State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: November 21, 2014

MHSUDS INFORMATION NOTICE NO.: 14-039

TO: COUNTY BEHAVIORAL HEALTH PROGRAM DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTOR'S ASSOCIATION
CALIFORNIA COUNCIL OF COMMUNITY MENTAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS

SUBJECT: FISCAL YEAR 2013-2014 COST REPORT POLICY

REFERENCE: SUPERSEDES MENTAL HEALTH SERVICE DIVISION (MHSD) INFORMATION NOTICE NO: 13-23 FISCAL YEAR (FY) 2012-2013 COST REPORT POLICY

EXPIRES: Retain until superseded

This letter outlines the submission and reporting requirements for the FY 2013-14 cost report. To the extent that there are differences between this letter and other prior Department of Health Care Services (DHCS) instructions, the requirements contained in this letter will prevail. Technical details regarding reporting and submission procedures and requirements are included in the FY 2013-14 Cost and Financial Reporting System (CFRS) Instruction Manual available on the DHCS Information Technology Web Services (ITWS) internet site at https://itws.dhcs.ca.gov.

I. SUBMISSION REQUIREMENTS

A. Cost Report Submission

The FY 2013-14 Cost Report automated templates are available through the DHCS ITWS–CFRS. Cost report submission for FY 2013-14 involves both electronic and hard copies. Section 14705 (c) of the Welfare and Institutions (W&I) Code requires county mental health facilities, clinics and programs to submit fiscal year end cost reports by December 31, 2014, following

the end of the fiscal year. The electronic submission process involves uploading the complete cost report through DHCS's ITWS system. To comply with Section14705 (c), counties must have uploaded the electronic submission by close of business on December 31, 2014. Counties must also submit one hard copy of the summary cost report, county detail cost report, and an original signed County Certification (MH 1940). The hard copy must be postmarked within ten days of the initial upload to validate the submission through ITWS.

Please mail hard copies to:

California Department of Health Care Services
Mental Health Services Division
Mental Health Cost Reporting Unit
Attn: (Your CFRS Analyst)
1500 Capitol Avenue, MS 2704
Sacramento, CA 95814

A list of CFRS analysts is available at
http://www.dhcs.ca.gov/provgovpart/Pages/MentalHealthPlanCostReporting.aspx

The following modifications have been made to the following cost report forms:

1. MH1901_Schedule_B
   a. Affordable Care Act Units column is added – Column P.
   b. Affordable Care Act 3rd Party Revenues column is added – Column Q.
   c. Units of Service for Affordable Care Act are for the period January 1, 2014 to June 30, 2014.
2. MH1960
   i. Affordable Care Act Administration line is added – Line 28
3. MH 1960_Hosp_05
   i. Affordable Care Act, Columns 16 and 17 are added.
4. MH 1960_Hosp 05_Hosp_Admin
   i. Affordable Care Act, Columns 14 and 15 are added.
5. MH 1960_PHYS_05_Physician _Admin
   i. Affordable Care Act, Columns 14 and 15 are added.
6. MH 1960_Hospital_10
   i. Affordable Care Act Columns 16 and 17 are added.
7. MH 1960_PHYS_10
   i. Affordable Care Act Columns 16 and 17 are added.
8. MH 1960_Hosp_15
   i. Affordable Care Columns 16 and 17 are added

9. MH 1960_PHYS_15
    i. Affordable Care Act columns 16 and 17 are added.
10. MH1963
    i. Affordable Care Act column is added – Column K
11. MH1966_HOSPINPT
    a. Affordable Care Act Units line is added - Line 13
    b. Affordable Care Act Costs line is added – Line 27
    c. Affordable Care Act Published Charges line is added – Line 28
12. MH1966_Mode 5-OTHR 24 Hour Service (All Other SFC),
    a. MH1966_Mode10–Day Service,
    b. MH1966_Mode15–Outpatient Services (Program 1),
    c. MH1966_Mode15–Outpatient Services (Program 2)
    d. Affordable Care Act Units line is added – Line 13
    e. Affordable Care Act Costs line is added – Line 27
    f. Affordable Care Act Published Charges line is added – Line 28
13. MH1968
    a. Affordable Care Act New Adult Group Cost Line is added – Line 22.
    b. Affordable Care Act SMA Upper Limit's line added – Line 23.
    c. Affordable Care Act Published Charges line is added – Line 24
    d. Affordable Care Act Gross Cost Reimbursement line is added – Line 25
    e. Affordable Care Act Revenue row added – Line 42
14. MH1979
    i. Affordable Care Act Net Reimbursement line is added – Line 29
15. MH1979B
    i. Form is added for inclusion of Certified Public Expenditures (CPE)
16. MH1991
    i. Affordable Care Act line is added

B. Amendments or Revisions

Amendments or revisions to the cost report that will materially change total costs are prohibited after the cost report is filed and certified. Any potential amendments or revisions identified after this date will be reviewed on a case-by-case basis.

