California Department of Health Care Services

**Fiscal Year 2017-18**

**Substance Use Disorder Cost Report For**

**Drug Medi-Cal Providers Participating In The**

**Organized Delivery System Waiver Program**

**Instructions For**

**Completing Cost Report Forms**

**A. GENERAL**

Section 14124.24(g) (1) of the Welfare and Institutions Code (WIC) requires that counties and contracted providers (except for those providing only narcotic treatment) submit substance use disorder (SUD) cost reports to the Department of Health Care Services (DHCS) by November 1 for the previous state fiscal year, unless DHCS grants a formal extension.

These cost report instructions and the applicable forms apply only to Drug Medi-Cal (DMC) certified providers who subcontract with a county that has a contract with DHCS to provide DMC-Organized Delivery System (ODS) services (or a county-operated DMC provider in the contracted county). Each DMC provider must submit the applicable cost report forms that reflect the services rendered to DMC beneficiaries, consistent with the authorities specified in the approved terms and conditions of the waiver. Contracting counties will submit an annual cost report that summarizes the total actual costs for service provider expenditures for the covered services.

**There is one Excel file that must be completed by the legal entity for each site of service(s) that has its own Drug Medi-Cal (DMC) number and DMC certification and maintains separate accounting records.** There are 28 worksheet tabs with data entry areas identified in yellow; however, most of the worksheet areas are automatically populated.

**B. DEFINITIONS**

1. “CMS” means the Centers for Medicare and Medicaid Services.
2. “Cost Center” means a department or other unit within an organization to which costs may be charged for accounting purposes.
3. “DHCS” means the California Department of Health Care Services.
4. “Direct costs” means those that are directly incurred, consumed, expanded and identifiable for the delivery of the specific covered service, objective or cost center. An example of direct costs would include unallocated wages/salaries of employees for the time devoted and identifiable specifically to delivery of the covered services or the final cost objective such as intensive outpatient treatment, outpatient treatment. Other direct costs may include direct materials, equipment, supplies, professional services and transportation that are directly acquired, consumed, or expended for the delivery of the specific covered service or objective.
5. “DMC” means Drug Medi-Cal.
6. “DMC-ODS” means the DMC Organized Delivery System, a voluntary program that offers counties the opportunity to expand access to care for DMC beneficiaries with substance use disorders.
7. “DMC unreimbursable costs” means costs that are not reimbursable or allowable in determining the provider’s allowable costs in accordance to the California’s Medicaid State Plan, the special terms and conditions of this 1115 demonstration waiver, federal and state laws and regulations, including 2 CFR Part 200 Subpart E, 42 CFR 413, Medicare Provider Reimbursement Manuals, , CMS non-institutional reimbursement policy and California Code of Regulations Titles 9 and 22 (to the extent that they do not conflict with federal cost principles).
8. “Indirect costs” means those costs: a) incurred for a common or joint objective benefiting more than one cost center or objective, and b) are not readily identifiable and assignable to the cost center or objectives specifically benefited, without effort disproportionate to the particular cost center or objective.
9. “Indirect cost rate” means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of the indirect costs to a direct cost base. A provider’s indirect cost rate must be determined and approved by a cognizant agency (federal or state agency).
10. “IOT” means intensive outpatient treatment.
11. “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.
12. “NTP” means narcotic treatment program treatment.
13. “OT” means outpatient drug free treatment.
14. “Percent of Direct Costs” means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of each modality or cost center’s direct costs to the total direct costs.
15. “SUD” means substance use disorder.
16. “WM” means withdrawal management.

**C. REPORTING REQUIREMENTS**

1. 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 Drug Medi-Cal regulations contained in California Code of Regulations (CCR) Title 9 and Title 22.

Providers must maintain fiscal and statistical records for the period covered by the cost report that are accurate and sufficiently detailed to substantiate the cost report data. The records must be maintained until the later of: 1) a financial audit is conducted: or 2) a period of ten years.

1. All records of funds expended and costs reported are subject to review and audit by DHCS and/or the federal government pursuant to the Welfare and Institutions Code Section 14124.24(g)(2) and 14170 and the Code of Federal Regulations Part 438.
2. Providers must compute allowable costs and determine their allocation methodology in accordance with applicable cost reimbursement principles in 42 CFR Part 413, CMS-Pub 15-1, 2 CFR Part 200 Subpart E, CMS non-institutional reimbursement policy, and CCR Title 9 and Title 22. The cost allocation plan must identify, accumulate, and distribute allowable direct and indirect costs and identify the allocation methods used for distribution of direct costs. For consistency, efficiency, and compliance with federal laws and regulations, the cost report identifies direct cost categories for each modality and uses a standard methodology of percentage of total direct cost to allocate indirect costs. 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 percentage of total direct cost, the provider must obtain their respective county’s prior approval, and the county must seek DHCS’s approval. DHCS will make a final determination of the propriety of the methodology used.

