

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS  
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## ADP BULLETIN

Title <b>COST ALLOCATION AND DRUG/MEDI-CAL REIMBURSEMENT</b>		Issue Date:  04-09-98  Expiration Date:	Issue No.  <b>98-18</b>
Deputy Director Approval  (signed by)  Desirée Wilson, Division of Administration	Function  <input type="checkbox"/> Information Management <input type="checkbox"/> Quality Assurance <input type="checkbox"/> Service Delivery <input checked="" type="checkbox"/> Fiscal <input type="checkbox"/> Administration	Supersedes Bulletin/ADP Letter No. Sections I & II of this letter supersede ADP Letter 95-45, Sections II & III, dated October 16, 1995. Section IA of this letter modifies the definition of unrestricted funds in ADP #96-66 to include any funds which are not Federal funds.	

**PURPOSE**

This letter is to provide information regarding the cost allocation process, its relationship to provisional Drug/Medi-Cal (D/MC) rates, and the risks related to inappropriate cost allocation processes. The letter will incorporate a recent change in policy regarding the use of State General Funds (SGF) and County Matching funds. Sections I and II of this letter will restate, modify, and supersede Sections II and III of ADP #95-45, issued October 16, 1995 (excerpt enclosed).

**DISCUSSION****I. General Cost Allocation and Reimbursement Considerations**

The following rules and guidelines need to be considered when establishing provisional rates for billing D/MC services.

- A. Costs attributable to D/MC may not be reimbursed by other Federal funding sources, nor may costs attributable to other Federal funding sources be reimbursed by D/MC. Non-Federal funds, including SGF, and County Matching funds may be used to pay for costs attributable to D/MC services rendered but not covered within the rate cap. This is a change in policy and supersedes statements contained in contract provisions and other ADP letters, but specifically ADP #95-45 and #96-66. This policy will be applied in settlement of cost reports for FY 1995-96 forward.
- B. Costs of services to D/MC beneficiaries outside the D/MC benefit but otherwise allowable under Medi-Cal Fee-For-Service (FFS) must be reimbursed under Medi-Cal FFS.
- C. Costs of services to D/MC beneficiaries outside both D/MC and Medi-Cal FFS may be reimbursed by Negotiated Net Amount (NNA) funding sources.
- D. Reimbursement for D/MC services is limited by Federal requirements, as referenced in Title 22, Section 51516.1, to the lowest of actual costs, the maximum rate, or the customary charge to private clients.

- E. Except for Narcotic Treatment Program (NTP) services, billing should be based on a provisional rate which approximates the actual cost per unit, not to exceed the maximum rate, in order to provide for cash flow needs and to enable adequate contract management.
- F. Services to D/MC beneficiaries must be equal in scope and duration to services provided to non-D/MC clients and consistent with the requirements of medical necessity; however, not all treatment activities are reimbursable under D/MC. Activities reimbursable under D/MC are specifically incorporated into Title 22.
- G. D/MC beneficiaries must not be required to pay a fee other than share of cost for any portion of their D/MC reimbursable treatment. Instances when a D/MC beneficiary may be required to pay a fee include:
  - 1. Services not reimbursable by D/MC, such as room and board; or
  - 2. In the absence of a D/MC slot, if the D/MC beneficiary chooses to occupy a private-pay slot. Refer to ADP #95-18.
- H. Customary charges to private pay clients should be established in a manner which will not jeopardize the full reimbursement of D/MC costs, up to the rate maximum. Providers should utilize sliding fee scales when necessary and appropriate. For further information on establishing a private charge structure, refer to ADP #96-05, #96-22, and #97-38. ADP #97-38 is specific to NTP providers, but may be helpful to other providers in understanding the concept and how it is applied.

## **II. Outpatient Drug Free (ODF) Cost Allocation Considerations**

For ODF services, costs must be allocated between individual and group counseling activities; among D/MC, Negotiated Net Amount (NNA), and private pay clients; and between Perinatal and regular D/MC client services. It is important for counties and providers to know how these costs will be settled at the time of the cost report in order to calculate a realistic provisional rate.

### **A. General Description of ODF Cost Allocation Worksheets**

Enclosed with this letter to each county is a diskette containing two types of Lotus 123 worksheets which will be used by the Department for cost report settlement and in performance of audits. It is similar to the diskette provided with the ADP #95-45, but is updated for changes to the law and regulations. The worksheet is usable with Lotus 123 version 2.4 or higher, and it may also be converted to other spreadsheet programs, such as QuattroPro and Excel.

The worksheet files are named HOURS (HOURSPN for perinatal) and AVERAGE (AVERAGPN for perinatal). The instructions for the worksheets are included on the diskette in WordPerfect 5.1 files.

