

DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
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ADP BULLETIN

Title Fiscal/Audit Questions and Answers		Issue Date: 08-17-98 Expiration Date: When Superseded	Issue No. 98-42
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PURPOSE

This Bulletin is to convey information regarding various fiscal/audit issues.

DISCUSSION

ADP Audit Services Branch staff were recently requested to respond to pre-developed questions in a presentation to California Association of Addiction Recovery Resources (CAARR). The following questions Nos. 1 - 13, reflect those questions and the answers provided during the presentation. In addition, question Nos. 14 and 15 were asked during the presentation, and a more complete answer is contained in this Bulletin. Question Nos. 16 and 17 were issues that have been brought to our attention through other channels.

1. What are the various types of contracts that are utilized by counties for fee-for- service, cost reimbursement, etc.?

Answer:

We would first like to confirm that there is an understanding of the terms mentioned in the question, in relation to Health and Safety Code (H&S) requirements. The H&S Code contains two parallel sections which deal with how counties may pay providers for services; 11818(b) for alcohol programs and 11987.5(a) for drug programs. Both sections state, in part, "The counties may enter into contracts with providers at actual cost or a negotiated rate."

Actual Cost Contracts

An actual cost contract with a provider, from the State's perspective, is simply one that requires settlement of the contract in a manner which limits reimbursement to the provider's actual cost of providing services, or the contract maximum, whichever is less. Typically, counties will negotiate an expected level of service, which a provider must meet in order to receive full reimbursement of costs. This ensures that the county is not funding empty beds/slots.

The mechanisms for payment of funds during the contract are generally at the discretion of the county. A county may choose to pay one-twelfth of a 12-month contract budget each month. Or, a county could

require invoices which reflect actual costs for each month. Any overpayment or underpayment is collected or paid when the year-end cost report is settled.

Negotiated Rate Contracts

These are sometimes referred to as fee-for-service contracts. We generally limit our use of the latter term to non-AOD Medi-Cal services to avoid confusion. According to the H&S Code, a negotiated rate is a "...specific and fixed dollar rate for a specified unit of service provided." Rates "... shall be based upon the projected cost of providing the services and projected revenues realized as a result of providing services." To justify these projections, "...The provider shall make available to the county information on prior years' actual cost of providing services and actual revenues."

The mechanism for payment of funds during the contract normally requires an invoice from the provider which identifies the number of units of service provided for the month.

There are some limitations to receiving full reimbursement of a negotiated rate, which are described in recent ADP letters/bulletins. In fact, two are just going out this week. The limitation that applies to residential programs involves the use of Federal SAPT Block Grant funds in the provider's contract. If an audit of such a negotiated rate contract is performed, it is possible that cost disallowances could still be assessed. The main reason would be to ensure that costs fully reimbursed by the rate do not include items which are unallowable in accordance with SAPT Block Grant requirements.

The limitation that affects other service modalities is where the funding mix includes Drug Medi-Cal dollars. In this event, negotiated rates "...shall be treated as provisional rates, subject to year-end settlement to actual costs."

Additionally, if an audit reveals that a rate was either too low to cover costs or excessively high, so as to provide revenue in excess of cost, a recommendation is made to adjust the rate to an appropriate level for future periods.

Drug Medi-Cal

In relation to the above two methods of reimbursement, Drug Medi-Cal providers are reimbursed in a slightly different manner pursuant to Title 22, CCR, Section 51616.1. With the exception of NTP providers, payment is made during the contract via a provisional rate. The only limitation on the provisional rate is that it cannot exceed the maximum allowance (often referred to as a rate cap). Interim settlement of a year-end cost report limits reimbursement to the lower of actual allowable costs or the maximum allowance. To the "entitlement" nature of D/MC, providers should not be limited by a contract amount.

However, if an audit is performed by ADP, an additional limitation on reimbursement will be considered, as required in Section 51616.1. This is the provider's usual and customary charge to the general public for the same or similar services. Medi-Cal will not reimburse more than this charge for services.

NTP providers are paid at fixed rates established in Section 51616.1, and are not subject settlement to actual costs. They are, however, limited to the lower of the fixed rate or the usual and customary charge to private patients.

2. What are NNA contract counties? How does this differ from counties with NNA agreements? What are the advantages and disadvantages of NNA contract counties?

Answer:

Providers must understand that Negotiated Net Amount (NNA) contracts are only for use between ADP and the counties. The premise is the negotiation of a bottom line total reimbursement for the county to receive for making available an agreed upon dedicated capacity. Contracts between counties and providers must meet the requirements discussed in Question No. 1.

