Behavioral Health Organizations

Fiscal/Program Requirements
&
Revenue and Expenditure (R&E)
Report Instructions

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PART I: OVERVIEW

The purpose of this document is to define the revenue, expenditure, fund balance, and elements and sub-elements specific to the Behavioral Health Organizations (BHO) integrated contract and Federal Block Grant expenditures.

Local government contractors must use the element/sub-element categories contained in this document when accounting for expenditures.

The fiscal policies set forth in this document are conditions for the receipt of funds and are mandatory.

This document is intended for use by BHO and local governments. Subcontractors of BHOs may be required to report data to BHOs using the Fiscal Program Requirements classifications.

GENERAL INSTRUCTIONS

1. Report BHO Behavioral Health Organization (BHO) revenues and expenditures (not provider revenues and expenditures).
2. Report the accounting method your BHO uses (Full Accrual, Modified or Cash Basis).
3. Report expenditures associated with reported revenues.
4. Report expenditure allocation method. Refer to the suggested Cost Allocation Guidelines for acceptable cost allocation methodologies.
5. Revenue and Expenditure (R&E) Report Format
   i) **Do not change or fill in gray areas**. Some gray areas are formulas which will automatically generate totals. Other gray cells are heading rows. Do not enter information into heading rows.
   ii) **Do not delete rows or add rows**. Insert comment boxes to a cell or enter notes in the column provided if clarification is necessary.
   iii) **Do not change the overall format.** Reports must be submitted in exactly the same format so that DBHR can summarize and condense the information into one Excel Workbook by linking the reports.
   iv) Columns in the R&E Report identify “Fund Source.”
6. The BHO should report current fund balances (the final date of the R&E reporting period). The fund balance should reflect reserves and fund balances held at the BHO—not held at the providers. *If there are variances between expected and reported fund balances an explanation must be provided.*

Report and Certification Due Dates

The R&E reports and Certifications are due within 45 days of the quarterly reporting period (September, December, March and June of each year).

Submit signed certification and other documents electronically to:
BHManagedCare@dshs.wa.gov

Corrections to Prior Period Reports

During a current State fiscal year (July – June)

If you discover an error in a previously submitted report, correct the error in the reporting period in which the error was discovered. For example, you're preparing the January-March report and you discover you made an error in the previous report (July-September) make the correction on the January-March report. Add a note to the report explaining the correction.

For a prior State fiscal year

If the error is not significant; correct the error in the report period in which the error was discovered. Add a note to the report explaining the correction. If the error is significant, the BHO should contact DBHR fiscal staff for consultation on how to proceed.

Special Legislative Funding (Provisos)

General Information

Report funds designated by the legislature for a specific purpose in the appropriate Revenue or Expenditure row.

If administrative dollars are allowed, be sure to clearly identify and break-out the proviso administrative dollars by funding type (Non-Medicaid R&E Row 138 for Jail funding, Non-Medicaid R&E Row 139 for PACT funding) in the Administrative Expenditure section. Program funds designated by the legislature for a specific purpose that are unspent at State fiscal year-end should be held in Reserve for Encumbrances.

PART II: REVENUES

The Fiscal Program Requirements are intended to assist the BHOs in reporting to BHA the revenues that support the set of expenditures detailed below. The revenues that should be included are only those received directly from BHA, funding the local county has provided, and other revenue sources received by the BHO that directly support mental health and substance use disorder activities. Note: Funds spent by providers outside of these revenue sources should not be reported on the R&E report unless it is used as local match to draw down Federal funds (Title XIX).

Revenue Account Definitions

Revenue information presented in this document refers to the type of revenues to be reported by BHOs to BHA. BHOs should report all revenue received from BHA, using the categories listed below and by fund sources. Revenues received directly by providers should be reported to BHA if (a) it is to be used as local match to draw down the Federal funds or (b) corresponding expenditures are reported. Third Party revenues received and used to support public (BHO) consumers need to be reported on the Third Party form.

MEDICAID REVENUES

Medicaid Revenues

Medicaid Revenues (Per Member Per Month - PMPM) (Medicaid R&E Line 2)

Funds received from the Prepaid Inpatient Health Plan (PIHP) contract. Payments are funded by Medicaid (PIHP Capitation - State and Federal Title XIX Funds).

Wraparound Intensive Services (WISe) (Medicaid R&E Line 3)

Funds received for Wraparound with Intensive Services "WISe", a program model that includes a range of service components that are individualized, intensive, coordinated, comprehensive and culturally competent and provided in the home and community. WISe is for children, youth, and young adults up to age twenty one (21).

Additional Medicaid (Medicaid R&E Line 4)

Additional federal funds received pursuant to the PIHP contract. The required match for these funds shall be provided by the Contractor from local funds eligible for federal match. Local funds do not include donations.

Other Medicaid Revenues

Other Medicaid Revenues- Describe Source (Medicaid R&E Line 6 & 7)

There may be a case where revenue is received from sources not listed above. BHOs must include a description of the nature and source of this revenue.

Revenues from Local

Local Match (includes Medicaid) (Medicaid R&E Line 9)

Funds received from local source and have been certified by the local authority as public funds. The Contractor must provide a completed Local Match Certification Form quarterly.

Evaluation and Treatment (E&T) (Medicaid R&E Line 10)

Funds received from local source for operation of Evaluation and Treatment Center. Do not report funds received from third-party source (e.g. other BHOs, insurance companies).

Interest (Medicaid R&E Line 11)

Revenue received from interest earned on Behavioral Health funds retained in the County or BHO and invested. Report interest earned on behavioral health funds if used as Medicaid match.

Other Local Funds – Describe Funds (Medicaid R&E Lines 12 & 13)

Funds received from other local sources. There may be a case where revenue is received from local sources not listed above. BHOs must include a description of the nature and source of this revenue.

NON-MEDICAID REVENUES

Non-Medicaid Revenues (See details in BHSC Exhibit F)

Non-Medicaid State (Non-Medicaid R&E Line 2)

Funds received from the Behavioral Health State Contract that are not detailed below.

Dedicated Marijuana Account (DMA) (Non-Medicaid R&E Line 3)

Funds received from the Dedicated Marijuana Account (I-502 fund).

Criminal Justice Treatment Account (CJTA) (Non-Medicaid R&E Line 4)

Funds received to provide alcohol and drug treatment services to offenders who are under the supervision of the courts.

State Drug Court (Non-Medicaid R&E Line 5)

Funds received to provide alcohol and drug treatment service to offenders who are under the supervision of a drug court.

Juvenile Drug Court (Non-Medicaid R&E Line 6)

Funds received to provide alcohol and drug treatment service to juvenile offenders who are under the supervision of a juvenile drug court.

Jail Services (Non-Medicaid R&E Line 7)

Funding to provide mental health services for mentally ill offenders while confined in a county or city jail. These services are intended to facilitate access to programs that offer mental health service upon mentally ill offenders' release from confinement. This includes efforts to expedite applications for new or re-instated Medicaid benefits.

