



PREVENTING UNALLOWABLE COSTS IN HCBS PAYMENT RATES

Division of Long Term Services and Supports
Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services

Training Objectives

- Review the definition of unallowable costs, including federal regulations surrounding unallowable costs in Home and Community-Based Services (HCBS) programs.
- Understand the significance of unallowable costs in HCBS by reviewing findings from the Department of Health and Human Services, Office of Inspector General (HHS-OIG).
- Understand basic concepts of how cost surveys and unallowable costs impact the HCBS Fee-For-Service (FFS) rate setting process.
- Discuss states' challenges in preventing unallowable costs and suggest mitigation strategies.

Preventing Unallowable Costs

- There are multiple places to document unallowable cost prevention methods in 1915(c) waiver application appendices.
 - Appendix I-2-a: Rate Determination Methods
 - States document any unallowable cost prevention methods utilized when provider cost reports or cost surveys are used.
 - Appendix I-5: Exclusion of Medicaid Payments for Room and Board
 - States describe the methodology used to exclude Medicaid payment for room and board in residential settings.
 - Appendix I-6: Payment for Rent and Food Expenses of an Unrelated Live-in Caregiver
 - States document the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver. States also describe the method used to reimburse these costs.

Federal Guidance

- The overarching guidance for rate setting methodology for Medicaid services, including HCBS, is §1902(a)(30)(A) of the Social Security Act.
 - “Payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that those services are available to the general population.”
- 42 CFR 441.303(b) requires that the state Medicaid Agency furnish CMS with sufficient information that includes:
 - “A description of the records and information that will be maintained to support financial accountability.”

Unallowable Costs Background

What are Unallowable Costs?

- Unallowable costs
 - Costs submitted for federal Medicaid reimbursement that do not comply with HCBS waiver program federal requirements.
 - Sometimes inappropriately included in the rate determination process or may fail to be identified in the billing validation process, resulting in unallowable Medicaid reimbursement.
- Common unallowable costs for HCBS waiver programs include but are not limited to:
 - Room and Board Costs
 - Costs unrelated to participant care
 - Third Party Liability (TPL)

Significance of Preventing Unallowable Costs

Summary of HHS-OIG Report

- In October 2016, following multiple audits, HHS-OIG reported that state Medicaid agencies claimed unallowable room-and-board costs and other unallowable and unsupported costs, resulting in at least \$176.5 million in unallowable and unsupported federal Medicaid reimbursement for services under their HCBS waiver programs.
- HHS-OIG summarized eight audits of HCBS waiver programs in four states, and found that:
 - “State agencies lacked adequate controls to ensure that HCBS programs complied with applicable federal requirements regarding the need to exclude unallowable room-and-board costs when determining payment rates.”
- HHS-OIG issued the following recommendations for CMS as a result.
 - “Share the findings with all state agencies to reinforce Medicaid requirements that prohibit the inclusion of unallowable room-and-board costs.”
 - “Encourage state agencies to review their procedures for calculating and claiming costs related to HCBS waiver programs.”

Costs Unrelated to Participant Care

- States may use the [Medicare Provider Reimbursement Manual Chapter 21](#) as a resource for determining costs ineligible for federal reimbursement.
 - The Medicare Provider Reimbursement manual provides multiple examples of costs that are unallowable because they are unrelated to participant care that may also be applicable to HCBS providers, including:
 - **Noncompetition agreement costs** – Amounts paid to the seller of an ongoing facility by the purchaser, including an agreement for the seller not to compete
 - **Provider Payments to Reserve Beds or Services** – An agreement amongst providers to reserve beds or services as part of discharge planning or any other applicable reasons. Note that this is unrelated to state retention payment arrangements with providers.
 - Retention payments allow an individual receiving Medicaid HCBS to retain their spot in a waiver and are only for the cost of service.
 - Retention payment policies may vary from state to state.
 - **Gifts, Donations, Costs of Entertainment, Fines** – All items are unrelated to patient care and are thus considered unallowable.

