

California School-Based Medi-Cal Administrative Activities Manual

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DEPARTMENT OF HEALTH CARE SERVICES

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**Centers for Medicare and Medicaid Services,
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California Local Governmental Agency Consortium**

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FORWARD

This California School-Based Medi-Cal Administrative Activities (SMAA) Manual (hereinafter referred to as “the SMAA Manual”) is designed to clarify and enhance school staff participation and provide audit protection for claiming units. The language in the School Manual is based on requirements embedded in the Federal Centers for Medicare & Medicaid Services’ (CMS’s) School-Based Administrative Activities Guide (May 2003, final version). The Department of Health Care Services (DHCS), formerly known as The Department of Health Services (DHS) will notify Local Educational Consortia (LECs) and Local Governmental Agencies (LGAs) through Policy and Procedure Letters (PPLs) of approved changes/revisions to the SMAA Manual. Each year, DHCS and the LEC/LGA committee will revise the SMAA Manual to update any changes and provide further clarification.

The SMAA Manual will continue to be a work in progress. Suggestions for improvement can be made to your regional LEC/LGA MAA coordinator. For definitions or descriptions of key terms, users may refer to the MAA Glossary in Section 3. For a quick guide to abbreviations and acronyms, users may refer to Appendix A.

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California School-Based SMAA Manual

SECTION 1

How to Use This Manual

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How to Use This Manual

The School Based Medi-Cal Administrative Activities (SMAA) Manual contains the policies and procedures that school claiming units must follow to submit a (SMAA) invoice to the Department of Health Care Services (DHCS) for reimbursement of the costs of performing SMAA. The SMAA manual also lists audit requirements. When this manual is revised, the effective date of the revision will be indicated at the bottom of each page.

The SMAA manual is the primary reference for information about SMAA program participation requirements. You should consult this manual before seeking other sources of information.

The term Local Educational Consortium (LEC) is a local agency that is one of the service regions of the California County Superintendent Educational Services Association (CCSESA). LECs participating in the SMAA program shall be responsible for the Local Educational Agencies (LEA) in its service region that participate in the SMAA program. Each LEC region holds a contract with DHCS to coordinate the SMAA program for school districts and County Offices of Education (COE) within its region.

The term LEA refers to the governing body of any school district or community college district, the County Office of Education, a state special school, a California State University campus, or a University of California campus.

The term Local Governmental Agency (LGA) is defined as County Department of Health or chartered city. An LGA participating in the SMAA program shall be responsible for the LEAs within the county that participate in the SMAA program.

LEC and LGA responsibilities in the SMAA program include, but are not limited to:

- Training the LEA SMAA Coordinators:
- Certifying the list of Time Survey Participants (TSPs):
- Coordinating, certifying and submitting SMAA invoices:
- Assigning Random Moment Time Survey (RMTS) central coding staff: and
- Supervising and providing oversight of the RMTS time survey process.

The term “claiming unit” is used to represent all types of school-related administrative units such as LEAs, Special Education Local Program Areas (SELPA), charter schools, COEs or a State funded college or university that are actively participating in the SMAA program. A claiming unit is typically an LEA that has submitted a claim or invoice to the SMAA program during a particular claiming period.

Organization

The SSMAA manual is organized into four topic areas:

- (Section 1) How to Use This Manual
- (Section 2) Medi-Cal Background
- (Sections 3-11) SMAA Policies and Procedures
- (Appendices) Appendices A, B, C, D, E, G, H, I, J

Numbering System

The bottom of each page has a unique number that identifies the section and page. For example, the number 2-1 indicates Section 2, page 1. The numbering system is designed to easily accommodate additions and deletions when the SMAA manual is updated.

SMAA Manual Updates/Policy and Procedure Letters

Annually, DHCS issues updates to the manual. Throughout the year, when changes occur in the SMAA 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 annual revision of the manual. Changes in federal requirements are reflected in the manual every state fiscal year (SFY) based on the State's approved process. The manual represents the California method of meeting federal requirements and applies to the applicable SFY being claimed.

The current manual can be found online at www.dhcs.ca.gov/provgovpart/Pages/SMAAManual.aspx.
Policy and Procedure Letters can be found online at <http://www.dhcs.ca.gov/formsandpubs/Pages/SMAATCMPPLs.aspx>.

SMAA Manual Inquires

If you have any questions about the contents of your manual, please contact your LEC/LGA Coordinator.

