

City and County of San Francisco
Department of Public Health
Population Health and Prevention

CDTA's Cost Report Training 101

Date: August 19, 2011

Time: 10:00 AM to 12:00 PM

Place: 101 Grove Street, Room 302

Presented by: Fiscal-Cost Report Unit



Agenda

- Introduction
- Objectives/Timelines
- Overview of Cost Report Cycle
- Definition/Purpose/Requirements
- Rates/Modalities/Units/Data
- Peek at Cost Reports/Back-up Documentation
- Common pointers – Contract Mod, CRDC, Settlement and Audit
- Cost Report Contact Information
- Reference Materials



Fiscal Cost Report Objectives

- To identify changes
- To clarify the cost report requirements
- Provide clear information
- Provide technical assistance
- Provide consistent communication
- Required by State and Federal Agencies

Cost Report Timelines

Universal County Timelines:

- July 1 Beginning of Fiscal Year authority
- June 30 Ending of Fiscal Year authority
- August 15 Final invoices due to Fiscal-Accts Payable Unit
- August 31 Final data entry of all services into Avatar
Manual Adjustment due to CBHS-Billing Unit
Final submission of PY Contract Modification
- January 31 Copy of Cost Report sent to Provider
- April 30 County Settles with Provider

Cost Report Timelines (Continued)

Mental Health Short Doyle Medi-Cal Cost Report:

- Sept 15 MH Providers Cost Report Training
- Oct 31 Provider MH Cost Report due to Fiscal–Cost Rpt Unit
- Dec 31 SDMC Cost Report due to the State
- 3 years after Original Submission – SDMC State Audit

Substance Abuse Alcohol Drug MediCal/NNA Cost Report:

- Aug 25 SA Providers Cost Report Training
- Sept 23 Provider Cost Report due to Fiscal–Cost Rpt Unit
- Nov 1 ADP Drug MediCal/NNA Cost Rpt due to the State
- Dec-Jan Single Audit

MH & SA Spin-Off Reports & Deadlines

MAA/TCM (MediCal Administrative Activities)

Quarterly and Annual Reports due December 31

SB90 –AB3632/SED Out-of-State Handicapped Children

Annual Reports due December 31

HSF-HCCI/LIHP –Healthy San Francisco

Monthly due 22nd day of each month

Annual Reports due March 31

QFFMR – Quarterly Federal Financial Monitoring Report

Quarterly due 60 days after the end of each quarter

Annual Reports due November 1

Overview of Cost Report Cycle

■ Budget

- Approval of County Budget Phase D
- Contract Award/Approved Provider Contract/CRDC
- Certified Legal Entity Number, Provider Number, and County's Avatar Program Code (Reporting Unit Code)
- Registered Modes and Service Functions at the State level (MediCal or Non MediCal)
- Establishment of Published Charges/Rates for Mental Health and Substance Abuse MediCal Providers only

Overview...Cont'd

■ Services

- Delivery of Services per contract agreement
- Recording of Services
- Quality Assurance review

■ Invoicing/Billing

- Provider Invoicing
- MediCal Billings

Overview...Cont'd

- Reconciliation/Validation
 - Reconciliation of State's Reimbursement per Explanation of Balances (EOB/835 Report) vs County Claims (837 Report)
 - Compilation of Actual and Statistical Data
 - Reconciliation of Provider's Statistical Data

Overview...Cont'd

■ Cost Report

- Fiscal Year-end Financial adjustment /accruals and Closing of Fiscal Books
- Submission of Provider's Actual Financial and Statistical Data to the County
- Submission of County's Actual Cost Report to the State

