Substance Use Disorder Cost Report Manual

Substance Use Disorder Program, Policy, and Fiscal Division

Fiscal Management and Accountability Section

September 2017

Table of Contents

Page No.

Chapter 1. Introduction

This manual provides counties and their contracted Drug Medi-Cal providers with the general guidelines and requirements for completing the Substance Use Disorder (SUD) cost report.

1.1 Definitions and Key Terms

a. 'BHS' means Behavioral Health Subaccount.
b. 'CCR' means the California Code of Regulations.
c. 'CFR' means the Code of Federal Regulations.
d. 'CMS' means the Centers for Medicare and Medicaid Services.
e. 'Cost center' means a department or other unit within an organization to which costs may be charged for accounting purposes.
f. 'CPE' means Certified Public Expenditure.
g. 'DHCS' means the California Department of Health Care Services.
h. 'Direct costs' means those that are directly incurred, consumed, expanded and identifiable for the delivery of a specific covered service, objective, or cost center.
i. 'DMC' means Drug Medi-Cal.
j. 'DMC-ODS' means the DMC Organized Delivery System.
k. 'DMC unreimbursable costs' means costs that are not reimbursable or allowable in determining the provider's allowable costs in accordance with the California's Medicaid State Plan, federal and state laws and regulations, including 2 CFR Part 200 Subpart E, CMS non-institutional reimbursement policy, and California Code of Regulations Titles 9 and 22.
l. 'Indirect Costs' means those costs: a) incurred for a common or joint objective benefitting more than one cost center or objective, and b) are not readily identifiable and assignable to the cost center or objectives specifically benefited.
m. 'Indirect cost rate' means a tool for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of the indirect costs to a direct cost base.
n. 'IOT' means intensive outpatient treatment.
o. 'Legal Entity' means an association, corporation, partnership, trust, or individual that has a legal standing and is certified to provide SUD services within the State of California.
p. 'Non-DMC' means any SUD services that are not funded with DMC.
q. 'NTP' means narcotic treatment program.
r. 'ODF' means outpatient drug free.
s. 'Percent of Direct Costs' means a methodology for determining the proportion of indirect costs each program should bear. It is the ratio (expressed as a percentage) of each modality or cost center's direct costs to the total direct costs.
t. 'Private Pay' means funds collected from an individual who self-pays for services (no public funds or private insurance).
u. 'SAMHSA' means the federal Substance Abuse and Mental Health Services Administration.

v. ‘SAPT’ means the Substance Abuse Prevention and Treatment block grant.
w. ‘Share of Cost’ means the monthly amount Medi-Cal requires a beneficiary to pay (or incur an obligation to pay) for services before Medi-Cal begins to pay.
x. ‘SUD’ means substance use disorder.
y. ‘SUDCRS’ means the Substance Use Disorder Cost Report System.
z. ‘USDR’ means uniform statewide daily reimbursement.

1.2 Purpose of Cost Report

Each year all counties are required to complete and submit an SUD cost report to DHCS. The purpose of the cost report is to:

a. Report counties’ annual costs/expenditures for SUD services, both Drug Medi-Cal (DMC) and non-DMC.
b. Compare and reconcile the amount of funds paid to the county with the actual costs of providing those services.
c. Document how state/federal funds were spent and ensure that set-asides and other categorical requirements were met.
d. Provide mandated service and expenditure data to oversight agencies (the Centers for Medicare and Medicaid Services and the Substance Abuse and Mental Health Services Administration).
e. Provide data for DHCS to develop annual DMC reimbursement rates and conduct statewide evaluation.

1.3 Authority

a. Health and Safety Code (HSC) Section 11852.5 and the Welfare and Institutions Code (WIC) Section 14124.24 (g)(1) require that counties and contracted providers (except for those providing only narcotic treatment) submit their SUD cost reports to DHCS by November 1 for the previous state fiscal year. The county must include the DHCS-provided certification form signed by the financial officer(s) or an authorized signatory, attesting to the validity and allowability of the reported cost data.

b. Pursuant to HSC Section 11758.46(j) and WIC Section 14124.24 (h), narcotic treatment program (NTP) providers that exclusively provide NTP services under the DMC program are not required to submit cost reports. Instead, they must submit performance reports by November 1 for the previous state fiscal year.
    1) An NTP to whom this applies must use the performance report format distributed by DHCS and estimate its budgets using the state established reimbursement rates.
    2) If the NTP contracts with the county, their claims for reimbursement must be identified within the county’s cost report in order to settle final reimbursement amounts.

1.4 Submission Requirements

Counties must report the following state/federal funds expended for SUD services, pursuant to their state-county contract(s):

a. Substance Abuse Prevention and Treatment (SAPT) Block Grant
b. State General Fund
c. Drug Medi-Cal Federal Financial Participation (FFP)
d. Behavioral Health Subaccount (2011 Realignment)

The county cost report must include SUD cost data from all their contracted providers and any county-operated providers. In addition, individual SUD cost reports from the county's contracted DMC providers on the DHCS-prescribed forms must be included and electronic copies forwarded to DHCS.

1.5 Cost Report Timeframes

Notwithstanding unforeseen circumstances or barriers, the timeline for the cost report process is shown below:

a. July or August: DHCS releases the forms and instructions to counties for the prior fiscal year's cost report.

b. November 1: County cost reports are due to DHCS.

    1) DHCS may grant an extension to the November 1 due date because of policy changes or unanticipated situations that delay the development of the annual cost report forms and/or require SUDCRS system updates.
    2) If a county does not meet the due date, DHCS has the right to withhold SAPT and/or DMC payments until the county has submitted the required cost report data/reports, pursuant to the county's contract(s) with DHCS.

c. Four months after receipt of county's cost report: DHCS completes settlement of the SAPT Block Grant funds. For non-DMC counties, this is the interim settlement. For DMC counties, this is a preliminary settlement.

d. Eighteen months after end of fiscal year: DHCS completes settlement of the DMC funds. This is the interim settlement for DMC counties.

e. Up to three years after cost settlement: DHCS may conduct a fiscal audit.

f. Three years after cost settlement: If DHCS did not conduct a fiscal audit, the cost settlement is final.

1.6 Overview of Cost Report Settlement Process

a. DHCS releases cost report forms, instructions, and supporting documents to counties.

b. Counties distribute appropriate forms and instructions to their contracted providers. (DHCS does not have prescribed data collection forms for non-DMC providers, so counties may use other forms or processes to collect cost report data from those contracted providers.)

c. Providers collect and report cost report data on the county or DHCS-required forms and submit them to the county.

d. The county enters cost report data into the SUDCRS and submits it to DHCS.

e. DHCS processes the SAPT settlement
    1) DHCS reconciles the SAPT allocation and payment amounts with county expenditures and verifies that set-asides and other categorical requirements were met. If necessary, DHCS requests the county to make adjustments to reflect carryover of unexpended funds from the prior year.
    2) DHCS sends the settlement letter to the county, and invoices or payments are processed, if applicable.
    3) If a county does not provide DMC services, their cost report settlement is complete (interim) after this phase. For all other counties, settlement is preliminary until the DMC funds are settled.

f. DHCS processes the DMC settlement
    1) DHCS compares the expenditures and billing units on the provider DMC forms with the entries made by the county in the SUDCRS to ensure data transfer was done accurately. If there were data entry errors, DHCS works with the county to make corrections.
    2) DHCS generates settlement forms using data pulled from the SMART (DMC payment) system and completes a detailed review of what DMC units were billed, paid, and disallowed. Then DHCS makes corrections and adjustments to the county's cost report data, if necessary. If DMC units were approved but not paid by DHCS prior to the payment cut-off period, the units will be reimbursed through the cost settlement.
    3) DHCS sends the interim settlement letter to the county which represents DHCS' complete settlement of the county cost report, and invoices or payments are processed, if applicable.

