

County-Based Medi-Cal Administrative Activities Manual

May 28, 2009

*State of California
Department of Health Care Services
Safety Net Financing Division
Administrative Claiming Local and Schools Services Branch*

In Cooperation with the:
Centers for Medicare and Medicaid Services
And the
California Local Governmental Agency Consortium

TABLE OF CONTENTS

Section	Title
i	ABOUT THIS MANUAL
1	CMAA BACKGROUND AND OVERVIEW
2	MAA CONTRACTS
3	CMAA CLAIMING PLAN INSTRUCTIONS
4	DETERMINING THE MEDI-CAL PERCENTAGE
5	TIME SURVEYS
6	MAA SUMMARY AND DETAIL INVOICES
7	MAA DOCUMENTATION
<i>APPENDIX A</i>	ABBREVIATIONS AND ACRONYMS
<i>APPENDIX B</i>	MAA GLOSSARY
<i>APPENDIX C</i>	MAA LEGAL CITATIONS
<i>APPENDIX D</i>	SKILLED PROFESSIONAL MEDICAL PERSONNEL

ABOUT THIS MANUAL

The California County-Based Medi-Cal Administrative Activities Manual (CMAA Manual) intends to help local governmental agencies (LGAs—counties and chartered cities¹) participate in the CMAA program and maintain proper documentation for their claiming units. The CMAA Manual is based on State and Federal codes and regulations and on the federal Centers for Medicare and Medicaid Services' (CMS's) Medicaid School-Based Administrative Claiming Guide (May 2003). Many of these requirements were defined or listed in the "Agreement between the Health Care Financing Administration and the California Department of Health Services," dated September 27, 1995, available at www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx via the link "MAC Agreement."

The State of California's Department of Health Care Services (DHCS) will issue periodic updates to the CMAA Manual. When changes occur in the CMAA program or when policies or procedures require clarification, DHCS will issue Policy and Procedure Letters (PPLs). The language in the PPLs will be incorporated into the CMAA Manual in the form of replacement pages. Each PPL requiring a replacement page will include a revised Table of Contents and replacement page(s). Annually, a PPL will be issued that lists PPLs issued during the past year by title and manual page number, if any pages were replaced.

Appendix A provides a list of abbreviations and acronyms.

Appendix B provides a list of definitions or descriptions of key terms.

Appendix C provides a list of relevant legal citations.

Appendix D contains information to help determine if staff qualifies as Skilled Professional Medical Personnel (SPMP).

The CMAA Manual is your primary reference for information on how to participate in the CMAA program. Consult this manual before seeking other sources of information. It contains the policies and procedures that LGAs must follow to submit their CMAA claiming plans and invoices to DHCS for reimbursement of the costs of performing CMAA. Especially if you are new to CMAA, be sure to read the **entire manual** before determining if you should participate.

Organization of This Manual

Front	About This Manual
Section 1	Background and Overview
Sections 2–7	Policies and Procedures
Appendices	Reference Material

However, this manual should not be your only source for determining whether your program complies with State and federal law. Additional requirements can be located

¹ "Chartered city" means a local city government that has a public health department certified by DHCS for participation in the Medi-Cal program.

in the CMAA contract; on the certification statements in the CMAA claiming plan and CMAA invoice; and in the following codes, regulations, and guidelines:

Title 42 United States Code, Section 1396 et seq.; 42 Code of Federal Regulations (CFR) Part 400 et seq.; and 45 CFR Part 95, California Welfare and Institutions (W&I) Code, Division 9, Part 3, Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) all as periodically amended; State-issued policy directives; and the federal Office of Management and Budget (OMB) Circular A-87, as periodically amended.

LGAs should study these codes, regulations, and guidelines. The CMAA Manual does not have the same legal standing as these laws and guidelines. For your convenience, excerpts or descriptions of these laws and guidelines are in Appendix C, along with links to websites where you might conduct further research.

An LGA is defined as a county, chartered city, or Native American Indian tribe or tribal organization. LGA claiming units may also be community-based organizations (CBOs) contracted with an LGA to conduct MAA. Whether public or private, each claiming unit must be located within the geographic service region of the LGA that submits its claims to DHCS (MAA Contract, Exhibit A (2)).

This manual is for the use of county and city governments that participate in CMAA. For information on participation by schools or (in the near future) Native American Indian tribes, please refer to the related manuals at www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx.

Numbering System. At the bottom of each page is a number that identifies the section and page. For example, the number 2-1 indicates Section 2, page 1. The numbering system's design is to accommodate additions and deletions when the CMAA Manual has updates. When DHCS revises this manual, staff will revise the effective date at the bottom of each updated page.

Policy and Procedure Letters. When the CMAA program changes, or when policies or procedures require clarification, DHCS will issue Policy and Procedure Letters (PPLs). DHCS will incorporate the PPLs into the CMAA Manual during the manual's periodic revisions.

Legal Citations. The text of this manual includes legal citations, such as 42 CFR §433.51, which are listed and described in Appendix C. The first number (42) is the "title" of the code or regulation. The abbreviation refers to the code or regulation. "§" stands for "section" and is followed by the section number.

If you have questions about the contents of the CMAA Manual, please contact your LGA MAA/TCM Coordinator.

SECTION 1

COUNTY-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES BACKGROUND and OVERVIEW

Table of Contents

Title	Page
The Federal Medicaid Program	1-1
The California County-Based Medi-Cal Administrative Activities Program	1-2
Claiming Plans	1-2
Medi-Cal Percentage	1-3
Time Surveys	1-4
Invoices	1-4
Allowable Activities	1-5
Allocated Activities	1-6
Subcontractors	1-7
Duplicate Payments	1-7
Steps in the MAA Claiming Process	1-8
Timely Response to DHCS Requests	1-9
Compliance with DHCS Due Dates	1-10

The Federal Medicaid Program

The Medicaid program is a national health care program established under Title XIX of the Social Security Act and administered by the federal Centers for Medicare and Medicaid Services (CMS). The Medicaid program furnishes medical assistance to families or individuals who are aged, blind, or disabled; and for identified eligible persons whose income and resources are insufficient to meet the cost of necessary medical services.

Medicaid is a State and federal partnership under which CMS establishes basic program rules. Each State administers the program and develops its own policies and guidelines for program administration within federal regulations. In California, the program administered is Medi-Cal.

The primary federal requirements for Medi-Cal involve how to determine who is eligible and what services to provide them. Federal Medicaid law requires Medi-Cal to serve certain categories of eligible persons and provide specific types of services. Federal Medicaid law also allows Medi-Cal to provide a variety of other services. These requirements are defined in California's Medicaid State Plan agreement with CMS.

States meeting program requirements receive federal funding in the form of federal financial participation (FFP), which is a reimbursement of actual expenditures for Medi-Cal services and administration. The FFP for MAA is 75 or 50 percent of total funds expenditures depending on the role of staff that perform MAA (42 CFR §433.15).

FFP is available to LGAs for the cost of administrative activities that directly support efforts to identify and enroll potentially eligible persons into Medi-Cal as described in the State Plan agreement with CMS. LGAs may claim for the cost of outreach and facilitating the enrollment process.

FFP is also available for some activities related to the provision of Medi-Cal services to Medi-Cal

For complete Medi-Cal eligibility information or other health-related services, please contact your nearest county social services office at the address or phone number listed on the DHCS website.

County contact information is available at <http://www.dhcs.ca.gov/individuals/Pages/CountyOffice.aspx>.

beneficiaries. These MAA include transporting beneficiaries to Medi-Cal services, contracting for Medi-Cal services, Medi-Cal program planning and policy development, and MAA/TCM coordination and LGA claims' administration. However, these MAA reimbursements are allowable only in support of services that:

- Are listed in the State Plan,
- Are not eligible for payment by a third party insurer,
- Are not provided for free to the general public,

- Establish a fee for each available service (i.e., medical service),
- Collect third party insurance information from all persons served (those enrolled in Medi-Cal and those not enrolled), and
- Bill other responsible third party insurers.

To perform MAA, there must be a valid Medi-Cal program to administer. LGAs may not knowingly submit claims for MAA conducted in support of Medi-Cal health care providers who do not comply with these federal requirements. LGAs must make a good faith effort to determine if the services provided through that Medi-Cal program conform to Medicaid law.

The California County-Based Medi-Cal Administrative Activities Program

MAA became a covered Medi-Cal benefit effective January 1, 1995 (W&I Code §14132.47). MAA is the proper and efficient administration of the Medi-Cal program. MAA assists eligible persons to apply for and access needed medical assistance.

Under California’s Medicaid State Plan agreement with CMS, DHCS is the “single State agency” responsible for the administration and oversight of the Medi-Cal program. DHCS contracts with LGAs to fulfill this agreement. DHCS also maintains interagency agreements with other State agencies (see the sidebar for an example) that serve Medi-Cal beneficiaries to fulfill the State Plan. LGAs must ensure that they do not duplicate these claims. Ultimately, all MAA conducted in California relies on regulation, oversight, and cost accounting from DHCS.

Claiming Plans. To participate in MAA, each LGA must enter into a contract with DHCS. As part of the contract, the LGA must submit a comprehensive claiming plan for each claiming unit performing MAA. The claiming unit is an entity within the LGA that performs MAA. The CMAA claiming plan must describe in detail:

- Each specific administrative activity the LGA will claim,
- The claiming units for which invoices will be submitted,
- The supporting documentation the claiming unit will maintain, and
- The development and documentation of costs related to MAA.

MAA through the California Department of Mental Health (CDMH)

DHCS has delegated authority to CDMH through an interagency agreement to administer the MHMAA program when participating county mental health programs perform allowable MAA. Participating county mental health programs submit their MHMAA claiming plan directly to CDMH. CDMH reviews the claiming plan and forwards each claiming plan to DHCS and CMS for additional review and approval. Participating county mental health programs also submit MHMAA invoices directly to CDMH for processing. CDMH submits approved invoices to DHCS for payment. CDMH MAA must not be part of the LGA comprehensive claiming plan (MAC Agreement, pg. 28).

DHCS reviews and approves the claiming plan. For first-time LGA participants in CMAA, CMS will also be reviewing these claiming plans. At its discretion, DHCS may submit other claiming plans to CMS for further review. To be claimable, the LGA must identify in a CMAA claiming plan what administrative activities it will conduct and what staff positions will conduct these activities. See Section 3 of this manual.

Each LGA's claiming plan remains in effect from year to year until amended in accordance with the claiming plan checklist.

Activities that require the LGA to complete a claiming plan amendment:

- Addition of Claiming Unit
- Addition of MAA category (activity)
- Addition of a subcontractor that performs MAA
- Change in the specific administrative activities conducted or the Medi-Cal services these activities help administer

Amend claiming plans in accordance with the Claiming Plan Amendment Checklist (www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx).

This is not an all-inclusive list of claiming plan amendment situations. Explain the situation on the checklist or attach an explanation if a circumstance arises that is not listed, LGAs that

submit claiming plans and claiming plan amendments for the first quarter must submit them by November 1 to be effective the previous July 1. Claiming plans and claiming plan amendments submitted for the second, third, or fourth quarters, once approved, become effective the first day of the quarter in which submitted to DHCS. For example, to submit a claiming plan or amendment for the second quarter (October–December), LGAs must have postmarked it by December 31 of that year, i.e., a U.S. Mail postmark or a receipt from an express delivery service dated no later than December 31 of the same quarter. An LGA may submit amendments at any time but may submit only one amendment package per quarter. Amendments are subject to the same approval process as claiming plans.

Medi-Cal Percentage. LGAs might or might not direct charge allowable MAA solely to the Medi-Cal population. Therefore, the costs associated with allowable MAA might require discounting to determine what portion of the population served is Medi-Cal eligible. The method of calculating the discount is to take an actual client count or use the DHCS-calculated Countywide Average, which is a percentage based on the total number of Medi-Cal recipients and the total number of all individuals served by the LGA. LGAs may also use other methods approved by DHCS and CMS to calculate the Medi-Cal percentage discount. The CMAA claiming plan must identify the Medi-Cal discounting method used. When creating invoices, LGAs may only use the discount method that DHCS approved on the related claiming plan. DHCS will deny invoices that use an unapproved discount method. (For further information, see Section 4, Determining the Medi-Cal Percentage.)

Time Surveys. LGAs must time survey annually for one month. This month may be either September or October at the discretion of the LGA. However, the LGA must consider its ability to meet the November 1 due date for first-quarter claiming plans. In either case, all time survey participants within a claiming unit must time survey in the same month. Alternatively, you may request to time survey in a different month by contacting your LGA MAA/TCM Coordinator who will make this request to DHCS 30 days prior to the month in which you wish to time survey (see Section 5).

When time surveying to CMAA, use only the “MAA-TCM Combined Time Survey” form available at www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx. This form helps ensure non-duplication of services between the CMAA and Targeted Case Management (TCM) programs. DHCS will deny invoices from LGAs that use a time survey form not issued by DHCS.

The time survey must reflect all of the paid time and activities (whether allowable or unallowable) performed by employees participating in the CMAA claiming plan. The time survey identifies Direct Patient Care and Other Programs/Activities, and ensures that those costs are not included in the claims for administrative activities. Time survey codes distinguish each activity an employee performs during a time survey period. The time survey is a legal document representing the actual time the person spends performing the MAA reported in the invoice.

Invoices. LGAs submit claims for MAA reimbursement to DHCS. For each claim for MAA costs, LGAs prepare a separate detailed quarterly invoice for each claiming unit. LGAs also prepare and submit a quarterly summary invoice for each claiming unit and attach the required checklists to ensure accuracy and completeness. The template for the detailed invoice blends the cost and revenue data into one spreadsheet that allows for the computation of the claim, adjusting for all necessary revenues and applying activity and Medi-Cal discount percentages. The LGA must provide DHCS with complete invoice and expenditure information no later than 18 months after the end of the quarter for which a claim is submitted. CMAA invoices submitted later than 18 months may not be paid. See Section 6 for instructions on MAA Summary and Detail Invoices.

A claiming unit can be:

- Part of a county governmental agency within the LGA (identifiable on LGA general ledgers)
- Part of a city governmental agency within the LGA (identifiable on city general ledgers)
- Part of another governmental agency within the LGA’s geographical region
- Part of a non- governmental agency within the LGA’s geographical region subcontracted by the LGA specifically to conduct MAA.

DHCS will approve the invoice, return the invoice for revision, or deny the invoice. An LGA can request that DHCS reconsider its denial of an invoice. An LGA must write and postmark or email such a request within 30 days from the receipt of the denial notice. This review is limited to a programmatic or accounting reconsideration based upon additional supporting documentation submitted to DHCS.

Allowable Activities. The following are allowable MAA. This list provides a general introduction. For a more detailed description of these activities, see Section 3, CMAA Claiming Plan, or Section 5, Time Surveys.

Medi-Cal Outreach	Bringing potentially eligible persons into the Medi-Cal system and helping enrolled beneficiaries obtain Medi-Cal services. Medi-Cal Outreach is divided into two sections, A and B.
Medi-Cal Outreach A (Activity A)	Providing information about Medi-Cal to the general population in order to encourage eligible persons to apply for Medi-Cal. Outreach A can also be a campaign or program directed toward bringing enrolled Medi-Cal beneficiaries into specific Medi-Cal covered services. These are service campaigns, targeted specifically to Medi-Cal services.
Medi-Cal Outreach B1 (Activity B1)	Bringing specific high-risk populations into health care services covered by Medi-Cal, targeting persons who are eligible and persons who are not eligible for Medi-Cal. This activity is discounted by the actual Medi-Cal client count or any other reasonable method approved by DHCS and CMS. The only difference between Activity B1 and Activity B2 is the discounting method.
Medi-Cal Outreach B2 (Activity B2)	Bringing specific high-risk populations into health care services covered by Medi-Cal, targeting persons who are eligible and persons who are not eligible for Medi-Cal. This activity is discounted by the countywide Medi-Cal average. The only difference between Activity B1 and Activity B2 is the discounting method.
Facilitating Medi-Cal Application (Activity C)	Explaining the Medi-Cal eligibility process and rules to prospective applicants, helping an applicant complete a Medi-Cal eligibility application, and gathering information related to the Medi-Cal application and to the eligibility determination and redetermination process. This does not include rendering the Medi-Cal eligibility determination itself.
Medi-Cal Non-Emergency Non-Medical Transportation (Activity D)	Arranging and providing non-emergency, non-medical transportation of enrolled Medi-Cal beneficiaries to Medi-Cal covered services provided by an enrolled Medi-Cal provider. When medically necessary, this activity may include the cost of accompanying Medi-Cal beneficiaries to Medi-Cal services.

Contracting for Medi-Cal Services and Medi-Cal Administrative Activities (Activity E) On an LGA-wide basis, coordinating contracts with community-based organizations or other provider agencies to provide Medi-Cal health care services and/or perform other Medi-Cal Administrative Activities, such as Outreach or Facilitating Medi-Cal Application.

Program Planning and Policy Development (Activity F) Developing strategies to increase the capacity of the Medi-Cal system and to close gaps in Medi-Cal services, this includes improving the delivery of Medi-Cal services and developing resource directories for Medi-Cal services and providers through interagency coordination.

MAA/TCM Coordination and LGA Claims Administration (Activity G) LGA-wide administration of MAA/TCM, which includes but is not limited to: drafting, revising, and submitting MAA claiming plans; serving as liaison between claiming programs within the LGA and DHCS; and ensuring that MAA claims do not duplicate Medi-Cal claims for the same activities from other providers.

Allocated Activities. The CMAA invoice allocates a portion of the costs of the following activities to the claimable amount of the invoice:

General Administration This activity involves the general program administrative functions that are eligible for cost distribution (per Office of Management and Budget Circular [OMB] A-87, available at <http://www.whitehouse.gov/omb/circulars/a087/a872004.html>) on an approved cost allocation basis. These activities include but are not limited to attending or conducting general, non-medical staff meetings; and developing and monitoring program budgets, site management, and supervision of staff. This also includes staff break time.

Paid Time Off (PTO) Paid Time Off includes vacation, sick leave, paid holiday time, paid jury duty, and any other paid employee time off. This does not include breaks, off-payroll time (dock), or the taking of compensatory time off (CTO).

Subcontractors. LGAs may contract with community-based organizations (CBOs) to perform MAA. If the contract specifies the activities, the CBO will perform and a specific total amount the LGA will pay the CBO to perform them, then the CBO does not need to time-survey. Whether the contract is specific or nonspecific, the contract's scope of work must describe the activities the CBO will perform, the staff that will perform the activity, and the deliverables (flyers, media announcements, meetings, and other contacts). Refer to Section 2 for additional information on contracting with CBOs.

Duplicate Payments. LGAs must ensure that they do not seek reimbursement of costs that the Federal Government has paid for under another program. These programs include those funded through block grants. See <http://www.mch.dhs.ca.gov/programs/factsheets.htm> for a complete list of MCAH programs. To determine the costs that are reimbursable under Medi-Cal, LGAs must review scopes of work and contract documents related to funding sources for their programs.

Of similar concern is the potential for duplication of services provided under other programs. Rates paid for services through the Home and Community-Based Services (HCBS) and MCAH programs pay for some of these administrative activities. LGAs must take measures to ensure that they do not duplicate administrative activities paid through HCBS and MCAH programs (see <http://www.dhs.ca.gov/mcs/mcod/MHCBSB/default.htm> for more information).

Furthermore, activities that are an integral part of, or an extension of, a medical service (e.g., patient follow-up, patient assessment, patient counseling, patient education or consultation, and patient billing activities) are not allowable as MAA. The fees and rates paid to Medi-Cal providers through managed care plans and fee-for-service programs pay for these administrative activities. The part of MAA that is claimable as administration of Medi-Cal services does not include these activities, referred to in the MAC Agreement (Attachment 3) as "physician-extender" activities.

LGAs must ensure that they do not duplicate outreach efforts that other agencies have performed. When developing outreach materials, LGAs must make a good faith effort to research and use available materials that support their campaigns. LGAs must ensure that MAA expenditures are proper and efficient. LGAs may not seek reimbursement for administrative activities that duplicate efforts of staff within or outside of the LGA. Duplicate payments are not allowable.

Note: This requirement does not prohibit conducting revised outreach campaigns toward Medi-Cal eligible persons targeted in previous campaigns but have not yet enrolled in Medi-Cal or accessed needed services. It also does not prohibit claims for the costs of reproducing available materials.

LGAs may not claim federal reimbursement of the costs of allowable administrative activities that have been or should have been reimbursed through an alternative method or funding source. The LGA must certify to DHCS that it has ensured no duplication in

its administrative claiming process. An LGA may not request reimbursement for more than the actual costs incurred by its MAA claiming unit, including reimbursements received from State, local, and federal sources (i.e., LGAs may not make a profit).

For more information on this topic, see the “Agreement between the Health Care Financing Administration and the State of California, Department of Health Services” (the MAC Agreement), dated September 27, 1995, Attachment 3. The MAC Agreement is available on the DHCS website for MAA/TCM at www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx.

Steps in the CMAA Claiming Process for New Claiming Units

1. Determine whether you are performing MAA or could perform MAA.
2. Identify staff in your organization that do or could perform MAA.
3. Determine if your MAA can be paid for with 100 percent of the costs using nonfederal public funds.
4. LGAs may collect and submit to DHCS certifications of public expenditures made by other State agencies.
5. If your organization is new to MAA, discuss with the LGA MAA/TCM Coordinator your interest in claiming for MAA. The LGA contracts with DHCS for reimbursement for MAA. Your organization must enter into an agreement with the LGA to be reimbursed for the performance of MAA. You can identify your LGA MAA/TCM Coordinator on the LGA Consortium website: <http://www.maa-tcm.net/contact.htm>.
6. Prepare a CMAA claiming plan describing in detail the MAA for which you intend to claim. The CMAA claiming plan must be submitted to DHCS by the LGA in the quarter in which you intend to begin claiming. DHCS and CMS must approve the plan prior to submitting claims. The LGA will inform you of the approval of your plan.
7. Conduct a month-long time survey (September or October) to determine the percentage of staff time spent performing allowable MAA. Alternatively, you may request to time survey in a different month by contacting your LGA MAA/TCM Coordinator who will make this request to DHCS 30 days prior to the month in which you wish to time-survey (see Section 5, Time Surveys).
8. For activities requiring discounting by the Medi-Cal percentage, determine the method you will use to conduct an actual count of persons served or ask the LGA for the countywide average percentage of Medi-Cal recipients.
9. Arrange to receive MAA training and instructions from the LGA MAA/TCM Coordinator.
10. Prepare a CMAA invoice. CMAA invoices are based on the actual costs of performing MAA and are submitted by the LGA to DHCS on a quarterly basis.
11. Maintain required program and fiscal audit file documentation.

Timely Response to DHCS Requests

CMAA claiming plans, amendments, and invoices are very time-sensitive. The longer it takes DHCS to receive essential corrections or backup information from LGA MAA/TCM Coordinators, the more claiming documents back up at DHCS. Delays in processing these documents have created workload backlog and affected timely payment of invoices. Therefore, DHCS enforces the following practice:

Step 1

The DHCS CMAA analysts, where applicable, will review the claiming plans, claiming plan amendments, time surveys, invoices, contracts, and support documents for each respective claiming unit, and shall notify the LGA MAA/TCM Coordinator by email when corrections and/or additional information is needed to complete the claim. The analyst shall request that the LGA MAA/TCM Coordinator send the corrections and/or additional information within five business days from the date of the email message.

Step 2

If the LGA MAA/TCM Coordinator does not respond within five business days or sends incomplete information, the DHCS CMAA analyst shall notify the LGA MAA/TCM Coordinator a second time by both email and telephone, and the LGA Consortium co-chairs and/or their designee will be copied. An additional five business days will be given for response.

Step 3

If the LGA MAA/TCM Coordinator does not respond, or sends incomplete information, by the end of the second five business days, the DHCS CMAA analyst shall return the claiming plan, claiming plan amendments, entire invoice package, and/or contract. The claiming plan and claiming plan amendments may only be submitted in the next quarter reporting period. **In addition, the CMAA invoice will be denied, as it is not adequately documented to be eligible for federal reimbursement.** If submitted within the 18-month deadline for payment and can be timely reviewed, approved and processed by DHCS, the invoice may be resubmitted.

Unforeseen exceptions or delays will be reviewed on a case-by-case basis and must be approved by DHCS management. DHCS will only receive these exception requests from LGA MAA/TCM Coordinators. An email explaining the situation must be sent to the DHCS CMAA analyst, and be copied to the CMAA Unit Manager and the Branch Manager.