Costs Unrelated to Participant Care

(Continued)

- Costs unrelated to participant care include but are not limited to:
 - Excessive administrative, program support and/or overhead costs.
 - Services reimbursed under a separate authority, such as institutional service costs and state plan service costs.
 - Employee travel unrelated to participant care, entertainment, fines and/or penalties.
 - Third Party Liability (TPL)
 - Per Social Security Act §1902(a)(25), the state or local agency administering the Medicaid program will take all reasonable measures to “ascertain the legal liability of third parties...to pay for care and services available under the plan.”
 - If another party is responsible for payment of services, the state may not submit a Medicaid claim for the same services.

Room and Board

- Room and Board Costs per Section 1915(c)(1) of the Act:
 - “The Secretary may by waiver provide that a state plan approved under this title may include as “medical assistance” under such plan payment for part or all of the cost of home or community-based services (**other than room and board**) approved by the Secretary which are provided pursuant to a written plan of care...”
- Room and Board* definition per 1915(c) Technical Guide, Page 309:
 - **Room** costs are categorized as shelter and property-related costs such as the rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative expenses.
 - **Board** costs are categorized as three meals a day or any other full nutritional regimen. Board does not include the provision of a meal at an adult day health or similar facility outside the participant’s home.

*Please note: Room and board costs are distinguished from transition services rendered as per State Medicaid Director Letter #02-008.

Room and Board Cost Exceptions

- Per the 1915(c) Technical Guide page 47, exceptions include but are not limited to:
 - **Temporary short-term respite services** as referenced in CFR §441.310(a)(2), *“Room and board may be claimed for temporary short-term respite services that are furnished in settings that are not the participant’s own private residence.”*
 - **Room and board costs for an unrelated caregiver** as referenced in CFR §441.310(a)(2), *“A state may elect to pay the portion of the rent and food that can be attributed to a live-in caregiver who furnishes services to a participant in the participant’s private residence.”*

Allowable HCBS Services with Room and Board-Like Elements

- There are multiple services eligible for federal HCBS Medicaid reimbursement that are similar to or may incorporate room and board-like elements but are **not** considered room and board. Some examples of these services include but are not limited to:
 - Community Transition Services
 - Home Accessibility Adaptations
 - Meal and Chore Services
- The services identified above all include rules that preclude these costs from being identified or reported as room and board.

Community Transition Services

- **Community Transition Services**
 - Non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated congregate living arrangement to a living arrangement in a private residence where the **person** is directly responsible for his or her own living expenses.
 - Allowable expenses are those expenses necessary to enable a person to establish a basic household that do **not** constitute room and board and may include but are not limited to:
 - Security deposits and set up fees that are required to obtain a lease on an apartment or home or utilities or service access including telephone, electricity, etc.
 - Essential household furnishings and moving expenses
 - Necessary home accessibility adaptations

Home Accessibility Adaptations

- **Home Accessibility Adaptations**
 - Physical adaptations to the private residence of the participant or the participant's family, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or enable the participant to function with greater independence in the home.
- **Exclusions**
 - Adaptations or improvements to the home that are of general utility, and are **not** of direct medical or remedial benefit to the participant.
 - Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation.
 - Home accessibility adaptations furnished to adapt living arrangements that are owned or leased by providers of waiver services.

Meals and Chore Services

- **Meals** per 1915(c) Technical Guide page 47:
 - A state may claim federal reimbursement for the costs of meals that are furnished as part of a program of adult day health or a similar activity conducted outside the participant's living arrangement on a partial day basis.
 - A waiver may also cover “meals on wheels” (or similar) services that provide one meal each day to waiver participants who live in their own private residence.
- **Chore Services** per 1915(c) Technical Guide page 289:
 - Services needed to maintain the home in a clean, sanitary and safe environment. This service may include heavy household chores such as home repairs, yard work, and heavy housecleaning.

Unallowable Costs in FFS Rate Setting: Rate Methodology Using Cost Surveys

Overview of HCBS FFS Rate Setting Types

- Cost survey data can be used for various Fee-For-Service (FFS) rates or reimbursement methodologies.
 - Fee Schedule Rate Setting
 - Tiered Rates
 - Bundled Rates
 - Cost Reconciliation
 - Negotiated Market Price
- States document rate methodology in detail in Appendix I-2-a of the 1915(c) waiver application.
 - *Note:* CMS has developed multiple training webinars to discuss rate setting methodologies and CMS expectations for rate setting in HCBS FFS programs. See <https://www.medicaid.gov/medicaid/hcbs/training/index.html> for more information.