Chapter 2. County Cost Report Responsibilities

2.1 SUDCRS Access and User Roles

a. The county must submit its SUD cost report to DHCS via the web-based Substance Use Disorder Cost Report System (SUDCRS). County access to SUDCRS is through the Behavioral Health Information System (BHIS) portal which is granted by DHCS through the following process:
   1) The county alcohol and drug program administrator must complete, sign, and submit a *County Approver Certification & Vendor Appointment Form* from their email address to DHCS at AODCOSTREPORT@dhcs.ca.gov. The form will identify the individual(s) whom the administrator has designated as the county's approver for the SUDCRS.
   2) DHCS will enroll the approver(s) and send them an email with their log-in information. The approver will then be able to log on to the BHIS portal and request access for additional county users (instructions are available on the BHIS portal).
   3) Once the approver requests access for another county user, the system administrator will create an account and send them their log-in information. This process to add new users may take up to three (3) business days.

b. There are three types of users in the SUDCRS, each with different functions and system rights. One individual may have multiple user roles.
   1) Approver: The approver is designated by the county alcohol and drug program administrator. The approver has independent authority to approve county user access requests (including vendors).
   2) Analyst: The analyst can perform data entry and run reports, but cannot submit data to DHCS.
   3) Supervisor: The supervisor is responsible for reviewing and submitting data to DHCS. The supervisor can perform the same functions as the analyst, but is the only user who can submit data to DHCS.

2.2 Distribute Forms and Instructions to Contracted Providers

It is the county's responsibility to distribute applicable cost report materials to its contracted providers.

a. As soon as DHCS releases the annual forms and instructions for the prior fiscal year's cost report, the county must distribute the DMC Cost Report (Excel) Workbook to their contracted DMC providers.

b. DHCS also provides a reconciliation report that reflects all approved and denied services by provider. The county should ensure that every provider on the report with approved services submits a DMC workbook.

c. DHCS typically gives counties three to four months to complete and submit their cost report, so it is critical that counties give their providers a due date that allows the county sufficient time to review provider data, return to the provider for corrections if needed, and enter the data into the SUDCRS.

d. Any manipulation to the cost report template format and/or formulas will deem the cost report null and void.

2.3 Collect and Review Data from Contracted Providers

County-contracted providers are responsible for providing accurate cost data to the county, and the county is responsible for collecting, reviewing, and verifying the integrity of the cost data submitted to them by their contracted providers.

2.4 Enter Cost Report Data into SUDCRS

a. After the county has received and reviewed all their provider cost data, they must enter required data into the SUDCRS via the County Fiscal Data entry screen.

b. General instructions for data entry are shown below (an SUDCRS User Manual with more detail is available on the BHIS portal):
   1) Select the provider, service type/code, and program code from the drop down boxes.
   2) Select 'Add Data.'
   3) Select funding lines from the drop down box (service and program codes selected will determine access to appropriate funding lines).
   4) Enter the amounts, unit counts, individual units of service, and NTP dosing and NTP group (if applicable). The visit days, total individual sessions, and the total of the individual units of services must match.
   5) Each line that is validated and correct will include a green check mark at the end of the row. If there is no check mark at the end, the row needs to be corrected.
   6) If the record contains both DMC and non-DMC funding, check the box titled, included in DMC set, which indicates that a DMC workbook is included for that provider.
   7) Select the 'Check It' button before exiting the provider record to check for errors. If there are errors on the page, a message will appear and the highlighted line(s) must be corrected before moving on.
   8) To continue data entry, go to Provider, Service, and Program from the drop down menus at the top and select 'Add Data'.
   9) If the record already exists, a prompt will display to edit the existing record and the 'Add Data' will not display.
   10) Select 'Clear Filters' to go back to the main data screen.

c. To assist the county transfer data from DMC providers' cost report workbooks into the SUDCRS, the county should use the Comparison Sheet tab for each modality. The county must enter the program code(s) and complete the 'SUDCRS Fiscal Detail' column by entering the total amounts they entered in the SUDCRS from the Cost Allocation and Reimbursed Units tab(s) of the provider's workbook.

d. Once all data entry for the fiscal year is complete, the user must run the Data Validation Report, which will display those records for which the 'Check-It' button was not selected. The user must go back to these specific records and select the 'Check-It' button to ensure no errors exist on the record before trying to submit the data. The county will not be able to submit the data if any records exist on this report.

e. The individual designated as the supervisor for the SUDCRS must review and submit the data to DHCS. If there are no errors, the supervisor will receive a 'Success' message and the County Data Status on the Dashboard will display 'Submitted.'

f. Once the supervisor submits the data to DHCS, the county data is locked—it cannot be edited and no new data can be entered unless the county contacts DHCS. However, county users can still view and run reports and export data to Excel.

2.5 Submit Hard Copy Forms to DHCS

After the county submits the cost report to DHCS via the SUDCRS, the county must also submit the following:

a. Electronic copies of their contracted DMC providers' cost report workbooks to aodcostreports@dhcs.ca.gov.

b. Hard copies of the following:
   1) The Provider Information and Certification (Tab 1) with the provider's original signatures.
   2) The County Certification (form MC 6229) with the appropriate original signatures.
   3) The year-end County DMC Administrative Expense Claim (form MC 5312).

c. Hard copies should be mailed to:

   Fiscal Management and Accountability Section, Cost Report Unit
   Department of Health Care Services, SUD-PPFD-FMAB Mail Station 2629
   P O Box 997413, Sacramento, CA 95899-7413 (U.S. mail) OR
   1500 Capitol Avenue, Sacramento, CA 95814 (overnight mail)

Chapter 3. Substance Abuse Prevention and Treatment (SAPT) Block Grant

3.1 Introduction

The SAPT block grant is a noncompetitive, formula grant mandated by the U.S. Congress and administered by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA). DHCS must submit an annual application to demonstrate statutory and regulatory compliance in order to receive SAPT block grant funds.

Upon enactment of the annual state budget act, DHCS allocates SAPT funds to all counties based on a standard methodology, and includes the funds in the state-county contracts. The county's expenditures of SAPT funds must be included on the SUD cost report.

3.2 General Guidelines for Spending

a. SAPT block grant funds may be used to plan, implement, and evaluate activities that prevent and treat substance abuse and promote public health. Specifically, SAPT can be used for the following purposes:
   1) Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
   2) Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance.
   3) Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.
   4) Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services.

b. SAPT funds are to be the funds of last resort. Medicaid and private insurance, if available, must be used first.

c. Any treatment services provided with SAPT funds must follow the treatment preferences established in 45 CFR 96.131(a):
   1) pregnant injecting drug users
   2) pregnant substance abusers
   3) injecting drug users
   4) all others

3.3 Restriction on Expenditure

a. DHCS allocates SAPT funds to counties to provide program funding for specific areas of need. These funds must be spent on those specific programs and cannot be used for other programs, unless specified.

b. SAPT block grant funding cannot be used for the following:
    1) To provide inpatient hospital services.
    2) To make cash payments to intended recipients of health services.
    3) To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment.
    4) To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds.
    5) To provide financial assistance to any entity other than a public or nonprofit private entity.
    6) To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS.
    7) To pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of Level I of the Executive Salary Schedule for the award year.
    8) To purchase treatment services in penal or correctional institutions.

c. The SAPT block grant cannot be used to supplant state-funded SUD programs. If SAPT funds were spent on a service that the county would have provided whether or not the SAPT funding had been received, the county supplanted state funds.

d. SAPT block grant funds cannot be used as the state share of DMC services, nor can SAPT be used to pay for costs of DMC services rendered but not covered within the state reimbursement rate cap.

3.4 Reporting SAPT Cost Data

The amount that a county reimburses a provider with SAPT funds using a negotiated rate is the amount that the county is to report as its costs to purchase services, regardless of the provider's actual cost. The exception to this is when the same service at the same location is also funded with DMC. In that case, reimbursement is limited to actual costs, in accordance with Medi-Cal reimbursement principles.

3.5 SAPT Funding Period

SAPT funds are awarded on a Federal Fiscal Year (FFY) basis (beginning on October 1), and the award has a 21-month spending period that overlaps two state fiscal years (SFY). For example, the obligation and expenditure period for the FFY 2018 award is from October 1, 2017 to June 30, 2019 (which begins in SFY 2017-18 and ends in SFY 2018-19).