Expanded Community Services (Non-Medicaid R&E Line 8)

ECS funding is to assist in the provision of community support services for long term state hospital patients. The funding is provided for the operation of community residential and support services for persons whose treatment needs constitute substantial barriers to community placement and who no longer require active psychiatric treatment at an inpatient hospital level of care, no longer met the criteria for inpatient involuntary commitment, and who are clinically ready for discharge from a state psychiatric hospital.

Program for Assertive Community Treatment (PACT) (Non-Medicaid R&E Line 9)

Funds received per the budget proviso for development and initial operation of high-intensity programs for active community treatment PACT teams.

ITA 180-Commitment Hearings (Non-Medicaid R&E Line 10)

Funds received to conduct 180-day commitment hearings.

Detention Diversion Review (Non-Medicaid R&E Line 11)

Funds received to conduct Detention Decision Reviews. This is a process the court completes when it receives a petition from an immediate family member, guardian, or conservator requesting a review of a designated mental health professional's decision to not detain following assessment, or not respond within 48 hours of a request for assessment. This process includes review of the petition and sworn statements for sufficient evidence to detain, and review of a declaration from the designated mental health professional who made the initial decision to not detain.

Assisted Outpatient Treatment (Non-Medicaid R&E Line 12)

Funds received to support Assisted Outpatient Treatment (AOT). AOT is an order for Less Restrictive Alternative Treatment for up to ninety days form the date of judgment. AOT shall not order inpatient treatment.

5480 – ITA Non-Medicaid (Non-Medicaid R&E Line 13)

Funds received to develop and maintain an integrated high intensity treatment team.

Housing & Recovery through Peer Services (HARPS) (Non-Medicaid R&E Line 14)

Funds received for the purposes of offering meaningful choice and control of housing and support services, utilizing Peer Housing Specialists, reducing homelessness and supporting the recovery and resiliency of individuals with serious mental illness.

Revenues from Federal (Non-Medicaid R&E Line 15)

Mental Health Block Grant (MHBG) (Non-Medicaid R&E Line 16)

Federal funds received under the Mental Health Block Grant. These funds are provided through the Mental Health Program as an indirect grant from the federal government to provide comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor progress in implementing a comprehensive, community-based mental health system.

Substance Abuse Block Grant (SABG) (Non-Medicaid R&E Line 17)

Federal funds received for the purposes of planning, carrying out, and evaluating activities to treat substance use disorder to include the abuse and/or illicit use of alcohol and other drugs.

Project for Assistance in Transition for Homeless (PATH) (Non-Medicaid R&E Line 18)

Federal funds received for the purposes of assisting individuals in accessing housing, mental health services, substance abuse treatment, disability benefits and other services to stabilize them and facilitate recovery

Roads to Community Living Grant (Non-Medicaid R&E Line 19)

Federal funds received for the purposes of helping people with complex, long-term care needs move back into the community.

Other Federal Grants from BHA (Non-Medicaid R&E Lines 20-26)

Federal funds received from BHA other than block grant. Describe and Identify.

Other Revenues (Non-Medicaid R&E Lines 27)

State Hospital Reimbursement (Non-Medicaid R&E Line 28)

Funds received for underutilizing of inpatient beds at the state hospitals.

Offender Re-Entry Community Safety Program (ORCSP) (Non-Medicaid R&E Line 29)

Funds received to plan and deliver support and treatment services for identified offenders releasing from prison.

Other State Grants – Describe Source (Non-Medicaid R&E Lines 30-32)

Funds received from the State for other contracted services. There may be a case where revenue is received from sources not listed above. BHOs must include a description of the nature and source of this revenue in reports submitted.

Revenues from Local (Non-Medicaid R&E Line 33)

Millage (Non-Medicaid R&E Line 34)

Local match funds collected by DSHS from the counties for the coordination and provision of community services for persons with developmental disabilities or mental health services. These funds are collected from the county governing authority are levied annually with a tax in a sum equal to the amount which would be raised by a levy of two and one-half cents per thousand dollars of assessed value against the taxable property in the county. All or part of the funds collected from the tax may be transferred to the state of Washington, department of social and health services, for the purpose of obtaining federal matching funds to provide and coordinate community services for persons with developmental disabilities and mental health services.

1/10 Sales Tax (Non-Medicaid R&E Line 35)

Funds received from county legislative authorities as a levy of 1/10 of 1 percent sales tax. Dedicated to new and expanded therapeutic courts for dependency proceedings, and new and expanded mental health and chemical dependency treatment services.

E&T (Non-Medicaid R&E Line 36)

Funds received from local source for operation of Evaluation and Treatment Center for Non-Medicaid clients. Do not report funds received from third-party source (e.g. other BHOs, insurance companies) as Medicaid or Non-Medicaid Revenue.

Intergovernmental (Non-Medicaid R&E Line 37)

Revenue received pursuant to a contract or agreement with another governmental entity, where the revenue is derived from the BHO performing services. This account does not include funding from BHO contracts.

Interest (Non-Medicaid R&E Line 38)

Revenue received from interest earned on BHO funds retained in the County or BHO and invested. Interest can be recorded in a locally designated sub element.

Other (Revenues from Local) – Describe Source (Non-Medicaid R&E Lines 38-40)

There may be a case where local revenue is received from sources not listed above. BHOs must include a description of the nature and source of this revenue in reports submitted.

Return of Prior State Fiscal Year Proviso Dollars (Non-Medicaid R&E Lines 41-44)

Funds designated by the legislature for a specific purpose from a prior fiscal year (held in Reserve for Encumbrances) that are returned to DBHR due to program under-spending should be accounted for as follows:

- Reduce Revenue
- Report under row labeled “Return of Prior State Fiscal Year Proviso Dollars” (row 41 on Non-Medicaid R&E).
- Report in the State column.
- Break-out the proviso funding being returned in the row provided.
    - Row 42 for Jail Service funding
    - Row 43 for PACT funding
    - Row 44 for ITA 180-day Commitment Hearings

PART III: EXPENDITURES

Reportable expenditures should only include costs associated with the revenues reported above.

MENTAL HEALTH -Expenditure Chart of Accounts & Definitions

564.40 Outpatient Service Costs (Medicaid R&E Line 15; Non-Medicaid R&E Line 45)

Costs for services to eligible clients provided on an outpatient basis consistent with WAC 388-865-0230, WAC 388-865-0400 through 0445, and WAC 388-865-0456 through 0462. Activities include assessment, diagnosis, treatment, prescreening and other services.

564.41 Crisis Services (Medicaid R&E Line 16; Non-Medicaid R&E Line 46)

Costs associated with providing evaluation and treatment of behavioral health crisis to individuals experiencing a crisis. A behavioral health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health or chemical dependency professional.