DHCS will not approve invoices related to a proposed claiming plan until it the plan itself has been approved. However, if you wish to submit invoices prior to the approval, please do so.

Compliance with DHCS Due Dates

All due dates in this manual are considered met if the documents have a US Mail postmark or a receipt from an express delivery service dated on or before the due date, unless otherwise specified.

SECTION 2

MAA Contracts

Table of Contents

Subject	Page
Overview	2-1
The California State Plan	2-1
The CMAA Contract between DHCS and the LGA	2-2
Funds-Only Increase to Current Contract	2-2
Subcontracts/Lateral Agreement/Memorandum of Understanding	2-3
CBO Subcontractors	2-5
LGA Administrative Fees	2-5
Contingency Fee Contracts	2-5
Host Entity/DHCS Contract	2-6

Overview

The CMAA program depends on a series of contracts, subcontracts, lateral agreements, and memoranda of understanding between the federal, State, and local agencies, as well as community-based organizations (CBOs), that work together to administer the Medi-Cal program. This section provides a brief overview of these contracts so that LGAs participating in CMAA can understand the context in which they contract with DHCS and CBOs to perform MAA.

Although each type of contract or agreement might appear similar to the others, each is unique in establishing a different level of responsibility for the actual activities and claiming procedures that make up this program. Each type of contract or agreement is based on State and federal statutes and regulations. To ensure the validity of MAA claims, LGAs should read these laws with the intention of putting them in practice through these contracts.

The California State Plan

California's Medicaid State Plan is an agreement between CMS and the State of California that establishes DHCS as the single agency in California responsible for administering the federal Medicaid program (i.e., Medi-Cal). The State Plan and its Amendments describe the Medi-Cal program and the services that it may provide. It also establishes the standards the State must meet in providing and accounting for the costs of these services, and how the accounting of costs for these services needs performed.

MAA is the proper and efficient administration of the California State Plan. The meaning of "proper and efficient administration" derived from relevant portions of the Social Security Act, Code of Federal Regulations, Office of Management and Budget Circulars, and related guidance from CMS.

The CMAA Contract between DHCS and LGAs

For an LGA to claim reimbursement for MAA, State law requires that a contract be in place between DHCS and the LGA (W&I Code §14132.47(b)). The CMAA contract (Exhibit E) defines the legal responsibilities of the LGA and DHCS to comply with all State and federal statutes and regulations regarding MAA claiming. Many of these legal citations are provided in Appendix C of this manual. Appendix C also contains website addresses for further research of these laws.

LGAs may not knowingly submit claims that are out of compliance with these laws. Although DHCS has endeavored to include in this manual all necessary guidance concerning the MAA program, this policy manual does not supersede State or federal law. LGAs are responsible for researching and studying these laws for themselves.

Note: With regard to Medi-Cal services, (such as targeted case management), LGAs must also make a good faith effort to ensure that these services are administered in compliance with Medi-Cal laws. LGAs may not knowingly submit claims for MAA conducted in support of services performed in a way that is out of compliance with these laws.

To start the contract process, the LGA must submit to DHCS a Letter of Intent to Participate. This letter can serve two purposes:

- Initiate a new contract for a term of up to three years.
- Extend the term of the current contract up to a total of five years.

LGAs not currently participating that would like to participate in CMAA, and LGAs whose current contract will expire on June 30, must submit a Letter of Intent to Participate in CMAA by the due date stated in the Letter of Intent to Participate. LGAs not currently participating must contact DHCS to receive the letter. LGAs, whose contracts expire, will be sent the letter. The LGA submits its request by letter along with its:

- Name,
- Federal Employer identification Number,
- Current contract number (if applicable),
- Indication that it intends to participate,
- Indication of the number of years it intends to participate, and
- Indication of the maximum amount payable for each of those years

Funds-Only Increase to Current Contracts. LGAs may need to amend the dollar amount in contracts that have not yet expired. LGAs should carefully monitor their contract amounts, invoices will not be paid if there are no sufficient funds remaining in the contract. To amend the contract, the LGA must submit a letter to DHCS stating the amended dollar amount requested for each fiscal year affected. This letter must be

submitted at least 180 days prior to the deadline for submitting the related invoice. If this deadline is not met, the invoice will be denied.

Subcontracts/Lateral Agreements/Memoranda of Understanding

The contract between DHCS and an LGA allows the LGA to act on behalf of other governmental agencies and CBOs within its geographic region to claim reimbursement for the cost of performing MAA. For these entities to participate in MAA, the LGA must establish a subcontract, lateral agreement, or memorandum of understanding (MOU) with those entities. These agreements must specify the requirements for the entities participating in them. (Such agreements ensure that the governmental entities that are part of the LGA be held responsible to the applicable terms and conditions of the contract between DHCS and the LGA.)

Note: The LGA must be able to certify that it has funded 100-percent of the amount claimed for performing MAA using allowable public funds.

For subcontractors to participate in MAA, State and federal law require the following:

1. The LGA must have a fully executed contract with its subcontractor effective the first day of the quarter for which the LGA submits a CMAA invoice to DHCS. The contract must state that the subcontractor will perform a designated set of functions claimable as allowable MAA. If the LGA is supplying the CPE to be eligible to seek federal reimbursement, the LGA must have expended 100 percent of the costs claimed for the performance of MAA before submitting a CMAA invoice to DHCS (42 CFR §433.51). The contract must state that the subcontractor will comply with the time survey and claiming method described in the CMAA claiming plan.
2. If the subcontractor contract with the LGA is non-specific as to the total amount the LGA will pay the subcontractor to perform MAA, then subcontractor staff that perform MAA must participate in the time survey. If the subcontractor contract is specific, then the subcontractor does not need to time survey.
3. LGAs must submit to DHCS a separate MAA Detail Invoice for each subcontractor. A MAA Summary Invoice that aggregates the information provided on the MAA Detail Invoice must accompany each invoice. The subcontractor's invoice must include the names of the subcontractor and the LGA.
4. CBO costs are eligible for reimbursement at the 50-percent rate of federal financial participation (FFP); they are not eligible for reimbursement at the enhanced rate (XIX SSA §1903(a)).
5. Local funds that support claims for reimbursement of the cost of performing MAA must be allowable public funds expended by the LGA. To qualify as a federally reimbursable MAA expense, the LGA must have made a CPE in support of activities listed on the CMAA claiming plan. CPE is an expenditure of non-federal public funds, as defined by federal regulation 42 CFR §433.51, that are used to support the performance of MAA within the claiming unit.

General Overview of CPE Requirements

The following is an overview of CPE requirements provided to give LGAs a clear understanding of the general requirements that are applicable to the CMAA program.²

Section 1903(a) of Title XIX of the Social Security Act provides, in part, that the Federal Government shall pay to the State a percentage “of the total amount expended” for providing medical assistance (which includes MAA Activities).³ (FMAP is only for services. It’s FFP for MAA).

Section 433.51 of title 42 of the Code of Federal Regulations (C.F.R.) provides that the amount expended must be “. . . certified by the contributing public agency as representing expenditures eligible for FFP under this section.”

Pursuant to section 1903(a), cited above, Medicaid is a “reimbursement” program. It is not a “matching” or “grant” program. This means that federal claiming by a State is based on actual expenditures that have been made by the State or by another public agency authorized to certify expenditures to the State for Medicaid services. Based on the State’s claim, federal reimbursement is then provided to the State. It is improper and insufficient for a public entity to certify expenditures that have not yet been made, for example, where the certification is based, in whole or in part, on an invoice or other billing that has not yet been paid. FFP is reimbursement for expenditures that have been made and DHCS is required to certify that those expenditures have actually been made before it can claim FFP.

Thus, the only amount that can be certified (the CPE) is the actual Medicaid expenditures that have been made by the public agency for which all supporting documentation is available at the time the claim is made by the State. Federal reimbursement with respect to the expenditure certified is paid to the State at 50 percent. For example, if the amount certified were \$100, then the claim would be for \$50 in FFP (.50 x 100).

Applying current CMS policy, the situations below are not compliant with current federal regulations governing CPEs. The situations can be summarized as follows:

1. Certification that funds are available at a state or local level. The “availability” of funds does not meet the federal requirement that state or local dollars have actually been expended by the contributed Public agency to provide administrative activities necessary for the proper and efficient administration of the Medi-Cal program.
2. A certification based on an estimate of Medicaid costs derived from surveys of health care providers. An estimate does not meet federal requirements that state

² For purposes of the CMAA program, LGAs are counties and chartered cities. (See Welf. & Inst. Code § 14132.44, subd. (o).)

³ 42 U.S.C. § 1396b(a).

or local dollars have actually been expended by the contributed Public agency to provide administrative activities necessary for the proper and efficient administration of the Medi-Cal program.

3. A certification that is higher than the actual cost or expenditure of the governmental unit that has generated the CPE (based on administration of activity necessary).
4. A certification that is anything less than 100 percent of the total-funds (total computable) expenditure. Federal reimbursement is available only as a percentage of the total-funds (total computable) Medicaid expenditure that has been certified. For example, a certification that certifies only the amount of the non-federal share of the total-funds expenditure is not acceptable.

CBO Subcontractors

LGAs may subcontract the performance of MAA to CBOs. All MAA that CBOs may perform are reimbursable only at the 50-percent rate of FFP. Federal law does not permit reimbursement at the enhanced FFP rate for any activities performed by CBOs (XIX SSA §1903(a)).

CBOs that perform MAA are subject to two restrictions on the activities they perform:

1. CBOs may not claim for Contracting for Medi-Cal Services and MAA.
2. CBOs may only claim for “support activities” under Program Planning and Policy Development (PP&PD), such as developing resource directories, preparing Medi-Cal data reports, conducting needs assessments, or preparing proposals for expansion of Medi-Cal services.

LGA Administrative Fees

LGAs participating in the CMAA program must ensure, by monitoring invoices that both the LGA and the claiming unit do not report administrative fees they charge to their claiming units as MAA costs. The cost of activities included on the CMAA invoice may only be claimed by one entity: if they are on the LGA invoice, they may not be claimed on other invoices, such as the subcontractor claiming unit invoices.

Contingency Fee Contracts

LGAs may not claim the costs of contingency fee contracts as MAA. That is, the amount an LGA pays a personal services contractor, business consultant, or private CBO may not be based on that entity’s ability to generate increased reimbursements or administrative fees for that LGA. Those costs are not claimable as MAA. The federal Office of Management and Budgets (OMB) Circular A-87, item 33, “Selected Items of Costs,” states:

Cost of professional and consultant services rendered by persons or organizations that are members of a particular profession or possess a special skill, whether or not officers or employees of the governmental unit, are

allowable, subject to section 14 when reasonable in relation to the services rendered and when not contingent upon recovery of the costs from the Federal Government. *[Emphasis added.]*

An LGA might violate this principle by reducing the amount of the administrative fee it charges its private CBOs in response to substantial increases in the amount of MAA the subcontractors conduct. Administrative fees should be on the LGA's actual costs basis, and should not be based on producing a "profit" for the LGA. DHCS may reimburse LGAs if payments to subcontractors are on a specific cost-accounting method basis (including a time survey) or on a specific contract.

LGAs may directly contract with business consultants (i.e., vendors) to administer parts of the CMAA program (e.g., claims administration). Such contracts must comply with all applicable federal requirements (e.g., competition, sole source provisions, and certified public expenditures) as specified in federal regulations. LGAs may not reimburse such vendors on a contingency fee basis and claim that cost (or projected cost) on their CMAA invoice. That is, vendors may not be encouraged to increase the LGAs amount of MAA claims in order to increase the amount the vendors are paid. If LGAs reimburse vendors using a flat fee schedule, they may claim that cost on their CMAA invoices.

Host Entity/DHCS Contract

DHCS contracts with one "host entity" to manage and collect the LGAs' share of DHCS's actual total costs to administer the CMAA program. This "host contract" identifies the projected costs for the coming fiscal year, including DHCS salaries, benefits, overhead, operating expenses, and equipment related to administration of the CMAA program. DHCS annually calculates these projected costs. As defined in W&I Code §14132.47, 50 percent of DHCS's actual costs of administering the CMAA program are paid after the completion of the contract period by LGAs that perform MAA.

The LGAs identify one participating LGA to serve as their "host entity." The host entity collects from each participating LGA its percentage of the LGAs' share of DHCS's actual costs associated with administering the CMAA program. The LGAs notify DHCS when this duty transfers to a different LGA.

Throughout the year, DHCS monitors the costs projected in the host contract to ensure that the actual DHCS costs of administering each component of the CMAA program not exceed the total projected costs stated in the host contract. At the end of the contract period, DHCS informs with the host entity of the total amounts reimbursed to each of the LGAs for MAA. The LGA Consortium then calculates each LGA's percentage of the total amounts claimed by all LGAs for their portions of the MAA program.

DHCS reviews and corrects its expenses before billing the host entity for their share of DHCS's actual administrative costs.

SECTION 3

CMAA CLAIMING PLAN INSTRUCTIONS

Table of Contents

Subject	Page
Overview	3-1
Initial Claiming Plans	3-1
Instructions for Preparing the Claiming Plan	3-2
Amendments to Claiming Plans	3-3
Instructions for Claiming Plan Amendments	3-4
Skilled Professional Medical Personnel	3-4
Using the Standardized Claiming Plan Format	3-7
Claiming Unit Functions Grid (the Grid)	3-7
Required Supporting Documentation and Position Descriptions/Duty Statements	3-8
Methods for Allocating Costs	3-8
(A) Medi-Cal Outreach A (Not Discounted)	3-9
(B1) Medi-Cal Outreach B1 (Discounted)	3-11
(B2) Medi-Cal Outreach B2 (Discounted)	3-13
(C) Facilitating Medi-Cal Application (Eligibility Intake)	3-15
Facilitating Healthy Families Application	3-16
(D) Medi-Cal Non-Emergency, Non-Medical Transportation	3-17
(E) Contracting for Medi-Cal Medical Assistance and for MAA	3-19
(F) Program Planning and Policy Development	3-21
(G) MAA/TCM Coordination and Claims Administration	3-23

Overview

This section contains instructions for LGAs to use when claiming federal financial participation (FFP) for MAA. These instructions include definitions of allowable MAA. The costs of these MAA activities are eligible for FFP reimbursement as long as LGAs comply with claiming requirements. The templates for use with these instructions are available on DHCS's CMAA website:

www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx.

LGAs that submit claiming plans and claiming plan amendments for the first quarter must submit them by November 1 to be effective, once approved, the previous July 1. Claiming plans and claiming plan amendments submitted for the second, third, or fourth quarters, once approved, become effective the first day of the quarter in which submitted to DHCS. For example, to submit a claiming plan or amendment for the second quarter (October – December), LGAs must have postmarked it by December 31 of that year, i.e., a U.S. Mail postmark or a receipt from an express delivery service dated no later than December 31 of the same quarter. An LGA may submit amendments at any time but may submit only one amendment package per quarter. Amendments are subject to the same approval process as claiming plans.

Initial Claiming Plans

Each LGA that intends to claim for the costs of MAA must submit a comprehensive claiming plan to DHCS. Claiming plans and subsequent amendments will become effective the first day of the quarter in which submitted. Such a claiming plan shall describe in detail all of the following:

- The categories of MAA the LGA intends to claim,
- The location and scope-of-work of the claiming unit(s),
- The types of employees (SPMP or non-SPMP) involved,
- The documentation the claiming unit will maintain to support its claim,
- The method used to document and track the costs of MAA (i.e., time survey or direct charge), and
- The discount method that will be used on invoices (i.e. CWA or ACC).

LGAs must submit additional documentation for certain categories of MAA, as explained in the instructions.

DHCS reviews each claiming plan. CMS also reviews claiming plans for first-time participants in CMAA. Once approved by DHCS and CMS, claiming plans form the basis for claiming MAA. If LGAs submit invoices that do not correspond to an approved claiming plan, DHCS will notify the LGA of the discrepancy. If corrections or requests for additional documentation are not provided, DHCS will deny the invoice.

Instructions for Preparing the Claiming Plan

For LGAs to draw down federal reimbursement of the cost of performing allowable MAA, each LGA must submit a comprehensive CMAA claiming plan package to the Department of Health Care Services (DHCS) for review and approval by DHCS.

Claiming plans are also reviewed by the federal Centers for Medicare and Medicaid Services (CMS) under the following circumstances:

- First-time LGA participants in CMAA
- When an alternate Medi-Cal discount method is proposed (other than CWA or ACC)
- At the discretion of DHCS or CMS

To facilitate the review process, LGAs must use the standardized claiming plan format included with the instructions.

A claiming plan and any subsequent amendments will remain in effect from year to year. LGAs must amend a claiming plan each time the scope of MAA is significantly changed.

Claiming plans and amendments are subject to DHCS approval. DHCS will notify each LGA in writing of the approval or disapproval. DHCS will provide technical assistance to LGAs, upon request, in the event of disapproval.

The effective date of the approved claiming plan and any subsequent amendments shall be no earlier than the first day of the quarter in which the claiming plan or amendment is submitted.

LGAs may submit invoices before DHCS has approved the related claiming plan or claiming plan amendment; however, DHCS will not approve such invoices until it approves the claiming plan or amendment. All invoices must agree with the CMAA claiming plan or amendment as approved.

A claiming plan package consists of separate claiming unit plans, one for each claiming unit performing MAA. Templates are available on DHCS's CMAA website: www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx.

The claiming plan package must include each of these items in the following order:

1. A complete Certification Statement including the following:
 - The name of the LGA,
 - The LGA's address,
 - The LGA's MAA/TCM Coordinator's phone number,
 - The typed name of the LGA's MAA/TCM Coordinator,

- The signature of the LGA's MAA/TCM Coordinator,
 - The title of the LGA's MAA/TCM Coordinator, and
 - The date the claiming plan package is signed.
3. Claiming Plan Amendment Checklist.
 4. Claiming Unit Functions Grid.
 5. Activity pages.
 6. Required supporting documentation.
 7. Position descriptions and/or duty statements.

Amendments to Claiming Plans

Each LGA's claiming plan remains in effect from year to year until it is amended by the LGA. For assistance with the preparation and submission of a CMAA Claiming Plan Amendment, please use the Claiming Plan Amendment Checklist available on the CMAA website.

Activities that significantly change the scope of MAA and therefore require the LGA to complete a Claiming Plan Amendment:

- Addition of a new Claiming Unit
- Addition of a new MAA category (activity)
- Addition of a new subcontractor
- Change in the specific administrative activities conducted or the Medi-Cal services these activities help administer

The above list is intended to address those situations where a complete amendment package is required. For all other changes, an e-mail may suffice along with the required documentation listed on the checklist. If a circumstance arises not listed on the checklist, you may explain the situation on the last item of the checklist.

If the proposed claiming plan amendment would require that a claiming unit conduct a time survey before claiming, the LGA must request authorization from DHCS 30 days prior to the beginning of the month in which the time survey will be conducted. See Section 5 regarding time surveying.

Instructions for Claiming Plan Amendments

LGAs may submit claiming plan amendments to add a claiming unit or significantly change the scope of MAA performed by their claiming units. A claiming unit is part of an LGA, such as a public agency or private community-based organization (CBO) contracted to an LGA to perform MAA, whose costs are identifiable as a separate budget unit. MAA claiming plan amendments must include the following:

1. A cover letter on LGA letterhead containing identifying information such as fiscal year and quarter amendment is to be effective.
2. A CMAA Claiming Plan Amendment Checklist for each claiming unit being added or changed.
3. The pages of the existing CMAA claiming plan that have changes. (Do not submit the entire claiming plan.)
4. When adding a new activity for a claiming unit, enter it into the claiming plan in the same order as is shown on the Grid.
5. A comprehensive package comprised of all amendments to the claiming units for the entire LGA, including a revised "Certification Statement" with a new date and an original signature. Consolidate amendments for all claiming units for which amendments are required and submit only one amendment package per quarter, following submission guidelines.

Skilled Professional Medical Personnel (SPMP)

An SPMP is an employee of a public agency who has completed a two-year-or-longer program leading to an academic degree or certification in a medically related profession and who is in a position that has duties and responsibilities requiring that professional medical knowledge and skills (MAC Agreement, pages 4, 23, 25, and Attachment 3, page 3).

See Appendix D for a complete discussion of SPMP requirements, as well as an SPMP Questionnaire, which must be completed and maintained in the LGA's CMAA audit file.

Completion of a program may be demonstrated by, possession of a medical license or certificate issued by a recognized national or staff medical licenser or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization.

The costs of CMAA program planning and policy development (PP&PD) that require skills of SPMPs are eligible for reimbursement at the 75-percent (enhanced) rate of FFP. This includes the cost of salaries, benefits, travel, and training for SPMPs and their directly supporting clerical and supervisory staff. Clerical staff in direct support of SPMPs must be employees of the same organization as the SPMP. The cost of MAA performed by SPMPs is not eligible for enhanced reimbursement when the MAA does not require SPMP-level skills (42 CFR §432.45). Medical services performed by SPMPs are not MAA; LGAs must not claim them (42 CFR §432.50). Overhead and non-personal services costs (such as rent, ordinary supplies, along with telephone and

computer charges) are chargeable at the 50-percent rate (Departmental Appeals Board Decision No. 1008 [1989]).

SPMPs are required to have education and training at a professional level in the field of medical care or appropriate medical practice before FFP can be claimable at 75 percent. Experience in the administration, direction, or implementation of the Medicaid program is not the equivalent of professional training in a field of medical care.

The costs of staff who directly supervise or support SPMP staff may be reimbursed at the 75-percent rate in proportion to the time these clerical staff perform those duties (42 CFR §423.2). The directly supporting staff must provide clerical services that are directly necessary for carrying out the professional medical responsibilities and functions of the SPMP. The SPMP must be immediately responsible for the work performed by the clerical staff and must directly supervise (immediately first-level supervision) the supporting staff and the performance of the supporting staff's work. Staff that assist the SPMP in direct provision of services are not claimable as SPMP.

In regards to the 75-percent FFP for clerical staff who provide direct support to SPMPs, the federal regulation states:

The directly supporting staff are secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that are directly necessary for the completion of the skilled professional medical responsibilities and functions of the skilled professional medical staff. The skilled professional medical staff must directly supervise the supporting staff and the performance of the supporting staff's work.

Additional information to help determine if staff's costs qualify for enhanced reimbursement and the SPMP Questionnaire are located in Appendix D.

<p><u>Submit claiming plan packages to:</u></p> <p><u>For Regular U.S. Postal Services Delivery Mail:</u></p> <p>Department of Health Care Services Safety Net Financing Division County-Based MAA Unit Attn: (Insert Program Analyst's name) MS 4603 P.O. Box 997436 Sacramento, CA 95899-7436</p> <p>Note: Mailing labels are available at www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx.</p>	<p><u>For Overnight or Express Mail:</u></p> <p>Department of Health Care Services Safety Net Financing Division County-Based MAA Unit Attn: (Insert Program Analyst's name) 1501 Capitol Avenue, Suite 71.2101 MS 4603 Sacramento, CA 95814</p> <p>Note: DHCS recommends using express delivery service to ensure timely delivery.</p>
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Using the Standardized Claiming Plan Format

The following pages contain instructions for completing the claiming plan templates. The claiming plan templates are located on DHCS's CMAA website: www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx. The claiming plan package must present this information in the order requested in these instructions.

Claiming Unit Functions Grid

Each claiming unit must provide the information requested on the template titled Claiming Unit Functions Grid. The numbers shown below correspond to the numbers shown on the Grid. Complete the Grid by entering:

1. The name of the LGA and the claiming plan submittal date/amendment date.
2. The claiming unit name.
3. The total number of staff employed in the claiming unit whether or not they perform MAA.
4. The claiming unit address.
5. The claiming unit contact person's name.
6. The claiming unit contact person's address.
7. The claiming unit contact person's telephone number.
8. A brief description of the specific functions performed by the claiming unit and how it pertains to MAA.
9. The job classifications for each of the staff who will complete a time survey or whose costs will be direct charged for the performance of MAA for which an invoice will be submitted. If some staff in a classification are considered Skilled Professional Medical Personnel (SPMP) and other staff are considered non-SPMP, enter the information for both SPMP and non-SPMP staff on the same line ensuring you list the numbers of each in the appropriate box for SPMP and non-SPMP.
10. The number of staff who are SPMP or non-SPMP (Appendix D).
11. The number of staff performing MAA by type of activity.

