State of California
Department of Health Care Services

Specialty Mental Health Services
Cost Report Training: Session 1
Audio Transcription

Tuesday, July 21, 2020

10:00 a.m. – 12:00 p.m.

[Title Slide: Specialty Mental Health Cost Report Training - Fiscal Year 2019-20 Template]

[No audio until 00:05:13,200]

Eileen: All right, good morning everyone. Welcome to the first session of the Specialty Mental Health Cost Report Training. My name is Eileen, I will be running the event behind the scenes here today. Presenting the training material is Chuck Anders. He is the Behavioral Health Financing Branch Chief here at the Department of Health Care Services. Before I hand it over to Chuck, we'll just go through a couple of housekeeping items.

[Slide: Housekeeping Items]

Eileen: As a reminder, this is the first training session, which has been broken into three 2-hour sessions. So the next week is July 28th and the session after that will be on August 4th. You may have already noticed that everyone has been muted upon entry into this webinar. And, note that there will be breaks during the training in which we'll allow time for questions. During these breaks, please use the "Raise Hand" feature to notify us that you would like to ask a question.

[Slide: "Raise Hand" icon]

Eileen: If you do not know what that looks like, it looks like this [icon with "Raise Hand" symbol]. It should be on the near the attendee panel and it's circled here in red. That's what the "Raise Hand" icon looks like. We will be calling on people in the order their hands were raised, so when it is your time to ask your question, we'll call on you, I'll unmute you on our end and then you can go ahead and ask your question. If you're having microphone issues, you can also leave your question in the chat and I will read it out loud to be answered. Also as a reminder, this session is being recorded and will be posted on the DHCS website for future access. And lastly, the training slides will be sent out after the training is complete. With all that being said, I'll hand it over to Chuck, whenever you're ready.

Chuck: Thank you, Eileen. Again, my name is Chuck Anders. I'm the Branch Chief over the Behavioral Health Financing Branch within Local Governmental Financing Division.

And as Eileen went over, we have scheduled three sessions and I believe each of them are two hours in duration. We are going to try to get through, we're going to work through as much of the content as we can today, and if we need additional sessions, there are placeholders set up so that we can continue to move through content that we can't finish today, because I'd like to make room for as much question and answer as participants need and I don't want us to have to feel pressure, or that we have to get through all of the content today. The structure of the training will start with, oh and Eileen, can you move to the next slide?

Eileen: Oh, yes.

Chuck: Thank you.

[Slide: Learning Objectives]

Chuck: Our learning objectives are the structure. First we'll start with what has changed from 18-19's. What are the new, what are the changes to the template that we implemented, and to also kind of walk through what are the policies that changed that required us to make changes to the template. And so once we get through that first section, we'll take a break for questions. As we're going through the those slides, I encourage you to note your questions, to raise your hand if you have a question, even at that time, to kind of get yourself into the queue, and then when we get to the end of that first segment, then we will open it up for questions. The next part, the next learning objective, is to understand the data that needs to be entered into each worksheet. So, the remaining portion of the training is more walking, and kind of addressing each worksheet separately and we will talk about - I'll review the data that needs to go into the worksheet and then the policy reasons for why we're asking for this data and how it's used to implement the reimbursement policies that we need to comply with when we're determining costs, when we're apportioning costs within the Medi-Cal program, and when we're determining the amount of federal, as well as State reimbursement that each Mental Health Plan is entitled to receive for Specialty Mental Health Services. Next slide.

[Slide: Changes to the Fiscal Year 2019-20 Cost Report Template]

Chuck: To begin with, we primarily made changes to only four worksheets in the 19-20 Cost Report. So we made some changes to the Mental Health 1900_Info form, we

made some changes to the 1901 Schedule B, some changes to the Mental Health 1960, and some changes to the Mental Health 1979.

[Slide: Changes to the Fiscal Year 2019-20 Cost Report Template]

Chuck: The next slides will talk in more detail about what those changes are. The first change on the 1900_Info is to ... The 1900_Info currently captures data that the county enters that tells us how much the county paid contract providers for Medi-Cal inpatient and Medi-Cal outpatient services. And this information is used to determine the cap on administrative costs that are eligible for reimbursement in both the Title 19 Medi-Cal program and the Title 21 CHIP program. And we have added additional time periods right. In 18-19, there was only one time period, and that was the full fiscal year, because there was only one cap, percentage cap for administrative costs. In 19-20 starting on March 1st of 2020, the Governor approved an increase in the cap that is used to determine administrative costs for Title 19 services that are eligible for reimbursement, to 30%. Currently, the cap is at 15% and the Governor signed Executive Order N-55-20 to increase that cap to 30% during the COVID-19 pandemic. And, in order for the Department to properly determine that 30% cap, it's important, it's necessary to know it needs to be based on costs incurred from March 1 through June 30. And then on the on the CHIP side, on the Children's Health Insurance Program side, the administrative costs that are apportioned to that program are reimbursed at the same percentage that services are reimbursed. And in fiscal year 19-20, the CHIP services, there are three separate Federal Medical Assistance Percentage rates that are used to reimburse services. The first is from July 1 through September 30th, and that is at 88%. I'm going to acknowledge here that there's an error in this slide and I apologize I didn't fix it, but what I'm telling you is accurate and then we will fix the slide before we send it out. The second time period is from October 1st through December 31st and that reimbursement rate is 76.5, and then the CARES Act increased the CHIP FMAP from 76.5 to 80.84%. So from January 1 through June 30th, there's a third FMAP that's 80.84%. And so there are three periods for the CHIP program as well, where counties will be asked to report the amount of costs incurred by contract providers or the amount that counties paid contract providers for services rendered for inpatient and for outpatient services rendered in those three periods. Okay, next slide, Eileen.

[Slide: Policy Changes for the Changes to the MH 1900_Info, non-CHIP beneficiaries]

Chuck: All right, that's what I just talked through, so apologize for that. Next slide.

[Slide: Policy Reasons for Changes to the MH1900_Info CHIP Beneficiaries]

Chuck: And next slide.

[Slide: Changes to MH 1901 Schedule_B]

Chuck: All right, changes to the 1901 Schedule B. Again, there are three periods for non CHIP settlement groups that include the ACA optional expansion. For non CHIP settlement groups, services are reimbursed at 50% for the period July 1 through 12/31. And then for the period January 1, 2020 through February 29, 2020, services continue to be reimbursed at 50%, but for the purposes of determining the appropriate cap on administrative costs we need to apportion, we need to separate costs that occurred from March 1st to 6/30, which is why we established the third period of March 1st to 6/30. So that's for Non-CHIP, and it also includes the ACA optional expansion, and the reason the ACA optional expansion has the third period is those costs go into the base for determining the 15% or the 30% cap on admin. And then for CHIP settlement groups and so this is MCHIP, and the MCAP program, we have four periods, four settlement groups. So the first is July 1 through September 30 and that is an FMAP rate of 88%. 10/1 through 12/31 that's an FMAP rate of 76.5%. And then 1/1 to 2/29 that is an FMAP rate of 80.84% and 3/1 to 6/30 and that's an FMAP rate of 80.84% as well. Next slide, Eileen.