Chapter 4. Drug Medi-Cal (DMC)

4.1 Introduction

a. Medi-Cal is California's federal Medicaid program. Within the broader Medi-Cal program, DHCS administers the Drug Medi-Cal (DMC) program.

b. DMC provides medically necessary SUD treatment services to eligible Medi-Cal beneficiaries for approved services. DMC clients must receive SUD services at a program DMC-certified by DHCS. The county where the provider is located must have a DMC contract with DHCS and the DMC-certified providers must subcontract with the county.[1]

4.2 DMC Funding

a. Reimbursement under the DMC program is available only for allowable costs incurred for providing DMC services to eligible Medi-Cal beneficiaries. The allowable costs must be determined in accordance with Medicare cost reimbursement principles in 42 Code of Federal Regulations (CFR) Part 413, CMS-Pub. 15-1, Section 1861 of the Federal Social Security Act (42 USC, Section 1395x); 2 CFR Part 200 Subpart E, CMS non-institutional reimbursement policy, and in DMC regulations contained in California Code of Regulations, Title 9 and Title 22.

b. DMC funding is a combination of federal, state, and local funds.
   1) The federal share for DMC is funded with Federal Medical Assistance Percentage (FMAP), also called federal financial participation (FFP). The federal percentage is based on the beneficiary's aid code and can vary from 100 percent to zero.
   2) The state or local share is funded with county Behavioral Health Subaccount (BHS) funds or state general funds (for expansions and new mandates).

c. When a provider's DMC costs exceed the state maximum allowance, the county must cover those costs with other funds. These may include county funds, provider contributions, or donations. In the cost report, these are identified as "unrestricted funds."

[1] Pursuant to Welfare and Institutions Code Section 14124.21, DHCS can enter into a contract directly with a DMC provider if the county chooses not to contract with that provider.

4.3 DMC Cost Settlement Methodology

a. The rate at which a county bills for DMC services is an interim rate until the cost report is settled.

b. DHCS is required to settle to the lower of the following:
   1) Actual cost.
   2) Usual or customary charge (a provider's published charge used to bill the general public, insurers, or other non-Medi-Cal payers and which is equivalent to the charge prevalent in the public SUD sector).
   3) State maximum allowance.

4.4 Responsibility for Collecting DMC Cost Data

a. Counties that provide DMC services must collect cost data from their contracted DMC providers via the DHCS-prescribed DMC cost report workbook.

b. DMC providers are responsible for completing the DMC cost report workbook and submitting it to the county. A workbook must be completed for each location that has a unique DMC number. The provider must certify that the cost report information is true, correct, and in compliance with federal law. Instructions for completing the workbook are included in the following chapter.

4.5 Year End Claim for County DMC Administrative Expenses

a. County claims for reimbursement of DMC administrative expenses must be submitted separately from the CPE-certified total direct service expenses, via the *Drug Medi-Cal Services Claim for Reimbursement of County Administrative Expenses* (form MC 5312).

b. Counties may choose to submit quarterly claims throughout the fiscal year or be reimbursed only once at cost settlement. However, all counties, whether they were reimbursed throughout the year or not, must submit a final claim that covers total county DMC administrative expenses for the entire fiscal year.

c. To complete the year end *Drug Medi-Cal Services Claim for Reimbursement of County Administrative Expenses*:
   1) Enter the date the form was completed, the county code, the county name, and lines 1 and 4 (lines 2, 3, 5, and 6 are formula generated).
   2) Line 1: Enter the DMC direct service treatment expenses billed during the fiscal year based on the direct service expenses reported on CPE forms.
   3) Line 4: Enter the actual administrative expenses incurred by the county during the fiscal year.
   4) The form must include the signed certification of the county alcohol and other drug program administrator and either the county auditor-controller, finance officer, or accounting officer.

d. During cost settlement, DHCS will compute the county's share of the administrative reimbursement in the following manner:

1) Establish county's administrative rate for DMC:
   A. Actual administrative rate as shown on Line 6 of the claim form; OR
   B. 15% (if the rate on line 6 is higher than 15%)
2) Generate report of county claims for the service fiscal year, by aid code, to determine the FFP and SGF amounts of all approved claims.
3) Apply the established administrative rate to the FFP and SGF amounts to determine the amount owed to the county.
4) If the county submitted quarterly claims for that year, the year-end amount owed will be reduced by the amount paid for the quarterly claims.

Chapter 5. DMC Provider Cost Report Workbook

5.1 History and Intent

a. In October 2015, the Centers for Medicare and Medicaid Services (CMS) approved DHCS' Medicaid State Plan Amendment (SPA) #15-013 which updated the rate setting and reimbursement methodologies for DMC services. As part of the SPA approval process, CMS required that California adjust its SUD cost report process so that providers demonstrate how allowable costs were determined and allocated.

b. The DMC provider cost report workbook was designed so providers must show how they determined which costs were direct and indirect, and how indirect costs were allocated by line item and modality. It helps verify that DMC providers properly allocated their SUD service expenses and reported those expenses accurately on the annual cost report.

c. The DMC provider cost report forms were reviewed and approved by CMS as part of the Medicaid SPA #15-013 review. Any substantive modification to the approved cost reporting form is subject to review and approval by CMS.

d. Every DMC-certified provider that contracts with the county and claims DMC services must complete the DMC Provider Cost Report Workbook.

e. DHCS provides a new workbook to the county each year to account for changes in policy, funding lines, federal financial participation percentages, etc. Counties are required to distribute the DMC Provider Cost Report Workbook to their contracted DMC providers by any method that will not change the electronic format of the templates.

f. The provider, after the completion of their cost report workbook, must return it to their county for review, verification, and approval. The counties are required to package these cost reports and submit the package to DHCS, as specified in Chapter 2, Section 2.5.

5.2 Cost Allocation Considerations

a. The provider must have a cost allocation plan that identifies, accumulates, and distributes allowable direct and indirect costs and identifies the allocation method(s) used for distribution of indirect costs.

b. The provider must determine their allocation methodology in accordance with applicable cost reimbursement principles in 42 CFR Part 413, CMS-Pub 15-1, 2 CFR Part 200 Subpart E, CMS non-institutional reimbursement policy.

c. Direct Cost Allocation
   1) The direct cost allocation methodology adopted by the provider must assign costs to a particular cost objective based on benefit received by that cost objective.
   2) Any method of distribution can be used that will produce an equitable distribution of cost.
   3) In selecting one method over another, consideration should be given to the additional effort required to achieve a greater degree of accuracy.

d. Indirect Cost Allocation
   1) For consistency, efficiency, and compliance with federal laws and regulations, the DMC workbook allocates indirect costs using a standard methodology. The workbook identifies the direct cost categories for each modality and uses the percentage of total direct costs to allocate indirect costs.
   2) DHCS recognizes that there are other allocation bases (such as percentage of direct salaries and wages) that result in an equitable distribution of indirect administrative overhead. However, if a provider wishes to use an allocation basis other than the standard methodology established in the cost report, the provider must obtain their respective county's prior approval. Before granting approval to the provider, the county must seek DHCS's approval and DHCS will make a final determination of the propriety of the methodology used.

5.3 Cost Report Records and Supporting Documentation

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

b. The provider must maintain fiscal and statistical records for the period covered by the cost report that are accurate and sufficiently detailed to substantiate the cost report data. The records must be maintained until the later of: (1) a financial audit is conducted: or (2) a period of three years following the date of the interim cost settlement.

c. All records of funds expended and costs reported are subject to review and audit by DHCS and/or the federal government pursuant to the Welfare and Institutions Code Section 14124.24(g)(2) and 14170.

5.4 General Guidelines for Completing Workbook

a. These guidelines and instructions for the DMC Cost Report Workbook apply to all DMC providers, both county-operated and those that contract with the county.[2]

b. The provider must complete a workbook for each location that has a unique DMC number. Organizational or corporate costs in the general ledger that are shared or allocated across multiple locations must be shown on the specific locations' workbooks.

c. The provider must report overall costs incurred related to SUD services at each location, from all funding sources (DMC and non-DMC). If non-SUD services are provided at the same location (such as mental health services) and the costs are shared or allocated across the two programs, the costs for both the SUD and the non-SUD must be included.

d. Before completing the workbook, the provider should gather all financial documents needed. The cost data on the DMC workbook must be based on the provider's general ledger. The reconciliation report distributed by DHCS to the county is also needed.

e. Data entry is required only in yellow highlighted cells. All other cells are auto-populated.

f. The provider must not change the worksheet template or formulas. Attempts to do so will deem the provider's cost report null and void.

g. The provider must complete the applicable tabs as shown below. The provider should not delete any tabs, even if they do not provide the specific modality, level of care, or service identified on the tab.

