LCBH can challenge and resolve these matters. Our objections are grounded in federal law, state law and policy, and fundamental principles of fairness, as detailed below.

1. Federal Law Prohibitions & State Responsibility for FFP Claims

Prohibition on FFP for Unsatisfactory Immigration Status: Section 1903(v) of the Social Security Act (SSA) explicitly prohibits federal Medicaid funding for medical assistance provided to individuals who lack satisfactory immigration status, except for services necessary to treat an emergency medical condition and, in some cases, for pregnancy-related services[1]. LCBH acknowledges this federal restriction and understand that it underlies the UIS recoupment at issue.

State Obligation to Ensure Proper Claiming: Federal regulations make clear that the state Medicaid plan must maintain fiscal controls and accounting systems to assure that claims for FFP are in accord with all applicable federal requirements[2]. DHCS is obligated to have systems and processes in place to prevent unallowable claims from ever being submitted for federal reimbursement.

When claims are questioned or deferred by CMS, "it is the responsibility of the State to establish the allowability of [the] deferred claim"[3] under 42 C.F.R. §430.40(b)(2). If a claim is ultimately determined to be unallowable, federal law requires CMS to disallow and recoup those funds from the State (SSA §1903(d)(2)(A))[3]. The burden falls on the State to identify and return any overpaid federal Medicaid funds; conversely, local agencies and providers rely on the State's guidance and systems to differentiate between allowable and unallowable claims.

In sum, federal law (SSA §1903(v)) absolutely disallows FFP for the services in question, and federal regulations place ultimate accountability on DHCS to comply with this law in its claiming practices. LCBH disputes the attempt to make LCBH financially responsible for a federal claiming error that was preventable and should have been caught at the State level.

While DHCS may cite AB 757 (1994) as general authority for implementing Medi-Cal policy, nothing in AB 757 authorizes retroactive recoupments of already-settled fiscal years outside of established audit and cost reporting processes. To the extent DHCS relies on AB 757 for this action, that reliance is misplaced and overbroad.

2. State Policies Acknowledging FFP Limits and County Good-Faith Compliance

DHCS Policy Guidance on UIS Claims: DHCS's own policies have long recognized the federal limits on claiming FFP for individuals with unsatisfactory immigration status. For example, in June 2022, DHCS issued Policy & Procedure Letter PPL 22-016 to all counties participating in the Medi-Cal County Inmate Program (MCIP) regarding services to inmates with UIS. That PPL explicitly notes that "non-emergency and non-pregnancy related services for beneficiaries with UIS are not eligible for [FFP]" and cites SSA §1903(v)(2) as prohibiting states from claiming federal funding for such services[1]. The PPL instructed counties to cease submitting claims for any non-emergency, non-pregnancy services provided to UIS individuals, and it confirmed that DHCS had "implemented system edits to the inmate claiming criteria that will appropriately deny claims ineligible for FFP"[4].

As of mid-2022, DHCS took on the responsibility to modify its claiming systems (e.g. MEDS and related Medi-Cal eligibility/claims logic) to ensure compliance with federal law going forward. LCBH, in turn, complied with this directive and relied on the State's updated systems to automatically flag or deny any improper claims for the UIS population.

FFP and SMHS "Emergency" Services: In Behavioral Health Information Notice No. 23-046 (Sept. 11, 2023), DHCS announced a change in classification of SMHS with respect to unsatisfactory immigration status. The guidance makes clear that under California's CMS-approved waivers, "SMHS are not classified as emergency services" for purposes of the Medicaid program, and therefore federal funds must not be claimed for SMHS provided to beneficiaries with unsatisfactory immigration status, even if those services were previously considered "emergency" in nature[5]. The BHIN goes on to state that claims submitted for individuals with UIS (such as recent qualified non-citizens in the five-year bar, or persons under PRUCOL status) will be denied in the Short-Doyle/Medi-Cal (SD/MC) system, and that services provided to populations covered under state-only Medi-Cal programs (e.g. young adults in SB 75, Older Adult Expansion) "will be reimbursed with State General Fund" rather than federal dollars[6]. DHCS noted that it deployed system changes in 2020, and again in May 2023, to implement these policies in the claims processing system[7][8].