Overview...Cont'd

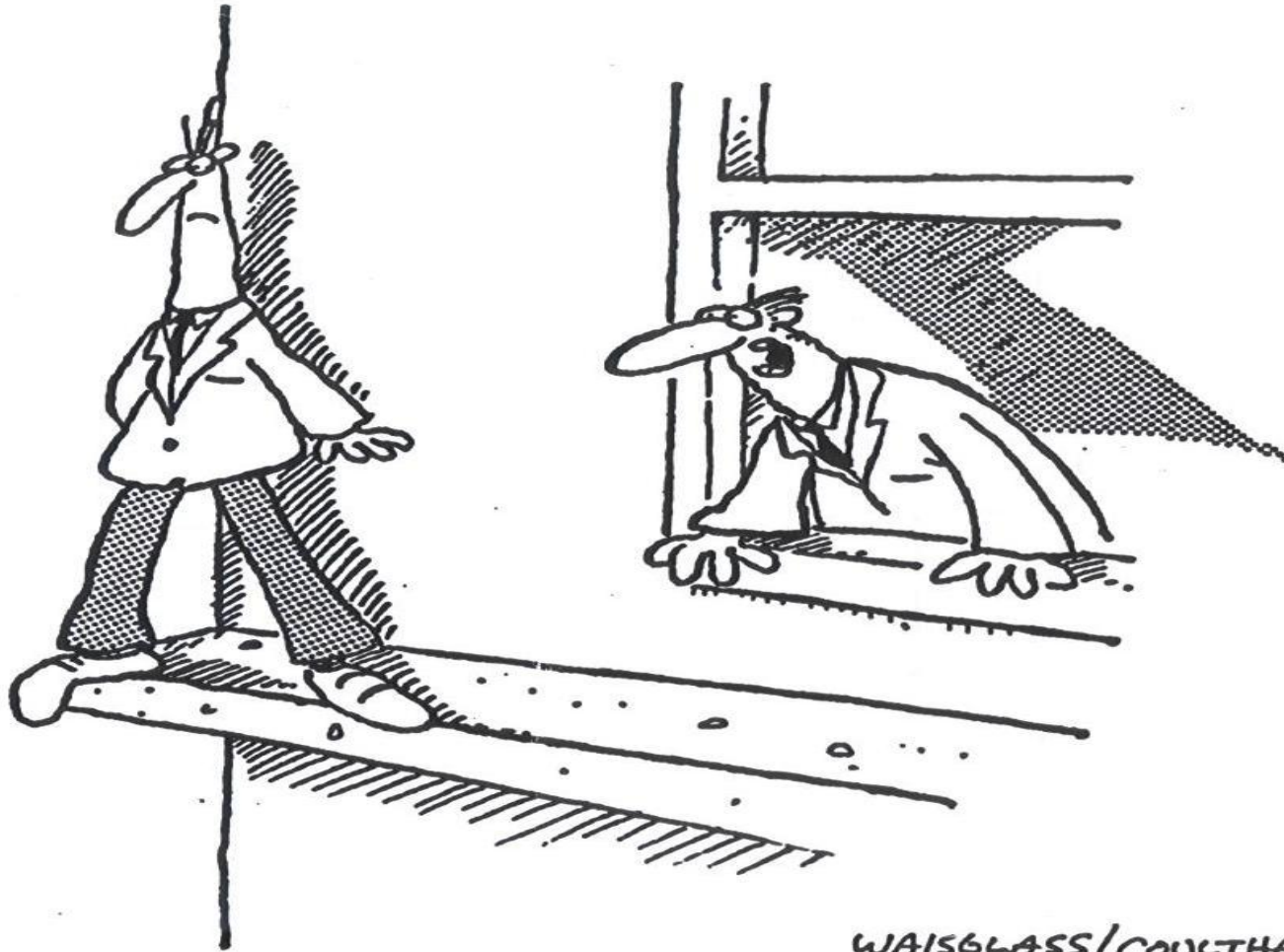
■ Settlement

□ County Settlement with the Providers

- Cost Reimbursement. Reimbursed based on actual cost to the maximum budgeted amount. Total year-to-date amount on 'Final' invoice should match the amount reported in the cost report
- Fee for Services. Reimbursed based on actual number of units multiplied by the approved contract rate.

■ State/Controller Single Audit

- State statute of limitation is 3 years



WAISGLASS/COULTHART

Before you go, could you tell me where you put the cost report file?”



Definition of Cost Report

Cost Report is an annual report required by the Federal/State that shows the County/Provider's actual uses, sources, and the services delivered.

Purpose of Cost Report

- Calculate cost per unit by service function
- Determine estimated net MediCal entitlement (Federal Financial Participation [FFP]) for each Legal Entity
- Identify uses and sources of funding
- Serve as the basis for the year end cost settlement, focused reviews and subsequent Fiscal audit
- Monitor Performance Contracts
- Serve as source for County fiscal year-end cost information

Contract Provider Requirements

- Every Legal Entity/Agency must submit a Cost Report
- Every Mental Health Provider (MediCal or Non-MediCal) must have a valid Legal Entity Number and Provider Number
- Every Substance Abuse Providers must have a valid Provider number
- All services (Modes/SFC's) must be registered at the State Provider Table
- Mental Health and Substance Abuse MediCal Providers must established and submit their Published Charges (Rates)
- Providers must keep adequate records and documents for State audit purposes.