State Plan Tab #	ODS Tab #	Tab Title	Must Be Completed By…
1	1	Provider Info and Certification	All providers
2	2	Overall Cost Summary	All providers (auto-populated)
3	3	Overall Detailed Costs	All providers
4	4	ODF Detailed Costs	ODF providers only (auto-populated)
5	5	ODF Detailed Adjustments	ODF providers only
6	6	ODF Cost Allocation	ODF providers only
7	7	ODF Reimbursed Units	ODF providers only
8	8	ODF Comparison Sheet	County (for ODF providers only)
NA	9	PH Detailed Costs	PH providers only (auto-populated)
NA	10	PH Detailed Adjustments	PH providers only
NA	11	PH Cost Allocation	PH providers only
NA	12	PH Reimbursed Units	PH providers only

[2] NTP providers that exclusively provide NTP services under the DMC program must submit a performance report instead of a cost report.

NA	13	PH Comparison Sheet	County (for PH providers only)
9	14	IOT Detailed Costs	IOT providers only (auto-populated)
10	15	IOT Detailed Adjustments	IOT providers only
11	16	IOT Cost Allocation	IOT providers only
12	17	IOT Reimbursed Units	IOT providers only
13	18	IOT Comparison Sheet	County (for IOT providers only)
14	19	Residential Detailed Costs	Residential providers only (auto-populated)
15	20	Residential Detailed Adjustments	Residential providers only
16	21	Residential Cost Allocation	Residential providers only
17	22	Residential Reimbursed Units	Residential providers only
18	23	Residential Comparison Sheet	County (for residential providers only)
N/A	24	NTP Detailed Costs	County Operated NTP providers only (auto-populated)
N/A	25	NTP Detailed Adjustments	County Operated NTP providers only
N/A	26	NTP Cost Allocation	County Operated NTP providers only
N/A	27	NTP Reimbursed Units	County Operated NTP providers only
N/A	28	NTP Comparison	County (for county-operated NTP providers only)

h. The sequence for completing the workbook is shown below:

1) Complete the Provider Information and Certification tab
2) Complete the Overall Detail Costs tab
3) For each modality/level of care provided, complete the tabs in the following order:
   A. Detailed Adjustments
   B. Cost Allocation
   C. Reimbursed Units
4) Review data, print, and sign the Provider Information and Certification attesting that the costs included are public expenditures eligible for FFP pursuant to 42 CFR 433.51.

i. Provider questions about completing the workbook should directed to county staff. DHCS will not respond to questions received directly from a county-contracted provider.

5.5 Workbook Instructions

The following instructions apply to both the ODS and non-ODS waiver cost report, unless otherwise noted.

a. <u>Provider Information and Certification</u>

The Provider Information and Certification (Tab 1) must be completed by all providers. The information entered here eliminates the redundant entry of county, provider name, DMC number and NPI on further cost report worksheets.

b. Overall Cost Summary

No data entry is required for this worksheet. A summary of the totals for all the cost centers reported by the provider is automatically populated from the Overall Detailed Costs worksheet.

c. Overall Detailed Costs

The Overall Detailed Costs worksheet (Tab 3) is the starting point for all providers completing the DMC Cost Report Workbook. The provider must enter all direct and indirect costs incurred related to SUD services. The provider must specify the allocation methodologies used to distribute costs across various cost centers.

1) Part A, Schedule of Expenditures for Direct Costs

   A. In column B ('From Accounting Records'), the provider must enter the program's total costs by applicable line item using their general ledger as reference.
   B. In columns D-H (columns D-J for ODS), enter total costs by line item that are directly attributable to each cost center/modality provided, including other SUD services and non-SUD services if applicable. An example of other SUD services includes SUD prevention services. Examples of non-SUD services include mental health, primary care, or any other program that shared costs with the DMC program.
   C. In column K (column M for ODS), enter an explanation of how direct costs were determined and assigned to the each cost center/modality (in accordance with applicable cost reimbursement standards). Some sources that are acceptable for determining and attributing direct costs include time sheets/payroll records, invoices, and rent/lease records. Add a footnote if necessary.
   D. The workbook identifies the direct cost categories for each cost center/modality and uses the percentage of direct costs to allocate indirect costs.
   E. The worksheet also distributes total general ledger indirect costs or cognizant agency-approved indirect cost rate using the percentage of total direct program costs.[3]

2) Part B, Supporting Schedules for Indirect Costs
   There is no data entry required for this section. The indirect cost for each line item and modality is computed based on the percentage of direct costs (the standard methodology) from Part A.

[3] If the provider has a cognizant agency-approved indirect cost rate, the total indirect costs are determined by applying the approved rate to the approved allocation base and is reported in the "Indirect Cost" line item in Schedule of Direct and Indirect Cost Part A. There is no need for the provider to itemize any indirect cost elements and no additional indirect cost can be claimed outside of the approved indirect cost rate.

3) Part C, Report of Expenditures for Total Costs
   A. The indirect costs that were calculated in Part B are totaled in Part C.
   B. The overall total should match the total from Part A.

d. Detailed Adjustment Worksheets

1) This is the first worksheet for each of the levels of care/modalities (ODF, IOT, Residential, and PH for ODS only). For each level of care/modality provided, the provider must break out their costs between the various types of service/program (such as individual or group, perinatal or non-perinatal).
2) Costs directly related only to services provided to clients funded by a specific program and funding source (such as perinatal) must be removed before calculating the allowable modality costs. Then the allowable adjusted gross modality costs are allocated to the different services within the modality. Finally, those direct costs are added back to the program type that benefited from the direct costs. (For example, perinatal-related costs, such as child care expenses, are removed from the total modality cost and added back to the perinatal program.)
3) In Section 1, 'DMC Unreimbursable Costs,' enter the costs that are not DMC reimbursable, private, and non-DMC, for the various service/program types that apply to the modality.
4) In Section 2, 'Direct Costs,' enter the direct costs charged to the cost center for private pay, DMC, and non-DMC for each service/program type.
5) Data entered from Sections 1 and 2 automatically populate cells in the corresponding modality's Detailed Costs worksheet and Cost Allocation worksheet.

e. Cost Allocation

This worksheet further identifies the breakout of costs between the modality's different services/programs and between private pay, DMC, and non-DMC. The bottom portion of the worksheet identifies the maximum reimbursement for DMC services. As described previously, the standard methodology for allocating indirect costs is the percentage of direct costs. The calculation for this methodology is built into the forms.

1) 'Allocate Costs Between Different Modalities' section:
   Non-ODS:
   A. For ODF, enter the number of group sessions for perinatal and non-perinatal, and the length of individual and group sessions for perinatal and non-perinatal. If the length is less than 50 minutes (individual) or 90 minutes (group), an adjustment is automatically made to the SMA. If the length is greater than 50 minutes (individual) or 90 minutes (group), the higher amount is used to compute direct staff hours; however, the reimbursement will not exceed the SMA.
   B. For IOT, enter the length of visit for perinatal and non-perinatal.
   C. For Residential, enter 24 hours.

ODS: Enter direct staff hours in each of the yellow highlighted areas (as applicable).

2) 'Units of Service' section: enter the number of units for private and non-DMC by the applicable service/program types.
3) 'Cost Per Unit of Service' section:
   Non-ODS: enter the SMA rate or usual/customary charges for each of the applicable service/program types.
   ODS: Enter the provider's customary charges for each service.
4) All other areas are automatically populated based on data entry on other worksheets.

f. Reimbursed Units

This worksheet identifies the specific reimbursement amounts by funding source and aid code type.

