



Fiscal Considerations for the DMC-ODS Pilot
Frequently Asked Questions
Updated July 2016

The following answers to frequently asked questions intend to provide clarification regarding the fiscal considerations for counties and providers electing to participate in the Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Program.

This document will be updated as necessary.

For additional information regarding the DMC-ODS Pilot Program:

- Visit <http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx>
- Contact us at DMCODSWAIVER@dhcs.ca.gov

Fiscal Resources:

- [Information Notice 15-034](#) – Drug Medi-Cal Organized Delivery System Pilot Fiscal Provisions
- [Information Notice 16-006](#) – Drug Medi-Cal Organized Delivery System Waiver County Implementation Fiscal Plan Guide

1. What is the interim rate-setting process and what are the parameters?

Annual interim rates for each covered service must be developed by the county for review and approval by the Department of Health Care Services (DHCS). DHCS has provided guidance and a format for rates development (see [Information Notice No. 16-006](#)), and will provide technical assistance upon request. The interim rates must conform to federal requirements pursuant to SSA §1903(w)(6) and §42 CFR 433.51. Interim rates should be calculated to include all estimated subcontractor expenditures and county direct and indirect costs for directly-delivered services.

2. Can the county set a rate range?

No.

3. What are some examples of factors for calculating interim rates?

DHCS will be releasing a recommended format for interim rate calculation that will

provide additional guidance and direction regarding the detail needed to support the county rate proposal. This will assist counties by providing a recommended format for supporting documentation and calculation of the proposed rates.

4. Are there rate-setting considerations for county-operated versus directly-delivered services?

Interim rates for purpose of federal financial participation are, with the exception of Narcotic Treatment Program services, proposed by the county and approved by the state for each service modality. County directly-delivered services are reconciled to actual cost consistent with the approved cost allocation methodology and subcontracted provider payments are considered expenditures subject to the lower of cost or customary charge.

5. Does the lower of cost or customary charge apply?

Yes, the cost reports are used to determine if the reconciled amount was the lower of cost or customary charge.

6. What inflation factors must be considered in interim rate-setting?

The State has selected the “Medicare Home Health Agency Market Basket Index” as the inflation factor to be applied by counties. Based on this index, the inflation factor for Fiscal Year 2016-17 is 2.4 percent.

7. What “deflator” factors must be considered in interim rate-setting?

No “deflator” factors are to be applied.

8. What are the claim submission timeframes for counties contracted to participate in the DMC-ODS Pilot Program?

The current Drug Medi-Cal Short Doyle 2 claims submission timeframes remain in effect unless waived by DHCS for good cause.

9. Are interim rates ultimately reconciled to cost? What is the process?

The county must complete and submit an annual cost report to reconcile the interim payments to the finalized cost report. Under or overpayment of federal funds will be addressed as a part of the final settlement process. The requirements for cost settlement will be outlined in the Centers for Medicare and Medicaid (CMS) approved Certified Public Expenditure (CPE) protocol which is an addendum to the waiver terms and conditions.

10. What happens if a county underestimates costs in the development of the interim rate?

Under or overpayment of federal funds to the contracting county will be addressed as a part of the final cost allocation and settlement process.

11. Are revenues other than 2011 realignment funds eligible to for federal match?

Yes. Other local funds are eligible to be used as the non-federal match as long as they are non-federal public funds and are otherwise eligible to be used as match consistent with the requirements outlined in SSA §1903(w)(6) and 42 CFR §433.51.

12. Can travel time be claimed under the DMC-ODS Pilot Program?

Yes. Counties may claim for travel time to and from providing direct services under the DMC-ODS Pilot Program. Travel and documentation time is to be included in the service time and must not be claimed separately. Travel and documentation time must be linked to the service provided, documented in the treatment notes, and subject to federal reasonableness standards.

13. What are reasonableness standards?

This information will be made available in the DMC-ODS Billing Manual.

14. Can services rendered in the community (i.e. outside of the four walls of the certified facility) be claimed?

Outpatient, including intensive outpatient, and case management services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community. Services can be provided in-person, by telephone, or by telehealth. However, if services are provided in the community, the provider delivering the service must be linked to a Drug Medi-Cal certified site / facility.

15. Can assessment activities be claimed?

Services rendered to conduct the required assessment to determine medical necessity and establish a treatment plan should be documented and claimed accordingly.