What is a Cost Survey?

- A cost survey is a tool used by states in which providers are tasked with reporting the costs involved with rendering waiver services.
- Cost surveys are typically used to:
 - Gauge rate sufficiency by determining whether existing payment rates are sufficient to cover provider costs
 - Establish payment rates
 - Identify unallowable costs
- States should develop a carefully planned process to both identify the provider pool to be surveyed and to administer the cost survey.

HCBS Cost Survey Process

State creates and issues a cost survey to a group of sampled providers.

Providers complete and submit the cost survey back to the state by a set due date.

State validates the data using internally set procedures, then analyzes the information to calculate the rate.

State recalibrates the cost survey process and determines the sample and frequency for future cost surveys.

Cost Surveys

- Cost surveys can directly impact provider reimbursement.
 - *Example 1 (Cost Reconciliation)*: The state establishes a payment arrangement using an interim rate based on projected costs. If actual provider reported costs are lower than projected, the provider may be required to pay back excess funds.
 - *Example 2 (Fee Schedule Methodology)*: The state utilizes prospective rate setting in which cost surveys are used to establish the initial rate for a service or change existing rates.
- Providers may therefore be incentivized to overstate or include unallowable costs in their cost survey submission.

HCBS FFS Cost Survey Process

- Cost surveys must include the following data:
 - Basic provider data (e.g., name, contact information, address, number of individuals served, area served, total revenue and expenditures).
 - Fiscal year for the data reported.
- Cost surveys can also include the following:
 - Cost data grouped by specific theme or category.
 - States outline what costs are considered allowable vs. unallowable
 - Cost categories or groupings dependent on the state's goals and catered to match those goals accordingly.
 - Audited Financial Statement (AFS) from an independent Certified Public Accountant (CPA).

Preventing Unallowable Costs in HCBS FFS Rate Setting

Potential Causes of Unallowable Costs

Overview

- The following are frequent pitfalls/issues states face, which increase the potential for including unallowable costs in the cost survey or rate setting process.
 1. Providers find cost survey guidance unclear.
 2. Cost survey review processes are not adequate to detect problems.

Unclear Cost Survey Guidance

Mitigation Strategies

- Develop robust cost survey instructions.
 - Instructions must clearly define cost categories and unallowable costs.
 - States may specify cost categories during cost survey development to group a set of common expenditures together. For example, states may elect to group all indirect costs together.
 - State should specify what indirect costs are considered unallowable (e.g., room and board, excessive overhead and general costs) and provide clear guidance as to how these costs should be reported.
 - Providers may interpret what is classified as an indirect cost differently. Therefore, states should take precautionary measures to ensure that providers do not unknowingly include unallowable costs in these categories.

Unclear Cost Survey Guidance

Mitigation Strategies (Continued 1)

- Develop robust cost survey instructions (Continued).
 - When creating instructions, reflect the nuance or uniqueness of the provider pool and state. Some considerations include:
 - Whether extended travel to rural areas are billable activities.
 - Under the Fair Labor Standards Act (FLSA), travel time between beneficiary or participant homes qualify as compensable worker time. States should consider variation in travel time amongst the provider pool when developing a cost survey.
 - The classification and allocation of costs when a provider serves multiple populations.
 - Considerations for providers rendering multiple services and/or serving multiple waiver and non-waiver authorities.

Unclear Cost Survey Guidance

Mitigation Strategies (Continued 2)

- Develop robust cost survey instructions (Continued).
 - When creating instructions, capture the nuance or uniqueness of the provider pool and state. Some considerations include (continued):
 - Review current financial reporting or service documentation requirements for the service on which the state is requesting the cost survey data. The state may be asking providers to isolate and/or track activity costs that are normally not tracked. If so, these areas may be more susceptible to errors.
 - For example, the state requests that personal care providers report how much time is spent performing administrative activities such as the documentation of an individual's daily activities or progress. This information is requested to determine how much provider time is spent on indirect administrative activities. If a provider does not normally track activities to this level of specificity, the results should be subject to additional scrutiny.