Since FY 1994-95, every county has an NNA contract with ADP. We refer to the document as a contract, rather than an agreement. Consideration of advantages and disadvantages depends on your

perspective. From an county's perspective, the main advantage of the NNA mechanism is that it allows a county to retain unused State General Fund (SGF) monies, which previously would have been returned to the State.

From an audit standpoint, the main disadvantage is that the unit of service definitions for NNA are different than for D/MC. This creates problems for the providers and auditors in that it necessitates conversion to some common basis for cost allocation purposes.

3. What are the state's procedures in auditing providers?

Answer:

We ensure audits are properly completed pursuant to OMB Circular A-133 for all providers who fall under this requirement. We review all reports and ensure adequate follow-up occurs.

In regard to our audit work, we cannot provide a comprehensive answer to this question, since much of our work is somewhat flexible and tailored to the specific circumstances and conditions found in the audit. In general, we can offer the following:

We build on audit work already performed, to the extent that work is found to be acceptable to meet our audit objectives.

We reconcile the county's cost report submitted to ADP to the provider's cost report.

We reconcile the provider's cost report to the provider's financial records.

We review recorded costs for allowability.

We test revenues to ensure that all revenue required to be reported was reported on the cost report.

4. How often are audits required?

Answer:

OMB Circular A-133 audits are required annually, in most cases, for those providers required to have them.

ADP's audits are required more frequently than we are able to perform them. Also, requirements for alcohol programs differ from requirements for drug programs. For alcohol programs, H&S Section 11817.8 requires ADP to "...annually audit the expenditures of any organization funded, in whole or in part, with funds administered by the department." For drug programs, H&S Section 11991.6 requires ADP to "...audit or contract to audit the expenditures of counties and direct contractors at least every three years, including a sample of subcontractors funded in whole or in part with funds administered by the department." Any clean-up legislation which ADP has input into will correct these inconsistencies and align the requirements with practical capability.

Today, there are many programs we have never audited, and we use this fact along with certain risk factors to select programs for audit. County cost reports and claim information provide most of our risk factors. In addition, we receive referrals from various sources to audit certain programs. At this time, most of our focus is on D/MC providers.

5. What areas do they put the most importance on?

Answer:

In relation to residential programs, most of our emphasis tends to be on determining allowable costs, including reviewing cost allocation methodologies for multi-program providers. Another major consideration is where negotiated rates have been used, how they have been set. We would want to see

that actual historical cost and revenue were used to establish the rate, and that the costs did not include unallowable costs or a profit component.

In relation to D/MC programs, a critical test is to determine the provider's customary charge to the general public for comparison to the D/MC cost per unit.

6. What are the leading audit exceptions when the state audits a program?

Answer:

As you can see in our internal article called "What Are Audit Findings?," (Exhibit 1 enclosed) most of our common findings involve D/MC. However, one of the issues we need to deal with for residential is the provision of D/MC outpatient services to clients of a residential program. This may, with the exception of sober living centers, represent a duplication of treatment billings. Refer to ADP #96-09 and #96-27.

7. What types of documentation are required to back up expenditures?

Answer:

First, a provider should have a formal set of financial records. This includes a general ledger, as well as books of original entry; cash receipts journal (register), cash disbursements journal (register), general journal. Entries in the books of original entry must be traceable to source documentation. Evidence of expenditure must be sufficient to substantiate that the expenditure was incurred and that the expenditure was necessary to the provision of service. This evidence would include paid invoices, canceled checks, contracts, purchase orders, receiving reports, etc.

8. What type of documentation must a program have to back up cost distribution (more than one contract)?

Answer:

A cost allocation plan should be maintained. This plan provides the allocation methodology and the statistical basis (or bases) upon which the allocation of various costs is computed. An audit should be able to test cost allocations to confirm that the plan was actually used.

Providers with several types of residential programs, such as detoxification, residential treatment, and transitional living centers, must realize that the cost per client-day is driven by the level of service provided. In other words, the amount of staff time required to carry out each program becomes a critical factor for allocation purposes. This is particularly important to recognize in situations where the same staff work in multiple programs. Some systematic accumulation of staff time then becomes a necessity. If programs are separately located, with separate staff, and separate cost accounts, there is no issue of shared direct costs, but some reasonable allocation process for indirect costs (administrative overhead) is still necessary. Also, counties and providers must be cognizant of the fact that the cost attributable to any residential program which does not provide treatment must not be funded with SAPT Block Grant funds.