Implicit in calculations performed in both worksheets is the understanding that face-to-face counseling staff hours provide a common and acceptable basis for allocating costs between group and individual counseling services.

Also, both worksheets prorate the rate maximum when average session lengths compute to less than 50 and 90 minutes for individual and group counseling sessions, respectively. This proration is required by Title 22 and is necessitated by the statutory provision that the rate maximum is based on 50 minute and 90 minute session lengths. This application of the statute provides incentive to set session lengths at the 50 and 90 minute standards. This is necessary, in most cases, to recover costs.

### **B. Specific Uses of the Worksheets**

The usefulness of the worksheets is described below in relation to setting provisional rates, tracking and reporting actual cost per session, and in determining any need for unrestricted funds to cover D/MC costs in excess of the cap.

#### **1. Provisional Rates**

Through entry of a few estimates or historically-based data, the worksheets will allocate costs between group and individual counseling and among funding sources. Data entry areas are highlighted in yellow for your convenience. Instructions provided on the diskette explain the data elements needed, as well as those which are optional, based on the particular circumstances of a

provider. Assuming the data entered represent reasonably accurate estimates, the provisional rates should approximate the actual cost per unit of service, minimize any year-end settlement differential, and maximize cash flow during the year.

The worksheet called AVERAGE (AVERAGPN for perinatal) may be the more useful before actual data is available, because it utilizes average session length for group and individual sessions. Along with other requested data, a provider would enter this average session length for individual sessions and for group sessions, either estimated or based on actual data.

## 2. Tracking and Reporting Actual Cost per Unit

When a provider has compiled year-to-date information on total face-to-face hours, total costs, etc., the HOURS worksheet should be very helpful. It will determine how well the program is doing in relation to justifying its provisional reimbursement.

Along with other required data, this worksheet requires total time for group sessions and individual sessions to be entered. It will use this data to compute average session length to date. Running this report during the year will provide a good picture of whether projected reimbursement will be sufficient to cover projected costs, and if not, whether available unrestricted funds would be sufficient to cover losses. Running the report at year-end will provide the figures to enter into the cost report in a way which will minimize unexpected settlement changes.

The AVERAGE worksheet may also be used for concurrent tracking, but average session length must be accurate to ensure an accurate result. If a provider's program is designed for 50 and 90 minute sessions, this should not pose a problem.

## 3. Unrestricted Funds

A key product of the worksheets is a computed amount identified as "unrestricted funds". This represents the amount of D/MC costs in excess of rate maximums (or prorated rate maximums) which must be covered with other funds. As indicated above, such other funds may not include any other Federal funds. They may include county overmatch, provider's contributions or donations, State General Funds, and county matching funds, to the extent such funds are available.

### **III. Inconsistencies Between D/MC and NNA Unit of Service Definitions**

There is some confusion created by differences between D/MC and NNA unit of service definitions. For ODF, the NNA unit of service is "staff hours", while the D/MC unit of service is a client-session. Staff hours have been defined by counties/providers for NNA funded services in several ways. For example, staff hours may have been defined as direct face-to-face staff hours, total hours of all direct staff, or total hours of all staff.

The direct face-to-face staff hours provide an appropriate basis for comparison to D/MC staff hours, since D/MC staff hours are computed based on average projected or actual face-to-face session length multiplied by the number of sessions projected or provided. The use of a different staff hour statistic for NNA clients would result in a larger number of staff hours, thus lowering the cost per staff hour for NNA services below that of D/MC. Such disparities are alleviated by the worksheet, because the information it utilizes allows for the computation of staff hours for all clients on the same basis.

### **REFERENCES**

The following references mentioned in this bulletin may be valuable in understanding the subject matter.

Title 22, Section 51516.1

ADP Letters 95-18, 96-05, 96-22, and 97-38

### **HISTORY**

There are two previous letters containing discussion of similar subject matter, which are referenced in this bulletin, as follows:

Title/Subject: Drug/Medi-Cal Billing Claims Guidelines For Fiscal Year 1995-96  
Issue Number: 95-45  
Date Issued: 10-16-95

Title/Subject: Allowable Funding Sources For Drug/Medi-Cal Costs  
Issue Number: 96-66  
Date Issued: 12-31-96

### **QUESTIONS/MAINTENANCE**

If you have any questions, please contact Gary Bellamy at (916) 322-4834 or Andy Dill at (916) 324-6406. Any specific questions regarding your cost report settlement should be discussed with your Fiscal Management Branch (FMB) analyst.

### **EXHIBITS**

Enclosed as Exhibit 1 is an excerpt from ADP #95-45, which is being restated, modified, or superseded.

### **DISTRIBUTION**

County Alcohol & Drug Program Administrators  
Drug/Medi-Cal Providers  
Wagerman Associates, Inc.  
Director's Advisory Council