[Slide: Policy Reasons for Changes to the MH 1901_Schedule B - non CHIP]

Chuck: Here are the reasons that I just went through as to why we made the updates. It's changes in the FMAP as well as the settlement or the admin settlement as well. Next slide.

[Slide: Policy Reasons for Changes to the MH1901 Schedule B - CHIP]

Chuck: And then I went through all of these for CHIP. Next slide.

[Slide: Changes to MH1960]

Chuck: All right, so changes to the MH 1960. So we've talked about the changes in the admin cap for the non-CHIP administrative costs as well as the reimbursement percentages that are applied to the CHIP administrative costs. And so we've broken out on the MH1960 administrative costs into those four periods of July 1 to 9/30, October 1 to December 31st, January 1 to February 29th, and March 1 to June 30th. And then in addition to that, we added lines to the MH1960 to allow counties to report costs that - Administrative costs as well as Utilization Review costs - that are eligible for General Fund reimbursement under the Prop. 30 rules that went into effect after September 30, 2012. Next slide, Eileen.

[Slide: Policy Reasons for Change to the MH 1960 - Four Time Periods]

Chuck: Okay, so the reasons for these changes for the four time periods - so there's a change to the CHIP FMAP. Title 42 of the Code of Federal Regulations sets the reimbursement rates for the Administrative Costs that are allocated to the CHIP program. And the regulations say that Administrative Cost should be reimbursed the same rates that services are reimbursed. For 19-20, for the CHIP program, the Federal Medical Assistance Percentages are 88% from July 1 to 9/30 76.5% from October 1 to December 31st, and 80.84% from January 1st to June 30th. We also broke out the January to June portions to include January to February and March to June, mostly for consistency with how we were doing it on the non-CHIP side. And then the other reason is the 15% cap applied to the Short Doyle Admin Cost, which increased that cap from 15% to 30%. This only applies to the Title 19 costs, though, the CHIP costs are limited to 10%. That's per the same Title 42 CFR regulations. Next slide.

[Slide: Policy Reasons for Change to the MH1960 - Additional Prop. 30 Lines]

Chuck: For the additional Prop 30 lines, so for each, for Admin, as well as for UR/QA, we added two lines for Prop 30. So what Prop 30 allows, is it requires that the State reimburse counties for increased cost to implement realign programs that result from legislation enacted after September 30, 2012. And if the requirement is a State requirement, then the State reimburses the full non-federal share. And if the requirement is a federal requirement, then the County and the State share in the non-federal share. So the State reimburses half of the non-federal share, and the county is responsible for the other half. There are new lines on the MH1960 that are federally-mandated. Prop 30 and State-mandated Prop 30, so that the State can, or the Department can, appropriately determine the portion of the non-federal share that is paid with General Fund. Go ahead, next slide.

[Slide: Changes to the MH1979]

Chuck: And then the changes to the MH1970. All of the changes to the MH1960 on the Admin and UR/QA side - we needed to make changes to the MH1970, to then allow those costs to flow correctly and for the cost report to apply the appropriate -- I'm sorry, the appropriate reimbursement percentage to determine the accurate Federal share as well as the accurate State share to reimburse those costs and so we've separated Administrative Costs into the same four periods contained on the MH 1960. We've separated the Prop 30 costs as well and we've added additional direct service lines to correspond with additional periods of time from the Schedule B. Okay, Eileen, next slide.

[Slide: Policy Reasons for Changes to the MH1979]

Chuck: I think I went through the reasons for these changes. In the 18-19 cost report. The Prop. 30 costs were entered directly onto the MH1979 and that caused some challenges with how costs were reported on the 1960. The total Administrative Costs reported on the 1960 should reflect all of the Administrative Costs, but in the 18-19 template, there was a need to - because the Prop. 30 admin costs and UR/QA costs were to be entered directly on the MH1979 that meant that any of the Administrative Costs reported on the 1960 needed to be net of the Prop. 30 cost, otherwise the cost report would be duplicating those costs and reimbursing them twice. So this change then fixes that problem so that all of the Administrative Costs are reported on the MH1960, and then the county is able to use the MH1965 to reclassify those costs into the appropriate buckets including Prop. 30. Next slide, Eileen.

[Slide: MH1901 Schedule A]

Chuck: Okay, so those were the new things that were added, so let's go ahead and take a break here and let's open it up for questions.

Eileen: Okay, again so if you could use the "Raise Hand" icon to ask any questions for Chuck. I'm hoping everyone sees that on there and the "Raise Hand" icon. So if you're not seeing that, please let me know in the chat. But Chuck, I do have a question from Emilia, she was asking up to when is the cap of 30%? Will it be the next fiscal year?

Chuck: Yeah, the 30% cap will end basically when the pandemic ends, so when the COVID-19 Public Health Emergency ends, that is when the Governor's Executive Order will end as well. So right now, the Governor has waived or modified the existing statute as a result of this Public Health Emergency, and so, what that means is we don't know, for 19-20, we know it runs through the end of the fiscal year, and then if it ends in 20-21, then we will issue an additional Information Notice to inform counties that the 30% cap has ended, it's reverted back to 15%. And then on an interim basis, we would update all of our claim forms to reflect. And then when we do this training again for 20-21, we'll need to have cost report templates that are able to separate costs into time periods that allow for the application of the 30% and the 15% cap, depending upon when the Public Health Emergency ends.

Eileen: Okay, and then we have a second question from Candee: How should we report patients' rights costs on the Mental Health Cost Report?

Chuck: So these are costs that are incurred to pay the salary benefits for a Patients' Rights Advocate I assume? The determination is whether or not the Patients' Rights Advocate is a cost that is incurred to administer the Specialty Mental Health Program or is the Patients' Rights Advocate a cost that's incurred or a requirement of the non Medi-Cal Mental Health Programs that the counties implement. I, unfortunately, do not know the answer to that question and don't want to hazard a guess, but I can reach out to our other divisions that handle that aspect of the program to confirm. My sense is that Mental Health Plans have an obligation under the Medi-Cal program to operate a grievance and appeal process, and if the Patients' Rights Advocate is part of that Medi-Cal grievance and appeal process, then the cost of that Patients' Rights Advocate or an office of the Patients' Rights Advocate - however many people are involved in that process - would be an eligible or an allowable Administrative Cost that's necessary to administer the program as laid out in the in the MHP contract, which requires a grievance and appeals process. But, not knowing specifically where the Patients' Rights Advocate and what the requirement is for that Advocate to be employed and do the work that that person or office does, I can't really answer it specifically. But I will reach out to others and we'll provide that response in writing.

Eileen: Okay, I have a couple more questions in chat. I'm not sure if the raise hand icon is working, I'll follow up on that, but otherwise I'll just be reading them out loud to you, Chuck.

Chuck: That works.

Eileen: We have a question from Kimberly. She's asking if for separating Administrative Costs for periods, can we calculate the cost for the full fiscal year and then allocate to the period by the percentage of the year? The reason I ask is because of the delays in invoicing. Some costs don't end up in the correct period.

