April 2022 V.1

DHCS-Cost Report Training with Audits FAQ

COST REPORT/SUDCRS AND DUE DATES

1. Can you please confirm the due date for FY 18-19 Cost Report?
   A: The new due date will be determined when the Substance Use Disorder Cost Report System (SUDCRS) is ready for data entry.

2. Will SUDCRS for both SPA and ODS be available mid-May?
   A: We anticipate SUDCRS to be available in Mid-May 2022 for FY 18/19. We will notify all counties as soon as it becomes available via email.

3. Where can we get the "SUD Cost Report Manual" mentioned in slide 56?
   A: This is included in the annual cost report mail out. Contact your DHCS county analyst if you need a copy.

4. Since SUDCRS remains un-opened at this time to check this out myself, will ODS services and DMC services be reported differently as I have one of each type of cost report from the providers that qualify for both.
   A: All services and expenditures for both SPA and ODS can be reported in SUDCRS, with different service codes to differentiate between SPA and ODS.

5. We started ODS waiver in the middle of fiscal year 18/19. Do we submit 2 cost reports for that fiscal year - 1 for SPA and 1 for ODS?
   A: That is correct.

6. How will a split year be entered in SUDCRS?
   A: One cost report for the part of the year under the SPA contract, another cost report for the later part of the year under the ODS contract.

7. A provider entered all costs from their GL in Tab 3 but prepared cost report for one DMC number but this provider has multiple sites. Is this acceptable?
   A: Providers' must prepare a cost report workbook for each DMC certified location in accordance with DMC Approved CPE protocols that states "there is one Excel file that must be completed by the legal entity for each service site that has its own DMC number and DMC certification and maintains its separate accounting records." If a provider maintains a multiple site GL or combined several location accounting records into one GL Accounting system, for cost reporting purpose, the provider must separately identify the portion of the costs for every licensed/certified DMC location within the organization.

8. Will V7 of the ODS cost report be accepted if the contractor has no NTP services? Or do all contractors have to submit on V9?
   A: V7 will be accepted if no NTP services are provided.

9. The Units of Services reported in cost reports should exclude voids and deleted units, correct?
   A: Yes, that is correct.

10. Is there a place in the cost report where these Units of Services should be reported if they are not to be excluded?
    A: No, only approved and denied units are recorded in the Cost Report.

11. Will SUDCRS be updated in the future to improve user interface? (For instance, being able to clear a Program or Service filter, but keep the Provider filter in place? This would allow for faster navigation/entry.) Also, portal subtotals that align to subtotals on the workbooks would allow for faster review.
    A: Thank you for your feedback, we will share this with our developers.

12. Is it possible for the drop down for County/FY be set to the one we are assigned or set to the latest FY?
    A: It is currently not available.

13. On Tab 2 of the cost report (Overall Cost Summary has $ listed in Other SUD Services), how are those amounts reported or should they be?
    A: It is reported on Tab 3 which feeds into Tab 2, based on expenditures from the general ledger.

14. On Tab 7 of the cost report (ODF Reimbursed Units), when there is an amount in various, should that be reported under funding line 80 or 82?
    A: It is at the discretion of the county to report any county funds with non-DMC funding lines, whichever is appropriate.

15. On the DMC cost report, if the amounts in Tab 7 are different from Tab 8 by .01 cent because of rounding? Is this ok?
    A: Yes, we understand rounding issues occur, thus .01 difference is acceptable.

16. There are some questions regarding the ODS Cost Report V9 and completing the Detailed Adjustments sections.
    <u>Ex 1</u>:
    Provider actual costs (3) Overall Detailed Costs $80, Customary Charge $80, County Reimbursed $100
    A: The County overpaid the provider because costs will be settled to the lower of actual costs or customary charge. The overpayment made by the County to the Provider is adjusted from the Accounts Receivable due to Provider or County recouped the overpayment on future reimbursements. This overpayment should be resolved between the County and Provider and will not be included in the county and state Fiscal Detail Report.

