Attachment AA
Drug Medi-Cal Organized Delivery System (DMC-ODS)
County Certified Public Expenditures (CPE) Protocol
(Updated September 16, 2020)

GENERAL

Consistent with 42 CFR 433.51, a State or a unit of local government may use for its share in claiming federal financial participation (FFP) its public funds appropriated directly to the State or local Medicaid agency, transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP. Public funds must not be federal funds unless specifically authorized by Federal law to be used for such purpose.
The certified public expenditures of each Drug Medi-Cal (DMC) Organized Delivery System (ODS) County are comprised of expenditures incurred for payments made to contracted providers, payments made to contracted managed care plans, and expenditures incurred by county-operated providers, for the furnishing of DMC ODS waiver services specified in the special terms and conditions of this 1115 demonstration waiver to eligible Medi-Cal beneficiaries.

DMC ODS county expenditures for contracted provider services are the payments made to the contracted providers for substance use disorder services rendered. For the NTP/OTP modality of service, each DMC ODS county pays contracted providers at the lower of the uniform statewide daily rate (USDR) or the provider's usual and customary charge to the general public for the same or similar services. For non-NTP/OTP modalities, each DMC ODS county pays contracted providers at county-specific negotiated rates, subject to contracted provider cost reconciliation as discussed below. The rates are proposed as part of the county fiscal plan that is submitted as addendum to the implementation plan and approved by the Department of Health Care Services (DHCS).

Each DMC ODS county that contracts with a managed care plan pays the managed care plan a county specific interim per utilizer per month (PUPM) rate for all substance use disorder services rendered by county and non-county providers to each user each month. Each county-specific PUPM rate is reviewed and approved by DHCS, and is subject to reconciliation as described below.

The county-specific negotiated rates are based on several criteria as required in the fiscal guidance that has been provided in Mental Health and Substance Use Disorders (MHSUDS) INFORMATION NOTICE NO: 15-034 and MHSUDS INFORMATION NOTICE NO: 16-050. The county will use the projected actual cost for services based on the most current prior fiscal year cost report data, where these services were previously available, with adjustments for increased projected beneficiary counts and the resulting projected increase in units of service (projected utilization) that will result from participation in the pilot. In the cases where the services have not been previously available, the counties will project staff hours for providing the services and calculate a projected cost per unit. Additional adjustments can be applied for inflation, using an approved government inflation factor, in similar manner to the county interim rate development.

The county-specific interim PUPM rates are based on the following criteria.

- Total enrollment for each county multiplied by assumed prevalence rates and penetration rates by age group equals estimated utilizers for each county.
- Estimated utilizers multiplied by the percentage of utilizers in Marin County, Riverside County, and San Mateo County who used each mode of service.
- Estimated utilizers by mode of services multiplied by the average rate per mode of service paid in Marin County, Riverside County, and San Mateo County or the Fiscal Year 2015-16 county cost trended forward, if available, determined the total cost for each mode of service.
- Summed the total cost across all modes of service to determine the total cost for the estimated utilizers.
- Divided the total estimated cost by the total estimated utilizers to determine the service component of the interim PUPM rate.

As the State reviews proposed county interim rates and county interim PUPM rates, the additional information that is considered in the review includes data that illustrates the contract providers' or contract managed care plan's projected cost per unit for each DMC ODS service. The State is able to provide oversight to the contract provider rate or contract managed care interim PUPM rate development at this stage of the review. If the projected expenditure or the projected utilization appears to be excessive or unsubstantiated, the State will provide feedback in the review process and request additional justification and/or correction to the projections. DMC ODS county expenditures for county-operated provider services are determined through county provider cost reports. Section 14124.24(9) (1) of the Welfare and Institutions Code (WIC) requires that legal entities (i.e., counties and contracted providers), except for those contracted providers providing only narcotic treatment, submit substance use disorder (SUD) cost reports to DHCS by November 1 for the previous state fiscal year, unless DHCS grants a formal extension. A county-operated narcotic treatment facility will be required to submit the complete SUD cost report. A county with an approved PUPM rate will not be required to submit a cost report for non-county-operated providers. The reconciliation of those payments will be subject to a reconciliation based on payments and actual encounters. A county with an approved PUPM rate will be required to submit a county provider cost report for county-operated providers, and payments for services rendered by county-operated providers will be reconciled to county-operated provider cost.

