CALIFORNIA DEPARTMENT OF
Mental Health

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

October 25, 2010

DMH LETTER NO.: 10-06

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) 2009-10 COST REPORT POLICY

REFERENCE: SUPERSEDES DEPARTMENT OF MENTAL HEALTH (DMH) LETTER NO. 10-01 FISCAL YEAR (FY) 2008-09 COST REPORT POLICY

This letter outlines the submission and reporting requirements for the FY 2009-10 cost report. To the extent that there are differences between this letter and other prior California DMH publications, the requirements contained in this letter will prevail. Technical details regarding reporting and submission procedures and requirements are included in the FY 2009-10 Cost and Financial Reporting System (CFRS) Instruction Manual available on the DMH Information Technology Web Services (ITWS). ITWS is accessed through the DMH web site at www.dmh.ca.gov.

I. SUBMISSION REQUIREMENTS

A. Cost Report Submission

The FY 2009-10 Cost Report automated templates are available through the DMH ITWS – CFRS. Section 5718(c) of the Welfare and Institutions Code (WIC) requires county mental health facilities, clinics, and programs to submit fiscal year-end cost reports by December 31st following the end of the fiscal year.

Cost report submission for FY 2009-10 involves both electronic and hard copies. The electronic submission process involves uploading the complete cost report through DMH's ITWS system. To comply with Section 5718(c), counties must upload the electronic submission by close of business on December 31, 2010. Detailed requirements regarding downloading templates,

naming conventions, and uploading completed cost reports are included in Appendix F of the FY 2009-10 CFRS Instruction Manual. Counties are also required to 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 Mental Health
Local Program Financial Support
Attn: (Your CFRS Analyst)
1600 9th Street, Room 120
Sacramento, CA 95814

Counties are to continue to access ITWS information through CFRS until further notice.

B. Cost Report Form Additions and Updates

Existing forms and schedules have been modified to:

1. Separately identify the cost of providing services to beneficiaries eligible under the Breast and Cervical Cancer Treatment and Prevention (BCCTP) Act of 2000.
2. Separately identify the units of service provided to beneficiaries eligible under certain restricted aid codes that reimburse emergency services at the regular Federal Medical Assistance Percentage (FMAP) and pregnancy related services at the enhanced FMAP.
3. Separately identify the cost of administering the Medicaid Children's Health Insurance Program (M-CHIP).
4. Eliminate State-approved negotiated rates.

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

1. **MH 1900 Info**
   Lines have been added to allow counties to report contract provider Short Doyle/Medi-Cal (SD/MC) gross reimbursement for services provided to beneficiaries eligible through the Medicaid Children's Health Insurance Program (SD/MC Enhanced (Children)). Contract provider gross reimbursement for inpatient and outpatient services populates Line 14, Columns B and C, of the MH 1979.

2. **MH 1901 Schedule A**
   The State eliminated State-approved negotiated rates and the negotiated rate incentive payment program. The MH 1901_Schedule_A no longer captures State-approved negotiated rates for particular service functions.

3. **MH 1901 Schedule B**
   Columns have been added to allow legal entities to separately report units of service and third party revenue for beneficiaries eligible under the BCCTP Act of 2000. Units of service provided to these beneficiaries are reimbursed at the enhanced FMAP.

4. **MH 1963**
   A column has been added to allow counties to separately report payments made to contract providers for Medi-Cal reimbursable units of service. The State needs this information to implement the Centers for Medicare and Medicaid Services' (CMS) recommendation that the State begin calculating the non-risk upper payment limit for each mental health plan beginning with State FY 2009-10.

5. **MH 1966**
   Lines have been added to the MH 1966 for Modes 05, 10, and 15 to capture units of service and calculate the total cost associated with providing services to beneficiaries eligible under the BCCTP Act of 2000. Lines have been deleted to remove the State-approved negotiated rate from the settlement process.

6. **MH 1968**
   Lines have been added to determine gross reimbursement for services provided to beneficiaries under the BCCTP Act of 2000. Lines have been deleted to remove State-approved negotiated rates from the cost settlement process. Lines have been deleted to eliminate the negotiated rate incentive payment program.

7. **MH 1979**
   Lines have been added to determine net reimbursement for cost incurred to administer the M-CHIP. Lines have been deleted to eliminate the negotiated rate incentive payment program.

C. Amendments or Revisions

Amendments or revisions to the cost report that will materially change total costs are prohibited after December 31, 2010. Any potential amendments or revisions identified after this date will be reviewed on a case-by-case basis.

D. Supporting Documentation

Counties must maintain the following list of supporting documents for the FY 2009-10 cost report:

1. Auditor-Controller's Report
   Counties should maintain work papers that reconcile the amount reported on the MH 1960, Calculation of Program Costs, Line 1, Column C, with the portion of the Auditor-Controller's Report that contains the date used in the cost report.

2. Disclosures
   Legal entities should use the disclosures worksheet in the detailed cost report to describe unusual situations or complex accounting applications that deviate from the standard cost reporting requirements. These disclosures are necessary to establish an audit trail.

3. 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. DMH has three years after a County has submitted its final 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 cost report is submitted. If DMH initiates an audit within three years of the date the final 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. Complete reliance on the SD/MC Explanation of Balance (EOB) reports is an inadequate source of record keeping for reimbursed units because certain approved claims, later deemed inappropriate, cannot be eliminated from the EOB reports. The EOB reports are appropriate for internal record keeping 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 DMH for use during the cost reporting year. The Provider/Legal Entity (PRV/LE) data files for your county may be accessed through the DMH ITWS – PRV/LE system. Organizations that do not have a legal entity number or need to verify a legal entity number should contact the Statistics and Data Analysis Section at (916) 654-2629.