564.42 Freestanding Evaluation and Treatment Services (Medicaid R&E Line 17; Non-Medicaid R&E Line 47)

Costs associate with treatments provided in freestanding inpatient residential (non-hospital) facilities licensed by the Department of Health (DOH) and certified by DBHR to provide medically necessary evaluation and treatment to the individual who would otherwise meet hospital admission criteria. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to; performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented. This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self - due to the onset or exacerbation of a psychiatric disorder. The severity of symptoms, intensity of treatment needs or lack of

necessary supports for the individual does not allow them to be managed at a lesser level of care. *This service does not include cost for room and board.* Do not report costs related to receipt of third-party revenue (e.g., other BHOs, insurance companies) as Medicaid or Non-Medicaid costs.

564.43 Mental Health Residential Treatment (Medicaid R&E Line 18; Non-Medicaid R&E Line 48)

Costs of a specialized form of rehabilitation service (non-hospital/non IMD) that offers a sub-acute psychiatric management environment for mental health services provided in residential setting. Individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, single residency occupancy (SRO) apartments) for extended hours to provide direct mental health care to an individual. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. *The costs reported should not include the costs for room and board, custodial care, and medical services.*

564.44 Other State Plan Outpatient Treatments (Medicaid R&E Line 19; Non-Medicaid R&E Line 49)

Costs associated with providing the following treatment modalities: Brief Intervention Treatment, Day Support, Family Treatment, Group Treatment, High Intensity Treatment, Individual Treatment, Intake Evaluation, Medication Management, Medication Monitoring, Peer Support, Psychological Assessment, Rehabilitation Case Management, Special Population Evaluation, Stabilization Services, and Therapeutic Psychoeducation. For definitions of these treatment modalities, please consult the approved state plan.

564.46 Mental Health Court (Non-Medicaid R&E Line 50)

Costs associated with Mental Health courts that divert offenders with mental health issues from incarceration to community-based treatment. These courts utilize mental health assessments, individualized treatment plans, and judicial monitoring to address the mental health needs of offenders and public safety concerns.

564.XX Other Outpatient Treatment (Non-Medicaid R&E Line 51)

564.XX Other Outpatient Treatment- (Non-Medicaid R&E Lines 52)

Costs associated with Outpatient services that do not fit into the above categories. BHO must identify and describe service.

564.XX Roads to Community Living Grant (Non-Medicaid R&E Line 53)

Costs associated with the. Roads to Community Living Project. This project is designed to help people with complex, long-term care needs move back into the community.

564.45 Support Services (Non-Medicaid R&E Line 54)

564.45 Supported Employment (Non-Medicaid R&E Line 55)

Costs for individuals with behavioral health issues, who desire to be employed that access an approach to vocational rehabilitation known as Supported Employment. This evidence-based practice adopted by SAMHSA assists individuals to obtain competitive work in the community and provides the supports necessary to ensure their success in the workplace.

Supported employment is a service for enrollees who are not currently receiving federally funded vocational services such as those provided through the Division of Vocational Rehabilitation. Services will include:

- An assessment of work history, skills, training, education, and personal career goals.
- Information about how employment will affect income and benefits the consumer is receiving because of their disability.
- Preparation skills such as resume development and interview skills.
- Involvement with consumers served in creating and revising individualized job and career development plans that include;
- Consumer strengths
- Consumer abilities
- Consumer preferences
- Consumer's desired outcomes
- Assistance in locating employment opportunities that is consistent with the consumer's strengths abilities, preferences, and desired outcomes.
- Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required.

564.45 Clubhouse (Non-Medicaid R&E Line 56)

Costs associated with Mental Health Clubhouse. A service specifically contracted to provide a consumer directed program to Medicaid enrollees. These services provided at a clubhouse may be in the form of support groups, related meetings, consumer training, peer support, etc. Consumers may drop in on a daily basis and participate, as they are able. Clubhouses must use the International Center for Clubhouse Development (ICCD) standards as guidelines. Mental health Clubhouse must operate at least ten hours a week after 5:30 p.m., Monday through Friday, or anytime on Saturday or Sunday. Services include the following:

- Opportunities to work within the clubhouse, which contributes to the operation and enhancement of the clubhouse community.
- Opportunities to participate in administration, public relations, advocacy and evaluation of clubhouse effectiveness.
- Assistance with employment opportunities; housing, transportation, education and benefits planning.
- Opportunities for socialization activities.
- Mental Health Clubhouses are not an alternative for day support services.

564.45 Respite Care (Non-Medicaid R&E Line 57)

Costs to provide Respite Care. A service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual consumer by someone other than the primary care givers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the consumer or caregiver's home, in an organization's facilities, in the respite worker's home etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of, a mental health professional.

564.20 Direct Service Costs (Excludes Outpatient) (Medicaid R&E Line 20; Non-Medicaid R&E Line 58)

Costs paid by the BHOs for services and related activities provided to or for BHO service recipients that address mental health or psychiatric needs, and where appropriate, activities that assist the service recipient with social supports, friends and recreation, daily living, personal safety, cultural needs, housing, finances, education, employment, legal assistance or referral, physical health, case management, or alcohol and/or other drug problems.

564.22 Residential (Non-Medicaid R&E Line 59)

Costs for placement at residential facilities and any non-facility residential support costs consistent with WAC 388-865-0235. It should not include the treatment costs reported in the Outpatient Services. Examples of costs that should be reported here are room & board costs paid by BHOs and treatment costs at Institute of Mental Disease (IMD) facilities. These costs emphasize least restrictive, stable, appropriate care consistent with WAC 388-865-0235.

564.24 Evaluation & Treatment (E&T) (Non-Medicaid R&E Line 60)

Costs associated with the operation of Evaluation and Treatment Centers.

564.24 Inpatient Treatment (Medicaid R&E Line 21; Non-Medicaid R&E Line 61)

Costs for a direct treatment modality in which the client is under the auspices of a hospital or E&T facility (excluding the freestanding E&T), 24 hours a day for evaluation, diagnostic, and therapeutic purposes. Inpatient services are provided in a psychiatric

hospital or a psychiatric ward of a general hospital or E&T facility. The treatment must include overnight care, but the client may spend time outside the hospital as part of the therapeutic process. Do not report costs related to receipt of third-party revenue (e.g. other BHOs, insurance companies) as Medicaid or Non-Medicaid costs.

564.25 ITA Commitment Services (Non-Medicaid R&E Line 62)

Costs related to involuntary commitments (WAC 388-865-0452 through 0454, 71.05 RCW and 71.35 RCW) including County Designated Mental Health Professional (CDMHP) costs.

564.26 ITA Judicial, Administrative & 180 Day Commitment Hearings (Non-Medicaid R&E Lines 63-64)

Judicial costs related to involuntary treatment hearings including required expert witness costs. (WAC 388-865-245)

564.28 Medicaid Personal Care (Non-Medicaid R&E Line 65)

Funds provided to the Aging and Disability Services Administration for general fund cost of Medicaid Personal Care used by the BHOs for consumers who are disabled (as per the Comprehensive Assessment) due solely to psychiatric disability when the payment was authorized by the BHOs.