Required Supporting Documentation and Position Descriptions/Duty Statements

1. The documents required to support each of the administrative activities that the LGA claiming unit intends to claim for FFP are listed on the instructions provided for each activity. Identify the activities supported by each document by placing on the front of each document the letter assigned to the administrative activity. The letters assigned to the activities are listed at the bottom of the Grid. For example A = Medi-Cal Outreach A; B = Medi-Cal Outreach B; C = Facilitating Medi-Cal Application; etc. Next to the MAA letter, place the number of the document. For example, if three documents are submitted to support the activity Medi-Cal Outreach A, separately number the documents as A-1, A-2, and A-3.
2. Position descriptions and/or duty statements for each classification performing MAA identified in the claiming plan must clearly show the performance of the activity identified in the claiming plan as being part or all of the employee's duties. The MAA duties described on the position descriptions and/or duty statements must be clearly identified. Clearly identify the MAA duty, by placing the letter assigned to the activity next to each activity described. The letters assigned to the activity are listed at the bottom of the Grid. For example A = Medi-Cal Outreach A; B = Medi-Cal Outreach B; C = Facilitating Medi-Cal Applications; etc. Be sure to delineate whether Activity B is B1 or B2.

NOTE: All duties of the classification must be listed on the position description/duty statement – not just those designated as MAA.

Methods for Allocating Costs

In order for LGAs to claim the costs of MAA, DHCS has approved the following methods for allocating costs:

1. Employee time surveys.
2. Direct charges.
 - a. A signed certification statement (included on the direct charges worksheet) must support direct charging based on employee salaries.
 - b. Receipts for actual costs incurred must support direct charging for non-salaried costs.

(A) Medi-Cal Outreach A - Not Discounted -

Description. Medi-Cal Outreach A is a campaign, program, or ongoing activity targeted toward;

1. Bringing potentially eligible persons into the Medi-Cal system to determine their Medi-Cal eligibility. This activity is directed toward potentially eligible persons to provide information about the Medi-Cal program and to encourage those individuals who may be eligible for Medi-Cal to apply for Medi-Cal.
2. Bringing enrolled Medi-Cal beneficiaries into Medi-Cal services. The activity is directed only toward Medi-Cal beneficiaries and not to the general public.

Note:

- Public health campaigns that consist of a separate segment targeted only toward bringing Medi-Cal eligible persons into Medi-Cal covered services are claimable as Outreach A only for the separate segment.
- Information and referral activity is allowable as Outreach A when it involves referring Medi-Cal eligible persons to Medi-Cal providers, or referring potential Medi-Cal eligible persons to apply for Medi-Cal.
- Targeted case management (TCM) case managers may conduct Outreach A as well as TCM, provided there is an accurate accounting of how the costs are separated through use of the Combined CMAA/TCM Time Survey form.

Subcontracting. The local governmental agency (LGA) may subcontract with nongovernmental entities or programs to conduct Outreach A. If the LGA chooses to direct-charge the Outreach A performed by subcontractors, it must be a specific contract that clearly describes the Outreach A to be performed, the method used for determining direct charge claiming, and the dollar amount to be paid to the subcontractor.

Note: LGAs may claim the costs of individual employees of subcontractors for the performance of both MAA and TCM.

Instructions for Preparing a Claiming Plan for Medi-Cal Outreach A.

For *each* campaign, program, or ongoing outreach, provide the following information, and identify it using the same numbering sequence as shown below:

1. Identify the type of Outreach A performed, and describe the associated activities.
2. Provide a clear description of how each Outreach A activity will be performed to achieve the objective.
3. Identify the target population.
4. Provide the length of time of the Outreach A activity, i.e., days and/or hours.

5. Provide the location(s) where the Outreach A activity will be conducted.
6. Provide the number of times Outreach A will be conducted during the fiscal year, or indicate if Outreach A is an ongoing activity.
7. If using other than time surveys, describe how the costs of Outreach A will be developed and documented.
8. Provide the name(s) of the subcontractor(s), if applicable.

Required Documents for a Medi-Cal Outreach A Claiming Plan.

Attach to the claiming plan the following documents:

1. Flyers, announcements, or any materials that describe the Outreach A campaigns. If materials are unavailable when submitting the claiming plan to DHCS, provide a statement that gives the location of where materials will be maintained for future DHCS and CMS review.
2. If direct charge invoices will be submitted, provide a list of subcontractors.
3. Copies of those sections of current subcontracts with CBOs entered into for the performance of Medi-Cal Outreach A that:
 - a. Clearly describe the Outreach A to be performed,
 - b. Describe how the time spent performing Outreach A will be documented,
 - c. Show the effective date of the contract,
 - d. Show the method used for determining direct charge claiming,
 - e. Specify the dollar amount to be paid to the subcontractor, if any and
 - f. Show the terms of the contract and be accompanied by a fully executed signature page.

(B1) Medi-Cal Outreach B1 - Discounted – Actual Client Count

Description. Medi-Cal Outreach B1 is a campaign, program, or ongoing activity directed toward bringing both Medi-Cal eligible and ineligible persons into health care services. Since these campaigns are only allowable to the extent they bring Medi-Cal eligible persons into Medi-Cal services, the following activities must be discounted by the Medi-Cal percentage:

1. Campaigns directed toward bringing specific high-risk populations into health care services.

For example: Media or direct-contact Outreach B campaigns directed toward high-risk populations, such as low-income or substance-abusing pregnant women, diabetics, HIV-positive persons, TB cases, etc., when these campaigns target both Medi-Cal eligible and ineligible persons, and when the health care services are covered by Medi-Cal.

2. Telephone, walk-in, or drop-in services for the purpose of informing or referring persons, including Medi-Cal beneficiaries, to services covered by Medi-Cal.
3. Conducting specific Medi-Cal health education programs that are included as part of a broader general health education program. The Medi-Cal portion may be allowable if the cost of the general health education program is discounted according to the Medi-Cal percentage.

The approved method to calculate the discount for Outreach B1 is the Medi-Cal actual client count. The actual client count must be calculated at least one month of each quarter for invoicing purposes. **The only difference** between B1 and B2 is the discounting method: please refer to Outreach B2 if using the countywide average method.

On the CMAA invoice, use only the approved discount method.

Note: Targeted Case Management (TCM) case managers may perform Outreach B1 activities, as well as TCM, provided there is an accurate accounting through use of the Combined CMAA/TCM Time Survey form.

Subcontracting. The LGA may subcontract with nongovernmental entities or programs to conduct Outreach B1. If the LGA chooses to direct-charge the Outreach B1 performed by subcontractors, it must be a specific contract that clearly describes the Outreach B1 to be performed, the method used for determining direct charge claiming, and the total dollar amount to be paid to the subcontractor.

Note: LGAs may claim the costs of individual employees of subcontractors for the performance of both MAA and TCM.

Instructions for Preparing a Claiming Plan for Medi-Cal Outreach B1

For *each* campaign, program, or ongoing Outreach B1, provide the following information in the order requested. Identify the information by using the same numbering sequence as shown below:

1. Identify the type of Outreach B1 performed, and describe the associated activities.
2. Provide a clear description of how each Outreach B1 activity will be performed to achieve the objective.
3. Identify the population targeted.
4. Provide the length of time of the Outreach B1, i.e., days and/or hours.
5. Provide the location(s) where the Outreach B1 will be conducted.
6. Provide the number of times the Outreach B1 will be conducted during the fiscal year, or indicate if Outreach B1 is an ongoing activity.
7. If using other than time surveys, describe how the costs of Outreach B1 will be identified and documented.
8. Provide the name(s) of subcontractor(s), if any.
9. Describe the method used to calculate the actual client count.

Required Documents for a Medi-Cal Outreach B1 Claiming Plan.

Attach to the claiming plan the following documents:

1. Flyers, announcements, or any materials that describe the Outreach B1 campaigns. If materials are unavailable when submitting the claiming plan to DHCS, provide a statement that gives the location at which materials will be retained for future DHCS and CMS review.
2. If direct charge invoices will be submitted, provide a list of subcontractors.
3. Copies of those sections of current subcontracts entered into with CBOs for the performance of Medi-Cal Outreach B1 that:
 - a. Clearly describe the Outreach B1 to be performed,
 - b. Describe how the time spent performing Outreach B1 will be documented,
 - c. Show the effective date of the contract,
 - d. Show the method used for determining direct charge claiming,
 - e. Describe how the Medi-Cal discount percentage will be applied,
 - f. Specify the total dollar amount to be paid to the subcontractor, if any, and
 - g. Show the terms of the contract and be accompanied by a fully executed signature page.

(B2) Medi-Cal Outreach B2 – Discounted –Countywide Medi-Cal Average or Other Method

Description. Medi-Cal Outreach B2 is a campaign, program, or ongoing activity directed toward bringing both Medi-Cal eligible and ineligible persons into health care services. Since these campaigns are only allowable to the extent they bring Medi-Cal eligible persons into Medi-Cal services, the following activities must be discounted by the Medi-Cal percentage:

1. Campaigns directed toward bringing specific high-risk populations into health care services.

On the CMAA invoice, use only the approved discount method.

For example: Media or direct contact Outreach B campaigns directed to high-risk populations, such as low-income or substance-abusing pregnant women, diabetics, HIV-positive persons, TB cases, etc., when these campaigns target both Medi-Cal eligible and ineligible persons, and when the health care services are covered by Medi-Cal.

2. Telephone, walk-in, or drop-in activities for the purpose of informing or referring persons, including Medi-Cal beneficiaries, to services covered by Medi-Cal.
3. Conducting specific Medi-Cal health education programs that are included as part of a broader general health education program. The Medi-Cal portion may be allowable if the cost of the general health education program is discounted according to the Medi-Cal percentage.

The approved method to calculate the discount for Outreach B2 is the countywide average (CWA). Invoices cannot be prepared until DHCS issues the policy and procedure letters (PPL) providing the CWA for the appropriate claiming period. **The only difference** between B1 and B2 is the discounting method: please refer to Outreach B1 if using the actual client count method.

Note: Targeted Case Management (TCM) case managers may perform Outreach B2 activities, as well as TCM, provided there is an accurate accounting through use of the Combined CMAA/TCM Time Survey form.

Subcontracting. The LGA may subcontract with nongovernmental entities or programs to conduct Outreach B2. If the LGA chooses to direct-charge the Outreach B2 performed by subcontractors, it must be a specific contract that clearly describes the Outreach B2 to be performed, the method used for determining direct charge claiming, and the total dollar amount to be paid to the subcontractor.

Note: LGAs may claim the costs of individual employees of subcontractors for the performance of both MAA and TCM.

Instructions for Preparing a Claiming Plan for Medi-Cal Outreach B2

For *each* campaign, program, or ongoing Outreach B2, provide the following information in the order requested. Identify the information by using the same numbering sequence as shown below:

1. Identify the type of Outreach B2 performed, and describe the associated activities.
2. Provide clear descriptions of how each Outreach B2 activity will be performed to achieve the objective.
3. Identify the population targeted.
4. Provide the length of time of the Outreach B2, i.e., days and/or hours.
5. Provide the location(s) where the Outreach B2 will be conducted.
6. Provide the number of times the Outreach B2 will be conducted during the fiscal year, or indicate if Outreach B2 is an ongoing activity.
7. If using other than time surveys, describe how the costs of Outreach B2 will be identified and documented.
8. Provide the name(s) of the subcontractor(s), if applicable.

Required Documents for a Medi-Cal Outreach B2 Claiming Plan.

Attach to the claiming plan the following documents:

1. Flyers, announcements, or any materials that describe the Outreach B2 campaigns. If materials are unavailable when submitting the claiming plan to DHCS, provide a statement that gives the location at which materials will be retained for future DHCS and CMS review.
2. A list of subcontractors, if direct charge invoices will be submitted.
3. Copies of those sections of current contracts entered into for the performance of Medi-Cal Outreach B2 that:
 - a. Clearly describe the Outreach B2 to be performed,
 - b. Describe how the time spent performing Outreach B2 will be documented,
 - c. Show the effective date of the contract,
 - d. Show the method used for determining direct charge claiming,
 - e. Specify the total dollar amount to be paid to the subcontractor, if any, and
 - f. Show the terms of the contract and be accompanied by a fully executed signature page.

(C) Facilitating Medi-Cal Application (Eligibility Intake)

Description. This activity includes the following tasks separately or in combination:

Note: This activity does not include the eligibility determination itself.

1. Explaining Medi-Cal eligibility rules and the Medi-Cal eligibility process to prospective applicants.
2. Assisting an applicant in filling out a Medi-Cal eligibility application.
3. Gathering information related to the application and eligibility determination/redetermination from a client, including resource information and third-party liability (TPL) information as a prelude to submitting a formal Medi-Cal application to the county social services department.
4. Providing necessary forms and packaging all forms in preparation for the Medi-Cal eligibility determination.

Note: Targeted Case Management (TCM) case managers may perform facilitating Medi-Cal application activities, as well as TCM, provided there is an accurate accounting through use of the combined CMAA/TCM Time Survey form.

Subcontracting. The LGA may subcontract with nongovernmental entities or programs to conduct eligibility intake. If the LGA chooses to direct charge the eligibility intake performed by subcontractors, the contracts must clearly describe the eligibility intake to be performed, the method used for determining direct charge claiming, and the dollar amount payable to the subcontractor.

Note: LGAs may claim the costs of individual employees of subcontractors for the performance of both MAA and TCM.

Instructions for Preparing a Claiming Plan for Facilitating Medi-Cal Application (Eligibility Intake)

Provide the following information and identify the information by using the same numbering sequence as shown below:

1. Identify the eligibility intake objective, and describe the associated activities.
2. Provide a clear description of how the eligibility intake activity will be performed to achieve the objective. Identify the staff performing the activity and describe what is performed, indicating when and where it is performed.
3. Indicate whether the eligibility intake is performed by the LGA's subcontractors or by claiming unit staff.
4. Provide the name(s) and address(es) of the subcontractor(s), if applicable.
5. If using other than time surveys, describe how the costs of the eligibility intake will be developed and documented.

Facilitating Healthy Families Application

LGAs receive a fee from the Healthy Families program when they help clients complete the Healthy Families/Medi-Cal for Children (HF/MCC) joint application (MC 321 HFP). When clients check “I do not want Medi-Cal” on this application, LGAs may not use those fees as support for the costs on their CMAA invoices. LGAs have two alternatives:

- If these fees are part of the funding that supports the CMAA invoice, the LGA must list these fees on the “MAA Funding (Revenue) Sources Worksheet” invoice attachment under Cost Pool 3a, Non-claimable.

OR,

- LGAs may use the list of fees they received that is attached to the Healthy Families warrant to claim the total amount of fees received (for both Medi-Cal and non-Medi-Cal application) under Cost Pool 6, Allocated Cost Revenue.

The “MAA Facilitating Medi-Cal Application (Eligibility Intake)” activity allows time spent facilitating the MC 321 HFP application to be claimed to MAA. However, if the enrollee checks the “I do not want Medi-Cal” box, section 16 of the MC 321 HFP, MAA may not be claimed. If the “I do not want Medi-Cal” box is checked, then time spent during the time survey month on Facilitating Medi-Cal Application must be coded to “Other Programs/Activities.”

Documents Required for a Claiming Plan for Facilitating Medi-Cal Application.

Attach to the claiming plan the following documents:

1. Flyers, announcements, or any materials that describe the facilitating Medi-Cal application campaigns. If materials are unavailable when submitting the claiming to DHCS, provide a statement that gives the location of where materials will be retained for future DHCS and CMS review.
2. A list of subcontractors, if direct-charge invoices will be submitted.
3. Copies of those sections of current contracts entered into for the performance of Facilitating Medi-Cal Application that:
 - a. Clearly describe the Facilitating Medi-Cal Application to be performed,
 - b. Describe how the time spent performing Facilitating Medi-Cal Application will be documented,
 - c. Show the effective date of the contract,
 - d. Show the method used for determining direct charge claiming,
 - e. Specify the dollar amount to be paid to the subcontractor, if any, and
 - f. Show the terms of the contract and be accompanied by a fully executed signature page.

Activity D: Medi-Cal Non-Emergency, Non-Medical Transportation

This activity includes arranging and/or providing non-emergency, non-medical transportation of Medi-Cal eligible persons to Medi-Cal services, and when medically necessary, accompaniment by an attendant. The term “non-medical” does not refer to the type of vehicle used, but to the condition of the transportation recipient. As stated in the “State Plan for Assurance of Transportation,” non-medical transportation indicates that the “recipient does not qualify for medical transportation.” Nonetheless, the State is obligated to “assure access to Medi-Cal services for Medi-Cal eligibles” (MAC Agreement, Attachment 5, page 3) and may, therefore, claim the cost of non-emergency, non-medical transportation as Activity D.

In contrast, “non-emergency, medical transportation” (not allowable under MAA) must be provided in ambulances, wheelchair vans⁴, or litter vans, and be supported by a Treatment Authorization Request (TAR) (22 CCR §51323). Public transportation (such as buses, taxis, and paratransit) does not qualify as medical transportation even though it may be accessible to wheelchairs. Neither CMS nor DHCS has approved such forms of transportation as Medi-Cal services. Therefore, LGAs may arrange and/or provide transportation using public transportation services if they choose to do so.

Claiming for a Separate Transportation Unit or Service. In situations where an LGA operates a separate transportation unit or contracts for the provision of transportation services, the costs to the unit or the subcontractor of actually providing the Medi-Cal non-emergency, non-medical transportation services for Medi-Cal eligible persons to Medi-Cal services is an allowable MAA cost. Cost may be calculated on a per-mile basis, on a per-trip basis, or by any other reasonable method (to be reviewed for approval by DHCS) and direct-charged on the CMAA invoice for each Medi-Cal client transported. If direct charge is used, it is not necessary to time-survey.

Direct-Charging Actual Costs of Transportation. In addition to the time spent arranging for and/or providing non-emergency, non-medical transportation, the actual transportation costs may be direct charged. Examples include taxi vouchers, bus tokens, mileage, costs of vans, drivers, etc. These costs are only allowable to the extent that the LGA incurs actual costs. LGAs must identify their actual costs. LGAs may not claim such transportation costs at a mileage rate, federal or otherwise, if not derived from actual costs.

Transportation Costs and TCM. LGAs may not claim this activity as MAA when performed by a TCM Case Manager. Code to TCM time spent arranging transportation for a TCM client to any Medi-Cal service. Time spent by the case manager transporting and/or accompanying the TCM client is coded to TCM only when providing case management services while transporting or accompanying the client. In either case, the cost of this time will be included in the TCM encounter rate and not claimable separately through MAA (MAC Agreement, page 23).

⁴ Wheelchair Van pertains to a vehicle which is modified, equipped and used for the purpose of providing nonemergency medical transportation for wheelchair van patients, and which is not routinely equipped with the medical equipment or personnel required for the specialized care required in an ambulance. (22 CCR §51151.5; also see W&I Code §14104.7.)

Instructions for Preparing a Claiming Plan for Medi-Cal Non-Emergency, Non-Medical Transportation

For *each* type of transportation performed, provide the following information. Identify the information by using the same numbering sequence as shown below.

1. Individually list and clearly describe each allowable type of transportation activity:
 - a. Arranging non-emergency, non-medical transportation;
 - b. Providing non-emergency, non-medical transportation; and
 - c. Accompanying Medi-Cal eligible persons to Medi-Cal services, when medically necessary.
2. Provide a clear and specific description of how each type of transportation activity will be performed.
3. Provide the name(s) of the subcontractor(s) performing the transportation, if applicable.
4. If using other than time surveys, describe how the costs of transportation will be documented.
5. Provide the method for calculating the Medi-Cal discount.

Documents Required for a Claiming Plan for Non-Emergency, Non-Medical Transportation.

Attach to the claiming plan the following documents:

1. A list of subcontractors, if direct charge invoices will be submitted.
2. Copies of those sections of contracts entered into for the performance of non-emergency, non-medical transportation that:
 - a. Clearly describe the non-emergency, non-medical transportation to be performed,
 - b. Describe how the time spent performing non-emergency, non-medical transportation will be documented,
 - c. Show the effective date of the contract,
 - d. Show the method used for determining direct charge claiming,
 - e. Describe how the Medi-Cal discount percentage will be applied, and
 - f. Specify the total dollar amount to payable to the subcontractor, if any.
 - g. This documentation must reflect a current contract: it must show the terms of the contract accompanied by a fully executed signature page.

(E) Contracting For Medi-Cal Services and Medi-Cal Administrative Activities

Description. This activity involves entering into contracts with community-based organizations (CBOs) or other provider agencies for the provision of Medi-Cal services and/or Medi-Cal Administrative Activities (MAA), other than Targeted Case Management (TCM). The costs of TCM subcontractor administration should be included in the TCM rate.

Note: Local governmental agencies (LGAs) have the option of claiming the costs of contract administration for allowable MAA, such as outreach, under that activity, or the costs are claimable under contract administration. Under no circumstances are the costs of contract administration for allowable MAA claimable under both contract administration and the activity, such as Outreach. Contracting for Medi-Cal Services are only claimable under contract administration.

Contracting for Medi-Cal Services and/or MAA is claimable as MAA under Activity E when the administration of those contracts meets all of the following criteria:

1. The contract administration is performed by an identifiable unit of one or more employees, whose tasks officially involve CMAA contract administration, according to their job position descriptions/duty statements.
2. The contract administration involves subcontractors that provide Medi-Cal services and/or MAA.
3. The contract administration is directed to one or more of the following goals:
 - a. Identifying, recruiting, and contracting with community agencies as Medi-Cal services and/or CMAA contract providers.
 - b. Providing technical assistance to Medi-Cal subcontractors regarding county, State, and federal regulations.
 - c. Monitoring provider agency capacity and availability.
 - d. Ensuring compliance with the terms of the contract.

Note: Tasks performed for contract administrative duties required for non-MAA or non-Medi-Cal services contracts are not considered Activity E and must not be invoiced.

Discounted Costs. The contracts administered must be for Medi-Cal services and/or MAA and may involve Medi-Cal populations only or may involve Medi-Cal and other indigent, non-Medi-Cal populations. When the contract involves a Medi-Cal and non-Medi-Cal population, one of the following methods must discount the costs of contract administration:

- Actual Client Count
- Countywide Average
- Other method pre-approved by DHCS and CMS

Direct Charge. If employees perform contract administration 100-percent of their time, the activity is claimable on the direct charge portion of the CMAA invoice and must reflect in the employee's position description/duty statement.

Not Claimable under MAA:

1. TCM case managers and LGA subcontractors *may not* claim contract administration.
2. The costs of contracting for TCM services with non-LGA providers should be claimed as part of the TCM rate. LGAs may not separately claim these costs as MAA.
3. The administrative costs of contracting by LGAs as service providers under managed care arrangements is not claimable as MAA and are considered to be in the capitation payment to the LGA.

Instructions for Preparing a Claiming Plan for Contracting for Medi-Cal Services and Medi-Cal Administrative Activities

1. Individually list each type of contract administered by the claiming unit and describe how staff performs contract administration for each type of contract.
2. For each contract, indicate whether the contract is for Medi-Cal populations only or for a combination of Medi-Cal and non-Medi-Cal populations.
3. For those contracts that combine both Medi-Cal and non-Medi-Cal populations, indicate the Medi-Cal population served by each contract and the method used to determine the Medi-Cal percentage.
4. For each contract, explain the method for allocating time spent by employees between Medi-Cal and non-Medi-Cal contract functions, if this will be the method of discounting used.

Documents Required for a Claiming Plan for Contracting for Medi-Cal Services and Medi-Cal Administrative Activities.

Attach to the claiming plan a sample of each of the types of contracts being administered (not all contracts).

(F) Program Planning and Policy Development

Description. This activity includes the following:

1. Developing strategies to increase Medi-Cal system capacity and close Medi-Cal service gaps. This includes analyzing Medi-Cal data related to a specific program or specific group.
2. Interagency coordination used to improve delivery of Medi-Cal services.
3. Developing resource directories of Medi-Cal services/providers.
4. For subcontractors (CBOs), some program planning and policy development (PP&PD) support services are allowable, such as developing resource directories, preparing Medi-Cal data reports, conducting needs assessments, or preparing proposals for expansion of Medi-Cal services. These activities are not reimbursable at the enhanced rate.

If the program serves both Medi-Cal and non-Medi-Cal clients, the costs of PP&PD activities must be discounted according to the Medi-Cal percentages.

In LGAs with countywide or citywide managed care arrangements, PP&PD activities are claimable as MAA only for those services that are not in the managed care contracts.

This activity is claimable ONLY if the administrative amounts being claimed for PP&PD persons and activities are not otherwise included in other claimable cost pools and if the amounts being claimed for such persons employed by (and activities taking place in) a service provider setting are not otherwise being reimbursed through the billable service rate of that provider.

