Drug Medi-Cal Service Claim for Reimbursement of County Administrative Expenses

County Name: County Code: _____ Date: _____

Fiscal Year: _____ Quarter/Total Fiscal Year: _____

☐ ODS Waiver Services ☐ Replacement Claim

Total Individuals Served:_____ Medi-Cal Individuals Served:_____

Individuals not Eligible for Federal Financial Participation: _____

Description	MCHIP	Drug Medi-Cal Administrative Expense
1. DMC Direct Services Treatment Expenses		
2. State Prop 30		
State Prop 30 Unused		
State Prop 30 Unused		
State Prop 30 Unused		
3. Contingency Management (CM) Administrative Expenses		
4A. Federal Prop 30 - Parity. State Plan Counties only.		
4B. Federal Prop 30 - Interoperability. ODS Counties only.		
Federal Prop 30 Unused		
Federal Prop 30 Unused		
5. Maximum Admin. Percent Allowed	10.00%	15.00%
6. Maximum Admin. Dollars (Line 1 x Line 5)		
7. Actual County DMC Admin. Expenses Including Prop 30 and CM		
8. Admin. Expenses Subject to Reimbursement (lower of Line 6 or 7)		
9. FFP Percentage	0.65	50%
10. Admin FFP (Line 8 x Line 9)	0	0
11. SGF Eligible Amount (From Lines 2 and 4)		
12. Medi-Cal Discount Percentage		
13. Non - Eligible Medi-Cal		
14. Total FFP	0	
15. Total SGF	0	
16. HCBS ARP Fund (From Line 3)		

I HEREBY CERTIFY under penalty of perjury that I am the official responsible for the administration of Drug Medi-Cal services in and for said claimant; that I am authorized to sign this certification on behalf of the County; that I have not violated any of the provisions of Sections 1090-1099 of the Government Code; that the amount for which reimbursement is claimed herein is in accordance with Welfare and Institutions Code Section 14124.24; that the claim is based on actual, total-fund expenditures for services to eligible beneficiaries; and that to the best of my knowledge and belief this claim is in all respects true, correct, and in accordance with the law. The County further certifies under penalty of perjury that: all claims for services provided to county clients have been provided to the clients by the County or County-contracted provider; the services were, to the best of the County's knowledge, provided in accordance with the client's written treatment plan; and that all information submitted to the Department of Health Care Services (DHCS) is accurate and complete. The County understands that payment of these claims from Federal and/or State funds, and any falsification or concealment of a material fact may be prosecuted under Federal and/or State laws. For Non-ODS Waiver counties, pursuant to the Code of the Federal Regulations (CFR) Title 42, Section 433.32, the County agrees to keep for a minimum of three years after final determination of costs is made through the DHCS cost report settlement process and retained beyond the three-year period if audit findings have not been resolved, a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. Pursuant to the Code of Federal Regulations (CFR) Title 42, Section 438.3 (u), ODS Waiver participating counties and their contracted non-NTP providers must maintain fiscal and statistical records for a period of ten years from the date of service for all claims for reimbursement of California to DHCS, the Medi-Cal Fraud Unit, California Department of Justice, Office of the State Controller, U.S. Department of Health and Human Services, or their duly authorized representatives. The County also certified under penalty of perjury that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, gender, or physical or mental disability.

County Alcohol & Other Drug Programs Administrator Signature

Date

I HEREBY CERTIFY under penalty of perjury that I am a duly qualified and authorized official of the herein claimant responsible for the examination and settlement of accounts; that I am authorized to sign this certification on behalf of the County, and that the information is to be used for filing a claim with the federal government for federal funds pursuant to CFR Title 42, Section 430.30. I understand that misrepresentation of any information provided herein constitutes a violation of state and federal law. I further certify under penalty of perjury that the claim is based on actual, total-funds expenditures made by the County of public funds that meet the requirements for claiming federal financial participation (FFP) pursuant to all applicable requirements of state and federal law, including, but not limited to CFR Title 42, Section 430.30 and 433.51, and the Federal Office of Management and Budget Circular A-87, and that the expenditures claimed have not previously been, nor will they be claimed at any other time as claims to receive FFP funds under Medicaid or any other program. I understand that DHCS must deny any payment if it determines that the certification is not adequately supported for purposes of claiming FFP. I understand that all the records of funds expended are subject to review and audit by DHCS and/or the federal government and that, pursuant to CFR Title 42, Section 433.32, all records necessary to fully disclose the extent of services furnished to clients must be kept for a minimum of three years after the final determination of costs is made through the DHCS cost report settlement process and retained beyond the three year period if audit findings have not been resolved. I understand that ODS Waiver records must be maintained for a period of ten years after the date of service for all claims for reimbursement, pursuant to the code of Federal Regulations (CFR) Title 42, Section 438.3 (u).