Ex 2:
Provider actual costs (3) Overall Detailed Costs $100, Customary Charge $80, County Reimbursed $80
A: In this scenario, there is a difference of $20 (excess costs), which will be settled with County Funds, BHS, Unrestricted, or Non-Perinatal backfills. This will be included in the county and state Fiscal Detail Report.

Ex 3:
Provider actual costs (3) Overall Detailed Costs $100, Customary Charge $80, County paid $80, Maximum contracted amount between county and provider is $80, DMC allowed costs is $50 based on actual vs published charges per below.
Funding lines: $50 DMC/SGF, $25 BHS, $5 General Fund
Which funding lines should the County report the extra $20 to match Provider's actual costs since these costs are not contracted between the County and Provider?
A: County may use DMC non-Perinatal backfill or Provider's unrestricted Funds for the $20 excess costs.

17. Per Cost Report manual dated July 2021, Recovery of Overpayments to providers is a required report that must be submitted to DHCS along with the county's cost report. Is that correct?
    A: A standard template has not been created to capture Recovery of Overpayments. In lieu of a standardized template, counties can submit their own report of all recoveries of overpayments from their providers.

18. By the time the portal opens, and the 60 days passes, we'll be 3 months behind the original "catchup" schedule. Will DHCS still plan for FY 19-20 to be submitted in October, or will deadlines push out?
    A: Amended deadlines will be forthcoming.

19. Will SUDCRS allow us to enter a negative number?
    A: No. The system business rules in the SUDCRS/BHIS portal will only allow for positive amounts to be entered.

20. We hope FY 18/19 due date can be postponed further as we just got trained. We would like to communicate to providers and they may need additional time to redo their CR. It would be greatly appreciated if the due date can be further postponed.
    A: The due date will be determined by the availability of SUDCRS. If more time is needed, and extension can be requested on letterhead and signed by an administrator.

21. Will CalAIM eliminate the annual DHCS SUD DMC cost report submission requirements along with the associated subsequent DHCS annual provider cost report audits?
    A: Claim will modify cost reporting in the future, but the full details have yet to be made available. The latest details can be found on CalAIM website.

22. Will CalAIM eliminate the annual FY settlement to actual provider costs for the SABG SUD providers?
    A: Please refer to answer in Question 21.

23. Can you tell us when the final year of Cost Reports will be (after CalAIM)?
    A: FY 22/23 will be the last year of the current cost-based cost reporting method – after that a different method of cost reporting will be required. The full details have yet to be made available.

24. Would there a practice portal where we can practice/train inputting the cost report?
    A: It is currently not available.

25. If the county reviews the provider's Cost Report, should the county signed the Provider Certification?
    A: The Provider should sign the Provider Certification, attesting the accuracy of the data.

26. We also provide Medication Assisted Treatment or MAT, these services are not claimable for DMCODS, is there a specific section we should report these? Or County Funds?
    A: MAT services are on the cost report. MAT are claimable on the cost report in the applicable Modality. Example of MAT is Residential 3.1 Medication Assisted Treatment Perinatal. The Cost and associated should be capture in the applicable section of the cost report such as Overall Detailed Cost Tab, in Cost Allocation Tab, Detailed Adjustment Tab and Reimbursed unit Tab.

27. We have providers that have submitted expenditures in their cost report for FY 2017-18 (that agree to their accounting records) that are in excess of what the County BHRS paid. When we report this amount, how should we adjust for that excess amount reported when compared to the amount paid by County so that we tie to BHRS' accounting records? Do we report that difference as a negative County costs in the spreadsheet? Or should we report this difference in another method?
    A: The amount that the county pays the provider is not recorded in the Cost Report. This is between the County and Provider. No other method is needed. The actual cost is limited to customary charge for ODS and lower of customary charge or SMA for SPA.