Chuck: I think the preference is that it would be based on the date the costs were incurred. Each county would have a set of costs that go into the Administrative Cost pool that then gets allocated to Title 19, Title 21, non Medi-Cal Prop. 30, all of those smaller buckets. I think our thought, or my thinking, was that the date those costs are actually incurred would be the basis for breaking them apart. It sounds like that may not be reasonable based on delays in invoicing, and it sounds like when payables are set up in your accounting system, and that the dates the payables are set up may not correspond to the fiscal year in which the cost should be reported. If this is Kimberly from Napa, maybe you and I can touch base on the phone and have a little bit more of a conversation about this since the Raise Hand feature isn't working. Kimberly, can you send a chat just with your last name and what county you're from and I'll circle back with you and then and then we can issue, again, an FAQ with a little bit more detail on this so that everyone can benefit from the response.

Eileen: I'm seeing it is Kimberly from Napa and also Roize from Riverside County had the same question.

Chuck: Okay. Awesome. All right.

Eileen: We have a couple more questions here. Crystal is asking: Has a new admin quarterly claim form been sent out or is it on the DHCS website? I have not yet seen one, or am I misunderstanding the new 30% cap?

Chuck: Yes. There is a new claim form for interim claims and it is posted to our DHCS website on the Specialty Mental Health side. We can send you a link to that specific page once this is over.

Eileen: Okay, Gabriel is asking are inpatient costs on the MH1900 bundled to include cost of service and admin cost together?

Chuck: Inpatient costs to the extent that the hospital, when they're determining their cost to provide a service, the hospital will typically step down a portion of their administrative costs into the cost for the inpatient stay, yes. What is reported on the MH1900_Info would include that step down of the hospital's administrative costs to the extent that's equal to what the county paid the hospital for the services rendered. Those administrative costs though aren't the same as the administrative costs that are reported on the MH1960 and then reimbursed based on 50% of direct services. The administrative costs there, we're talking about the cost to perform a number of administrative functions that are necessary to implement the managed care program or the Mental Health Plan, like beneficiary notification, like grievance and appeal processes, like notice of adverse benefit determination, like utilization management processes, those kinds of things that the county does. There are other costs that providers incur that are administrative in nature, but it's not the same as the 15% that we've been talking about. Go ahead, what's the next question?

Eileen: Ben is asking when is the start date for the CMS to waive the customary charges limitations?

Chuck: Thank you for raising that. I didn't include that in the changes. We will definitely address that as we get to the MH1968. The other reason for breaking these costs apart in the way that we did is that part of the waiver that CMS approved during the pandemic did waive the usual and customary charge limitation that's currently applied to services that are rendered by contract providers. We will talk more about that when we get to the MH1968. I appreciate the question. We did miss that as one of the changes that has been implemented in this new template. And so the date again is from March 1st, so the effective date of the waiver request that we submitted to CMS and CMS approved was March 1, 2020.

Eileen: Prop. 30 started September 30th. How will the cost report for the prior fiscal year starting in fiscal year 2012-2013 to the present be affected? Will that just be adjusted during settlement or audit?

Chuck: I think the first Prop. 30 costs came into being with the performance outcome system. I honestly can't recall when that went into place. It wasn't in 12-13. I believe it was more like 16-17 or 17-18 even. I am pretty sure that we have had an opportunity for counties to report those costs in the Cost Report so that we could appropriately reimburse the non-federal share. But again, I will go back and confirm whether or not that's the case. What we can do is confirm what in what fiscal year did we first have Prop. 30 costs and did the Cost Report for that fiscal year and subsequent fiscal years

allow for the counties to separately report to us those Prop. 30 costs so that we can reimburse the General Fund Share? If not, then we'll have to think through how to best resolve that.

Eileen: And the last question I'm seeing here is from Kimberly from Napa: Is there a definition for an Administrative cost in the fiscal year 19-20 Cost Report manual? I would like to know the difference between admin and indirect costs and what costs can be classified as indirect?

Chuck: Thank you for that question Kimberly. We do have an Information Notice that is currently with our Deputy Director for review, that we will be releasing hopefully soon, that does address that question. It addresses the question of what is an administrative cost and within that definition of administrative costs, you could have either direct administrative costs or indirect administrative costs. Direct administrative costs would be reported - and we'll get to this when we get to the MH1960 - but those direct administrative costs would be reported under the columns A and B as direct cost of administration and again those are administrative costs that you can directly assign to a specific function of administration. In the Information Notice that should be coming out soon, the functions of administration that we're talking about are all of those tasks and functions that need to be performed in order to comply with the administrative requirements in the MHP contract. So for example that would include - and I think I've mentioned this before - that would include all of all the beneficiary agreements and appeal processes that the county has to administer, notice of adverse benefit determinations ... I'm not an expert in the contract, so I can't go through all of them, but the contract does lay out specifically what counties need to do as a Mental Health Plan in order to comply with the requirements of Title 42 and primarily part 438. And again, Kimberly, when we talk about the other issue, if you have other questions about that, I can talk in more detail with you about that and then we can also, if necessary, well, we probably won't do a "Frequently Asked Questions" since we do have an Information Notice that should be coming out soon that will address it.

Eileen: Okay I think that's all the questions that we have so far. Just as a reminder, I'm not sure if everyone is seeing the Raise Hand function, but if you go to the part of the screen where you have the mute and etc., buttons and then click on participants you might be able to see that “Raise Hand” icon that I was showing during the housekeeping section. But otherwise, hopefully Chuck, this is working out for you, where I'm just reading out the questions out loud.

Chuck: It is. It's working out. I just clicked on participants and it opened up the list of participants and then at the very bottom on the right hand side you can see a hand. If you put your cursor on it, it says “Raise Hand”, and if you click that, then Eileen will know that you want to talk.

Eileen: Yes.

Chuck: Great. All right so now let's move on to the MH1901_Schedule A. Some of these are going to be pretty fast and straightforward, and some of them, where there are more changes, there may be some more technical discussion. They may take more time. I will try to stop every 10 to 15 minutes for questions or I'll just kind of gauge it. First is the next schedule is the MH1901_Schedule A. The purpose of this schedule primarily is for the provider that completes the cost report, to enter their usual and customary charge for each service that the provider rendered and is reporting in the cost report. This is used in two ways in the cost report. The first is if the provider, when we get to the Schedule C we can talk more about that, but if the provider is wanting to allocate cost to different service functions using the relative value methodology on the Schedule C, then the Schedule A will need to include a customary charge for the services that are reported in the cost report. That is one of the bases that can be used to perform the relative value allocation on the Schedule C. The other reason that is needed is for contract providers. The State Plan, as well as the CPE protocol, limits reimbursement to the lower of cost or charges for outpatient services and then it also limits reimbursement for inpatient services, regardless of the provider type, to the lower of cost or charges. Even if it's a county providing inpatient services, those inpatient services are still limited to the usual and customary charge for the same service. And, that inpatient service will also continue to be applied during the pandemic. The CMS only approved our request for the usual and customary charge to not be applied for outpatient services. But CMS was clear that they will still require the usual customary charge to limit reimbursement for inpatient services. Next slide.