Unclear Cost Survey Guidance

Mitigation Strategies (Continued 3)

- Develop robust cost survey instructions (Continued).
 - Providers should verify that they have both read and understood the requirements outlined in the cost survey.
 - Include a certification page that requires a chief decision maker (e.g., CEO/CFO/Accounting Manager, etc.) to verify or acknowledge that the submitted cost survey does not contain any unallowable costs.

Unclear Cost Survey Guidance

Mitigation Strategies (Continued 4)

- Specify uniform accounting rules to complete the surveys.
 - States should consider provider's current financial reporting procedures when developing cost survey instructions.
 - Specify the exact accounting methods providers must use.
 - For example, determine whether the providers should employ cash basis vs. accrual basis accounting methods for reporting their financial data. This distinction impacts how and when providers account for revenue and expenses.
 - A provider reporting costs using the accrual method recognizes an annual expenditure paid monthly as a lump sum in the beginning of the year whereas a provider using the cash basis would not. This may result in the state receiving disparate responses for the same cost categories.
 - Require providers to report costs for a specified period.
 - For example, if the state fails to specify the exact reporting period in the cost survey, some providers could report current year data while others might report last year's data. As a result, the state may be unable to compare costs and/or compile the cost data due to providers reporting costs for differing periods.

Unclear Cost Survey Guidance

Case Study Background

- A state wishes to set an interim rate for case management services for Developmentally Disabled (DD) individuals:
 - The state chooses to use a cost survey to collect provider cost data to set the rate.
 - Cost Survey Data requested: 6 month period January – June 2018.
- **Cost Survey Instructions**
 - *“The survey must include costs for providing case management services to Medicaid recipients. Report specifically, salaries of the employees in the agency”*
- **Challenge:**
 - Providers are tasked with reporting costs based on unclear instructions. Providers may report costs in a manner that does not allow for the state to identify Medicaid waiver specific expenses or may unknowingly include unallowable costs.

Unclear Cost Survey Guidance

Case Study Questions

1. What type of information would providers submit for the *salaries and wages* section after receiving an unclear set of instructions from the state?
2. How can the state improve their cost survey instructions?

Unclear Cost Survey Guidance

Case Study Answers

- What happened following the cost survey rate development process?
 - For employee salaries, providers submitted cost surveys that included all employee wages in the agency, including payments for employees who did not perform any services for waiver individuals.
 - Providers' wages and salaries costs were inflated.

Unclear Cost Survey Guidance

Case Study Answers (Continued)

- **How can the state mitigate this challenge?**
 - Include sufficient detail to describe requested cost survey information, such as:
 - Detail the cost category definition and what should be included. See below for a brief example.
- **Cost Survey Instructions:**

Case Management Employee Salaries and Wages – Line 1

“This line captures case managers’ total gross salaries and wages paid and accrued, including bonuses. Include only case manager salaries who render Medicaid waiver services to individuals with a developmental disability (DD). For those case managers who serve individuals both in and outside of the waiver, allocate salaries and wages based on the percentage of time spent working with waiver individuals. For example, if a case manager spends 60% of their time rendering services to waiver individuals and earns an annual salary of \$40,000, report \$24,000 in salaries and wages.”

Inadequate Review Process For Cost Survey Data

Mitigation Strategies

- An outlier is an observation that lies an abnormal distance from other values in a random sample from a population.
 - Outliers occur in the cost survey process when a provider submits abnormally high or low costs for a specific cost item or category.
- Develop a plan to both identify and address outliers found in cost survey data.
 - Outlier data submitted as part of the cost survey may lead to rate increases or decreases that are not feasible or do not align with state expectations.
 - The state may need to evaluate whether outliers are distorting the data and producing unreasonable payment rates.

Inadequate Review Process For Cost Survey Data

Mitigation Strategies (Continued 1)

- Strategies to minimize the impact of cost survey outliers
 - Reach out to providers to request a detailed line item breakdown to verify that there are no errors. Allow an opportunity to correct the errors, if necessary.
 - If the state determines that there were no errors, the state may consider:
 - Adjusting its rate methodology to adapt to the cost data collected.
 - For example, the state initially proposes that program support costs will not account for more than 5% of the final rate. However, the cost data received indicates that program support costs account for a larger portion of costs than initially projected. The state should consider adjusting its methodology to increase or remove the cap for program support costs.
 - Including the cost outlier.
 - Creating hard caps for cost categories most susceptible to outliers.