28. Where and how do we represent the amounts that are reported by providers in their cost reports that are higher than the Certified Public Expenditures (amount paid to the provider)? When the county has not paid the amount within the allowed 75 days window after period close, if these costs (costs reported by provider higher than County paid) are disallowed, then how and where should it be reported?
    A: Accrued expenses are reported in the benefiting period in which it is incurred, regardless of when it is paid (i.e., Cost Reporting FY 2020-2021). Providers are required to pay or liquidate its obligations within 75 days after the close of the cost report period in order for unpaid salaries. If payment is not made within 75 days after the close of fiscal period, the unpaid salaries are not includable in allowable costs either

in the period when earned or in the period when paid. However, if a Provider is unable to meet its obligations due to County's delay in payment to them and the cost report for FY 2020-21 is still open, Provider may include the unpaid salaries (as County's description) on the benefiting cost reporting year.

42 FR §413.100 (c), Recognition of accrued costs, states that:

(1) General. Although Medicare recognizes, in the year of accrual of costs for which a provider has not actually expended funds during the current cost reporting period, for purposes of payment Medicare does not recognize the accrual of costs unless the related liabilities are liquidated timely.

(2) Requirements for liquidation of liabilities. For accrued costs to be recognized for Medicare payment in the year of the accrual, the requirements set forth below must be met with respect to the liquidation of related liabilities. If liquidation does not meet these requirements, the cost is disallowed, generally in the year of accrual.

29. If a county has a federally approved indirect cost rate, does the county have to use that indirect cost report when completing the cost report, or can they allow the cost report to calculate the indirect costs as the difference between total costs and directs costs as it currently does?
A: The cost report is designed to automatically calculate the indirect costs rate.

According to the Substance Use Disorder Cost Report Manual workbook instructions, "the worksheet also distributes total general ledger indirect costs or cognizant agency-approved indirect cost rate using the percentage of total direct program costs. (If the provider has a cognizant agency-approved indirect cost rate, the total indirect costs are determined by applying the approved rate to the approved allocation base and is reported in the "Indirect Cost" line item in Schedule of Direct and Indirect Cost Part A. There is no need for the provider to itemize any indirect cost elements and no additional indirect cost can be claimed outside of the approved indirect cost rate.)"

RECONCILIATION REPORT

30. In the Reconciliation Report, there are fractional units. Should providers drop the fraction or round it off?
A: For ODS counties, fractional units are acceptable. Providers can enter fractional units, no need to round up or down.

31. Will the approved unit of service be provided for ODS Counties?
A: Yes, they are usually sent out with the ODS documents but please contact your DHCS analyst for an updated reconciliation report.

32. Can the State issue the reconciled UOS before the release of Cost Report Forms?
A: Yes, it is usually mailed out with forms, but the county can request an additional reconciliation report from their DHCS analyst.

33. It would be very helpful for counties to enter their data if the reconciliation report includes a breakdown of ODS units by individual/group.
    A: These conditions are included in the reconciliation report. If not, please contact your DHCS analyst for an updated reconciliation report.

34. Should we exclude voids and deletes from the unit count that we submit in cost reports? If they are to be included, where do we report them? My understanding was that they can be excluded.
    A: Voids are no longer considered as units. Denied units are included in the total units submitted.

RATES/GROUP SESSIONS

35. Should provider's costs be related to the particular county?
    A: Yes, provider's cost should be associated to the county they are providing services for.

36. Can you clarify the group time calculation?
    A: A standard 15 minute interval as 1 unit of service is calculated by: The number of minutes in a group session plus travel time, divided by number of beneficiaries in the group. The total minutes per beneficiary will have documentation time added. A 90 minute group session with 30 minutes of travel time, for 12 people would result in 10 minutes per person, with 5 minutes documentation time added would come to 15 minutes.

37. On slide 38 for ODS group sessions, can you verify that we do not have to enter the number of group sessions anymore?
    A: That is correct – that information is fed from the Reimbursed Units tab.

38. We have providers that do not have official published rates, which rates do we report?
    A: Please see CCR Title 22: 51516.1 on reimbursement rates for DMC. The County ODS contract should include the Provider's Customary Charge; otherwise, County cannot enter into an ODS contractual relationship with a Provider. A provider's usual and customary rates are what Provider charges non Medi-Cal.