9. What are the "bibles" for allowed and disallowed expenditures?

Answer:

SAPT Block Grant and SGF

Residential programs are likely to receive some combination of SAPT Block Grant and SGF. Generally, the SAPT Block Grant defers to the State's procedures for expenditure of its own funds. These would be found in the H&S Code, primarily Sections 11818 and 11991.2, in Title 9, CCR, Section 9424, and in the State-County contract. These State laws and regulations are vague and general, making reference to costs which are "necessary to the provision of service". Consequently, when questions arise, we sometimes refer to OMB circulars for answers regarding cost principles. OMB Circular A-122 provides the guidance for non-profit organizations.

In addition, there are a few specific restrictions attached to the SAPT Block Grant, which can be found in 42 USC § 300-x, 45 CFR, Part 96, and in the Grant Award. These restrictions are as follows:

Pay the salary of an individual at a rate in excess of \$125,000 per year.

Provide inpatient hospital services, with some exceptions related to medically necessary hospital-based substance abuse services, as defined under 45 CFR 96.135(c).

Make cash payments to recipients of health services.

Purchase or improve land, purchase construct, or permanently improve (other than minor remodeling) any building or facility, or purchase major medical equipment, unless a waiver is approved in accordance with 45 CFR 96.135(d).

Satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.

Provide financial assistance to any entity other than a public or nonprofit private entity.

Provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Services determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS.

Refer to ADP Bulletin #98-16, Federal Block Grant Expenditure Restrictions, for more detail.

Drug Medi-Cal

If a program has mixed funding which includes D/MC, then settlement is to actual costs in accordance with Medi-Cal cost principles. In this instance, negotiated rates become provisional, as opposed to fixed rates.

Most common references are Title 22, CCR, primarily Section 51616.1; HCFA-15, the Federal Medicare cost guidelines; and definitions of services covered under D/MC, as contained in the Utilization Control Plan (now being incorporated into Title 22) and Title 9 CCR licensing and certification standards.

10. Why do counties get copies of audit reports, and if there's a problem, why do the counties get a bill?

Answer:

The county is ADP's contractor. Any finding against a provider is actually a finding that the county has overpaid a provider, resulting in ADP overpaying the county due to incorrect cost report information. ADP recovers from the county, and the county's collection effort to recover from the provider is its own concern. However, many counties include a provision in their contracts that requires repayment by providers for audit adjustments. There may be instances where the county shares some responsibility, due to misleading statements to the provider or the use of contractual language which conflicts with laws and regulations. Such circumstances could affect the county's ability to recover funds from the provider. However, such deficiencies do not effect the State's ability to recover from the county, nor the Federal Government's ability to recover from the State.

11. When are CPA audits required?

Answer:

We will answer this briefly, and provide you a phone number for any further questions.

OMB Circular A-133 audits are required of any provider that expends Federal funding (excluding Medi-Cal) of \$300,000 or more in a given fiscal year. The Circular explains the scope and possible scope limitations under certain circumstances.

H&S Code, Chapter 5, Section 38041, requires that any direct service contractors with the State who receive \$25,000 or more in Federal and/or State funds have an audit in accordance with Government Auditing Standards. This applies to few if any service providers at this time, since most contracts are with the counties.

12. Are CPA audits required for entire program operation, or just those that relate to contract budgets?

Answer:

This is a somewhat technical question. An audit of an entire organization is referred to as a "single audit", while an audit of just one contract or one service modality is referred to as a "program-specific audit". Conditions which allow a program-specific audit in lieu of a single audit are identified in OMB Circular A-133. Generally, a single audit is required unless the provider expends Federal awards under only one (1) Federal program (excluding research and development). If this is the situation, and the Federal program's laws and regulations or grant agreements do not require a financial statement audit, then the provider may elect to have a program specific audit performed.

While your CPA should be familiar with the OMB Circular A-133 direction on this topic, you may direct immediate questions to Dave Mar at (916) 324-2193.

13. What are the procedures for appeal when a program disagrees with audit exceptions?

Answer:

Any ADP audit report which contains a financial finding or a recovery resulting from the final audit settlement, provides the process for filing an appeal and a general description of the resolution process. ADP has interagency agreements with the Department of General Services, Office of Administrative Hearings for all non-Medi-Cal audits. For Medi-Cal, there is an interagency agreement with Department of Health Services, Audit Appeals Bureau, to hold the hearings.

