

INSTRUCTIONS FOR ODF **AVERAGE WORKSHEET (ODFAVG) and
PERINATAL AVERAGE WORKSHEET (PODFAVG)**

The ODF **Average** Worksheet (ODFAVG) may be used to develop the ODF cost report. There are separate worksheets for DMC and Perinatal Medi-Cal. Entries are only required on page 1 in the blank cells highlighted in yellow (shaded on hard copy). All other cells contain formulas. **PLEASE DO NOT CHANGE ANY OF THE FORMULAS.**

Providers will maintain the following documentation:

1. Group Sessions
 - (a) Group rosters by client name showing the payor for each client.
 - (b) Date, start time, and end time of the session.
 - (c) Counselor's name.
2. Individual Sessions
 - (a) Counselor's calendar, schedule, etc. which indicates the name of the client, date, start time, and end time of every individual counseling session.
3. All documentation must be traceable to client records.

The following are Form ODFAVG instructions:

Page 1

LINE 1 TOTAL GROSS COSTS – **Enter** the **total costs** to operate the program in Column D. These costs must be traceable to the provider's accounting records.

LINE 2 ADJUSTMENTS FOR MEDI-CAL UNREIMBURSABLE COSTS – **Enter** the costs of **services that are program requirements**, but are not allowable within the Utilization Control Plan in Column A and Column C. The Medi-Cal share of such costs must be identified and entered as a cost chargeable to the NNA and/or Private cost center.

(For example: Some Perinatal required services, such as child care (baby sitting), is a Perinatal requirement that is not Medi-Cal reimbursable. Also, certain SAPT Block Grant requirements for HIV and TB would not be Medi-Cal reimbursable.)

LINE 3 ADJUSTMENTS FOR DIRECT COSTS – **Enter** the costs of **services** that are applicable to a single cost center.

(For example: URC Costs are a direct cost only to the Medi-Cal cost center. The amount of such costs would be indicated in the Medi-Cal cost center).

LINE 4 TOTAL ADJUSTMENTS FOR MEDI-CAL UNREIMBURSABLE AND DIRECT COSTS – **Computed by formula.** Total of all Medi-Cal unreimbursable and direct costs entered in Lines 1 and 2.

LINE 5 ADJUSTED GROSS COSTS TO BE DISTRIBUTED – **Computed by formula.** Total gross costs (LINE 1) minus total Medi-Cal unreimbursable and direct costs (LINE 4). These costs represent equal services to all clients.

LINE 6 COUNTY MEDI-CAL ADMINISTRATION – **Enter** the amount of county administration (**URC, billing, and training**) incurred by the county. These costs must be supported by the county's accounting records.

LINE 7 TOTAL COSTS (PROGRAM AND COUNTY MEDI-CAL ADMINISTRATION) – **Computed by formula.** Adds total adjustments for Medi-Cal unreimbursable and direct costs (LINE 4), adjusted gross costs to be distributed (LINE 5), and county Medi-Cal administration (LINE 6).

LINE 8 TOTAL GROUP SESSIONS FOR THE YEAR – **Enter** the number of group sessions held by the provider. This information must be documented by the provider. To Column “A”, Line “R”, on appropriate Form 7895ODF. (Note: Use Data Entry Sheet to enter data.)

(For example, if a provider holds 2 group sessions a day, 5 days a week, 52 weeks a year – this number will be 520).

LINE 9 NUMBER OF GROUP SESSIONS BY COST CENTER – For each cost center, **enter** the number of sessions in which at least one (1) of the cost center’s clients participated. This information must be documented by the provider. To Columns B, C, and D, Line “R”, on appropriate Form 7895ODF (Note: Use Data Entry Sheet to enter data.)

(For example, of the 520 total groups sessions (LINE 8 example), review of the group rosters indicated private clients participated in 120 groups, Medi-Cal clients in 490 groups, and NNA clients in 410 groups – enter 120 (Private), 490 (Medi-Cal), and 410 (NNA).