The SUD cost report forms are structured to obtain each legal entity's methodology for allocating costs between the various services provided by the legal entity, separate by provider number. The provider must demonstrate in their cost report the allocation base they used to distribute their total program costs to specific SUD programs and modality types.
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. There are 23 worksheet tabs with data entry areas identified in yellow; however, most of the worksheet areas are automatically populated.

The SUD cost reporting forms were reviewed and approved by the Centers for Medicare and Medicaid Services (CMS) as part of the Medicaid state plan amendment 09-022 review. Direct

costs and indirect costs are recognized consistent with federal cost principles, including 2 CFR 200 Subpart E, Medicare cost principles (42 CFR 413 and Medicare Provider Reimbursement Manual Parts 1 and 2), and Medicaid non-institutional reimbursement policy. Any substantive modification to the approved cost reporting form is subject to review and approval by CMS. For the purposes of determining DMC ODS county certified public expenditures for county-operated and contract providers under the 1115 waiver, each county as contractor with the State receives and aggregates the legal entity cost reports into a cost report for all DMC ODS services provided under the contract to eligible Medi-Cal beneficiaries. The county is responsible for certification of public expenditures. DHCS is reconciling the county cost, based on the aggregate of costs incurred by the county for payments to all subcontracted providers and costs incurred by the county-operated providers. Cost reports completed by non-county (i.e., contracted) legal entities (which are required to file cost reports for non-NTP services under the Medicaid state plan), and cost reports completed by county-operated providers, are used to determine the DMC ODS expenditures under the 1115 waiver. These cost reports are used to determine if the reconciled amount was the lower of cost or customary charge (and in the case of dosing and individual/group sessions provided by county-operated NTP providers, the lowest of USDR or cost or customary charge). These cost reports are subject to audit by State and Federal authorities.

DEFINITIONS

1. "CMS" means the Centers for Medicare and Medicaid Services.
2. "Cost center" means a department or other unit within an organization to which costs may be charged for accounting purposes.
3. "DHCS" means the California Department of Health Care Services.
4. "Direct costs" means those that are directly incurred, consumed, expanded and identifiable for the delivery of the specific covered service, objective or cost center. Examples of direct costs include unallocated (i.e., directly assigned or directly charged) wages/salaries of employees for the time devoted and identifiable specifically to delivery of the covered services or the final cost objective such as intensive outpatient treatment, outpatient drug free treatment. Other direct costs may include direct materials, equipment, supplies, professional services and transportation that are directly acquired, consumed, or expended for the delivery of the specific covered service or objective.
5. "DMC" means Drug Medi-Cal.
6. "DMC unreimbursable costs" means costs that are not reimbursable or allowable in determining the provider's allowable costs in accordance to the California's Medicaid State Plan, the special terms and conditions of this 1115 demonstration waiver, federal and state laws and regulations, including 2 CFR Part 200 Subpart E, 42 CFR 413, Medicare Provider Reimbursement Manuals, CMS non-institutional reimbursement policy and California Code of Regulations Titles 9 and 22 (to the extent that they do not conflict with federal cost principles).
7. "Indirect costs" means those costs: a) incurred for a common or joint objective benefiting more than one cost center or objective, and b) are not readily identifiable and assignable to the cost center or objectives specifically benefited, without effort disproportionate to the particular cost center or objective.
8. "Indirect cost rate" means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of the indirect costs to a direct cost base. A

provider's indirect cost rate must be determined and approved by a cognizant agency (federal or state agency).

9. "IOT" means intensive outpatient treatment.
10. "Legal Entity" means each county alcohol and drug department or agency, each corporation and its subsidiaries, sole proprietors, partnerships, agencies, or individual practitioners providing alcohol and drug treatment services under contract with the county alcohol and drug department or agency or with DHCS.
11. "NTP" or "OTP" means narcotic treatment program treatment.
12. "ODF" means outpatient drug free treatment.
13. "Percent of Direct Costs" means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of each modality or cost center's direct costs to the total direct costs. Percent of Direct Costs is a variation of the Indirect Cost Rate which allows the allocation of indirect costs by line item rather than in aggregate.
14. "Interim Per Utilizer Per Month(PUPM) Rate" means the approved county specific monthly interim rate paid per beneficiary who utilized at least one substance use disorder service for the month in which the service(s) is rendered.
15. "PH" means partial hospitalization.
16. "SUD" means substance use disorder.
17. "Total Utilizer Months" means the number of months during which all beneficiaries utilized at least one substance use disorder service.