_____

Title
(County Auditor-Controller, Finance Officer, or County Alcohol & Other Drug Programs Accounting Officer)

_____ _____

Signature Date

Completed form is due within 60 calendar days following the end of the service quarter. Email as an attachment to sudfmab@dhcs.ca.gov.

Instructions

Heading Instructions: Select the County Name from drop down menu, County Code will populate, and date the claim form is submitted. From the dropdown selections, select the Fiscal Year in which costs were incurred and then select the applicable Quarter or Total for Fiscal Year. Check the box for ODS Waiver Services if the county is an ODS Waiver Services. Check the box for Replacement Claim if submitting a replacement claim. Enter total individual served, Medi-Cal individuals served and individuals not eligible for Federal Financial Participation.

Line Item Instructions:

Round all figures to the nearest cents. Round down for FFP.

1. Enter the direct facility expenditures incurred during the quarter by the county for each program (MCHIP and Drug Medi-Cal) based on the treatment claim costs for each program typically reported on claim form MC 5312. Refer to the Short-Doyle Medi-Cal Aid Code Master Chart on DHCS website for a definition of the Medi-Cal aid codes included in each program. Direct facility expenditures include claims for county providers and contract providers reimbursed through the Short-Doyle Medi-Cal DMC system.

2. Enter the total for State Prop. 30 expenses incurred for each program (MCHIP and DMC). The non-federal share is reimbursed with 100% State General Fund (SGF).

3. Enter the total for Contingency Management Administration Expenses for each program (MCHIP and DMC). The non-federal share is reimbursed with 100 % of HCBS ARP Fund until December 31, 2024. CM admin claiming available for participating counties only. Final claims accepted 8/15/2024.

4A-4B. Enter the total Federal Prop. 30 for each program (MCHIP and DMC). The non-federal share is shared between the County and SGF. For State Plan Counties only, Parity claiming is available for dates of service after 7/1/2022. Please see DMC Parity Information Notice for claiming specifics. For DMC ODS Counties only, Interoperability claiming is available.

5. The maximum allowed administrative percentage is shown for each program. No entry required.

6. The maximum allowed administrative amount is shown for each program (Line 1 x Line 5). No entry required.

7. Enter the total administrative expenditures incurred for the program during the quarter. Enter the actual allocated administrative expenditures incurred for the programs, including costs in Line 2, Line 3 and Line 4. Counties should allocate total administrative expenditures between the programs consistent with the allocation approaches allowed for in the cost report, which include (1) the relative percentage of program recipients in the population served by the county or (2) the gross costs of each program. Counties should apply the same approach consistently from quarter to quarter and on the year end cost report. Please note, entry required.

8. Lower of Line 5 or Line 6. No entry required.

9. FFP percentage. No entry required

10. The Federal Financial Participation for each program is computed. No entry required.

11. The amount eligible for SGF for Line 2 and Line 3 is computed. No entry required.

12. Medi-Cal Discount Percentage calculated. No entry required.

13. Non - Eligible Medi-Cal percentage calculated. No entry required.

14. Total FFP amount calculated. No entry required.

15. Total SGF amount calculated. No entry required.

16. The amount eligible for HCBS ARP Fund for Line 3 is computed. No entry required.

Certifications:

Each claim form must include the signed certification of the County Alcohol and Other Drug Programs Administrator and either County Auditor-Controller, Finance Officer, or County Alcohol and Other Drug Programs Accounting Officer.

Send all claims to: SUDFMAB@dhcs.ca.gov