California School-Based SMAA Manual

SECTION 2

Medi-Cal Background

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Overview

The Medicaid program is a national health care program designed to furnish medical assistance to families, the aged, blind, disabled and to individuals whose income and resources are insufficient to meet the cost of necessary medical services. The program, established under Title XIX of the Social Security Act, is administered by the Centers for Medicare and Medicaid Services (CMS), which is part of the federal Department of Health and Human Services (DHHS). Medicaid is a state/federal partnership under which the Federal Government establishes basic program rules. In California, Medicaid is referred to as Medi-Cal. Each state administers the program and can develop its own rules and regulations for program administration within the confines of the federal rules.

States must meet certain federal requirements to participate in the Medicaid program. States that meet these requirements receive federal funding in the form of Federal Financial Participation (FFP) for all Medicaid expenditures. The FFP rate for Medi-Cal Administrative Activities (SMAA) currently is set at fifty percent.

The primary requirements imposed on states that wish to participate in the Medicaid program relate to eligibility for the program and to services covered by the program. Federal Medicaid law defines certain categories of eligible individuals and specific types of health care coverage that must be provided by any state wishing to operate a Medicaid program. Title XIX also offers a variety of optional eligibility groups and types of service, which a state may or may not choose to cover. In addition, the Federal Government establishes general standards by which states must operate their Medicaid programs; however, development of program options and the details of program operation and administration are the responsibility of the states themselves.

The Department of Health Care Services (DHCS) and individual Local Educational Agencies (LEA) claiming units promote access to health care for students in the public school system, preventing costly or long-term health care problems for at-risk students, and coordinating students' health care needs with other providers. A "claiming unit" refers to a school-sponsored program administered by an LEA, which is a school district, County Office of Education (COE), Special Education Local Program Area (SELPA), or State-funded College or University providing Medi-Cal-covered health services. Many of the activities performed by school staff meet the criteria for SMAA claiming. The primary purpose of the SMAA program is to reimburse school claiming units for these activities. The term "services" refers to direct Medi-Cal-billable services provided by a Medi-Cal provider in a school or community setting. LEA-billable services are conducted through schools, and these direct services must be reported in Code 2 on the SMAA time survey. The term "activities" typically refers to SMAA time, which is not claimable through the LEA Billing Option, but is claimable through SMAA.

Medicaid in the School Setting

Medicaid is a critical source of health care coverage for children. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. EPSDT services include periodic health screening, vision, dental, and hearing services. The Medicaid statute also requires that states provide any medically necessary health care services listed in Section 1905(a) of the Social Security Act to an EPSDT recipient even if the services are not available under that state's Medicaid plan to the rest of the Medicaid population. States are required to inform Medicaid eligibles under age 21 about EPSDT benefits; set distinct periodicity schedules for health screenings, dental, vision, and hearing services; and report EPSDT performance information annually to CMS. For more information about EPSDT, refer to the CMS Medicaid website at www.cms.gov.

Administrative activities discussed in the SMAA manual that are claimable to Medicaid must be those associated with or in support of the provision of Medicaid-coverable medical services. The Medicaid medical services that are provided in schools are:

1. Those that are specified in an Individualized Education Plan (IEP) and Individual Family Service Plans (IFSP)
2. EPSDT-type primary and preventive services provided in those schools by providers who also bill non-Medicaid children.

Other administrative activities not associated with a covered Medicaid medical service may be covered in schools and include: conducting Medicaid outreach; facilitating Medicaid eligibility determinations; and providing Medicaid-related training, translation, and general administration. Schools can provide their students a wide range of health care and related services, which may or may not be reimbursable under the Medicaid program. The services can be categorized as follows:

- **IDEA-related health services.** The Individuals with Disabilities Education Act (IDEA) was passed to “ensure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for employment and independent living (Section 601[d]).” IDEA authorizes federal funding to states for medical services provided to children through a child's IEP, including children who are covered under Medicaid. In 1988, Section 1903(c) of the Social Security Act was amended to permit Medicaid payment for medical services provided to Medicaid-eligible children under IDEA through a child's IEP.
- **Section 504-related health services.** Section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to handicapped children. These services may include health care services similar to those covered by IDEA and Medicaid. These services are described in an Individualized Service Plan (ISP) and are provided

free of charge to eligible individuals. These services may NEVER be billed to Medicaid because the Department of Education is a liable third party.