Counties' Good-Faith Reliance on State Systems: These state directives and system edits underscore that counties have acted in good-faith reliance on DHCS's eligibility and claiming systems. The Medi-Cal eligibility determination for each beneficiary, including the coding of immigration status and scope-of-benefits (emergency-only, state-funded full scope, etc.), is managed through State-run systems such as MEDS and CalSAWS. Counties do not control the underlying eligibility logic that tags a beneficiary as FFP-eligible or not; counties must rely on

the aid codes and eligibility status that the State's systems output. Likewise, the SD/MC claims adjudication system (maintained by DHCS and its fiscal intermediaries) is programmed to approve or deny claims based on those aid codes and federal eligibility rules.

If LCBH submitted claims for services to certain beneficiaries in past years, it was because those individuals appeared in State systems as eligible for reimbursement at the time. LCBH had no access to the "back-end" logic that determined whether a claim would be charged to federal vs. state funding. In fact, DHCS's own actions show that any erroneous FFP claims were the result of State system configurations. DHCS had to "implement edits" and "deploy system changes" in 2020, 2022, and 2023, to properly enforce the federal restrictions[4][7].

Further, the claim in Regular Policy Change 199 that DHCS "did not identify and was not fully reimbursed for all of the psychiatric inpatient hospital service expenditures between CY 2011 and 2020" due to issues with aid codes has no bearing on the matter at hand. DHCS should not use a failure to add new aid codes that allegedly resulted in DHCS not identifying expenditure amounts for the Mental Health Subaccounts as a justification for recouping funds in a separate case where DHCS aid codes were improperly implemented resulting in reporting errors to CMS and subsequent CMS overpayments.

It would be fundamentally unfair to penalize counties for claims that the State's systems initially accepted and paid (with federal share) due to State-level delays or errors in implementing federal policy. LCBH fully complied with all DHCS guidance available during the claim periods in question, and LCBH promptly adapted to new guidance (as in PPL 22-016 and BHIN 23-046) when issued. There was no wrongdoing or negligence by LCBH; to the contrary, any improper federal claiming was inadvertent and directly traceable to State instructions or automated processes.

Many of the impacted claims (2014–2020) fall well outside the three-year audit window codified in Welfare & Institutions Code §14170. By pursuing recoupments now, DHCS is effectively reopening cost reports that are statutorily closed, undermining counties' reliance on fiscal finality.

3. Objections to Recoupment Process – Lack of Data and Violation of Due Process

DHCS has chosen to frame this action as a "Regular Policy Change" (Policy Change #199 in the Medi-Cal Estimate) rather than as audit findings or cost report adjustments. This reframing appears intended to bypass the statutory appeal process under WIC §14171. By embedding the recoupment into the budget process, DHCS denies counties the notice and hearing rights that would otherwise apply. This raises serious due process concerns.

No Claim-Level Detail Provided: The recoupment notice of August 15, 2025, lists aggregate amounts that DHCS seeks to recover for "SMHS Inpatient" and "UIS" categories, but crucially, it does not include any claim-level identification or documentation. Regular Policy Change 199 similarly claims "[DHCS] is recoupling the amounts that were the responsibility of the county" without any evidence. LCBH has not been provided with a list of the specific clients, service dates, provider claims, or federal amounts that compose these recoupment totals. This lack of transparency makes it impossible for LCBH to audit or verify the accuracy of the alleged overpayments. LCBH cannot determine, for example, whether the UIS recoupment includes

individuals who were in fact receiving only emergency or pregnancy services (which would be allowable for FFP), or whether some claims have been misattributed to our county.

Without claim-level data, LCBH is effectively prevented from mounting any meaningful review or defense. LCBH's right to due process is undermined when given a bill for hundreds of thousands of dollars with no explanation beyond broad labels. LCBH objects to this deficient notice, which fails to meet basic standards of administrative due process and accountability. At a minimum, DHCS should be required to furnish the detailed data identifying each disallowed claim so that LCBH can cross-check it against our records and federal criteria.

