Department of Health Care Services
Fiscal Management and Accountability Branch (FMAB)

Fiscal Year 2015-2016
Substance Use Disorder Cost Report

Frequently Asked Questions

COST REPORTS AND SETTLEMENT

Q1: What are the major changes for the FY 2015-16 cost report?

Beginning with FY 2015-16, the DMC forms that are part of the cost report were changed to obtain each provider's methodology for determining allowable costs and assigning them between their various cost centers. Examples of cost centers include DMC modalities (ODF, IOT, residential, NTP), other non-DMC substance use disorder (SUD) services, as well as non-SUD programs.

Other changes are related to the implementation of Senate Bill 75, the HIV fund set-aside allocation moved to discretionary, and the increase of federal reimbursement from 65 to 88 percent for enhanced aid codes.

Q2: Is the cost assignment and allocation process a new requirement?

Per federal law, providers are required to have a cost allocation plan that accurately identifies, accumulates, and distributes allowable direct and indirect costs. This information is reviewed during DHCS fiscal audits; however, the Center for Medicare and Medicaid Services (CMS) is now also requiring that providers submit their total program costs in the cost report and demonstrate how those allowable costs were determined and allocated.

Q3: When will the FY 2015-16 cost report be due?

In its cost report letter dated October 13, 2016, DHCS extended the mandated November 1, 2016 due date to January 30, 2017. Due to several issues that have delayed counties' abilities to submit cost reports within that timeframe (readiness of the reconciliation reports and the FY 15-16 SUD Cost Report System), **DHCS has extended the due date to March 31, 2017.**

Q4: Does the county have to mail to DHCS all the DMC workbooks with the providers' original signed certifications, or can we mail just the provider certification page with the original signature and email the remainder of the DMC forms?

The county can email DHCS the DMC workbooks—they only need to mail the first page of each provider's workbook with the original signed certification.

Q5: Can DHCS add extra non-DMC program codes to the cost report so that our county can do more detailed tracking of specific programs (such as CalWorks, drug courts, etc.)?

DHCS will not be including any additional program codes for non-DMC services. The current program codes are sufficient to track all programs and funds that must be reported to the state. Counties should use their own internal tracking systems if more detailed information is needed at the local level.

Q6: What happens if a provider's actual DMC costs are higher than the State approved rates?

If a provider exceeds the statewide maximum allowable rate for reimbursement, the county is responsible for using other DMC-approved funds to cover the excess costs (such as county or Behavioral Health Subaccount funds). Please reference the *Funding Line Descriptions* (Exhibit F of the cost report materials) for detailed descriptions of funding lines and their use.

Q7: Since the federal share of DMC services (federal financial participation, or FFP) is paid to counties when services are approved, under what circumstance would the county owe FFP during cost settlement?

The rate at which a county bills for DMC services is an interim rate until the cost report is settled. DHCS is required to settle at the lower of the maximum state rate or actual cost. So, if the county billed DMC at the maximum state rate and their actual cost was lower as reported on their cost report, there would be an amount due.

Q8: What is the allowable county administrative rate for DMC?

The administrative expenses claimed by the county for DMC services should be actual and reasonable, but the maximum is 15 percent.

NEW DRUG MEDI-CAL COST REPORT FORMS

Q9: Who is responsible for completing the new DMC forms?

Providers are responsible for completing the appropriate DMC forms and submitting them to the county. The provider must certify that the cost report information is true, correct, and in compliance with federal law.

Q10: How will the change to the DMC cost report forms impact providers?

For providers, the impact of the changes to the DMC forms should be minimal. The structure of the DMC forms have changed, but basically, the only new information to be reported is the provider's overall costs incurred related to SUD services and how they determined what was allowable and attributable to a specific modality, as recorded in their general ledger. Providers are not expected to use or create a different methodology for determining reimbursable costs as a result of this change, nor should they have to make any changes in how they identify expenses as directly attributed to the provision of a specific program or service.

