SCOPE:

County Mental Health & Substance Abuse/Mental Retardation Administrators
County Mental Health & Substance Abuse/Mental Retardation Fiscal Officers

PURPOSE:

To set forth policy and procedure for cost settlement activity associated with Medicaid initiatives for mental health & substance abuse services and mental retardation community-based services.

BACKGROUND:

To date, the Office of Mental Health and Substance Abuse Services (OMHSAS) and the Office of Mental Retardation (OMR) have received Federal approval of an amendment to the State Medicaid Plan allowing payments on behalf of persons eligible for Medicaid for the following services:

- MHSAS - Intensive Case Management
- MHSAS - Family-Based Services
- MHSAS - Resource Coordination
- MR - Targeted Services Management

Information specific to the Mental Health and Substance Abuse Services' Crisis Intervention is contained in Attachment 4.

Information specific to those counties under HealthChoices for Mental Health and Substance Abuse Services is contained in Attachment 5.


COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Bureau of Financial Operations, Policy and Field Services Section, Report Review and Compliance Unit (717) 787-3760
The county program determines service delivery systems as county-operated or contracted with independent providers. Providers and/or counties are required to adhere to all productivity standards and governing regulations as applicable to each service activity. With contracted services, the county program negotiates rates eligible for Federal Financial Participation for each specific service to be funded as per the counties annual plan. All rates are based upon estimated costs for each service; therefore, subject to cost settlement. Reference: Title 55 Pennsylvania Code 4300 County Mental Health and Substance Abuse Services and Mental Retardation Fiscal Regulations governing county negotiated fees. Since cost settlement impacts on two (2) distinct funding mechanisms supporting these services, a reconciliation process is being implemented which will uniformly capture adjustments specific to advanced State Grant funding and Federal reimbursements accrued through direct invoicing of MAMIS. In order for cost settlement to work properly, reporting of Federal Medicaid revenues must be on the accrual basis reflective of billable units of service rendered during the fiscal reporting period.

PROCEDURE:

The Cost Settlement Report (CSR) implemented in this Bulletin serves as the vehicle to capture the interim reconciliation to actual costs for community-based Medicaid initiatives based upon accrued expenditures and accrued Medicaid revenues for each service activity. CSRs must be completed by the county program operating as the provider of service and by all independent contractors for each service activity within each fiscal reporting period. The CSR must be completed when a reimbursement rate has been negotiated and approved and when FFP has been received. The CSR is designed to compare overall accrued expenditures eligible for DPW State/Federal participation to combined DPW State/Medicaid accrued revenues. This approach eliminates the need to cost settle to multiple interim rates negotiated for a particular service activity within any given fiscal reporting period. This CSR should be incorporated as an essential component of the county program's existing fiscal year closing activity, with results ultimately represented on the Annual Income and Expenditure Report for the preceding fiscal reporting period.

The county MHSAS/MR program is responsible for the following:

1. Completion of CSRs for community-based Medicaid initiative service activities that are county-operated;

2. Review and approval of CSRs for community-based Medicaid initiative service activities that are contracted with independent providers;

3. Completion of the Cost Settlement Summary;

4. Submission of the Cost Settlement Summary and supporting CSR documents for service activity to the Department of Public Welfare, Bureau of Financial Operations for the preceding fiscal reporting period; and
5. Reporting of expenditures, Medical Assistance revenues and DPW participation of the Income and Expenditure Report Schedule MH/MR 16 that is reflective of interim settlements for both service delivery systems; and

6. Authorization in writing of the state matching funds available to satisfy underpayment settlements.

7. Collection of State grant fund overpayments and payment of additional State grant funds when available to satisfy settlements as necessary with contracted providers.

8. Comparison of the budgeted units identified in the rate setting process to the actual units provided and reported on the CSR. If the actual units reported are less than the estimated budgeted units, a narrative must be submitted as part of the cost settlement package which details the reasons why the productivity standard was not met. This information will be supplied to the appropriate Program Office for their review. Assistance may be offered by the Program Office when indicated.

Specific instructions for completion of the CSR and the Cost Settlement Summary are provided in this Bulletin. Also provided is a document flow chart to illustrate the process.