39. Can the Provider's customary charge be more than the negotiated interim rate between the county and the State?
    A: Yes, but we will settle to the lower rate.

40. Please define "Negotiated Rates". Is it between Interim Rate between our county and the State or the Interim Rate between our county and our providers?
    A: A negotiated rate can be between the county and the provider, which should be documented in the county-provider contract. A negotiated rate can also be the "interim" rate between the state and the county, which allows the state to pay the county.

However, the state will settle appropriately to the lower of the allowable actual cost or customary charge.

41. What happens when the Provider's customary charge is less than the DMC actual unit cost, but the DMC services "cost" more due to DMC contractual requirements?
A: Depending on whether it's a SPA contract or an ODS contract. For a SPA cost report, we settle to the lowest of State Maximum Rate, Customary Charge, or Allowable Cost. For an ODS cost report, we settle to the lower of Actual Allowable Cost or Customary Charge.

OVERALL DETAIL/DETAILED ADJUSTMENT

42. Can you please give a scenario where a provider would need to use the Detailed Adjustments tab in the template?
A: When a service is non-reimbursable (such as Room & Board – where it is inserted in the Unreimbursable Costs section of the tab). This is the first worksheet for each of the levels of care/ modalities. For each level of care/modality provided, the provider must break out their Direct and un-reimbursable costs between the various types of service/program (such as individual or group, perinatal or non-perinatal).

43. Can you please provide a few specific examples of what kind of costs can be included in the Detailed Adjustment tab- Direct Costs section?
A: Direct treatment cost specific to a modality or expanded service identified in the Detail Adjustment Tab. Examples are Residential 3.1. 3.3 & 3.5. Non Perinatal and Expanded Services such as Physician Consultation, Case Management- Non Perinatal, Recovery Services Group, Medical Assisted Treatment- Non Perinatal and etc.

44. Do all the cost in the direct columns in Tab (3) Overall Detailed Costs need to "broken/allocated" per LOC in Tab (5) OT Detailed Adjustments in the direct table? Or is Tab 5 only for adjustments?
A: Only direct costs that are directly attributable to the specific cost object for that service need to be inserted to the Direct Costs section (3.1, 3.3, etc.). For non-reimbursable costs, such as Food and Lodging, those costs were entered in the Overall Detailed Costs tab, but must be taken out in the DMC un-reimbursable Costs section because they cannot be claimed.

45. Can you explain more on how to use the adjustment tab on the cost report template?
A: Only direct costs that are directly attributable to the specific cost object for that service need to be inserted to the Direct Costs section (3.1, 3.3, etc.). For non-reimbursable costs, such as Food and Lodging, those costs were entered in the Overall Detailed Costs tab, but must be taken out in the DMC un-reimbursable Costs section because they cannot be claimed.

46. ODS CR, Overall Detail cost, Tab (3) Our County provides Recovery, Case Management, Physician consultation, WM1.0, and WM2.0, services in which columns would these cost be included or reported?
    A: Please refer to the Cost Report, as each modality has its own tabs. For recovery services, case management, WM1.0 and WM2.0, please refer to the OT tabs.

47. Using example above, would they be included as part of the direct costs of Outpatient Costs (Column D)?
    A: That is correct.

48. Should cell NW124 on the Detailed Adjustment tab match the total costs on the Overall Detailed Costs tab?
    A: Not necessarily. Please see response to #49.