564.29 State Hospital Reimbursements WSH/ESH (Non-Medicaid R&E Line 66)

Costs associated with utilization of state hospital's beds over the allotted beds (over censes).

564.27 Other Direct Service Costs (Medicaid R&E Line 22; Non-Medicaid R&E Line 67)

564.27 Other Direct Costs (Medicaid R&E Lines 23 & 24; Non-Medicaid R&E Lines 68-69)

Costs that do not fit any other Direct Costs category above. Describe and identify service. Explanations must be given in reports submitted.

564.50 Direct Service Costs (Program/Pilot) (Medicaid R&E Line 25; Non-Medicaid R&E Line 70)

564.51 Jail Services (Non-Medicaid R&E Line 71)

Costs to provide mental health services for mentally ill offenders while confined in a county or city jail. These services are intended to facilitate access to programs that offer mental health service upon mentally ill offenders' release from confinement. This includes efforts to expedite applications for new or re-instated Medicaid benefits.

564.52 Expanded Community Services (Non-Medicaid R&E Line 72)

Costs to provide community residential and support services for persons whose treatment needs constitute substantial barriers to community placement and who no longer require active psychiatric treatment at an inpatient hospital level of care, no longer

met the criteria for inpatient involuntary commitment, and who are clinically ready for discharge from a state psychiatric hospital.

564.53 Program for Assertive Community Treatment (PACT) (Medicaid R&E Line 26; Non-Medicaid R&E Line 73)

Costs related to development and initial operation of high-intensity programs for active community treatment (PACT) teams as described in the budget proviso. The Program for Assertive Community Treatment is an evidence-based practice for people with the most sever and persistent mental illnesses, with active symptoms and impairments, and who have not benefited from traditional outpatient programs. PACT serves people with severe and persistent mental illness who also experience significant difficulties with daily living activities. Traditional mental health services have not been adequate to address needs. This consumer group is often homeless, incarcerated, and misunderstood as resisting or avoiding treatment.

564.54 Wraparound Intensive Services (WISe) (Medicaid R&E Line 27; Non-Medicaid R&E Line 74)

Costs related to Wraparound with Intensive Services "WISe", a program model that includes a range of service components that are individualized, intensive, coordinated, comprehensive and culturally competent and provided in the home and community. WISe is for children, youth, and young adults up to age twenty one (21).

564.54 Evidence Based Wraparound (EBP) (Non-Medicaid R&E Line 75)

Costs associated with approaches that develop and coordinate care plans that build on the strengths of the child, youth, and family.

564.57 Offender Re-Entry Community Safety Program (ORCSP) (Non-Medicaid R&E Line 76)

Costs associated with providing services under the ORCSP contract used to plan and deliver support and treatment services for identified offenders releasing from prison.

564.58 Project for Assistance in Transition for Homeless (PATH) (Non-Medicaid R&E Line 77)

Costs associated with providing services under the PATH contract.

564.59 Mental Health Block Grant (MHBG) & (Non-Medicaid R&E Line 78)

Total costs associated with providing services under the Mental Health Block Grant.

564.xx Housing & Recovery through Peer Services (HARPS) (Non-Medicaid R&E Line 79)

Expenditures used for the purposes of offering meaningful choice and control of housing and support services, utilizing Peer Housing Specialists, reducing homelessness and supporting the recovery and resiliency of individuals with serious mental illness.

564.54 Other Federal Grant Expenditures (Non-Medicaid R&E Line 80-82)

Federal Costs that do not fit any other Direct Costs category above. Describe and identify service. Explanations must be given in reports submitted.

SUBSTANCE USE DISORDER - Expenditure Chart of Accounts & Definitions

566.30 Community Engagement and Referral Services (Medicaid R&E Line 30; Non-Medicaid R&E Line 83)

566.30 BHO Community Engagement and Referral Services Capitation/Case Rate (Non-Medicaid R&E Line 84)

Costs associated with community engagement and referral services that are paid using a case rate or a capitated payment method.

566.31 Engagement and Referral (Non-Medicaid R&E Line 85)

Engagement and referral services are used to identify hard-to-reach individuals with possible substance use disorder and to engage these individuals in an assessment and ongoing treatment services as deemed necessary. Costs can be reimbursed for activities associated with providing information on substance use disorders, the impact of substance use disorders on families, treatment of substance use disorders, and treatment resources that may be available as well as re-engaging individuals in the treatment process. This does not include ongoing therapeutic or rehabilitative services.

566.32 Alcohol/Drug Information School (Non-Medicaid R&E Line 86)

Costs incurred for Alcohol/Drug Information schools to provide information regarding the use and abuse of alcohol/drugs in a structured educational setting. Alcohol/Drug Information Schools must meet the certification standards in WAC 388-877B. (The service as described satisfies the level of intensity in ASAM Level 0.5)

566.33 Opiate Dependency Outreach (Non-Medicaid R&E Line 87)

Costs incurred with outreach and referral services to special populations such as opiate dependent or injecting drug users (IDU) individuals. Opiate Dependency Outreach is specifically designed to encourage injecting drug users (IDUs) and other high-risk groups such as opiate dependent individuals to undergo treatment.. Costs include providing information and skills training to non-injecting, drug using sex partners of IDUs and other high-risk groups such as street youths. Programs may employ street outreach activities, as well as more formal education and risk-reduction counseling. Referral services include referral to assessment, treatment, interim services, and other appropriate support services. Costs do not include ongoing therapeutic or rehabilitative services.

566.36 Interim Services (Non-Medicaid R&E Line 88)

Services to individuals who have been denied admissions to a treatment program on the basis of the lack of the capacity to reduce the adverse health effects of substance abuse, promote the health of the individual, and reduce the risk of transmission of disease. Such services are provided until the individual is admitted to a treatment program. Services include referral for prenatal care for a pregnant patient, brief screening activities, the development of a service plan, individual or group contacts to

assist the person either directly or by way of referral in meeting his/her basic needs, updates to advise him/her of treatment availability, and information to prepare him/her for treatment, counseling, education, and referral regarding HIV and tuberculosis (TB) education, if necessary referral to treatment for HIV and TB.

566.37 Community Outreach (Non-Medicaid R&E Line 89)

Outreach is an activity of providing critical information and referral regarding behavioral health services to people who might not otherwise have access to that information. This may include assisting individuals to navigate through different systems including health care enrollment, scheduling appointments for a substance use disorder assessment and ongoing treatment, or providing transportation to appointments. Outreach tasks may include educating communities, family members, significant others, or partners about services and to support access to services where care coordination may be necessary. Costs to be covered may also include responding to requests for information to be presented both in and out of the treatment facility by individuals, the general public and community organizations.