No Formal Appeal Opportunity: Additionally, the recoupment notice did not advise LCBH of any right or process to appeal the determination. Under California law, providers are generally entitled to an administrative appeal of audit findings or overpayment determinations made by DHCS. Welfare & Institutions Code §14171 directs the DHCS Director to establish appeal processes for grievances arising from audit findings or final settlements (under WIC §14170)[9]. In typical Medi-Cal audit scenarios, a provider or local entity would receive a formal audit report or Statement of Findings and have an opportunity to appeal through an impartial hearing process before any recoupment is finalized[9][10].

Here, by contrast, LCBH was never provided with an audit report or any preliminary notice. LCBH received a unilateral demand for repayment long after the fact, with no stated avenue for appeal or review. This approach is procedurally improper. If DHCS believes an overpayment exists, it must follow the established protocols: issue a report or detailed finding, allow the affected party to contest it, and only then proceed to recovery if upheld. Skipping straight to recoupment not only violates the spirit of WIC §14171, but it also deprives LCBH of the opportunity to exercise its rights to challenge the basis of the claim.

LCBH urges DHCS to recognize that LCBH is effectively in the position of a "provider" in this context (as the entity that furnished the services and received reimbursement) and thus is entitled to the same appeal rights as any provider facing an alleged overpayment. By failing to provide claim data and bypassing the appeal process, DHCS has denied LCBH a fair chance to be heard on these issues.

4. Cost Report Finality and Reliance Interests

Many of the claims at issue date back several years. Our understanding is the SMHS inpatient recoupment may pertain to services delivered and cost-settled in fiscal years that are already long closed out. California law recognizes the importance of finality in cost reporting. Welfare & Institutions Code §14170(a)(1) deems that cost reports (and other provider fiscal data) "shall be considered true and correct unless audited or reviewed by the department within ... three years after the close of the period covered by the report, or after the date of submission of the report, whichever is later."[11] If DHCS does not act to audit or adjust a cost report within three years, the reported payments stand as final and non-recoverable[12]. This statute protects providers and local entities from indefinite vulnerability to retroactive recoveries, allowing them to plan budgets with certainty once a reasonable period has passed.

LCBH's SMHS cost reports for past fiscal years were settled in good faith based on the information and rules in effect at that time. If the recoupment now being demanded reaches back

beyond the three-year audit window, it contravenes the finality provisions of state law. LCBH urge DHCS to carefully consider WIC §14170 and related regulations before pursuing any recoupment for periods that should be closed. Reopening final settlements years later is neither legally sound nor equitable, especially for reasons that boil down to a change in DHCS's interpretation or system programming –.

Furthermore, California Code of Regulations, Title 22, §51047 contemplates that any overpayment discovered via audit will lead to a prompt demand for repayment issued within 60 days of the audit report, with recovery actions commencing 60 days thereafter[13][14]. In this case, there was no such audit report or timely demand tied to a specific audit process. If DHCS had identified an error in claiming methodology (for example, discovering in 2023 that certain 2019 emergency psychiatric claims should not have been FFP), the appropriate course would have been to issue a formal finding at that time and allow LCBH to respond. By delaying until August 2025, and then sending a summary bill, DHCS has not adhered to the typical timelines or procedures for Medi-Cal overpayment recovery. This delay prejudices LCBH, which must now resurrect old records and attempt to piece together what happened without the benefit of a contemporaneous audit trail.

5. Request for Relief – Rescission or Formal Appeal Pathway

For all the above reasons, LCBH strenuously objects to the SMHS Inpatient and UIS recoupment amounts assessed in the August 15, 2025, notice. LCBH respectfully request that DHCS rescind these recoupments in full. LCBH should not be held financially liable for federal claiming disallowances that arose from system-level issues and policy decisions outside of LCBH's control, especially when LCBH delivered the services to Medi-Cal beneficiaries in good faith compliance with State directives. DHCS has other means to address the federal disallowance such as seeking reconsideration of the FFP disallowance from CMS or absorbing the cost at the State level using the State General Fund (as DHCS policy in BHIN 23-046 indicates for certain populations[6]). Shifting the entire burden to counties, without due process, sets a troubling precedent and undermines the partnership between State and counties in administering Medi-Cal services.