SUMMARY OF STATE-DEVELOPED COST REPORT

Modifications to the Current CMS Approved SUD Cost Report Forms

In order to collect accurate cost data for the additional services offered in the DMC ODS, it will be necessary to insert sections into each of the four modality-specific worksheets to capture data for all of the added DMC ODS services that will be offered in each level of care. These include adding case management, physician consultation, withdrawal management, recovery services. and additional medication-assisted treatment. DHCS will also need to add new tabs for Partial Hospitalization (PH) services. These tabs will also include the additional DMC ODS services as described above. These changes will not change how the forms calculate the amounts; they will just add the additional services into the current structure.

The other necessary modification is to remove the current statewide rates that are currently included on the forms. The Cost Allocation tab of the forms will calculate the cost per unit based on total allowable cost/total allowable units. This cost per unit will be used to reconcile the interim payments. The state will not use the current DMC Maximum Allowed for the ODS cost settlement. However, all other limits including the USDR for NTP services and customary charges will continue to apply as they do under the state plan for DMC services.

Inpatient hospital-based residential and withdrawal management services include ASAM levels 3.7 and 4.

These services are reimbursable in the DMC ODS when they are delivered by a licensed and certified chemical dependency rehabilitation hospital (CDRH) or a licensed and certified

freestanding acute psychiatric hospital (FAPH). CMS requires the use of the form CMS 2552-10 for all hospital cost reporting. Contracted CDHRs and FAPHs must submit a copy of the CMS 2552-10 to the county for the purpose of DMC ODS cost reporting. The information from the CMS 2552-10 submitted to the county will be used to identify the relevant cost data that the county will enter into the cost report system.

Cost Report Forms Description:

Provider Information and Certification Worksheet (Tab 1)
This worksheet collects legal entity details, including entity name, address, other contact information, and all related legal entity information under the same county contract. This worksheet is also where the legal entity representative signs and certifies that the cost report is accurate and complies with all Federal and State requirements.

Overall Cost Summary Worksheet (Tab 2)
This worksheet displays a summary of the totals for all the cost centers being reported. No data entry is necessary in this worksheet; information will automatically populate from the Overall Detailed Costs worksheet.

Overall Detailed Costs Worksheet (Tab 3)
This worksheet requires the legal entity to enter all necessary data related to all direct and indirect costs being reported. This worksheet must reflect all costs incurred by the legal entity related to their SUD services and it must demonstrate the allocation methodologies used by the legal entity (in accordance with applicable cost reimbursement standards) to distribute their costs across various cost centers.

Detailed Costs Worksheet (Tab 4 - ODF: Tab I - PH: Tab 12 - IOT: Tab 16 - Residential: Tab 20 - NTPI
This worksheet displays the results of all calculations for the cost reported for the specific modality. No data entry is necessary in this worksheet; information will automatically populate from other worksheets.

Detailed Adjustments For DMC Unreimbursable & Direct Costs Worksheet (Tab 5 - ODF: Tab 9 - PH: Tab 13 - IOT: Tab 17 - Residential: Tab 21 - NTP

This worksheet allows the legal entity to enter the breakout of costs from the program's general ledger for each of the cost categories between the different services. This information automatically populates data in the Detailed Costs worksheet and the Cost Allocation worksheet.

Cost Allocation Worksheet (Tab 6 - ODF; Tab 10 - PH: Tab 14 - IOT: Tab 18 Residential: Tab 22 - NTP)

This worksheet further identifies the breakout of costs between the different services and between private pay, DMC and non-DMC. The legal entity will enter the units of service and the rates that have been charged for the services. The worksheet calculates the maximum

reimbursement for DMC services. All other areas are automatically populated based on data entry in other worksheet tabs.

