FY 2020-21 Cost Report Training Questions & Answers
<9/23/2021>

Cost Report Due Date & Template

1. What is the due date of the cost report? Is it Sept 15 or Sept. 30?
   The FY 2020-21 Cost Report is due on September 30, 2021.

2. Will the Sept 30 deadline be extended based on the availability of the final CR template?
   The County will automatically extend the deadline to two weeks after the final Cost Report template is posted on the website or the previously approved extension request, whichever occurs later. We will send out an email notification once the final CR template is ready on the website.

3. Is there a significant change on the cost report template?
   County tested the FY 2020-21 CR template proposed by Department of Health Care Services (DHCS) and the following changes were noted:

   a. The enhanced FMAP carried over from the FY 2019-20 March 1 – June 30, 2020 period except for Enhanced Children MC and MC Access Program, effective October 1, 2020.

   b. "State funded beneficiaries" replaced "SB75" as the description on form MH1901B. State funded beneficiaries covers SB75 as well as other beneficiaries with unsatisfactory immigration status that the State is responsible for. You are to report total combined SB75 as well as SB104 (expanded SB75 through age 25) UOS here. DMH has confirmed that the SB75 UOS count on the 701UP includes services to both populations.

   c. SD/MC UOS combines both regular/other MC + Medi-Medi crossover UOS on form MH1901B.

4. Is the template divided in periods or is the whole year?
   FY 2020-21 does not have a non-COVID (7/01/2019 – 2/28/2020) and COVID (3/01/2020 – 6/30/2020) period like FY 2019-20; therefore, FY 2020-21 should be considered one period. However, UOS should be reported according to the periods identified for various Medi-Cal subfunds since the Federal Matching Assistance Percentage (FMAP) may be different (ref. Attachment 14).

5. Do we have an approximate date on when the Cost Report Template will be available?
   DHCS advised the template would be ready on August 20, 2020, but it still has not been released for use. We do not have another update at this time, but we will send out an email to notify CR preparers once the template is available + posted to our website.

6. If we ask for an extension, do we still have to pay the $100 a day?
   If the extension is granted, you will not incur the $100 per day fine until the day after the approved extension request (if the Cost Report has not been submitted).

7. If we needed to submit a revised Cost Report for FY2019-20, who do we contact?
   Please contact Tracy Namkung, Settlement Section Manager at tnamkung@dmh.lacounty.gov.

8. What is the difference between DHCS Cost Report and the Cost Report DMH sent out?
   The DHCS CR template does not include all the County specific supplemental schedules. Form numbers with prefix MH are DHCS forms. Form numbers with prefix LAC are County forms.

9. Our organization has not started yet. We were just awarded a contract. When do we need to complete a cost report?
   Please note that Legal Entity Contract Exhibit A - Financial Exhibit (Financial Provisions), Paragraph O, ANNUAL COST REPORTS, indicates that "…. for each fiscal year or portion thereof that a Contract is in effect, the contractor shall provide County with a Cost Report."

Rates - CMA, PC, Provisional

1. Was the CMA waived for FY 2020-21? How will the LE get reimbursed? At Cost?
   CMA is waived for purposes of Cost Report and Cost Settlement for FY 2020-21, but remains in place as the maximum rate for provisional payment during the fiscal year. LEs are paid out at the rate billed up to the CMA during the year in progress. At the point of CR + Cost Settlement, DMH will calculate interim settlement and final settlement at actual cost for FY 2020-21 up to your contract funded program limits identified in the contract financial summary.

2. Will the County provide a letter on the waiver for FY 2020-21?
   County has posted a copy of the Adopted Board Letter to our Cost Report website under handouts. CMA will continue to be waived as described in the BL until DHCS' waiver of lower of cost or charge (for CR + Cost Settlement) expires at the end of the pandemic.