566.39 Brief Intervention (Medicaid R&E Line 31; Non-Medicaid R&E Line 90)

A time limited, structured behavioral intervention using substance use disorder brief intervention techniques, such as evidence-based motivational interviewing techniques, and referral to treatment services when indicated. Services may be provided at, but not limited to, sites exterior to treatment facilities such as hospitals, medical clinics, schools or other non-traditional settings.

566.40 Triage Services (excludes hospital level of care) (Medicaid R&E Line 32; Non-Medicaid R&E Line 91)

566.41 Crisis Stabilization (Non-Medicaid R&E Line 92)

Services provided on a very short term basis to intoxicated or incapacitated individuals on the streets or in other public places and may include general assessment of the patient's condition, an interview for diagnostic or therapeutic purposes, and transportation home or to an approved treatment facility. Services may be provided by telephone or in person, in a facility or in the field, and may or may not lead to ongoing treatment. This does not include the costs of ongoing therapeutic services.

566.42 Acute Withdrawal Management (Detoxification) (Medicaid R&E Line 33; Non-Medicaid R&E Line 93)

Withdrawal Management services provided to an individual to assist in the process of withdrawal from psychoactive substance in a safe and effective manner. Acute withdrawal management provides medical care and physician supervision for withdrawal from alcohol or other drugs. (Limited to 3-5 days for Medicaid State Plan Services)

566.43 Sobering Services (Non-Medicaid R&E Line 94)

Costs incurred to provide shelter services for short-term (12 hours or less) emergency shelter, screening, and referral services to persons who need to recover from the effects of alcohol. Services include medical screening, observation and referral to continued treatment and other services as appropriate.

566.44 Involuntary Commitment (Non-Medicaid R&E Line 95)

Costs incurred for services employed to identify and evaluate alcohol and drug involved individuals requiring protective custody, detention, or involuntary commitment services in accordance with RCW 70.96A.120-140. Costs include case finding, investigation activities, assessment activities, and legal proceedings associated with these cases.

566.45 Sub-Acute Withdrawal Management (Detoxification) (Medicaid R&E Line 34; Non-Medicaid R&E Line 96)

Costs incurred for withdrawal management services provided to an individual to assist in the process of withdrawal from psychoactive substance (includes alcohol) in a safe and effective manner. Sub-Acute is nonmedical withdrawal management or patient self-administration of withdrawal medications ordered by a physician, provided in a home-like environment. (Limited to 3-5 days for Medicaid State Plan Services)

566.50 Outpatient Treatment Services (Medicaid R&E Line 35; Non-Medicaid R&E Line 97)

566.50 BHO Outpatient Treatment Services Capitation/Case Rate (Medicaid R&E Line 36; Non-Medicaid R&E Line 98)

Costs associated with outpatient treatment services that are paid using a case rate or a capitated payment method.

566.51 Outpatient Treatment - Group and Individual (Medicaid R&E Line 37; Non-Medicaid R&E Line 99)

Services provided in a non-residential substance use disorder treatment facility including assessment and case management. Outpatient treatment services must meet the criteria in the specific modality provisions set forth in WAC 388-877B. Services are specific to client populations and broken out between group and individual therapy. (The service as described satisfies the level of intensity in ASAM Level 1)

566.59 Opiate Substitution Treatment (Medicaid R&E Line 38; Non-Medicaid R&E Line 100)

Costs incurred to provide assessment and treatment services to opiate dependent patients. Services include prescribing and dispensing of an approved medication, as specified in 212 CFR Part 291, for opiate substitution services in accordance with WAC 388-877B. Both detoxification and maintenance are included, as well as physical exams, clinical evaluations, individual or group therapy for the primary patient and their family or significant others. Additional services include guidance counseling, family planning and educational and vocational information. (The service as described satisfies the level of intensity in ASAM Level 1)

566.64 Case Management (Medicaid R&E Line 39; Non-Medicaid R&E Line 101)

Case management services are services provided by a Chemical Dependency Professional (CDP), CDP Trainee, or person under the clinical supervision of a CDP who will assist clients in gaining access to needed medical, social, education, and other services. Does not include direct treatment services in this sub element. This covers costs associated with case planning, case consultation and referral services, and other

support services for the purpose of engaging and retaining clients in treatment or maintaining clients in treatment. This does not include treatment planning activities required in WAC 388-887B.

566.60 Support Services (Non-Medicaid R&E Line 102)

566.60 BHO Support Services Capitation/Case Rate (Non-Medicaid R&E Line 103)

Costs associated with support services that are paid using a case rate or a capitated payment method.

566.61 Therapeutic Interventions for Children (Non-Medicaid R&E Line 104)

Cost incurred to provide services promoting the health and welfare of children accompanying parents who participate in the residential substance abuse program. Services include: developmental assessment using recognized, standardized instruments; play therapy; behavioral modification; individual counseling; self-esteem building; and family intervention to modify parenting behavior and/or the child's environment to eliminate/prevent the child's dysfunctional behavior.

566.67 Childcare Services (Non-Medicaid R&E Line 105)

Costs incurred to provide childcare services, when needed, to children of parents in treatment in order to complete the parent's plan for substance use disorder treatment services. Childcare services must be provided by licensed childcare providers or by providers operating in accordance with the provisions set forth in WAC's published by the Department of Health and Department of Early Learning for the provision of childcare services.

566.69 Pregnant, Post-Partum, Or Parenting (PPW) Women's Housing Support Services (Non-Medicaid R&E Line 106)

Costs incurred for support services to PPW in a transitional residential housing program designed exclusively for such clients. Costs include facilitating contacts and appointments for community resources for medical care, financial assistance, social services, vocational, childcare needs, outpatient treatment services, and permanent housing services. This includes services to family or significant others of a person currently in transitional housing.

566.80 Residential Treatment (Medicaid R&E Line 40; Non-Medicaid R&E Line 107)

566.80 BHO Residential Treatment Capitation/Case Rate (Non-Medicaid R&E Line 108)

Costs associated with residential treatment that are paid using a case rate or a capitated payment method.