[Slide: Usual and Customary Charge Definition]

Chuck: Usual and customary charge definition. This is for those who will need to report their usual and customary charge on Schedule A, I encourage all providers to consult the Provider Reimbursement Manual 15-1 Chapter 26 and then this specific information comes from 2604.3. What's important is that the uniform charge is the provider's established charge. It needs to be in effect and applies consistently to most patients. A usual and customary charge is not an amount that's charged to only some of the patients. It needs to be charged to most patients. If you don't have an established

charge schedule applied to most patients, then you can look at the most frequent or typical charges imposed uniformly. But again, it has to be imposed uniformly; it can't be imposed randomly or some patients get charged this, and some get charged another rate. In addition to charging, they also have to be collected. Even if you're charging 100 dollars, but in most cases you're only collecting 50, then the usual and customary charge wouldn't be 100, it would need to be 50. There are some specific rules regarding what are patients liable for payment. So it would be important to look at those rules really carefully as you're determining what the usual and customary charge is to enter on the Schedule A. Next slide.

[Slide: MH 1901 Schedule B]

Chuck: All right, Schedule B. The purpose of the 1901 Schedule B is for providers to report their total units of service and third party revenue, and then to also report units of service by individual Medi-Cal eligibility groups and then to identify the correct settlement type. The policy for units and the reason why we ask for units of service is that those units of service by eligibility group are used to apportion costs for outpatient services to the appropriate Medi-Cal program and then to apply the appropriate Federal Medical Assistance Percentage to determine the correct federal reimbursement. The third-party revenue is collected because, as many of you know, CMS is the payer of last resort. If there are other payers, or other entities, or other health coverage that is liable to reimburse for the services rendered, for example, one would be Medicare, Medicare may cover the same or some similar services that are provided to Medi-Cal beneficiary under the Specialty Mental Health Program and Medicare should reimburse first, and then the residual, or the amount left, that Medi-Cal would have paid if Medicare hadn't paid, less what Medicare paid, is the amount that Medi-Cal will reimburse. Those are rules that CMS puts out and that we need to abide by. Then the Medi-Cal eligibility groups - the reason for then asking for units of service to be reported in these different Medi-Cal eligibility groups, is to ensure that we're reimbursing counties the appropriate federal share and that we're drawing down the appropriate federal share from the federal government. So each of the Medi-Cal eligibility groups is really a group of aid codes for whom services are reimbursed at the same rate. The other reason for Medi-Cal eligibility groups is there are some requirements where CMS requires the Department to report costs differently or separately for beneficiaries that are enrolled through those programs. For example, on the Schedule B, we have a group for the Breast and Cervical Cancer Treatment and Prevention Program that is reimbursed at 65%; we have a group for beneficiaries who are receiving services through the pregnancy benefit that are also reimbursed at 65%. And those even though they have the same FMAP, they're separated because CMS has directed DHCS to report the BCCTP cost separately on the CMS-64. And then lastly, there are some beneficiaries that are enrolled in Medi-Cal, and the costs for those services are subject to Prop. 30

reimbursement as well General Fund reimbursement. So there's the groups that are in our current template include the children up to age 19 that are enrolled in state-only Medi-Cal under Senate Bill 75, and then in the current fiscal year that group was expanded to the young adult population. Excuse me for a minute, I will be right back.

[No audio]

Chuck: Okay, sorry about that, one of my kids turned on the TV. Some of the challenges of working from home. Okay, let's get back to what we were doing. For Medi-Cal eligibility groups, there are the SB 75 and the young adult expansion that is necessary to, again, apportion costs that are 100% General Fund. And then lastly, the settlement type, our reimbursement policy, the settlement type, lets DHCS know what the reimbursement rules that should be applied to units and costs that are reported on that line. So again, some of those settlement types were established for Prop. 30. That one settlement type is CCR and that is so that providers and counties can report the units of service that were associated with participation in a child and family team, or assessments that are conducted, and required to be conducted, before placing a child in a STRTP. And that CR settlement type lets the cost report template know that the costs apportioned to that service function are eligible for federal reimbursement, as well as General Fund reimbursement for the non-federal share. Okay, I am going to take a break here and open it up for questions.

Chuck: Or, actually Eileen, can you go to the next slide just to make sure we're done with Schedule B? Okay, let's finish Schedule B. I apologize, I was starting to get into what the settlement types are, and then we'll go from there. The settlement types include: CR, that's cost reimbursement, and so that is the most common settlement type. That settlement type should be chosen for most services reported, and it tells the cost report template that these services, these units of service, are subject to be settled to the lower of allowable cost or customary charges when rendered by contract providers, or allowable costs when rendered by county providers. TBS is another. This is reserved for services that are rendered by an individual provider, contracted with a county, to only provide TBS services and because of that it's not subject to the customary charge limitations. So these are what the cost report terms program services and within the State Plan Amendment 09-004, as well as the CPE protocol. It discusses the services and clearly exempts them from the customer charge limitation. Mental Health Service: these are a different set of services, but our program services are all the same. These are services that are provided by individual or group providers as defined in Title 9. These are those providers that are able to provide services under the scope of practice under their license, and they've historically, prior to consolidation of the inpatient and outpatient service delivery system under the 1915(b) waiver in the mid-

90’s, these providers were able to provide services through the fee-for-service system, and bill directly to the fiscal intermediary within DHCS. The reason for separating these units and services out is that these are individuals or group providers that contract directly with the county, but do not have a requirement to submit a cost report. And many times their primary function is to provide professional services to beneficiaries who are admitted to hospitals. Next slide.

[Slide: Settlement Types (Cont.)]

Chuck: The ASO settlement type. So, some counties may contract with an administrative service organization. The administrative service organization then would facilitate the authorization and payment of services that are provided to beneficiaries that are out of county. Historically, this was often used for children who were placed out of county through the foster care system and the administrative service organization maintain a network of providers in other counties and then perform some of the authorization and payment functions that the MHP would otherwise perform for providers within their county network. It's important that the costs that are reported for units of service that are provided through an ASO are only those costs that the county pays to the ASO for the provision of services. There are likely costs that the county must pay the ASO for the administrative functions that it performs, like authorization. There may be other things, and CMS in 2010, in their financial management review, were clear in instructing the Department that those payments to the ASO for administrative functions needed to be reported as administrative costs, and they had to be reimbursed as administrative costs as well, and reported to CMS as administrative costs. And then the HOSP settlement type: any Mode 05 service function 10-19 services need to have the HOSP settlement type that indicates the service was provided by a hospital provider. But even other modes of service, Mode 15 or Mode 10 services that are provided through a hospital need to have the HOSP settlement type. What this tells the cost report is that the costs for those services are reported on the appropriate MH1960_Hospital forms and a cost to charge ratio or, cost per day for routine cost centers, is used to apportion those costs to all of the different settlement groups. But we still need the units of service on the Schedule B, and we still need the units on Schedule B so that we can determine the usual and customary charge for those services. We can appropriately apply the usual and customary charge limitation on MH1968. And then the last one is CCR and that's the one that I already explained before we moved on to the next slide. Eileen, next slide.

Chuck: Okay, now I'll stop. I apologize for the kind of jerkiness in this process, but if there are any questions, let's go ahead and start taking those as related to Schedule A or Schedule B.