- **General health care services.** These services are typically mandated by the school district or state and include health care screenings, vision exams, hearing tests, a scoliosis exam, and other services, provided free of charge to all students. Services provided by the school nurse (e.g., attending to a child's sore throat, dispensing medicine) may also fall into this category. These general health care services often resemble EPSDT services. These services may be reimbursed by Medicaid, subject to third party and free care provisions.

Federal funding is available for the cost of administrative activities that directly support efforts to identify and enroll potential eligibles into Medicaid and that directly support the provision of medical services covered under the state Medicaid plan. To the extent that school employees perform administrative activities that are in support of the state Medicaid plan, federal reimbursement may be available. However, Medicaid Third Party Liability (TPL) rules and CMS's free care policy limit the ability of schools to bill Medicaid for some of these health services and associated administrative costs.

- **TPL requirements** preclude Medicaid from paying for Medicaid-coverable services provided to Medicaid beneficiaries if another third party (e.g., other third party health insurer or other federal or state program) is legally liable and responsible for providing and paying for the services.
- **The "free care" policy** precludes Medicaid from paying for the costs of Medicaid-coverable services and activities that are generally available to all students without charge and for which no other sources of reimbursement are pursued.

These policies preclude Medicaid reimbursement for either Section 504 services or general health care services, because schools are legally liable and responsible for providing and paying for these services and activities. CMS's free care policy also precludes Medicaid reimbursement, because these services and activities are provided free of charge to all students. To the extent that health care services are not Medicaid reimbursable under these policies, associated administrative costs also cannot be claimed. In order for Medicaid payments to be made available for general health care services, the school providers must:

1. Establish a fee for each service that is available;
2. Collect third party insurance information from all those served (Medicaid and non-Medicaid); and
3. Bill other responsible third party insurers.

Schools are legally liable for providing IDEA-related health services at no cost to eligible students; however, Medicaid reimbursement is available for these services, because

Section 1903(c) of the Social Security Act allows Medicaid to be primary to the U.S. Department of Education for payment of the health-related services provided under IDEA. Medicaid covers services included in an IEP under the following conditions:

- The services are medically necessary and are included in a Medicaid-covered category (e.g., speech therapy, physical therapy);
- All other federal and state Medicaid regulations are followed, including those for provider qualifications; comparability of services; and the amount, duration, and scope provisions;
- The services are covered by Medicaid or are available under EPSDT; and
- The medical service must be provided to a Medicaid-eligible student.

CMS recognizes that Medicaid TPL rules and free care provisions serve to limit the ability of schools to bill Medicaid for covered services and associated administrative costs provided to Medicaid-eligible children. While there are exceptions to these policies for Medicaid services provided to children with disabilities pursuant to an IEP under IDEA, many schools provide a range of services that would not fall under these exceptions, including services provided by school nurses.

Eligibility Requirements

As noted above, Title XIX was originally designed to serve the needs of families and of aged, blind, and disabled persons whose income is insufficient to pay the costs of their medical expenses. Since the inception of the program in 1965, however, many new categories of eligibles have been added to the program. Some of these eligible groups are “mandatory coverage groups”; that is, any state wishing to participate in Medicaid must cover these individuals as a condition of participation. Other groups of eligibles are “optional coverage groups”; that is, the state has the option to cover or to refuse to cover these individuals. Under federal Medicaid law, there are currently about 50 categories of eligibles, nearly half of which are mandatory coverage groups. California covers all mandatory groups and the vast majority of the optional groups.