Inadequate Review Process For Cost Survey Data

Mitigation Strategies (Continued 2)

- Strategies to minimize the impact of cost survey outliers.
 - Consider using median or mean calculations as appropriate to better represent the data captured.
 - Use **median** values when there are outliers.
 - Use **mean** values when the data submitted is close in value.
 - Consider setting maximum reimbursement levels for certain cost categories.
 - States may consider benchmarking their existing rates and/or existing rate methodology with the rates produced by the submitted cost survey data.
 - For example, states may consider whether new cost survey data is producing rates that are significantly higher or lower than what is currently being paid within the state and surrounding areas. If applicable, states may also compare previous cost category data with the new submission. Using this information, the state can establish caps for cost categories to avoid these cost categories disproportionately representing provider costs.

Inadequate Review Process For Cost Survey Data

Mitigation Strategies (Continued 3)

- Thoroughly review the cost survey data to identify potential outliers.
 - Allow time for cost surveys to be thoroughly reviewed prior to inclusion in the rate setting and rate reimbursement process.
 - Establish the standard that cost surveys will be subject to additional follow-up and review.
 - Request audited financial statements to accompany the provider's cost survey submission and use them as a reference when reviewing provider cost submissions.

Inadequate Review Process

Case Study Background

- A state wishes to perform a cost survey in which five similarly sized home health agencies are surveyed.
 - Based on the cost survey, the average program support costs are \$1.5 million, accounting for more than 25 percent of provider costs.
- **Challenges**
 - Program support costs are considered a high risk category as they do not relate to direct care, and its costs are subject to more variation amongst providers. However, unusually high or excessive program support costs can be considered an unallowable costs particularly in instances in which a program support cost assumption is used that does not adequately represent the provider pool. The state must exercise caution in verifying that reported program support costs represent the provider pool and are not overstated.
 - Previously, program support costs represented 10 percent of provider costs, and currently a 10 percent program support assumption is built into current provider payment rates
 - Two of the five cost survey submissions contain outliers. One provider reported program support costs of \$3.5 million representing 40% of the provider's total reported costs and another reported costs of \$500,000 representing 8% of the provider's total reported costs.

Inadequate Review

Case Study Questions

1. How should the state address the two outlier submissions?
2. Should the state consider existing program support costs/assumptions when developing new payment rates?

Provider Name	Program Support Costs
Provider 1	\$3,500,000
Provider 2	\$1,000,000
Provider 3	\$1,350,000
Provider 4	\$1,150,000
Provider 5	\$500,000
Total	\$7,500,000

Inadequate Review Process

Case Study Answers

- **How can the state mitigate this challenge?**
 - Consider using the median program support value, which is less affected by outliers.
 - Reach out to the providers who submitted the outliers and reinforce what should and should not be included in this cost category.
 - Review the outlier cost submissions and proactively seek out potentially unallowable costs.
 - Institute a cap on program support costs, restricting the growth of this cost category in comparison to existing payment rates.

Preventing Unallowable Costs Through HCBS Post-Payment Audit and Billing Validation

Pre-payment Billing Validation

- Per page 256 of the 1915(c) Technical Guide, billing validation refers to “pre-payment and other processes that are designed to ensure that only valid billings are included in the state’s claim for Federal Financial Participation.”
- States should employ edits in Medicaid Management Information Systems (MMIS) to prevent unallowable costs.
 - Identify third party payer coverage (i.e., TPL) when processing claims (e.g., Veterans Affairs, or Medicare A, Medicare D, etc.) for the services rendered.
 - Determine if there are retention payments authorized by the state. If not, identify duplicate claims filed during periods of institutional stays.
 - Ensure that when accounting for claims for retention services, the duplicate claims do not exceed the amount of time allowed for the retention service.