3. Any suggestions on how to calculate the Published Charge Rate?
   Each contractor may have a different method of calculating Published Charge. Generally, DMH updates our Published Charges annually prior to the start of each fiscal year. Our rates are published for 30 days prior to public hearing and presentation to the County's Board of Supervisors for approval. We start with the prior year actual expenditures from our Cost Report and factor in any changes (+

and -) to costs to derive an estimated expenditure base. Next, we project/forecast UOS by Mode and Service Function Code (SFC) based on historical trend, with consideration of new program implementation. Finally, we distribute total expenditures based on a relative value method (prior year actual cost per unit * current year projected UOS) and divide through by the current year projected UOS to get the current year estimated cost per unit.

4. Do we still need to enter Published Charge Rate if County will settle actual cost?
   Yes, please complete the Published Charge information in your Cost Report forms.

Reports - 701UP and FinClaim/rptClaimlist

1. Where can I get the 701UP report?
   If you need a 701UP report, please contact your Cost Report Analyst. However, FinClaimlist report contains the 701UP report.

2. Will DMH provide 701UP report with a format that is aligned with the State Cost Report Template?
   701 UP Report data elements are aligned with the State Cost Report Template, except for State Funded Beneficiaries and MHSA PEI by Age Group. Please note that the 701 UP report identified the UOS by Payor (by MC subfund, nMC, or MC Denied), such as EPSDT: SDMCPmts, MCHIP: SDMCPmts, MCHIP-EPSDT: SDMCPmts, Medicaid Expansion-MCE: SDMCPmts, Oth MC: Enhcd BCCTP, Oth MC: Enhcd Pregancy, Oth MC: SB75, Oth MC: SDMCPmts, Non-MediCal, or Medi-Cal Denied. We will not provide 701UP report with a format that is aligned with the State Cost Report Template due to timing and continued unavailability of the State's final template. For State Funded Beneficiaries, during the Cost Report Training, we have already confirmed that SB75 UOS on the 701 UP report includes both SB75 and the SB104. For PEI UOS by age group, County CIOB provides rpt_FinClaimList in each LE's SIFT (or EFT) folder. Rpt_FinClaimList has data elements for Plan Name, AgeGroup and FinRptAgeGroup that can be used to identify PEI UOS by age group if you are not using your internal records.

3. I use the FinClaim report for cost report. Is 701UP report developed from FinClaim data?
   We are in the process of verifying the source of 701UP and FinClaim data from CIOB and will provide an update when it is available.

4. Please explain "enhanced". Is this EPSDT?
   Enhanced is the FMAP for eligible MCHIP, BCCTP, pregnant women beneficiaries who are approved to receive the Enhanced benefit from Medi-Cal Aid codes. MCHIP enhanced services are EPSDT eligible services.

5. How do we identify the State Funded claims (SB75) in the rptClaimlist?
   The SB75 UOS on the FinClaims includes both SB75 and the SB104.

6. Which category is for SB75 and SB104 reporting category?

Report UOS delivered to SB75 and SB104 under the category State-funded Beneficiaries on the MH1901B.

7. Please let me know where does the FSP, CGF, OCS, and PEI unit go which category and what form #?
   UOS by funded program should be reported in LAC102 (CGF) and LAC102_S_MHSA (FSP, OCS, and PEI).

8. Is the Mode/SFC issue fixed? Units were going to the wrong mode, ex: 42 - 52, 52 to 10. The SFC in Contractor's billing system is different from 701UP.
   This issue relates to contractor electronic health records mapping to DMH IBHIS system. Settlement Section requested DHCS audits to settle UOS in aggregate for specific SFC range(s). So far, DHCS audits has accepted prior requests. If a reconciliation of Contractor's billing system and DMH UOS from 701-UP report are not matching, please submit a HEAT ticket to explore possible mapping issue. Open a HEAT ticket using the HEAT app: https://lacdmhheat.saasit.com.

9. How to separate CHIP and Non-CHIP in 701UP? Are EPSDT and Other Medi-Cal reported as Non-CHIP and MCHIP – EPSDT reported as CHIP?
   From the 701 UP report, MCHIP (MCHIP-EPSDT SDMC and MCHIP SD/MC) UOS should be reported on the Cost Report Form MH 1901B or LAC102 and supplemental schedules as Enhanced Children CHIP services. In addition, Non-CHIP (E2, E4, or E5) and MCHIP (MCHIP eligible aid codes except for E2, E4, E5) units are based on Aid Codes. Payor and Aid Codes information are also found in the rpt_FinClaimList.