California School-Based SMAA Manual

SECTION 3

SMAA Glossary

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SMAA Glossary

Administrative Unit	An LEC/LGA Region or Consortium that is responsible for the administration of the SMAA program.
Actual Client Count (ACC)	A Medi-Cal percentage that is determined from the total number of Medi-Cal eligibles within a claiming unit divided by the total number of all individuals served by the claiming unit. Actual Client Count was formerly also known as the Actual Count or Actual Head Count.,
Allowable Time	Time spent by claiming unit personnel doing claimable SMAA activities as determined by the Random Moment Time Survey methodology or direct charge documentation.
Audit File	The documents and records that the LEA/LEC/LGA develops and maintains in support of SMAA invoice(s). This file is used to support the invoice during site reviews and audits.
Cal-SAFE	The California School-Age Families Education (Cal-SAFE) program is designed to increase the availability of support services necessary for enrolled expectant/parenting students, to improve academic achievement and parenting skills, and to provide a quality child care/development program for their children. This comprehensive, continuous, and community-linked school-based program replaces the Pregnant Minors Program (PMP), School Age Parenting and Infant Development (SAPID) Program, and Pregnant and Lactating Students (PALS) Program.
California County Superintendents Educational Services Association (CCSESA)	The California County Superintendents Educational Services Association (CCSESA) is a statewide network of the 58 County Superintendents of Schools who have organized themselves in order to work closely with state authorities to implement programs efficiently, in response to the needs of districts and schools.
Centers for Medicare & Medicaid Services (CMS)	Formerly known as the Health Care Financing Administration (HCFA), CMS is the federal agency that oversees the Medicaid and Medicare programs. Medicaid is a national health care program designed to assist families. Medicaid (known as Medi-Cal in California) offers assistance to any aged, blind or disabled persons whose income and resources are insufficient to meet the costs of necessary medical services.
Central Coder	Staff assigned by each LEC/LGA/Consortia to determine SMAA codes for TSP moment responses.
Certification Statement	A statement certifying that the information in the SMAA invoice is true and correct and accurately reflects the performance of SMAA activities. This statement is signed by the LEC/LGA Coordinator and the LEA Coordinator.

Certified Public Expenditure (CPE)	Non-federal public funds spent by a public entity (a government/public agency, including public schools) for providing SMAA or TCM services. Certified public expenditures include only those expenditures made by a LEC, LGA, LEA, or other governmental agency for services that qualify for federal reimbursement.
Child Find	Through the Individuals with Disabilities Education Act of 1997 (IDEA), all children with disabilities residing in the state who are in need of special education and related services must be identified and evaluated to determine if services are required.
Child Health and Disability Prevention (CHDP)	A preventive health-screening program serving California children where children and youth with suspected problems are referred for diagnosis and treatment. CHDP works with a broad range of health care providers and organizations, including private physicians, local health departments, schools, and others, to ensure that eligible children and youth receive appropriate services. All children enrolled in Medi-Cal are CHDP-eligible, but not all children participating in CHDP are Medi-Cal eligible.
Claimable Activities	Activities that may be claimed as allowable under the SMAA Program.
Claiming Plan	(Replaced by the term “Operational Plan.”)
Claiming Unit	Represent all LEAs, Special Education Local Program Area (SELPA), charter school, , County Offices of Education).
Clarifying Questions	An open ended question posed by the central coding staff to a TSP to gain additional information to assign the correct SMAA code.
Community-Based Organizations (CBO)	Organizations based/located in the LEA’s local community providing support services to families in accessing medical services, including programs and services covered by Medi-Cal.
Consultant / Consulting Firm / Vendors	An individual or agency that sub-contracts with an Administrative Unit to manage all or portions of the SMAA program.
Contingency Fee	Amount paid to vendor or other entity based on a percentage of the invoice. This fee arrangement is not a claimable administrative cost in the SMAA program.
Cost Pool(s) (CP)	Cost Pools are the basis of SMAA claims (invoices). All costs for a claiming unit must be included in one of the two Cost Pools or on the Direct Charge Worksheet.
Department of Health Care Services (DHCS)	The single state agency responsible for the administration and oversight of the Medicaid (Medi-Cal) program in California.