14. Since providers are being asked to expand capacity, how are they able to do this with reimbursement being limited to actual cost in most cases, and with limitations on construction?

Answer:

It is true that expenditures for purchase or construction of buildings are not allowable costs for SAPT Block Grant or SGF reimbursement. Health and Safety Code Sections 11818 (a) and 11991.2 state that reimbursement shall not be made for expenditures for purchase or construction of buildings, except remodeling expenses as provided for in regulations, for expenditures for purposes for which state reimbursement is claimed under any other provision of law, or for expenditures pursuant to Section 11755.5.

However, ADP does have a general waiver of the SAPT prohibition, provided that a specific approval process is followed. Please contact your county for details on the process.

There are other means of recovering certain costs related to start-up or expansion, which are more commonly used, as itemized below.

Depreciation

Title 9, California Code of Regulations (CCR), Section 9424, Reimbursable Expenditures, includes "Depreciation of fixtures and equipment of county-operated programs and privately operated agencies as established in the Accounting Standards and Procedures for Counties, State of California, State Controller."

The term "fixtures" in the above section includes buildings purchased or constructed and major remodeling/renovation/additions which add value to property. Depreciation is the only allowable means of recovering such costs.

Minor Remodeling

On April 26, 1994, ADP and the U.S. Dept. of Health and Human Services (HHS), Office of Civil Rights, entered into a Voluntary Compliance Agreement (VCA). The VCA covers existing residential alcohol and other drug (AOD) service providers, that are under contract with the County and that are subrecipients of HHS financial assistance. These facilities were required to be accessible in their entirety to nonambulatory adults by December 31, 1995. When providers expand their operating capacity, minor remodeling costs associated with program accessibility can be recouped by using SAPT Block Grant funds. However, any proposed remodeling for a building cannot materially increase the value of the building or the total cost exceed \$50,000 over a three-year period. (Refer to ADA Circular 94-04 for details on conditions and the requirements.) Other funding sources, such as ADA tax credit and tax deduction, are also listed in this circular.

Start-Up Costs

Providers, with the exception of NTP programs, are able to claim certain costs as "start-up costs." This is allowed under D/MC, in accordance with Provider Reimbursement Manual Section 2132. D/MC costs meeting the definition of start-up costs may be amortized over a 60-month period from the date of certification.

Provider Reimbursement Manual Section 2132.3, "Cost Treatment for Medicare Reimbursement", contains the following language:

"Where a provider prepares all portions of its facility for patient care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratably over a period of 60 consecutive months beginning with the month in which the first patient is admitted for treatment . . . Where a provider prepares portions of its facility for patient care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for patient care services during different periods of time . . . If a provider expands its facility by constructing or purchasing additional buildings or wings, start-up costs should be capitalized and amortized separately for these areas . . . Start-up costs that are incurred immediately before a provider enters the program and that are determined to be immaterial by the intermediary need not be capitalized, but rather, may be charged to operations in the first cost reporting period. In the case where a provider incurs start-up costs while in the program and these costs are determined to be immaterial by the intermediary, these costs need not be capitalized, but may be charged in the periods incurred."

Start-up costs are allowed for other funds based on department policy, as defined in ADP #89-27, "Reimbursement of Expenses Incurred Prior to Commencement of Services." This policy statement generally mirrors the Provider Reimbursement Manual, except that it further defines the terms "immediately before entering the program" and "immaterial". It states that the start-up costs that are incurred no more than 90 days before a provider furnishes service to the first client and that are determined by the Department to be immaterial need not be capitalized, but rather, may be charged to operation in the period incurred. As a general rule, the Department will consider start-up costs that do not exceed 15 percent of the provider's yearly reimbursable costs of operation to be immaterial. A County may advance such start-up costs to providers subject to the following conditions:

1. The County determines that an advance payment is essential for the effective implementation of the program.
2. Advances are made pursuant to a written contract with the provider which specifies those start-up activities to be reimbursed, requires commencement of program operations within 90 days, and otherwise meets applicable contract requirements. (Refer to Title 9 Section 9426.)
15. If a D/MC provider has clients who are funded by the Veteran's Administration (VA) benefits, are these clients considered private and their benefits used for purposes of determining the provider's usual and customary charge?