1) Enter all approved and denied units using the information from the provider reconciliation report.
   A. Approved Units: Enter the approved unit information for each type of service for each aid code type from the reconciliation report provided by DHCS (unless the county or provider has more recent updated data).
   B. Denied Units: Enter the denied unit information for each type of service from the reconciliation report provided by DHCS. Denied units are not broken out by aid code type.
2) Share of Cost and Insurance: The remainder of this worksheet requires data entry only if units were funded by beneficiaries' share of cost or insurance.

g. Detailed Costs

There is no data entry on this tab; however, the provider should review the auto-populated cells to check for possible entry errors on other worksheets.

1) After completing the Detailed Adjustments, Cost Allocation, and Reimbursed Units tabs for a modality, go back to that modality's Detailed Costs worksheet to review the results.
2) The 'Overall Total Costs as Allocated' in Part I of the modality's Detailed Costs worksheet should match:
   A. The total for the modality in Part C on the Overall Detailed Costs tab.
   B. The 'Total SUD Services' (Section 1) on the modality's Cost Allocation tab.
   C. The 'Overall Total Costs as Allocated' on the modality's Cost Allocation tab.

h. Comparison Sheet

There is no data entry required by the provider on this worksheet (the county must complete the yellow-highlighted cells).

Chapter 6. DMC-ODS Waiver Requirements

This chapter is only applicable to counties that have an executed intergovernmental agreement with DHCS to administer DMC Organized Delivery System (DMC-ODS) services. All federal and state regulations that pertain to the cost report for the regular state plan services are still applicable to the DMC-ODS services unless otherwise noted in this chapter.

6.1 ODS Expanded Services

a. The county must provide access to a full continuum of SUD benefits modeled after the American Society of Addiction Medicine (ASAM) Criteria.

b. The additional required services (beyond regular DMC) are:
   1) Residential (for all populations, no bed capacity limit)
   2) Withdrawal management (at least one level)
   3) Case management
   4) Physician consultation
   5) Recovery services

c. Optional Services:
   1) Medicated assisted treatment (MAT)
   2) Partial hospitalization
   3) Withdrawal management (additional levels)
   4) Inpatient hospital-based services

DMC-ODS Level of Care or Service	Required	Optional
Early Intervention	X (thru fee for service or managed care	
Outpatient Treatment	X	
Intensive Outpatient Treatment	X	
Partial Hospitalization		X
Recovery Services	X	
Case Management	X	
Physician Consultation	X	
Narcotic Treatment (NTP)	X	
Non-NTP Medicated Assisted Treatment (MAT)		X
Withdrawal Management (WM) (Levels 1, 2, 3.2)	X (at least one level)	X (additional levels)
Residential Treatment (Levels 3.1, 3.3, 3.5)	X (all within 3 years)	
Inpatient Hospitalization (RES and WM Levels 3.7 and 4)		X

d. For FY 2016-2017, DHCS established new program codes, service codes, and funding lines for the expanded ODS services.

6.2 Quality Assurance and Utilization Review (QA/UR)

a. QA/UR activities include reviews of physicians, health care practitioners, and providers to determine whether:
   1) Services were reasonable and medically necessary.
   2) The quality of the services met professionally recognized standards of health care.

b. Counties may submit claims for reimbursement of the FFP share of QA/UR expenses through a quarterly invoicing process (outside of the Short-Doyle system).

c. Information on the claim process and list of reimbursable QA/UR tasks and activities is included in Information Notice #17-011.

6.3 Cost Settlement Methodology

a. For non-NTP services, DHCS will settle to the lower of actual cost or usual or customary charge.

   1) The county will aggregate the provider cost reports into a cost report for all DMC ODS services provided under the contract.
   2) The DMC providers' cost reports are used to determine the lower of actual cost or customary charge (the Cost Allocation tab will calculate the cost per unit based on total allowable cost/total allowable units).
   3) DHCS reconciles the aggregate amount per service with payments made to the county based on the interim rate and under- or over-payment of federal funds and state general fund will be addressed as a part of the final settlement process.

b. For NTP services, the county pays providers at the lower of the USDR or the provider's usual and customary charge to the general public for the same or similar services. The USDR for NTP services and customary charges will continue to apply as they do under the state plan for DMC.

6.4 Auditing and Recordkeeping

Pursuant to 42 CFR Section 438.3 (u), the county must retain, and require subcontractors to retain, as applicable, the following information for a period of no less than ten years: enrollee grievance and appeal records in Section 438.416, base data in Section 438.5(c), medical loss ratio reports in Section 438.8(k), and the data, information, and documentation specified in Sections 438.604, 438.606, 438.608, and 438.610.

6.5 Recovery of Overpayments to Providers

Pursuant to 42 CFR Section 438.604(a)(7), the county must report annually to DHCS on their recoveries of overpayments to providers. This report must be submitted to DHCS along with the county's cost report. DHCS will provide the form to the counties with other forms and instructions for the annual cost report.

SERVICE CODES Fiscal Year 2016-17

Service Code		DMC Billing Unit of Service	Cost Report Reportable Unit
Support Services			
00	County Support	NA	Hours
01	Quality Assurance	NA	Hours
02	Training	NA	Hours
03	Program Development	NA	Hours
04	Research and Evaluation	NA	Hours
05	Planning, Coordination, Need Assessment	NA	Hours
06	Start Up Costs	NA	Hours
09	Alteration or Renovation	NA	Hours
Primary Prevention			
11	Other	NA	1
12	Information Dissemination	NA	1
13	Education	NA	1
14	Alternatives	NA	1
15	Problem Identification and Referral	NA	1
16	Community-Based Process	NA	1
17	Environmental	NA	1
Secondary Prevention			
18	Early Intervention	NA	Hours
19	Outreach/Intervention	NA	Hours
20	Intravenous Drug User (IDU or IVDU)	NA	Hours
21	Referrals/Screening/Intake	NA	Hours
Nonresidential			
30	Intensive Outpatient Treatment (IOT)	Visit	Visits
32	Aftercare	NA	Hours
33	Outpatient Drug Free (ODF) Group	90 minutes	Non-DMC: Hours; DMC: Per person
34	Outpatient Drug Free (ODF) Individual	50 minutes	Non-DMC: Hours; DMC: Per person
35	Interim Treatment Services (CalWORKS Only)	NA	Hours
Narcotic Treatment			
41	Outpatient Methadone Detox (OMD)	NA	Slot days
42	Inpatient Methadone Detox	NA	Bed days
43	Naltrexone	visit	Non-DMC: Visits; DMC: Per person
44	Rehabilitative/Ambulatory Detox (Other than Methadone)		Slot days
48	Narcotic Replacement Therapy - All Services	Dosing: daily; Individual: 10 minutes; Group: 10 minutes	Dosing: daily; Individual: 10 minutes; Group:10 minutes

SERVICE CODES Fiscal Year 2016-17 (continued)

Residential			
50	Free-Standing Residential Detoxification	NA	Bed days
51	Residential/Recovery Long Term (over 30 days)	Day	Non-DMC: bed days; DMC: per day
52	Residential/Recovery Short Term (up to 30 days)	Day	Non-DMC: bed days; DMC: per day
53	Hospital Inpatient Detoxification (24 hour)	NA	Bed days
54	Hospital Inpatient Residential (24 hour)	NA	Bed days
55	Chemical Dependency Recovery Hospital (CDRH)	NA	Bed days
56	Transitional Living Center (Perinatal/Parolee Only)	NA	Bed days
57	Alcohol/Drug Free Housing (Perinatal/Parolee Only)	NA	Bed days
Ancillary Services			
22	Perinatal Outreach	NA	Hours
63	Cooperative Projects	NA	Hours
64	Vocational Rehabilitation	NA	Hours
66	Tuberculosis Services	NA	Hours
67	Interim Services (within 48 hours)	NA	Hours
68	Case Management	NA	Hours
69	Primary Medical Care (Perinatal Only)	NA	Hours
70	Pediatric Medical Care (Perinatal Only)	NA	Hours
71	Transportation (Perinatal Only)	NA	Hours
72	HIV Counseling Services	NA	Hours
73	HIV/AIDS Education	NA	Hours
74	HIV Infectious Disease Services	NA	Hours
75	HIV Therapeutic Measures for HIV Positives	NA	Hours
76	HIV Referral Services	NA	Hours
77	HIV Outreach	NA	Hours
88	AB 109 Services	NA	Hours
Driving Under the Influence			
90	Driving Under the Influence	NA	Persons Served