Upon receipt of the county program's CSR report package, the Bureau of Financial Operations will verify the information. If a discrepancy is identified, immediate contact will be made with the county program. The Bureau of Financial Operations will provide written notification to the county program of all MAMIS adjustments initiated. This information will be provided simultaneously to the Office of Mental Health and Substance Abuse Services and the Office of Mental Retardation.

INTERIM SETTLEMENTS: The interim settlement will be based upon accrued expenditures and accrued revenues. The results are ultimately represented on the Annual Income and Expenditure Report for the corresponding fiscal period in which services were rendered. NOTE: MR Targeted Services Management rate setting does not currently contain a Non-MA (Non-FFP) component. Therefore, TSM Costs, not overall Case Management Costs, should be utilized for Cost Settlement. (Please refer to CSR Instructions, Attachment 2. Page 6 for specific instructions.)

**Overpayments**

**Federal Portion:** The service provider will have a credit (negative balance) applied to the MAMIS provider file to satisfy the Federal portion of the claim. This is accomplished through a Gross Adjustment request initiated by the Bureau of Financial Operations to the Office of Medical Assistance Programs. The overpayment credit will be offset against active invoices in MAMIS.

**State Portion:** The county program is responsible to collect State overpayments from the contracted providers. State overpayments may be represented as those State match funds utilized for Federal Financial Participation (FFP) and/or 100% State funds ineligible for Federal Financial Participation (Non-FFP).
Underpayments

Each individual county administrative unit will determine through fiscal year closing activity if additional State funds are available within their existing allocations to meet (full or partial) actual costs for providing services. In this instance, all units subject to retroactive settlement (both MA eligible (FFP) and Non-MA eligible (Non-FFP) must be reimbursed at the same level for any given period of time within the fiscal year. In other words, such reimbursement cannot discriminate between Federally funded and non-Federally funded services. Federal funds utilized for the reimbursement of an underpayment for MA eligible services require verification of (and are limited by the availability of) a lump sum State match. A State Match Verification (SMV) must accompany the CSR. If no State dollars are available from the county program, no additional Federal dollars may be obtained. If the adjustment to FFP is due to productivity, not meeting the established standard, the justification for the lower productivity should be reviewed and incorporated into the counties' decision of what amount of the adjustment to provide state matching funds for.

Federal Portion: The service provider will have a debit (positive balance) applied to the MAMIS file, via gross adjustment, to generate the Federal portion due in a lump sum. This payment will be identified on a future Remittance Advice.

State Portion: The provider is reimbursed in a lump sum by the county with State funds, as determined available within the county program's existing allocation.

Restriction: In those years where we have applied a Federal categorical cap, if you are requesting additional payments supporting TSM services which are MA eligible this will be subject to Program Office review and approval.

FINAL SETTLEMENTS:

Related documentation supporting the information reported by the county programs should be held for a minimum of four (4) years after the close of the fiscal reporting period or until all related settlement issues have been resolved by the Department, whichever is later. Community-based, Medicaid initiative cost settlement procedures as implemented in this Bulletin will be referenced in the Department of Public Welfare’s Single Audit Supplement. The county program is responsible for (1) determining any variances between interim and final schedules, (2) reporting changes to State grant funding and (3) requesting MAMIS Gross Adjustments through the next available Annual Income and Expenditure Report submitted to the Department. To facilitate these determinations, the Department requires that county programs include the CSR as a required supplemental schedule for independent audits received from contracted service providers. The county programs are now required to submit the final CSR (based on audited information) to the Department when processing final actions. If requesting an underpayment be sure to include the State Match Verification form on the second page of the CSR.
Criteria for Satisfying Final Settlements

Overpayments

Any variance between the interim and final CSR, which results in an overpayment, must be satisfied. The corresponding Federal and State portions will be collected in the same manner as described for interim settlements.

Underpayments

In accordance with MH/MR Fiscal Regulation 4300.147, Deficits, current year Department allocated funds may not be utilized to pay for a deficit incurred during a prior period without the approval of the Secretary of Public Welfare. Therefore, variances between the interim and final CSR reflecting an underpayment can be satisfied; however, only up to the maximum amount of available State grant funds that were reported as unexpended in that prior period and budgeted for within the current fiscal reporting period.