B. Transaction Service Period

Units of service and related revenues reported on the FY 2009-10 cost report must reflect services and transactions that occurred during the period of July 1, 2009, through June 30, 2010.

C. Federal Financial Participation (FFP)

Direct service costs are apportioned to SD/MC clients based on units of service at the service function level. During FY 2009-10, services provided to beneficiaries within the following settlement groups are reimbursed at the following FMAP:

Settlement Group	FMAP
Regular SD/MC	61.59%
SD/MC Enhanced (Children)	65.00%
SD/MC BCCTP	65.00%
SD/MC Refugee	100.00%
Healthy Families	65.00%

Administrative costs are apportioned to SD/MC-Other, SD/MC Enhanced (Children), Healthy Families, and Non Reimbursable. During FY 2009-10, administrative costs are reimbursed at the following rates:

Program	Rate
SD/MC – Other	50.00%
SD/MC Enhanced (Children)	50.00%
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, DMH established a Schedule of Maximum Allowances (SMA) that details the SD/MC maximum allowable rates for FY 2009-10. The SMA for FY 2009-10 was published in DMH Information Notice 10-08. These rate limits apply to all SD/MC eligible services.

E. Categorical Funding

Categorical funds must be used for the purpose for which they were appropriated in the Budget Act of 2008. Non-State General Funds used to match FFP for each program category should be reported under Other Fund Sources on form MH 1909, Supplemental Cost Report Data by Program Category.

The 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, as those funds are reported on MH 1994, Report of Mental Health Managed Care Allocation and Expenditures). These forms assist DMH with properly accounting for funds in the correct Budget Act appropriation. Expenditures in excess of the State General Fund (SGF) allocation should be entered in the appropriate column for Other Fund Sources.

The MH 1912, Supplemental Cost Report Data for Special Education Program, is designed to identify total Special Education Pupils (SEP) costs, regardless of funding source. The MH 1912 will be used for reporting total program costs associated with the SEP mandate to the California Legislature and the California Department of Education.

F. Rollover Categorical Funds

Pursuant to WIC Section 5715, a county may retain categorical SGF that has been allocated to it but not expended during the fiscal year for an additional 12 months. Categorical SGF that was allocated in FY 2008-09 but not expended in FY 2008-09 should be reported as rollover on the MH 1908, Supplemental State Resource Data, and expenditures in FY 2009-10 should be reported on the appropriate MH 1909 Rollover. The Department will recoup, through the invoicing process, any categorical SGF that was allocated in FY 2008-09 that have not been expended by the end of FY 2009-10.

G. Realignment Funds and Maintenance of Effort (MOE) Funds

The county's realignment funds (sales tax receipts, vehicle license fees, and local program MOE per WIC Section 17608.05) expended on mental health services during the cost reporting year should be identified on Line 21 of the MH 1992, Funding Sources.

H. State Approved Negotiated Rate

The Department eliminated State-approved negotiated rates. The FY 2009-10 cost report does not allow legal entities to report State-approved negotiated rates. State-approved negotiated rates are no longer part of the cost settlement process.

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

Report expenditure of funds from Budget Item 4440-103-0001, Community Services – Other Treatment for Mental Health Managed Care, on the MH 1994.

J. Mental Health Services Act

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

K. 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 2009-10 must be submitted to DMH by December 31, 2010. 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, 2010. A county may not include in its cost report MH MAA units of service 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, Supporting Documentation for the Method Used to Allocate Total Cost to Mode of Service and Service Function. 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 MAA 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.

L. 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 2009-10, the per diem Medi-Cal rate for administrative days is $351.26 for July 1, 2009, through February 23, 2010, and $381.37 for February 24, 2010, through June 30, 2010.

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.

If a legal entity uses a hospital administrative day published charge rate to charge both Medi-Cal and non-Medi-Cal clients, the non-Medi-Cal units may be included on the MH 1901 Schedule B, Worksheet for Units of Service and Revenues by Mode and SF.

M. Medicare/Medi-Cal Crossover Units

In the FY 2009-10 cost report, Medicare/Medi-Cal crossover 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 of cost, published charge, or SMA analysis.

N. 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 Program Costs.

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

During FY 2009-10, the SGF for EPSDT medically necessary specialty mental health services provided to full scope Medi-Cal eligible individuals under 21 years of age was provided to counties by DMH through a distribution (not an allocation) process. On the MH 1992, Funding Sources, this estimated State

share of EPSDT expenditures should be reflected as revenue on Line 19 and shown on the MH 1940, Year End Cost Report, Line 16, for information only. Final calculation and settlement of the EPSDT SGF match will occur after the final county cost report settlement, using SD/MC claims data and settled SD/MC cost data.

P. Healthy Families

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.

Q. Therapeutic Behavioral Services (TBS)

TBS should be reported under Mode 15, SF 58. 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 DMH as actual cost to the county under the county legal entity detailed cost report using the TBS settlement type. Legal entities providing TBS ONLY are required to complete a cost report using the 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 Cost Reimbursement settlement type. It should be noted that TBS may not be provided unless the child/youth is receiving other EPSDT specialty mental health services.

R. 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 DMH 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 lower of actual cost for payments made to the FFS/MC provider or schedule of maximum allowances.

S. 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.

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 DMH and 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 2009-10. 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 process is expected to occur between September and October of 2011.

B. Final Settlement

After the SD/MC reconciliation process is complete, Local Program Financial Support determines the final settlement of both federal and State funds and sends that information to the county and DMH accounting for payment or collection.

If you have any questions, please contact your CFRS analyst at (916) 654-2314.

Sincerely,

Original Signed by

STEPHEN W. MAYBERG, Ph.D.
Director