Eileen: Chuck, while everyone is raising their hands or sending their questions in, do you mind if I provide a clarification that might help them find the Raise Hand icon?

Chuck: Absolutely.

Eileen: Going back to this panel here, again the Raise Hand icon looks like this. However, to get to this panel where you will see this icon over here, you'll first have to click on the blue person here and that will open up the attendee panel in which you can click on the Raise Hand icon. So that's where that would be located if you're having trouble finding it. Otherwise, it looks like Kimberly is asking should psychiatric health facilities, PHF, be reported as HOSP? They are not necessarily a hospital.

Chuck: No, the psychiatric health facilities aren't considered hospitals in this in this context. They're an outpatient provider.

Eileen: Okay. I'm seeing that Kimberly is raising her hand so hopefully that did provide some clarification on where to find that. Otherwise, I don't have any other questions or raised hands.

Chuck: Okay, perfect. So we'll move on then. All right so the next schedule that we wanted to talk about was Schedule C. The primary purpose of Schedule C is to allocate service costs each service type as reported on Schedule B and costs can be reported -- The first set is you can choose an allocation method and there are three allocation methods to choose: Directly Allocated, Published Charges, or Rate for Allocation. If you choose the directly allocated option, then the provider will enter its costs in either the allocated column or the directly assigned column, and we'll talk a little bit more about what that means. Directly allocated means that the provider will enter their cost in Schedule C as they determined, and then the work papers that they maintain to demonstrate how those costs were allocated will need to be maintained for auditors. A provider may also select published charges. And so as I mentioned before when talking about the Schedule A, if the provider selects published charges, then it is saying that it wants the Schedule C to allocate costs for specific Modes and service functions using the published charge that is reported on the Schedule A as the basis for that allocation. We will talk a little bit more about how that relative value calculation works within the Schedule C so that everyone's clear on how it operates. Then, rate for allocation. The provider may also choose a rate for Allocation, and if the provider

selects rate for allocation, then that will choose the data from the Schedule A again to perform a relative values calculation. That rate for allocation may be the published charge or it may also be another rate that a provider may enter on the Schedule A, like a county contract rate. And then the Schedule A will select one of those rates to populate the rate for allocation column. When it does, if that is chosen on Schedule C, it will use that rate from the Schedule A to perform the relative value calculation. Okay, Eileen, next slide.

[Slide: MH 1901 Schedule C (Cont.)]

Chuck: Eligible direct cost. If you chose not to use a relative value calculation, then the provider needs to report the costs that are directly assigned to each service function in a column in the eligible direct cost column. If the settlement type is TBS, MHS, or ASO, then costs must be reported in the eligible direct costs column. The reason for that is eligible direct costs are costs that are directly assigned to that specific service function, and if the settlement type is TBS, MHS, or ASO, then the Department's expectation is the county knows exactly what it paid the Provider. So what it paid the provider for the TBS service for the Mode 15 mental health service or what it paid the ASO for the service rendered to the provider. So again, these are program’s true costs, where the providers are contracted to the county, but not providing cost reports to the county or to the Department, and the amount that the county is reporting on the cost report are the amounts that the county paid the provider for the services rendered. So if the settlement type is TBS, MHS, or ASO, and costs are reported in the directly allocated data column, you will see an error on the right hand side of that table that tells you, well, it'll just be an error. And the column won't populate at all. To fix that, then enter those same costs into eligible direct costs and that should resolve the error. Directly Allocated Data: these are report costs that are allocated, rather than directly assigned, so again, this is where there's some type of allocation method that is used to determine the proportion of costs incurred, to provide treatment services, provide direct services that are allocated to a specific service function. They're not directly assigned, but there's a pool of costs that are directly assigned to medical assistance as a whole, and then those costs may be allocated to specific service functions based on time that staff spent performing those services, or some other appropriate method of allocation. Directly allocated data must be used for settlement types CR, CCR, MAW, and HOSP, as well Modes of service 45 and 60 and then the relative value calculation. The next column will show a relative, if you selected either rate for allocation or published charge in the Schedule C, then a relative value calculation will be performed for other 24-hour services, so not inpatient for day services, and for outpatient services, with a CR settlement type. So if there's a different settlement type, then it won't perform a relative value calculation for the service function. Next slide.

[Slide: Relative Value Calculation]

Chuck: Here's how the relative value calculation works. Column G will be equal to total units in Column D multiplied by the published charge or rate for allocation in Schedule A, depending upon the allocation method chosen. And that is how that percentage in Column G is calculated. Then Column H is equal to the amount in Column G for the service function, divided by the total of Column G. So the sum of Column H should be-- I apologize, Column H is the percentage. Column I, then, is equal to the total units, the total non-hospital cost in cell 11, plus total known hospital costs in columns E and F, multiplied by the allocation percentage in Column H. So in essence, it takes those costs that have not yet been allocated, and it multiplies it by the percentage in Column H to allocate those costs that haven't been allocated to each specific service function where the provider chose to allocate costs using the relative value method. Next slide.

[Slide: MH 1960]

Chuck: Okay. The MH 1960. I think this is where it gets really fun. The primary purpose of the MH1960 is to identify direct costs and to allocate indirect costs to the administrative, utilization review, and quality assurance, and the medical assistance cost centers. So the total cost reported in columns A and B should tie to the general ledger. Please report costs associated with both hospital and non-hospital costs. This is a change in instruction, or a clarification of instruction, where the instructions may not have been as clear in the past. But if your general ledger includes both hospital and non-hospital costs, we think it's appropriate to populate the MH1960 with both hospital and non-hospital costs and then we'll talk about where and how to adjust out those hospital costs in other forms on the cost report. Otherwise, if the general ledger includes both hospital non-hospital costs and the MH1960 only includes non-hospital costs, and it seems like it's less likely that the two will tie and there will need to be work papers associated to show what’s in the 1960, what's been eliminated from what's in the general ledger to get to what's in the 1960. So in the next set of lines, lines 1 to 23 are for indirect costs. These are costs that cannot be directly assigned to any one of the cost centers identified above. So they can't be directly assigned to the cost of administration of the Mental Health Plan, to utilization, review, and quality assurance activities, or to the provision of medical assistance. For administration, what we have said, and what Kimberly had asked the question in the past, but the costs for administration are those costs that are incurred to perform those administrative functions that are required in the Mental Health Plan contract, and then it's the same for utilization, review, and quality assurance. There are a couple of, I think they're called

Attachments, within the MHP contract that are specific, that say what the MHP has to do relative to a utilization management program, prior authorization, concurrent authorization, all of those kinds of functions fall within UR/QA. Then the last is the provision of medical assistance. All of the costs that can be directly assigned to the provision of therapy, case management, rehabilitation services, those kinds of things, would be a direct cost, and then any cost, then, that falls across these different cost centers would naturally then be indirect. Because they cannot be assigned, they can't be directly assigned, to each of those cost centers without -- if they can't be directly assigned without Herculean effort. And then direct costs would be lines 24, 30, 36, 42, 48, and 56. So these are, again, if you can directly assign the cost to administration, to UR/QA, or to medical assistance, then enter those direct costs on these lines. Then, next slide, Eileen.