Q11: During an audit, what level of detail will providers be required to demonstrate for cost allocation?

The level of detail on how allowable costs were determined and reported is up to the provider to document; however, the organization must be able to support each reported expenditure and revenue by records that clearly identify their sources by line items, modalities, direct and indirect costs. Revenue must also be classified based on their funding sources.

Q12: What can a provider do if they have closed their books on FY 2015/16 and they have not accounted correctly for the necessary allocation distribution of direct and indirect cost?

CMS requires that all DMC providers account for their costs correctly on the DMC forms. If the provider did not appropriately allocate their costs, the provider will need to make revisions before the final cost report submission.

Q13: We already submitted our cost report to the county. Do we need to resubmit it?

If the information submitted by the provider to the county does not meet the new CMS requirements, the provider will need to submit additional data to the county, along with the signed provider certification.

Q14: Is the acceptable direct cost allocation methodology and guidance already available? Can I obtain a copy of this guideline that I can share with our providers?

The guidance for costs allocation methodology is identified in 42 CFR Part 413, CMS Pub 15-1, 2 CFR Part 200 Sub Part E, Non institutional reimbursement policy. The methodology adopted by the provider must assign costs to a particular cost objective based on benefit received by that cost objective. Any method of distribution can be used which will produce an equitable distribution of cost. In selecting one method over another, consideration should be given to the additional effort required to achieve a greater degree of accuracy.

Q15: My organization has multiple provider locations/service types with separate NPI numbers. Does that mean I need to complete multiple workbooks that all reconcile back to my general ledger?

Yes, there needs to be one workbook for each location/DMC number (unless it is a “satellite” location with the same DMC number as the parent location). Organizational or corporate costs in the general ledger that are shared or allocated across multiple locations must be shown on the specific locations’ workbooks.

Q16: What general ledger information should be included in column A?

All costs for that specific DMC location (DMC #) must be included. In addition, if the organization shares or allocates overall costs across multiple DMC locations, the costs allocated to that location must also be included in column A.

Q17: Our organization has a mental health program at the same site as the DMC program. Do we need to include the mental health program costs in column A?

If the general ledger for each program is totally separate, the mental health costs should not be included. However, if costs are shared or allocated across two or more programs (for example, a counselor provides services to both DMC and MH clients), the costs for all programs must be included.

Q18: During the training, we were told that certain cells on various tabs should match. Can you please identify those cells?

The following is an example of the cells that should match related to the ODF services tabs (the titles of the cells are similar in the IOT and residential tabs):

Tab 3, Total Direct and Indirect Costs for ODF (cell B145)
Tab 4, Total ODF Overall Total Costs (cell J58)
Tab 6, Total ODF SUD Services (cell G12)
Tab 6, Overall ODF Total Costs as Allocated (cell G62)

Q19: What is the approved method for allocating indirect costs on the new DMC cost report?

The approved method for allocating indirect costs is the percentage of direct costs. The calculation for this methodology is built into the forms.

Q20: Our county's providers use other methods to allocate indirect costs, such as relative value. Are other methods acceptable to use instead of the percentage of direct costs?

If a provider wishes to use an allocation basis other than the one prescribed in the cost report <u>and it is consistent with OMB Circular A-87</u>, the provider must obtain their respective county's prior approval. Before granting approval to the provider, the county must submit a request to DHCS with a sample of the methodology and DHCS will make a final determination of the propriety of the methodology used (relative value is not an acceptable method to allocate indirect costs).

DMC Reconciliation Report

Q21: When will DHCS be providing to counties the DMC units reconciliation report that shows approved and denied units by provider, by aid code?

DHCS will be resending the reconciliation reports to the counties by Monday, November 14, 2016. If your county does not receive the report by that date, please contact your assigned FMAB analyst. DHCS has been unable to resolve the issues related to multiple DMC locations using the same NPI; therefore, in those cases, there may be missing providers or false approved units.