Procedure for Reporting Prior-Year Adjustments

When the county program operates as the provider of service, reporting of final State grant funding and Federal participation adjustments must occur through the County Single Audit.

When the county program contracts with independent providers, the county administrative unit is responsible to report State grant funding and Federal participation adjustments resulting from service provider audits as prior-year adjustments on the next available Annual Income and Expenditure Report. Funding of Program Services Schedules, MH 15 and MR 15, Column 6, has been revised to isolate all prior-year audit adjustments related to cost settlement of Medicaid-initiative services. Detailed instructions on the reporting of prior year adjustments will be contained in the I&E instruction package.

Attachment 1. Cost Settlement Document Flow
Attachment 2. CSR Form and Instructions
Attachment 3. Cost Settlement Summary
Attachment 4. Crisis Intervention Instructions
Attachment 5. Instructions pertaining to counties which have changed to HealthChoices.
COST SETTLEMENT DOCUMENT FLOW

County program prepares CSR for county-operated services.

Contractor prepares CSR and submits to the county program for approval.

County program reviews and approves CSRs. Interim settlements are incorporated into year-end closing adjustments and annual I&E report process. CSRs and Cost Settlement Summary are forwarded to BFO.

BFO performs CSR verification and contacts county program to resolve any discrepancies. BFO supplies productivity information to Program Office.

BFO forwards MAMIS Gross Adjustment requests to Office of Medical Assistance Programs for processing within 60 days.

BFO provides written notification to county program of MAMIS adjustments initiated by the Department.

BFO provides written notification to Program Office (OMHSAS or OMR) of MAMIS adjustments initiated.

County program provides written notification to contracted providers of MAMIS adjustments initiated by the Department.
## Service Delivery Analysis

<table>
<thead>
<tr>
<th>Actual Units</th>
<th>Budgeted Units</th>
<th>Budgeted Expenditures</th>
<th>Approved Billable Rate(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Expenditures

1. **Total Program Expenditures**
   - Less: Retained Revenue Allowance
   - Less: Other Expenses Not Allowable for Federal Reimbursement
   - Expenditures Eligible for DPW State/Federal Participation

## Revenues

1. **MAMIS Federal Revenue**
2. **Match Funds for 3(1)**
3. **Revenues Supporting Non-FFP Units**
   - Net Program Revenues (1+2+3)
   - Revenues Supporting Expenditures from 2b & 2c
   - Total Program Revenues

## Expenditures Minus Revenues (2d-3a)

### Underpayment / (Overpayment)

**$0**

## Service Delivery

<table>
<thead>
<tr>
<th>Actual Units</th>
<th>Actual Rate</th>
<th>Reconciled Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ERR</td>
<td>ERR</td>
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</tbody>
</table>

## Reconciliation

1. **FFP**
2. **Non-FFP**

## State/Federal Split of Difference:

<table>
<thead>
<tr>
<th>Federal - Underpayment (Overpayment)</th>
<th>ERR</th>
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</thead>
<tbody>
<tr>
<td>State - Underpayment (Overpayment)</td>
<td>ERR</td>
</tr>
</tbody>
</table>

### BFO/CSR

6/00
8. Reconciliation Recap

<table>
<thead>
<tr>
<th>Overpayment</th>
<th>ERR</th>
<th>MAMIS Gross Adjustment Requested</th>
<th>ERR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underpayment</td>
<td>ER</td>
<td>MAMIS Gross Adjustment Requested to Initiate Payment</td>
<td>Complete State Match Verification</td>
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**STATE MATCH VERIFICATION**

<table>
<thead>
<tr>
<th>PROVIDER INFORMATION</th>
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<tbody>
<tr>
<td>Provider Name</td>
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<tr>
<td>Provider MA ID Number</td>
</tr>
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<table>
<thead>
<tr>
<th>Service Dates</th>
<th>Begin</th>
<th>End</th>
<th>Units of Service</th>
<th>State Match Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/99</td>
<td></td>
<td>6/30/00</td>
<td>Gross Adjustment</td>
<td></td>
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<table>
<thead>
<tr>
<th>Signature</th>
<th>Title</th>
<th>Date</th>
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<table>
<thead>
<tr>
<th>Signature and Title of Person Completing CSR</th>
<th>Name of Provider</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature and Title of Person Reviewing and Accepting CSR</th>
<th>Name of County/County</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

I certify that the interim reconciliation of the rate negotiated for this Medicaid Initiative for the period shown is true and correct to the best of my knowledge, and is reflective of accrued Medicaid revenues, and minimal service delivery requirement as prescribed by the Department.