Contract Provider Requirement...Cont'd

MH or SA original back-up documentations due to Fiscal Cost Report Unit -101 Grove St., Room 116 by the respective due dates

- Signed Cost Report Cover Letter and Check List
- Actual Cost on the Contract Analysis (MH1950)
- Trial Balances of Expenditures/GL Balances
- Schedule of Depreciation if applicable
- Published Charges schedule if applicable

Agency's Audited Financial Statement & Management Letter ,if applicable, (hard or electronic copy) due to Duane Einhorn at 1380 Howard St., 4th Floor for upload in COOL (Contract Online)

Type of Rates

- Actual Rates
 - Actual expenditures / total actual units.
- SMA Rates (State Maximum Allowable Rate)
 - Maximum allowable state reimbursement (See Schedule B)
- Published Rate/Charges
 - Customary schedule of rates per services provided to MH Clients that is posted at the provider's clinic. Each provider should have their own customary rates.
 - Note: Provider's cannot use the contract rate or the County's Board rates.

Type of Rates...Cont'd

- **Contract Rates**

- Rates negotiated between the Provider and the County.

- **County Board Rates**

- Yearly rates approved by the Board of Supervisors.
- Used as the Published Charges for the City-run Facilities and SFGH.

Principle of Lower of Cost or Charges

The State reimburses the MediCal Direct service based on the principle of Lower of Cost or Charges (LCC). This is the comparison of Actual Rate vs SMA rate vs Published Charges

Example:

Description	SMA Rate	Published Charges	Actual Rate
Mode 15, SFC 01	1.89	2.00	1.50
Mode 15, SFC 01	1.89	1.80	2.00
Mode 15, SFC 01	1.89	2.00	2.30

Types of Modes of Services and Service Functions Codes/Service Codes

Mental Health and Substance Abuse cost and units are captured by Modes of Services and Service Function Codes (SFC's) (See reference materials)

- Schedule A MH CFRS Format Table
- Schedule B MH Mode & SFC Information
- Schedule C ADP Fiscal Data Element
- Schedule D ADP Service Codes Comparison
- Schedule E ADP Service Code Description/Unit Information

Type of Units

■ MediCal Units

- Regular MediCal
- Crossover Units
- Healthy Families
- Enhanced Children
- Refugees
- Low Income Health Program
- Perinatal MediCal
- Alcohol Drug MediCal

■ Short Doyle and NNA Units (Non-MediCal)



Types of Data

- **Statistical Data** relates to the actual total units of services delivered and unduplicated client count for the fiscal year.
- **Financial Data** relates to the actual financial expenditures and revenues for the fiscal year.

Cost Report Back-up Spreadsheet

- **MH1950 (Contract Analysis)**

Comparison of Budget vs. actual expenditures and revenues data. Budget is based on the recent approved contract modification. Actual is based on Trial Balances and or Summary of GL Accounts. (See Reference Sample)

- **Relative Value**

Measures the value of each service function codes to the total mode. (See Reference Sample)

Quick Peek at relevant MH SD/MC Detail Cost Report

- **MH1900** **Information Sheet**
- MH 1901 Schedule A Various Rates Schedule (SMA, Published Charges, Contract Rates for Non MediCal SFC's)
- MH 1901 Schedule B All Units by Settlement Type, by Modes, and SFC's
- MH 1901 Schedule C Relative value allocation of direct costs
- MH 1960 Calculation of Program Costs
- MH1964 Allocation of Costs to Modes of Service
- **MH1966s** **Allocation of Cost to SFC**
- MH 1968 Determination of SD/MC Direct Services and MAA Reimbursement
- MH 1979 SD/MC Preliminary Desk Settlement
- **MH 1992** **Funding sources**

Quick Peek at relevant SA Paradox Report

- A) Fiscal Detail by Modality by Provider by Service by Program

**Note: Best bet is to look at SA Provider's 1950-
Contracts Analysis Report**

Cost Report Pointers

Mental Health SDMC:

- FY 10-11 FMAP Sharing Ratio Period as follows:
 - Jul 1, 2010 – Dec 31, 2010 = 61.59%/38.41%
 - Jan 1, 2011 – Mar 31, 2011 = 57.20%/42.80%
 - Apr 1, 2011 – Jun 30, 2011 = 56.20%/43.80%
- Healthy Families and Enhanced FFP Sharing Ratio is 65% Federal Share and 35% State Share.
- Prop 63/MHSA (Mental Health Services Act) expenditures are reported only in the SDMC County Summary Cost Report.
- TBS (Therapeutic Behavioral Services) are reimbursed the same rate as MHS Services
- AB3632/SEP services are only services on the Individualized Education Plan (IEP). AB3632 services begin with the mental health assessment after referral from the Local Education Agency pursuant to the IEP. Pre-referral services are not considered AB3632 services.
- EPSDT (Early Periodic Screening & Diagnostic Treatment) requires 10% County match to the State General Fund and the rest is SDMC FFP. (50%FFP/ 40% SGF/ 10% County). Clients are 100% MediCal eligible.

Cost Report Pointers...Continued

- CALWORKS (California Work Opportunity and Responsibility to Kids) program is identified separately in SDMC. Services rendered must be NonMediCal. HSA administer this program.
- ISA (Integrated Service Agency) is based on actual costs to the county for payments made to the providers.
- MHS (Mental Health Specialty [Managed Care PPN's]) are reimbursed at lower of cost or SMA, classified as Program 2.
- ASO (Administrative Services Organization) based on actual costs to the county for payments made to the Fiscal intermediary for children placed outside of the county.
- MAA (MediCal Administrative Activities) is based on actual costs per approved County MH MAA claiming plan.
- Provider's funding, In-Kind, Grants, Projects, some Work Order funds cannot be used for MediCal Match.
- ARRA will no longer be a stand alone funding stream. It is now merged with regular FFP's
- No more SACPA funding.

Cost Report Pointers...Continued

- SA Primary Prevention funding must enter their statistical data in CALOMS.
- SA SAPT Primary Prevention must be used only for Primary Prevention.
- SAPT HIV Set Aside funding are used for Ancillary, 65-HIV Early Intervention Services only
- No Client Fees in Primary Prevention.
- Food (Meals) and Housing costs are not a MediCal eligible costs.
- Individual Session defaults to 50 minutes per session.
- Requirement for a MediCal group session is minimum of 4 or more to a maximum 10 clients per session. Group Sessions default = 90 minutes per session
- Total # of Face-to-Face visits in a group sessions is the number of clients in the group
- Summary of actual Group Sessions must be submitted and accounted daily attendance sheets must be maintained for back-up documentation.

Reminders on Contract Modification

- CDTA and Provider need to check that the contract conforms to the actual units delivered and recorded in Avatar.
- If there is discrepancy between budgeted and actual, contract must be modified before the term of the contract expires. Failure to do so may result in a negative cost report settlement – Provider owing the DPH.
- Correction of Contract Rate in CRDC and Invoice form. Both rates should match.
- Settlement Type (FFS or CR should clearly be identified in CRDC)

Consequences of Contract Inconsistencies

Scenarios	Consequences
A) Actual Delivered Services are not budgeted	Loss of revenues both for the Providers and the County (Lower Actual Rate compared to SMA and Contract Rate)
B) MediCal Contract Maximization.	Audit Disallowances, Loss of revenues
C) Unidentified Program Codes in relation to Spin-off Cost reports i.e. HSF/LIHP and AB3632	Loss of revenues. (No Contract Rate, No county claim)
D) Expenditure shift between modality due to over/under production of delivery of services	Loss of revenues. (Abnormal actual rates; Funding limitation)
E) Movement of funding between Exhibits due to Mid-year cuts or changes in the contract award	Delay in payment to Providers due to delay in funding adjustment. Settlement limited to the exhibits total funding i.e. Work Order Funds, Projects, Grants, 100% GF funded NonMediCal services i.e. Outreach, Socialization, etc.