C. Supporting Documentation

Counties must maintain the following list of supporting documents for the FY 2013-14 cost report:

1. Auditor-Controller's Report
   Counties must maintain work papers that reconcile the amounts reported on the MH 1960, Columns A & C, with the portion of the Auditor-Controller's Report that contains the data used in the cost report.

2. Maintenance of Records and Systems
   Legal entities must maintain all accounting and management information system reports necessary to verify detailed data contained in the cost report for future audits. DHCS has three years after a County has submitted its final amended cost report to begin an audit. Legal entities must maintain all records necessary to verify data in the cost report for at least three years after the final amended cost report is submitted. If DHCS initiates an audit within three years of the date the final amended cost report was submitted, legal entities must maintain all records until the audit is complete. In addition, counties must maintain an internal reporting system to track SD/MC units and revenues approved and for which payments were made. The 835-payment remittance advice from the SD/MC billing system is provided for claim submission reconciliation purposes, but cannot be used to substitute for an entity's original internal reporting or data tracking system.

II. COST REPORT POLICY

A. Legal Entity Number

All county and contract providers must have a valid and current provider number, which is associated with a legal entity number issued by DHCS for use during the cost-reporting year. The Provider/Legal Entity (PRV/LE) data files for your county may be accessed through the DHCS ITWS–PRV/LE system. Organizations that do not have a legal entity number or need to verify a legal entity number should contact the County Customer Service Section at ProviderFile@dhcs.ca.gov .

B. Transaction Service Period

Units of service and related revenues reported on the FY 2013-14 cost report must reflect services that occurred during the period of July 1, 2013, through June 30, 2014.

C. Federal Financial Participation (FFP)

Non-hospital direct service costs are apportioned to SD/MC beneficiaries based on units of service at the service function level. Hospital costs are apportioned to SD/MC beneficiaries based upon a cost per day for routine cost centers and a cost-to-charge ratio for ancillary and other non-routine cost centers. During FY 2013-14, services provided to beneficiaries within the following settlement groups are reimbursed at the following Federal Medical Assistance Percentage (FMAP). Please consult the Short Doyle/Medi-Cal Aid Codes Master Chart to determine which aid codes to report in which settlement group. This chart is available from: http://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx.

Settlement Group	**FMAP**
Regular SD/MC – 07/01/13 – 6/30/14	50.00%
SD/MC Enhanced (Children)	65.00%
SD/MC Enhanced (BCCTP)	65.00%
SD/MC Enhanced (Pregnancy)	65.00%
SD/MC Enhanced Refugee	100.00%
Healthy Families Program	65.00%

Administrative costs are apportioned to SD/MC-Other, SD/MC Enhanced (Children), Healthy Families, and Non Reimbursable. During FY 2013-14, administrative costs are reimbursed at the following rates:

Program	**Rate**
SD/MC – Other	50.00%
SD/MC Enhanced (Children)	65.00%
Healthy Families Program	65.00%

Costs incurred to perform Medi-Cal Administrative Activities (MAA) and SD/MC Utilization Review activities are reimbursed at 50 percent or 75 percent, depending upon the activities performed and the staff performing the activities. Allowable MAA and Utilization Review activities performed by eligible Skilled Professional Medical Personnel (SPMP) are reimbursed at 75 percent. All other MAA and Utilization Review activities are reimbursed at 50 percent.

D. Reimbursement Limitation Policy

In accordance with State laws and regulations, DHCS has eliminated the Schedule of Maximum Allowance (SMA) rates for FY 2013-14, except for administrative day services. Federal Regulations (42 CFR §447.253) require states that elect to provide inappropriate level of care services to pay less than the inpatient hospital level of care services. As such, DHCS will continue to limit reimbursement of administrative day services to the SMA.

