DEPARTMENT OF MENTAL HEALTH
1600 - 9THSTREET
SACRAMENTO, CA 9.5814
(916) 654-2378

October 27, 1998

DMH LETTER NO: 98-04

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

SUBJECT: 1997-98 FISCAL YEAR (FY) COST REPORT SETTLEMENT POLICY

EXPIRES: Retain Until Superseded

This letter outlines the submission and reporting requirements for the FY 1997-98 cost report. To the extent that there are differences between this letter and other California Department of Mental Health publications, the requirements contained in this letter will prevail.

I. SUBMISSION REQUIREMENTS

A. Cost Report Submission

Counties are to submit a separate cost report for each legal entity. Welfare and Institutions Code Section 5718(c) requires county mental health facilities, clinics and programs to submit fiscal year-end cost reports by December 3 1 st following the close of the fiscal year.

Fiscal Year 1997-98 year-end county cost report packages for mental health facilities, clinics and programs are to be submitted to the California Department of Mental Health no later than Thursday, December 3 1, 1998.

One original and two paper copies of the cost report should be sent to the following address:

California Department of Mental Health
County Cost Reporting and Data Collection
1600 9th Street, Room 150
Sacramento, CA 95814
ATTN: Susan Brown

B. Cost Report Forms

Counties that do not use the Department's printed cost report forms must submit facsimiles identical to the Department's forms. Draft copies should be submitted in advance to the Department for approval.

Major changes to the FY 1997-98 cost report forms are as follows:

1. Change in Federal Financial Participation

Cost report forms MH 1966A & B, MH 1968 and MH 1979 were revised to incorporate the changes in the federal sharing ratio (see item G for further details).

2. Mental Health Managed Care

In FY 1997-98 the budget line item, 4440-103-001 Community Services Other Treatment for Mental Health Managed Care includes Phase II funds for Medi-Cal Consolidation.

C. Amendments or Revisions

Amendments or revisions to the cost report are not appropriate after December 3 1, 1998. However, corrections identified by the Department which are necessary to facilitate processing or to prevent undue hardship to counties can be made. Unapproved revisions made after December 3 1, 1998, 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 1997-98 cost report is as follows:

1. 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 Form MH 1960, Line 1, Column 3.

2. 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. A detailed explanation of the "Other Adjustment" item on Form MH 1960, Line 4. In addition, rollover funds, except for Hospital Inpatient Consolidation funds from FY 1996-97, should be included as a positive adjustment on this line, if not included in total Mental Health Expenditures, Line 1.

We believe that the above minimum documentation will meet HCFA standards, ensure counties of the continued availability of Federal Financial Participation (FFP), and enable Cost Report/Data Collection staff to perform an adequate desk review.

11. COST REPORT POLICY

A. Inpatient Administrative Days

Inpatient administrative day costs must be reflected in Mode of Service 05, Service Function Code 19 only. Form MH 199 1 was designed to calculate the SD/MC maximum allowance plus ancillary and physician costs for administrative days. Please note that there is a single per diem Medi-Cal rate for administrative days of $214.90.

All legal entities with hospital administrative days should complete Form MH 1991 per the instructions. Costs for ancillary and physician services related to patients on administrative day status should be included in the gross costs (Line 3) of MH 1966. On MH 1966, Lines 12 through 14A will also include physician and ancillary costs.

The amount for ancillary and physician services is limited to the costs claimable under Section 5 15 11 (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.

Non-Medi-Cal Units

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 10 of the Form MH 1966.

B. Categorical Funding

Categorical funds must be used for the purpose for which they were appropriated in the Budget Act of 1997. Accordingly, Special Education Pupil funds (AB 3632) may only be used for assessment, treatment, and case management services. Costs in inappropriate modes (e.g., Administration or Outreach) will be adjusted or the cost report will be returned to the county for correction.

Form MH 1909 should identify each budget item and categorical fund expenditure and units of service by legal entity, mode, and service function. Please include a completed MH 1909 form for each budget item (except for managed care funds, Budget Item 4440-103-001) with your cost report package to assist the Department in properly accounting for match 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 Federal Financial Participation (FFP) do not require local county matching funds.

C. Realignment Funds

The county's realignment funds (sales tax receipts, Vehicle License funds, and local program maintenance of effort funds per Welfare and Institution Code Section 17608.05) should be identified on Form MH 1992, line 20.

D. Transaction Service Period

Units of service and related revenues reported on the FY 1997-98 cost report must reflect services and transactions occurring during the period of July 1, 1997 through June 30, 1998 only.

E. Reimbursement Limitation Policy

In accordance with State laws and regulations, the Department established SD/MC maximum allowances (rates) for FY 1997-98 (DMH Letter 97-06). These rate limits apply to all SD/MC eligible services. Please refer to Enclosure A.

F. 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 maximum reimbursement rates (SMA) established by the Department. If there is no negotiated rate with the Department then actual cost rates up to the SMA will be reimbursed.

G. Federal Financial Participation

The state/federal sharing ratio for SD/MC during 1997-98 is as follows:

First Quarter (July 1, 1997 through September 30, 1997): the FFP matching ratio for Medi-Cal reimbursable mental health treatment services is 50.23 percent for the federal share and 49.77 percent for the state share.

Balance of the Fiscal Year (October 1, 1997 through June 30, 1998): the FFP matching ratio for Medi-Cal reimbursable mental health treatment services is 5 1.23 percent for the federal share and 48.77 percent for the state share.

The FFP matching ratio for skilled professional medical personnel engaged in quality assurance oversight remains at 75 percent federal share/25 percent state share. Other quality assurance costs and all other administrative costs, including MAA, remain at the 50/50 percent ratio. The Department's cost report forms for 1997-98 have been modified to reflect these changes. All legal entities must be able to detail units of service provided from July 1, 1997 through September 30, 1997 and those units of service provided from October 1, 1997 through June 30, 1998.

H. Reporting of Revenues

Medicare and all other third party revenues should be reported on an accrual basis in the cost report.

I. Medicare/Medi-Cal Crossover Revenues

In the 1997-98 cost report, Medicare/Medi-Cal crossover units are to be settled in the same manner as other Medi-Cal units. Consequently, they are subject to a comparison of lower of cost, published charge, SMA rate and negotiated rate data on Form MH 1966. Such comparison will determine the calculation of Medicare/Medi-Cal Crossover gross reimbursement on Form MH 1968.

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

During 1997-98, state general fund match for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program of medically necessary services to full-scope Medi-Cal eligible beneficiaries under 21 years of age was provided to counties through interim payments (not an allocation). On Form MH 1992, Funding Sources, the estimated state share of EPSDT expenditures are to be reflected as a revenue on Line 18.

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.

K. 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 the Department for use during the cost report year. If a provider does not have this association, then any provider costs submitted by this provider will be disallowed.

To ensure that all providers are properly attached with a legal entity number, please call Sara Gilb, Statistical and Data Analysis Section at (916) 327-9318.

L. Medi-Cal Administrative Activities (MAA)

Counties must have an approved MAA claiming plan on file with the Department of Mental Health prior to claiming MAA costs in the cost report. Counties that claim MAA costs without an approved claiming plan will have those associated MAA costs removed from the cost report.

III. FEDERAL BLOCK GRANTS

A. Federal Block Grant Cost Reports

Counties receiving Substance Abuse and Mental Health Services Administration (SAMHSA) 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 the Department'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 1997-98. DMH Letter 94-03 contains information regarding the reporting of FFP in SAMHSA grant funded programs.

If you have any questions, please call your CR/DC liaison.

Sincerely,

LINDA A. POWELL
Deputy Director
Administrative Services

Enclosure