NOTE: Since most group sessions contain participants from all cost centers, the number of group sessions will not add up to the total on Line 8.

LINE 10 TOTAL GROUP FACE TO FACE VISITS (GROUP UNITS OF SERVICE) – **Enter** the actual number of clients who participated in each of the group sessions. This information must be documented by the provider. No comparable line on Form 7895ODF. (Note: Use Data Entry Sheet to enter data.)

LINE 11 INDIVIDUAL FACE TO FACE VISITS – **Enter** one (1) unit for each individual counseling session regardless of the length of time of the session. This information must be documented by the provider. To Line “L” on appropriate Form 7895ODF.

LINE 12 AVERAGE MINUTES IN AN INDIVIDUAL FACE TO FACE SESSION – **Enter** the average length of time in **minutes** of all individual face to face sessions for the year.

(For example, a provider held 1,000 individual face to face sessions of various time lengths for a total of 47,200 minutes. The average minutes would be 47.20 (47,200 divided by 1000).

LINE 13 AVERAGE MINUTES IN A GROUP FACE TO FACE SESSION – **Enter** the average length of time in **minutes** of all group face to face sessions for the year. Keep in mind that school-based programs of shorter duration will reduce the average.

(For example, a provider held 1,000 group sessions of various time lengths for a total of 75,000 minutes. The average minutes would be 75.00 (75,000 divided by 1000).

LINE 14 PERCENT OF GROUP FACE TO FACE VISITS – **Computed by formula.** Percentage of each cost center’s group units (LINE 10) to the total group units of service (COLUMN D, LINE 10). These percentages will be used in the computation of group staff hours for each cost center.

LINE 15 GROUP HOURS – **Computed by formula.** The total group sessions for the year (COLUMN D, LINE 8) multiplied by the average minutes in a group face to face session (LINE 13) times the percent of group face to face visits (LINE 14).

LINE 16 PERCENT OF TOTAL HOURS WITHIN COST CENTER – **Computed by formula.** Within each cost center, group hours (LINE 15) divided by total staff hours (LINE 20). This percentage will be used to compute the cost of group sessions.

LINE 17 PERCENT OF INDIVIDUAL UNITS OF SERVICE – **Computed by formula.** Percentage of each cost center’s individual face to face units (LINE 11) to the total individual face to face units of service (COLUMN D, LINE 11).