Consequences of Contract Inconsistencies Sample

A) Contract CRDC not corrected for unbudgeted services:

Per Latest Approved Contract CRDC: (Budget)

Mode/SFC	#Units	Ct Rate	SMA Rate	Board Rate	Amount
15/10 MHS Svcs	200	2.00			\$400

Per Final Invoice: (Actual Year-to-Date)

15/10 MHS Svcs	200	2.00			\$400
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Per Avatar Gross Delivered Data: (Actual Year-to-Date, Rounded off)

15/10 MHS Svcs	180			3.33	\$599
15-60 Medication	20			5.95	\$119
Total	200				\$718

Consequences of Contract Inconsistencies Sample

A) Contract CRDC not corrected for unbudgeted services:
Continued..

Per SDMC Cost Report: Additional Information Provider's Final Trial Balance - \$390

Mode/SFC	#Units Per Avatar	Ct Rate	SMA Rate	Cost Report Actual Rate	Relative Value %	Amount Based on Actual Per Prov Trial Balance
15/10 MHS Svcs	180	2.00	2.61	1.80	83.04%	\$324
15-60 Medication	20	0.00	4.82	3.30	16.96%	\$ 66
Total	200					\$390

Consequences of Contract Inconsistencies Sample

A) Contract CRDC not corrected for unbudgeted services:
Continued..

Per County Settlement with Provider:

Consequences: Provider will not be credited for the 20 units of Medication Monitoring. Provider will shoulder the cost . The \$40 will be returned to the County

Mode/SFC	#Units	Ct Rate	SMA Rate	Actual Rate	Per FAMIS Amt Paid to Provider	Amount
15/10 MHS Svcs	180	2.00	2.61	1.80		\$360
15-60 Medication	20	0.00	4.82	3.30		0
Total	200				\$400	\$360

Consequences of Contract Inconsistencies Sample

A) Contract CRDC not corrected for unbudgeted services:
Continued..

Per State Settlement with County:

Consequences: Loss of revenues. County will not get credit for the unbudgeted 20 units nor MediCal credits if any for the 15-60 Medication Monitoring. County will settle with Actual Rate which is lower than the Contract Rate

Mode/SFC	#Units	Ct Rate	SMA Rate	Actual Rate	Per Published Rates	Amount
15/10 MHS Svcs	180	2.00	2.61	1.80	2.25	\$324
15-60 Medication	20	0.00	4.82	3.30	0.00	0
Total	200					\$324

Consequences of Contract Inconsistencies Sample

B) MediCal Contract Maximation:

Consequences: Loss of FFP revenues \$6. WOF State Disallowance \$5.

Description	Budget per Apprvd Contract	Actual Per Cost Report	County Settlement to Provider	State Settlement	Revenue Loss / State Disallowance
Total Uses	\$100	\$115			
Sources:					
FFP	30	36		30	<6>
Realignment	20	24		20	<4>
GF	10	10			
WOF-State fund	40	45			<5>
Total Sources	\$100	\$115	\$100	\$50	<15>

Consequences of Contract Inconsistencies Sample

C) MediCal Contract Maximation:

Consequences: Loss of revenues \$10 . WOF State Disallowance \$5.

Description	Budget per Apprvd Contract	Actual Per Cost Report	County Settlement to Provider	State Settlement	Revenue Loss / State Disallowance
Total Uses	\$100	\$115			
Sources:					
FFP	30	36		30	<6>
Realignment	20	24		20	<4>
GF	10	10			
WOF-State fund	40	45			<5>
Total Sources	\$100	\$115	\$100	\$50	<15>

CRDC Common Errors

- Consistency on the use of CRDC Form
- Boxes on Header information must be properly completed.
- SA Legal Entity # is the Organization Name; MH Legal Entity # is 5-digit character assigned by the State.
- SA Provider # is 6-digit character and MH Provider number is 4-digit character assigned by the State. Both should follow the registered facility location.
- Avatar Program Codes (old RU), Modality and Service codes must be properly identified. All services must have assigned Mode and Service Codes be it fiscal intermediary.
- Exhibit A description of service should Match CRDC Modality and service codes. (no longer true per CDTA, Exhibit A is generalized)
- Unit Information, if available, in Exhibit A should match CRDC, else, CRDC and Invoice Form should match.
- Consistency and uniformity in measurements of units by modality/SFC's

CRDC Common Errors (Continued)

- Cost Reimbursement budget must provide budgeted statistical data: direct service units or indirect staff hours.
- Missing Rates on FFS; missing Published Charges on MediCal Providers.
- Look out for abnormally high or low rates.
- Certain Fundings are in need of County Match i.e. CDCI
- Check for the Extensions and Footers.
- Settlement Type (FFS or CR) should clearly be identified in CRDC
- Make sure providers enter units in the Avatar System that are contracted. Ramifications might happen during cost report and settlement process.
- Combining two provider numbers in one CRDC is a no-no
- Exhibits with Missing CRDC.

