CALIFORNIA DEPARTMENT OF
Mental Health

1600 9th Street, Sacramento, CA 95814
(916) 654-2309

October 3, 2003

DMH LETTER NO.: 03-05

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: FISCAL YEAR (FY) 2002-03 COST REPORT POLICY

REFERENCE: Supersedes DMH Letter 02-04
FY 2002-03 COST AND FINANCIAL REPORTING SYSTEM INSTRUCTION MANUAL

This letter outlines the submission and reporting requirements for the FY 2002-03 cost report. To the extent that there are differences between this letter and other prior California Department of Mental Health (DMH) publications, the requirements contained in this letter will prevail. Technical details regarding reporting and submission procedures and requirements are included in the FY 2002-03 Cost and Financial Reporting System Instruction Manual available through download from the DMH Information Technology Web Services (ITWS) – Cost and Financial Reporting System (CFRS). This is accessed through the DMH website at www.dmh.ca.gov.

I. SUBMISSION REQUIREMENTS

A. Cost Report Submission

The FY 2002-03 Cost Report automated templates are available through the DMH ITWS - CFRS. Counties are to submit a completed county cost report package that includes a separate detailed cost report for each county and contract legal entity and a county summary report. Welfare and Institutions Code Section 5718(c) requires county mental health facilities, clinics and programs to submit fiscal year-end cost reports by December 31st following the close of the fiscal year.

Fiscal Year 2002-03 year-end county cost report packages from county mental health agencies are to be submitted to DMH by close of business on Wednesday, December 31, 2003. Cost report submission for FY 2002-03 involves both electronic and hard copies. The electronic submission process involves uploading the cost report through the DMH's ITWS system. Detailed requirements regarding naming conventions, downloading templates, and uploading completed cost reports are included in Appendix G of the FY 2002-03 Cost and Financial Reporting System Instruction Manual. One hard copy of the complete cost report package, including an original signed MH 1940, (County Certification), must be submitted to DMH through the mail. It must be received within 10 working days of the upload to validate the submission through ITWS.

Mail to:

California Department of Mental Health
County Financial Reporting System
Attn: Kim Wimberly
1600 9th Street, Room 120
Sacramento, CA 95814

B. Cost Report Forms

The major change to the FY 2002-03 cost report forms are as follows:

Change in Federal Financial Participation (FFP)

Cost report forms MH 1966 (Allocation of Costs to Service Function), MH 1968 (Determination of SD/MC Direct Services and MAA Reimbursement) and MH 1979 (SD/MC Preliminary Desk Settlement) were revised to incorporate the changes in the FFP sharing ratios (See Section II, Item C, for further details) effective October 1, 2002 and to reflect different "enhanced" FFP ratios for certain Medi-Cal aid codes. The increase in FFP rate of 54.35 effective April 1, 2003 will not be included on the cost report. However, cost reports will be settled to the higher rate in the fall of 2004.

C. Amendments or Revisions

Major amendments or revisions to the cost report are not allowed after December 31, 2003. Corrections identified by DMH, which are necessary to facilitate processing or to prevent undue hardship to counties, can be made. Unapproved revisions made after December 31, 2003, will be placed in the county's cost report file for audit purposes.

D. Supporting Documentation

The list of supporting documents necessary for the FY 2002-03 cost report is as follows:

1. Auditor-Controller's Report
   Reference to the page(s) of the county's Auditor-Controller's Report containing mental health data used in the cost report. The Auditor-Controller's Report itself is not required, however counties should maintain work papers that reconcile the amount reported on MH 1960 (Calculation of Program Costs), Line 1, Column 3.

2. Payments to Contract Providers
   Summary of payments to contract providers, MH 1960, Line 3, listed by provider, with amounts of payments (back-up to MH 1960). Former fee-for-service Medi-Cal hospitals are to be included if payments to these hospitals are reflected in Total Expenditures (MH 1960, Line 1).

3. Other Adjustments (Provide Detail)
   A detailed explanation of the "other adjustment" item (positive or negative) on MH 1960, Line 4. For example, if the amount reported on line 1 from the county auditor-controller's report includes the costs of the county substance abuse program, the costs of the substance abuse program would be deducted on line 4. Also, if the COWCAP (Countywide Cost Allocation Plan) A-87 costs are not included in the county auditor-controller's report, these costs would be added on line 4. Other situations that are unique for individual legal entities should be addressed on line 4. A supporting schedule must be submitted to detail and document the rationale for the adjustments.