- LINE 18 INDIVIDUAL HOURS – **Computed by formula.** The individual face to face visits (LINE 11) multiplied by the average minutes in an individual face to face session (LINE 12) divided by 60 (minutes).
- LINE 19 PERCENT OF TOTAL HOURS WITHIN COST CENTER – **Computed by formula.** Within each cost center, individual hours (LINE 18) divided by total staff hours (LINE 20). This percentage will be used to compute the cost of individual counseling sessions (units).
- LINE 20 TOTAL STAFF HOURS – **Computed by formula.** Group hours (LINE 15) plus individual hours (LINE 18). To Line “S”, on appropriate Form 7895ODF. (Note: Use Data Entry Sheet to enter data.)
- LINE 21 PERCENT OF TOTAL STAFF HOURS – **Computed by formula.** Percentage of each cost center’s staff hours (LINE 20) to the total staff hours (COLUMN D, LINE 20). These percentages will be used to distribute costs to each cost center.
- LINE 22 TOTAL MEDI-CAL UNREIMBURSABLE COSTS – **Computed by formula.** From PAGE 1, LINE 2s.
- LINE 23 TOTAL DIRECT COSTS – **Computed by formula.** From PAGE 1, LINE 3s.
- LINE 24 TOTAL DISTRIBUTED ADJUSTED GROSS COSTS – **Computed by formula.** Adjusted gross costs to be distributed (COLUMN D, LINE 5) times the percent of total staff hours (LINE 21).
- LINE 25 TOTAL PROGRAM COSTS – **Computed by formula.** Adds total Medi-Cal unreimbursable costs (LINE 22), total direct costs (LINE 23), and total distributed adjusted gross costs (LINE 24) for each cost center.
- LINE 26 TOTAL COSTS FOR DISTRIBUTION – **Computed by formula.**
- For **Private and NNA**, the amount is from total program costs (LINE 25).
- For **Medi-Cal**, adds total direct costs (LINE 23) and total distributed adjusted gross costs (LINE 24).
- LINE 27 DISTRIBUTED GROUP COSTS – **Computed by formula.** Total costs for distribution (LINE 26) times percent of total (group) hours within a cost center (LINE 16).
- LINE 28 TOTAL GROUP COUNTY ADMINISTRATION COSTS – **Computed by formula.** County Medi-Cal administration costs (LINE 6) multiplied by the percent of total (group) hours within cost center (LINE 16). To “DMC County Administration” line on appropriate Form 7895ODF. (Note: Use Data Entry Sheet to enter data.)
- LINE 29 GROUP TREATMENT COSTS – **Computed by formula.** Add distributed group costs (LINE 27) and total group county administration costs (LINE 28).
- LINE 30 COST PER GROUP SESSION – **Computed by formula.** Group treatment costs (LINE 29) divided by the number of group sessions by cost center (LINE 9).
- LINE 31 COST PER GROUP FACE TO FACE VISIT – Group treatment costs (LINE 29) divided by total group face to face visits (LINE 10).
- LINE 32 GROUP DRUG/MEDI-CAL MAXIMUM RATE PER GROUP FACE TO FACE VISIT – **Computed by formula.** The maximum rate is computed based on the **average minutes in a group face to face session**. If the average minutes in a group face to face session (LINE 13) is **equal to or greater than 90 (minutes)**, the maximum rate PER GROUP FACE TO FACE VISIT WILL BE \$30.28 (PN \$61.33). If the average minutes in a group face to face session is **less than 90**

(minutes), the maximum rate will be reduced proportionally by multiplying the CAP by the average minutes in a group session (LINE 13) divided by 90 (minutes).

(For example, the average minutes of all Medi-Cal group session is **81** minutes, the rate cap of \$30.28 would be reduced to \$27.25 (\$30.28 times 81 divided by 90).

LINE 33 MAXIMUM ALLOWABLE MEDI-CAL COSTS FOR GROUP FACE TO FACE VISITS – **Computed by formula.** The **lower** of the cost per group face-to-face visit (LINE 32) or the Drug/Medi-Cal maximum rate per face-to-face visit (LINE 32) times the number of group face-to-face visits by cost center (LINE 10).

LINE 34 ADJUSTED COST PER GROUP FACE TO FACE VISIT (**PROVISIONAL RATE**) – **Computed by formula.** The maximum allowable Medi-Cal costs for group sessions (LINE 33) divided by the total group face to face visits (LINE 10).

LINE 35 COSTS MOVED TO UNRESTRICTED FUNDING SOURCES – **Computed by formula.** The group treatment costs (LINE 29) less the maximum allowable Medi-Cal costs for group sessions (LINE 33).

LINE 36 DISTRIBUTED INDIVIDUAL COSTS – **Computed by formula.** Total costs for distribution (LINE 26) times percent of total (individual) hours within a cost center (LINE 19).

LINE 37 TOTAL INDIVIDUAL COUNTY ADMINISTRATION – **Computed by formula.** County Medi-Cal administration costs (LINE 6) multiplied by the percent of total (individual) hours within cost center (LINE 19).

LINE 38 INDIVIDUAL TREATMENT COSTS – **Computed by formula.** Add distributed individual costs (LINE 36) and total individual county administration costs (LINE 37).