Post-Payment Reviews

- Review claims data on a routine basis to ensure unallowable costs are not part of provider billings.
 - Example 1: Room and board for unrelated caregiver.
 - Review the documentation (i.e., invoices) submitted for payment and ensure room and board only covered the expenses of the unrelated caregiver.
 - Example 2: Any MMIS edits discussed in Billing Validation.
 - Randomly sample claims data and review to ensure the MMIS edits are holding and identifying accurate TPL or institutional stays.
- See the below Financial Accountability presentation link for additional strategies for post-payment reviews.
 - <https://www.medicare.gov/medicaid/hcbs/downloads/hcbs-9-financial-accountability.pdf>

Other Considerations for Mitigation Strategies

- Provider outreach can assist states in identifying errors early in the process and also allow states to identify problems where providers may need more assistance. Provider outreach activities may include:
 - Proactively reaching out to providers to solicit comments, feedback and answer questions. This information can be used to improve the cost survey process over time and assist in avoiding reporting errors.
 - Provide training opportunities to assist providers in completing the cost survey. These trainings can be in-person, via webinars, or may be written and disseminated by mail or email.

Summary: Unallowable Cost Challenges and Mitigation Strategies

1. Cost Survey Instructions

- In the cost survey instructions:
 - ✓ Define cost categories and unallowable costs.
 - ✓ Capture the uniqueness of the provider pool and program.
 - ✓ Verify that providers understand the requirements.
 - ✓ Reflect providers' existing financial reporting procedures.

2. Review of Cost Survey Data

- Allow time to thoroughly review cost surveys.
- Develop a plan to identify and address outliers found in the cost survey.
- Reach out to providers to confirm and/or verify the data submitted.
- Use median or mean calculations as appropriate
- Set max reimbursement levels for certain cost categories.

3. Pre and Post-Payment Review

- Employ MMIS edits that identify TPL, duplicate claims, or claims filed during institutional stays with no retention payment policy in the state.
- Perform routine post-payment reviews to ensure no unallowable costs are part of the provider billings.

Summary

- HHS-OIG identified multiple states' rates and payments that included unallowable costs and resulted in the discovery of overpayments.
- One of the most prevalent issues identified in HCBS FFS rate setting and reimbursement is the inclusion of unallowable costs, including room and board costs.
- States should be diligent in defining cost categories when applicable and should also explicitly identify unallowable costs.
- States can adopt multiple strategies to mitigate unallowable cost risks.
- State approaches to unallowable costs should evolve and states should continue to be flexible.

References

1. HHS-OIG. *State Agencies Claimed Unallowable and Unsupported Medicaid Reimbursements for Services Under the Home and Community-Based Services Waiver Program*. October 2016.
Downloaded from:
<https://oig.hhs.gov/oas/reports/region7/71603212.pdf>
2. Medicare Provider Reimbursement Manual, Chapter 21.
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929.html>
3. US Department of Commerce, National Institute of Standards and Technology, Information Technology Laboratory. Engineering Statistics Handbook. Chapter 7.1.6, “What are outliers in the data?”
Downloaded from:
<https://www.itl.nist.gov/div898/handbook/prc/section1/prc16.htm>

Additional Resources

- Copies of the HCBS Training Series – Webinars presented during SOTA calls are located in below link:

<https://www.medicaid.gov/medicaid/hcbs/training/index.html>

- The 1915(c) Technical Guide is located here:

<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf>

Additional Resources (Continued)

- This session focuses on unallowable costs relating to reimbursement and rate setting.
- Refer to the following Statewide Operation and Technical Assistance (SOTA) presentations for additional information regarding fiscal integrity and rate setting.
 - [Financial Accountability](#)
 - [Ensuring the Integrity of HCBS Payments: Billing Validation Methods](#)
 - [Data Validation \(web only SOTA\)](#)
- For additional information related to unallowable and unsupported costs, refer to the following:
 - US Health and Human Services – Office of Inspector General (HHS-OIG) Report from October 2016:
 - [State Agencies Claimed Unallowable and Unsupported Medicaid Reimbursements for Services Under the Home and Community-Based Services Waiver Program](#)
 - [Optional Appendix I and J Checklist](#)

Questions & Answers

For Further Information

For questions contact:

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SOTA Feedback Survey

- Please go to the following survey in the link and give us your feedback on this SOTA:
 - <https://www.research.net/r/UnallowableCosts>