Reimbursed Units Worksheet (Tab 7 - ODF: Tab 1l - PH: Tab 15 - IOT: Tab 19 Residential: Tab 23 - NTP)

This worksheet requires the legal entity to enter the approved units of DMC service based on a report generated by DHCS. There are areas on this sheet that are automatically populated from other worksheets. The worksheet produces specific reimbursement amounts by funding source and aid code category. The county will use the amounts from this worksheet for data entry into the cost report system application.

PUPM Reconciliation Report Description

The PUPM Reconciliation Report reconciles costs eligible for reimbursement with the total PUPM payments the county made to the Managed Care Plan (i.e., Certified Public Expenditures). For non-NTP services provided by non-county-operated providers, cost eligible for reimbursement are equal to the lower of the amount the managed care plan paid the contract provider or the prevailing charge for the same or similar service. For non-NTP services provided by county-operated providers, costs eligible for reimbursement are equal to county-operated provider's allowable cost. Reimbursement for non-NTP inpatient hospital services, provided either by non-county-operated providers or county-operated providers, will not exceed the provider's customary charge for the service. For NTP services provided by non-county operated providers, the cost eligible for reimbursement is equal to the lower of the USDR, or the provider's usual and customary charge for the same or similar services. For NTP services provided by county-operated providers, the cost eligible for reimbursement is equal to the lower of county-operated provider's allowable cost, the USDR, or the provider's usual and customary charge for the same or similar service. The following describes each tab in the PUPM Reconciliation Report and how it is used to calculate costs eligible for reimbursement and to compare those costs eligible for reimbursement to the county's certified public expenditures.

DMC ODS County Information Worksheet

This worksheet captures detailed contact information for the DMC ODS County and its contracted managed care plan. Contact information includes the county code; county name; managed care plan; and name, phone number, and e-mail address of the person the county wants the state to contact with questions about the PUPM Reconciliation Report.

Total Beneficiaries Served Worksheet

The DMC ODS County or contracted managed care plan must enter the total unduplicated beneficiaries served by month and aid code group based upon a report generated by DHCS. This worksheet calculates Total Utilizer Months.

Approved Units of Service Worksheet – Non-County-Operated Providers

The DMC ODS County or contracted managed care plan must enter on this worksheet the total approved units of service rendered by non-county-operated providers for the reporting fiscal year by aid code group, modality, and population (i.e., perinatal or non-perinatal) based upon a report generated by DHCS.

Cost Per Unit of Service Worksheet – Non-County-Operated Providers

The DMC ODS County or contracted managed care plan must enter on this worksheet the cost of services for each DMC ODS covered service modality provided to Medi-Cal beneficiaries enrolled in the DMC ODS County for which the reconciliation report is submitted. This worksheet calculates the cost per unit of service for each service modality. This worksheet is also prepopulated with the prevailing charge for each service modality. The USDR is the prevailing charge for NTP services.

Third Party Revenue Worksheet

The managed care plan must enter any revenue it received from third parties for the units of service reported in the Approved Units of Service Worksheet.

Eligible Cost Worksheet

This worksheet calculates the managed care plan's eligible costs for each DMC ODS service modality. Eligible costs for each service modality is equal to the total units of service multiplied by the cost per unit of service minus third party revenue.

Eligible Prevailing Charges Worksheet

This worksheet calculates the total prevailing charges less third party revenue for each DMC ODS service modality. Eligible prevailing charges is equal to the total units of service multiplied by the prevailing charge per unit of service minus third party revenue.

Cost Allocation Worksheet

This worksheet calculates the proportion of eligible costs that are to be reimbursed by the federal government, state government, and county government by service modality.

Prevailing Charges For Non-County-Operated Providers Allocation Worksheet

This worksheet calculate the proportion of eligible prevailing charges that would be reimbursed by the federal government, state government, and county government by service modality.

UPL/Budget Neutrality Demonstration Worksheet

This worksheet compares the total actual cost to total prevailing charges by aid code group, selects the lower of total actual cost or prevailing charges, and calculates federal reimbursement based upon the lower of total actual cost or prevailing charges.