49. a) Should the total of Total Adjustments for DMC Unreimbursable Costs + Total Adjustments for Direct Costs in Tab 5 then equal overall total in Tab 3? b) And total direct in Tab 3 then equal Total Adjustments for Direct Costs in Tab 5?
    A:
    (1) No, the total will not equal to the total in Tab 3; however, the total in the Detailed Adjustment Tab is linked to Cost Allocation Tab line 211 (Total Adjustment). The total here reduces Total general ledger SUD residential in “Column F” line 11 to determine “Adjusted Residential Gross Cost to be Distributed “(line 212) of the cost Allocation Tab.
    (2) Tab 3 represents specific modality costs related to providing service for the cost center while Tab 5 relates to added service that is specific to a treatment service within the modality such as Perinatal service’s childcare care consultant expense in the OT Modality or expanded services cost for Case Management – Non Perinatal within Residential or ODF which is already included in the total in Tab but a separated in Tab 5 (Detailed Adjustment).

CASE MANAGEMENT

50. Is Case Management considered as Enhancement costs? Can they enter costs in Detail Adjustments?
    A: Yes, case management is an expanded (enhancement) service. The associated costs and units are entered in detailed adjustment and reimbursed unit tabs respectively. The cost report template is formulated to compute cost per unit.

51. If the cost for Case Management is only $1.13, do the provider need to enter cost for Case Management in Detail adjustment? How about if the costs were already reported in Tab 3? What should be done?
    A: For the Overall Detailed Costs amounts, leave them alone. For the Detailed Adjustments tab, make sure all costs directly attributable to that cost object are captured. For the Overall Detailed Costs, include Case Management Costs in the applicable modality where the services were rendered. For the Detailed Adjustments

tab, make sure all costs directly attributable to CM are captured with related UOS reported in the applicable Tabs such as Reimbursed units, Cost Allocation and Detailed Adjustment Tab. Responses #52 and #53 also apply.

52. Is Case Management costs in Tab 3? Would the provider have to remove from Tab 3 if they include in Detailed Adjustments?
    A: Yes, all expanded service costs, direct and non-reimbursable costs are reported in Tab 3 and removed from the associated services in the Detailed Adjustment Tab when the cost are separately reimbursable or treated as direct cost in the Cost Allocation Tab.

NTP

53. If NTP's are providing case management, would they also need to provide their customary charged? Even if their contract with the county is to provide only to MC clients? Would ODS – negotiated rate applies?
    A: Yes, their customary charge will be included in their ODS Contract and will settled to allowable actual cost per unit or customary charge.

54. Some NTP providers charge a bundled rate, which is a monthly flat fee instead a set rate for each service. How should they determine the customary charge in this case?
    A: The provider and county should determine the component rate the units billed, the state does not provide bundled services. The County NTP is settled to the lower of customary charge or USDR except for County run program, which is based on the lower of actual costs or USDR. Please refer SUD Cost Report Manual, page 30.

55. NTP provided methadone, individual counseling and group counseling, should the provider complete the cost report V5 & /or V9?
    A: NTP provider can complete the Performance report V6 or ODS Cost Report V9.

56. Would all NTP's need to complete an annual Cost Report for FY 19-20, regardless if they have MATs or not?
    A: More details to come in the FY 19-20 mail out.

57. A Performance Report is needed for additional MAT services but the Performance Report wouldn't calculate the reimbursement for such services. We have a hard time getting cost reports from our NTP providers as there are contradicting instructions from DHCS.
    A: If NTP providers are providing additional ODS services, they would need to complete a full Cost Report, not a Performance Report. The NTP performance reports were updated to include MAT services and emailed to counties on 5/24/2022.

58. What is the County's responsibilities for the NTP cost reports since NTP providers are required to submit cost reports directly to DHCS?
    A: There will be more details in the FY 19-20 mail out.

RESIDENTIAL/ROOM AND BOARD

59. How do Residential providers show Room & Board costs on the cost report, which are not covered by DMC?
    A: It is entered in the Overall Costs tab in Column B, then applied to the service it pertains to (OT, PH, IOT, RES, etc.). Then, in the Detailed Adjustments tab of that service, it is reduced by placing the amount in the DMC Un-reimbursable Costs section of the pertinent service.

60. How do we report the Room & Board portion for residential program in SUDCRS?
    A: Room & Board costs should be entered in the Overall Detailed Costs tab, but must be taken out in the DMC Un-reimbursable Costs section because they cannot be claimed.