**D. COST REPORT WORKSHEET SECTIONS AT A GLANCE**

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| --- | --- |
| Tab 1 | Provider Information and Certification |
| Tab 2 | Overall Cost Summary |
| Tab 3 | Overall Detailed Costs |
| Tab 4 | Outpatient Treatment (OT) Detailed Costs |
| Tab 5 | OT Detailed Adjustments  |
| Tab 6 | OT Cost Allocation |
| Tab 7 | OT Reimbursed Units |
| Tab 8 | OT Comparison |
| Tab 9 | Partial Hospitalization (PH) Detailed Costs |
| Tab 10 | PH Detailed Adjustments |
| Tab 11 | PH Cost Allocation |
| Tab 12 | PH Reimbursed Units |
| Tab 13 | PH Comparison |
| Tab 14 | Intensive Outpatient Treatment (IOT) Detailed Costs |
| Tab 15 | IOT Detailed Adjustments  |
| Tab 16 | IOT Cost Allocation |
| Tab 17 | IOT Reimbursed Units |
| Tab 18 | IOT Comparison |
| Tab 19 | Residential (RES) Detailed Costs |
| Tab 20 | RES Detailed Adjustments  |
| Tab 21 | RES Cost Allocation |
| Tab 22 | RES Reimbursed Units |
| Tab 23 | RES Comparison |
| Tab 24 | NTP Detailed Costs |
| Tab 25 | NTP Detailed Adjustments |
| Tab 26 | NTP Cost Allocation |
| Tab 27 | NTP Reimbursed Units |
| Tab 28 | NTP Comparison |

**E. DETAILED INSTRUCTIONS FOR EACH WORKSHEET**

The sequence for completing the workbook is shown below:

1. Complete the Provider Information and Certification worksheet
2. Complete the Overall Detail Costs worksheet
3. For each modality/level of service provided, complete the worksheets in the following order:
4. Detailed Adjustments
5. Cost Allocation
6. Reimbursed Units
7. 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.

**Provider Information and Certification Worksheet**

This worksheet collects provider details, including entity name, address, National Provider Identifier (NPI), and contact information. The provider officer or administrator must sign and certify that the cost report is accurate and complies with all federal and state requirements. The certification must be submitted to DHCS with an original signature.

**Overall Cost Summary Worksheet**

This worksheet displays a summary of the totals for all the cost centers reported. No data entry is necessary in this worksheet; information automatically populates from the Overall Detailed Costs worksheet.

**Overall Detailed Costs Worksheet**

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.

1. Part A, Schedule of Expenditures for Direct Costs
2. 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.
3. In columns D-J, 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. Examples of other SUD services include services provided with SAPT funds. Examples of non-SUD services include mental health, primary care, or any other program that shared costs with the DMC program.
4. In column M, 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.
5. The worksheet identifies the direct cost categories for each cost center/modality and uses the percentage of direct costs to allocate indirect costs.
6. The worksheet also distributes total general ledger indirect costs or cognizant agency-approved indirect cost rate using the percentage of total direct program costs.[[1]](#footnote-1)
7. Part B, Supporting Schedules for Indirect Costs
	1. There is no data entry required for this section.
	2. The indirect cost for each line item and modality is computed based on the percentage of direct costs (the standard methodology) from Part A.
8. Part C, Report of Expenditures for Total Costs
	1. There is no data entry required for this section.
	2. The indirect costs that were calculated in Part B are totaled in Part C.
	3. The overall total should match the total from Part A.

**Detailed Costs Worksheets (OT, PH, IOT, RES, NTP)**

This worksheet displays the results of all cost calculations for the different modalities or services. No data entry is necessary in this worksheet; information automatically populates from other worksheets.

**Detailed Adjustments Worksheets (OT, PH, IOT, RES, NTP)**

This is the first worksheet for each of the levels of care/modalities (OT, PH, IOT, Residential and NTP). 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).

Costs directly related only to services provided to clients funded by a specific program and funding source (such as perinatal) must be removed in the Overall Detailed Costs tab 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 be entered in Detailed Adjustments tab) 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.)

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

**Cost Allocation Worksheets (OT, PH, IOT, RES, NTP)**

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.

1. ‘Allocate Costs Between Different Modalities’ section: Enter direct staff hours in each of the yellow highlighted areas (as applicable).
2. ‘Units of Service’ section: Enter the number of units for private and non-DMC by the applicable service/program types.
3. ‘Cost Per Unit of Service’ section: Enter the provider’s customary charges for each service.

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

**Reimbursed Units Worksheets (OT, PH, IOT, RES, NTP)**

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

1. Enter all approved and denied units using the information from the provider reconciliation report.
2. 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).
3. 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.
4. 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.

**Comparison Worksheets (OT, PH, IOT, RES, NTP)**

This document identifies the comparison between the DMC worksheet (Cost Allocation) and the Fiscal Detail Pages in the web based cost report. The county must identify and enter the appropriate information to identify the Service and Program from the DMC Settlement forms with the information entered into the web based cost report. In some instances, more than one Non-DMC or DMC Program Code could be entered (for example, 272 for Minor Consent and 102 for DMC Regular).

In the “Non-DMC Program Codes” field, list the Non-DMC program codes for the cost and unit information shown on these DMC forms that are also entered in the web based cost report; leave blank if no Non-DMC information is reported on the DMC forms.

In the “DMC Program Codes” field, list the DMC program codes for the cost and unit information shown on these DMC forms that is also entered in the web based cost report.

In the “SUDCRS Fiscal Detail” column, record the totals for each type of information from Fiscal Detail Pages from the web based cost report for the listed Non-DMC or DMC programs, as appropriate. One cannot be completed without the other. The DMC cost report forms are incomplete without this information properly filled in by the user.

1. 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. [↑](#footnote-ref-1)