Substance Use Disorder Cost Report Manual

Audits and Investigation Division

Cost Report and Tracking Section

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Chapter 1. Introduction

This manual provides counties and their contracted Drug Medi-Cal providers with the general guidelines and requirements for completing the Substance Use Disorder (SUD) cost report.

1. Definitions and Key Terms

a. “BHS” means Behavioral Health Subaccount.

b. “BHIS” means the Behavioral Health Information System portal through which SUDCRS is accessed.

c. “CCR” means the California Code of Regulations.

d. “CFR” means the Code of Federal Regulations.

e. “CMS” means the Centers for Medicare and Medicaid Services.

f. “Cost center” means a department or other unit within an organization to which costs may be charged for accounting purposes.

g. “COVID 19” means the pandemic that occurred in 2020.

h. “CPE” means Certified Public Expenditure.

i. “DHCS” means the California Department of Health Care Services.

j. “Direct costs” means those that are directly incurred, consumed, expanded and identifiable for the delivery of a specific covered service, objective, or cost center.

k. “DMC” means Drug Medi-Cal.

l. “DMC-ODS” means the DMC Organized Delivery System.

m. “DMC unreimbursable costs” means costs that are not reimbursable or allowable in determining the provider’s allowable costs in accordance with the California’s Medicaid State Plan, federal and state laws and regulations, including 2 CFR Part 200 Subpart E, CMS non-institutional reimbursement policy, and California Code of Regulations Titles 9 and 22.

n. “HSC” means Health and Safety Code

o. “Indirect Costs” means those costs: a) incurred for a common or joint objective benefitting more than one cost center or objective, and b) are not readily identifiable and assignable to the cost center or objectives specifically benefited.

p. “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.

q. “IOT” means intensive outpatient treatment.

r. “Legal Entity” means an association, corporation, partnership, trust, or individual that has a legal standing and is certified to provide SUD services within the State of California.

s. “Non-DMC” means any SUD services that are not funded with DMC.

t. “NTP” means narcotic treatment program.

u. “ODF” means outpatient drug free.

v. “ODS” means Organized Delivery System, otherwise known as ‘the waiver” .

w. “PC” means Penal Code

x. “Percent of Direct Costs” means a methodology 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.

y. “Private Pay” means funds collected from an individual who self-pays for services (no public funds or private insurance).

z. “SABG” means the Substance Abuse Prevention and Treatment block grant.

aa. “SAMHSA” means the federal Substance Abuse and Mental Health Services Administration.

bb. “SAPT” is the prior term used for SABG.

cc. “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.

dd. “SMART” means Short Doyle Medi-Cal ADP Remediation Technology. It is the DMC payment system.

ee. “SPA” means State Plan Amendment.

ff. “SUD” means substance use disorder.

gg. “SUDCRS” means the Substance Use Disorder Cost Report System.

hh. “USDR” means uniform statewide daily reimbursement.

ii. “WIC” means Welfare and Institutions Code

2. Purpose of Cost Report

Each year all counties are required to complete and submit an SUD cost report to DHCS. The purpose of the cost report is to:

a. Report counties’ annual costs/expenditures for SUD services, both DMC and non-DMC.

b. Compare and reconcile the amount of funds paid to the county with the actual costs of providing those services.

c. Document how state/federal funds were spent and ensure that set-asides and other categorical requirements were met.

d. Provide mandated service and expenditure data to oversight agencies (CMS and SAMHSA).

e. Provide data for DHCS to develop annual DMC reimbursement rates and conduct statewide evaluation.

3. Authority

a. HSC Section 11852.5 and the WIC Section 14124.24 (g)(1) require that counties and contracted providers (except for those providing only narcotic treatment as specified in part "b" below) submit their SUD cost reports to DHCS by November 1 for the previous state fiscal year. The county must include the DHCS-provided certification form signed by the financial officer(s) or an authorized signatory, attesting to the validity and allowability of the reported cost data.

b. Pursuant to WIC Section 14124.24 (h), NTP providers that exclusively provide NTP services under the DMC program to probationers (PC Section 1210.1), parolees (PC Section 1210.1) or indigent patients (WIC Section 14021.52) are not required to submit cost reports. Instead, they must submit performance reports by November 1 for the previous state fiscal year. All others must submit a cost report. (Effective July 1, 2019)

   i. An NTP to whom this applies must use the performance report format distributed by DHCS and estimate its budgets using the state established reimbursement rates.

   ii. If the NTP contracts with the county, their claims for reimbursement must be identified within the county's cost report in order to settle final reimbursement amounts.