<table>
<thead>
<tr>
<th>County MH/MR Administrator Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

**CSR SUMMARY**

A. Total Program Expenditures (2a) 
B1. MAMIS Federal Revenue Reported on line 3(1) 
B2. MAMIS gross adjustment requested (section 8) 
B. Total Adjusted MA revenue (B1 + B2) 
C. Other revenue (A minus B)
COST SETTLEMENT REPORT (CSR) INSTRUCTIONS

SELECT INTERIM OR FINAL.
SELECT COUNTY OR PROVIDER OPERATED.

HEADER DATA:

ENTER COUNTY/JOINDER NAME
ENTER PROVIDER NAME; ENTER "SAME" IF COUNTY-OPERATED
ENTER PROVIDER TYPE
ENTER PROVIDER MA ID#
ENTER FISCAL YEAR 99-00 IF NOT ALREADY ENTERED
ENTER PROGRAM: MHSAS OR MR
ENTER REVISION # IF THIS IS A REVISED FORM
ENTER SERVICE ACTIVITY; ONE OF THE FOLLOWING CODES:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>PROGRAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>IC</td>
<td>INTENSIVE CASE MANAGEMENT</td>
<td>(MHSAS ONLY)</td>
</tr>
<tr>
<td>FB</td>
<td>FAMILY BASED SERVICES</td>
<td>(MHSAS ONLY)</td>
</tr>
<tr>
<td>RC</td>
<td>RESOURCE COORDINATION</td>
<td>(MHSAS ONLY)</td>
</tr>
<tr>
<td>TSM</td>
<td>TARGETED SERVICES MANAGEMENT</td>
<td>(MR ONLY)</td>
</tr>
</tbody>
</table>

NOTE: All amounts and percentages reported should be rounded to the nearest whole dollar, except for Item 5, Actual Rate computation based on cost which will be rounded to 4 decimals (ex: $24.6837).

1. Service Delivery Analysis

   a. Enter Actual and Budgeted Units provided for MA (FFP) eligible services.

   b. Enter Actual and Budgeted Units provided for Non-MA (Non-FFP) eligible services.

   c. Combined Total of Actual and Budgeted Units is calculated for you.

   d. Enter Budgeted Expenditures and approved Billable Rates. Budget information is representative of the service entities rate setting process.

2. Expenditures

   a. Enter total program expenditures. **Do not include expenditures associated with a Health Maintenance Organization (HMO).** Do not include program funded expenditures or startup costs unless included in the rate setting package.

   b. Enter retained revenue allowance.

   c. Enter expenditures not reimbursable according to Federal regulations. For OMHSAS programs this would include only the State Reimbursable Costs listed in the rate setting package for each service activity.

   d. The difference of (2a - 2b - 2c) to determine net expenditures eligible for DPW State/Federal participation (total Federally allowable costs) is calculated for you.
3. Revenues

(1) **MAMIS Federal Revenue**: Enter the amount of received, invoiced, and accrued Federal Medicaid revenues.

(2) **Match Funds**: Enter the amount of match funds supporting MA eligible service units. Match funds may be representative of allocated State grant funds, contracted CHIPP funds, county match, interest or a combination thereof.

**Supporting Calculation**: Federal revenues divided by the applicable Federal medical assistance percentage (FMAP) equals total State and Federal participation. This result minus the amount of Federal revenues equals the match portion. The match portion is identified on the State Match verification documents.