County Contracted MCP Reconciliation Worksheet

This worksheet reconciles contracted managed care plan's actual costs eligible for reimbursement with the County interim PUPM payments to the managed care plan. The County or the contracted managed care plan must enter actual costs eligible for reimbursement by aid code group for county-operated providers as determined in the cost report form described on page 5. The worksheet adds the actual costs eligible for reimbursement for non-county-operated providers to calculate the total costs eligible for reimbursement. The county must enter the total interim payments made to the managed care plan. The amount of total costs eligible for

reimbursement less County interim payments to the contracted managed care plan equals the amount due to or from the contracted managed care plan.

DHCS County Reconciliation Worksheet

This worksheet reconciles the DMC ODS County's final total payments to the contracted managed care plan for DMC ODS services with total interim payments made to the DMC ODS County for those services. The DMC ODS County received an overpayment when interim payments exceed the DMC ODS County's final total payments. DHCS will recoup any overpayments to the DMC ODS County and return the overpayment to the federal government. The DMC ODS County received an underpayment when its final total payments to the managed care plan exceed interim payments. DHCS will made addition interim payments to the DMC ODS County when there is an under payment. DHCS will not pay a DMC ODS county more than the amount it paid the managed care plan for DMC ODS services rendered.

County Certification

The County Auditor Controller must certify the final total payments to the managed care plan as reported in the Total Payments Worksheet.

INTERIM RATE SETTING METHODOLOGY

Each county's interim CPE claim submitted to the state will be based on the services provided and the approved county interim rates or county interim PUPM rate for the covered services. Annual county interim rates for each covered service will be developed by the county and approved by the State. Annual county interim PUPM rates for the covered services will also be approved by the State. The approved interim rates will be specified in the State/County contract. These interim rates must conform to SSA §1903(w)(6) and §42 CFR 433.51. All interim payments for services rendered by contract providers and county operated providers will be subject to annual reconciliation and cost settlement consistent with Federal and State requirements. All interim payments for services rendered through contracts with a managed care plan will be subject to an annual reconciliation.

Proposed county interim rates must be developed for each required and (if indicated) optional service modality. The proposed county interim rates must be developed consistent with the terms and conditions of the Waiver, written guidance provided by DHCS, and federal certified public expenditure (CPE) requirements related to interim payments; and are subject to annual reconciliation and cost settlement.

Proposed county interim PUPM rates must be developed for all required and optional service modalities. The proposed county interim PUPM rates must be developed consistent with the terms and conditions of the Waiver, written guidance provided by DHCS, and federal certified public expenditure (CPE) requirements related to interim payments; and are subject to annual reconciliation.

The proposed county interim rates and county interim PUPM rates should be based on the most recently calculated or estimated total county cost with adjustments for projected increases in utilization and the application of the Home Health Agency Market Basket inflation factor. The proposed interim rate should be calculated for each service including both county directly delivered (if appropriate), and subcontracted fee for service provider costs. For county-operated services the county will be reimbursed based on actual allowable costs. County payments to contracted fee for service providers and managed care plans are considered to be actual expenditures according to the terms and conditions of the waiver.

Uniform Statewide Daily Reimbursement Rate Methodology for DMC ODS Narcotic Treatment Programs

The uniform statewide daily reimbursement (USDR) rate for the daily dosing service is based on the average daily cost of providing dosing and ingredients, core and laboratory work services as described in State Plan Amendment (SPA) 09-022, Section D. The daily cost is determined based on the annual cost per patient and a 365- day year, using the most recent and accurate data available, and in consultation with narcotic treatment providers, and county alcohol and drug program administrators. The uniform statewide daily reimbursement rates for NTP Individual and Group Counseling are based on the non-NTP Outpatient Drug Free Individual and Group Counseling SMA rates as described under SPA 09-022, Section E.1.a.
For interim rate purposes, county-operated NTP/OTP providers are reimbursed at the USDR for dosing, individual/group sessions. However, additional ODS services available to county-operated NTPs (case management, physician consultation, recovery services) will be reimbursed at county interim rates discussed above.

For a county that contracts with a managed care plan, the USDR rates for NTP services will serve as the upper payment limit for reconciliation purposes. The managed care plan will pay the provider the lower of the USDR or the provider's usual and customary charge for NTP services.