SERVICE CODES Fiscal Year 2016-17 (continued)

ODS Waiver Services			
91	ODS Group Counseling	15 minutes	15 minutes
92	ODS Individual Counseling	15 minutes	15 minutes
93	ODS Case Management	15 minutes	15 minutes
94	ODS Physician Consultation	15 minutes	15 minutes
95	ODS Recovery Services Individual	15 minutes	15 minutes
96	ODS Recovery Services Group	15 minutes	15 minutes
97	ODS Recovery Services Case Management	15 minutes	15 minutes
98	ODS Recovery Services Monitoring	15 minutes	15 minutes
99	ODS Non-NTP Medically Assisted Treatment (MAT)	15 minutes	15 minutes
100	ODS Non-NTP MAT - Buprenorphine	Dose	Dose
101	ODS Non-NTP MAT - Disulfiram	Dose	Dose
102	ODS Non-NTP MAT - Naloxone	Dose	Dose
103	ODS Non-NTP MAT - Vivitrol	Dose	Dose
104	ODS Non-NTP MAT - Acamprosate	Dose	Dose
105	ODS Intensive Outpatient Treatment (IOT)	15 minutes	15 minutes
106	ODS Partial Hospitalization	Day	Day
107	ODS Withdrawal Management 1	Day	Day
108	ODS Withdrawal Management 2	Day	Day
109	ODS Withdrawal Management 3.2	Day	Day
110	*ODS Withdrawal Management 3.7 **	*Day*	*Day*
111	*ODS Withdrawal Management 4.0 **	*Day*	*Day*
112	ODS Residential 3.1	Day	Day
113	ODS Residential 3.3	Day	Day
114	ODS Residential 3.5	Day	Day
115	*ODS Residential 3.7 **	*Day*	*Day*
116	*ODS Residential 4.0 **	*Day*	*Day*
117	ODS NTP MAT Buprenorphine	Dose	Dose
118	ODS NTP MAT Disulfiram	Dose	Dose
119	ODS NTP MAT Naloxone	Dose	Dose
120	ODS NTP Methadone - all services	Dosing: daily; Individual: 10 minutes; Group: 10 minutes	Dosing: daily; Individual: 10 minutes; Group: 10 minutes

**These services are not yet available to claim.*

PROGRAM CODES
Fiscal Year 2016-2017

Non-ODS Waiver

Program Code Listing	Program Code #
Non-DMC Non-Perinatal	1
Non-DMC Perinatal	3
Non-DMC Non-Perinatal - Other	4
Non-DMC Non-Perinatal - Other	5
Non-DMC Non-Perinatal - Other	6
Non-DMC Non-Perinatal - Other	7
Non-DMC Perinatal - Other	10
Non-DMC Perinatal - Other	11
Non-DMC/DSS CalWORKs	14
Non-DMC/DSS CalWORKs - Other	15
Non-DMC Adolescent Treatment	20
DMC 100% BHS Non-Minor Consent Non-Fed	87
DMC 100% BHS Non-Minor Consent Non Fed (Perinatal)	88
DMC EPSDT	90
DMC EPSDT - Perinatal	91
DMC Minor Consent	92
DMC Minor Consent - Perinatal	93
DMC Private Pay	94
DMC Perinatal	95
DMC Perinatal - Other	96
DMC Non-Perinatal	97
DMC Non-Perinatal - Other	98
DMC Non-Perinatal - Other	99
DMC Non-Perinatal - Women with Dependent Children (WDC)	100

PROGRAM CODES (continued)
Fiscal Year 2016-2017

DMC-ODS Waiver

Program Code Listing	Program Code #
DMC ODS Private Pay	101
DMC ODS Non-Perinatal	102
DMC ODS Perinatal	103
DMC ODS Minor Consent Non-Perinatal	104
DMC ODS Minor Consent Perinatal	105
DMC ODS 100% BHS Non-Minor Consent Non Fed Non Perinatal	106
DMC ODS 100% BHS Non-Minor Consent Non Fed Perinatal	107
DMC ODS Case Management Non-Perinatal	108
DMC ODS Case Management Perinatal	109
DMC ODS Physician Consultation Non-Perinatal	110
DMC ODS Physician Consultation Perinatal	111
DMC ODS Recovery Services Individual Non-Perinatal	112
DMC ODS Recovery Services Individual Perinatal	113
DMC ODS Recovery Services Group Non-Perinatal	114
DMC ODS Recovery Services Group Perinatal	115
DMC ODS Recovery Services Recovery Monitoring/Substance Abuse Assistance Non-Perinatal	116
DMC ODS Recovery Services Recovery Monitoring/Substance Abuse Assistance Perinatal	117
DMC ODS Recovery Services Case Management Non-Perinatal	118
DMC ODS Recovery Services Case Management Perinatal	119
DMC ODS Withdrawal Management 1 Non-Perinatal	120
DMC ODS Withdrawal Management 1 Perinatal	121
DMC ODS Withdrawal Management 2 Non-Perinatal	122
DMC ODS Withdrawal Management 2 Perinatal	123
DMC ODS Withdrawal Management 3.2 Non-Perinatal	124
DMC ODS Withdrawal Management 3.2 Perinatal	125
DMC ODS Medication Assisted Treatment (MAT) Non-Perinatal	126
DMC ODS Medication Assisted Treatment (MAT) Perinatal	127
DMC ODS Non-NTP MAT Buprenorphine Non-Perinatal	128
DMC ODS Non-NTP MAT Buprenorphine Perinatal	129
DMC ODS Non-NTP MAT Disulfiram Non-Perinatal	130
DMC ODS Non-NTP MAT Disulfiram Perinatal	131
DMC ODS Non-NTP MAT Naloxone Non-Perinatal	132
DMC ODS Non-NTP MAT Naloxone Perinatal	133
DMC ODS Non-NTP MAT Vivitrol Non-Perinatal	134
DMC ODS Non-NTP MAT Vivitrol Perinatal	135
DMC ODS Non-NTP MAT Acamprosate Non-Perinatal	136
DMC ODS Non-NTP MAT Acamprosate Perinatal	137