PEI – New Group

1. What are the PEI reporting categories in the cost report? If so, does the 701UP provide this information?
   The LAC102 supplemental schedule (LAC102_S_MHSA) was amended to reflect the same reporting requirement as the Mental Health Services Act (MHSA) Annual Revenue and Expenditure Report (ARER). This report requires us to report PEI expenditures for clients 25 and under. The information should be available from your internal records or the FinClaim report, but the 701UP does not categorize UOS by age group.

2. Is it possible to request CIOB to have a report separating the PEI in the same manner as required in the cost report to help with cost report preparation? Would the special report be ready before the cost report template posted?
   For PEI UOS by age group – you will need to use FinClaim report if you are not using your internal records.

3. Is there a list which will assist with identifying which category our funded categories belong to?

Both financial summary and 701UP report have funded program information. Furthermore, 701UP has payor source information, such as: SD/MC, MCHIP, MCE, and SB75. Especially, if the services are EPSDT eligible, 2011 Realignment should be allocated based on Match allocation Schedule. We also save Match allocation schedule in the cost report training website.

Manual Invoice and Other Questions

1. At the time of Cost Report submission, for Attachment 9A, LE total invoice for FY 2020-21 might not be the same as payment received from the County, which $ should be reported, actual payment received, or actual payment received plus outstanding invoices FY2020-21?
   The LE contract specifies a billing deadline for invoice submission. To the extent the invoice was submitted for payment timely and is still pending approval/payment, please report the total cost billed in your CR. CR staff will reconcile against our Accounting Division's record of payment and follow up with the Program office for pending approvals. If there are any discrepancies, we may reach out to your CR preparer.

2. If we did any MH or non-MH services, do we do a cost report even though our billing system has not set up?
   Yes, you should submit a Cost Report.

3. What types of insurance would be considered as Medi-Cal? We have patients with direct Medi-Cal insurance, patients with Managed Care Medi-Cal, and patients with Medicare and secondary insurance.
   If any patient has Medi-Cal or private insurance and your LE billed the services to the County as MC services, it should be considered as MC Services. If your LE billed any services to Medicare or 3rd party insurance first, any payment received in order to claim Medi-Cal should be reported as third party revenues related to providing MC services.

   You may benefit from several trainings held by DMH's CBO regarding Medi-Cal eligibility and private insurance. Please email them at CBO@dmh.lacounty.gov.

4. Affordable Care Act: is this not a straight Medi-Cal?
   ACA – is the Medicaid expansion population. Depending on the aid code, it seems that ACA reimbursement is 90% FMAP + 10% SGF in FY2020-21.

   a. Which services are included in Affordable Care Act? Should I include L.A. Care and Obamacare patients in ACA?
      ACA claims payor will be determined based on the aid code. ACA eligible aid code can be found in the Short-Doyle/Medi-Cal Aid Code Master Chart. The most up-to-date Short-Doyle/Medi-Cal Aid Code Master Chart is available on the Department of Health Care Services Mental Health Services Division (DHCS MHSD) Library webpage

(https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx). Access the Short-Doyle/Medi-Cal Aid Code Master Chart directly using the link below: https://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/Aid-Code-Master-Chart.pdf.

Also, County CBO issues it Dispatch bulletin when the State DHCS updated SD/MC Aid Code Master Chart. Please see the latest post under the link at http://file.lacounty.gov/SDSInter/dmh/1102548_NGACBOBulletin21-002-Short-DoyleMedi-CalAidCodeMasterChartUpdated.pdf.

5. How should we report denied units on the cost report? Should we report them as Non-MC?
   This answer depends on the disposition of the denied unit. For example, if it was denied for MC reimbursement without it being rebilled, it would still count as a SMHS UOS so include it in the total UOS. In this case, you may opt to report it either as MC or nMC UOS. Either way, it will be counted as a nMC UOS for settlement purposes. But if the denied UOS was rebilled, do not count both denied and the rebilled UOS twice, report it only once. If you have a specific question relating to this matter, please contact your CR analyst.