Not Allowable:

1. If staff performing this function are employed fulltime by LGA service providers, such as clinics, the full costs of the employee's salary are assumed included in the billable service and separate MAA claiming is not allowed. (MAC Agreement, page 25).
2. This activity is not allowable for staff that perform services part-time in an LGA provider setting, such as a clinic, and are performing PP&PD activities relating to the provider setting in which they perform services.
3. PP&PD is not allowable when performed by Targeted Case Management (TCM) case managers.

Direct Charge. Costs are claimable on the direct charge portion of the CMAA invoice if employees perform PP&PD activities 100 percent of their paid working time. Costs for persons performing PP&PD functions less than 100 percent of their time will be on a time survey basis. The Time Survey is not required when PP&PD is performed 100-percent of the employee's time and the PP&PD Direct Charges Worksheet is used.

Instructions for Preparing a Claiming Plan for Program Planning & Policy Development

The LGA must submit a detailed claiming plan that identifies:

1. Units or classifications claimed and whether or not they are Skilled Professional Medical Personnel (SPMPs).
2. Each type of allowable PP&PD tasks performed by the staff, individually listed.
3. The types of health programs involved (if the activity is performed in the LGA's health department).
4. The location(s) where activity(ies) is/are performed.
5. Whether staff perform PP&PD activities full-time or part-time. For part-time performance of activities, indicate whether staff deliver direct services part-time in a billable setting, and identify the setting.
6. The method used to determine the Medi-Cal discount percentage.
7. Claiming method that will be used, i.e., direct-charge or time survey. Explain the method.
8. Which PP&PD activities subcontractors and consultants are performing.

Documents Required for a PP&PD Claiming Plan.

Attach to the claiming plan the following documents:

1. List of subcontractors, if applicable.
2. Copies of those sections of contracts entered into for the performance of PP&PD that:
 - a. Clearly describe the PP&PD to be performed,
 - b. Describe how the time spent performing PP&PD will be documented,
 - c. Show the effective date of the contract,
 - d. Describe the method used to determine direct charge claiming (how the Medi-Cal percentage discount will be applied), and
 - e. Show the dollar amount payable to the subcontractor, if any.
 - f. This documentation must reflect a current contract: it must show the terms of the contract accompanied by a fully executed signature page.
3. Resource directories, if available.
4. A list of staff employed in provider settings who are involved with the four allowable MAA tasks: developing strategies, interagency coordination, developing resource directories, and contracted support services. As noted, PP&PD is not allowable if LGA services providers, such as clinics, employ staff performing this function full-time.

(G) MAA/TCM Coordination and LGA Claims Administration

Description. The Medi-Cal Administrative Activities (MAA)/Targeted Case Management (TCM) Coordination and Local Governmental Agency (LGA) Claims Administration staff may claim the costs of the following activities, as well as any other reasonable activities directly related to the LGA administration of TCM services and MAA on an LGA-wide basis (MAC Agreement, page 26; CMAA contract, Attachment A(9)). Each of the following activities performed under this activity must be detailed in the claiming plan:

1. Drafting, revising, and submitting CMAA claiming plans, TCM cost reports, and performance monitoring plans.
2. Serving as liaison with claiming units within the LGA and with the State and Federal Governments on MAA/TCM. Monitoring the performance of claiming units.
3. Administering LGA claiming, including overseeing, preparing, compiling, revising, and submitting MAA/TCM claims on an LGA-wide basis to the State.
4. Attending training sessions, meetings, and conferences involving TCM and/or MAA.
5. Training LGA program and subcontractor staff on State, federal, and local requirements for MAA/TCM claiming.
6. Ensuring that MAA/TCM claims do not duplicate Medi-Cal claims for the same activities from other providers. This includes ensuring there is no duplication of services when a Medi-Cal beneficiary receives TCM services from more than one case manager.
7. Payment of the portion of the MAA/TCM participation fee that is not used to pay DHCS expenditures or compensation for the LGA Executive Committee or the Host Entity. Each year, DHCS issues a PPL stating the percentage of the participation fee that is claimable and describing how LGAs may claim it (for example, see PPL 06-018 at www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx).

Direct Charge. LGA employees whose position descriptions/duty statements include the administration of MAA/TCM on an LGA-wide basis may claim directly for the costs of these activities on the CMAA invoice as a direct charge. In addition, an LGA's costs incurred in its preparation and submission of MAA claims at any level, including staff time, supplies, and computer expenses may be direct-charged. If MAA/TCM coordination and/or LGA claims administration staff are performing this function part-time, along with other duties, they must certify the percentage of total time spent performing the duties of MAA/TCM coordination and/or LGA claims administration each month of the quarter they invoice. (Do not assign a percentage of time spent on each allowable activity. Provide only the total percentage of time spent performing all the applicable activities listed in numbers 1 through 7 above.) If direct charging, the percentage certified for staff performing MAA/TCM coordination and LGA claims administration must be used as the basis for federal claiming. Because this activity is defined as "LGA-wide" (MAC Agreement, page 26), CBOs may not time-survey, claim, or direct charge to this activity.

Note: The time of the staff performing MAA/TCM coordination and LGA claims administration must not be included in both the TCM cost report and CMAA claiming plans or invoices, because the costs associated with the time are to be direct charged. Charges for supervisors, clericals, and support staff for these employees may be allocated based upon the percentage of certified time of the MAA/TCM coordination and LGA claims administration staff (MAC Agreement, pg 27).

Instructions for Preparing a Claiming Plan for MAA/TCM Coordination and LGA Claims Administration

1. Individually list each type of allowable MAA/TCM coordination and LGA claims administration performed, and describe how staff perform this activity.
2. Indicate whether staff perform this activity part-time in addition to other duties.
3. Describe the method that will be used for claiming, i.e., direct-charge or time survey.
4. Indicate whether subcontractors or consultants are performing any MAA/TCM coordination and LGA claims preparation activities.

Documents Required for a MAA/TCM Coordination and LGA Claims Administration Claiming Plan.

Copies of those sections of current contracts entered into for the performance of MAA/TCM coordination and LGA claims administration that:

1. Clearly describe the MAA/TCM coordination and LGA claims administration to be performed,
2. Describe how the time spent performing MAA/TCM coordination and LGA claims administration will be documented,
3. Show the effective date of the contract,
4. Describe the method used to determine direct charge claiming,
5. Show the dollar amount to be paid to the subcontractor, if any, and
6. Show the terms of the contract and be accompanied by a fully executed signature page.

Note: LGAs need submit just one example of each **type** of contract (not all contracts).

SECTION 4

Determining the Medi-Cal Percentage

Table of Contents

Subject	Page
Overview	4-1
MAA That Must Be Discounted	4-1
Definition of the Medi-Cal Percentage	4-2
Approved Methods	4-2
Actual Client Count	4-3
Countywide Average	4-4

Overview

For some MAA, LGAs claim allowable costs based on how many members of a group of people are Medi-Cal beneficiaries: this number is “the Medi-Cal percentage.” Costs are reducible, or “discounted”, by the Medi-Cal percentage when the activity is directed toward a group of people that is only partly comprised of Medi-Cal eligible persons. Descriptions of the allowable methods for determining the Medi-Cal percentage are in the following pages. The method an LGA uses may vary for each type of MAA it performs. For each group of people it serves, an LGA must determine the Medi-Cal percentage for one full month each quarter. An LGA must identify in its claiming plan the method it uses to determine the Medi-Cal percentage and may not change this method without a claiming plan amendment.

Note: LGAs must submit their CMAA invoices using the same Medi-Cal discount method cited in the related CMAA claiming plan. DHCS will not accept invoices based on a different Medi-Cal discount method than the one cited in the related claiming plan.

MAA That Must Be Discounted

Medi-Cal Outreach B1: LGAs discount this activity by the actual Medi-Cal client count or any other method approved by DHCS and the federal CMS. The only difference between B1 and B2 is the discounting method.

Medi-Cal Outreach B2: LGAs discount this activity by the countywide Medi-Cal average as published by DHCS. The only difference between B1 and B2 is the discounting method.

Activity D, Medi-Cal Non-Emergency, Non-Medical Transportation: This activity must be discounted when provided to both Medi-Cal and non-Medi-Cal populations.

Activity E, Contracting for Medi-Cal Services and Medi-Cal Administrative Activities: This activity must be discounted when the contracts administered under it provide services to both Medi-Cal and non-Medi-Cal populations.

Activity F, Program Planning & Policy Development (PP&PD): This activity must be discounted when the programs for which PP&PD are performed serve both Medi-Cal and non-Medi-Cal populations.

Definition of the Medi-Cal Percentage

The Medi-Cal percentage is the number of Medi-Cal beneficiaries in a group served by the claiming unit or LGA divided by the total number of people in that group. The numerator is the number of the Medi-Cal beneficiaries served by the claiming unit, and the denominator is the total number of persons served by the claiming unit.

Persons who would be Medi-Cal eligible but (1) have not applied for Medi-Cal, (2) have not been determined to be enrolled in Medi-Cal, or (3) whose status is “pending,” may not be included in the numerator of the calculation to determine the Medi-Cal percentage.

The term “enrolled” means that the individual has gone through a formal eligibility determination process and that the county social services agency has determined the client to be eligible and currently able to receive Medi-Cal services.

At any given point in time, “share of cost” clients or “spend down” clients might not be enrolled in Medi-Cal. Clients who have not met their share of cost are not considered Medi-Cal eligible for this purpose and are not to be included in the numerator of the calculation.

Note: The above discussion of Medi-Cal percentage applies to the discount methods referred to as “countywide average” and “actual client count.”

Approved Methods

State and federal guidelines require that the method used to determine the Medi-Cal percentage be “statistically valid.” The two approved methods are “actual client count” and “countywide average.” These methods are described below.

Each claiming unit within an LGA may use a different method. To determine which method to use, consider the nature of the claiming unit and the kind of client data it collects. After receiving State and federal approval, the claiming unit must employ the approved method each quarter so that the Medi-Cal percentage is current with the period of costs reflected on the CMAA invoice. If a claiming unit elects to change methods, such as from “actual client count” to “countywide average,” the LGA must file a CMAA claiming plan amendment no later than the end of the quarter in which the claiming unit wishes to use the new method.

Alternate Methods

Other methods are possible; however, an LGA must obtain prior review and approval of that method from DHCS and CMS by including the proposed method in the CMAA claiming plan.

If the proposed method is not approved, the LGA will be notified and given the option to resubmit the claiming plans or invoices using an alternate approved method.

LGAs should expect disapproval of a method if "staff judgment" or "management determinations" are used to calculate it.

Actual Client Count

The Medi-Cal percentage based on the actual client count is the fraction of a claiming unit's total target population that consists of Medi-Cal beneficiaries. To determine the actual client count, identify the total number of Medi-Cal beneficiaries and the total number of individuals served by the claiming unit, defined in the claiming plan as the target population. The claiming unit must identify the Medi-Cal status of each person in the target population. The Medi-Cal percentage is the number of Medi-Cal beneficiaries divided by the total number of individuals actually served. An actual client count must be taken for one full month of each quarter in which claims will be submitted; less often is not acceptable. The Medi-Cal percentage must be current with the quarter being claimed.

To document client Medi-Cal status, the claiming unit must record the Medi-Cal ID number of each person served, if they have one.

Subcontracting for the performance of Medi-Cal services and MAA or PP&PD might involve more than one subcontract or program. The Medi-Cal percentage may vary for each contract the LGA administers or by each program for which the LGA performs PP&PD. See Section 6, MAA Summary and Detailed Invoice, for information on determining the Medi-Cal percentage for PP&PD. LGAs may use a similar procedure to determine the Medi-Cal percentage for subcontracting for Medi-Cal services and MAA.

Determining the Actual Client Count Medi-Cal Percentage for Specific MAA.

For the activities below, the claiming unit must first determine the number of Medi-Cal beneficiaries actually served and the total number of individuals actually served. The Medi-Cal percentage is the number of Medi-Cal beneficiaries served divided by the total number of individuals served.

Outreach B. To determine the actual client count the claiming unit will identify the total number of Medi-Cal beneficiaries and the total number of individuals actually served.

Non-Emergency, Non-Medical Transportation. When this activity provides to both Medi-Cal and non-Medi-Cal populations, documentation must be maintained to record the number of Medi-Cal beneficiaries and total number of individuals for whom this transportation is arranged or provided.

Contracting for Medi-Cal Services or MAA. This activity may involve more than one contract. The Medi-Cal percentage may vary for each contract; therefore, the Medi-Cal percentage must be determined for each contract.

Program Planning & Policy Development. Claiming Units direct their PP&PD efforts toward Medi-Cal services that will benefit populations similar to those they serve; therefore, to determine the actual client count the claiming unit will identify the total number of Medi-Cal beneficiaries served and the total number of individuals served.

Countywide Average

If a claiming unit finds it difficult to collect a population's Medi-Cal information, it may use as its own Medi-Cal percentage the percentage of the county's total population that consists of Medi-Cal beneficiaries. Twice per year, DHCS will issue a PPL that notifies LGAs of the current countywide average.

SECTION 5

Time Surveys

Table of Contents

Subject	Page
Purpose of the Time Survey	5-1
Time Survey Training	5-1
When to Conduct a MAA Time Survey	5-2
The MAA/TCM Combined Time Survey Form	5-3
Who Should Complete the MAA/TCM Combined Time Survey Form	5-4
How to Complete the MAA/TCM Combined Time Survey Form	5-5
Activity Descriptions	5-6
(A) Medi-Cal Outreach A (Not Discounted) Form	5-7
(B1 & B2) Medi-Cal Outreach B1 & B2 (Discounted)	5-8
(C) Facilitating Medi-Cal Application (Eligibility Intake)	5-9
(D) Medi-Cal Non-Emergency, Non-Medical Transportation	5-10
(E) Contracting for Medi-Cal Medical Assistance and for MAA	5-11
(F) Program Planning and Policy Development	5-12
(G) MAA/TCM Coordination and LGA Claims Administration	5-15

Purpose of a CMAA Time Survey

The MAA/TCM Combined Time Survey is the approved method for determining the percentage of time spent on each of the allowable administrative activities, each of the unallowable activities, and each of the allocated activities.

Under the federal Office of Management and Budgets Circular A-87 (OMB A-87), Attachment B, item 8, a payroll system tracking all work time is normally required when seeking federal reimbursement. The time survey provides a substitute system for allocating salaries and wages in place of daily activity reports. Training confirms the uniformity and integrity of the time survey process.

Time survey results must be reasonably representative of work performed throughout the year.

The annual time survey results are used to prepare the quarterly CMAA invoices for all quarters of that fiscal year, unless superseded by a DHCS approved subsequent time survey. LGA claiming units that elect to participate in CMAA must conduct a required time survey.

Time Survey Training

To help staff understand which activities to code to MAA, LGAs must provide CMAA time survey training each year. DHCS annually conducts "Train-the-Trainers" sessions prior to the time survey months. DHCS issues a PPL each year informing LGAs of the dates these training sessions will be held (typically in June or July). Attendance is mandatory for each LGA MAA/TCM Coordinator or authorized alternate. DHCS Train-the-Trainers materials, including presentation slides from recent training sessions, are available on the DHCS website.

Staff must identify on the time survey what they each do during their workdays for one month. This time survey month should be representative of an average month of work. Time survey training may be conducted during the time survey month; however, LGAs must ensure that they do not load the time survey month with training. To do so would create an inaccurate picture of the amount of time staff typically spends on MAA-related activities during other months of the year.

When to Conduct a CMAA Time Survey

DHCS has designated the annual CMAA time survey to occur in either September or October. The LGA may request to time survey in July or August for the first quarter or request to conduct an initial or subsequent time survey after the first quarter of each fiscal year.

Reasons to conduct a time survey after the first quarter may include, but are not limited to, the following:

1. A change has occurred in the percentage of time the claiming unit spends performing MAA.
2. A new claiming unit, position/classification, or MAA activity was added to a previously approved claiming plan. A time survey is required for the claiming unit to claim reimbursement for these additions.

To do this, the LGA must submit to DHCS a completed Time Survey Request template, which must bear the MAA Coordinator's original signature and be postmarked at least 30 days prior to the month in which the time survey is to be conducted. If the request is approved, the time survey would be in effect from the first day of the quarter in which it is conducted, and would remain in effect unless superseded by a subsequent time survey during that fiscal year.

If the LGA must withdraw its request to conduct a subsequent time survey, the LGA must write a letter (sent by mail with an original signature) requesting the withdrawal that arrives at DHCS at least three working days before the first day of the quarter in which the LGA was to have conducted the time survey. DHCS evaluates such requests on a case-by-case basis. The LGA must not assume that the submission of a request to withdraw its intention to conduct a time survey relieves the LGA of its responsibility to conduct the time survey. Unless notified in writing by DHCS to the contrary, the LGA must conduct the time survey it previously requested.

Once DHCS approves the subsequent CMAA time survey request, the LGA must conduct the time survey and use its results to prepare the CMAA invoice for that quarter and subsequent quarters of the fiscal year. The results of the subsequent CMAA time survey will be in effect until superseded by an additional approved subsequent CMAA time survey or by the mandatory time survey in the next fiscal year.

The MAA/TCM Combined Time Survey Form

The MAA/TCM Combined Time Survey form provides a single form for both the CMAA and TCM programs. Only this form may be used. To obtain the CMAA-TCM Combined Time Survey forms, go to www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx.

The time survey form captures all time spent on claimable and non-claimable CMAA and TCM activities for the entire month. The results of the MAA/TCM Combined Time Surveys are an important factor to determine reimbursable costs for eligible activities.

CMAA includes:

- Medi-Cal Outreach A, B1, and B2,
- Facilitating Medi-Cal Application (Eligibility Intake),
- Arranging for and/or Providing Medi-Cal Non-Emergency, Non-Medical Transportation,
- Contracting for Medi-Cal Services and Medi-Cal Administrative Activities,
- Program Planning and Policy Development, and
- MAA/TCM Coordination and LGA Claims Administration.

Note: Overtime or CTO is coded to the activity being performed when it is earned; it is not recorded on the time survey form when it is taken.

The activities on the MAA/TCM Combined Time Survey form are grouped according to the program to which they apply. Some are CMAA-only activities; some are TCM-only activities, and others are activities that might be performed by CMAA or TCM staff.

Who Should Complete the CMAA Time Survey

LGA claiming unit staff that perform any of the MAA activities described above and whose position classification is included in the currently approved claiming plan must time-survey unless approved for direct charge only. These staff must only code to the MAA activities for which the claiming plan approves them. Staff who do not perform any of these CMAA activities or whose position classification is not included in the claiming plan must not time-survey. Staff who were present during the time survey month but did not time-survey to any MAA activity must not be included in the summary MAA percentages.

MAA/TCM Coordination staff that do not perform other MAA or TCM are not required to time survey. Their costs may be direct charged if this is stated in an approved claiming plan. If the staff perform any other CMAA, they must time survey.

For guidance on claiming for activities conducted by Skilled Professional Medical Personnel (SPMPs), see Appendix D.

Community-Based Organizations (CBOs). Employees of CBOs who perform any allowable MAA and/or TCM must participate in the time survey if the CBO contract with the LGA is “non-specific”; that is, the contract does not specifically identify the total amount payable for these activities. CBO employees must check the box labeled “CBO”.

Employees of CBOs need not participate in a time survey if the CBO contract with the LGA is “specific; that is, the contract:

1. Clearly describes the MAA it will perform, and
2. Specifies the total amount the LGA will pay the CBO to perform these activities.

Note: DHCS now allows an employee of a CBO to perform certain MAA activities and TCM, subject to the same limitations as an employee of an LGA.

How to Complete the MAA/TCM Combined Time Survey Form

General Instructions: To ensure accuracy, the time survey will need to be completed:

- By tracking activities throughout the course of the day; daily, not at the end of the week.
- Thoroughly, accurately, and legibly
- In ink or pencil, or electronically, but must be signed in blue ink
- Only by the person identified on the time survey form

Any corrections done **only** by the person whose hours were recorded on the time survey template. Corrections must be done using a single strikeout and initialed with non-black ink. Do not use whiteout. Additional instructions on how to complete the time survey are on the MAA/TCM Combined Time Survey form.

Note: Time surveys are legal documents that serve as the basis for MAA claiming. DHCS recommends completing the time surveys in ink.

How to code time on the time survey for training:

1. Staff trained during time survey month to perform specific Medi-Cal administrative activities should code that time to that specific activity, such as Outreach A or Facilitating Medi-Cal Application, if approved in the Claiming Plan.
2. Staff trained during time survey month on any other MAA-related duties, such as how to complete the time survey, should code that time to General Administration. The activity involved in completing the time survey form and compiling the secondary documentation should be coded to General Administration.
3. LGA staff conducting training, who are eligible to perform MAA/TCM Coordination and Claims Administration (Activity G) may code that time to that activity.
4. Other staff conducting training during time survey month should code their time either to the specific activity being trained or to General Administration, as described in 1. and 2. above.

Supporting Documentation. LGAs must base their CMAA invoices on time surveys. Because the CMAA invoice uses the time survey to determine the portion of costs eligible for reimbursement, supporting documentation is required to substantiate the time survey. Staff certification is not sufficient. There are two types of supporting documentation for time surveys:

- Secondary documentation, such as activity samples, and
- Source documentation, as is required for all MAA claims.

Secondary documentation includes any information that provides evidence of the type of activity to which the staff member time-surveyed. Such information helps ensure that each staff member who time surveys correctly understands how to time survey and if they are time surveying to appropriate activities. LGAs may demonstrate this understanding by retaining at least two written samples of activities, or other documentation, that describe at least two occurrences of each type of MAA and or TCM activity listed on the MAA/TCM Combined Time Survey form to which the staff member surveys. Such documentation may include, but is not limited to, file notes, copies of a calendar page with notations, announcements of events the staff member participated in, or event sign-in logs. A clear audit trail must exist from time survey to documentation. This must include, but is not limited to, the staff member's name and the date of the occurrence.

For example, if a staff member time surveys to Outreach B2 and Facilitating Medi-Cal Application, four activity samples or equivalent documentation would be required: two for each type of activity performed that month that illustrates the actual activity performed. If a staff member performs a MAA activity such as Outreach B2 only once during the month, documentation of this one occurrence is sufficient.

Source documentation substantiates the amount of time coded on the time survey by the specific staff who participated. LGAs are required to substantiate time surveyed for MAA claims for federal financial participation (FFP). LGAs are responsible for the documentation of all costs claimed, including those associated with personnel time. Sufficient documentation must support the nature and amount of all activities time surveyed. Each LGA is responsible to determine what specific documentation it can provide to demonstrate the validity of its costs. This documentation must be retained in the program's audit files and available for review throughout the required retention period, as set forth in 42 CFR §433.322. DHCS, CMS, or other auditing agencies may disallow costs not substantiated by supporting documents.

Activity Descriptions

MAA Outreach Overview

This section provides guidance on how to differentiate between Outreach A (not discounted by the Medi-Cal percentage) and Outreach B1 or B2 (discounted by the Medi-Cal percentage). Both Outreach A and Outreach B1 or B2 may consist of

separate campaigns or may be ongoing activities. LGAs may conduct outreach toward groups or individuals directly or through media campaigns. LGAs may also conduct Outreach A and Outreach B1 or B2 toward service providers, agencies, or community groups to refer individuals who are potentially eligible for Medi-Cal to Medi-Cal eligibility offices, and individuals who are eligible for Medi-Cal to Medi-Cal services. LGAs may code time spent training staff to perform MAA Outreach (A, B1, or B2) to that activity. Time spent training staff to complete the time survey form and supporting documentation may only be coded to General Administration. For guidance on claiming for activities conducted by specialized professional medical personnel (SPMPs), see Appendix D.

Activity A: Medi-Cal Outreach A (Not Discounted)

There are two purposes for this type of Outreach:

1. Bring potential eligible persons into the Medi-Cal system to determine their Medi-Cal eligibility. This involves informing individuals or the general public about the benefits and services that the Medi-Cal program offers, and encouraging and referring them to apply for Medi-Cal benefits. The general public may consist of various population groups, some of which could be categorized as high risk, such as low-income pregnant women.

OR

2. Bring Medi-Cal beneficiaries into Medi-Cal services. This involves informing, encouraging, and referring Medi-Cal beneficiaries to access Medi-Cal covered services. This type of outreach is directed only toward persons known to be Medi-Cal beneficiaries, and not to the general public. LGAs should use language in Outreach A materials clearly indicating that the message is directed toward Medi-Cal beneficiaries and that referrals are only to Medi-Cal services.