DHCS Tape Match	A process used to identify the number of Medi-Cal eligible students enrolled in a claiming unit and used as the basis to calculate their Medi-Cal percentage.
Direct Charge	Direct invoicing of certain costs. Staff who perform Medi-Cal eligible activities who can certify 100 percent of their paid time. These staff have the option of doing direct invoicing for certain costs and must be able to provide documentation that supports this percentage. Direct charging is also permitted for non-salary and/or overhead costs associated with SMAA specific reimbursable activities (designated as 'non-salary costs'); such as, travel, training, printing, computer, or other equipment costs SMAA
Duty Statement	Document describing the current duties and responsibilities assigned to a specific position. Each duty statement is required to include, in a single document, both the full scope of work and the approved SMAA activities.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	The EPSDT service is Medicaid's Comprehensive and Preventive Child Health program for individuals under the age of 21. The EPSDT program consists of two mutually supportive, operational components: (1) assuring the availability and accessibility of required health care resources; and (2) helping children who are eligible for Medicaid and their parents or guardians to effectively use these resources.
Enhanced Reimbursement	A federal financial participation (FFP) rate equal to 75 percent.
Family PACT	Family PACT (Planning, Access, Care and Treatment) Program is a Medi-Cal family planning reproductive health clinical services program.
Federal Financial Participation (FFP)	States must meet certain federal requirements to participate in the Medicaid program. States that meet these requirements receive federal funding in the form of FFP for all Medicaid expenditures.
Free Care Principle	Services provided to Medi-Cal beneficiaries must not be billed to Medi-Cal when the same services are offered for free to non-Medi-Cal beneficiaries. The only exception is for IEP students.
Healthy Start	California Healthy Start program provides students and their families with links to community resources through school-based family resource centers.
High-Risk Person	An individual with a behavior or condition that, based on scientific evidence or theory, is thought to directly influence susceptibility to a specific health problem.
High Risk Population	A population or group of individuals with behaviors or conditions that, based on scientific evidence or theory, is thought to directly influence susceptibility to a specific health problem.
IDEA	Individuals with Disabilities Act

Individualized Education Program or Plan (IEP)	A legal agreement composed by educational professionals, with input from the child’s parents, for students identified as disabled in accordance with IDEA requirements. This agreement guides, coordinates, and documents instructions that are uniquely designed to meet the student’s needs. See Appendix J
Initial Evaluation/Reevaluation	Before special education and related services are provided, the State Educational Agency, another State agency, or an LEA determines whether a child has a disability and identifies that child’s special/specific educational needs. A reevaluation determines whether the child continues to be disabled and identifies the continuing educational needs of the child. Reevaluations must be conducted at least once every three years.
Indirect Cost Rate	The percentage that represents the relationship between an organization’s indirect costs to its direct costs. There is a standardized method of charging individual programs for their share of indirect costs. Internal indirect costs typically include the portion of costs of a department’s administrative and office staff that the LEA allocates as support for the SMAA claiming unit, such as legal, accounting, and personnel staff costs. External indirect costs typically include the costs of the central control agencies of the LGA/LEC, such as Auditor-Controller, Treasurer, General Services, and Personnel.
Individualized Family Service Plan (IFSP)	A written plan for providing early intervention services to a child eligible under Title 34, Code of Federal Regulations, Section 303.340, and the child’s family. The individualized family service plan enables the family and service provider(s) to work together as equal partners in determining the early intervention services that are required for the child with disabilities and the family.
Invoice	The SMAA Detail Invoice with supporting worksheets and the SMAA Summary Invoice are to be used for the SMAA claiming process. The invoice package claiming documents that must be included and submitted to DHCS in the following order are: 1) SMAA Summary Invoice; 2);Activities and Medi-Cal Percentages Worksheet; 3) Time Survey Summary Report; 4) Direct Charges Worksheet, 5) Payroll Data Collection Worksheet, 6) Payroll Data Collection & Other Summary Sheet (maintain actual staff ledger reports for audit purposes); 7) Costs and Revenues Worksheet; 8) Supporting Documentation; 9) Roster Report(s);
Job/Position Description	An official document describing the necessary knowledge, skills, abilities, education, certification, and minimum qualifications for a specific employment classification. The job/position description also defines the employee’s scope of work and the variety and complexity of general tasks performed.

Local Educational Agency (LEA)	The governing body of any school district or community college district, the County Office of Education, a state special school, a California State University campus, or a University of California campus.
LEA Coordinator	An individual who administers SMAA for an LEA.
LEA Medi-Cal Billing Option	A mechanism for LEAs to bill Medi-Cal for specific health and direct medical services provided to students and their families in the school setting. Services provided through this program include assessments, treatments, and Targeted Case Management.
Local Educational Consortium (LEC)	Represents one of the 11 service regions of the California County Superintendents Educational Services Association (CCSESA).
Local Governmental Agency (LGA)	Local public health office or county agency that oversees the SMAA program for its county.
LEC/LGA Coordinator	An individual who administers the SMAA program for the region or county.
Managed Care Organizations (MCO)	Health maintenance organization designed to oversee services and costs for individual clients.
SMAA Contract	For an LEC/LGA to claim reimbursement for SMAA, Welfare and Institutions Code Section 14132.47(b) requires that a contract be in place between DHCS and the LEC/LGA. A contract is an agreement between DHCS and the LGA/LEC that describes the SMAA services to be performed, invoicing and payment, and the amount payable under the agreement.
Master Moment List	Includes the claiming unit identifying information, the name of each participant selected for the time survey and the date and time of the moment selected for that participant.
Medi-Cal Administrative Activities (SMAA)	Activities necessary for the proper and efficient administration of the Medi-Cal program.
Medi-Cal Discount	The Medi-Cal percentage is used to discount costs on the SMAA invoice for specific activities only available to Medi-Cal beneficiaries.
Medi-Cal Eligible	An individual who is currently eligible to receive Medi-Cal benefits.
Medi-Cal Percentage	The Medi-Cal percentage is the fraction of a total population (target population) that consists of Medi-Cal beneficiaries. The numerator is the number of students served by the claiming unit that are Medi-Cal beneficiaries, and the denominator is the total number of enrolled students served by the claiming unit.