[Slide: MH 1960 (Cont.)]

Chuck: We just went through these, these are the definitions of direct and indirect. Next slide.

[Slide: MH 1960 (Continued)]

Chuck: And then net costs for allocation. Column G calculates the sum of C, D, and E and F. Column G reflects the total cost to be allocated between Medi-Cal and non Medi-Cal programs. Cost allocation for indirect costs. For each indirect cost center, you'll need to allocate all of those indirect costs down to your direct cost centers in Column G or I, using some appropriate allocation methodology. It could be proportion of costs or there could be more direct, if we're talking about administration, and you're allocating rent of a building, that is shared by folks that are performing administrative functions, and for folks that are providing direct services, what percentage of square footage do each of those teams occupy? Then, to allocate the rent or facility cost based on those percentages - that would be a reasonable method. Re-classing. Column I displays all the costs re-classed. We'll talk when we get to the MH1965 about the reclassification of costs. The MH1965 will need to be used to reclassify administrative costs and UR/QA costs that are reported as direct costs, as well as indirect costs, that are allocated to any of those cost centers. The MH1965 will be used to reclassify those total costs to Title 19, Title 21, non Medi-Cal, Prop. 30, etc. Next slide.

[Slide: MH 1961]

Chuck: I think this is a good time to take a break. I've been going for about 20 more minutes, so I'll stop here, and if there are any questions, you can use the Raise Hand feature or send a chat to Eileen.

Eileen: Okay, I am seeing raised hands now.

Chuck: Good work, Eileen.

Eileen: Thank you.

Eileen: I have a question from Mary Ann. Is it possible to have an eligible direct cost for a CR cost settlement type? Currently, we are reporting Mode 60 SFC (70-78) under Eligible Direct Cost in MH1901_Schedule C.

Chuck: Eileen, can you go back to the settlement type? Or to the Schedule C, I apologize. One more, can you go back one more? Go forward. Yeah, forward. Again.

Chuck: Okay. Is it Mode 45 and 60? And you want to be able to report Mode 45 and 60 as an eligible direct cost?

Eileen: The question is: was it possible to have an eligible direct cost for a CR cost settlement type? We are reporting currently Mode 60 SFC (70-78) under Eligible Direct Costs in MH1901_Schedule C.

Chuck: I don't know the answer to the question. Let me go back, and I think we need to look at the template and see what it does when we do that, and then if it's reacting in a way that isn't appropriate, then we can change it. Conceptually, it seems you should be able to have - I think conceptually we'd have to think that through. I think initially we may have said no, because if we did …

Eileen: Mary Ann is following up and she said: "That's how we've been reporting it in years past with no errors. Just wondering if that's the correct way."

Chuck: If there weren't errors then continue to do it, but I thought there were errors, so we'll go back and I'll just confirm how the cost report is working. I apologize if I didn't explain it correctly here.

Eileen: The next question is from Crystal. Can you give specific examples of what is considered indirect costs and direct costs? Is there a list somewhere? Where will extra technology costs due to COVID come into play?

Chuck: Extra technology costs are administrative. Well, let's back up here. If you're a provider and you're purchasing technology to provide services, then the cost of that technology should be built into the rate that the Mental Health Plan is paying that contract provider for services rendered. And typically, a business would then depreciate or amortize those over the life of that technology. As they use the technology, then they would charge the payer for the use of that technology. It would be in the rate, basically. If the question is if a provider purchases technology and it costs $5000, is there a way for that contract provider to get reimbursed for that $5000 cost? I think that's a different question, and maybe we can take that offline and talk it through. The definitions in Title 2 of the code of Federal Regulations for Direct Costs and Indirect Costs are the ones that are in this PowerPoint deck. Direct costs are cost that can be directly assigned to a specific cost objective. The cost objectives in this case are administration and administration is the performance of those functions that have to be performed as identified in the Mental Health Plan contract. The other is utilization review/quality assurance. Again, those functions that have to be performed to implement the UR and the QA requirements that are contained in the Mental Health Plan contract. The other cost center is medical assistance. Those functions that need to be performed in order to provide medical assistance to beneficiaries and, for example, if we're talking about medical assistance if there is a clinic that is a contract provider or if the county operates a clinic, and that clinic employs staff that provide services, staff that support the provision of those services in some way, and then all the costs that are accumulated in that clinic are appropriately directly assigned to the provision of medical assistance and can be reported as a direct cost of medical assistance. Similarly, if there are organizational units within the county that perform administrative functions required by the contract, so for example, if the county has a unit that does contract negotiation with providers, then that's a function that is necessary to maintain an appropriate provider network, which is required in the Mental Health Plan contract, the cost of that unit, including employees, computer equipment, all that, once appropriately depreciated, can be directly assigned to cost administration. Similarly, for UR/QA. If, though, let's say there's a clinic that does medical assistance, but the staff in that clinic are also involved in contract negotiation, or some utilization review/quality assurance work then, it's not as

simple to directly assign all of those costs to medical assistance. Those costs would need to be allocated in some way between the two or three cost centers that benefit from the cost incurred or accumulated within that unit. I hope that's helpful. I think we can also set up a separate call to dig down into this a little bit more, and it also might be helpful to have the Information Notice that I referenced earlier formally posted as well before we have that, so that we're all talking from a more formal policy statement on how this should work.

Eileen: Chuck, I'm getting a question: If you can please repeat the last scenario that you just said?

Chuck: Oh okay, so I think if you have an organizational – let's say you have a clinic, and within that clinic you have direct practitioners, you have a clinic supervisor, and maybe that clinic supervisor is also involved in reviewing RFPs that come in for potential contract providers, maybe they're also involved in some data analysis, or reviewing requests for authorization or … I'm making stuff up here, right. But if that were to happen, then the cost accumulated within that clinic that includes the time of the supervisor who is both supervising the provision of medical assistance within the clinic and then also doing some other activities that are administrative in nature, such as reviewing requests for proposals for potential contract providers, there would need to be some method of allocating a portion of the cost accumulated in a clinic to administration. It couldn't all be directly assigned to the cost of medical assistance.

Eileen: Okay, I have two questions from Ruby. The first one: is there a percentage for indirect cost limit?

Chuck: There isn't an indirect cost limit; there isn't a percentage for that. If a county has a federally approved indirect cost rate, that federally approved indirect cost rate, to the extent that it's applicable here, can be used to allocate indirect costs.

Eileen: And the second question is: indirect versus direct on IT costs. Should the cost of the unit reporting system be indirect cost and then allocate to admin, UR, and direct services?

Chuck: Can you repeat the question?

Eileen: Yes. Indirect versus direct on IT costs. Should the cost of the unit reporting system be indirect cost and then allocate to admin, UR, and direct services?