If a public health campaign contains a separate segment targeted only toward bringing Medi-Cal beneficiaries into Medi-Cal covered services, only that segment would be time-surveyed to Outreach A. For example: An LGA conducts a two-hour presentation to Medi-Cal and non-Medi-Cal persons on the importance of prenatal care, with one hour devoted to informing the Medi-Cal eligible persons how to access Medi-Cal prenatal care services providers. One hour would be coded to Other Programs/Activities; the other hour would be coded to Outreach A.

Outreach A includes referring persons who are eligible for Medi-Cal to Medi-Cal services or referring persons who are potentially eligible for Medi-Cal to Medi-Cal eligibility workers. Outreach A may include telephone, walk-in, or drop-in services only when:

1. The service is exclusively to refer potentially Medi-Cal eligible persons to apply for Medi-Cal and/or to refer Medi-Cal beneficiaries to Medi-Cal covered services (e.g., a Medi-Cal referral hotline).

2. The person time surveying can clearly identify the time spent referring potentially eligible persons to apply for Medi-Cal and/or referring Medi-Cal beneficiaries to Medi-Cal covered services.

The intention of conducting Outreach A must not only be to inform clients of services but also to encourage them to apply for Medi-Cal benefits or to refer them to eligibility offices. Without encouraging persons who are potentially eligible for Medi-Cal to apply for benefits, this activity would be Outreach B1 or B2 (discounted). It is important that staff understand the intent of Outreach A (not discounted) and incorporate these required elements into their outreach efforts.

Activities B1 and B2: Medi-Cal Outreach B1 and B2 (Discounted by a Medi-Cal Percentage Method)

Outreach B1 and B2 include outreach campaigns, programs, or ongoing activities directed toward bringing both Medi-Cal and non-Medi-Cal persons into health care services (not housing, food, or cash assistance). This activity is performed with no specific intention of getting these groups or individuals to apply for Medi-Cal. Outreach B1 and B2 are discounted by the Medi-Cal percentage because the costs are only claimable to the extent that the activity brings Medi-Cal eligible persons into Medi-Cal services.

Staff must be aware of which Medi-Cal discount method will be used for a particular outreach activity in order to code appropriately to Outreach B1 or Outreach B2:

- Outreach B1 is outreach that will be discounted by an actual client count or other DHCS-approved method for determining the Medi-Cal percentage.
- Outreach B2 is outreach that will be discounted by using the DHCS-issued countywide average Medi-Cal percentage.

Outreach B1 or B2 consists of direct contact, general telephone, walk-in, or drop-in services for the purpose of informing or referring both Medi-Cal eligible persons and Medi-Cal beneficiaries to Medi-Cal services. This type of outreach is not directed toward bringing potentially Medi-Cal eligible persons only into the Medi-Cal system.

The portions of broad campaigns for general health education that focus on Medi-Cal services, benefits, and enrollment are allowable under Outreach B1 or B2. However, that portion of time not focused on Medi-Cal services must be coded to Other Programs/Activities. An example would be a Well Child campaign that includes education on how to care for a sick child (Other Programs/Activities), as well as information on accessing Medi-Cal covered Well Baby Clinics (Outreach B).

Activity C: Facilitating Medi-Cal Application (Eligibility Intake)

Facilitating Medi-Cal Application (Eligibility Intake) includes the following activities separately or in combination:

- Explaining Medi-Cal eligibility rules and the Medi-Cal eligibility process to prospective applicants,
- Helping an applicant fill out a Medi-Cal eligibility application,
- Gathering information from a client related to the application and to the client's eligibility determination/redetermination, including resource information and third-party liability (TPL) information as a prelude to submitting a formal Medi-Cal application to the county social services department,
- Providing necessary forms and packaging all forms in preparation for the Medi-Cal eligibility determination

Note: This activity does not include the eligibility determination itself.

Although this activity may seem similar to Medi-Cal Outreach A, Facilitating Medi-Cal Application is more proactive and involves providing specific assistance rather than general information and referral. Employees completing the time survey must be able to distinguish between these two activities. Examples include:

- Conducting a presentation for prospective applicants on the Medi-Cal application process,
- Providing Medi-Cal application packets, including the actual application and instructions for completing the forms, to community centers serving prospective applicants,
- Providing translation services to assist non-English speakers in filling out the Medi-Cal eligibility application,
- Outposting a community worker at a Medi-Cal eligibility office to help applicants with Medi-Cal eligibility forms and to answer questions,
- Helping applicants complete the Medi-Cal eligibility application and packaging the application forms for delivery to the Medi-Cal eligibility office,
- Working with an applicant's guardian to obtain copies of documents needed in order to apply for Medi-Cal

For the Healthy Families/Medi-Cal application (MC321):

If the "I do not want Medi-Cal" box is checked, then time spent during the time-survey month on facilitating Medi-Cal application must be coded to "Other Programs/Activities." See page 3-16.

LGAs may code time spent training staff to perform MAA Activity C: Facilitating Medi-Cal Application (Eligibility Intake) to that activity. Time spent training staff to complete the time survey and the secondary documentation may only be coded to General Administration.

Activity D: Medi-Cal Non-Emergency, Non-Medical Transportation

This activity includes arranging and/or providing non-emergency, non-medical transportation of Medi-Cal eligible persons to Medi-Cal services, and when medically necessary, accompaniment by an attendant. The term “non-medical” does not refer to the type of vehicle used, but to the condition of the transportation recipient. As stated in the “State Plan for Assurance of Transportation,” non-medical transportation indicates that the “recipient does not qualify for medical transportation.” Nonetheless, the State is obligated to “assure access to Medi-Cal services for Medi-Cal eligibles” (MAC Agreement, Attachment 5, page 3) and may, therefore, claim the cost of non-emergency, non-medical transportation as Activity D.

In contrast, “non-emergency, medical transportation” (not allowable under MAA) must be provided in ambulances, wheelchair vans⁵, or litter vans, and be supported by a Treatment Authorization Request (TAR) (22 CCR §51323). Public transportation (such as buses, taxis, and paratransit) does not qualify as medical transportation even though it may be accessible to wheelchairs. Neither CMS nor DHCS has approved such forms of transportation as Medi-Cal services. Therefore, LGAs may arrange and/or provide transportation using public transportation services if they choose to do so.

LGAs may code time spent training staff to perform MAA Activity D: Medi-Cal Non-Emergency, Non-Medical Transportation to that activity. Time spent training staff to complete the time survey and the secondary documentation may only be coded to General Administration.

Claiming for a Separate Transportation Unit or Service. In situations where an LGA operates a separate transportation unit or contracts for the provision of transportation services, the costs to the unit or the subcontractor of actually providing the Medi-Cal non-emergency, non-medical transportation services for Medi-Cal eligible persons to Medi-Cal services is an allowable MAA cost. Cost may be calculated on a per-mile basis, on a per-trip basis, or by any other reasonable method (to be reviewed for approval by DHCS) and direct charged on the CMAA invoice for each Medi-Cal client transported. If direct charge is used, it is not necessary to time survey.

Direct-Charging Actual Costs of Transportation. In addition to the time spent arranging for and/or providing non-emergency, non-medical transportation, the actual transportation costs may be direct-charged. Examples include taxi vouchers, bus tokens, mileage, costs of vans, drivers, etc. These costs are only allowable to the extent that the LGA incurs actual costs. LGAs must identify their actual costs. LGAs may not claim such transportation costs at a mileage rate, federal or otherwise, not derived from actual costs.

⁵ Wheelchair Van pertains to a vehicle which is modified, equipped and used for the purpose of providing nonemergency medical transportation for wheelchair van patients, and which is not routinely equipped with the medical equipment or personnel required for the specialized care required in an ambulance. (22 CCR §51151.5; also see W&I Code §14104.7.)

Transportation Costs and TCM. LGAs may not claim this activity as MAA when performed by a TCM case manager. Code to TCM time spent arranging transportation for a TCM client to any Medi-Cal service. Time spent by the case manager transporting and/or accompanying the TCM client is coded to TCM only when providing case management services while transporting or accompanying the client. In either case, the cost of this time will be included in the TCM encounter rate and not claimable separately through MAA (MAC Agreement, page 23).

Activity E: Contracting for Medi-Cal Services and Medi-Cal Administrative Activities

This activity involves entering into contracts with CBOs or other provider agencies for the provision of Medi-Cal health care services (other than TCM) and/or performance of MAA. Contract Administration includes:

- Identifying, recruiting, and contracting with community agencies as Medi-Cal services and/or CMAA contract providers,
- Providing technical assistance to Medi-Cal subcontractors regarding county, State, and federal regulations,
- Monitoring provider-agency capacity and availability,
- Ensuring compliance with the terms of the contract

LGAs may only claim for this activity when performed by an identifiable unit of one or more employees whose job descriptions include CMAA Contract Administration. The employee is not required to time survey and should direct charge if performing CMAA Contract Administration 100 percent of his or her paid time.

TCM case managers and CBOs may not claim Contract Administration.

LGAs may not claim as MAA the administrative costs of contracting as service providers under managed care arrangements; such costs are part of the capitation payment to the LGA.

The MAA/TCM Combined Time Survey form has two categories of Contract Administration:

- Contract Administration A (not discounted): Employees are to time survey to Contract Administration A when the contract(s) they are administering only involve Medi-Cal populations and/or MAA.
- Contract Administration B (discounted): Employees are to time survey to Contract Administration B when the contract(s) they are administering involve both Medi-Cal and non-Medi-Cal populations. On the CMAA invoice, the costs of Contract Administration B must be discounted by the Medi-Cal percentage. The basis for determining this Medi-Cal percentage must be described in the CMAA claiming plan.

Activity F: Program Planning and Policy Development

Program Planning and Policy Development (PP&PD) includes:

- Developing strategies to increase the capacity of the Medi-Cal system and to close gaps in Medi-Cal services,
- Analyzing Medi-Cal data related to a specific program or group,
- Improving the delivery of Medi-Cal services through interagency coordination, and
- Developing resource directories of Medi-Cal services and providers

This activity is claimable when it is performed, part- or full-time, by staff whose duty statements specifically identify PP&PD as part of their jobs. If the PP&PD involves programs that serve both Medi-Cal and non-Medi-Cal clients, the costs of PP&PD activities must be allocated using the Medi-Cal percentages that apply to the programs.

For guidance on claiming for activities conducted by Skilled Professional Medical Personnel (SPMPs), see Appendix D.

For staff of CBOs, allowable PP&PD activities are limited to support services, such as developing resource directories, preparing Medi-Cal data reports, conducting needs assessments, or preparing proposals for expansion of Medi-Cal services.

In counties with countywide managed care arrangements, PP&PD activities are claimable only for those services excluded from the managed care contracts. The rates paid for services through managed care programs already include the costs of PP&PD.

LGAs may code time spent training staff to perform MAA Activity F: Program Planning and Policy Development to that activity. Time spent training staff to complete the time survey and supporting documentation may only be coded to General Administration.

This activity is not allowable if:

- LGA service providers, such as clinics, employ staff performing this function full-time. The full costs of the employee's salary are assumed included in the billable fee-for-service rate, and separate MAA claiming is not allowed
- Staff who deliver services part-time in an LGA service provider setting, such as a clinic, are performing PP&PD activities relating to the service provider setting in which they deliver services
- Performed by Targeted Case Management (TCM) case managers

The MAA/TCM Combined Time Survey form has four categories of PP&PD:

- PP&PD "A" (not discounted) Employees are to time-survey to PP&PD "A" when the PP&PD is related to programs serving only Medi-Cal clients

- PP&PD “B” (discounted) Employees are to time survey to PP&PD “B” activities conducted toward both Medi-Cal beneficiaries and Medi-Cal ineligible persons. On the CMAA invoice, the costs of PP&PD “B” must be discounted by the Medi-Cal percentage. The basis for determining this Medi-Cal percentage must be described in the CMAA claiming plan
- SPMP PP&PD “A” (not discounted) requires professional medical knowledge and skills of Skilled Professional Medical Personnel (SPMP), and is performed by an SPMP when the PP&PD is related to programs serving only Medi-Cal clients.
- SPMP PP&PD “B” (discounted) requires professional medical knowledge and skills of an SPMP, and is performed by an SPMP conducted toward both Medi-Cal beneficiaries and Medi-Cal ineligible persons

Direct Charge. LGAs may claim the costs of PP&PD on the direct charge portion of the CMAA invoice if employees perform PP&PD activities 100 percent of their paid working time. This activity is claimable only if the administrative amounts being claimed for PP&PD staff and their activities are not otherwise included in other claimable cost pools. The costs for staff performing PP&PD functions less than 100 percent of their time will be based on a time survey.

Examples of Allowable PP&PD:

1. Developing a plan to initiate *Mobile Clinic* services to provide CHDP exams and immunizations.
2. Developing an interagency *referral* and *tracking* system to expedite access to Medi-Cal services.
3. Participating on an *Interagency Perinatal* Task Force to develop strategies to improve access to pediatric services.
4. Participating on an *OB-GYN Advisory Committee*, comprised of physicians, managed care representatives, county employees, and community agency representatives. The purpose of the committee is to develop strategies to improve access to and increase OB-GYN services for Medi-Cal beneficiaries.
5. Participate on the *St Vincent de Paul* Medical Advisory Committee. The purpose of the Committee is to identify health needs of the homeless, particularly families with children, and to develop strategies to address those needs. The majority of the clients are potentially Medi-Cal eligible.
6. Working in collaboration with *school nurses* and community providers on a community needs assessment, development and implementation of services, and evaluation; the planned services include the full range of Medi-Cal services used by children.
7. Developing and reviewing policies and procedures for coordinating medical services for *geriatric* patients.
8. Developing and maintaining *Medi-Cal resource* information and *directories* of services.

9. Developing and overseeing the *Medi-Cal Infant to Age Three* project to increase use of Medi-Cal services and Targeted Case Management.
10. Consulting with medical providers on Medi-Cal policies and procedures to ensure that clients receive the *Medi-Cal services* for which they are eligible.
11. Coordinating, planning, and developing policies related to children's health services, which includes obtaining resources for Medi-Cal covered *school-linked health services*.
12. Serving on the *Infant Mortality Review Committee*, which reviews causes of death to identify medical issues in children under age one; the purpose is to develop objectives of prevention and medical intervention for high-risk families.
13. Developing and implementing a telephone line for *Spanish language* Medi-Cal referral.
14. Collecting, analyzing, and reporting Medi-Cal *statistical data* to evaluate service needs and program use.
15. Attending the *Infant Immunization Initiative* planning meetings to plan, implement, and evaluate increased Medi-Cal covered immunization services.
16. Recruiting for and accompanying Medi-Cal beneficiaries to a meeting to address barriers to Medi-Cal *enrollment and the use* of Medi-Cal services.
17. Conducting surveys or focus groups with clients regarding access to and the effectiveness/appropriateness of current Medi-Cal services.

Examples of Unallowable PP&PD:

1. Participating in a *Youth Services Networking Breakfast* to discuss the causes of teen pregnancy.
2. Developing *interagency policies* and procedures to identify battered women.
3. Attending monthly Community Forum meetings, the purpose of which is *networking* and information sharing.
4. Proposal writing in a collaborative setting with other agencies for services *not related* to Medi-Cal.
5. Planning meetings with other agencies for services *not related* to the Medi-Cal program.
6. Conducting *referral to providers* regarding services not related to Medi-Cal.
7. Conducting surveys or focus groups with school site councils regarding *Non-Medi-Cal* services.
8. Attending *general training* on promoting community collaboration.

Activity G: MAA/TCM Coordination and LGA Claims Administration

MAA/TCM Coordination and LGA Claims Administration include:

- Drafting, revising, and submitting CMAA claiming plans, TCM cost reports, and performance monitoring plans
- Serving as liaison with claiming units within the LGA and with the State and Federal Governments on MAA/TCM. Monitoring the performance of claiming units
- Administering LGA claiming, including overseeing, preparing, compiling, revising, and submitting MAA and TCM claims on an LGA-wide basis,
- Attending training sessions, meetings, and conferences involving MAA and/or TCM
- Training LGA program and subcontractor staff on State, federal, and local requirements for MAA/TCM claiming
- Ensuring that MAA and TCM claims do not duplicate Medi-Cal claims for the same activities from other providers. This includes ensuring no duplications when a Medi-Cal beneficiary receives TCM services from more than one case manager
- Payment of the portion of the MAA/TCM participation fee not used to pay DHCS expenditures or compensation for the LGA Executive Committee or the Host Entity. Each year, DHCS issues a PPL stating the percentage of the participation fee that is claimable and describing how LGAs may claim it

Examples of MAA/TCM Coordination (separate from LGA Claims Administration):

- Disseminating MAA-related policy, procedure, and training documents to MAA claiming units,
- Ensuring proper execution of CMAA contracts and TCM Provider Agreements,
- Preparing CMAA claiming plans and Claiming Plan Amendments,
- Developing protocols for implementation of MAA and/or TCM at the local level,
- Providing MAA and TCM-related training,
- Responding to requests for information regarding the MAA and TCM programs,
- Reviewing and compiling the results of the MAA/TCM time surveys,
- Ensuring compliance with TCM case manager documentation,
- Ensuring compliance with TCM “free care” and TPL policies,
- Maintaining MAA and TCM audit files
- Monitoring Medi-Cal TCM provider-agency capability and availability,

Examples of LGA Claims Administration (separate from MAA/TCM Coordination):

- Preparing TCM Cost Reports,
- Entering Medi-Cal data from the TCM encounter logs into the data collection system,
- Reconciling TCM Medi-Cal encounter claims reported as rejected by the State,
- Maintaining and analyzing TCM management information systems,
- Preparing and submitting CMAA invoices,
- Correcting or revising CMAA invoices rejected by the State,
- Developing and maintaining a record keeping system for documenting MAA direct charge expenses,
- Ensuring that MAA and TCM claims are submitted by the required due dates

Staff that only perform MAA/TCM Coordination and LGA Claims Administration are not required to time survey. However, the time survey can be used as a tool to support the percentage of time that is certified as being spent on these activities. Staff who perform MAA/TCM Coordination and LGA Claims Administration and perform other MAA and/or TCM must time survey.

Direct Charging for MAA/TCM Coordination and LGA Claims Administration.

Direct charging is permitted for the costs of staff performing MAA/TCM Coordination and LGA Claims Administration at the LGA level or MAA Claims Administration at the claiming unit level. These staff are not required to participate in the MAA/TCM time survey process. However, they must certify on a monthly basis the percentage of time spent and be able to provide documentation supporting this percentage. Their duty statements must show that these activities are part of their job. Charges for supervisors, clericals, and support staff for these employees may be allocated based upon the percentage of certified time of the MAA/TCM Coordination and LGA Claims Administration staff. The costs of TCM claiming activity at the TCM provider level are to be included in the TCM rate.

SECTION 6

MAA Summary and Detail Invoices

Table of Contents

Subject	Page
Overview	6-1
Entering Data	6-2
MAA Detail Invoice	6-3
Completing the Header	6-3
Cost Pools	6-5
Entering Cost Data	6-6
Medi-Cal Discount Percentages	6-8
Activity Percentages	6-8
Funding Source Worksheet 1	6-9
Assigning Funding Sources	6-10
Direct Charges Worksheet 2	6-12
Other Costs	6-13
Where to Enter Data	6-13
PP&PD Worksheet 3	6-15
Examples of Other Costs	6-16
Required Supporting Documentation	6-17
Claiming for Subcontractors	6-18
MAA Summary Invoice	6-19
Variance	6-20
Submitting the Invoices	6-21
Payment Process	6-22
Corrections and Revisions	6-22
Revised Invoices with a Credit Balance	6-23

Overview

This section contains instructions for preparing and submitting the quarterly CMAA invoice. Each quarterly invoice must include the total costs and total revenues (funding sources) of the claiming unit (i.e., budget unit). All invoices must be submitted within 18 months of the end of the quarter claimed.

The MAA claiming process includes the following documents:

- MAA Detail Invoice,
- MAA Funding (Revenue) Sources Worksheet 1,
- MAA Direct Charges Worksheet 2,
- Program Planning and Policy Development Worksheet 3,
- MAA Summary Invoice,
- Checklist for preparing the MAA Detail Invoice,
- Checklist for preparing the MAA Summary invoice,
- Invoice Variance Documentation (when applicable).

Note: Only DHCS-authorized templates may be used for invoicing. Invoices submitted on unauthorized documents will be denied.

The MAA claiming documents are available online at www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx. The automated MAA Detail Invoice (in Excel) and supporting worksheets allow the preparer to enter costs, funding sources, activity percentages, Medi-Cal discount percentages, and heading information just once. The data entered on the worksheets will automatically carry forward to the MAA Detail Invoice. The lines and columns where data may be entered are marked "(Enter)," and the cells are not shaded. All other sections off the MAA Detail Invoice are automatically calculated and are shaded. Do not change the spreadsheet's formulas or formats because this would alter the calculation of the federal financial participation (FFP).

- **The Detail Invoice is formatted to fit on legal paper only.**
- **The Summary Invoice is formatted to fit on letter paper.**

Entering Data. Enter data into the spreadsheet only in cells that indicate “(Enter).” **Never** enter data in the shaded areas or in sections marked “Formula”: doing so will alter the spreadsheet and cause it to calculate the claim incorrectly. Obtain the data to input from external sources, such as accounting system reports, spreadsheets, journals, payroll records, etc. Enter into the spreadsheet only those data elements that appropriately reflect costs and funding sources applicable to the claiming unit. Once all amounts are entered, the spreadsheet will automatically calculate the claim.

All amounts entered into the invoice will need supporting documentation that links it to the specified cost pool or funding source: these documents must be maintain in the audit file, and be readily available to DHCS audit and program staff. For example, salaries and benefits assigned to SPMP by entry into Cost Pool 1 should be evidenced by payroll documentation to show the expenditure of such salaries and benefits on individuals who qualify as SPMP.

Percentages. Cells that require entry of an amount shown as a percent are formatted to display the number as a percent. Enter data into these cells as decimals. For example:

35% should be keyed as “0.35”

5% should be keyed as “0.05”

100% should be keyed as “1”

Rounding. Round up all numbers to two decimal points. If the third decimal place is a “5” or higher, round up. Otherwise, round down. For example:

35.674% should be entered as “35.67”

12.075% should be entered as “12.08”

49.463% should be entered as “49.46”

MAA Detail Invoice

For each period claimed, all costs and funding sources for the claiming entity must be assigned to one of the cost/funding source pools (indicated on the invoice as “CP”) or be direct-charged. The LGA may either:

- Include all costs/funding sources for a program, or
- Include only those costs/funding sources for the unit that performs MAA and that are reimbursable through the MAA claiming process

The second option is only permissible if the costs/funding are in a separate budget unit and can be identified separately on financial documents.

The MAA Detail Invoice calculates the total costs and the funding that must be offset from costs. The worksheet multiplies the net costs by the appropriate Medi-Cal discount percentage (shown on the invoice as “MC%”), activity percentages, and FFP to determine the amount to be reimbursed.

Before preparing the MAA Detail Invoice, review the following documents to ensure you are using the most current information.

- Policy and Procedure Letters (PPLs) applicable to the year claimed (available at www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx),
- Approved claiming plan and applicable amendments for the quarter claimed,
- Applicable CMAA contracts,
- CMAA Manual

Completing the Header. Each MAA Detail Invoice must contain the following items:

- Identify the LGA (County or City name),
- Contract Number: Use the number specific to the period of service (FY) claimed,
- Period of Service: Identify the period of time covered on the invoice,
- Program: Identify the major program such as Public Health, Public Guardian, etc.
- Claiming Unit: Identify the unit within the program as identified in the claiming plan. For example, the claiming unit may be Field Nursing for Public Health. The program and claiming unit names will be the same if the claim is for the entire program. For example, the Public Guardian program might not have any subunits. On that invoice, “Public Guardian” would have been entered as both the Program and the Claiming Unit.

If the invoice is for a **subcontractor** of the claiming unit, the name of the subcontractor must also be identified by adding it to the name of the claiming unit. For example, if Public Health has a perinatal claiming unit that subcontracts with ABC subcontractor to perform outreach, the claiming unit could be designated “perinatal-subcontractor ABC.”

- **Invoice Number:** The invoice numbering system identifies the fiscal year and the quarter claimed. For example, invoice number 07/08-1 is the claim for the first quarter (July 1, 2007–September 30, 2007) of fiscal year 2007-08.

<u>Invoice Number</u>	<u>Period of Service</u>
07/08-1	July 1, 2007–September 30, 2007
07/08-2	October 1, 2007–December 31, 2007
07/08-3	January 1, 2008–March 31, 2008
07/08-4	April 1, 2008–June 30, 2008

- Corrected or Revised Invoice Numbers are followed by “C” or “R” and the number (1, 2, 3) of the correction or revision. For example, invoice 07/08-1-C1 is the first corrected version of the first-quarter invoice for fiscal year 2007-08. See page 6-23 for additional information.