Non-Public Schools	A nonpublic, nonsectarian school, certified by the state, that enrolls individuals with exceptional needs pursuant to Individualized Education Program or Plan (IEP) (EC Sec. 56034).
Nonspecific Contract	The contract is "nonspecific," meaning that the contract does not specifically define the SMAA activities to be performed and the cost for each allowable activity, the contractor's staff must time survey and include those costs in the Time Survey Cost Pool
45 CFR Part 75	A circular issued by the Federal Government that provides mechanisms and guidelines for State and local governments to account for costs when administering federal programs. The information contained in OMB A-87 has been incorporated into the federal code at 45 CFR Part 75 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards.
Operational Plan (OP)	Documentation the claiming unit uses to perform SMAA and that includes the audit file documentation that supports the invoice.
Participation Fee	LECs/LGAs participating in SMAA are required to pay a fee to cover actual costs related to DHCS administration of the SMAA program.
Personal Services Contractor	An entity (non-employee) that has entered into an agreement with a claiming unit to perform essential administrative and programmatic services, including SMAA services, and for whom an employee/employer relationship exists that can be demonstrated. An employee/employer relationship exists when the claiming unit's management supervises the entity and provides direct medical services to the LEA.
Policy and Procedure Letter (PPL)	Notification from DHCS to all LEC/LGA coordinators of new procedures or to clarify policy and procedural issues.
Quarter Averaging Worksheet	The moments for each SMAA Code must be entered manually in tab 6 of the invoice; the worksheet then automatically calculates the average.
Quarterly Summary Invoice	The summary or aggregate of costs for each claiming unit on each quarterly SMAA detail invoice. Prepared by the LEC/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 reimbursement to the LEC/LGA for the quarter.
Random Moment Time Survey (RMTS)	A time survey methodology is used to accurately assess a participant's work time for the purpose of billing SMAA. This survey samples the participant's activities during the full work day and when school is in session. The survey samples both SMAA and non-SMAA activities.
Revenue	Funding received by an LEC, LGA or LEA.

Revenue Offset	Revenue offset identifies federal funds so that they are not duplicated. The Revenue Offset Worksheet provides a systematic approach to calculate the dollars that must be offset from the claim.
Roster Report	A list of all employees eligible to participate in the SMAA program including their name, work schedule, employee identification number (if applicable), job classification, work email address, and school calendar.
School Claiming Unit	An entity within the LEC/LGA, such as any LEA, school district, COE, Special Education Local Plan Area (SELPA), State-funded college, or Healthy Start program that performs SMAA.
Service Providers	A provider of Medi-Cal services in California that contract with the LEC/LGA.
Single State Agency	The single state agency is DHCS and the Medicaid program which is called Medi-Cal in California. DHCS is the single state agency responsible for the administration and oversight of the Medicaid (Medi-Cal) program in California.
Specific Contract	A contract that describes the SMAA to be performed and the specific amount to be paid for each activity. Specific contracts are those contracts that do specifically define the SMAA activity to be performed and the cost for each SMAA activity. The costs for these contracts should be direct-charged on the Direct Charge Worksheet. For example, this may include a contract to provide a specific SMAA service, such as creating and distributing Medi-Cal literature or advertising for Outreach services for a specific cost.
Subcontractor	A vendor/sub recipient that enters into a contract with the LEA/LEC/LGA to perform SMAA-related services.
Time Survey/Study	The approved methodology for determining the percentage of costs allowable for each SMAA activity.
Unallowable Costs	Costs that may not be included in the claim and can consist of the following: Direct costs related to staff that are not identified as eligible time survey participants. Costs that are paid with 100 percent federal funds. Any costs that have already been fully paid by other revenue sources.
504 Accommodations	Section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to handicapped children. These services may include health care services similar to those covered by IDEA and Medicaid. These services are described in an Individualized Service Plan (ISP) and are provided free of charge to eligible individuals. These services may NEVER be billed to Medicaid because the Department of Education is a liable third party.