566.81 Intensive Inpatient Residential Treatment Services (Medicaid R&E Line 41; Non-Medicaid R&E Line 109)

Costs incurred for a concentrated program of substance use disorder treatment, individual and group counseling, education, and related activities for alcoholics and addicts excluding room and board in a twenty-four-hour-a-day supervised facility in accordance with WAC 388-887B. (The service as described satisfies the level of intensity in ASAM Level 3.5)

566.82 Long-Term Care Residential Treatment Services (Medicaid R&E Line 42; Non-Medicaid R&E Line 110)

Costs incurred for the care and treatment of chronically impaired alcoholics and addicts with impaired self-maintenance capabilities including personal care services and a concentrated program of substance use disorder treatment, individual and group counseling, education, vocational guidance counseling and related activities for alcoholics and addicts excluding room and board in a twenty-four-hour-a-day supervised facility accordance with WAC 388-877B. (The service as described satisfies the level of intensity in ASAM Level 3.3)

566.83 Recovery House Residential Treatment Services (Medicaid R&E Line 43; Non-Medicaid R&E Line 111)

Costs incurred for a program of care and treatment with social, vocational, and recreational activities designed to aid alcoholics and addicts in the adjustment to abstinence and to aid in job training, reentry to employment, or other types of community activities, excluding room and board in a twenty-four-hour-a-day supervised facility accordance with WAC 388-877B. (The service as described satisfies the level of intensity in ASAM Level 3.1)

566.XX Other Services (Medicaid R&E Line 44-46; Non-Medicaid R&E Line 112)

566.XX Substance Abuse Block Grant (SABG) (Non-Medicaid R&E Line 113)

Total costs associated with providing services under the Substance Abuse Block Grant.

566.91 Family Hardship (Non-Medicaid R&E Line 114)

The provision of transportation and lodging for family members traveling from their home to the treatment facility for distances over 50 miles within Washington State in support of Medicaid funded youth who are receiving services in a Residential facility in order to allow them to participate in treatment with the youth.

566.92 Recovery Support Services (Non-Medicaid R&E Line 115)

A broad range of nonclinical services that are designed to assist individual and families to become stable and maintain long term recovery from substance abuse, delivered through a variety of community and faith-based groups, treatment providers, schools, and other specialized services. Services can be provided by a single entity or a consortium of health and human service providers.

566.93 Room and Board (Non-Medicaid R&E Line 116)

For services in a 24-hour-a-day setting this is the provision of accessible, clean and well-maintained sleeping quarters with sufficient space, light and comfortable furnishings for sleeping and personal activities along with nutritionally adequate meals provided three times a day at regular intervals. Medicaid and Non-Medicaid patients should be recorded. Room and Board must be provided consistent with the requirements for Residential Treatment Facility Licensing through the Department of Health WAC 246-337.

566.94 State Drug Court (Non-Medicaid R&E Line 117)

Costs incurred to provide alcohol and drug treatment service to offenders who are under the supervision of a drug court.

566.95 Juvenile Drug Court (Non-Medicaid R&E Line 118)

Costs incurred to provide alcohol and drug treatment service to juvenile offenders who are under the supervision of a juvenile drug court.

566.99 Other Miscellaneous Services (Non-Medicaid R&E Line 119)

566.99 Miscellaneous (Non-Medicaid R&E Line 120-122)

This is to be used only with costs incurred for special projects and activities that cannot correspond to any other service category. The entry of any costs in this activity must have agreement of the DBHR Behavioral Health Administrator.

BHO INTEGRATION - Expenditure Chart of Accounts & Definitions

564.30 Direct Service Support Costs (BHO only, exclude provider) (Medicaid R&E Line 48; Non-Medicaid R&E Line 124)

BHO level only costs incurred in the process of providing services and activities for clients. Direct services support costs do not include costs for services directly provided to clients.

564.31 Utilization Management and Quality Assurance (Medicaid R&E Line 49; Non-Medicaid R&E Line 125)

Costs for activities designed to ensure that adequate quality care is provided to eligible clients. Activities include development of placement criteria, conducting utilization management activities, an independent quality review team function, and other quality assurance functions.

564.32 Information Services (Medicaid R&E Line 50; Non-Medicaid R&E Line 126)

Costs incurred for the maintenance of a patient tracking system for service recipients, per RCW 71.24.035, and all other information services development and reporting functions. Includes Information Services (Technical) staff, computer equipment, data lines, and other costs associated with an information services system.

564.33 Public Education (Medicaid R&E Line 51; Non-Medicaid R&E Line 127)

Costs for consultation, education and public information activities related to primary populations or agency services. *Examples* include individual case planning and consultation for clients of other human service organizations; enhancing understanding of chronic mental illness and serious mental disturbances through the media, providing workshops and other training to develop skills of ancillary providers in dealing with mental disorders and populations, and disseminating information and material about mental health services.

564.35 Crisis Telephone (Dedicated Hotline) (Medicaid R&E Line 52; Non-Medicaid R&E Line 128)

Costs associated with telephone services provided by trained personnel supervised by mental health professionals which includes triage, referral, and telephone based support to individuals experiencing a mental health crisis.

564.36 Transportation (BHO) (Medicaid R&E Line 53; Non-Medicaid R&E Line 129)

Costs associated with providing transportation to clients to and from covered BHO medical services.

564.37 Interpreter Services (Medicaid R&E Line 54; Non-Medicaid R&E Line 130)

Costs associated with providing interpreter services to a client who is deaf, deaf-blind, hard of hearing or limited English proficient during a necessary service performed by a BHO provider.

564.38 Ombudsman (Medicaid R&E Line 55; Non-Medicaid R&E Line 128)

Costs to provide an independent ombuds service consistent with WAC 388-865-0250.

564.34 Other Direct Service Support Costs (Medicaid R&E Line 56; Non-Medicaid R&E Line 132)

564.34 Other Direct Services Support Costs (Medicaid R&E Lines 57-58; Non-Medicaid R&E Lines 132-134)

Costs that do not fit any other Direct Services Support Costs category above. Describe and identify service. Explanations must be given in reports submitted to DBHR.

564/566.10 ADMINISTRATIVE COSTS

Costs for the general operation of the BHO system. These activities cannot be identified with a specific direct or direct services support function.

564/566.11 BHO Administration (Medicaid R&E Line 61; Non-Medicaid R&E Line 137)

Costs of operating contract monitoring, accounting, general clerical support, legal, facility and similar operating the BHO. Activities include planning, coordination, contracting, fiscal and costs. Also includes allowable costs of services provided by those activities normally identified with central county government that have been allocated to the BHO using an established methodology consistent with the approved cost allocation plan. Direct Care Staff should be charged to the appropriate direct service costs. Treatment Program Supervisors should be charge to the appropriate direct service costs. Management Information System Staff (costs associated with managing patient data system) should be charged to Information Services (Direct Service Support Cost).

566.13 Jail Service Administration (Non-Medicaid R&E Line 138)

Administrative costs for Jail Services.

566.13 PACT Administration (Non-Medicaid R&E Line 139)

Administrative costs for PACT.

564.13 Other Administrative Costs (Medicaid R&E Lines 62-64; Non-Medicaid R&E Line 140-141)

Costs that do not fit in the categories above. BHO's cost of acquisition for capital assets should be reported as a one-time, other cost at the time of payment.

564.34 Capital Projects Expenditures/Acquisitions (Non-Medicaid R&E Lines 142-144)

Include only those costs related to capital projects expenditures and acquisitions.