Answer:

Provider Reimbursement Manual (PRM) Section 2604.3 defines customary charges as those uniform charges listed in a provider's established charge schedule which is in effect and applied consistently to most patients and recognized for program reimbursement. Where a provider does not have an established charge schedule in effect and applied to most patients, the determined 'customary charges' are the most frequent or typical charges imposed uniformly for given items or services. However, in either case, in order to be considered customary charges, they must actually be imposed uniformly on most patients and actually be collected from a substantial percentage of 'patients liable for payment on a charge basis.' Such charges must also be recognized for program reimbursement.

If a provider has a uniform charge listed in an established charge schedule in effect and applied consistently to most patients, and recognized for program reimbursement, then the listed charge is the customary charge for comparison to costs for reimbursement purposes irrespective of the presence of VA patients.

If a provider does not have an established charge schedule, but has a customary charge imposed uniformly on most patients, and non-VA patients comprise most of the non-Medi-Cal patients, then the charge imposed on those non-VA patients would be used in the lower of cost or charges calculation.

According to PRM Section 2604.3 B (1) (b), if VA patients comprise most of the non-Medi-Cal patients, and they are represented by a plan or agent under contract or agreement to make payment directly to the provider on a basis other than full charges, in other words, the provider receives payment directly from the VA in the name of the patients, then the VA patients would not be liable for payment on a charge basis, and thus these patients should not be considered for determining the provider's usual and customary charge for purpose of the lower of cost or charges reimbursement principle.

Please note that the conclusion reached by this analysis is contrary to the Congress's intent in enacting the lower of cost or charge reimbursement principle. The Congress intended the budgets of the Medicare and Medicaid programs not be increased by bearing some of the costs of non-program patients. This result will have the net effect of the Medicaid program bearing some of the costs of providing services to non-Medicaid, i.e., VA patients.

16. For a negotiated rate residential program, which allows a client a weekend leave from the program as part of a reward or incentive policy, must these days of absence be deducted for billing purposes?

Answer:

This depends primarily on the county/provider contract negotiation process. If this is a long-standing policy which is used fairly extensively, the county may wish to use actual historical client-days attended as a basis for determining the negotiated rate. If this is the case, the rate would be higher than a rate using enrolled client-days, and absences should be deducted.

However, if historical enrolled client-days are used in establishing the negotiated rate, the provider should be able to bill for all client-days of enrollment in the program. In other words, days for which a client is enrolled in the program, regardless of physical presence would be billable client-days, and no deduction for absences would be necessary.

From an auditing perspective, issues of materiality and the clarity of the negotiated rate development would have to be considered. Isolated instances of client absences and/or ambiguity regarding the statistical basis for establishing the negotiated rate would likely result in a management finding, as opposed to a financial finding.

17. For a residential program with a negotiated rate, are both a client's date of admission and date of discharge billable client-days?

Answer:

No. Payment for either the date of admission or the date of discharge may be made, but not both. An analogy would be a hotel customer being asked to pay for the day he/she checks in and the day he/she checks out. Counties should make this policy clear to their residential providers, preferably through contract language. This policy is found in the Alcohol Services Reporting System Manual for County Alcohol Programs (ASRS) Section IV, "Cost Guidelines and Reporting Units

REFERENCES

42 USC § 300-x.31
45 CFR Part 96 Block Grant
CCR Title 9. Rehabilitative and Developmental Services
CCR Title 22. California Medicaid Program
OMB Circular A-133 Audit of Institutions of Higher Education and Other Non- profit Institutions
OMB Circular A-122 Cost Principles for Non-profits
Health and Safety Code (H&S)
Provider Reimbursement Manual (HCFA 15)
Alcohol Services Reporting System Manual for County Alcohol Programs (ASRS)
ADA Circular 94-04 Funding Sources/Planning for Making Facilities Accessible to Nonambulatory Persons,
December 27, 1994.

HISTORY

ADP Letters:

ADP Bulletin #98-16 Federal Block Grant Expenditure Restrictions
ADP #96-09 Certification of Drug/Medi-Cal Clinics, February 29, 1996
ADP #96-27 Enforcement of ADP #96-09, June 3, 1996.
ADP #89-27 Reimbursement of Expenses Incurred Prior to Commencement of Services, April 17, 1989.

QUESTIONS/MAINTENANCE

Any questions on the content of this bulletin should be directed to Andy Dill, Assistant Audit Manager, at (916) 324-6406 or Gary Bellamy, Audit Manager, at (916) 322-4834.

EXHIBITS

Article from Administrative Update Bulletin, dated October 6, 1997, "What Are Audit Findings?"

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