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SECTION 4

SMAA Overview

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Definition

The School-Based Medi-Cal Administrative Activity (SMAA) program authorizes governmental entities to submit claims and receive reimbursement for activities that constitute administration of the federal Medicaid program. The program allows school claiming units to be reimbursed for some of their administrative costs associated with school-based health and outreach activities that are not claimable under the Local Educational Agency (LEA) Medi-Cal Billing Option Program or under other Medi-Cal programs. In general, the cost of school-based health and outreach activities reimbursed under SMAA consist of referring students/families for Medi-Cal eligibility determinations, providing health care information and referral, coordinating and monitoring health services, and coordinating services between agencies. 45 CFR 75 establishes cost principles and standards for determining costs for federal awards carried out through grants, cost reimbursement contracts, and other agreements with State and local government units.

Unlike the LEA Medi-Cal Billing Option, individual claims for each service rendered to or on behalf of a student and the service documentation are not specifically required under the SMAA program. However, it is necessary to determine the amount of time school staff spend performing SMAA activities using the approved time survey methodology. SMAA. The results of the time survey are then used in a series of calculations to determine the percentage of school costs that can be claimed under SMAA. SMAA reimbursement to school claiming units is made from federal Medicaid funds.

LEA Participating in SMAA

To participate in SMAA, all LEAs must:

1. Contract through either their regional Local Educational Consortium (LEC) or county Local Governmental Agency (LGA)
2. Submit a Time Survey Participant Universe list to their LEC/LGA for pre-approval
3. Submit calendars for their participants to their LEC or LGA
4. Ensure participants are not 100% federally funded
5. Complete a Roster Report and
6. Participate in a Random Moment Time Survey (RMTS);
7. Review LEA Coding Report
8. Submit an invoice for reimbursement
9. Maintain an operational/audit file

RANDOM MOMENT TIME SURVEY (RMTS)

RMTS is the approved time survey methodology for determining the percentage of costs that are considered reimbursable. A claiming unit staff member that participates in the time survey process is herein referred to as a Time Survey Participant (TSP). Time and survey results represent all moments submitted (whether allowable or unallowable) performed by TSPs in the SMAA claiming program. . Time survey codes distinguish

between each activity, a TSP is engaged in during a time survey moment. During a time survey moment, a TSP must fully describe the activity performed. The time survey result will then be used to identify, measure, and allocate the claiming unit staff time that is devoted to Medi-Cal reimbursable activities.

The Time Survey is considered a legal document representing the SMAA activities reported in the invoice.

Invoicing for SMAA

Each claiming unit submits a separate detailed quarterly invoice to the LEC or LGA. The LEC/LGA must prepare and submit to DHCS, a quarterly summary invoice for each claiming unit's detailed invoice. The detail invoice is where the cost and revenue data are entered, adjustments to revenues are done, and time survey result activities and the Medi-Cal discount percentage is applied, where appropriate.

The LEC/LGA must provide DHCS with complete invoice and expenditure information no later than 15 months after the end of the quarter for which SMAA were performed. For example:

FY	Time Frame of Qtr.	Qtr.	Period Ending <i>Last day of Q + 15 months</i>	Due Date from LEC/LGA	SMAA Due Date to DHCS Accounting*	Accounting Due Date <i>(2 yrs. from last day of Q0 or 8Qs)</i>
14/15	July 1 – Sept. 30, 2014	1 st	Sept. 30 + 15 months	Dec. 31, 2015	Sept. 9, 2016	Sept. 30, 2016
14/15	Oct. 1- Dec 31, 2014	2 nd	Dec. 31 + 15 months	March 31, 2016	Dec. 9, 2016	Dec. 31, 2016
14/15	Jan. 1 – Mar. 31, 2015	3 rd	Mar. 31 + 15 months	June 30, 2016	March 9, 2017	March 31, 2017
14/15	Apr. 1 – June 30, 2015	4 th	June 30 + 15 months	Sept. 30, 2016	June 9, 2017	June 30, 2017

*** Dates are subject to change**

Certified Public Expenditures (CPE)

CPE, means expenditures that a governmental entity certifies it has incurred in furnishing health care services to eligible enrollees, which may be used as a mechanism for providing the non-federal share of the allowable federal payments under the LIHP, in accordance with 42 C.F.R. §433.51.