Once the header information has been entered on the MAA Detail Invoice, the worksheet will automatically transfer it to each of the related worksheets.

The information entered on the MAA Detail Invoice must be consistent with the approved claiming plan or subsequent claiming plan amendments. DHCS will return to the LGA invoices that are not consistent with the claiming plan or its amendments.

Note: The name of the claiming unit on the MAA Detail Invoice and attachments must match the name on the approved claiming plan.

Cost Pools. The Detail Invoice has seven cost pools. All costs for the claiming unit must be included in one of the cost pools or on the Direct Charges Worksheet.

Cost Pool 1. Staff whose costs should be included in Cost Pool 1:

- Designated as Skilled Professional Medical Personnel (SPMP) **and** have participated in the activity time survey; or
- Clerical staff who work for, are supervised by, and provide “direct clerical support” to the SPMP in Cost Pool 1, as shown on the organizational chart; or
- Supervisors of the SPMP in Cost Pool 1, as shown on the organizational chart

Cost Pool 2. Staff whose costs should be included in Cost Pool 2:

- All non-SPMP staff who participated in the time survey; or
- Clerical staff who work for the staff in Cost Pool 2, as shown on the organizational chart; or
- Supervisors of the staff in Cost Pool 2, as shown on the organizational chart; or
- Personal services contractors, regardless of SPMP status, for whom an employer/employee relationship with the agency cannot be demonstrated

Note: If the clerical staff or supervisors split their time between cost pools, the proportionate share of their costs may be based on the number of staff supervised or supported in each cost pool or other documented method.

Under the following circumstances, the costs of staff that were not present during the time survey month must be assigned to Cost Pool 1 or 2:

1. The staff position classification is in the approved claiming plan;
2. The staff position classification would normally perform MAA, which can be documented; and
3. Any of the following:
 - a. The staff was on paid or unpaid leave during the entire time survey month, or
 - b. The staff left the claiming unit prior to the time survey month, or
 - c. The staff was hired by the claiming unit after the time survey month

Cost Pool 3a. This cost pool includes costs associated with staff who:

- Do not perform MAA and are not included in any of the other cost pools or on Direct Charges Worksheet 2. This typically includes staff who provide treatment, counseling, clinical services, lab services, or other non-claimable activities of the claiming unit; or
- Perform MAA, who were present during the time survey month and did not participate in the time survey

Cost Pool 3b. (FORMULAS ONLY—DO NOT ENTER ANY DATA HERE.) This cost pool shows the difference between the total cost and the claimable costs from Direct Charges Worksheet 2. Do not enter costs into this cost pool: these cells contain formulas only. The costs shown automatically transfer from Direct Charges Worksheet 2. The amounts shown automatically combine into Cost Pool 3a, line L, on the first page of the MAA Detail Invoice.

Cost Pool 4. (FORMULAS ONLY—DO NOT ENTER ANY DATA HERE.) This cost pool shows direct charges from Direct Charges Worksheet 2 that are reimbursed at the enhanced rate. Do not enter costs into this cost pool: these cells contain formulas only. Costs shown on this worksheet were entered on PP&PD Worksheet 3. These costs automatically transfer from Direct Charges Worksheet 2.

Cost Pool 5. (FORMULAS ONLY—DO NOT ENTER ANY DATA HERE.) This cost pool shows the direct charges from Direct Charges Worksheet 2 that are reimbursed at the non-enhanced rate. Do not enter costs into this cost pool: these cells contain formulas only. These costs automatically transfer from Direct Charges Worksheet 2.

Cost Pool 6. Costs include general or administrative staff in the claiming unit:

- Who did not time survey;
- Whose costs are not included in any department/program (internal) or in the countywide (external) indirect rate;
- Whose costs are not direct charged; **AND**
- Who, by the nature of their work, support the staff in the other cost pools

These staff may include management, secretarial, fiscal, supervisory, and clerical staff not included in the other cost pools. Their costs will be allocated to the other cost pools based on the ratio of personnel costs.

Entering Cost Data. The Federal Government requires that LGAs report actual expenditures, not estimates. Therefore, costs must be claimed when they have actually been incurred; not merely budgeted (OMB Circular A-87, page 1).

Line A: Enter the **salary** costs of the staff assigned to CP1, CP2, CP3a, and CP6.

Line B: Enter the **benefit** costs of the staff assigned to CP1, CP2, CP3a, and CP6.

Note: Benefits should be determined by the standard conventions of the LGA's accounting system. Exact amounts should be used if they are available. However, if the LGA normally computes these costs as a percentage of salaries, then use this method to determine benefit costs.

Line D: Enter the cost of Personal Services Contractors in CP2, CP3a, and CP6.

Line H: Enter the other costs directly attributable to CP1, CP2, and CP3a if they can properly be identified. Non-claimable costs must be listed in CP3a. Otherwise, enter the “**other costs**” on line H of CP6 for allocation to the other cost pools. Generally, the “other costs” include the normal day-to-day and monthly operating expenses necessary to run the claiming unit. A more detailed discussion of Other Costs begins on page 6-17.

Other Costs also include departmental/agency (internal) and countywide/citywide (external) overhead or indirect costs. Internal indirect costs typically include the portion of costs of a department’s administrative and office staff that the LGA allocates as support for the MAA budget unit, such as legal, accounting, and personnel staff costs. External indirect costs typically include the costs of the central control agencies of the LGA, such as Auditor-Controller, Treasurer, General Services, and Personnel. The costs included in internal and external costs vary from LGA to LGA.

The federal Office of Management and Budgets (OMB) issued guidelines for federally subsidized programs to use in claiming indirect costs. Refer to OMB Circular A-87 for additional information on cost allocation and accounting principles related to claiming for MAA. OMB Circular A-87 is available online at www.whitehouse.gov/omb/circulars/a087/a087-all.html.

LGAs submit external indirect cost rate plans (ICRPs) or countywide cost allocation plans (CWCAPs), usually prepared through the county/city Auditor-Controller’s Office, to the State Controller’s Office. LGAs must prepare and maintain internal ICRPs with the LGA’s audit file for each claiming unit. These plans must be prepared in accordance with the provisions of OMB Circular A-87. **Costs included in an internal ICRP or in Direct Charges Worksheet 2 must not be entered as a separate cost in any of the cost pools.** Attachment A in OMB Circular A-87 identifies costs that may be included as “Other Costs” (ICRP is detailed in Attachment A, Part F).

Medi-Cal Discount Percentages (Lines AB, AC, AE, AG, and AI). Enter the claiming unit's Medi-Cal discount percentage for the period claimed for the activities that must be discounted. Unlike the activity percentages, **the Medi-Cal discount percentage must be determined for each quarter claimed.** These percentages must be determined by an actual count or the countywide average provided by DHCS. DHCS must approve any other method prior to use.

Note: LGAs must submit their CMAA invoices using the same Medi-Cal percentage discount method approved in the related CMAA claiming plan. DHCS will not accept invoices that are based on a different Medi-Cal discount method than is cited in the related claiming plan.

Indicate the method used to determine the Medi-Cal discount percentage for each activity with an "X" in the area designated on the MAA Detail Invoice. CWA means the countywide average: it is calculated on a calendar year and is the same for the 3rd and 4th quarters of the first fiscal year, and the 1st and 2nd quarters of the following fiscal year. AC means the actual client count: it must be recalculated every quarter. See Section 4 for further information.

Some activities do not have to be multiplied by the Medi-Cal discount percentage. Listed below, these activities are identified on lines AA, AD, AF, AH, AJ, and AK. The spreadsheet contains a percentage of 100 percent, which must not be altered for these activities as follows:

- Medi-Cal Outreach (A)
- Facilitating Medi-Cal Application
- Contract Administration (A)
- Program Planning and Policy Development (A)
- MAA/TCM Coordination and LGA Claims Administration

Activity Percentages. (Lines AA–AP): For Cost Pool 1 and Cost Pool 2, enter the activity percentages determined from a one-month time survey conducted during the month designated by DHCS or from a DHCS-approved subsequent time survey. The total for each cost pool must equal 100 percent. The MAA activity percentages calculated in the first quarter will remain unchanged and in effect for the remaining quarter of the fiscal year, unless a new time survey is approved and conducted.

Funding Sources Worksheet 1

The purpose of offsetting funding against cost is to arrive at the net cost of conducting MAA that is eligible for federal reimbursement. To determine when to record funding, each claiming unit (budget unit) must analyze its fiscal documents (i.e., budgets and ledgers) that itemize the funding. Fiscal documents should generally record funding against the corresponding cost of the period for which MAA is claimed. If claiming units receive funds at one time for the entire year, they may divide these funds between quarterly invoices. Do not report the entire annual funding on one quarterly invoice: this would result in the need for corrections or revisions of other quarterly invoices for that fiscal year.

If the claiming unit received unanticipated funding for the current fiscal year, or for a prior fiscal year not previously offset, it should offset the funding in the current fiscal year as explained above. If the claiming unit receives this funding in the last quarter of the current fiscal year, the claiming unit must report it in that quarter.

On Funding Sources Worksheet 1, list all funding sources of the claiming unit. To arrive at the net cost, for which the Federal Government will match, it is necessary to offset all applicable funding sources. In general, the only funds that claiming units do not need to offset are LGA general funds, other local public funds, and MAA reimbursements. The following rules govern which funds received by a program must be offset, i.e., subtracted from costs before a federal reimbursement is determined.

1. All federal funds, along with maintenance of effort and other state/local matching funds required by the federal grant.

Note: Federal funds received by an LGA are identifiable in financial reports by a five-digit number from the Code of Federal Domestic Assistance (CFDA – e.g., 93.197 Childhood Lead Poisoning). The CFDA website allows searches of funding sources by name or number at <http://12.46.245.173/cfda/cfda.html>.

2. All State General Funds that previously matched by the Federal Government (i.e., block grants that are part State/part federal). This includes Medi-Cal fee-for-service money.
3. State General Funds specifically targeted or earmarked to the delivery of medical assistance services are not usable again to draw down federal reimbursement for administrative activities.
4. Insurance payments collected from nongovernmental sources are not usable to draw down federal reimbursement for administrative activities. Offset these funds if the related expenses are included in the invoice.
5. Compensation for assisting with the Medi-Cal for Children/Healthy Families (HF/MCC) application (MC 321 HFP). To avoid duplicate billing situations that might result from receiving application assistance fees while claiming MAA, each LGA must list these fees on the “MAA Funding (Revenue) Sources Worksheet” attachment, under State General Fund. LGAs have two alternatives:

- If these fees are part of the funding that supports the CMAA invoice, the LGA must list these fees on the “MAA Funding (Revenue) Sources Worksheet” invoice attachment under Cost Pool 3a, Non-claimable.

OR,

- LGAs may use the list of fees they received that is attached to the Healthy Families warrant to claim the total amount of fees received (for both Medi-Cal and non-Medi-Cal application) under Cost Pool 6, Allocated Cost Revenue.

Assigning Funding Sources to Cost Pools. The Funding (Revenue) Sources Worksheet provides for the application of the funding source to the appropriate cost pool. Therefore, before entering the amounts, the preparer must follow these steps:

- Classify funding sources by type, i.e., Insurance, Medicare, etc..
- Determine the purpose of the funding, i.e., Direct Patient Care, Counseling, Outreach, etc.
- Assign the funding source to the appropriate cost pool

While costs are assigned to a cost pool based on the staff assigned to that pool, funding is assigned according to the **purpose** of the funding, not necessarily related to the associated staff. Because funding is normally for a service or product, it is often unidentified with staff in the same way as salaries and benefits. The rationale for assigning a funding source to a specific cost pool should be documented and retained as part of the audit file.

The Funding Sources Worksheet has seven sections:

- Medi-Cal Fees and Match
- Federal Grants and Match
- State General Funds
- Medicare
- Insurance
- Fees
- Other Revenue (Funding Sources)

Assign all funding sources to these seven sections. If additional rows are required, insert them just above the “Total” line in each section; this way, the formulas will be unaffected. Adding rows to this worksheet may cause it to print out on multiple pages. Submit all pages.

The “Purpose” column is to identify the purpose of the funding/revenue. Keep the purpose brief but descriptive enough so the reviewer can determine if funding has been assigned to the correct cost pool.

Use the “Not Offset” column to identify allowable funding sources that do not need offset against costs. This includes MAA reimbursements, LGA general funds, realignment funds, and all other allowable funding sources used to perform MAA. Identify these funding sources so the reviewer can reconcile the claiming unit’s total costs to its total funding.

Assign funding sources that must be offset against costs to the appropriate cost pool. Each section has columns identifying which cost pool will be offset by the funding source. Do not assign funding sources to cells that show “XXX.”

Assign to Cost Pool 6 funding sources that are not associated with any particular activity or not identified to a specific cost pool, but should be offset against the claiming unit. This allocates the funds to offset to the other cost pools based on total cost.

Unallowable funding that supports direct charged PP&PD must be assigned to CP3, CP4, and CP5 according to the percentage of cost allocated to non-claimable, enhanced, and non-enhanced.

Other unallowable funding that supports direct charged non-enhanced costs must be assigned to CP3 and CP5 in accordance with the percentage of costs allocated to non-claimable and non-enhanced.

Assign funding sources that support CP1 or CP2 costs to CP1 or CP2 on the Funding Sources Worksheet. Assign funding sources for non-claimable activities to CP3.

For example, a Public Health Nurse who performs both MAA and non-MAA must time-survey. Assign all costs for this nurse to CP1. Assign all funding for payment of direct health care to CP3. Also, assign funding for any other non-MAA to CP3. Only funding for MAA may be assigned to CP1.

If a single allowable funding source supports MAA and non-MAA, it may be divided on the Funding Sources Worksheet to show the portion that supports MAA in the non-offset column and the portion that supports non-MAA in CP3.

Once all the funding sources have been assigned, the Funding Sources Worksheet will automatically sum the columns and transfer them to MAA Detail Invoice form, line O. Funding Sources Worksheet 1 with the signed certification statement must be submitted with the MAA Detailed Invoice.

Direct Charges Worksheet 2

Allowable costs for time and resources related to MAA are determined through either a time survey or separately identified and direct-charged. The Direct Charges Worksheet 2 captures costs determined through methods other than the time survey.

Costs may be direct charged only if identified for direct-charge in the CMAA claiming plan. Unlike the costs allocated through the time survey, costs to be direct charged must be tracked monthly throughout the fiscal year. LGAs may not use annual time survey percentages to calculate direct charge amounts. Itemize these costs separately on Direct Charges Worksheet 2 and include documentation for them in the LGA's audit file.

Before submitting claims for claiming units that also provide TCM services, be certain that these activities are not also included in the administrative costs of the TCM cost report.

When determining which costs to direct-charge, make sure that those costs do not appear anywhere else on the MAA Detail Invoice because this would result in duplicate claiming. After completing Direct Charges Worksheet 2, submit it with the certification statement, signed by the authorized person, along with the MAA Detail Invoice.

The following instructions describe how to use the Direct Charges Worksheet 2 for the specified activities. Only complete and submit Direct Charges Worksheet 2 if you are direct-charging one or more of the following activities.

Only complete and submit Direct Charges Worksheet 2 if you are direct-charging costs.

MAA/TCM Coordination and LGA Claims Administration. Direct charge the costs of staff performing MAA/TCM Coordination and LGA Claims Administration at the LGA level or LGA Claims Administration at the claiming unit level. Do not factor this activity by the Medi-Cal discount percentage. Separately list each staff performing this activity along with his or her corresponding percentage of time spent performing it. Certify the percentage of staff time associated with MAA/TCM Coordination and LGA Claims Administration by signing the Direct Charges Worksheet. A separate certification statement is not required.

Direct charging is also permitted for the related "Other Costs" of staff performing MAA Coordination and LGA Claims Administration. For example, Other Costs that may be direct-charged include equipment used exclusively to perform MAA. These costs should be listed on a separate line of the direct charge worksheet. The percentage should be 100.

Program Planning and Policy Development (PP&PD). Direct charge costs for staff that perform PP&PD 100 percent of their paid time. If performed less than 100 percent,

allocate the costs according to the time survey results. See the section below on PP&PD for more information.

Medi-Cal Non-Emergency, Non-Medical Transportation. The actual cost of providing Medi-Cal Non-Emergency, Non-Medical Transportation may be direct charged. These costs include bus tokens, taxi fares, mileage, etc. There are two ways to direct charge these costs.

1. Record in the MAA Transportation column all costs for transporting all clients to a Medi-Cal covered service. Then factor the costs by the appropriate Medi-Cal discount percentage.
2. Record in the MAA Transportation column only the costs of transporting Medi-Cal clients to Medi-Cal covered services. Enter 100% as the Medi-Cal factor.

Other Costs. Non-personnel costs associated with the performance of MAA may be direct-charged. Identify the activity associated with these costs. Also, determine if the cost must be factored by a Medi-Cal percentage. The discount for non-personnel costs might differ from the discount for the activity.

Where to Enter Data. The Direct Charges Worksheet 2 is divided into four sections:

- Section 1: PP&PD Enhanced - Cost Pool 4
- Section 2: PP&PD Non-Enhanced - Cost Pool 5
- Section 3: Non-Enhanced - Cost Pool 5
- Section 4: Total to Cost Pool 3b

Sections 1 and 2: The first two sections are for costs related to the performance of PP&PD when performed 100 percent of paid staff time. Costs are not entered directly into these two sections, but are entered on the PP&PD Worksheet 3 and are automatically transferred from this worksheet to Sections 1 and/or 2 of Direct Charges Worksheet 2. This worksheet automatically transfers data from section 1 to cost pool 4, and data from section 2 to cost pool 5 on the MAA Detailed Invoice. Steps for this process are in the section below on PP&PD Worksheet 3.

Section 3: Use this section to enter all direct charged costs, other than PP&PD. The worksheet automatically transfers data from this section of the worksheet to Cost Pool 5 on the MAA Detailed Invoice.

- Enter costs only in unshaded cells in the appropriate cost column of Section 3 of the Direct Charges Worksheet 2. Use the separate columns provided to record the costs for salaries and benefits of claiming unit staff, Contracts (specific), MAA Transportation, and Other Costs. Do not enter PP&PD costs in this section.
- In the Description section, list the categories of costs to be direct-charged as defined in the approved claiming plan.
- For each category of costs to be direct charged, enter a Medi-Cal discount percentage **OR** a Time Factor in the Medi-Cal/Certified Time Factor column.

- For MAA/TCM Coordination and LGA Claims Administration costs, enter the time percentage in the Medi-Cal/Certified Time Factor column. As this activity does not require discounting by a Medi-Cal percentage, the time percentage is the only factor applied. If this activity is performed 100 percent of the staff's paid time, enter "1" in the column. If more than one person is to be direct-charged for this activity and the certified time percentages are different, enter each position and the certified time percentage separately. Occasionally, a staff member may perform MAA/TCM Coordination and LGA Claims Administration on a part-time basis and perform other administrative duties that would be entered in Cost Pool 6 (see example 3 below). If actual costs associated with the performance of this activity, such as travel, are to be direct charged, list these costs on a separate line and enter the cost in the column labeled "Other Costs."

Note: When assigning a factor to costs such as equipment or travel associated with MAA/TCM Coordination and Claims Administration, it is critical to evaluate how much of the costs are claimable as MAA. This factor may frequently be different from the factor used to certify the time spent on that activity.

- For activities requiring a Medi-Cal discount percentage, enter the percentage discount in the Medi-Cal/Certified Time Factor column. Use the method identified in the approved claiming plan to determine the appropriate Medi-Cal discount percentage.
- For activities requiring a time factor percentage, enter the percentage under the column heading Medi-Cal/Certified Time Factor. These percentages might differ each quarter because they are determined on an on-going basis.

Examples for Section 3

1. The cost of transportation may be direct charged in one of two ways.
 - a. The first is to record the cost for transporting only Medi-Cal eligible persons to a Medi-Cal service. In this case, the activity would not be discounted by a MC% (enter "1" in the cell to show 100-percent Medi-Cal discount percentage).
 - b. The second alternative is to record the cost of transporting all clients to a Medi-Cal covered service. Determine the MC% by actual client count or countywide average, according to the claiming plan, and enter this percentage in the column titled Medi-Cal/Certified Time Factor. The discount percentage used must have been identified in the claiming plan.
2. A MAA/TCM Coordinator spends 85 percent of his or her time on MAA/TCM Coordination and LGA Claims Administration. Additionally, an accountant spends 45 percent of his/her time preparing claims. List the MAA/TCM Coordinator and enter "85" in the Medi-Cal/Certified Time Factor column. If the Coordinator's costs are associated with MAA, list them on a separate line in the "Other Costs" column; the factor should be 100 percent. List the accountant separately, and enter a "45" in the Medi-Cal/ Certified Time Factor column.

3. A staff member performs MAA/TCM Coordination and LGA Claims Administration on a part-time basis and performs other administrative duties that would be entered in Cost Pool 6. If so, the LGA must determine the percentage of time spent on MAA/TCM Coordination and LGA Claims Administration and multiply the staff's salary and benefits by this percentage. The resulting costs are entered in section 3, and the certified time factor is 100 (entered as "1"). The remaining costs would be assigned to Cost Pool 6.

Section 4: This section is a summary of the non-claimable costs determined from Section 3 and the PP&PD Worksheet 3. Do not enter data in this section. The worksheet automatically transfers these totals to Cost Pool 3b on the MAA Detail Invoice.

Program Planning & Policy Development Worksheet 3

The PP&PD Worksheet 3 calculates the reimbursable amount for PP&PD activities that are being direct charged. This activity may be direct-charged only if performed by a unit of one or more employees who spend 100 percent of their paid time performing program planning and policy development. The worksheet automatically transfers the claimable portion of this activity to Direct Charges Worksheet 2.

If staff perform PP&PD less than 100 percent of their paid time, it may not be direct charged. Instead, staff must time-survey and record their time spent performing this activity under either PP&PD (A) or PP&PD (B) for Invoices prior to FY 2007-08. Costs for these employees should be included in Cost Pool 1 or Cost Pool 2, not on the PP&PD Worksheet. Beginning with FY 2007-08, record time spent performing PP&PD under:

- PP&PD (A),
- PP&PD (B),
- SPMP PP&PD (A), or
- SPMP PP&PD (B).

Only complete and submit PP&PD Worksheet 3 if you are direct charging this activity.

PP&PD is the only activity that currently qualifies for enhanced funding when performed by an SPMP. PP&PD activities qualify for enhanced funding only when the activities require the skill level of an SPMP. SPMP employees who perform only this activity are not required to participate in

the annual time survey; however, they must track the time monthly they spend on PP&PD, performing general administrative activities, taking paid time off, and performing non-MAA and non-PP&PD activities. General administration is not reimbursable at the enhanced rate (75%). Non-SPMP staff must also track time spent on PP&PD, General Administration, and Paid Time Off even though all time is reimbursable at the non-enhanced rate. A description of the method used to track the time spent on the different programs must be in the claiming plan.

The worksheet is divided into two sections, one for SPMPs and one for non-SPMPs. The section for SPMPs takes into account the salary and benefits for reimbursement at the enhanced rate (75%) while calculating all other costs at the non-enhanced rate (50%). Enter SPMP and non-SPMP costs in the appropriate section. For each program type, enter the amount of time spent and the appropriate Medi-Cal discount percentage, if any.

The worksheet's design is to accommodate the following program types:

1. Medi-Cal Services for Medi-Cal beneficiaries only: programs developed for a Medi-Cal covered service for Medi-Cal beneficiaries only. The Medi-Cal discount percentage is always 100 percent.
2. Medi-Cal Services (general population): programs developed for a Medi-Cal covered service but may be available to the entire county/city population. The MC% should be the countywide average.
3. Non-Medi-Cal Program: programs for services not covered under the Medi-Cal program; therefore, it is not claimable. The Medi-Cal discount percentage is zero, and the cell is preformatted.
4. Medi-Cal Programs with identified Medi-Cal beneficiaries: programs that are for Medi-Cal covered services and the Medi-Cal population to benefit from the program are specifically identifiable. The worksheet's design is to accommodate seven of these program types. Others may be added by inserting rows on the spreadsheet, which requires copying the Excel formulas.

All shaded areas of the worksheet contain formulas; do not enter data in these areas. The worksheet automatically transfers the claimable portion of costs to Direct Charges Worksheet 2, Section 1 or 2. The worksheet automatically transfers the non-claimable portion of costs to Section 4.