4. Submission Requirements

Counties must report the following state/federal funds expended for SUD services, pursuant to their state-county contract(s):

a. Substance Abuse Prevention and Treatment (SABG) Block Grant

b. State General Fund

c. Drug Medi-Cal Federal Financial Participation (FFP)

d. Behavioral Health Subaccount (2011 Realignment)

The county cost report must include SUD cost data from all their contracted providers and any county-operated providers. In addition, individual SUD cost

reports from the county's contracted DMC providers on the DHCS-prescribed forms must be included and electronic copies forwarded to DHCS.

5. **Cost Report Timeframes**

   Notwithstanding unforeseen circumstances or barriers, the timeline for the cost report process is shown below:

   a. July or August: DHCS releases the forms and instructions to counties for the prior fiscal year's cost report.

   b. November 1: County cost reports are due to DHCS.

      i. DHCS may grant an extension to the November 1 due date because of policy changes or unanticipated situations that delay the development of the annual cost report forms and/or require SUDCRS system updates.

      ii. If a county does not meet the due date, DHCS has the right to withhold SABG and/or DMC payments until the county has submitted the required cost report data/reports, pursuant to the county's contract(s) with DHCS.

   c. Four months after receipt of county's cost report, DHCS completes settlement of the SABG Block Grant funds. For non-DMC counties, this is the interim settlement. For DMC counties, this is a preliminary settlement.

   d. Eighteen months after end of fiscal year, DHCS completes settlement of the DMC funds. This is the interim settlement for DMC counties.

   e. Up to three years for SPA cost reports, and 10 years for ODS cost reports, DHCS may conduct a fiscal audit after the cost settlement.

   f. If DHCS did not conduct a fiscal audit, the cost settlement is final after three years for SPA cost reports, and 10 years for ODS cost reports.

6. **Overview of Cost Report Settlement Process**

   a. DHCS releases cost report forms, instructions, and supporting documents to counties.

   b. Counties distribute appropriate forms and instructions to their contracted providers. (DHCS does not have prescribed data collection forms for non-DMC providers, so counties may use other forms or processes to collect cost report data from those contracted providers.)

   c. Providers collect and report cost report data on the county or DHCS-required forms and submit them to the county.

   d. The county enters cost report data into the SUDCRS and submits it to DHCS.

   e. DHCS processes the SABG settlement

i. DHCS reconciles the SABG allocation and payment amounts with county expenditures and verifies that set-asides and other categorical requirements were met. If necessary, DHCS requests the county to make adjustments to reflect carryover of unexpended funds from the prior year.

ii. DHCS sends the settlement letter to the county.

iii. If a county does not provide DMC services, their cost report settlement is complete (interim) after this phase. For all other counties, settlement is preliminary until the DMC funds are settled.

f. DHCS processes the DMC settlement

i. DHCS compares the expenditures and billing units on the provider DMC forms with the entries made by the county in the SUDCRS to ensure data transfer was done accurately. If there were data entry errors, DHCS works with the county to make corrections.

ii. DHCS generates settlement forms using data pulled from the SMART system and completes a detailed review of what DMC units were billed, paid, and disallowed. Then DHCS makes corrections and adjustments to the county's cost report data, if necessary. If DMC units were approved but not paid by DHCS prior to the payment cut-off period, the units will be reimbursed through the cost settlement.

iii. DHCS sends the interim settlement letter to the county which represents DHCS' complete settlement of the county cost report, and invoices or payments are processed, if applicable.

Chapter 2. County Cost Report Responsibilities

1. Distribute Forms and Instructions to Contracted Providers

It is the county's responsibility to distribute applicable cost report materials to its contracted providers.

a. As soon as DHCS releases the annual forms and instructions for the prior fiscal year's cost report, the county must distribute the DMC Cost Report (Excel) Workbook to their contracted DMC providers.

b. DHCS provides a reconciliation report that reflects all approved and denied services by provider. The county should ensure that every provider on the report with approved services submits a DMC workbook. An Excel workbook is not required for providers without DMC services. Instructions for completion are in Chapter 3.

c. DHCS typically gives counties three to four months to complete and submit their cost report, so it is critical that counties give their providers a due date that allows the county sufficient time to review provider data, return to the provider for corrections if needed, and enter the data into the SUDCRS.

d. Any manipulation to the cost report template format and/or formulas will deem the cost report null and void.

2. Collect and Review Data from Contracted Providers

County-contracted providers are responsible for providing accurate cost data to the county, and the county is responsible for collecting, reviewing, and verifying the integrity of the cost data submitted to them by their contracted providers.

3. Enter Cost Report Data into SUDCRS

After the county has received and reviewed all their provider cost data, they must enter required data into the SUDCRS via the County Fiscal Data entry screen. Instructions are in Chapter 4 below and in the SUDCRS manual on the SUDCRS web site (available after login, under the "help" tab at the top).