LINE 39 COST PER INDIVIDUAL SESSION (FACE TO FACE VISIT) – **Computed by formula.** Individual treatment costs (LINE 38) divided by total individual face to face visits (LINE 11).

LINE 40 INDIVIDUAL DRUG/MEDI-CAL MAXIMUM RATE – **Computed by formula.** The maximum rate is computed based on the **average minutes in an individual face to face session.** If the average minutes in an individual face to face session (LINE 12) is **equal to or greater than 50 (minutes)**, the maximum rate will be \$71.25 (PN \$101.99). If the average minutes in an individual face to face session is **less than 50 (minutes)**, the maximum rate will be reduced proportionally by multiplying the CAP by the average minutes in an individual session (LINE 12) divided by 50 (minutes).

(For example, the average minutes of all Medi-Cal individual sessions is **45** minutes, the rate cap of \$71.25 would be reduced to \$64.13 (\$71.25 times 45 divided by 50).

LINE 41 MAXIMUM ALLOWABLE MEDI-CAL COSTS FOR INDIVIDUAL SESSIONS – **Computed by formula.** The **lower** of the cost per individual session (LINE 39) or the individual Drug/Medi-Cal maximum rate (LINE 40) times the number of individual face to face visits (LINE 11).

LINE 42 ADJUSTED COST PER INDIVIDUAL SESSION (**PROVISIONAL RATE**) – **Computed by formula.** The maximum allowable Medi-Cal costs for individual sessions (LINE 41) divided by the total individual face to face visits (LINE 11).

LINE 43 COST MOVED TO UNRESTRICTED FUNDS – **Computed by formula.** The individual treatment costs (LINE 38) less the maximum allowable Medi-Cal costs for individual sessions (LINE 41).

LINE 44 TOTAL REIMBURSABLE COSTS – **Computed by formula.**

For **Unrestricted funds**, adds group costs moved to unrestricted funding sources (LINE 35) and individual costs moved to unrestricted funding sources (LINE 43).

For **Private and NNA**, adds group treatment costs (LINE 29) and individual treatment costs (LINE 38).

For **Medi-Cal**, add the maximum allowable Medi-Cal costs for group sessions (LINE 33) and maximum allowable Medi-Cal costs for individual sessions (LINE 41).

LINE 45 COST PER GROUP STAFF HOUR – **Computed by formula.**

For **Unrestricted**, group costs moved to unrestricted funding sources (LINE 35) divided by Medi-Cal group hours (COLUMN B, LINE 15).

For **Private and NNA**, group treatment costs (LINE 29) divided by group hours (LINE 15).

For **Medi-Cal**, maximum allowable Medi-Cal costs for group sessions (LINE 33) divided by group hours (LINE 15).

LINE 46 COST PER INDIVIDUAL STAFF HOUR – **Computed by formula.**

For **Unrestricted**, individual costs moved to unrestricted funding sources (LINE 43) divided by Medi-Cal individual hours (COLUMN B, LINE 18).

For **Private and NNA**, individual treatment costs (LINE 38) divided by individual hours (LINE 18).

For **Medi-Cal**, maximum allowable Medi-Cal costs for individual sessions (LINE 41) divided by individual hours (LINE 18).

LINE 47 COST PER TOTAL STAFF HOUR – **Computed by formula.**

For **Unrestricted**, total reimbursable costs (LINE 44) divided by total staff hours for Medi-Cal (COLUMN B, LINE 20).

For **Private, Medi-Cal, and NNA**, total reimbursable costs (LINE 44) divided by total staff hours (LINE 20).

LINE 48 TOTAL MEDI-CAL COSTS (GROUP + INDIVIDUAL TREATMENT) – **Computed by formula.**
Group treatment costs (LINE 29) added to individual treatment costs (LINE 38). This is the total costs allocated to Medi-Cal and can be verified by adding total unrestricted reimbursable costs (LINE 44) to total Medi-Cal reimbursable costs (COLUMN B, LINE 44).