4. Disclosures
   Explanations of unusual situations or anomalies to the regular cost reporting requirements should be disclosed in this section for audit purposes. A worksheet in the detail cost report workbook is available for such disclosures.

5. Maintenance of Records and Systems
   All accounting and management information system reports used to verify detailed data reported in the cost reports must be maintained for future audit purposes. In addition, counties must maintain an internal reporting system to track SD/MC units and revenues that were approved and are valid. Complete reliance on the SD/MC Explanation of Balance (EOB) reports is not sufficient because certain approved claims, later deemed inappropriate, cannot be eliminated from these EOB reports. These reports can be used to verify internal records but should not be used in lieu of an internal reporting or tracking system.

It is believed that the above documentation will meet federal Centers for Medicare and Medicaid Services (CMS) requirements, ensure counties of the continued availability of FFP, and enable DMH Cost and Financial Reporting System staff to perform a desk review.

II. COST REPORT POLICY

A. Legal Entity Number

All county and contract providers must have a valid and current provider number, which must be associated with a legal entity number issued by DMH for use during the cost reporting year. While SD/MC certification and claims are submitted and processed using provider numbers, cost reports are submitted using legal entity numbers.

The Provider/Legal Entity (PRV/LE) data files for your county can be accessed through the DMH ITWS – PRV/LE system. To ensure that all providers are properly assigned to a legal entity number, please call the Statistical and Data Analysis Section at (916) 653-6257.

B. Transaction Service Period

Units of service and related revenues reported on the FY 2002-03 cost report must reflect services and transactions occurring during the period of July 1, 2002 through June 30, 2003 only.

C. Federal Financial Participation Percentages

Direct service costs are apportioned to SD/MC clients based on units of service at the service function level. In FY 2002-03, units of service are to be reported according to the period of time during which services were provided. This separate identification of units for the first quarter and for the balance of the fiscal year is necessitated by the change in the FFP sharing ratio for SD/MC by federal fiscal year. During FY 2002-03 the federal: state sharing ratio is as follows:

First Quarter (July 1, 2002 through September 30, 2002)
Regular SD/MC: FFP = 51.40%; State Share = 48.60%
Enhanced Children SD/MC: FFP = 65.98%; State Share = 34.02%
Healthy Families: FFP = 65.98%; State Share = 34.02%

Balance of the Fiscal Year (October 1, 2002 through June 30, 2003)
Regular SD/MC: FFP = 50.00%; State Share = 50.00%
Enhanced Children SD/MC: FFP = 65.00%; State Share = 35.00%
Healthy Families: FFP = 65.00%; State Share = 35.00%

Full Fiscal Year (July 1, 2002 through June 30, 2003)
Enhanced SD/MC Refugees: FFP = 100%; State Share = 0%
Regular SD/MC Administration: FFP = 50%; State Share = 50%
Regular Quality Assurance/U.R.: FFP = 50%; State Share = 50%
SPMP Quality Assurance/U.R.: FFP = 75%; State Share = 25%
Regular MAA: FFP = 50%; State Share = 50%
SPMP MAA: FFP = 75%; State Share = 25%
Healthy Families Admin.: FFP = 65.25%; State Share = 34.75%

The retroactive SD/MC FFP change effective April 1, 2003 will not be reflected on the cost report. The additional FFP rate will be accounted for during the settlement process.

D. Reimbursement Limitation Policy

In accordance with State laws and regulations, DMH established a schedule of maximum allowances (SMA) that details the SD/MC maximum allowable rates for FY 2002-03 (DMH Letter 02-05). These rate limits apply to all SD/MC eligible services. Please refer to Enclosure A.

E. Categorical Funding

Categorical funds must be used for the purpose for which they were appropriated in the Budget Act of 2002. Accordingly, SEP (Special Education Pupil) funds (also known as "AB 3632") may only be used for assessment, treatment, and case management services. Expenditures of non-state general funds for this program in administration and other modes may be reported as funded through other fund sources on form MH 1909 (Supplemental Cost Report Data By Program Category).