61. If the contracted Provider has various programs, such as residential program and a separate ODF, the Provider would submit separate cost reports?
    A: No, the Provider can submit it in the same cost report, just in their respective modalities.

62. The way Tab 21, RES Cost Allocation allocating costs between RES 3.1 and RES 3.5 would result in the same CPU for both service levels. Shouldn't RES 3.5 be at a higher rate since it requires a higher level of care?
    A: If the provider has a different customary charge for the lower or higher level of care, the template will use this if it is lower than the calculated cost per unit. It depends on direct cost components assigned to the cost center in the Detailed Adjustment. The CPU is determined to capture Provider's treatment costs of providing services. So the cost per UOS will depend on treatment cost component that went into services provided in the Direct Cost Component of the Enhance Services in the Detailed Adjustment Tab. Similar to #51 and #52 responses.

63. How is service code 58 Room & Board related to the ODS Cost Report v1.9 in the SUDCRS?
    A: It may be used for un-reimbursable costs, as entered with non-DMC program codes in SUDCRS. Room and Board is a non-Reimbursable Residential Service line item. Please refer to response in # 60.

64. On Slide 28 - Does Room & Board go in "Other-SUD" or "Non-SUD"?
    A: It will go with the service that pertains to the Room & Board (IOT, OT, PH, etc.). Please consult with your County on how they want you claim this cost component.

65. If Room & Board are reimbursable by Block grant and if we put it in the un-reimbursable column of the spreadsheet then how do we claim for block grant?
    A: You may use non-DMC program codes with service code 58.

66. How should we report Room & Board in SUDCRS as DMC Un-reimbursable Costs? Should the Program Code be 97 as "DMC" or 1 "Non-DMC" costs, or something else? I

know the Service Code is 58 for ODS but since this is “DMC” non-reimbursable costs, I don’t know what Program code I should consider this as.
A: Non-DMC program codes can be used, refer to Exhibit B in the mail out.

67. Room & Board costs should include salary, operation costs etc. so it should not be just "Food" cost being recorded under the DMC Un-reimbursable Costs. Why in the example, there is only $9,305 reported under "Food" category?
A: That is correct, Room & Board costs should include salary, operation costs and etc. so it should not be just “Food” cost being recorded under the DMC Un-reimbursable Costs. This is only one example of a cost report received by one county and provider. Based on a provider’s general ledger there can be differences as to which expenditure lines they choose to allocate their specific costs on the Tab 3 for overall detailed costs. For this training walkthrough, Food and Lodging expenses were used only as one example of DMC un-reimbursable costs under Residential services.

68. Should Room & Board costs be included on the Det. Adj. tab in the Un-reimbursable "DMC" column?
A: Yes.

69. Is there any reason to differentiate between Men’s and Women's Residential as long as it is not perinatal services?
A: Adult residential is only available in ODS.

70. Do we need to check the "Included in DMC Set" when reporting the Room & Board portion of a DMC residential program?
A: No, since this is a non-DMC cost.

71. Room & Board costs are not separated by Residential treatment types from our Provider. Do we have to allocate the R&B costs to each Residential treatment by UOS?
A: Direct charge (invoicing) to the benefiting cost center is preferable; however, compatible unit basis of allocation is also acceptable.

72. We will be reporting Room & Board expenses as Other SUD services instead of un-reimbursable costs (this is how providers have categorized the costs in their submitted reports). The Other SUD services do not roll up in the DMC-ODS rate calculations for the DMC eligible service in the same manner as the un-reimbursable costs are excluded. In other words, the effect appears to be the same. The reason we want to report Room & Board as other SUD services is because these services are not reimbursable by DMC but they are reimbursable by SABG block grant and we want the un-reimbursable costs column to represent costs that are disallowed. For example, lobbying costs, or food costs etc. rather than mix them up with costs that may be allowed with other sources of funds. Is reporting board and care as Other SUD services, acceptable?
A: This is up to the discretion of the county to decide how to report on the cost report.