4. Submit Electronic Forms to DHCS

After the county submits the cost report to DHCS via the SUDCRS, the county must also submit the following:

a. Electronic copies of their contracted DMC providers' cost report workbooks to aodcostreport@dhcs.ca.gov . The file names of the Excel workbooks must have the DMC and Provider numbers at the beginning of the file names or as the file names. For example, provider Frosty's Treatment Center with DMC number 6099 and Provider number 606099 would be named "6099-606099", or "6099-606099 Frosty's Treatment Center" with "Frosty's Treatment Center" being whatever the county needs

in the file name. Confirm the DMC numbers – they are not always the last 4 digits of the provider number. Confirm that the correct provider number is being used.

b. Electronic copies of the following:

   i. The Provider Information and Certification (Tab 1) with the provider's original signatures.

   ii. The County Certification (form MC 6229) with the appropriate original signatures.

   iii. The year-end County DMC Administrative Expense Claim (form MC 5312). Instructions for completion are in Chapter 6.

   Note: Due to COVID 19, electronic signatures are currently accepted on the above three documents. This may change as the situation with COVID 19 changes. Hard copies will be needed in addition to the electronic copies if electronic signatures cease to be accepted.

c. If hard copies become required, they should be mailed to:

   Via US Mail:

   Department of Health Care Services
   Audits and Investigation, Cost Report Tracking Section II
   P O Box 997413, MS 2109
   Sacramento, CA 95899-7413

   VIA UPS/FEDEX/USPS Express:

   Department of Health Care Services
   Audits and Investigation, Cost Report Tracking Section II
   1500 Capitol Avenue
   Sacramento, CA 95814

Chapter 3. DMC Provider Cost Report Workbook

1. History and Intent

a. In October 2015, the CMS approved DHCS' Medicaid State Plan Amendment (SPA) #15-013 which updated the rate setting and reimbursement methodologies for DMC services. As part of the SPA approval process, CMS required that California adjust its SUD cost report process so that providers demonstrate how allowable costs were determined and allocated.

b. The DMC provider cost report workbook was designed so providers must show how they determined which costs were direct and indirect, and how indirect costs were allocated by line item and modality. It helps verify that DMC providers properly allocated their SUD service expenses and reported those expenses accurately on the annual cost report.

c. The DMC provider cost report forms were reviewed and approved by CMS as part of the Medicaid SPA #15-013 review. Any substantive modification to the approved cost reporting form is subject to review and approval by CMS.

d. Every DMC-certified provider that contracts with the county and claims DMC services must complete the DMC Provider Cost Report Workbook.

e. DHCS provides a new workbook to the county each year to account for changes in policy, funding lines, federal financial participation percentages, etc. Counties are required to distribute the DMC Provider Cost Report Workbook to their contracted DMC providers by any method that will not change the electronic format of the templates.

f. The provider, after the completion of their cost report workbook, must return it to their county for review, verification, and approval. The counties are required to package these cost reports and submit the package to DHCS, as specified in Chapter 2.

2. Cost Allocation Considerations

a. The provider must have a cost allocation plan that identifies, accumulates, and distributes allowable direct and indirect costs and identifies the allocation method(s) used for distribution of indirect costs.

b. The provider must determine their allocation methodology in accordance with applicable cost reimbursement principles in 42 CFR Part 413, CMS-Pub 15-1, 2 CFR Part 200 Subpart E, CMS non-institutional reimbursement policy.

c. Direct Cost Allocation

    i. The direct cost allocation methodology adopted by the provider must assign costs to a particular cost objective based on benefit received by that cost objective.

    ii. Any method of distribution can be used that will produce an equitable distribution of cost.

    iii. In selecting one method over another, consideration should be given to the additional effort required to achieve a greater degree of accuracy.

d. Indirect Cost Allocation

    i. For consistency, efficiency, and compliance with federal laws and regulations, the DMC workbook allocates indirect costs using a standard methodology. The workbook identifies the direct cost categories for each modality and uses the percentage of total direct costs to allocate indirect costs.

    ii. DHCS recognizes that there are other 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 allocation basis other than the standard methodology established 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.

3. Cost Report Records and Supporting Documentation

a. The provider must maintain a formal set of financial records that includes a general ledger, as well as books of original entry (cash receipts journal/register, cash disbursements journal/register, and a general journal). Entries in the books of original entry must be traceable to source documentation. Evidence of expenditure must be sufficient to substantiate that the expenditure was incurred and that the expenditure was necessary for the provision of service. This evidence includes paid invoices, cancelled checks, contracts, purchase orders, and receiving reports.

b. The provider 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 until the later of: (1) a financial audit is conducted: or (2) a period of three years for SPA cost reports and 10 years for ODS cost reports following the date of the interim cost settlement.

c. All records of funds expended and costs reported are subject to review and audit by DHCS and/or the federal government pursuant to the WIC Section 14124.24(g)(2) and 14170.