Q22: If DHCS' reconciliation report does not match the county's internal units of service tracking reports, should the county use their own reports since these are the data we can support in an audit?

The reconciliation report provided by DHCS is a courtesy to the county to allow them to reconcile their internal records with the approved and denied units shown in DHCS' SMART payment system. If the two do not agree and the county believes their records are correct, they should use their own reports and notify their county analyst about the discrepancy.

FUNDING AND ALLOWABLE EXPENDITURES

Q23: Can a county's State General Fund (SGF) allocation for expanded IOT services be carried over to subsequent years?

SGF for IOT expansion is a reimbursement, not an allocation. The money cannot be rolled-over to subsequent years if unspent. If a county does not meet their SGF spending base, it is reflected as cost savings for the state.

Q24: Can SAPT funds be used to provide services to youth in juvenile hall?

No, SAPT funds cannot be used to provide any services to individuals who are incarcerated.

Q25: Why is the Human Immunodeficiency Virus (HIV) Early Intervention Services (EIS) set aside no longer available in the FY 2015-16 SAPT allocation?

In FFY 2016, California's AIDS case rate fell below the threshold guidelines for states designated as HIV-EIS recipients, so the 15-16 HIV allocation was moved to the discretionary category. However, DHCS recently received federal approval to allow counties to expend the portion of the FFY 2016 HIV funds that were allocated in FY 15-16. Counties who spent those funds will need to notify DHCS how much was spent and DHCS will adjust their allocation (move that amount from discretionary back to HIV).

Q26: Can a county-contracted provider bill for meals in a residential, perinatal setting?

No, food costs are not allowed in Drug Medi-Cal (DMC) programs. Costs of employee meals are allowable DMC costs under specific conditions as identified in the Provider Reimbursement Manual, Part 1 (CMS Publication 15-1). These costs must meet the test for reasonableness and necessity of the expense and be defined as either salary or a fringe benefit specifically identified in the employee manual; such costs should be reported in either "Salary and Wages" or "Employee Benefits".

Q27: Are "start-up costs" still applicable for county SUD programs and how can the county go about utilizing start-up costs? What other ways can counties access funds for SUD infrastructure?

Start-up costs are an appropriate expenditure for SAPT funds (not DMC). Those costs associated with the initial development of a program within the 90 days immediately prior to the provider's ability to provide services. Typically, these costs include (but are not limited to) those for administrative and staff salaries, training, rent, utilities, and repairs.

Q28: Can SAPT Block Grant be used to help cover the costs of a program that is Drug Medi-Cal certified and providing covered DMC services to Medi-Cal beneficiaries?

No, SAPT cannot be used to cover the costs of DMC services. However, the county can shift the uncovered costs of a DMC provider to non-DMC and use a variety of other funds to cover those costs (this would also be applicable if the provider has denied DMC units). Funding lines that are specifically designated to cover DMC costs in excess of the rate cap include Provider Unrestricted Funds (funding line 82a), County Unrestricted Funds (funding line 82b), and Behavioral Health Subaccount (funding line 101).

Q29: What funds can be used to pay for alcohol/drug free housing and sober living environments?

Alcohol/drug free housing (ADH) and sober living environments (SLE) are not licensed residential treatment programs and do not provide treatment services. Therefore, state allocated funds (SAPT or DMC) cannot be used for these services. Counties may use BHS funds for these services for perinatal populations only. Within perinatal programs (program codes 3, 10, 11), BHS may be used for Transitional Living and Alcohol and Drug-Free Housing (service codes 56 and 57). Except for the instance noted above, BHS that is counted toward maintenance of effort (MOE) for SAPT Block Grant is not available for SLEs.

Q30: If a DUI program has multiple locations, is the 10 percent maximum of fees that can be retained as DUI profit/surplus specific to each location or applied across the provider organization?

The 10 percent maximum of fees that can be retained as DUI profit/surplus is specific to each location/license number.