PART IV: RESERVES AND FUND BALANCES

Reserves and Fund Balances information presented in this document refers to the type of fund balances to be reported by BHOs to DBHR on a quarterly basis. BHOs should report their current fund balances at the final date of the reporting period to DBHR, using the categories listed below. Reserves and fund balances amounts reported are those held at the BHO, not those held by providers. *Note: Reserves and Fund Balances are held at the BHO. These are the balances in the account as of the last date of the reporting period, not just the change from one period to the next.*

Reserves are maintained to ensure sufficient solvency and cash flow to pay for future obligations.

Reserves and Fund Balances to be reported to DBHR include:

Operating Reserve

Funds designated from revenue sources that are set aside into an operating reserve account by official action of the BHO governing body. Operating reserve funds may only be set aside to maintain adequate cash flow for the provision of services.

Capital Reserve

Funds designated from revenue sources that are set aside into a capital reserve account by official action of the BHO governing body. Capital reserve funds may only be set aside for the construction, purchase or remodel of a building or major asset.

Risk & Inpatient Reserve

The Risk Reserve is established to cover claims and liabilities if premium revenue is less than incurred expenses and, as such, is essentially a solvency reserve for the program.

For non-Medicaid reserves, the risk reserve is limited to Crisis, Inpatient and Involuntary Treatment Act (ITA) service costs as BHOs are required to pay for these services even if costs exceed funding levels in a particular year.

Funds mandated to be designated from premium payment (capitation payment) revenue sources that are set aside into a risk reserve account by official action of the BHO governing body. Risk reserve funds may only be set aside for use in the event costs of providing Medicaid services exceed the revenue the BHO receives. This includes funds designated from revenue sources to pay for future inpatient hospital claims.

Reserve for Encumbrances

Funds designated from revenue resources that are legally restricted for specific purposes either through official action of the BHO governing body or legal commitments. At year-end, this account represents prior-year appropriation authority carried forward to the next year. Examples are outstanding purchase orders, and fund set aside pending litigation outcome, unspent proviso funds expected to be paid back.

Use encumbrance reserve:

- At year end if prior year appropriation authority is being carried forward to pay for a future service
- For estimated and/or known litigation amounts
- Unspent proviso funds expected to be recovered by the Division of Behavioral Health and Recovery

Do not use encumbrance reserve:

- For services that have been provided and not yet paid for — this is considered an accrual
- For routine contracts — this amount is expected to be paid from current revenue
- For contracts to be paid from future revenues

Acceptable Uses

An encumbrance should be reserved to cover one-time or rare cash expenditures, such as litigation, purchases of real property or purchases of depreciable expenses, such as system upgrades, when cash outlays exceed amounts included as depreciation in the rate-setting process. Funds may also be used to cover new initiatives or services not covered by Medicaid, or to enhance quality or access to care. The following list of acceptable expenditures is not exhaustive, but should be a reasonable indicator of allowable uses for encumbrance reserve funds.

Capitation Shortfalls

Capitation shortfalls are typically due to high utilization or high expenses due to unanticipated rises in pricing or cost. If medical expenses exceed capitation, risk reserve or Inpatient reserve funds due to an unforeseen event, such as an epidemic or steep rises in pricing, encumbrance reserves may be redirected to cover shortfalls in Incurred but Not Reported (IBNR) on an annual basis.

Litigation and Non-Operating Expenditures

Expenses incurred for litigation should be rare or one-time expenditures, and therefore would not be built into the rate-setting process or covered through normal capitation. Non-operating expenses, such as the cost of moving an office or costs to shut down an operation, are also excluded from the rate-setting process, but may be necessary to increase the efficiency or effectiveness of a BHO operation.

Real Property and Depreciable Assets

Buildings, leasehold improvements, equipment, furniture and other capital assets are expenditures necessary for sustaining the BHO, but are only allowed as depreciation in the rate-setting process. Expenditures for real property and depreciable assets should be used for efficient and effective administration of Medicaid through sound business practices. System conversion or development costs intended to maintain or improve the efficiency of the BHO are allowable to the extent they are capitalized. Repairs to existing equipment or capital assets are allowable if they are capitalized and exceed $5,000 or the amount established by the Internal Revenue Service.

New (Start-Up) Initiatives or Closeout Initiatives

While organization costs require prior approval from the State and CMS, outreach programs used to establish new initiatives that improve the quality of care or access to care for Medicaid recipients are allowable to the extent they are not normally expensed as administrative costs. For example, the first and last year that a BHO operates to manage Medicaid recipients, costs may be higher due to start-up or closeout of program activities and staff. The costs that exceed normal operating costs should be excluded from the rate-setting process, and are therefore acceptable as expenditures from encumbrance reserve funds.

Enhanced Services

Excess encumbrances may be used to fund additional services to Medicaid enrollees beyond those covered under the Medicaid contract. These expenditures are not considered in subsequent Medicaid rate periods, which may lead to a natural reduction in the reserve levels over time.

Unreserved Fund Balance

Funds designated from revenue sources that have not been spent in the fiscal period they were received. These funds have not been set aside into a specific reserve account by official action of the BHO governing body, but they may be identified by the BHO for a specific use.

PART V: OTHER INSTRUCTIONS

Cost Allocation Guidelines

Capitation/Cost Reimbursement Method or Combination

Under this method, the BHO will collect their service providers reported expenditures. The expenditures reported may need to be adjusted to match the payments made by the BHO. If service providers report administrative costs, these costs will be re-allocated to direct service costs. See examples below:

Example:

The BHO contracts with a service provider using a capitation or cost reimbursement methodology. The BHO's payments to the service provider totaled $120,000. The service provider reports expenditures in the amount of $105,000.

The BHO will need to increase service provider reported expenditures by $15,000 and re-allocate $5,000 in administrative costs to direct costs. Total amount to be re-allocated is $20,000.

The provider spends $105,000 on Non-Medicaid as follows:

$30,000 for Crisis Services

$10,000 for Freestanding Evaluation and Treatment (E&T)

$10,000 for Residential Treatment

$50,000 for Other State Plan Outpatient Treatment

$100,000

$ 5,000 for administrative costs

$105,000 = Total service provider reported costs.

Step 1: Increase service provider expenditures by $20,000 based upon the percentage of expenditures reported.

Category of Expenditure	**Percent of Total Expenditures**	**Amount of increase ($20,000) apportioned to each expenditure category**
Crisis Services	30,000/100,000 = 30%	$20,000 x .30 = $ 6,000
Freestanding E&T	10,000/100,000 = 10%	$20,000 x .10 = $ 2,000
Residential Treatment	10,000/100,000 = 10%	$20,000 x .10 = $ 2,000
Other Outpatient Treatment	50,000/100,000 = 50%	$20,000 x .50 = $10,000
Total	100%	$20,000

Step 2: Add combined adjustments to service provider reported expenditures.