4. General Guidelines for Completing Workbook

a. These guidelines and instructions for the DMC Cost Report Workbook apply to all DMC providers, both county-operated and those that contract with the county.

b. The provider must complete a workbook for each location that has a unique DMC number. Organizational or corporate costs in the general ledger that are shared or allocated across multiple locations must be shown on the specific location's workbooks.

c. The provider must report overall costs incurred related to SUD services at each location, from all funding sources (DMC and non-DMC). If non-SUD services are provided at the same location (such as mental health services) and the costs are shared or allocated across the two programs, the costs for both the SUD and the non-SUD must be included.

d. Before completing the workbook, the provider should gather all financial documents needed. The cost data on the DMC workbook must be based on the provider's general ledger. The reconciliation report distributed by DHCS to the county is also needed.

e. Data entry is required only in yellow highlighted cells. All other cells are auto- populated.

f. The provider must not change the worksheet template or formulas. Attempts to do so will deem the provider's cost report null and void.

g. The provider must complete the applicable tabs. All providers must complete tabs 1 (Provider Info and Certification), 2 (Overall Cost Summary), which is automatically populated, and 3 (Overall Detailed Cost). Then for each modality the provider has, the provide must complete all tabs related to those modalities except for the Comparison Sheet tab. The county completes the Comparison Sheet tab after the data is entered into SUDCRS.

   The provider should not delete any tabs, even if they do not provide the specific modality, level of care, or service identified on the tab.

h. The sequence for completing the workbook is shown below:

   i. Complete the Provider Information and Certification tab

   ii. Complete the Overall Detail Costs tab

   iii. For each modality/level of care provided, complete the tabs in the following order:

1. Detailed Adjustments
2. Cost Allocation
3. Reimbursed Units

iv. Review data, print, and sign the Provider Information and Certification attesting that the costs included are public expenditures eligible for FFP pursuant to 42 CFR 433.51.

i. Do not make any changes to the formulas or format of the workbook including adding, subtracting or hiding any tabs and or changing the names of the tabs. Such changes will result in the workbook being sent back for correction.

j. Provider questions about completing the workbook should directed to county staff. DHCS will not respond to questions received directly from a county- contracted provider.

5. Workbook Instructions

The following instructions apply to both the ODS and non-ODS waiver cost report, unless otherwise noted.

a. Provider Information and Certification

The Provider Information and Certification (Tab 1) must be completed by all providers. The information entered here eliminates the redundant entry of county, provider name, DMC number and NPI on further cost report worksheets.

b. Overall Cost Summary

No data entry is required for this worksheet. A summary of the totals for all the cost centers reported by the provider is automatically populated from the Overall Detailed Costs worksheet.

c. Overall Detailed Costs

The Overall Detailed Costs worksheet (Tab 3) is the starting point for all providers completing the DMC Cost Report Workbook. The provider must enter all direct and indirect costs incurred related to SUD services. The provider must specify the allocation methodologies used to distribute costs across various cost centers.

i. Part A, Schedule of Expenditures for Direct Costs

1. In column B (“From Accounting Records”), the provider must enter the program” s total costs by applicable line item using their general ledger as reference.
2. In columns D-H (columns D-J for ODS), enter total costs by line item that are directly attributable to each cost

center/modality provided, including other SUD services and non-SUD services if applicable. An example of other SUD services includes SUD prevention services. Examples of non- SUD services include mental health, primary care, or any other program that shared costs with the DMC program.

3. In column K (column M for ODS), enter an explanation of how direct costs were determined and assigned to the each cost center/modality (in accordance with applicable cost reimbursement standards). Some sources that are acceptable for determining and attributing direct costs include time sheets/payroll records, invoices, and rent/lease records. Add a footnote if necessary.
4. The workbook identifies the direct cost categories for each cost center/modality and uses the percentage of direct costs to allocate indirect costs.
5. 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.)

ii. Part B, Supporting Schedules for Indirect Costs

There is no data entry required for this section. The indirect cost for each line item and modality is computed based on the percentage of direct costs (the standard methodology) from Part A.

iii. Part C, Report of Expenditures for Total Costs

1. The indirect costs that were calculated in Part B are totaled in Part C.
2. The overall total should match the total from Part A.

d. Detailed Adjustment Worksheets

i. 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 costs between the various types of service/program (such as individual or group, perinatal or non-perinatal).