CRDC Common Errors (Continued)

- Crestwood needs proper identification of Mode and service codes
- AB3632 Program does not allow claims for 15-70 OP Crisis Intervention
- Start-up Costs happens only during the first year of the program.
- Every Program must have an assigned provider number (Edgewood, IFR, etc)
- Family Mosaic Capitated services are not billable to MediCal
- Budgeted Capital Outlay/Capital improvement must be identified in the Detail Budget.

Settlement Procedure

- Inquiry on the Settlement must be directed to Fiscal Cost Report Unit.
- Provider's no response after the due date is equivalent to an agreement to the settlement.
- Settlement not paid by Provider will automatically be deducted from the monthly invoices.
- Provider must submit an invoice to be paid, if the County owes the Provider.

Settlement – (FFS) Fee For Services Sample A

Services are grouped together by type of settlement, by services per CRDC, by funding source to the maxed of the approved contract.

A	B	C	D	E	F	G	H	I
Description	Budget Amt per Apprvd Cts	Budget Units	Rate per Apprvd Cts/crd c	Per Adj Avata r Units	Per Fa mis Paid Amt	Actual Earned (Col D x Col E)	County Settlement (Lower of Col B or Col G)	Refund from Pr ovider (Col F – Col H)
FFS: GF								
Fac 1 15-01	\$400	200	2.00	500	\$400	\$1,000		
Fac 2 15-10	250	100	2.50	50	125	125		
Subtotal DS	\$650	300			525	1,125	\$650	<\$125>
Fac 1 10-30	\$800	10	80.00	20	800	\$1,600		
Fac 2 10-40	300	10	30.00	5	150	150		
Subtotal DS-GF	\$1,100	20			\$950	1,750	\$1,100	<\$150>
Total	\$1,750	320			\$1,475		\$1,750	<\$275>

Settlement – (FFS) Fee For Services Sample B

Scenario B: Case of Mixed Funding Sources.

A	B	C	D	E	F	G	H	I
Description	Budget Amt per Apprvd Cts	Budget Units	Rate per Apprvd Cts/cr dc	Per Adj Avatar Units	Per Famis Paid Amt	Actual Earned (Col D x Col E)	County Settlement (Lower of Col B or Col G)	Refund from Provider (Col F – Col H)
FFS:-WOF								
Fac 1 15-01	\$400	200	2.00	500		\$1,000		
Fac 2 15-10	250	100	2.50	90		225		
Subtotal	\$650	300			650	1,225	\$650	-0-
FFS-GF								
Fac 1 10-30	\$800	10	80.00	5		\$400		
Fac 2 10-40	300	10	30.00	5		150		
Subtotal	\$1,100	20			1,100	550	\$550	\$450
Total	\$1,750	320			\$1,750		\$1,200	\$450

Settlement – (CR) Cost Remibursement Sample C

Scenario C: Trial balance is lower than Final Invoice and FAMIS Paid Amount

Description	Budget per Approved Cts	Actual Per Final Invoice	Per FAMIS Paid Amt	Per Provider Trial Balance	County Settlement	Refund from Provider
Uses:						
Salaries	\$75	\$75		\$60		
MFB	25	25		20		
Operating	10	10		20		
Indirect Cost	11	11		11		
Total Uses	\$121	\$121	\$121	\$111	\$111	\$10
UOS (15-10)	48	40	40	40		
Unit Rate/Svc	\$2.50	\$3.03	\$3.03	\$2.78		

Settlement – (CR) Cost Remibursement Sample D

Scenario D: Actual Invoice is lower than Provider Trial Balance and Paid FAMIS Amt