E. 2011 Realignment: Senate Bill 1020 (Chapter 40, Statutes of 2012)

Expenditures from funds the county received for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Mental Health Managed Care from the Behavioral Health Subaccount of the Local Revenue Fund 2011 should be reported on the MH 1992, Line 19.

F. 1991 Realignment Funds and Maintenance of Effort (MOE) Funds

The county's 1991 realignment funds (sales tax receipts, vehicle license fees, and local program MOE per W&I Code Section 17608.05) expended on mental health services during the cost-reporting year should be identified on Line 20 of the MH 1992, Funding Sources.

G. Community Services – Other Treatment for Mental Health Managed Care (County Only)

Mental Health Managed Care was realigned through Senate Bill 1020 (Chapter 40, Statutes of 2012). Please report the expenditure of funds received from the Behavioral Health Subaccount of the Local Revenue Fund 2011 on Line 19 of the MH 1992.

H. Mental Health Services Act (MHSA)

All legal entities must report expenditures from MHSA funds by purpose on the MH 1992. Counties may use MHSA funds as match for other funding sources, such as Federal Financial Participation (FFP).

I. Mental Health (MH) Medi-Cal Administrative Activities (MAA)

Counties participating in the MH MAA claiming process must have an approved MH MAA claiming plan. Invoices must be submitted quarterly and all final

invoices for FY 2013-14 must be submitted to DHCS by December 31, 2014. The MH MAA units reported on the cost report must equal the units contained in the MH MAA invoices submitted to the Department by December 31, 2014. A county may not include in its cost report MH MAA units that have not been included on a MH MAA invoice submitted for the cost reporting Fiscal Year.

Costs for MH MAA must reflect actual costs and, therefore, must be directly allocated on the MH 1901 Schedule C. An eligibility factor is applied to certain MH MAA that may be provided on behalf of individuals who are and are not Medi-Cal eligible. Most MH MAAs are reimbursed at a rate of 50 percent.

Some MH MAA performed by SPMP are reimbursed at a rate of 75 percent, as identified in Item C of this section.

J. Inpatient Administrative Days

Expenditures allocated to inpatient administrative days must be reflected in Mode 05, Service Function (SF) 19 only. Form MH 1991, Calculation of SD/MC Hospital Administrative Days, was designed to calculate the SD/MC maximum allowance plus physician and ancillary costs for administrative days. For FY 2013-14, the per diem Medi-Cal rate for administrative days is $416.95 for July 1, 2013, through June 30, 2014.

Legal entities with hospital administrative days are required to complete the MH 1991. Procedures are in place to ensure that these costs are included in actual costs, published charges, and SMAs to ensure that the calculation of the lower of cost or charges principle is applied correctly.

The amount for physician and ancillary services is limited to the costs claimable under Section 51511(c) of Title 22, California Code of Regulations (CCR). Since counties have not been reimbursed for ancillary and physician services provided to inpatients on administrative day status during the fiscal year, reimbursement for these services will be made through the cost report settlement process. Reflecting administrative day costs and related ancillary and physician service charges in SF 19 is presently the only procedure available for seeking SD/MC reimbursement.

Medicare does not recognize hospital administrative days as a reimbursable service. Therefore, Medicare/Medi-Cal crossover units do not apply to hospital administrative days.

K. Medicare/Medi-Cal Crossover Units

In the FY 2013-14 cost report, Medi-Medi units are to be settled in the same manner as other regular SD/MC units. Consequently, these units and costs appear on the MH 1966, Allocation of Costs to SF-Mode Total, and are subject to a lower cost or customary charge analysis.

L. Administrative Service Organization

The California Mental Health Director's Association (CMHDA) discontinued managing the Administrative Service Organization (ASO) effective June 30, 2004. The county of origin (the county where the child's Medi-Cal eligibility was determined) continues to be responsible for ensuring services are provided to their beneficiaries who are placed out of county. Counties may contract with an ASO to assist the county with authorizing and paying for services provided to beneficiaries placed outside of the county. These units of services should be reported on the MH 1901 Schedule B, using the ASO settlement type.

Only the direct cost of providing services to beneficiaries placed out of county should be allocated to these units of service on the MH 1901 Schedule C. The per-member per-month administrative fee paid to the ASO to provide this service may not be included in the costs allocated on the MH 1901 Schedule C. The per-member per-month administrative fee should be allocated to the cost of administering the Specialty Mental Health Waiver on the MH 1960, Calculation of Non-Hospital Program Costs.