Examples of Other Costs. "Other Costs" are those costs, other than salary and benefits, necessary for the proper and efficient administration of Medi-Cal. While many operating (other) costs are claimable, some are not. Below are a list of typical costs that may be claimed for reimbursement and a list of costs that are not claimable and must be listed as "Other Costs" in Cost Pool 3a. **Both lists are only examples and are not comprehensive.**

Claimable Operating (Other) Costs:

- Office supplies
- Office furniture
- Computers and software
- Data processing costs
- Purchased clerical support

- Office maintenance costs
- Utility costs
- Building/space costs (with capitalization limits)
- Repair and maintenance of office equipment
- Vehicle rental/amortization and fuel
- Facility security services
- Printing and duplication costs
- Agency publication and advertising costs
- Personnel and payroll services costs
- Property and liability insurance (excluding malpractice insurance)
- Professional association/affiliation dues
- Legal representation for the agency
- Indirect costs when determined to be in accordance with OMB Circular A-87

All of the above are claimable costs only if they do not relate to non-claimable categories of cost. For example, repair and maintenance of office equipment used to support activities of SPMPs in Cost Pool 1 are claimable costs. The repair and maintenance of an X-ray machine or lab equipment are not claimable costs and must be entered as “Other Costs” of Cost Pool 3a.

Non-Claimable Operating Costs:

- Malpractice insurance
- Equipment used for providing medical treatment
- Medical supplies
- Drugs and medications
- Payments made to resolve audits
- Costs of elected officials and their related costs
- Costs for lobbying activities
- Fund Raising

Required Supporting Documentation. With each MAA Detail Invoice submitted for payment, include the Funding Sources Worksheet 1 that has a certification statement with an original signature.

If costs are being direct-charged on a MAA Detail Invoice, LGAs must submit:

- Direct Charges Worksheet 2 that includes a certification statement with an original signature.

- Program Planning and Policy Development Worksheet 3, if applicable.

With the initial quarterly claim for each fiscal year, LGAs must submit:

- A list of all classifications of staff whose costs have been assigned to CP6 and the number of staff in each of the classifications.
- Description of “Other Costs” categories for each cost pool except CP3a.

Note: DHCS may request that LGAs also submit this information for additional quarterly claims.

Claiming for Subcontractors

A separate MAA Detail Invoice is required for each CBO that contracts to perform MAA. However, Personal Services Contractors (see page 6-5) may be included on the claiming unit’s invoice. The requirement to provide cost and funding data for cost pools depends on the existence and purpose of the contract between the LGA program and the CBO and on the funding source used to pay the CBO.

If the contract is “non-specific,” meaning that the contract does not specifically identify the total amount payable for each allowable activity, CBO staff must time survey. To have those costs factored by the time-survey results, the contractor must enter costs into CP2 for both SPMP and non-SPMP individuals. If operating expenses and overhead costs are an integral part of the contract amount, these costs may be entered on the first page of the MAA Detail Invoice on line H, “Other Costs.”

If the contract is “specific,” meaning that the contract identifies the specific amount the LGA will pay the CBO for each activity, it is not necessary for the CBO staff to time-survey. In this case, enter costs in Section 3, Non-Enhanced CP5, of the Direct Charges Worksheet 2. In the “Description” section, list separately each activity included in the contract (e.g., Outreach A, Outreach B) with the associated contract amount (costs) entered in the “Other Costs” column. Identify the Medi-Cal discount percentage when performing the following activities:

- Medi-Cal Outreach (B1 and B2)
- Arranging for Transportation
- Program Planning and Policy Development (B)

When the LGA program contracts to perform specific activities, using only unmatched General Funds, the LGA does not need to list all of the CBO’s funding sources. The LGA must certify the source of the contract funding and that no offset is required because the funds are unmatched LGA general funds only. This certification should be on county/city letterhead and signed using the same certification statement found on the Funding Source (Revenue) Worksheet or on Worksheet 1.

MAA Summary Invoice

Use the MAA Summary Invoice to aggregate information from the MAA Detail Invoice onto a single page that identifies the cost categories for reimbursable costs associated with Cost Pools 1 & 2 and the Direct Charges. Each Detail Invoice should have a separate accompanying MAA Summary Invoice. The MAA Summary Invoice must be on letterhead.

Complete the LGA MAA Summary Invoice as follows:

Local Governmental

- Agency:** Enter the name of the county or city.
- Program/Department:** Enter the name of the program or department under which the claiming unit performs MAA.
- Contract Number:** Enter the contract number that corresponds to the period of service.
- Claiming Unit:** Enter the name of the claiming unit as it appears in the claiming plan Approval Letter Grid.
- Period of Service:** Enter the period of services for the MAA Detail Invoice by date each quarter, i.e., 7/1/07 to 9/30/07.
- Invoice Number:** Enter the invoice number that corresponds to the MAA Detail Invoice number, which is the fiscal year followed by the number of the quarter, i.e., 07/08-1.
- Line 1:** Enter the amount identified on line CG of the MAA Detail Invoice.
- Line 2:** Enter the amount identified on line CH of the MAA Detail Invoice.
- Line 3:** Enter the amount identified on line CI of the MAA Detail Invoice. This amount must not exceed half the amount of allowable public funds expended (CPE) for this invoice.

If the MAA Detail Invoice must be adjusted, the CMAA Unit in DHCS can make these adjustments after consulting with the LGA. The CMAA Unit will adjust the MAA Summary Invoice accordingly.

Variance

MAA invoices for each claiming unit are submitted quarterly by the LGA. When a claiming unit has more than a 20 percent (+/-) variance (in dollars) between consecutive quarters or between the current quarter and the same quarter in the prior fiscal year, the variance must be explained. DHCS will not process invoices that have more than a 20-percent (+/-) variance between consecutive quarters or between the current quarter and the same quarter in the prior fiscal year without an adequate explanation of the reason(s) for the variance(s).

LGAs can choose to use their own forms. However, the documentation must contain a clear, detailed and self-explanatory reason as to why the variance occurred. It must be submitted on LGA letterhead and signed in **blue** ink by the LGA Coordinator.

DHCS created a sample Invoice Variance Template, which is available on the CMAA website.

Submitting the MAA Detail and MAA Summary Invoices

The LGA MAA/TCM Coordinator must review all invoices for completeness and accuracy before submitting them to DHCS. DHCS will return, without review, all invoices submitted using an incorrect format. To expedite the review and payment process, it is necessary to follow all of the instructions. Each of the following items must be included, dated and signed in **blue** ink where indicated by the LGA MAA/TCM Coordinator or the authorized signer identified on the LGA MAA/TCM Coordinator Roster:

- Cover letter on letterhead, identifying any irregularities or variations on the CMAA Detail Invoice
- MAA Summary Invoice on letterhead
- MAA Detail Invoice
- Funding (Revenue) Sources Worksheet 1
- Direct Charges Worksheet 2 (if direct-charging)
- Program Planning and Policy Development Worksheet 3 (if direct charging)
- Review Checklists:
 - for MAA Detail Invoice
 - for MAA Summary Invoice
- Supporting documentation for Cost Pool 6 and Other Costs
- Variance on letterhead, if needed
- Additional documentation, when requested by DHCS.

Note: Please do not send multiple copies of any claiming forms, just the original copy dated and signed in **blue** ink by the LGA's MAA/TCM Coordinator or authorized signer.

Mail invoices to:

<u>For Regular U.S. Postal Services Delivery Mail:</u>	<u>For Overnight or Express Mail:</u>
Department of Health Care Services Safety Net Financing Division County-Based MAA Unit Attn: (Insert Program Analyst's name) MS 4603 P.O. Box 997436 Sacramento, CA 95899-7436	Department of Health Care Services Safety Net Financing Division County-Based MAA Unit Attn: (Insert Program Analyst's name) 1501 Capitol Avenue, Suite 71.2101 MS 4603 Sacramento, CA 95814
Note: Mailing labels are available at www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx .	Note: DHCS recommends using express delivery service to ensure timely delivery.

Payment Process

When LGAs submit invoices to the CMAA Unit at DHCS, analysts review the invoices for fiscal integrity and compare them to the related approved claiming plans. Once the CMAA Unit approves the invoices, they will forward the invoices to the Accounting Section. The Accounting Section prepares the invoices for payment and forwards them to the State Controller's Office (SCO), which issues warrants payable to the LGA Treasurer. Once SCO issues a warrant, the LGA may expect to receive it within two weeks.

DHCS reports all paid invoices to the federal Centers for Medicare and Medicaid Services (CMS) each fiscal quarter using the Quarterly Medicaid Statement of Expenditures, Form CMS 64 (CMS 64). DHCS must report all invoices within two years of the end of the quarter claimed (45 CFR 95.7). DHCS returns all invoices submitted beyond the two-year timeframe without processing them. To comply with this requirement and to allow adequate time for DHCS review and processing, LGAs must submit invoices to DHCS within 18 months of the end of the quarter claimed.

DHCS will not hold invoices that do not have sufficient funds remaining in their related contracts. Instead, DHCS will return these invoices to the respective LGA pending resolution of the funding problem. A cover letter will be sent advising the LGA of the reason the invoices were returned. To avoid this problem, each LGA's MAA/TCM Coordinator should carefully monitor their contract amounts before submitting invoices.

Corrections and Revisions

The CMAA Unit reviews all invoices LGAs submit to DHCS for payment. If the CMAA Unit finds errors or if they require additional documentation, the staff will contact the LGA's MAA/TCM Coordinator. It may be possible to resolve the error by phone or email, or by the LGA submitting additional documentation. The CMAA Unit will hold the invoice until it receives the information it needs to make the required corrections or revisions.

When the LGA corrects and returns the invoice, it must identify it as a "Corrected Invoice" in the cover letter (stating the reason for the correction) and in the invoice number. The invoice number should reflect the correction by adding a C-1 to the invoice number. If subsequent corrections are required, the invoice number will reflect the number of the corrected invoice (e.g., C-2).

Sometimes, after an invoice has been processed and paid, an LGA may discover the need to revise the invoice. In these situations, the LGA should refigure the invoice and submit it to DHCS. The LGA must identify the invoice as a "Revised Invoice" in the cover letter (stating the reason for the revision) and in the invoice number by adding "R-1" to it.

LGAs may not knowingly submit incorrect invoices as placeholders in order to meet the 18-month submission deadline for CMAA. This practice is contrary to the certification made by each LGA Coordinator on each MAA invoice—that the information provided be

“true and correct, based on actual expenditures incurred for the period claimed.” The Certification Statement also informs LGA Coordinators “that knowing misrepresentation constitutes violation of the Federal False Claims Act.” DHCS will not approve invoices that are determined to be placeholders. If the LGA anticipates a delay in submitting invoices by the due dates, the Late Invoice Submission Request form needs signed and submitted by the LGA Coordinator, at least two weeks prior to the due date.

Revised Invoices with a Credit Balance (LGA was overpaid). To revise a CMAA invoice that has been paid and that has a credit balance, submit:

- A cover letter on letterhead explaining why the revision was necessary;
- Revised invoice templates including, but not limited to, the MAA Detail Worksheet and Summary invoice, including all of the required supporting documentation;
- A MAA Revised Invoice Credit Form; and
- A warrant amounting to the credit balance, if any, made payable to “Department of Health Care Services.”

The CMAA Revised Invoice templates and the MAA Invoice Credit template are available on the CMAA website at

www.dhcs.ca.gov/provgovpart/Pages/LocalGovernment.aspx.

Note: Corrections and Revisions always require a new MAA Summary Invoice, Checklist, Detail Worksheet, and (if required) Variance (See Section 1 for the 3-Step Process for responding to DHCS requests.)

SECTION 7

MAA Documentation

Table of Contents

Subject	Page
Overview	7-1
Record Keeping and Retention	7-1
Building and Maintaining an Audit File	7-2
Audit File Contents	7-2
Time Survey Materials	7-2
CMAA Claiming Plans and Amendments	7-2
Invoice Documents	7-3
Contracts	7-3
Program Site Reviews	7-4
Audits & Investigations Fiscal Audits	7-5
External Audits	7-6

Overview

LGAs are responsible for the documentation of all costs claimed, including those associated with personnel time. The nature and amount of all activities time surveyed needs supported by sufficient documentation. LGAs are advised that in the event of a program review or audit, time survey samples do not constitute sufficient source documentation to substantiate all activities, time, or costs for MAA claiming.

Existing regulations and agreements require documentation that demonstrates compliance with all CMAA program requirements. These regulations and agreements include, but are not limited to: the CMAA contract with DHCS; Office of Management and Budgets (OMB) Circular A-87; and 42 CFR Sections 413.20, 413.24, 433.32, and 433.51.

Additionally, Centers for Medicare and Medicaid Services (CMS) Publication 15-1, Sections 2300 and 2304, requires that the LGA provide adequate cost data based on financial and statistical records to support all of their actual incurred costs that are eligible for reimbursement. This data must be correct, accurate, and in sufficient detail to support payments made for services (or administrative activities) rendered to beneficiaries.

Each LGA is responsible to determine what specific documentation it can provide to demonstrate the validity of its costs.

Record Keeping and Retention

LGAs must maintain all records in an audit file and/or in readily reviewable form, organized by program, and available for review or audit by staff of the State and Federal Governments upon request (42 CFR §433.322). Federal regulations require that LGAs retain records for three years after the end of the quarter in which the LGA made the expenditures. Exhibit D of the CMAA contract requires LGAs and/or their subcontractors to retain records for three years from the date of final payment under this Agreement, and for such longer periods, if any, as is required by applicable statute. If an audit is in progress, LGAs must retain all records relevant to the audit until the audit is complete or until the final resolution of all audit exceptions, deferrals, and/or disallowances. LGAs are advised to comply with the most stringent of these requirements.

This documentation must be retained in the program's audit files and/or available for review throughout the required retention period, as set forth in (42 CFR §433.322). Costs not substantiated by source documents may be disallowed by DHCS, CMS, or other auditing agencies.

Building and Maintaining an Audit File

Each LGA must develop an audit file beginning the first quarter in which it conducts a time survey. This documentation allows LGAs to respond to State and federal audit inquiries and to maintain historical integrity of LGA records when staff leave the LGA and new staff replace them.

The following guidelines apply to the development of an audit file. LGAs can reduce the risk of audit disallowances by adhering to these guidelines. LGAs should keep documentation unique to each claiming unit in a separate file or binder. In some cases, required documentation for each quarterly claim will be identical, i.e., organization charts, position descriptions, duty statements etc. In other cases, materials will be too voluminous to keep in the file, e.g., time cards. In either case, LGAs should keep documentation in the audit file that will notify auditors where they can find the documentation. It may also be helpful to maintain, and refer to, a general MAA file for documentation used from quarter to quarter. All materials referenced must be available for review throughout the record retention period.

Audit File Contents

The following list is a guide on what to include in the audit file for each claiming unit. The list is general; it is not all-inclusive. Do not rely on this list alone; other sections of this manual contain important additional information on audit requirements.

Time Survey Materials

- Listing of employees who participate in each time survey, including name, position classification, and SPMP status, if applicable
- Original time-survey form signed by the employee and the employee's supervisor
- Copies of time cards for the time survey period of all staff participating in the time survey, or reference to their location.
- Secondary documentation (time survey samples) supporting time survey results
- Time survey training materials and sign-in sheets

CMAA Claiming Plans and Amendments

- The approved claiming plan and any approved amendments denoting changes to the claiming plan and/or activities performed by the claiming unit
- Supporting documentation for the claiming plan, including flyers, brochures, contracts, and resource directories
- The organization's official duty statements and/or position descriptions for the staff performing MAA. These must contain language showing that the position and duties match the activities in the CMAA claiming plan
- Copies of the SPMP Questionnaire used to determine if the staff qualifies as Skilled Professional Medical Personnel (SPMP). Include a copy of the

employee's current medical license or certification as applicable. Refer to Appendix D.

- An organizational chart, depicting how the claiming unit fits into the total organizational structure.
- An organizational chart showing the relationship of SPMP clerical staff and SPMP supervisors to SPMPs

Invoice Documents

- Worksheets, spreadsheets, and methods used in developing the invoice, including the basis for assigning costs and revenues to cost pools. This includes documentation that supports all costs and funding sources identified in the claim, such as payroll records, general ledgers, and other accounting source documents.
- Copies of method for calculating the agency indirect cost rate
- Documentation of the method, calculations, and supporting data used to determine the Medi-Cal percentage in the MAA claim. See Section 4, Determining the Medi-Cal Percentage
- Copies of the computations used to calculate the activity results percentages
- Copies of the computations and/or receipts used to calculate the direct charge amounts, if any

Contracts

- The contract between DHCS and the LGA
- All lateral agreements, contracts or subcontracts between the LGA and other governmental entities
- Contracts or subcontracts between any governmental entities participating in MAA/TCM and their contract agencies
- Contracts or subcontracts between the LGA and non-governmental entities

Program Site Reviews and Desk Reviews

DHCS is responsible for oversight of the CMAA program. DHCS processes claims for reimbursement of costs of performing MAA. DHCS pays its LGA contractors based on their CMAA invoices and subsequently submits its own claims for reimbursement of these costs to CMS. In submitting these claims, DHCS certifies to CMS that DHCS and its LGA contractors have complied with federal law while performing MAA. If CMS (or its auditing agency, the Office of the Inspector General) determine that DHCS and/or its subcontractors have not complied with federal law, CMS may defer or disallow payments to DHCS for its MAA claims. Subsequently, DHCS would be required to recoup payments made to LGAs (W&I Code §14132.47(g) (2)).

The CMAA Unit reviews CMAA claiming plans, invoices, and time surveys to ensure that LGAs comply with program requirements. As required by CMS, DHCS conducts program site reviews every four years of each LGA participating in MAA. DHCS may also initiate a site review or desk review based on their review of claims data or on observations from other sources that indicate program irregularities. After receiving the required documentation from LGAs, DHCS conducts desk reviews.

As stated above, LGAs must maintain all records in readily reviewable form and available for review or audit by staff of the State and Federal Governments upon request. CMAA analysts provide 30-day advance notice of a site review to the LGA MAA/TCM Coordinator. However, law does not require this advance notice. The advance notice includes a list of documents needed for the site visit.

Typically, the notification of a site review will specify the number of DHCS staff who will participate and the types of records they will review. Although DHCS staff are authorized by law to access any LGA documents related to the LGA's CMAA program, a program site review typically focuses on a specific fiscal year and includes but is not limited to:

- Confirming the validity of time surveys by comparing employee time cards to the original time surveys and to secondary documentation (see Section 5),
- Reviewing brochures, fliers, and other materials used to conduct outreach,
- Confirming that staff claimed as SPMPs have the appropriate licenses or credentials and perform claimable activities,
- Interviewing staff to identify the type of activities that are claimed as MAA,
- Reviewing LGA materials used to provide staff program and time survey training, and/or
- Reviewing invoices and back up documentation for the fiscal year under review.

Following a program site review, the CMAA Unit will issue a letter summarizing its observations and requesting corrective actions, if needed. If the reviewers identify significant violations of State or federal regulations, DHCS might:

- Request repayment of reimbursements (if both parties agree that no valid program documentation is available)
- Request additional documentation within a specified timeframe verifying that corrections have been made
- Defer payment of CMAA invoices pending the LGA's correction of these violations
- Schedule a follow-up site review to confirm corrections have been made
- Refer the LGA's CMAA program to the Audits and Investigations (A&I) Division of DHCS for fiscal audit

Observations and corrective actions resulting from a program site review are subject to appeal. Requests for appeal of these corrective actions will be forwarded to A&I to establish a formal audit and appeal process. Such requests may be made by mail to:

Department of Health Care Services
Safety Net Financing Division
Administrative Claiming Local and Schools Services Branch
Attn: (Branch Chief)
P.O. Box 997436, MS 4603
Sacramento, CA 95899-7436

If sending requests by overnight or express mail, use this address:

Department of Health Care Services
Safety Net Financing Division
County-Based MAA Unit
Attn: (Branch Chief)
1501 Capitol Avenue, Suite 71.2101, MS 4603
Sacramento, CA 95814

Audits & Investigations Fiscal Audits

A&I is administratively independent from the Medi-Cal program. This separation allows A&I auditors to conduct fiscal audits without influence from program management or consideration of program needs. Their mission is to ensure that payments for programs in which DHCS has oversight are made in compliance with State and federal law. A&I auditors investigate financial and personnel records and all other documentation that supports a claim to ensure that they are consistent with the requirements for CMAA claiming plans, invoices, and time surveys.

The specific procedures of A&I auditors are confidential to the parties involved in an audit. Typically, A&I would issue a letter notifying an LGA that a fiscal audit will take place and requesting certain documentation.

Audits typically last from one to two weeks. Audits conducted by A&I are subject to time constraints specified in State law; A&I issues the details of these time constraints in their letters to the LGA they are auditing. The findings of audits are subject to formal appeal rights that might lead to hearings before an administrative law judge. As with time constraints, these details are specified in letters issued by A&I and are beyond the scope of this manual.

External Audits

Several governmental agencies outside of DHCS may also conduct reviews of LGAs and their subcontractors. These agencies include, but are not limited to:

- The California Bureau of State Audits (BSA),
- The California Bureau of Medi-Cal Fraud & Elder Abuse (BMFEA) within the California Department of Justice,
- The Office of State Audits and Evaluations (OSAE) within the California Department of General Services,
- The federal Centers for Medicare and Medicaid Services (CMS), and
- The federal Office of the Inspector General (OIG)

As with reviews and audits conducted by DHCS, LGAs must provide these agencies access to CMAA audit files, as required by 42 CFR §433.322. DHCS must also comply with such audits. Both LGAs and DHCS have formal appeal rights in such audits; there are descriptions of these rights at the time of the audit.

BSA is the independent external State auditor of all State programs. BSA is the State's independent auditor to ensure the effective and efficient administration and management of public funds and programs.

BMFEA investigates reports of Medi-Cal fraud. BMFEA prosecutes Medi-Cal providers who commit fraud.

OSAE helps the California Department of Finance supervise the State's financial and business policies by conducting independent audits, evaluations, and related services.

The federal CMS has auditors that work full-time reviewing Medi-Cal policies and procedures, including the CMAA program. These auditors may initiate audits of LGAs and their subcontracted CBOs.

OIG oversees the administration of Social Security Administration (SSA) programs, including Medicaid (i.e., Medi-Cal). OIG conducts evaluations and investigations related to SSA programs. OIG also evaluates weaknesses in SSA programs, and makes recommendations for needed improvements and corrective actions.

APPENDIX A

Abbreviations and Acronyms

Abbreviation/ Acronym	Term
ACC (also AC)	Actual Client Count
CBO	Community-Based Organization
CCR	California Code of Regulations
CFR	Code of Federal Regulations
CHDP	Child Health and Disability Prevention
CMAA	County-Based Medi-Cal Administrative Activities
CMS	Federal Centers for Medicare & Medicaid Services
CMS-64	CMS Report of Expenditures, Form 64
CP	Cost Pool
CPSP	Comprehensive Perinatal Services Program
CTO	Compensatory Time Off
CWA	Countywide Average
DHCS	Department of Health Care Services
DHHS	Federal Department of Health and Human Services
CDMH	California Department of Mental Health
CPE	Certified Public Expenditure
e.g.	<i>Exempli gratia</i> [Latin], meaning “for example.”
FFP	Federal Financial Participation
GA	General Administration
Grid	Claiming Unit Functions Grid
HCFA	Health Care Financing Administration (old name for CMS)
ICRP	Indirect Cost Rate Plan
i.e.	<i>id est</i> [Latin], meaning “that is,” as in “equal to.”
LGA	Local Governmental Agency
MAA	Medi-Cal Administrative Activities
MAC	Medi-Cal Administrative Claiming (precursor to MAA)

Abbreviation/ Acronym	Term
MCAH	Maternal, Child Adolescent and Health
MC%	Medi-Cal Discount Percentage
MOU	Memorandum of Understanding
MHMAA	Mental Health Medi-Cal Administrative Activities
OMB A-87	Federal Office of Management and Budget Circular A-87
PPL	Policy and Procedure Letter
PP&PD	Program Planning and Policy Development
PSC	Personal Services Contractor
PTO	Paid Time Off
SCO	State Controller's Office
§	Symbol for "section," as in a section of law.
SMAA	School-based Medi-Cal Administrative Activities
SPMP	Skilled Professional Medical Personnel
TCM	Targeted Case Management
TPL	Third Party Liability
W&I Code	California Welfare and Institutions Code
XIX	Title "nineteen" in Roman numerals; used for federal statute.