INTERIM MEDICAID PAYMENTS

The State makes interim payments of FFP to the DMC ODS counties based upon submitted expenditures. The DMC ODS counties will submit monthly CPE claims to the state for interim payments for services provided during the fiscal period. When submitting a claim for FFP for services provided by a county-operated or contracted provider, the DMC ODS county is required to certify that it has made expenditures on which the claim for FFP is based, that the expenditures are no greater than the actual county cost of providing services, and that the expenditures meet all federal and State requirements for claiming FFP.
Interim payments for FFP for county contracts with county-specific rates by covered service will be available through claim adjudication for those expenditures the contracting county has officially certified. This certification must satisfy all federal Medicaid and State Medi-Cal CPE, full funds expenditure (federal and non-federal share expenditure), and claims integrity requirements. Claims will be reimbursed at the annual interim rates for each covered service developed by the county participating in the demonstration and approved by the State. All interim rates must conform to 42 CFR. 433.51, and all certified public expenditures continue to

be subject to annual reconciliation and cost settlement consistent with Federal and State requirements.

Interim payments of FFP for services rendered through county contracts with managed care plans will be available through claim adjudication at the county Interim PUPM rate for those expenditures the contracting county has officially certified. This certification must satisfy all federal Medicaid and State Medi-Cal CPE, full funds expenditure (federal and non-federal share expenditure), and claims integrity requirements. Claims will be reimbursed at the interim PUPM rate developed by the county participating in the demonstration and approved by the State. All interim PUPM rates must conform to 42 CFR. 433.51, and all certified public expenditures continue to be subject to annual reconciliation consistent with Federal and State requirements.

INTERIM RECONCILIATION OF INTERIM MEDICAID PAYMENTS - COUNTY SPECIFIC RATES

Consistent with the cost report submission, acceptance, reconciliation, and settlement process outlined in the state plan for DMC services, DHCS will complete the interim settlement of the DMC ODS county cost report no later than eighteen months after the close of the State fiscal year. Each DMC ODS county's expenditures that are used to claim interim FFP payments are reconciled to its State-developed cost report package for the State fiscal year in which services were provided. Each DMC ODS county cost report package is an aggregate of expenditures incurred for payments made to contracted providers and expenditures incurred by county-operated providers as determined through individual legal entity cost reports. Reimbursement under the DMC ODS program is available only for allowable costs incurred for providing DMC ODS services during the fiscal year to eligible Medi-Cal beneficiaries as specified in the special terms and conditions of this 1115 waiver demonstration. If, at the end of the interim reconciliation process, it is determined that a county received an overpayment, the overpayment is properly credited to the federal government in accordance with 42 CFR 433.316. If, at the end of the interim reconciliation process, it is determined that a county received an underpayment, an additional payment is made to the county. The State uses the following process to complete its interim reconciliation of interim Medicaid payments of FFP.

Participating counties and their contracted non-NTP providers must maintain fiscal and statistical records for the period covered by the cost report that are accurate and sufficiently detailed to substantiate the cost report data. The records must be maintained for a period of ten years from the date of service for all claims for reimbursement. All records of funds expended and costs reported are subject to review and audit by DHCS and/or the federal government pursuant to the California Welfare and Institutions Code Section 14124.24(g)(2) and 14170.

Participating counties and their contracted non-NTP providers must compute allowable costs and determine their allocation methodology in accordance with applicable cost reimbursement principles in 42 CFR Part 413, CMS-Pub 15-1 and 15-2, 2 CFR Part 200 Subpart E, CMS noninstitutional reimbursement policy, and California Code of Regulations (CCR) Title 9 and Title 22 (to the extent that they do not conflict with federal cost principles). Direct and indirect costs are determined and allocated using a methodology consistent with that approved for DMC state plan services, except that the methodology is applied to waiver services. The cost allocation

plan must identify, accumulate, and distribute allowable direct and indirect costs and identify the allocation methods used for distribution of indirect costs. Although there are various methodologies available for determining actual direct costs and for allocating actual indirect costs, for consistency, efficiency and compliance with federal laws and regulations, the cost report identifies direct cost categories for each modality and establishes a standard methodology of percentage of total direct cost to allocate indirect costs. This methodology is a variation of the indirect cost rate methodology in 2 CFR Part 225 (OMB Circular A-87) and 2 CFR Part 230 (OMB Circular A-122). DHCS recognizes that there are other indirect cost allocation bases (such as percentage of direct salaries and wages) that result in an equitable distribution of indirect administrative overhead. However, if a provider wishes to use an indirect cost allocation basis other than the one prescribed in the cost report, the provider must obtain their respective county's prior approval. Before granting approval to the provider, the county must seek DHCS's approval and DHCS will make a final determination of the propriety of the methodology used. All allocation plans will still be subject to a review during a DHCS financial audit.