**Example**:

<table>
<thead>
<tr>
<th></th>
<th>7/1/99 - 9/30/99</th>
<th>10/1/99 - 6/30/00</th>
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</thead>
<tbody>
<tr>
<td>Federal revenues</td>
<td>$60,000</td>
<td>$80,000</td>
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<tr>
<td>Divided by FMAP</td>
<td>.5377</td>
<td>.5382</td>
</tr>
<tr>
<td>Total St./Fed. Participation</td>
<td>$111,586</td>
<td>$148,643</td>
</tr>
<tr>
<td>Minus Federal revenues</td>
<td>-60,000</td>
<td>-80,000</td>
</tr>
<tr>
<td>Match Requirements</td>
<td>$51,586</td>
<td>$68,644</td>
</tr>
</tbody>
</table>

(3) **Revenues Supporting Non-FFP Unit**: Enter the amount of revenue supporting federal allowable costs for MA ineligible (Non-FFP) service units. The revenues may be a representative of allocated State grant funds, contracted CHIPP funds, county match, interest or a combination thereof.

a. The total of net program revenues (1+2+3) supporting Federally allowable costs, subject to reconciliation, will be calculated for you.

b. The amount of Other Revenue sources supporting non-Federally allowable costs reported on lines 2b and 2c will be calculated for you. Other Revenue sources may be representative of State funds, county match, interest, VA income, restricted grants, and retained revenue.

c. Total Program Revenues will be calculated for you. This is the total of 3a + 3b. **Do not include revenues associated with an HMO.**

4. Expenditures Minus Revenues

- The difference of (2d - 3a) to determine underpayment/overpayment will be calculated for you.

5. Service Delivery

- Actual Units (the same as Item 1) will be entered for you.

- Actual Rate will be entered for you (2d divided by Combined Units, Item 5c) rounded to four decimal places.

- Reconciled Revenues (Actual Units times Actual Rate for 5a, 5b, and 5c) will be entered for you.
6. Reconciliation
   a. MA (FFP) Eligible: The Reconciled Revenues from Item 5a and Actual Revenues from Items 3(1) + 3(2) will be entered for you to compute the difference.
   b. Non-MA (Non-FFP): The Reconciled Revenues from Item 5b and Actual Revenues from Item 3c(3) will be entered for you to compute the difference.

If Reconciled Revenues are greater than Actual Revenues, the result represents underpayment "Due to Provider" status.

If Reconciled Revenues are less than Actual Revenues, the result represents (overpayment) "Due from Provider" status.

7. State/Federal Split of Difference
   FFP: Federal
   a. The result from Item 6a times the Federal Medical Assistance Percentage (FMAP) to determine Federal portion of difference will be entered for you.
   FFP: State
   b. The result from item 6a times the percentage to determine State portion of difference will be entered for you.
   Non-FFP: State
   c. The result from Item 6b to determine Non-FFP State portion of difference will be entered for you.

8. Reconciliation Recap
   Complete the action required unless it is an overpayment. Overpayments are entered for you.
   
   Overpayment
   a. This amount of Total FFP Federal difference as calculated in the reconciliation will automatically be entered for you (Result from Item 7a).
   
   Underpayment
   b. Enter the total or a portion of the FFP Federal as calculated in the reconciliation (Item 7a) to initiate payment, supported by a SMV representing the availability of State match funds.

   Enter the State Match applicable to the amount of FFP requested in 8b. If 8b is selected, the State Match Verification must be completed. The Provider Name, ID number and type of services will be entered for you.

   Provide the appropriate signature, title and date on the form.

   c. Enter "x" to indicate that no MAMIS adjustment is required; State match funds, are unavailable for payment.
Provide the appropriate signature and title of the person completing the CSR and the name of the provider organization (if applicable).

Provide the appropriate signature and title of the person reviewing and accepting the CSR at the County/Joinder. Enter the name of the County/Joinder and the date.

All CSRs require the County MH/MR Administrator’s signature.

**CSR Summary**

A - The Total Expenditures reported on line 2A will calculate for you.

B1 - The amount of MAMIS Federal Revenue reported on line 3(1) will calculate for you.

B2 - The adjustment to MAMIS Federal Revenues requested in Section 8, Reconciliation Recap will calculate for you.

B - The result of B1 plus B2 will calculate for you.

C - The result of line A minus line B will calculate for you. This is reflective of all other revenue sources, Department allocated funds, as well as Costs Over Allocation.