APPENDIX B

GLOSSARY

Actual Client Count (ACC)	A Medi-Cal percentage that is determined from the total number of Medi-Cal recipients within a claiming unit divided by the total number of all individuals served by the claiming unit. Actual Client Count was formerly known as the Actual Count or Actual Head Count.
Allowable Time	Time spent by identified personnel doing activities that may be claimed as allowable Medi-Cal Administrative Activities (MAA), as determined by time surveys or direct charge documentation.
Audit File	A readily reviewable file of documentation supporting the LGA's MAA claims, organized by program, and available to State and federal auditors on request (42 CFR §433.322).
Case Managers	Individuals performing Targeted Case Management (TCM) and who meet the qualifications as outlined in the California State Plan and the California Code of Regulations (22 CCR §51272).
Centers for Medicare and Medicaid Services (CMS)—formerly known as the Health Care Financing Administration (HCFA)	The federal agency that oversees the Medicaid program, a national health care program designed to furnish assistance to families; to aged, blind, and disabled individuals; and to individuals whose income and resources are insufficient to meet the cost of necessary medical services (see Section 1).
Certified Public Expenditure (CPE)	An LGA's nonfederal public funds used to pay explicitly for 100 percent of the cost of MAA for Medi-Cal eligible persons.
Certification Statements	Statements signed by authorized LGA staff stating that the information in the claiming plan and on the invoice is true and correct and that it accurately reflects the performance of MAA activities described in the claiming plan
Claimable Activities	Activities that may be claimed as allowable under the MAA program as defined in State and federal law and regulation.
Claiming Plan	A description of activities claimed as allowable MAA. Each LGA participating in MAA must submit a claiming plan to DHCS.

Claiming Unit	Part of an LGA, such as a public agency or private community-based organization (CBO) contracted to an LGA to perform MAA, whose costs can be segregated as a separate budget unit.
Community-Based Organization (CBO)	Nongovernmental entities (private organizations) located in the LGA's geographical region that provide programs and services covered by Medi-Cal. LGAs may subcontract the performance of MAA to CBOs.
Cost Pool (CP)	The cost centers that are the basis for the MAA claim. The MAA invoice has six cost pools, aggregating expenditures for Skilled Professional Medical Personnel (SPMP); non-SPMP; Direct Services/Non-Claimable costs; Direct Charge and Allocated Costs.
Countywide Average (CWA)	The percentage of the county's total population that are Medi-Cal beneficiaries. A list of these percentages, by county, is available from DHCS (see Section 4).
Direct Charge	Direct invoicing of certain costs identified as 100 percent allowable. These costs are entered in the Direct Charge section of the MAA invoice. Some Direct Charge costs must be discounted by the Medi-Cal percentage. Direct charges must be itemized and explained in back-up documentation to be included in the audit file.
Duty Statement	Document describing all of the current duties and responsibilities assigned to a specific position and how they relate to MAA. Includes the position classification and the program or claiming unit name. When duties qualify as a MAA activity, the proper MAA activity letter is to be identified following the activity.
Enhanced Functions	Those MAA performed by Skilled Professional Medical Personnel (SPMP) and that require the medical expertise of an SPMP. Currently, the only enhanced function is Program Planning and Policy Development (PP&PD). The cost of time spent by an SPMP performing these activities is reimbursed at the enhanced rate of 75 percent.

Enhanced Funding	For PP&PD activities: The enhanced federal rate of 75 percent may be claimed for salaries, benefits, travel and training of SPMP and their directly supporting clerical staff that are involved in activities that require their medical expertise and are necessary for proper and efficient administration of the Medicaid State Plan (Medi-Cal).
Federal Financial Participation (FFP)	The proportion of allowable costs to be reimbursed by the federal government based on professional status of staff.
Host Entity	The LGA designated by all LGAs participating in the MAA/TCM programs to be the administrative and fiscal intermediary between DHCS and all participating LGAs. DHCS contracts with one “host entity” to manage and collect the LGAs’ share of DHCS’s actual total costs to administer the MAA program.
Invoice	The set of claim forms submitted by the LGAs to DHCS to obtain reimbursement for the cost of allowable MAA.
Local Governmental Agency (LGA)	A county or chartered city.
MAA/TCM Coordinator	The person designated by the LGA to coordinate the MAA and TCM programs.
Medi-Cal Administrative Activities (MAA)	The proper and efficient administration of the Medi-Cal State Plan by DHCS, which contracts with LGAs to conduct MAA locally. LGAs can draw down federal reimbursement for their costs of performing allowable MAA.
Medi-Cal Administrative Activities Contract	The legal document or contract between DHCS and the LGA that authorizes participation in the MAA program.
Medi-Cal Administrative Claiming (MAC) Agreement	“Agreement between the Health Care Financing Administration and the State of California, Department Of Health Services,” dated September 27, 1995. Legal agreement between CMS and DHCS resolving a \$315 million deferral of claims for MAA and TCM. Established MAA and TCM as separate programs.
Medi-Cal Beneficiary	An individual who is currently enrolled in the Medi-Cal program.

Medi-Cal Discount	The Medi-Cal percentage used to discount costs on the MAA invoice: also known as the actual client count or countywide average.
Medi-Cal Eligible	An individual who is currently eligible to receive Medi-Cal benefits and health services.
Medi-Cal Percentage (MC%)	The fraction of a population who are Medi-Cal beneficiaries. Determined from actual client count or countywide averages. See the manual Section 4, "Determining the Medi-Cal Percentage."
Nonspecific Contract	The contract does not specifically identify the amount to be paid to a private community-based organization for performing each allowable activity.
Office of Management And Budget (OMB) Circular A-87	Federal Executive Branch guidelines for federal claims. State and local governments that administer federal programs refer to OMB A-87 for guidance on how to account for and determine which costs are eligible for reimbursement.
Personal Services Contractors (PSC)	A private organization or individual contracted by the public agency to perform activities that directly support the MAA program). Eligible for federal reimbursement at only the 50-percent level.
Policy and Procedure Letter (PPL)	DHCS guidance to LGA Coordinators of new policies and procedures or to clarify policy and procedural issues.
Position Description	An official document describing the necessary knowledge, skills, abilities, education, certification, and minimum qualifications for a specific employment classification. The position description also defines the employee's scope of work, the variety and complexity of general tasks performed, and the supervision exercised.
Quarterly Summary Invoice	The summary or aggregate of costs on each quarterly MAA detail invoice. Prepared by an LGA on behalf of all claiming entities or programs within its jurisdiction; it is submitted on the agency's letterhead and is the amount to be subject to FFP reimbursed to the LGA for the quarter.
Revenue	Funding used by an LGA to support the claiming unit that performs MAA.

Revenue Offset	The required deduction from an LGA's claim for allowable MAA. The Revenue Offset Worksheet provides a systematic approach to calculating the funding sources that must be offset from the claim.
Single State Agency	A state agency charged with administering the Medicaid program. In California, the single State agency is the California Department of Health Services.
Skilled Professional Medical Personnel (SPMP)	An employee of a public agency who has completed a two-year-or-longer program leading to an academic degree or certification in a medically related profession and who is in a position that has duties and responsibilities requiring that professional medical knowledge and skills. See Appendix D.
Specific Contract	A contract with a community-based organization (CBO) that specifies the activities the CBO will perform and the specific amount the LGA will pay the CBO for each activity.
State Plan	A comprehensive written statement submitted by the State to CMS describing the nature and the scope of its Medicaid program and giving assurance that it will be administered in conformity with specific federal requirements. The State Plan serves as a basis for federal financial participation (FFP) in Medi-Cal.
State Plan Amendments (SPAs)	The vehicle used to amend, add, or delete material from the California State Plan.
Subcontractor	An entity that enters into an agreement (contract, lateral agreement, Memorandum of Agreement or Understanding) with the LGA to perform MAA.
Targeted Case Management (TCM)	Services that assist a Medi-Cal eligible individual in a defined target population to gain access to needed medical, social, educational, and other services.
Time Survey	The approved method to determine the percentage of costs that are allocable to each administrative activity or TCM service claimed by the LGA.

APPENDIX C

LEGAL CITATIONS

Comparing Administrative Activities to Medical Assistance

The following pages provide:

1. The basic legal codes and regulations related to Medi-Cal Administrative Activities (MAA).
2. The basic legal codes and regulations related to Targeted Case Management (TCM).
3. A side-by-side comparison of the codes and regulations for these two programs.

This list is by no means comprehensive. It only intends to provide a basis for identifying the fundamental differences between performing Medi-Cal administration (such as MAA) and providing Medi-Cal services (such as TCM). By presenting the legal basis for these two programs, the reader can help ensure the proper and efficient administration of the Medi-Cal program.

The full text of these laws can be found at the following websites:

Title XIX of the Social Security Act:

http://www.ssa.gov/OP_Home/ssact/title19/1900.htm.

Title 42 of the United States Code: <http://www.gpoaccess.gov/fr/index.html>

Title 42 of the Code of Federal Regulations: <http://www.gpoaccess.gov/fr/index.html>

Office of Management and Budgets Circular A-87:

http://www.whitehouse.gov/omb/circulars/a087/a87_2004.html.

Welfare and Institutions Code:

<http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=wic&codebody=&hits=20>.

Title 22 of the California Code of Regulations: <http://ccr.oal.ca.gov>.

Medi-Cal Administrative Activities (MAA)	Medi-Cal Medical Assistance (such as TCM)
<p>XIX SSA Sect 1901</p> <p>Enable each State "to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."</p>	<p>XIX SSA Sect 1901</p> <p>Enable each State "to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."</p>
	<p>W&I Code Sect 14059</p> <p>"Health care provided under this chapter may include diagnostic, preventive, corrective, and curative services and supplies essential thereto, provided by qualified medical and related personnel for conditions that cause suffering, endanger life, result in illness or infirmity, interfere with capacity for normal activity including employment, or for conditions which may develop into some significant handicap."</p> <p>W&I Code Sect 14131 ff.</p> <p>"The Medi-Cal Benefits Program comprises a department-administered uniform schedule of health care benefits...." Following sections detail benefits.</p> <p>Targeted Case Management (TCM)</p> <p>XIX SSA Sect 1915(g)</p> <p>(g)(1) A state may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B).... (2) For purposes of this subsection, the term "case management services" means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.</p>

Medi-Cal Administrative Activities (MAA)	Medi-Cal Medical Assistance (such as TCM)
W&I Code Sect 14132.47	W&I Code Sect 14132.44
<p>The cost of conducting allowable administrative activities for Medi-Cal eligibles. DHCS, as the single State agency responsible for administration of the Medi-Cal program (W&I Code Sect 14100.1), may contract with local governmental agencies (LGAs) or local educational consortia (LECs) to conduct MAA. LGAs or LECs may subcontract MAA with private, nonprofit, community-based organizations (CBOs).</p>	<p>(l) TCM services are services which assist beneficiaries to gain access to needed medical, social, educational, and other services. Services provided by TCM providers, and their subcontractors, shall be defined in regulation, and shall include at least one of the following:</p> <ol style="list-style-type: none"> (1) Assessment. (2) Plan development. (3) Linkage and consultation. (4) Assistance in accessing services. (5) Periodic review. (6) Crisis assistance planning.
Funding for Administration	Funding for All Medical Assistance (including TCM)
XIX SSA Sect 1903(a)(2)	XIX SSA Sect 1903(a)(1)
<p>"Sums expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan." MAA is reimbursed <u>Federal Financial Participation (FFP)</u> at 90, 75, or 50 percent of claimable costs, depending on the role of the person conducting the activities.</p>	<p>"The Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966— (1) an amount equal to the <u>Federal medical assistance percentage (FMAP)</u> (as defined in section 1905(b), subject to subsections (g) and (j) of this section and subsection 1923(f)) of the total amount expended during such quarter as medical assistance under the State plan."</p>
42 CFR Sect 433.15	42 CFR Sect 433.10
<p>"(a) Basis. Section 1903(a) (2) through (5) and (7) of the Act provide for payments to States, on the basis of specified percentages, for part of their expenditures for administration of an approved State plan.</p> <p>(b) Activities and rates. " 90% for family planning or development of online claiming systems, 75% for necessary administration provided by Skilled Professional Medical Personnel (SPMP) and utilization reviews, 50% for non-SPMP administration.</p>	<p>"Sections 1903(a)(1), 1903(g), and 1905(b) provide for payments to States, on the basis of a <u>Federal medical assistance percentage</u>, for part of their expenditures for services [medical assistance, including TCM] under an approved State plan."</p>

Medi-Cal Administrative Activities (MAA)	Medi-Cal Medical Assistance (such as TCM)
42 CFR Sect 433.51	42 CFR Sect 433.51
"(a) Public funds may be considered as the State's share in claiming Federal Financial Participation (FFP) if they meet the conditions specified in paragraphs (b) and (c) of this section. (b) The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section. (c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds."	"(a) Public funds may be considered as the State's share in claiming Federal Financial Participation (FFP) if they meet the conditions specified in paragraphs (b) and (c) of this section. (b) The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section. (c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds."
Funding for Medi-Cal MAA only	Funding for Medi-Cal TCM only
W&I Code Sect 14132.47(c)	W&I Code Sect 14132.44(f)
As a condition for participation in the Administrative Claiming process, each participating local governmental agency or each local educational consortium shall, for the purpose of claiming federal Medicaid matching funds, enter into a contract with the department and shall certify to the department the amount of local governmental agency or each local educational consortium general funds or any other funds allowed under federal law and regulation expended on the allowable administrative activities.	The department shall require that each participating local governmental agency or each local educational consortium certify to the department both of the following: (1) The availability and expenditure of 100 percent of the nonfederal share of the cost of performing Administrative Claiming process activities. The funds expended for this purpose shall be from the local governmental agency's general fund or the general funds of local educational agencies or from any other funds allowed under federal law and regulation.
Pending Policy and Procedure Letter	Policy and Procedure Letter 05-005
Same as for TCM but with MAA language.	"The legal basis for claiming most federal Medicaid reimbursement, including TCM, is found in Title XIX of the Social Security Act, Section 1903(a),1 which provides, in part, that the federal government shall pay to the State a percentage "of the total amount expended" for providing medical assistance, which includes TCM services." To be eligible to draw down FFP, LGAs must expend 100 percent of the cost of providing TCM to Medi-Cal beneficiaries.
Form CMS-64	Form CMS-64
The form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, has been used since January 1980 by the Medicaid State agencies to report their actual program benefit costs and administrative expenses to the Centers for Medicare & Medicaid Services (CMS). CMS uses this information to compute the Federal financial participation (FFP) for the State's Medicaid Program costs.	The form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, has been used since January 1980 by the Medicaid State agencies to report their actual program benefit costs and administrative expenses to the Centers for Medicare & Medicaid Services (CMS). CMS uses this information to compute the Federal financial participation (FFP) for the State's Medicaid Program costs.

Medi-Cal Administrative Activities (MAA)	Medi-Cal Medical Assistance (such as TCM)
	Funding for Other Medi-Cal Services (except MAA and TCM)
	42 CFR Sect 430.30
	Lists steps of the Medicaid grant award process, from submitting estimated costs to draw down advanced payments to the State to confirming allowable costs of the claim to reconciling costs. References 45 CFR Sect 74.70 ff.
	45 CFR Sect 74.70 ff.
	Sections 74.71 through 74.73 contain closeout procedures and other procedures for subsequent disallowances and adjustments.
	Form CMS-37
The Secretary of Health and Human Services is authorized by Congress under Title XIX of the Social Security Act (Act) to make funds available to the states for the purposes set forth in the annual Medicaid appropriation. To insure that adequate funds are available for the efficient operation of the Medicaid program, the Secretary has determined that budget estimates from the states for Medical Assistance Payments and Administration costs shall be reported, prior to the beginning of each quarter, on Form CMS-37, the Medicaid Program Budget Report.	
Form CMS-64	
Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, has been used since January 1980 by the Medicaid State agencies to report their actual program benefit costs and administrative expenses to the Centers for Medicare & Medicaid Services (CMS). CMS uses this information to compute the Federal financial participation (FFP) for the State's Medicaid Program costs.	
45 CFR Sect 95.7	45 CFR Sect 95.19
Under the programs listed in Sec. 95.1, we will pay a State for a State agency expenditure made after September 30, 1979, only if the State files a claim with us for that expenditure within 2 years after the calendar quarter in which the State agency made the expenditure. Sec. 95.19 lists the exceptions to this rule.	The time limits in Sec 95.7 and 95.10 do not apply to any of following: (a) Any claim for an adjustment to prior year costs. (b) Any Claim resulting from a audit exception. (c) Any claim resulting from a court ordered retroactive payment. (d) Any claim for which the Secretary decides there was good cause for the State's not filling it within the time limit.

APPENDIX D

DETERMINING THE QUALIFICATIONS OF SKILLED PROFESSIONAL MEDICAL PERSONNEL

Skilled Professional Medical Personnel (SPMP)

This appendix contains information to help LGAs determine if their staff are qualified to perform MAA that require SPMP skills and that are eligible for enhanced reimbursement at the 75 percent (enhanced) rate of federal financial participation (FFP). This information is based on CMS's "Title XIX Financial Management Review Guide" (Section 1, SPMP). At the end of this section is the SPMP Questionnaire, which may be given to staff to help ensure their qualifications for performing MAA.

The costs of CMAA program planning and policy development (PP&PD) that require skills of SPMPs are eligible for reimbursement at the 75-percent (enhanced) rate of FFP. This includes the cost of salaries, benefits, travel, and training for SPMPs and their directly supporting clerical and supervisory staff. Clerical staff in direct support of SPMPs must be employees of the same organization as the SPMP. The cost of MAA performed by SPMPs is not eligible for enhanced reimbursement when the MAA does not require SPMP-level skills (42 CFR §432.45). Medical services performed by SPMPs are not MAA; LGAs must not claim them (42 CFR §432.50). Overhead and non-personnel services costs (such as rent, ordinary supplies, and telephone and computer charges) may be charged at the 50-percent rate (Departmental Appeals Board Decision No. 1008 [1989]).

The cost of MAA that require skills of Skilled Professional Medical Personnel (SPMP) is eligible for reimbursement at the 75-percent (enhanced) rate of FFP. This includes the cost of salaries, benefits, travel, and training for SPMPs and their directly supporting clerical staff. Clerical staff in direct support of SPMPs must be employees of the same organization as the SPMP. The cost of MAA performed by SPMPs is not eligible for enhanced reimbursement when the MAA does not require SPMP-level skills. Medical services performed by SPMPs may not be claimed as MAA (42 CFR §432.50).

MAA (PP&PD only) that may require SPMP skills include:

- Liaison on medical aspects of the program with providers of services and other agencies that provide medical care,
- Furnishing expert medical opinions,
- Reviewing complex billings from physicians,
- Participating in medical review, or
- Assessing, through case management activities, the necessity for and adequacy of medical care and services.

The salaries and benefits of clerical staff who directly support SPMP staff may be reimbursed at the 75-percent rate in proportion to the time these clerical staff perform those duties (42 CFR Section 423.2). However, the operating expenses for these staff may only be reimbursed at the 50-percent rate. The directly supporting staff must provide clerical services that are directly necessary for carrying out the professional medical responsibilities and functions of the SPMP. The SPMP must be immediately responsible for the work performed by the clerical staff and must directly supervise (immediately first-level supervision) the supporting staff and the performance of the clerical staff's work.

To qualify as an SPMP staff must have completed:

...a 2-year or longer program leading to an academic degree or certification in a medically related profession. This is demonstrated by possession of a medical license, certificate, or other document issued by a recognized National and State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the administration, direction, or implementation of the Medicaid program is not considered the equivalent of professional training in the field of medical care (42 CFR §432.50.)

This requirement may be fulfilled by completion of a program leading to the same certificate/licensure as a two-year or longer program, even if the student did not require two or more years to complete that program.

In regard to the 75 percent FFP for clerical staff who provide direct support to SPMPs, the CFR states:

The directly supporting staff are secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that are directly necessary for the completion of the skilled professional medical responsibilities and functions of the skilled professional medical staff. The skilled professional medical staff must directly supervise the supporting staff and the performance of the supporting staff's work.

Classifications Eligible for Enhanced Funding

LGAs must substantiate the SPMP status of their staff. The job specification of SPMP staff must stipulate that the incumbent is from one of the classifications below, and the program duty statement must reflect enhanced and non-enhanced activities.

- A. Skilled Professional Medical Personnel (SPMP) per the Title 42, Code of Federal Regulations (CFR), Chapter IV, and the Federal Register are:
 1. Physician,
 2. Registered Nurse,
 3. Physician Assistant,
 4. Dentist,

5. Dental Hygienist,
 6. Nutritionist—with a Bachelor of Science (B.S.) degree in Nutrition or Dietetics and eligible to be registered with the Commission of Dietetics Registration (R.D.),
 7. Medical Social Worker—with a Master's degree in Social Work (M.S.W.) with a specialty in a medical setting,
 8. Health Educator—with a Master's degree in Public or community Health Education and graduated from a institution accredited by the American Public Association or the Council on Education for Public Health,
 9. Licensed Vocational Nurse—who have graduated from a two-year program, and
- B. SPMP per the U.S. Department of Health and Human Services Departmental Appeal Board decisions:
1. Licensed Clinical Psychologist—with a Ph.D. in psychology.
- C. SPMP per California Department of Health Services policy:
1. Licensed Audiologist- -certified by the American Speech and Hearing Association,
 2. Licensed Physical Therapist
 3. Licensed Occupational Therapist- -registered by the National Registry of American' Occupational Therapy Association,
 4. Licensed Speech Pathologist, and
 5. Licensed Marriage, Family and Child Counselors.
- D. Directly supporting staff:
1. Clerical Staff—in direct support of and supervised by Skilled Professional Medical Personnel,
 2. The employer's job specification must require clerical skills, and
 3. The program duty statement must reflect clerical functions in support of Skilled Professional Medical Personnel.

SPMP includes only professionals in the field of medical care. SPMP does not include non-health professionals, such as public administrators, medical budget directors or analysis, lobbyists, or senior managers of public assistance or Medicaid programs.

Direct support staff means clerical staff who:

- Is a secretarial, stenographic, copy file, or record clerk that provides direct support to the Skilled Professional Medical Personnel,
- Provides **clerical services** directly necessary for carrying out the professional medical responsibilities and functions of the Skilled Professional Medical Personnel, and
- Has **documentation** such as a job description, that the services provided for the Skilled Professional Medical Personnel are directly related and necessary to the election of the SPMP responsibilities.

Professional Education and Training

Skilled Professional Medical Personnel are required to have education and training at a professional level in the field of medical care or appropriate medical practice before FFP can be claimed at 75 percent. "Education and training at professional level" means the completion of two-year or longer program leading to an academic degree or certificate in a medically related profession. Completion of a program may be demonstrated by possession of a medical license or certificate issued by a recognized national or state medical licenser or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the administration, direction, or implementation of the Medicaid program will not be considered the equivalent of professional training in a field of medical care.

5. Did your educational program lead to a certification or registration by a health or health-related national or California certifying organization? _____

If **YES**, please provide certification/registration type and number (if appropriate), the name of the certifying organization, and sign this form and turn it in. Please attach a copy of the certification or registration you received, and a C.V., if available.

Certification/Registration Type	Cert./Reg. Number
Certifying/Registry Organization	

If **NO**, proceed to Question 6.

6. Did part of your educational program involve medical or health-related training including fieldwork (e.g., in health, mental health, or substance abuse)? _____

If **YES**, describe the training/fieldwork, sign the form and turn it in.

(Attach a copy of any certificates or documentation describing your training, and a C.V. if available.)

If **NO**, proceed to Question 7.

7. As part of your educational program, did you take any courses that had a medical or health-related focus (e.g., about health, mental health, or substance abuse)? _____

If **YES**, list these courses below, sign this form and turn it in.

(Attach a copy of any certificates or course completion notices you received, and a C.V. if available.)

If **NO**, proceed to Question 8.

8. How many years of experience do you have performing duties in a health or human services field?
 Please attach documentation of your experience.

- 3 or more years
- 2 years
- 1 year
- Less than 1 year

9. Does your direct supervisor have designation as an SPMP? _____

Please sign below and turn this form in.

 Signature of Claimant/Employees Date

Supervisor's statement of additional qualifying requirements for SPMP status:

Supervisor's Recommendations:

 Signature of Supervisor Date

I have reviewed the form and the attached documentation and have determined:

Circle classification and either Yes or No.	Meets Essential Requirements	Does Not Meet Essential Requirements
1. SPMP	Yes / No	Yes / No
2. Directly Supporting Clerical Staff	Yes / No	Yes / No

 Signature Medi-Cal Administrative Program Manager Date