ii. Costs directly related only to services provided to clients funded by a specific program and funding source (such as perinatal) must be removed before calculating the allowable modality costs. Then the allowable adjusted gross modality costs are allocated to the different services within the modality. Finally, those direct costs are added back to the program type that benefited from the direct costs. (For example, perinatal-related costs, such as child care expenses, are removed from the total modality cost and added back to the perinatal program.)

iii. In Section 1,"DMC Unreimbursable Costs," enter the costs that are not DMC reimbursable, private, and non-DMC, for the various service/program types that apply to the modality.

iv. In Section 2,"Direct Costs," enter the direct costs charged to the cost center for private pay, DMC, and non-DMC for each service/program type.

v. Data entered from Sections 1 and 2 automatically populate cells in the corresponding modality's Detailed Costs worksheet and Cost Allocation worksheet.

e. Cost Allocation

This worksheet further identifies the breakout of costs between the modality's different services/programs and between private pay, DMC, and non-DMC. The bottom portion of the worksheet identifies the maximum reimbursement for DMC services. As described previously, the standard methodology for allocating indirect costs is the percentage of direct costs. The calculation for this methodology is built into the forms.

i. "Allocate Costs Between Different "Modalities" section: Non-ODS:

1. For ODF, enter the number of group sessions for perinatal and non- perinatal, and the length of individual and group sessions for perinatal and non-perinatal. If the length is less than 50 minutes (individual) or 90 minutes (group), an adjustment is automatically made to the SMA. If the length is greater than 50 minutes (individual) or 90 minutes (group), the higher amount is used to compute direct staff hours; however, the reimbursement will not exceed the SMA.
2. For IOT, enter the length of visit for perinatal and non-perinatal.
3. For Residential, enter 24 hours.

   ODS: Enter direct staff hours in each of the yellow highlighted areas (as applicable).

ii. “Units of Service” section: enter the number of units for private and non-DMC by the applicable service/program types.

iii. “Cost Per Unit of Service” section:

Non-ODS: enter the SMA rate or usual/customary charges for each of the applicable service/program types.

ODS: Enter the provider’s customary charges for each service.

iv. All other areas are automatically populated based on data entry on other worksheets.

f. Reimbursed Units

This worksheet identifies the specific reimbursement amounts by funding source and aid code type.

i. Enter all approved and denied units using the information from the provider reconciliation report.

1. Approved Units: Enter the approved unit information for each type of service for each aid code type from the reconciliation report provided by DHCS (unless the county or provider has more recent updated data).

2. Denied Units: Enter the denied unit information for each type of service from the reconciliation report provided by DHCS. Denied units are not broken out by aid code type.

ii. Share of Cost and Insurance: The remainder of this worksheet requires data entry only if units were funded by beneficiaries’ share of cost or insurance.

g. Detailed Costs

There is no data entry on this tab; however, the provider should review the auto- populated cells to check for possible entry errors on other worksheets.

i. After completing the Detailed Adjustments, Cost Allocation, and Reimbursed Units tabs for a modality, go back to that modality’s Detailed Costs worksheet to review the results.

ii. The ”Overall Total Costs as Allocated” in Part I of the modality’s Detailed Costs worksheet should match:

1. The total for the modality in Part C on the Overall Detailed Costs tab.

2. The ”Total SUD Services” (Section 1) on the modality’s Cost Allocation tab.

3. The ”Overall Total Costs as Allocated” on the modality’s Cost Allocation tab.

h. Comparison Sheet

There is no data entry required by the provider on this worksheet (the county must complete the yellow-highlighted cells from the Fiscal Detail Pages report from SUDCRS).

Chapter 4. Substance Use Disorder Cost Report System (SUDCRS)

1. SUDCRS Access and User Roles\

a. The county must submit its SUD cost report to DHCS via the web-based SUDCRS. County access to SUDCRS is through the BHIS portal which is granted by DHCS through the following process:

   i. The county alcohol and drug program administrator must complete, sign, and submit a County Approver Certification & Vendor Appointment Form from their e-mail address to DHCS at AODCOSTREPORT@dhcs.ca.gov . The form will identify the individual(s) whom the administrator has designated as the county's approver for the SUDCRS.

   ii. DHCS will enroll the approver(s) and send them an e-mail with their log-in information. The approver will then be able to log on to the BHIS portal and request access for additional county users (instructions are available on the BHIS portal).

   iii. Once the approver requests access for another county user, the system administrator will create an account and send them their log-in information. This process to add new users may take up to three business days.

b. There are three types of users in the SUDCRS, each with different functions and system rights. One individual may have multiple user roles.

   i. Approver: The approver is designated by the county alcohol and drug program administrator. The approver has independent authority to approve county user access requests (including vendors).

   ii. Analyst: The analyst can perform data entry and run reports, but cannot submit data to DHCS.

   iii. Supervisor: The supervisor is responsible for reviewing and submitting data to DHCS. The supervisor can perform the same functions as the analyst, but is the only user who can submit data to DHCS.