DMC FUNDING LINE COMBINATIONS
Fiscal Year 2016-17

Aid Code Group Abbreviation	Funding Line	Funding Line Description
REG	200-b	DMC Fed 50% T19 - Regular - Tied to FL 101a-b
REG	101a-b	DMC BHS 50% - Regular - Tied to FL 200-b
REGSB75	204-b	DMC SGF 100% T19 - Regular for Undocumented Individuals < age 19
MC	101a-mc	DMC BHS 100% - Minor Consent Clients
RRP	200-c	DMC Fed 100% - Refugee
MCHIPE	202-d	DMC Fed 88% T21 - MCHIP - Tied to FL 102a-d
MCHIPE	102a-d	DMC BHS 12% - MCHIP - Tied to FL 202-d
MCHIPSB75	204-d	DMC SGF 100% T21 - MCHIP for Undocumented Individuals < age 19 - Tied to FL 103a-d
HFE	202-e	DMC Fed 88% T21 - MCHIP Healthy Families Program Transition - Tied to FL 102a-e
HFE	102a-e	DMC BHS 12% - MCHIP Healthy Families Program Transition - Tied to FL 202-e
BCCTP	200-f	DMC Fed 65% T19 - BCCTP - Tied to FL 101a-f
BCCTP	101a-f	DMC BHS 35% - BCCTP - Tied to FL 200-f
AWPO	200-g	DMC Fed 65% T21 - Pregnancy Only - Tied to FL 101a-g
AWPO	101a-g	DMC BHS 35% - Pregnancy Only - Tied to FL 200-g
CWTCVAPTV	101a-cw	DMC BHS 100% - CalWorks Trafficking Victim
TLICSB75	204-h	DMC SGF 100% T21 - Targeted Low Income Children for Undocumented Individuals < age 19
TLICE	202-h	DMC Fed 88% T21 - MCHIP Targeted Low Income Children - Tied to FL 102a-h
TLICE	102a-h	DMC BHS 12% - MCHIP Targeted Low Income Children- Tied to FL 202-h
LIHP eff 1/1/17	206-i	DMC Fed 95% T19 - Low Income Health Program - Tied to FL 103a-i
LIHP eff 1/1/17	103a-i	DMC SGF 5% T19 - Low Income Health Program - Tied to FL 206-i
HPE	200-k	DMC Fed 50% T19 - Hospital Presumptive Elig - Tied to FL 101a-k
HPE	101a-k	DMC BHS 50% - Hospital Presumptive Eligibility - Tied to FL 200-k
HPEMCHIPE	202-m	DMC Fed 88% T21 - Hospital Presumptive Eligibility MCHIP - Tied to FL 102a-m
HPEMCHIPE	102a-m	DMC BHS 12% - Hospital Presumptive Eligibility MCHIP - Tied to FL 202-m
ICUA19	200-n	DMC Fed 50% T19 - ACA Infants/Children < age 19 - Tied to FL 101a-n
ICUA19	101a-n	DMC BHS 50% - ACA Infants/Children < age19 - Tied to FL 200-n
ICUA19SB75	204-n	DMC SGF 100% T19 - ACA Infants/Children < age 19
MCHIPICUA19E	202-r	DMC Fed 88% T21 - ACA MCHIP Infants/Children < age 19 - Tied to FL 102a-r
MCHIPICUA19E	102a-r	DMC BHS 12% - ACA MCHIP Infants/Children < age 19 - Tied to FL 202-r
PAOCRT21E	202-s	DMC Fed 88% T21 - MCHIP ACA Parents/Other Caretakers - Tied to FL 102a-s
PAOCRT21E	102a-s	DMC BHS 12% - MCHIP ACA Parents/Other Caretakers - Tied to FL 202-s
PAOCRT19	200-t	DMC Fed 50% T19 - ACA Parents/Other Caretakers - Tied to FL 101a-t
PAOCRT19	101a-t	DMC BHS 50% - ACA Parents/Other Caretakers - Tied to FL 200-t
PAOCRT19SB75	204-t	DMC SGF 100% T19 - ACA Parents/Other Caretakers for Undocumented Individuals < age 19
PWT19	200-v	DMC Fed 50% T19 - ACA Pregnant Women - Tied to FL 101a-v
PWT19	101a-v	DMC BHS 50% - ACA Pregnant Women - Tied to FL 200-v
PWT19SB75	204-v	DMC SGF 100% T19 - ACA Pregnant Women for Undocumented Individuals < age 19
PWT21	200-w	DMC Fed 65% T21 - ACA Pregnant Women - Tied to FL 101a-w
PWT21	101a-w	DMC BHS 35% - ACA Pregnant Women - Tied to FL 200-w
CHIPSITA19	200-x	DMC Fed 65% T21 - ACA CHIP - Tied to FL 101a-x
CHIPSITA19	101a-x	DMC BHS 35% - ACA CHIP - Tied to FL 200-x
NEPNA1964 eff 7/1/16 - 12/31/16	200-y	DMC Fed 100% T19 - Adults Newly Eligible Aged 19-64
NEPNA1964 eff 1/1/17	206-y	DMC Fed 95% T19 - Adults Newly Eligible Aged 19-64 - Tied to FL 103a-y
NEPNA1964 eff 1/1/17	103a-y	DMC SGF 5% T19 - Adults Newly Eligible Aged 19-64 - Tied to FL 206-y

DMC FUNDING LINE COMBINATIONS (continued)
Fiscal Year 2016-17

Aid Code Group Abbreviation	Funding Line	Funding Line Description
CWTCVAPTV	70p-cw	DMC SGF 100% - IOT Exp - CalWorks Clients
MC	70p-mc	DMC SGF 100% - IOT Exp - Minor Consent Clients
REG	201-b	DMC Fed 50% T19 - IOT Regular - Tied to FL 70p-50
REG	70p-50b	DMC SGF 50% - IOT Exp - Regular - Tied to FL 201-b
REGSB75	205-b	DMC SGF 100% T19 - IOT Exp - Regular for Undocumented Individuals < age 19
MCHIPE	203-d	DMC Fed 88% T21 - IOT Exp - MCHIP - Tied to FL 71p-12d
MCHIPE	71p-12d	DMC SGF 12% - IOT Exp - MCHIP - Tied to FL 203-d
MCHIPSB75	205-d	DMC SGF 100% T21 - IOT Exp - MCHIP for Undocumented Individuals < age 19 - Tied to FL 72p-12d
HFE	203-e	DMC Fed 88% T21 - IOT Exp - MCHIP Healthy Families Program Transition - Tied to FL 71p-12e
HFE	71p-12e	DMC SGF 12% - IOT Exp - MCHIP Healthy Families Program Transition - Tied to FL 203-e
BCCTP	201-f	DMC Fed 65% T19 - IOT Exp - BCCTP - Tied to FL 70p-35f
BCCTP	70p-35f	DMC SGF 35% - IOT Exp - BCCTP - Tied to FL 201-f
AWPO	201-g	DMC Fed 65% T21 - IOT Exp - Pregnancy Only - Tied to FL 70p-35g
AWPO	70p-35g	DMC BHS 35% - IOT Exp - Pregnancy Only - Tied to FL 201-g
TLICSB75	205-h	DMC SGF 100% - T21 IOT Exp - Targeted Low Income Children for Undocumented Individuals < age 19
TLICE	203-h	DMC Fed 88% T21 - IOT Exp - MCHIP Targeted Low Income Children - Tied to FL 71p-12h
TLICE	71p-12h	DMC SGF 12% - IOT Exp - MCHIP Targeted Low Income Children- Tied to FL 203-h
HPE	201-k	DMC Fed 50% T21 - IOT Exp - Hospital Pres Elig - Tied to FL 70p-50k
HPE	70p-50k	DMC SGF 50% - IOT Exp - Hospital Pres Elig - Tied to FL 201-k
HPEMCHIPE	203-m	DMC Fed 88% T21 - IOT Exp - Hospital Presumptive Eligibility MCHIP - Tied to FL 71p-12m
HPEMCHIPE	71p-12m	DMC SGF 12% - IOT Exp - Hospital Presumptive Eligibility MCHIP - Tied to FL 203-m
ICUA19	201-n	DMC Fed 50% T19 - IOT Exp - ACA Infants/Children < age 19 - Tied to FL 70p-50n
ICUA19	70p-50n	DMC SGF 50% - IOT Exp - ACA Infants/Children < age 19- Tied to FL 201-n
ICUA19SB75	205-n	DMC SGF 100% T19 - IOT Exp ACA Infants/Children < age 19 for Undocumented Individuals
MCHIPICUA19E	203-r	DMC Fed 88% T21 - IOT Exp - ACA MCHIP Infants/Children < age 19 - Tied to FL 71p-12r
MCHIPICUA19E	71p-12r	DMC SGF 12% - IOT Exp - ACA MCHIP Infants/Children < age 19 - Tied to FL 203-r
PAOCRT21E	203-s	DMC Fed 88% T21 - IOT Exp - MCHIP ACA Parents/Other Caretakers - Tied to FL 71p-12s
PAOCRT21E	71p-12s	DMC SGF 12% - IOT Exp - MCHIP ACA Parents/Other Caretakers - Tied to FL 203-s
PAOCRT19	201-t	DMC Fed 50% T19 - IOT Exp - ACA Parents/Other Caretakers - Tied to FL 70p-50t
PAOCRT19	70p-50t	DMC SGF 50% - IOT Exp - ACA Parents/Other Caretakers - Tied to FL 201-t
PAOCRT19SB75	205-t	DMC SGF 100% T19 - IOT Exp - ACA Parents/Other Caretakers for Undocumented Individuals < age 19
PWT19	201-v	DMC Fed 50% T19 - IOT Exp - ACA Pregnant Women - Tied to FL 70p-50v
PWT19	70p-50v	DMC SGF 50% - IOT Exp - ACA Pregnant Women - Tied to FL 201-v
PWT21	201-w	DMC Fed 65% T21 - IOT Exp - ACA Pregnant Women - Tied to FL 70p-35w
PWT21	70p-35w	DMC BHS 35% - IOT Exp - ACA Pregnant Women - Tied to FL 200-w
CHIPSITA19	201-x	DMC Fed 65% T21 - IOT Exp - ACA CHIP - Tied to FL 70p-35x
CHIPSITA19	70p-35x	DMC SGF 35% - IOT Exp - ACA CHIP - Tied to FL 201-x
REG	206-b	DMC Fed 50% T19 - Regular - Tied to FL 103a-b
REG	103a-b	DMC SGF 50% - Regular - Tied to FL 206-b
MC	103a-mc	DMC SGF 100% - Minor Consent Clients
MCHIPE	206-d	DMC Fed 88% T21 - MCHIP - Tied to FL 103a-d
MCHIPE	103a-d	DMC SGF 12% - MCHIP - Tied to FL 206-d
HFE	206-e	DMC Fed 88% T21 - MCHIP Healthy Families Program Transition - Tied to FL 103a-e
HFE	103a-e	DMC SGF 12% - MCHIP Healthy Families Program Transition - Tied to FL 206-e
BCCTP	206-f	DMC Fed 65% T19 - BCCTP - Tied to FL 103a-f
BCCTP	103a-f	DMC SGF 35% - BCCTP - Tied to FL 206-f
AWPO	206-g	DMC Fed 65% T21 - Pregnancy Only - Tied to FL 103a-g
AWPO	103a-g	DMC SGF 35% - Pregnancy Only - Tied to FL 206-g
CWTCVAPTV	103a-cw	DMC SGF 100% - CalWorks Trafficking Victim
TLICE	206-h	DMC Fed 88% T21 - MCHIP Targeted Low Income Children - Tied to FL 103a-h
TLICE	103a-h	DMC SGF 12% - MCHIP Targeted Low Income Children- Tied to FL 206h
HPE	206-k	DMC Fed 50% T19 - Hospital Presumptive Elig - Tied to FL 103a-k
HPE	103a-k	DMC SGF 50% - Hospital Presumptive Eligibility - Tied to FL 206-k
HPEMCHIPE	206-m	DMC Fed 88% T21 - Hospital Presumptive Eligibility MCHIP - Tied to FL 103a-m
HPEMCHIPE	103a-m	DMC SGF 12% - Hospital Presumptive Eligibility MCHIP - Tied to FL 206-m
ICUA19	206-n	DMC Fed 50% T19 - ACA Infants/Children < age 19 - Tied to FL 103a-n
ICUA19	103a-n	DMC SGF 50% - ACA Infants/Children < age19 - Tied to FL 206-n
MCHIPICUA19E	206-r	DMC Fed 88% T21 - ACA MCHIP Infants/Children < age 19 - Tied to FL 103a-r
MCHIPICUA19E	103a-r	DMC SGF 12% - ACA MCHIP Infants/Children < age 19 - Tied to FL 206-r
PAOCRT21E	206-s	DMC Fed 88% T21 - MCHIP ACA Parents/Other Caretakers - Tied to FL 103a-s
PAOCRT21E	103a-s	DMC SGF 12% - MCHIP ACA Parents/Other Caretakers - Tied to FL 206-s
PAOCRT19	206-t	DMC Fed 50% T19 - ACA Parents/Other Caretakers - Tied to FL 103a-t
PAOCRT19	103a-t	DMC SGF 50% - ACA Parents/Other Caretakers - Tied to FL 206-t
PWT19	206-v	DMC Fed 50% T19 - ACA Pregnant Women - Tied to FL 103a-v
PWT19	103a-v	DMC SGF 50% - ACA Pregnant Women - Tied to FL 206-v
PWT21	206-w	DMC Fed 65% T21 - ACA Pregnant Women - Tied to FL 103a-w
PWT21	103a-w	DMC SGF 35% - ACA Pregnant Women - Tied to FL 206-w
CHIPSITA19	206-x	DMC Fed 65% T21 - ACA CHIP - Tied to FL 103a-x
CHIPSITA19	103a-x	DMC SGF 35% - ACA CHIP - Tied to FL 206-x