Chuck: I'm not sure what the unit system is, are we talking about an electronic health record? If that's what we're talking about, that is most appropriately just directly assigned to the cost of administration, as appropriately depreciated. But if we're talking about computer equipment that is used within a clinic to manage the clinic to provide treatment, those kinds of things, then that computer equipment that is only used for the clinic, and the clinic only provides medical assistance, then the cost of that computer appointment would be directly charged to the cost of providing medical assistance. Maybe it would be helpful for us to talk through the specific scenario that you have in mind. Again, on a separate call so Eileen, if you could be jotting down these separate call topics, and then maybe we could schedule a call - more of a call, and less of this formal webinar, and we can talk through some of these scenarios in a little more detail, and get those questions answered. Maybe we can have a monthly check-in - I'm just throwing things out - So if you want to respond through chat and say ‘Yeah, I like that’ that would be helpful. Maybe we can just do monthly calls with the Behavioral Health Financing Branch and counties to talk through some of these really specific cost questions and provide technical assistance, on a routine basis. Then, folks can join as they see it useful or not. If they don't see the specific content or agenda for each call to be helpful. Then, we could send out requests for agenda items routinely before those calls. Just a thought. I think for the specifics, since some of the “Raise Hand” feature isn't working, and we're chatting using the chat function, I think would be helpful for us to have a dialogue about some of these things. Because the specifics are important, and I don't know that I'm understanding all the specifics.

Eileen: I am seeing now that I can unmute Ruby for her question.

Chuck: Okay, perfect.

Eileen: If you would like me to do that now or --

Chuck: Yeah, great!

Eileen: Okay, Ruby, you are unmuted. Go ahead and ask your question.

Ruby: Okay, thank you so much, for the admin cost, it’s AVATAR. So I'm just wondering for what you just said, you're talking about the situation for CBO. Then how about for the county, if we have AVATAR for the direct services, what’s the appropriate way to report it?

Chuck: Yeah, AVATAR is an administrative cost, so you're purchasing a billing system, in essence, right. And that billing system is managing all of your units of service. You're using that data, and it may actually be directly billing the A-37 transaction that's submitted to the Short Doyle system for reimbursement. There may be folks within clinics, then, that are entering data into that database, but the actual AVATAR database, it's administrative costs that's necessary in order for you to bill appropriately. It's necessary for you to provide data on encounters that we need to maintain for CMS purposes, but it's not necessary to actually render the treatment.

Ruby: Okay, I got you. Thank you. Can I ask one more question?

Chuck: Yeah!

Ruby: Again, about the indirect cost limit percentage, I remember the admin costs used to have, before COVID, just have 15% cap right?

Chuck: Yeah.

Ruby: Then I remember I read somewhere, it said indirect cross is part of admin, and admin has a 15% cap. Then if this is right logic, then should indirect cost have a limit?

Chuck: No. So admin and indirect aren't the same. An indirect cost can be a cost that is ultimately assigned to the administration cost center but it also includes costs that can ultimately be assigned to the medical assistance cost center. The 15% limit on administrative costs does not apply to indirect costs.

Ruby: Okay, I see. Is there somewhere we can find the wording, the regulations on that?

Chuck: Yeah, so I think in the definitions in this slide deck of direct and indirect, I may have referenced the title too, [inaudible] the section, but if not, we'll make sure that when we send the slide deck out, it does have those references in it. The other part is the Information Notice that I referenced before that's currently in, hopefully, final review and will be coming out the counties soon for their review, will provide more detailed explanation regarding the treatment of direct cost, indirect cost. That will make this all, I think, clearer for everyone.

Ruby: That's awesome, thank you so much.

Eileen: Okay, I have a question from - I'm sorry I'm not pronouncing your name correctly, it's Shahrzad - Shahrzad is asking if A-87 costs are indirect costs?

Chuck: A-87 is a reference to the cost principles for state and local governments. But it's also used to reference the external indirect costs that are allocated to the Mental Health department when they're reported on the cost report. I think on the cost report there's a line that's called A-87 costs, and those A-87 costs are the cost of county council and other departments within the county structure that benefit the Mental Health department in some way, and the county then allocates a portion of those costs to all of those - I'm guessing it's done this way - but to those revenue producing departments. Those then do show up on the indirect cost line - and I think it's the very last line, line 23, and then those get allocated to administration, UR/QA, or medical assistance as appropriate. Again, I think that is a question that we've had discussed with our Audits and Investigations team in the past. My expectation is that the Information Notice that I've mentioned before will help to clarify that in more detail once it's out and posted.

Eileen: And the last question that I have for right now … Well, first of all, I just want to note that people are saying that a monthly call or conversation would be great.

Chuck: All right, we'll do that.

Eileen: The last question I have is from Kimberly. We have allocated our indirect cost using the gross cost method. The cost report auditor has asked us to create different allocation methods for each type of indirect cost. For example, square footage for building space or number of staff for shared copy machines.

Chuck: Is the question - are you asking us to opine on what's the appropriate allocation method?

Eileen: That's all I have from Kimberly so far. She's asking, ‘do we need to have different allocation methods for each type?

Chuck: I think that's the cleanest way to do it. If there's a reasonable statistic that can be used to support the allocation, as I was mentioning earlier, like rent or the cost of a building, that is an indirect cost, and using square footage would be an appropriate statistic to use to allocate those costs to the final cost objectives. I think it would be helpful to go through each type of cost that's reported as an indirect cost, and consider what the appropriate statistic would be to step those costs down into one of the three final cost objectives. But, we can talk if you want to talk more about that, Kimberly, you can send me an email, and I can give you my phone number, and you can give me a call since we're all working from home and my phone number is my cell.

Eileen: Kimberly is saying: ‘yes let's talk more.’

Chuck: Okay.

Eileen: Okay, and that's all the questions I have for right now.

Chuck: Okay, awesome, thanks. Where did we end? I think we'll go for another five minutes and then we'll break again for questions and I think we'll be done. Were we done with – we’re on to the MH1961, right?

Eileen: I believe so.

Chuck: Yeah, the MH1961. One more forward, perfect, all right. Okay, there you go, awesome, all right.

[Slide: MH 1961]

Chuck: The 1961. The primary purpose of MH1961 is to remove costs reported on the 1960 that are not mental health costs. In column A, you want to enter the amount of the adjustment. A negative number reduces costs, and a positive number increases costs from the 1960. So, for example, if you have in your general ledger and in your total cost reported on the MH1960, you have the cost of providing Substance Use Disorder Treatment Services because you may be in a consolidated department that doesn't maintain a separate set of books for each program, then you would want to enter on to the MH1960 the cost of the Substance Use Disorder program that is included on the MH1960. And it would be a negative number so that it gets adjusted out. Column B, then, is the line number. So, you want to select from the drop down list the line number that's associated with the cost center that you want to adjust. For example, if it's the A-87 line, which I think was line 23, you would enter line 23. Then, Column C is an MH1960 description. This column is automatically populated and it's based on the line number that you pick in column B. All right, next slide.

[Slide: MH 1961 Examples]

Chuck: Some additional examples, I already went through the Substance Use Disorder example. Another one would be hospital costs. As I mentioned when we were going through the 1960, that if your general ledger includes the cost of providing hospital services, here on the 1960 then, you're going to adjust out those costs. If all those costs are reported on the medical assistance direct cost center line, then you would want to enter that line number and then enter a negative number to remove all the hospital costs. Those hospital costs could include, if you're accounting for the cost of the reductions in your 91 realignment distribution that occur after a beneficiary receives a psych inpatient service in a fee-for-service hospital and that hospital is paid by DHCS and then DHCS recoups the non-federal share through the 1991 realignment offset. If your county, then, accounts for that as an expenditure of some sort in your accounting system, then this would be the place to remove those costs from the 1960. Or, if you operate a hospital and the costs of that hospital are included in the general ledger for the Mental Health department or the Mental Health Plan, and those costs are on MH1960. This would be a place where you would then remove those costs from the MH1960 Okay, next slide.