2. Enter Cost Report Data into SUDCRS

a. After the county has received and reviewed all their provider cost data, they must enter required data into the SUDCRS via the County Fiscal Data entry screen.

b. General instructions for data entry are shown below (an SUDCRS User Manual with more detail is available on the BHIS portal):
    i. Select the provider, service type/code, and program code from the drop down boxes.
    ii. Select ”Add Data.”
    iii. Select funding lines from the drop down box (service and program codes selected will determine access to appropriate funding lines).
    iv. From the Excel cost report, enter the amounts, unit counts, individual units of service, and NTP dosing and NTP group (if applicable). The visit days, total individual sessions, and the total of the individual units of services must match.
    v. Each line that is validated and correct will include a green check mark at the end of the row. If there is no check mark at the end, the row needs to be corrected.
    vi. If the record contains both DMC and non-DMC funding, check the box titled ”included in DMC set” which indicates that a DMC workbook is included for that provider.
    vii. Select the ”Check It” button before exiting the provider record to check for errors. If there are errors on the page, a message will appear and the highlighted line(s) must be corrected before moving on. The report cannot be submitted until the ”Check It” button is clicked.
    viii. To continue data entry, go to Provider, Service, and Program from the drop down menus at the top and select ”Add Data” .
    ix. If the record already exists, a prompt will display to edit the existing record and the ”Add Data” will not display.
    x. Select ”Clear Filters” to go back to the main data screen.
c. To assist the county transfer data from DMC providers’ cost report workbooks into the SUDCRS, the county should use the Comparison Sheet tab for each modality. The county must enter the program code(s) and complete the ”SUDCRS Fiscal Detail” column by entering the total amounts they entered in the SUDCRS from the Cost Allocation and Reimbursed Units tab(s) of the provider’s workbook.
d. Once all data entry for the fiscal year is complete, the user must run the Data Validation Report, which will display those records for which the ”Check-It” button was not selected. The user must go back to these specific records and select the ”Check-It” button to ensure no errors exist

on the record before trying to submit the data. The county will not be able to submit the data if any records exist on this report.

e. The user must then run the Fiscal Detail Report for the Nonresidential, Narcotics Treatment, Residential, and/or ODS Waiver Services, depending on where the county's DMC services are entered into SUDCRS. The county must then transfer the information from the Fiscal Detail Report to each of the Excel Cost Reports and ensure that the data matches. If the data does not match, either the Excel Cost Report or SUDCRS needs to be corrected until a match is achieved. This is the check that the data was correctly entered.

f. The individual designated as the supervisor for the SUDCRS must review and submit the data to DHCS. If there are no errors, the supervisor will receive a "Success" message and the County Data Status on the Dashboard will display "Submitted."

g. Once the supervisor submits the data to DHCS, the county data is locked—it cannot be edited and no new data can be entered unless the county contacts DHCS. However, county users can still view and run reports and export data to Excel.

Chapter 5. Substance Abuse Prevention and Treatment (SABG) Block Grant

1. Introduction

The SABG block grant is a noncompetitive, formula grant mandated by the U.S. Congress and administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). DHCS must submit an annual application to demonstrate statutory and regulatory compliance in order to receive SABG block grant funds.

Upon enactment of the annual state budget act, DHCS allocates SABG funds to all counties based on a standard methodology, and includes the funds in the state- county contracts. The county's expenditures of SABG funds must be included on the SUD cost report.

2. General Guidelines for Spending

a. SABG block grant funds may be used to plan, implement, and evaluate activities that prevent and treat substance abuse and promote public health. Specifically, SABG can be used for the following purposes:

   i. Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.

   ii. Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance.

   iii. Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.

   iv. Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services.

b. SABG funds are to be the funds of last resort. Medicaid and private insurance, if available, must be used first.

c. Any treatment services provided with SABG funds must follow the treatment preferences established in 45 CFR 96.131(a):

   i. pregnant injecting drug users

   ii. pregnant substance abusers

   iii. injecting drug users

   iv. all others

3. **Restriction on Expenditure**

    a. DHCS allocates SABG funds to counties to provide program funding for specific areas of need. These funds must be spent on those specific programs and cannot be used for other programs, unless specified.

    b. SABG block grant funding cannot be used for the following:

        i. To provide inpatient hospital services.

        ii. To make cash payments to intended recipients of health services.

        iii. To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment.

        iv. To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.

        v. To provide financial assistance to any entity other than a public or nonprofit private entity.

        vi. To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS.

        vii. To pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Level I of the Executive Salary Schedule for the award year.

        viii. To purchase treatment services in penal or correctional institutions.

    c. The SABG block grant cannot be used to supplant state-funded SUD programs. If SABG funds were spent on a service that the county would have provided whether or not the SABG funding had been received, the county supplanted state funds.

    d. SABG block grant funds cannot be used as the state share of DMC services, nor can SABG be used to pay for costs of DMC services rendered but not covered within the state reimbursement rate cap.