Description	Budget per Approved Cts	Actual Per Final Invoice	Per FAMIS Paid Amt	Per Provider Trial Balance	County Settlement	Refund from Provider
Uses:						
Salaries	\$75	\$60		\$60		
MFB	25	25		20		
Operating	10	10		20		
Indirect Cost	11	11		11		
Total Uses	\$121	\$106	\$121	\$111	\$106	\$15
UOS (15-10)	48	40	40	40		
Unit Rate/Svc	\$2.50	\$2.65	\$3.03	\$2.78		

From State Auditors Desk

■ **Statistical Data**

- **Gross Units**
- **Approved MediCal Units**
- **Unduplicated Client Counts**

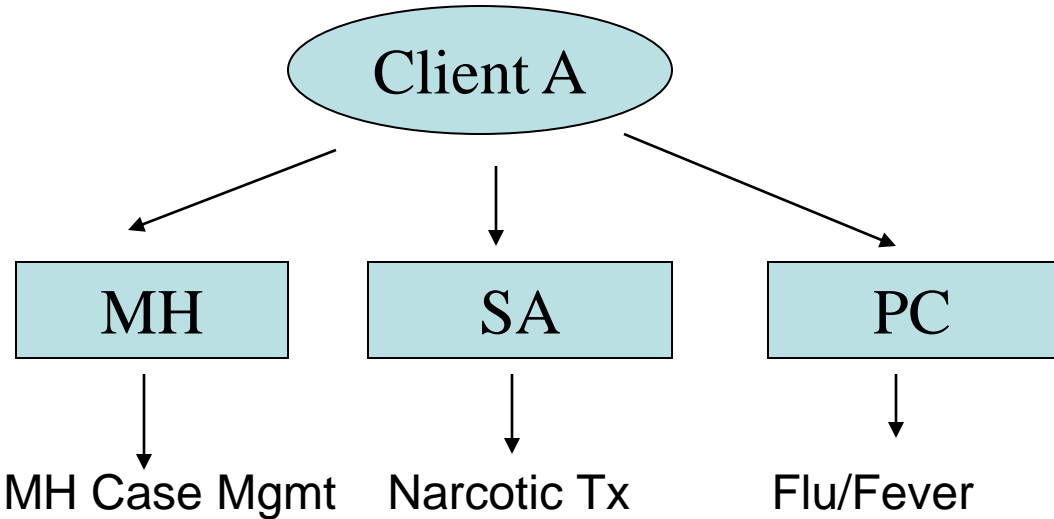
■ **Financial Data** (Availability of local match to Fed MediCal)

- **Expenditures and CPE** (Certified Public Expenditures)
 - Board & Care costs in Residential Facilities
 - Provider's Contracts
 - Fiscal Intermediary Costs
 - Indirect Rates/Actual Costs
- **Revenues**
 - 3rd Party Payor revenues e.g. MediCare, Insurance, Client Fees
 - FFP Actual vs Budget
- **Published Charges**



**“I thought ‘good accounting practices’
was just a suggestion.”**

Multi Diagnosed Client from Fiscal Perspective



- Svcs Delivered:

MH Case Mgmt

Narcotic Tx

Flu/Fever

- Recording:

- Units	60 minutes	1 Slot Day	15 minutes
- Expenditures	\$\$\$	\$\$\$	\$\$\$
- Revenues	\$\$\$	\$\$\$	\$\$\$
- FAMIS IC	MH IC	SA IC	PC IC
- Client Count	1	1	1

Note IC = Index Code

General Contact Information

- Fiscal - Cost Report: Address: 101 Grove St, Room 110
San Francisco, Ca 94102

By Fax:

(415) 554-2550 – MH Cost Report EOB Reconciliation Fax (Rm 110)

(415) 554-2739 – SA & MH Cost Report Fax (Rm 116)

By Telephone:

(415) 554-2825 – Anne Okubo, Deputy Chief Finance Officer

(415) 554-2539 – Nelly Lee, Finance Manager- Bdgt/Rev/Cost Rpt/ Analysis

(415) 554-2540 – Lizza Leviste, Cost Report Unit Supervisor

(415) 554-2971 – James Wang, Principal Cost Report Analyst

(415) 554-2543 – Hai Feng Liu, Principal Cost Report Analyst

(415) 554-2536 – Clifford Gee, Principal Cost Report Analyst

(415) 554-2524 – Annabel Martinez, Principal Account Clerk

(415) 554-2754 – Carmen Flores – Sr Account Clerk

THE END



Have a smooth Cost Report sailing process!!!!