**NOTE:** MR Targeted Services Management Rate Setting does not currently contain a Non-MA (Non-FFP) component. Therefore, TSM Costs, not overall Case Management Costs, should be utilized for Cost Settlement. The following line items are not applicable to MR-TSM and zero "0" should be entered.

- Item 1b: Non-MA (Non-FFP) Units
- Item 3c: Revenues Supporting Non FFP Unit
- Item 5b: Non-MA (Non-FFP) Units and Reconciled Revenues
- Item 6b: Non-FFP Reconciliation
- Item 7c: Non-FFP State Difference

Upon county program review and approval of CSRs, please forward CSRs, accompanied by an approved Cost Settlement Summary for each service activity to the Report Review and Compliance Unit as follows:

Report Review and Compliance Unit
Department of Public Welfare
Bureau of Financial Operations
Bertolino Building, Third Floor
P.O. Box 2675
Harrisburg, PA 17105-2675
## COST SETTLEMENT SUMMARY

**COUNTY PROGRAM**

**COMPLETED BY**

**SERVICE ACTIVITY**

**PERIOD** FY 1999-00

<table>
<thead>
<tr>
<th>PROVIDER 1</th>
<th>PROVIDER 2</th>
<th>PROVIDER 3</th>
<th>PROVIDER 4</th>
<th>PROVIDER 5</th>
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<tr>
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<tr>
<td>A. TOTAL PROG EXPEND.</td>
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<tr>
<td>B. MA REVENUE</td>
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<tr>
<td>C. OTHER REVENUE</td>
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<td>$0</td>
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<td>$0</td>
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<td>3. Other Revenue</td>
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<td>4. Costs Over Allocation</td>
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<td>TOTAL OTHER REV (C1-C4)</td>
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<th>PROVIDER 8</th>
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<th>PROVIDER 10</th>
<th>PROVIDER 11</th>
<th><strong>CSR</strong></th>
<th><strong>ADDITIONAL EXP &amp; REV</strong></th>
<th><strong>GRAND TOTAL</strong></th>
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<td>C. OTHER REVENUE</td>
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<td>$0</td>
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COST SETTLEMENT SUMMARY INSTRUCTIONS

A Cost Settlement Summary is required to be completed for each service activity, reflective of supporting CSR documentation. The format will accommodate information for eleven providers; if the county has more contracted providers, use additional sheets and provide a grand total.

HEADER DATA:

ENTER COUNTY/JOINDER NAME
ENTER NAME OF PERSON COMPLETING FORM
ENTER FISCAL YEAR i.e., 99-00
ENTER SERVICE ACTIVITY; ONE OF THE FOLLOWING CODES:

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>IC</td>
<td>INTENSIVE CASE MANAGEMENT - (MHSAS ONLY)</td>
</tr>
<tr>
<td>FB</td>
<td>FAMILY BASED SERVICES - (MHSAS ONLY)</td>
</tr>
<tr>
<td>RC</td>
<td>RESOURCE COORDINATION - (MHSAS ONLY)</td>
</tr>
<tr>
<td>TSM</td>
<td>TARGETED SERVICES MANAGEMENT - (MR ONLY)</td>
</tr>
</tbody>
</table>

For each provider enter the required information from the individual Cost Settlement Reports. The information is obtained from the CSR Summary on the bottom of page 2 of each Cost Settlement Report. This Summary is to assist in the reconciliation of Cost Settlement information to the I&E Report.

For Each Provider:

Enter the Provider’s Name on the top line, abbreviate as necessary.

Enter the Provider’s Total Program Expenditures on Line A, this is from Line A on the CSR Summary.

Enter the adjusted MA Revenue on Line B, this is from Line B on the CSR Summary.

The amount of Other Revenue supporting Total Program Expenditures on Line C will be entered for you, from Line C on the CSR Summary.

The amount shown on Line C is the total of;

C1 State Reimbursement,
C2 County Match,
C3 Other Revenue and,
C4 Costs over Allocation, including CHIPP and DPW Non-Reimbursables.

You must enter C1, C2, C3, and C4 for each provider. THE TOTAL OTHER REVENUE AMOUNT MUST EQUAL THE AMOUNT ON LINE C.