MH 1909 should identify each budget item, categorical fund expenditure and units of service by legal entity, mode, and service function. Include a completed MH 1909 for each budget item (except for managed care funds, Budget Item 4440-103-0001) with your cost report package to assist DMH in properly accounting for funds in the correct Budget Act appropriation. Expenditures in excess of the State General Fund allocation should be entered in the appropriate column of "County Matching Funds", "Medi-Cal FFP Share", or "Other Fund Sources".

A separate MH 1909 is to be prepared for program category funds rolled over from the previous fiscal year.

Categorical State General Funds used as a match for FFP do not require county matching funds.

Rollover Categorical Funds

Allocated categorical State General Funds not expended during the year of allocation are credited to the county during Final Settlement and must be spent during the next fiscal year. Any categorical funds not spent within 2 years of allocation are taken back from the county. A separate MH 1909 must be completed for reporting Rollover expended during FY 2002-03.

F. County Matching Funds

For State General Fund dollars allocated by DMH, counties with populations over 125,000 are required to match the funds by a ratio of 90% State General Funds to 10% county matching funds. Only Budget Act Item 4440-131-0001 SEP funds are required to be matched by the county.

G. Realignment Funds and Maintenance of Effort Funds

The county's realignment funds (sales tax receipts, Vehicle License funds, and local program maintenance of effort (MOE) funds per Welfare and Institution Code Section 17608.05) expended on mental health services during the reporting year should be identified on MH 1992 (Funding Sources) line 21.

H. Negotiated Rate Legal Entities

Negotiated rate legal entities will be controlled to their negotiated SD/MC contract rates, which in no case will be greater than the SMA established by DMH. If there is no negotiated rate approved by DMH, then reimbursement will be based on the lower of cost, charges or SMA. Please refer to DMH Notice No. 02-08 for more information on FY 2002-03 SD/MC Negotiated Rates.

I. Community Services - Other Treatment for Mental Health Managed Care - (County Only)

Report expenditures and utilization of these funds on MH 1994 (Report of Mental health Managed Care Allocation and Expenditures) as part of the County Summary cost report.

County legal entities are to enter the amount of the funds from Community Services – Other Treatment for Mental Health Managed Care allocation expended on non-Managed Care services (for these purposes defined as "Other Mental Health Services") on line 9 of MH 1994. These funds will be treated as a Funding Source in the detail legal entity cost reports.
The MH 1960 instructions insure that the costs and units funded by the portion of this allocation designated for "Other Mental Health Services" is included in the cost report. During FY 2002-03, rollover of FY 2001-2002 Mental Health Managed Care funds expended for Other Mental Health Services (line 2a and 2b of MH 1994) should also be included in the cost report.

J. Medi-Cal Administrative Activities (MAA)

Counties participating in MAA must have a state and federally approved Mental Health MAA claiming plan and must have all invoices for FY 2002-03 submitted to DMH by December 31, 2003. MAA units reported on the cost report are not allowed to be modified during the SD/MC Reconciliation process.

Costs for MAA activities must be actual cost and therefore must be directly allocated. An eligibility factor is applied to certain MAA activities that may be provided on behalf of non-SD/MC as well as SD/MC clients.
The FFP sharing ratio for regular MAA units is 50% and for Skilled Professional Medical Personnel (SPMP) the sharing ratio is 75% as described in Section II, Item C, above.

K. Inpatient Administrative Days

Inpatient administrative day costs must be reflected in Mode of Service 05, Service Function Code 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 2002-03, there are two per diem Medi-Cal rates for administrative days of $231.30 (July 1 – July 31, 2002) and $236.38 (August 1, 2002 – June 30, 2003).

All legal entities with hospital administrative days should complete MH 1991 per the instructions. 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), Title 22 of the California Code of Regulations. 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 Service Function Code 19 is presently the only procedure available for seeking SD/MC reimbursement.

Medi-Cal/Medicare Crossover Units

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

If a Legal Entity has a hospital administrative day published charge rate that is used to charge both Medi-Cal and Non-Medi-Cal clients then Non-Medi-Cal units may be included on Line 12 of MH 1966.

L. Medicare/Medi-Cal Crossover Revenues

In the FY 2002-03 cost report, Medicare/Medi-Cal crossover units are to be settled in the same manner as other regular SD/MC units. Consequently, they are subject to a comparison of lower of cost, published charge, SMA rate and negotiated rate data on MH 1966.