4. **Reporting SABG Cost Data**

    The amount that a county reimburses a provider with SABG funds using a negotiated rate is the amount that the county is to report as its costs to purchase services, regardless of the provider's actual cost. The exception to this is when the same service at the same location is also funded with DMC. In that case,

reimbursement is limited to actual costs, in accordance with Medi-Cal reimbursement principles.

5. SABG Funding Period

SABG funds are awarded on a Federal Fiscal Year (FFY) basis (beginning on October 1), and the award has a 21-month spending period that overlaps two state fiscal years (SFY). For example, the obligation and expenditure period for the FFY 2018 award is from October 1, 2017 to June 30, 2019 (which begins in SFY 2017-18 and ends in SFY 2018-19).

Chapter 6. Drug Medi-Cal (DMC)

1. Introduction

a. Medi-Cal is California's federal Medicaid program. Within the broader Medi-Cal program, DHCS administers the DMC program.

b. DMC provides medically necessary SUD treatment services to eligible Medi-Cal beneficiaries for approved services. DMC clients must receive SUD services at a program DMC-certified by DHCS. The county where the provider is located must have a DMC contract with DHCS and the DMC-certified providers must subcontract with the county. (Pursuant to WIC Section 14124.21, DHCS can enter into a contract directly with a DMC provider if the county chooses not to contract with that provider and if the county is not ODS.)

2. DMC Funding

a. Reimbursement under the DMC program is available only for allowable costs incurred for providing DMC services to eligible Medi-Cal beneficiaries. The allowable costs must be determined in accordance with Medicare cost reimbursement principles in 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.

b. DMC funding is a combination of federal, state, and local funds.

   i. The federal share for DMC is funded with Federal Medical Assistance Percentage (FMAP), also called federal financial participation (FFP). The federal percentage is based on the beneficiary's aid code and can vary from 100 percent to zero.

   ii. The state or local share is funded with county Behavioral Health Subaccount (BHS) funds or state general funds (for expansions and new mandates). The percentage combines with the FFP to equal 100%.

c. When a provider's DMC costs exceed the state maximum allowance, the county must cover those costs with other funds. These may include county funds, provider contributions, or donations. In the cost report, these are identified as" unrestricted funds" and are listed in a lump sum under "various" in the Excel portion of the cost report submission. The county allocates the "various" according to the funding used.

3. **DMC Cost Settlement Methodology**
    a. The rate at which a county bills for DMC services is an interim rate until the cost report is settled.
    b. DHCS is required to settle to the lower of the following:
        i. Actual cost.
        ii. Usual or customary charge (a provider's published charge used to bill the general public, insurers, or other non-Medi-Cal payers and which is equivalent to the charge prevalent in the public SUD sector).
        iii. State maximum allowance.
4. **Responsibility for Collecting DMC Cost Data**
    a. Counties that provide DMC services must collect cost data from their contracted DMC providers via the DHCS-prescribed DMC cost report workbook.
    b. DMC providers are responsible for completing the DMC cost report workbook and submitting it to the county. A workbook must be completed for each location that has a unique DMC number. The provider must certify that the cost report information is true, correct, and in compliance with federal law. Instructions for completing the workbook are included in Chapter 3.
5. **Year End Claim for County DMC Administrative Expenses**
    a. County claims for reimbursement of DMC administrative expenses must be submitted separately from the CPE-certified total direct service expenses, via the Drug Medi-Cal Services Claim for Reimbursement of County Administrative Expenses (form MC 5312).
    b. Counties may choose to submit quarterly claims throughout the fiscal year or be reimbursed only once at cost settlement. However, all counties, whether they were reimbursed throughout the year or not, must submit a final claim that covers total county DMC administrative expenses for the entire fiscal year.
    c. To complete the year end Drug Medi-Cal Services Claim for Reimbursement of County Administrative Expenses:
        i. Enter the date the form was completed, the county code, the county name, and lines 1 and 4 (lines 2, 3, 5, and 6 are formula generated).