The total of amounts in Lines A, B, C, C1, C2, C3, and C4 for all providers will be entered for you in the CSR Subtotal column.
Expenditures in excess of those reported on the Cost Settlement Report, such as for program funded or start up costs which were not included in the rate setting package may be incorporated in the I&E Report. Those expenditures and the offsetting revenue will be reported in the Additional Expenditure & Revenue Column of the Cost Settlement Summary.

The amount in the CSR Subtotal Column for Line A will be added to the amount in the Additional Expenditure Column of Line A. The Total will be placed in the Grand Total Column. This amount should correspond to Line II, Total Expenditures, of the I&E MH 16 or MR 16 for the applicable cost center.

The amount in the CSR Subtotal Column for Line B will be placed in the Grand Total Column. This amount should correspond to Line IVc, Medical Assistance-General of the I&E MH 16 or MR 16 for the applicable cost center.

The CSR Subtotal Column of Line C will be representative of all Other Revenue supporting Total Expenditures. The amount in Line C must equal the total of C1, C2, C3, and C4.

The amount in the CSR Subtotal Column for Line C1 will be added to the amount in the Additional Expenditure Column of Line C1. The Total will be placed in the Grand Total Column. This amount should correspond to Section V, DPW Reimbursement of the I&E MH 16 or MR 16 for the applicable cost center.

The amount in the CSR Subtotal Column for Line C2 will be added to the amount in the Additional Expenditure Column of Line C2. The Total will be placed in the Grand Total Column. This amount should correspond to Section VI, County Match of the I&E MH 16 or MR 16 for the applicable cost center.

The amount in the CSR Subtotal Column for Line C3 will be added to the amount in the Additional Expenditure Column of Line C3. The Total will be placed in the Grand Total Column. This amount should correspond to Section IVh, Other Revenue of the I&E MH 16 or MR 16 for the applicable cost center.

The amount in the CSR Subtotal Column for Line C4 will be added to the amount in the Additional Expenditure Column of Line C4. The Total will be placed in the Grand Total Column. This amount should correspond to Section IIIe, Other Revenue of the I&E MH 16 or MR 16 for the applicable cost center.
Crisis Intervention Instructions

Cost Settlement is **only** applicable for providers where a rate has been negotiated and MAMIS has been invoiced. If a service such as Telephone Crisis is funded by the fee schedule or has been program funded and no FFP reimbursement from MAMIS has been requested or received, the cost settlement process would **not** apply.

This policy is in accordance with Mental Health and Substance Abuse Services Bulletin OMH-98-04, Mental Health Substance Abuse Services Crisis Intervention Fee Schedule. This Bulletin discusses the procedures that apply to the "phase-in" to the published fee schedule and how this policy relates to the Cost Settlement process. For FY 1999/00 those providers who are billing Medical Assistance at the established fee schedule or below have no requirement to cost settle. Those providers which are billing Medical Assistance through the “phase-in” process to meet the fee schedule are required to cost settle each crisis component to which "phase-in" applies.

For providers who are allowed to cost settle, the components of Crisis Intervention and the service activity abbreviations for each component are:

- Telephone Crisis: CI TEL
- Walk-In Crisis: CI WI
- Mobile Crisis-Individual: CI MOB-ID
- Mobile Crisis-Team: CI MOB-TM
- Medical Mobile Crisis: CI MM
- In-Home Support Crisis: CI IHS
- Residential Crisis: CI RES

Whenever a service activity or a service code is to be input on the CSR or the Cost Settlement Summary, the service activity Crisis Intervention, as well as the specific component of Crisis Intervention must be entered.
COUNTIES UNDER HEALTHCHOICES FOR FISCAL YEAR 1999/00

All counties are required to cost settle Targeted Service Management with the Office of Mental Retardation.

Under Health Choices, the Southeast and Southwest counties listed below do not cost settle service activities with the Office of Mental Health and Substance Abuse Services (OMHSAS):

Bucks  Allegheny  Lawrence
Chester  Armstrong/Indiana  Washington/Greene
Delaware  Beaver  Westmoreland
Montgomery  Butler  
Philadelphia  Fayette