6. In a prior year, we used the FinClaim to report UOS. This included Denied-MSO, & we were instructed to use 701UP, which showed fewer UOS. Will these UOS increase after time?
   The Cost Report Section does not produce these reports. If you feel your data does not align with DMH's records, please submit a HEAT ticket to inquire: https://lacdmhheat.saasit.com.

7. If we had rejected/denied claims because we went over our CMA to a specific funding bucket; who do we contact?
   Claims are not rejected/denied for CMA, which is the maximum billing rate per minute for provisional payments. If the claim was denied because the maximum contract allocation (MCA) was overspent, please contact your CMMD analyst.

8. How do we resubmit claims denied because we went over our funding bucket? 1 cent?
   Please contact Central Business Office (CBO) to get clarification why the claims were denied and whether denied claims are able to be resubmitted to State. If the claims were denied by the County due to over MCA and still able to bill as MC units, please review the funding utilization to determine if the funding limitation can be resolved through the final shift request. Once final shift requests are completed, your agency may re-submit the claims so that County is able to certify the expenditure. Also, if there is still some funding available in your contract, providers can change the billing rate as a means to submit the claims at lower than provisional rate. Cost Settlement will be calculated at actual cost per unit up to the contract funding limits and paid through the interim settlement process.

9. If we will resubmit those denials or fix them, will I report them as Medi-Cal?
   Generally, yes, UOS should be reported as MC if errors are fixed and resubmitted. Remember that the final MC count will be determined at the point of SMHS Reconciliation that can still be updated your report of MC UOS, but not be changed total SMHS UOS by each mode and Service Function Code so it is more important that the latter is correct.

10. Do we input the CARES reimbursement as 3rd party revenue?
    If CARES funding was used to pay for your SMHS expenditures, please enter an adjustment to gross cost on form MH 1961. If you have a specific question relating to this matter, please contact your CR analyst.

11. Does DMH provide training for new providers for UOS reconciliation, claiming, reconciliation/audit, etc.?
    Currently, DMH does not have a Cost Settlement Training, but we are happy to develop such training if it will be helpful to you.

12. Who do we contact to appeal results of reconciliation?
    Please contact Tracy Namkung, Settlement Section Manager at TNamkung@dmh.lacounty.gov or your settlement section analyst if you disagree or are disputing the County's record of State MC approved UOS.

13. How does the cost be allocated based on Directly Allocated? How to calculate the indirect cost using the relative value cost allocation method?
    Direct allocation to Mode and SFC is similar to the Provisional Rate Request exercise only instead of budgeted expenses, you will use your actuals to directly allocate to Mode and SFC, then divide by your actual UOS by Mode and SFC to get the actual cost per minute.

    Relative value is calculated using Published Charge * UOS by Mode and SFC. Then, calculate percent to total for each Mode and SFC. Total gross expenditures are then spread by the same percent distribution. The final step is to divide by actual UOS for each Mode and SFC to get the estimated actual cost per minute.

14. Can you post the revised cost report schedules for various FYs so we can submit the revised cost report in a timely manner?
    Yes, we will post the Settlement timeframes to our website. Please note that updates to this schedule occur quarterly and are shared at DMH's All Provider Meeting.

15. When the template for the Shift Fund Request will be available for us to download?
    The Final Shift template is posted to the CR website.

16. What if we didn't include our WRAP SFC 70-78 under DMH cost in our LAC 101? How will it impact our rate calculation?

Rates will be too high if you included the invoiced cost as part of your expenditure base for rate reimbursed SMHS instead of direct charge.

17. What's the FMAP % for FY20-21?
    FMAP varies by MC subfund and time period. Please reference handout # 14 for more information.

PPP

1. How do we report PPP loan in FY 2020-21 Cost Report if we received PPP loan in FY 2020-21?
   The portion of your PPP loan used to fund SMHS expenditures should be reported as an adjustment to gross cost on the MH1961.