Such comparisons in aggregate with other SD/MC aggregates will determine the calculation of Medicare/Medi-Cal Crossover gross reimbursement on MH 1968.

M. CMHDA's Administrative Service Organization (ASO)

The ASO sponsored by the California Mental Health Director's Association (CMHDA) allows for assurance of payments for services to out-of-county foster children by the county of beneficiary. These expenditures are to be reported as Program II - ASO expenditures on the county's detail legal entity cost report.

N. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

During FY 2002-03, State General Fund match for the EPSDT program of medically necessary services to full-scope Medi-Cal eligible beneficiaries under 21 years of age was provided to counties through interim advance payments (not an allocation). On MH 1992, the estimated state share of EPSDT expenditures should be reflected as revenue on Line 19 and shown on MH 1940 (Year-End Cost Report), Line 16, for information only. Final calculation and settlement of EPSDT State General Fund match will occur after the final county cost report settlement using SD/MC claim payments and settled SD/MC cost data.

O. Healthy Families

Healthy Families SED (Seriously Emotionally Disturbed) units and associated costs that are the responsibility of county mental health agencies are to be specifically reported in the cost report. The claiming and reporting requirements and calculation of the FFP utilizes the same reimbursement methodology as SD/MC services. However, the FFP sharing ratio is at an enhanced percentage as identified in Section II, Item C, above. The reimbursement for Healthy Families administration is limited to 10% of program cost, however the FFP sharing ratio for Healthy Families administration is 65.25%. This is the weighted average of the two FFP percentages for Healthy Families.

P. Therapeutic Behavioral Services (TBS)

TBS services should be reported under Mode 15, Service Function Code 58. Organizational providers that contract with county mental health agencies to provide ONLY TBS services are not required to submit cost reports. The county should settle costs with these providers and report these settled costs to DMH as actual cost to the county under their county legal entity detailed cost report in Program II - TBS costs. Contract organizational providers that provide other mental health services in addition to TBS services are required to submit a cost report.

Contract organizational providers are restricted from using Program II –TBS and shall report any TBS services and costs under the regular Program I, Mode 15, Service Function Code 58.

Q. Specialty Mental Health Services (MHS)

Former Fee-for-service/Medi-Cal (FFS/MC) MHS individual and group providers are to be paid and settled between the county and the providers. Counties should be billing Medi-Cal on behalf of all of these providers by utilizing a procedure code crosswalk to service functions (California Code of Regulations 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 DMH purposes. These units and actual costs will be reported in the County's detailed legal entity cost report under Program II – MHS. Settlement of these costs will require comparison to the SMA only.

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

Services and expenditures of 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 MH 1992.

III. FEDERAL BLOCK GRANTS

A. Federal Block Grant Cost Reports

Counties receiving SAMHSA (Substance Abuse and Mental Health Services Administration) Federal Block Grants are required to submit separate cost reports for these federal funds. Such cost reports will be settled in the manner identified in DMH's policy and Federal Block Grant letters. Specific Federal Block Grant cost report instructions will be addressed in a separate SAMHSA letter.

B. Inclusion of Federal Grants in the Cost Report

Although a separate cost report is required to settle Federal Block Grant reimbursement, Federal Block Grant amounts must also appear in the cost report, Form MH 1992, on the appropriate grant line.

C. Federal First Dollar Policy

The "Federal First Dollar" policy continues to apply in FY 2002-03. DMH Letter 94-03 contains information regarding the reporting of FFP in SAMHSA grant funded programs.

IV. SETTLEMENTS

A. Initial Settlement

If deemed necessary by DMH, an initial settlement of FFP funds may be performed to collect funds from those counties that have been paid amounts in excess of what the settlements determine prior to the SD/MC reconciliation process described below.

B. 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. For FY 2002-03, this process is scheduled to occur between August and October of 2004.

C. Final Settlement

After completion of the SD/MC reconciliation, a final settlement of both federal and state funds is calculated and sent to the county and DMH Accounting for payment or collection.

If you have any questions, please contact your County Financial Reporting System analyst or call (916) 654-2314.

Sincerely,

(Original Signed By)

STEPHEN W. MAYBERG, Ph.D.
Director

Enclosure