Category of Expenditure	**Adjusted Expenditures**
Crisis Services	$30,000 + $ 6,000 = $ 36,000
Freestanding E&T	$10,000 + $ 2,000 = $ 12,000
Residential Treatment	$10,000 + $ 2,000 = $ 12,000
Other Outpatient Treatment	$50,000 + $10,000 = $ 60,000
Total	$120,000

Service Provider Costs

If the primary reimbursement method for service providers is fee-for-service, assuming administrative costs are part of the direct service costs, no further allocation of costs is needed.

Fee-For-Service Payment Method Using Service Provider Reported Revenues and Expenditures

BHOs on a fee-for-service payment methodology that do not collect service provider's reported revenues and expenditure reports can pull a detailed expenditure report by internal account code to complete the BHO's R&E report. If

service providers report administrative costs, these costs will be re-allocated to direct service costs.

Note: In some cases, the rate created for the fee-for-service may include an amount to cover administrative costs so there will be no need to reallocate the administrative costs to the direct services

Guideline for reporting Direct Service Costs and Direct Service Support Costs

Direct Care Staff – all costs of direct care staff should be charged to the appropriate direct service costs. (E.g. Residential, E&T, Inpatient Treatment, etc.)

Program Supervisors – all costs of supervisors of a treatment program should be charged to the appropriate direct service costs.

Information Services Staff – See BHO Integration (Non-Medicaid R&E Line 132)

Management – management activities that do not involve direct supervision of treatment services should be charged to BHO Administration.

Administrative staff – staff assigned to support treatment programs should be charged to Other Direct Service Support Costs. See BHO Integration (Non-Medicaid R&E Line 133-134)

Secretarial, general clerical staff, accounting staff, budget staff, contract staff should be reported as BHO Administration Costs.

Professional Services – administrative professional services such as accounting, auditing, and legal should be charged to BHO Administration.

Clinical professional services such as psychiatric, clinical, treatment or program related should be charged to appropriate direct service cost centers.

Insurance – should be allocated based upon the coverage. For example, professional liability insurance should be allocated to appropriate direct service categories such as Residential, E&T or Inpatient.

Guideline for Allocating Non-Personnel Costs

Facility Operations & Maintenance – the costs should be allocated based on square footage. Costs include rent, repair, maintenance, utilities, and janitorial services.

Telephone – the costs should be allocated to appropriate expenditure category based upon usage. If costs cannot be tracked by usage, allocation by FTEs or staff salaries is also acceptable.

Training/Travel – should be allocated based on the purpose of the training/travel.

Equipment – should be allocated by usage.

Vehicle – should be allocated by usage.

Other – costs not specifically addressed above should be allocated by applying a reasonable measure of benefit or usage.

Guideline for allocation of costs between BHO Medicaid and Non-Medicaid expenditure fund sources:

Direct Service Costs - Direct Service Costs should be allocated between Medicaid and Non-Medicaid Expenditure reports based on each category of service hours submitted to DBHR.

Direct Service Costs– some direct support categories can be tracked separately (transportation services, Interpreter Services, Crisis Telephone). If such tracking is not possible, direct service hours may be used to allocate these costs.

Administrative Costs – if these costs can be tracked by activity (may be through time study), please do so. Think about the following activities, which are requirements for serving Medicaid enrollees, when tracking: EQRO, BBA requirement, grievance and fair hearing process, appeal process, notice of action. If these costs cannot be tracked per activity as stated above, then allocate them based on the direct service hours. For all costs that cannot be tracked to an activity with service hours, it is acceptable to use the revenue percentage received from DBHR for Medicaid and Non-Medicaid to allocate all indirect expenses.

THIRD PARTY REVENUE REPORT INSTRUCTIONS

Third Party Revenue report is used to report revenue received from Other Federal Sources, Medicare, insurance companies, and directly from clients for services rendered. This includes revenue collected from Medicare, insurance companies, co-payments, and other sources. The Contractor must certify that a process is in place to demonstrate that all third party revenue resources for services provided under this Agreement are identified, pursued, and recorded by the Subcontractor, in accordance with Medicaid being the payer of last resort.

Third Party Revenue Report (Add comments in notes column)

Row 1. Revenues from Federal Sources

- Heading Row: Federal Funds directly received from sources other than the DBHR that have not been previously reported.

Row 2. Federal Grants

- Include federal grants directly received from sources other than the DBHR.
- Do not include any federal grants reported in the Medicaid or Non-Medicaid report.

Row 3. Other Federal Sources
Row 4. Other Federal Sources
Row 5. Other Federal Sources
Row 6. Revenues from Insurance

- Heading Row: Report funds received from third party insurance.

Row 7. Medicare
Row 8. Insurance Companies

Row 9. Other Payments Received
Row 10. Other Payments Received
Row 11. Revenue from Clients
- Heading Row: Report funds received from clients for sliding scale fees here.

Row 12. Client Payments
Row 13. Other Client Payments
Row 14. Other Client Payments
Row 15. Revenues from Other
Row 16. Revenues from Other
Row 17. Revenues from Other
Row 18. Revenues from Other

FEDERALLY QUALIFIED HEALTH CENTER (FQHC) REPORT INSTRUCTIONS

Enter any funds paid to Federal Qualified Health Center's currently contracted with. Enter funds separately for Mental Health (MH) and Substance Abuse Disorder (SUD) services.

PREGNANT, POST-PARTUM, AND PARENTING (PPW) Expenditures

Enter expenditures for Substance Use Disorder services paid to support PPW services by Medicaid, State-Only, CJTA, Dedicated Marijuana Account (DMA), and SABG. Total expenditures are required for Medicaid, State-only (including CJTA and DMA) to track for the State Maintenance of Effort required by the Substance Abuse Block Grant (SABG). SABG expenditures are necessary to track the 10% set-aside required in the SABG contract for PPW services.

YOUTH EXPENDITURES

Enter expenditures for Substance Use Disorder services paid to support Youth by Medicaid, State-Only, CJTA, Dedicated Marijuana Account (DMA), and SABG. Total expenditures are required for Medicaid, State-only, CJTA and DMA to track for the State I-502 reporting requirements. "Youth" means a person from age ten (10) through age seventeen (17).

CRIMINAL JUSTICE TREATMENT ACCOUNT (CJTA) EXPENDITURES

Enter any expenditures paid to support CJTA Services. Enter total CJTA expenditures including State Drug Court, 30% innovative (as described below), expenditures contracted directly to the court and its corresponding local match dollars.

30% Innovative Expenditures

At a minimum thirty percent (30%) of the CJTA funds for special projects that meet any or all of the following conditions:

- An acknowledged best practice (or treatment strategy) that can be documented in published research.
- An approach utilizing either traditional or best practice approaches to treat significant underserved population(s).
- A regional project conducted in partnership with at least one other entity serving the service area.
- CJTA Special Projects. DSHS retains the right to request progress reports on CJTA special projects.

R&E CERTIFICATION FORM

Complete and submit with R&E report quarterly.

LOCAL MATCH FORM

Complete and submit the Local Match Certification Form quarterly with each R&E.