DMC FUNDING LINE COMBINATIONS (continued)
Fiscal Year 2016-17

Aid Code Group Abbreviation	Funding Line	Funding Line Description
REG	207-b	DMC Fed 50% T19 - IOT Regular - Tied to FL 72p-50
REG	72p-50b	DMC BHS 50% - IOT Exp - Regular - Tied to FL 207-b
MC	72p-mc	DMC BHS 100% - IOT Exp - Minor Consent Clients
MCHIPE	207-d	DMC Fed 88% T21 - IOT Exp - MCHIP - Tied to FL 72p-12d
MCHIPE	72p-12d	DMC BHS 12% - IOT Exp - MCHIP - Tied to FL 207-d
HFE	207-e	DMC Fed 88% T21 - IOT Exp - MCHIP Healthy Families Program Transition - Tied to FL 72p-12e
HFE	72p-12e	DMC BHS 12% - IOT Exp - MCHIP Healthy Families Program Transition - Tied to FL 207-e
BCCTP	207-f	DMC Fed 65% T19 - IOT Exp - BCCTP - Tied to FL 72p-35f
BCCTP	72p-35f	DMC BHS 35% - IOT Exp - BCCTP - Tied to FL 207-f
AWPO	207-g	DMC Fed 65% T21 - Pregnancy Only - Tied to FL 72p-35g
AWPO	72p-35g	DMC BHS 35% - Pregnancy Only - Tied to FL 207-g
CWTCVAPTV	72p-cw	DMC BHS 100% - CalWorks Trafficking Victim
TLICE	207-h	DMC Fed 88% T21 - IOT Exp - MCHIP Targeted Low Income Children - Tied to FL 72p-12h
TLICE	72p-12h	DMC BHS 12% - IOT Exp - MCHIP Targeted Low Income Children- Tied to FL 207-h
HPE	207-k	DMC Fed 50% T21 - IOT Exp - Hospital Pres Elig - Tied to FL 72p-50k
HPE	72p-50k	DMC BHS 50% - IOT Exp - Hospital Pres Elig - Tied to FL 207-k
HPEMCHIPE	207-m	DMC Fed 88% T21 - IOT Exp - Hospital Presumptive Eligibility MCHIP - Tied to FL 72p-12m
HPEMCHIPE	72p-12m	DMC BHS 12% - IOT Exp - Hospital Presumptive Eligibility MCHIP - Tied to FL 207-m
ICUA19	207-n	DMC Fed 50% T19 - IOT Exp - ACA Infants/Children < age 19 - Tied to FL 72p-50n
ICUA19	72p-50n	DMC BHS 50% - IOT Exp - ACA Infants/Children < age 19- Tied to FL 207-n
MCHIPICUA19E	207-r	DMC Fed 88% T21 - IOT Exp - ACA MCHIP Infants/Children < age 19 - Tied to FL 72p-12r
MCHIPICUA19E	72p-12r	DMC BHS 12% - IOT Exp - ACA MCHIP Infants/Children < age 19 - Tied to FL 207-r
PAOCRT21E	207-s	DMC Fed 88% T21 - IOT Exp - MCHIP ACA Parents/Other Caretakers - Tied to FL 72p-12s
PAOCRT21E	72p-12s	DMC BHS 12% - IOT Exp - MCHIP ACA Parents/Other Caretakers - Tied to FL 207-s
PAOCRT19	207-t	DMC Fed 50% T19 - IOT Exp - ACA Parents/Other Caretakers - Tied to FL 72p-50t
PAOCRT19	72p-50t	DMC BHS 50% - IOT Exp - ACA Parents/Other Caretakers - Tied to FL 207-t
PWT19	207-v	DMC Fed 50% T19 - IOT Exp - ACA Pregnant Women - Tied to FL 72p-50v
PWT19	72p-50v	DMC BHS 50% - IOT Exp - ACA Pregnant Women - Tied to FL 207-v
PWT21	207-w	DMC Fed 65% T21 - ACA Pregnant Women - Tied to FL 72p-35w
PWT21	72p-35w	DMC BHS 35% - ACA Pregnant Women - Tied to FL 207-w
CHIPSITA19	207-x	DMC Fed 65% T21 - IOT Exp - ACA CHIP - Tied to FL 72p-35x
CHIPSITA19	72p-35x	DMC BHS 35% - IOT Exp - ACA CHIP - Tied to FL 207-x