ii. Line 1: Enter the DMC direct service treatment expenses billed during the fiscal year based on the direct service expenses reported on CPE forms.

iii. Line 4: Enter the actual administrative expenses incurred by the county during the fiscal year. Line 4 must be less than line 1.

iv. The form must include the signed certification of the county alcohol and other drug program administrator and either the county auditor-controller, finance officer, or accounting officer.

d. During cost settlement, DHCS will compute the county's share of the administrative reimbursement in the following manner:

i. Establish county's administrative rate for DMC:

1. Actual administrative rate as shown on Line 6 of the claim form; OR

2. 15% (if the rate on line 6 is higher than 15%)

ii. Generate report of county claims for the service fiscal year, by aid code, to determine the FFP and SGF amounts of all approved claims.

iii. Apply the established administrative rate to the FFP and SGF amounts to determine the amount owed to the county.

iv. If the county submitted quarterly claims for that year, the year-end amount owed will be reduced by the amount paid for the quarterly claims.

Chapter 7. DMC-ODS Waiver Requirements

This chapter is only applicable to counties that have an executed intergovernmental agreement with DHCS to administer DMC Organized Delivery System (DMC-ODS) services. All federal and state regulations that pertain to the cost report for the regular state plan services are still applicable to the DMC-ODS services unless otherwise noted in this chapter.

1. **ODS Expanded Services**
    a. The county must provide access to a full continuum of SUD benefits modeled after the American Society of Addiction Medicine (ASAM) Criteria.
    b. The additional required services (beyond regular DMC) are:
        i. Residential (for all populations, no bed capacity limit)
        ii. Withdrawal management (at least one level)
        iii. Case management
        iv. Physician consultation
        v. Recovery services
    c. Optional Services:
        i. Medicated assisted treatment (MAT)
        ii. Partial hospitalization
        iii. Withdrawal management (additional levels)
        iv. Inpatient hospital-based services

DMC-ODS Level of Care or Service	Required	Optional
Early Intervention	X (thru fee for service or managed care	
Outpatient Treatment	X	
Intensive Outpatient Treatment	X	
Partial Hospitalization		X
Recovery Services	X	
Case Management	X	
Physician Consultation	X	
Narcotic Treatment (NTP)	X	
Non-NTP Medicated Assisted Treatment (MAT)		X
Withdrawal Management (WM) (Levels 1, 2, 3.2)	X (at least one level)	X (additional levels)
Residential Treatment (Levels 3.1, 3.3, 3.5)	X (all within 3 years)	
Inpatient Hospitalization (RES and WM Levels 3.7 and 4)		X

d. DHCS has established new program codes, service codes, and funding lines for the expanded ODS services.

2. Quality Assurance and Utilization Review (QA/UR)

a. QA/UR activities include reviews of physicians, health care practitioners, and providers to determine whether:

   i. Services were reasonable and medically necessary.

   ii. The quality of the services met professionally recognized standards of health care.

b. Counties may submit claims for reimbursement of the FFP share of QA/UR expenses through a quarterly invoicing process (outside of the Short-Doyle system).

c. Information on the claim process and list of reimbursable QA/UR tasks and activities is included in Information Notice #17-011.

3. Cost Settlement Methodology

a. For non-NTP services, DHCS will settle to the lower of actual cost or usual or customary charge.

   i. The county will aggregate the provider cost reports into a cost report for all DMC ODS services provided under the contract.

ii. The DMC providers' cost reports are used to determine the lower of actual cost or customary charge (the Cost Allocation tab will calculate the cost per unit based on total allowable cost/total allowable units).

iii. DHCS reconciles the aggregate amount per service with payments made to the county based on the interim rate and under- or over-payment of federal funds and state general fund will be addressed as a part of the final settlement process.

b. For NTP services, the county pays providers at the lower of the USDR or the provider's usual and customary charge to the general public for the same or similar services. The USDR for NTP services and customary charges will continue to apply as they do under the state plan for DMC.

4. Auditing and Recordkeeping

Pursuant to 42 CFR Section 438.3 (u), the county must retain, and require subcontractors to retain, as applicable, the following information for a period of no less than ten years: enrollee grievance and appeal records in Section 438.416, base data in Section 438.5(c), medical loss ratio reports in Section 438.8(k), and the data, information, and documentation specified in Sections 438.604, 438.606, 438.608, and 438.610.

5. Recovery of Overpayments to Providers

Pursuant to 42 CFR Section 438.604(a)(7), the county must report annually to DHCS on their recoveries of overpayments to providers. This report must be submitted to DHCS along with the county's cost report. DHCS will provide the form to the counties with other forms and instructions for the annual cost report.