[Slide: MH 1962]

Chuck: All right, the MH1962. The purpose of the MH1962, again, it's another form used to adjust costs on the MH1960. These adjustments are to ensure that the costs reported on MH1960 comply with Medi-Cal cost reimbursement principles. Column A, you would

enter the amount of an adjustment. It could be a positive number, and that will increase costs, or a negative number. If, for example, the cost reported on the MH1960 included the cost of depreciable assets, and it included the full cost, and assets weren't depreciated, then here you would make an adjustment to reduce those costs so that it's only reflecting the portion of that asset that was used, or the depreciation expense in the current year to be compliant with principles of reimbursement under Medicaid, which requires the depreciation of long-lived assets. Then, in out-years if you're continuing to depreciate that asset then you may have positive adjustments to add in the depreciation expense that may not have been included in the cost reported on the MH1960. Because if the county had expended the entire cost in the year of purchase, Column B, you want to select the line number on the 1960 from the drop down list. Column C will automatically populate the name of the cost center. That could help if you accidentally select the wrong line number but don't notice it, but then you look at the cost center and you say, ‘oh that's not what I want to do’ and go back and fix what happened. All right, next slide.

Eileen: Chuck, before we move on to the next slide, I’m getting a question if you could please repeat the portion on the depreciable cost?

Chuck: Sure, it’s just an example. If a county doesn't depreciate … typically, in an accrual basis of accounting when you purchase an asset you'll capitalize the asset, which means that the dollars that went out the door won't show up as expense, but you’ll show a reduction in cash, and an increase in the asset side so it's an entirely balance sheet transaction. Then, over the life of the asset, the asset will be reduced and the expenses will be increased, right. The Medicaid principles require is that assets be depreciated and that Medicaid only reimburses the depreciation expense in a year. It doesn't provide federal reimbursement for the entire cost of the asset in the year that it’s purchased. It reimburses, in essence, the amount of the asset used in the year, in the cost reporting year. And that's another way, in my understanding, of seeing the depreciation expense. Depending on if this is even an issue, I don't know, but if it is, then you would need to make an adjustment here to reduce, if in year one you purchase an asset, and this is the year you purchase the asset, if you're reporting the full cost of the asset as an expense on the MH1960, then it's necessary to reduce that to just the portion of that asset that was depreciated in the cost reporting year. And then, in subsequent years, if you had fully expensed the cost in year one and year two, then your general ledger would show no cost for that asset, no depreciation expense. But, you still want to show that depreciation expense and ensure that it gets built into the cost eligible for reimbursement so that you continue to have the opportunity to get reimbursed for the portion of the asset that you use each year. Can we go to the next slide or and then maybe when we stop, we can revisit that question too if they're not clear.

Eileen: Okay. I'm getting, 'thank you for repeating', so I think we're good to move to the next slide.

[Slide: MH 1962 Examples]

Chuck: Awesome. Here's another example that's very pertinent, or relevant to our current situation with the pandemic, and that's the Paycheck Protection Program Loans. Some of your contract providers may have applied for and received loans under the Paycheck Protection Program, and they may have spent and used the money from those loans to pay their staff, or to incur other expenses or to cover other expenses allowable under the Paycheck Protection Program. And to the extent that those are expenditures that are allowable and the provider is not going to be required to return that money to the lender, or in other words, that the federal government is going to cover that loan, then it's necessary for the provider to make an adjustment to its costs to reduce its cost by the amount of the money it received from the Paycheck Protection Program Loan that it spent in the cost reporting fiscal year. So within fiscal year 19-20, so the expense would have to have occurred before July 1st of 2020 and be reflected in the cost in the 1960. They need to reduce those costs by that amount of money that they spent from the Paycheck Protection Program. And this will ensure that the federal government is not reimbursing those costs again. They've already paid the provider for those costs by cancelling that portion of the loan, and those costs are now no longer eligible for federal reimbursement under the Medicaid program. Okay, next slide.

Chuck: So I'm going to stop there, because we have four more minutes and I imagine that there might be a lot of questions about the Paycheck Protection Program.

Eileen: Okay, so I was seeing that Brant Golsong was raising his hand, although he's raised and lowered it a couple of times. Brant, I will be unmuting you in case you did have a question to ask. So, you're unmuted, Brant, if you are able to talk.

Brant: I'm okay on the questions, thank you.

Chuck: All right, so the PPP was clear, that's great.

Eileen: Other than that, I'm just getting questions on if we have supervisors who are not attending the training right now. What is the best way to follow up, or to reach you, Chuck? How can they go about it from here?

Chuck: I'm always available by email, but also as Eileen had mentioned at the beginning, this webinar is being recorded and once we finish all of the sessions, we will post the webinar and supervisors who weren't able to attend then could view it and listen to it online and then if there are questions that those folks have after that, they can always contact us at the Department and we can help to clarify anything that may not have been clear.

Eileen: I have a question from Sara Lee, 'I have a PPP question. If the provider does not qualify for loan forgiveness should PPP still be excluded?'

Chuck: No, if they don't qualify for loan forgiveness that means that they're going to have to provide all the money back. So first they have to spend the money. So they applied for a loan, they received the loan, but they haven't spent any of the loan, then all that money has to go back, right. Or, at least, if they didn't spend it in this fiscal year. Then there are no costs that they've incurred in this fiscal year that they were able to cover, in essence, with the PPP loan. Now, if they did make expenditures, and they're concerned that those expenditures may not be eligible, and for some reason the federal government is going to want them to return that money to the bank or to the federal government, then I think that's a challenging question. And I think to be as conservative as possible, if you spent the money in fiscal year 19-20, so the money was spent before July 1, 2020, then you should adjust it out of the costs that are eligible for reimbursement. But if they didn't spend any of it and they're going to give it all back, then there's no adjustment to make.

Eileen: I have a question from Juan, how will PPP be reported on the MH 1992?

Chuck: It won't, because we're adjusting it out. What we're doing is on the 1962, you would enter a negative adjustment to reduce the costs that ultimately flow into the 1992, so it's not captured at all. I will make sure, I will go back and confirm that that's how the data flows. I'm pretty sure it is. That's how I was thinking it worked, but I will go ahead and confirm that and make sure that right now, we don't think it needs to be on the 1992 because it's not part of the gross cost that make its way to the 1992.

Eileen: All right, that is all the questions that I have for right now.

Chuck: Okay. All right, well we're only a minute over, so at the next session, we'll start with the MH 1963 and continue to move forward and see how far and how much further we can get. In the meantime if you have any questions, please feel free to contact me or MedCCC. MedCCC might be the more appropriate venue as well. Thank you all, appreciate it. Take care and stay safe.

Eileen: Thank you, everyone.