73. The training instruction is to include Room & Board costs under Residential in the Tab 3 (Over Detailed Costs) and later adjust the costs in the Detailed Adjustment Tab as un-reimbursable costs.
    (1) If the program delivered Res 3.1, 3.3, 3.5, WM3.2 and has Room & Board costs associated to each service, should the un-reimbursable costs be allocated to each service (Res 3.1, 3.3, 3.5, WM 3.2 in this scenario) delivered?
    (2) Are the total un-reimbursable costs for Room & Board reported under service code 58 – Room and Care in the SUDCRS?

    A: a) Yes, that is correct.
    b) Yes, service code 58 is an option.

74. Are DMC-ODS Residential SUD providers (i.e., 3.1, 3.2, & 3.5 etc.) required to allocate their facility costs (e.g., rent, utilities, maintenance) to Treatment and Food & Lodging (also known as Room & Board (R&B)) based on square footage (SF)?
    (1) Residential facility's Food and Lodging SF comprises 7,500 SF of the facility and Treatment SF comprises just 2,500.
    (2) Total Facility costs are $100,000 (rent, utilities, and maintenance)
    (3) Food & Lodging (R&B) would be allocated $75,000 and Treatment would be allocated $25,000 of the Facility costs.

    A: No, all costs related to providing Food and Lodging services such as rent, utilities, cafeteria staff salary & et cetera are required to be reported and itemized in the Detail Adjustment Tab (Tab 20). Direct costs are itemized as well. The total of Non-Reimbursable Costs and total Direct Costs in Detail Adjustment (Tab 20) is formulated to automatically link to Tab 21. Then total of Reimbursable Costs and Direct Costs is deducted from SUD RES (Tab 21) total to arrive at "Adjusted Gross Cost to be Distributed" in Tab 21. The Adjusted Gross costs to be distributed is then allocated by staff hours to determine the treatment costs component in Tab 21.

    (a, b & c): The County's assumption to allocate Food & Lodging and Treatment cost and costs by square footage is erroneous. The worksheet is designed to allocate treatment cost by staff hours. See Cost Allocation (Tab 21).

    Finally, if food costs are not directly charged, they can be allocated using number of meals served. If this data is not available, providers can use total direct cost for each enhanced or expanded service component or compatible unit of service to allocate food costs.

75. Alternatively, can Residential providers allocate the Facility costs based on Percentage of Direct Cost?
    (1) Using the same provider above, Total direct Food & Lodging (R&B) costs are $475,000 and total direct Treatment costs are $525,000.
    (2) Total Facility costs are $100,000 (rent, utilities, and maintenance)
    (3) Food and Lodging would be allocated $47,500 and Treatment $52,500 of the Facility costs.

A: Only if the facility sq. ft. for each of the services (3.1, 3.2 & 3.5 etc.) is not known. For food and lodging allocation, please refer to answer in Question #72.

76. Are Residential Treatment providers required to allocate Administration costs to Food and Lodging (Room & Board) and to Treatment services based on Percentage of Direct Cost or Percentage of Direct Labor Cost?
    (1) Using the same provider above. Total Administration costs are $250,000.
    (2) Food & Lodging (R&B) receives $118,750 (47.5% x $250,000), and Treatment receives $131,250 (52.5% x $250,000) of the total Facility costs.

    A: The cost report worksheets is designed to automatically compute the Administration indirect cost for residential modality in Tab 3. The Provider does not need to do anything. The food and lodging costs is itemized in Tab 3 and linked to the Detailed Adjustment Tab. The Administration for residential is based on total gross costs, including food in Tab 3. Please follow the cost report instructions and template in Tab 3.