M. Healthy Families Program

Expenditures associated with reimbursable units of service provided to Healthy Families beneficiaries that are the responsibility of county mental health agencies must be reported in the cost report. The claiming and reporting requirements and calculation of FFP utilize the same reimbursement methodology as SD/MC services. However, expenditures are reimbursed at an enhanced rate of 65 percent, as identified in Item C of this section. The reimbursement for Healthy Families administration is limited to 10 percent of program costs.

N. Transition of Healthy Families Program Beneficiaries to Medi-Cal

Healthy Families Program beneficiaries receive new aid codes when they transition to the Medi-Cal program. Please report units of service to beneficiaries

with these new aid codes as enhanced children. Expenditures will continue to be reimbursed at an enhanced rate of 65%.

O. Therapeutic Behavioral Services

Therapeutic Behavioral Services (TBS) should be reported under Mode 15, SF 58. Non-organizational providers that contract with county mental health agencies to provide ONLY TBS are not required to submit cost reports. The county should settle costs with these providers and report these settled costs to DHCS as actual cost to the county under the county legal entity detailed cost report using the TBS settlement type. Legal entities providing TBS ONLY services are required to complete a cost report using the Therapeutic Behavioral Services (TBS) settlement type. Contract organizational providers that provide other mental health services in addition to TBS are required to submit a cost report using the CR settlement type. It should be noted that TBS may not be provided unless the child/youth is receiving other EPSDT specialty mental health services.

P. Mental Health Services

Former Fee-for-Service/Medi-Cal (FFS/MC) Mental Health Services (MHS) individual and group providers are to be paid and settled between the county and the providers. Counties should bill Medi-Cal on behalf of all these providers by utilizing a procedure code crosswalk to service functions (CCR 1840.304) and using a legal entity and provider number set up by providers' discipline. Individual and group providers do not submit cost reports for DHCS purposes.

These units of service and associated costs are reported in the county's detailed legal entity cost report using the MHS settlement type. The MHS settlement type reimburses the actual cost for payments made to the FFS/MC provider.

Q. California Work Opportunity and Responsibility to Kids (CalWORKS)

Expenditures of the CalWORKS funds for mental health services are to be shown in the cost report. The funds received for these purposes are to be reported by mode of service on the MH 1992. Legal entities reporting these units of service and costs should use the CAW settlement type.

R. In Home Behavioral Services and Intensive Care Coordination

In Home Behavioral Services (IHBS) and Intensive Care Coordination (ICC) should be reported on the Schedule B with a distinct service function code. IHBS should be reported with SFC 57 and ICC should be reported with SFC 07. Please reference MHSD Information Notice 13-1 for more information.

III. FEDERAL BLOCK GRANT

A. Federal Block Grant Cost Reports

Counties that receive payments from the Block Grant for Community Mental Health Services (SAMHSA Block Grant) and/or Projects for Assistance in Transition from Homelessness (PATH) are required to submit separate cost reports for these federal funds. These cost reports will be settled in the manner described in the Federal Block Grant letters. Specific Federal Block Grant cost report instructions will be addressed in a separate designated grant letter.

B. Inclusion of Federal Grants in the Cost Report

Although a separate cost report is required to settle Federal Block Grant reimbursement, expenditures from these Federal Block Grants must be reported on the MH 1992 on the appropriate grant lines.

C. Federal First Dollar Policy

The “Federal First Dollar” policy established with DMH Letter No. 90-07 continues to apply in FY 2013-14. The expenditure of Federal Block Grant funds before the use of other governmental funds is termed the “Federal First Dollar” policy. DMH Letter 94-03 provides the guidelines for the claiming and reporting of FFP for the federal grant funded programs.

IV. SETTLEMENTS

A. SD/MC Reconciliation

The SD/MC reconciliation process allows counties to add or reduce Medi-Cal units of service and revenue that have changed subsequent to the cost report submission for each legal entity. This reconciliation must be completed within 18 months after the close of the fiscal year.

B. Final Settlement

After the SD/MC reconciliation process is complete, DHCS determines the final settlement of federal and state funds and sends that information to the county and DHCS accounting for payment or collection.

If you have any questions, please contact your CFRS analyst. A list of CFRS analysts and county assignments is available at the following link:
http://www.dhcs.ca.gov/provgovpart/Pages/MentalHealthPlanCostReporting.aspx

Sincerely,

Karen Baylor, Ph.D., LMFT, Deputy Director
Mental Health & Substance Use Disorder Services