2. How is the PPP adjustment on MH1961 get allocated to the cost for each SFC for MHS? Does it allocate by relative value?
   A negative adjustment on the MH1961 will reduce the aggregate SMHS reimbursable costs, which will result in a lower actual cost per unit.

3. The PPP adjustment on MH1961 will reduce our cost per unit. Does that mean our funding buckets are measured with that new cost per unit? For instance, we'd have more space in our funding buckets since the cost per unit is lower.
   Yes, that sounds correct.

4. A follow up to that question, will we be penalized for having a lower cost per unit for this one odd year of PPP funding? For instance, future provisional rate calculations.
   If your actual cost per unit is lower than your provisional rate, County will collect the overpaid amounts, if any, through the interim settlement process. County will consider the PPP loan as justification for why a prospective provisional rate may be higher than the actual cost per unit + inflation factor from the most recent Cost Report.

5. Our PPP Loan Adjustment was already reported in FY 2019-20 Cost Report, we shouldn't have to report it again, correct?
   Only the portion of your PPP loan used to offset SMHS cost should be included in your CR. If you used a portion of your loan in FY 2019-20 and a portion of your loan in FY 2020-21, then you should include the applicable amounts as adjustments to your gross costs on the MH 1961.

   a. So if our SBA PPP forgivable loan of $4M is approved. Then we list the $4M on state form MH 1961. How about the county form? Do we need to list it on the county form?
      Only the portion of your $4M PPP loan used to offset SMHS cost this FY 2020-21 should be included in your FY 2020-21 CR, and reported in the MH1961.

The total adjustment in MH1961 should also be reported on the LAC 101, line14 (PLUS: SD/MC Adjustments).

Special Funding – CARES Act , COTT & OTT

1. Our behavioral health is part of hospital services. We received CARES ACT. Do we need to report any portion of CARE ACTS funding to cost report? If yes, what allocation would you recommend?
   If a portion of your CARES funding was used to pay for your SMHS expenditures, then you would need to report it on your SDMC CR. If your CARES funding was not used for your SMHS program, you do not need to include it in your CR.

2. We need more specific instruction how to incorporate CARES act SBA PPP into the cost report. What form?
   Generally, if you used a Payroll Protection Program loan to fund any of your SMHS expenditures, you need to adjust out the portion of costs already reimbursed. The adjustment can be entered on the MH1961. The total adjustment in MH1961 should also be reported on the LAC 101, line14 (PLUS: SD/MC Adjustments).

3. Do we include the CARES act funding we received outside of the DMH contracts directly from the state as 3rd party revenue on the cost report?
   The SDMC Cost Report is for the SMHS program. If you received CARES funding directly and not through the DMH contract for various services, and did not use the CARES funding to fund any portion of your SMHS expenses, then you do not need to include CARES funding in your CR. However, to the extent the CARES funding was used to fund a portion of costs related to your SMHS program – you will need to report accordingly.

4. Is COTT/OTT based on billed or paid invoices. I still have invoices not paid.
   To the extent invoices were submitted timely for payment + approved/pending approval by the Program office, please include unpaid amounts in your Cost Report. CR staff will reconcile the amounts reported against Accounting Division payment records and follow up with Program staff to determine status of approval. If you have questions, you may need to reach out to your CR preparer.

5. Does Aftercare Services have to be included in the STRTP units?
   Yes, include UOS provided as part of aftercare (6 month transition in community setting) since this is part of the STRTP program design.

6. Our agency uses the 701UP, how can I identify STRTP units and cost?
   Generally, if your STRTP or group home has its own location, the 701UP would capture UOS by provider number. If you have more than one program operating from the same location, you may need to refer to your own internal records in order to identify the UOS specific to your STRTP.

7. Do we need to separate INN 2 and CARES Act fund if we received both?
   The services provided for INN2 should be different than the CARES Act Promotores Program. INN2 expenditures should be separately identified since it is a different funding source with different services than CARES Act.

8. What is the SFC for CARES Act?
   60/78, invoiced direct services.