77. Can Residential providers report their Total Residential Costs (combined Facility & Administration, Direct Treatment, and Room & Board (Food & Lodging) in Tab 3 column B by line item cost category, but the report their Residential Treatment costs in Column G, their Room & Board (Food & Lodging) costs in columns J or K by line item?
    (1) For example. Provider identifies costs including personnel as either F&A, Treatment, or Room & Board (Food & Lodging)
    (2) The provider's direct Treatment costs by line-item cost are reported in column G.
    (3) The provider's direct Room & Board (Food and Lodging) costs by line-item cost (e.g. direct salaries and employee benefits, food, supplies, etc.) are reported in either Other SUD Services column J or Non-SUD Services cost centers column K.
    (4) The Admin costs applicable to both R&B and Treatment are allocated to R&B and Treatment based on Percentage of Direct Cost
    (5) The Facility costs applicable to R&B and Treatment are allocated to R&B and Treatment based on SF or alternatively (#2 above is ok) percentage of direct cost (Treatment direct costs vs. Room & Board direct costs)

    A: Yes, if the county elects this option, it is acceptable to report Residential Food & Lodging in column J or K with proper documentation as explained in Question #72.

NON-SUD/OTHER SUD/PRIVATE/SHARE OF COST

78. What are considered non DMC units? Please provide an example
    A: Non DMC units are unit of service recorded for Insurance, Private or Insurance clients such as Blue Shield, Cigna, & Blue Cross, etc.

79. On Slide 38 - Will you please provide an example of a "non-DMC" unit?
    A: BlueCross, SABG. A treatment service that is not defined as a DMC service; see CCR Title 22: 51341.1 for a list of DMC services.

80. Is Recovery Residence considered "Other SUD" or "Non-SUD"?
    A: SUDS services that does not fit into available Direct Modality/Service in Tab 3.

81. What's the difference between private and non-DMC unit?
    A: Private Pay units are cash paying customers who are self-funded. It is possible to be matched to a sliding scale. Non-DMC units are paid by other non-DMC funding sources such as the Substance Abuse Block Grant, county funds, etc. Some of the other funding sources are also used when DMC units cost more than what the State will pay. See response to #79.

82. Does the private pay have to be broken down into various services? What if the Provider records their private pay services as lump sum bundle?
    A: They need to be broken down as they are used to help calculate the cost per unit.

83. Would the share of cost units be consider as approved units and included with the approved units?
    A: Yes, they are approved units. According to SUD Cost Report User Manual, ""Share of Cost" means the monthly amount Medi-Cal requires a beneficiary to pay (or incur an obligation to pay) for services before Medi-Cal begins to pay." Refer to CCR, Title 22, Section 50561 & 50655 for more Share of Costs details.

MISCELLANEOUS

84. Will this training be recorded and posted?
    A: This training is recorded and will be posted online.

85. Will the responses for the questions asked during this training be provided as part of Q&A?
    A: Yes.

86. By when will the training be posted?
    A: We are currently working with our IT and it will be posted as soon as possible. Counties will be notified when it is posted.

87. Can we possibly have the slides in PDF? I am unable to open the PowerPoint.
    A: Slides have been converted to PDF and will be posted online.

88. What is the regulation /citation for using the lower of cost of charges?
    A: 42 Code of Federal Regulations (CFR) Part 413, CMS-Pub. 15-1, Section 1861 of the Federal Social Security Act (42 USC, Section 1395x); 2 CFR Part 200 Subpart E, CMS non-institutional reimbursement policy, and in DMC regulations contained in California Code of Regulations, Title 9 and Title 22 (Section 51516.1 for DMC and ODS Waiver contract).

89. When will DHCS Analysts have access to telephone?
    A: Our IT Department is working on a system to enable us to use our computers, but if you leave a voicemail then it will get forwarded to the Analyst's email.

90. How do DHCS determine the settlement amount of the county admin costs?
    A: DHCS takes the lower of: 1) Calculated amounts in Form MC5312, or 2) It calculates allowable county admin costs based on the approved costs from the Funding Adjustment worksheet.

91. How can county report Measure O in their Cost Report if they use it to fund some of their SUD programs?
    A: It is up to the county's discretion to report their usage of these funds properly when reporting their expenditures on the cost report. Measure O is a specific-county funding type and should be reported in accordance to the services the funding benefited.