INTERIM RECONCILIATION OF INTERIM PUPM PAYMENTS

DHCS will complete the interim reconciliation and settlement of DMC ODS counties' interim PUPM payments to managed care plans with which they contract no later than twelve months after the close of the State fiscal year. Each DMC ODS county that contracts with a managed care plan must submit a PUPM Reconciliation Report to DHCS by November 1st following the close of the fiscal year. DHCS staff will review the PUPM Reconciliation Report to validate the total beneficiaries served, total approved units of service, and rate per service modality. If the Interim Reconciliation Worksheet shows that the DMC ODS County made additional payments to the managed care plan, DHCS will make an additional payment of FFP to the DMC ODS County. If the Interim Reconciliation Worksheet shows that the DMC ODS County recouped a portion of the Interim PUPM payments already paid to the managed care plan, DHCS will recoup those funds from the DMC ODS County and return them to the federal government. Participating counties and their contracted managed care plan must maintain fiscal and statistical records for the period covered by PUPM Reconciliation report that are accurate and sufficiently detailed to substantiate the PUPM reconciliation data. The records must be maintained for a period of ten years from the date of service for all claims for reimbursement.
All records of funds expended and services rendered are subject to review and audit by DHCS and/or the federal government pursuant to the California Welfare and Institutions Code Section 14124.24(g)(2) and 14170.

FINAL RECONCILIATION OF INTERIM MEDICAID PAYMENTS

Consistent with the cost report submission, acceptance, reconciliation, and settlement process outlined in the state plan for DMC services, the State will audit and complete the final reconciliation and settlement of the cost report or PUPM reconciliation within three years from the date of the interim settlement. The audit performed by the State determines whether the income, expenses, and statistical data reported on the cost report or reconciliation are reasonable, allowable, and in accordance with State and federal rules, regulations, and Medicare principles of reimbursement issued by the Department of Health and Human Services and CMS. The audit also determines that the county's cost report accurately represents the actual cost of operating the

DMC program in accordance with Generally Accepted Accounting Principles (GAAP), Title 42, Code of Federal Regulations (42 CFR), Office of Management and Budget (OMB) Circular A-87, Generally Accepted Auditing Standards (GAAS), Generally Accepted Governmental Auditing Standards (GAGAS) as published by the Comptroller General of the United States and other State and federal regulatory authorities. The State audit staff compares the FFP due to the county in the audited cost report with all interim payments, including the interim settlement and supplemental payments to eligible entities. The purpose of this comparison or review is for the State to determine if an overpayment or underpayment exists, and ensure that any overpayment of FFP is promptly returned to the federal government per 42 CFR 433.316 and 433.320. If the State determines that the county received an underpayment, the State makes an additional payment to the county.

COVID-19 PUBLIC HEALTH EMERGENCY

Notwithstanding any other provisions in this Attachment, the following modified requirements will apply for non-NTP services provided on or after March 1, 2020, until the COVID-19 public health emergency ends:

- **Each DMC ODS county may pay contracted providers at up to 100 percent above the approved county-specific negotiated rates, subject to contracted provider cost reconciliation as discussed in this Attachment.**
- **For purposes of interim Medicaid payments, claims will be reimbursed at the lower of the county's billed amount or the approved annual interim rates for each covered service increased by 100 percent.**
- **For purposes of interim and final reconciliation, DHCS will settle interim payments for outpatient services to actual allowable cost. The limitation of customary charges is suspended.**
- **For inpatient hospital-based residential and withdrawal management services (including ASAM levels 3.7 and 4), DHCS will continue to settle interim payments to the lower of actual allowable cost or usual and customary charges.**

To the extent necessary to implement these modified requirements, all conflicting provisions in this Attachment are suspended.