If DHCS is unwilling to rescind the recoupments, the County requests, at minimum, that DHCS provide a formal appeal process consistent with WIC §14171, including disclosure of the underlying claim-level data. Alternatively, DHCS should consider backfilling these disallowed claims with State General Fund, as it has done for other Medi-Cal populations (e.g., SB 75 young adult expansion, Older Adult Expansion). Finally, DHCS should explore federal avenues for relief, such as seeking reconsideration from CMS or pursuing waiver authority, rather than shifting the burden retroactively to counties.

Thank you for your attention to this urgent matter. LCBH values its collaborative relationship with DHCS and our shared mission to serve Medi-Cal beneficiaries and hopes to resolve this issue in a manner that respects both federal requirements and the realities of county administration. Please direct any response or correspondence on this dispute to my office, with a copy to County Counsel, at the address above. County representative will make themselves available to meet or confer with DHCS at your convenience to discuss potential solutions.

Sincerely,

Elise Jones
Director, Lake County Behavioral Health Dept.

CC: DHCS Legal Division; DHCS Audits & Investigations; County of Lake Board of Supervisors; California State Association of Counties (CSAC)

Sources Cited:

Social Security Act §1903(v)(1)–(2) [1] (42 U.S.C. §1396b(v)): Prohibition on FFP for services to individuals not lawfully present, except emergency or pregnancy-related services.

42 C.F.R. §430.40(b)(2)[3]; 42 C.F.R. §433.32(a)[2]: State responsibility to ensure claims are allowable and to maintain systems aligning with federal requirements.

Social Security Act §1903(d)(2)(A)[3]: CMS obligation to disallow and recoup overpayments of federal Medicaid funds.

DHCS PPL No. 22-016 (June 28, 2022)[1][4]: DHCS guidance to counties (MCIP) confirming no FFP for non-emergency, non-pregnancy services for UIS individuals; implementation of system edits to deny such claims.

DHCS BHIN No. 23-046 (Sept. 11, 2023)[5][6][7]: Clarification that SMHS are not considered emergency services for UIS beneficiaries; federal funds not claimable for SMHS to unsatisfactory-status individuals; State funding to be used for state-only Medi-Cal populations.

Welf. & Inst. Code §14170(a)(1)[11]: Cost reports deemed true and correct (final) if not audited within three years of the reporting period, absent fraud or concealment.

22 Cal. Code Regs. §51047[13][14]: Timeline for DHCS to issue overpayment demands after an audit finding (60 days) and to commence recovery (60 days after demand), and related procedures.

Welf. & Inst. Code §14171[9]: Providers' right to administrative appeal processes for audit findings and final settlements; requirement that DHCS establish such processes by regulation.

Footnotes

[1] [4] PPL 22-016 Unsatisfactory Immigration Status MCIP

https://www.dhcs.ca.gov/provgovpart/Documents/PPL-22-016-Unsatisfactory-Immigration-Status-MCIP.pdf

[2] [3] California Department of Health Care Services, DAB No. 3099 (2023) | HHS.gov

https://www.hhs.gov/about/agencies/dab/decisions/board-decisions/2023/board-dab-3099/index.html

[5] [6] [7] [8] BHIN 23-046 Emergency Services & SMHS for Medi-Cal Members with Unsatisfactory Immigration Status.pdf

https://www.dhcs.ca.gov/Documents/BHIN-23-046-Emergency-Services-SMHS-for-Medi-Cal-Members-with-Unsatisfactory-Immigration-Status.pdf

[9] [10] Microsoft Word - W & I 14171

https://www.dhcs.ca.gov/services/medi-cal/Documents/SNF%20Quality%20Workgroup/W%20and%20I%2014171.pdf

[11] [12] California Welfare and Institutions Code § 14170 (2024) :: 2024 California Code :: U.S. Codes and Statutes :: U.S. Law :: Justia

https://law.justia.com/codes/california/code-wic/division-9/part-3/chapter-7/article-5-3/section-14170/

[13] [14] Cal. Code Regs. Tit. 22, § 51047 - Recovery of Overpayments | State Regulations | US Law | LII / Legal Information Institute

https://www.law.cornell.edu/regulations/california/22-CCR-51047