A CPE is an expenditure certified by a LEC, LGA, or other certifying governmental agency for expenditures paid by claiming unit using eligible revenues on services that qualify for federal reimbursement. In order to meet CPE requirements and receive federal financial participation (FFP), all claiming units must obtain and maintain

supporting documentation verifying:

1. 100 percent of the expenditures eligible for reimbursement are specifically related to performing the administrative activities and services of the Medi-Cal program;
2. The administrative activity and service expenditures eligible for reimbursement are restricted to the actual costs incurred and must actually be expended and paid prior to requesting FFP reimbursement
3. The funds expended to account for the actual costs are from revenue sources allowable under all applicable state and federal laws and regulations; and

The contributing public agency must certify to their allowable expenditures for the actual costs of providing services and/or activities. If a claiming unit has a question regarding eligible CPE or actual costs at the claiming unit, they should contact DHCS.

Contingency Fees

Pursuant to the Centers for Medicare & Medicaid Services' (CMS) Medicaid School-Based Administrative Claiming Guide, Medicaid claims for the costs of administrative activities and direct medical services may not include fees for consultant services that are contingent upon recovery of costs from the federal government nor shall they include contingency fee arrangements.

Should school districts or local educational agencies choose to use the services of consultants they must follow the policy as stated in 45 CFR 75, which states in Attachment B (32)(a), Professional Service Costs, that:

Costs of professional and consultant services rendered by persons who are members of a particular profession or possess a special skill, and who are not officers or employees of the governmental unit, are allowable, subject to subparagraphs b and c when reasonable in relation to the services rendered and **when not contingent upon recovery of the costs from the Federal Government.**

Medi-Cal claims for the costs of administrative activities and direct medical services should not include fees for consultant services that are based on, or include, contingency fee arrangements. Thus, if payments to consultants by schools are contingent upon payment by Medi-Cal, the consultant fees may not be used in determining the payment rate of school-based services and/or administration. If payments to consultants by schools are based on a flat fee, the consultant fees may be used in determining the payment rate of school-based services and/or administration.

Claiming units may directly contract with consultants to administer parts of the SMAA program. Such contracts must comply with all applicable federal requirements (such as competition and sole source provisions, and certified public expenditures) and which are specified in accordance with 42 C.F.R. §433.51.. Claiming units may not

reimburse vendors on a contingency fee basis and claim that cost on their SMAA invoices. If claiming units reimburse vendors using a flat fee schedule, they may claim that cost on their SMAA invoices. (See Section 9 for explanation of allowable fees.)

Consultant / Consulting Firm / Vendor Fees

LECs/LGAs may enter into agreements with Consultants / Consulting Firms / Vendors for the administration of the SMAA program. These agreements may be based on a per-person fee, or a flat fee reimbursement. However, if the fees are being claimed for reimbursement on any of the quarterly invoice(s), those fees will be limited depending on the details of the sub-recipient contract.

- Per-person fee reimbursement will be limited to: 1) no more than fifteen percent of the total amount claimed during a given fiscal year; and 2) only DHCS approved job classifications that participate in the quarterly Time Survey.
- Flat fee reimbursement will be limited to no more than fifteen percent of the total amount claimed during a given fiscal year.

Duplicate Payments

Federal, State, and local governmental resources must be expended in the most cost-effective manner possible. LEA providers shall adhere to and comply with all Federal Health and Human Services (HHS) and CMS requirements with respect to billing for services provided by other health care professionals under contract with the LEA and must avoid duplication of services and billing with other programs. In determining the administrative costs that are reimbursable under Medi-Cal, duplicate payments are not allowable. All direct services are identified as Code 2: Direct Medical Services and are non-billable and non-claimable for SMAA. LECs/LGAs may not claim FFP for the costs of allowable administrative activities that have been or should have been reimbursed through an alternative mechanism or funding source. The LEC/LGA must provide assurances to DHCS of non-duplication through its administrative claims and the claiming process. Furthermore, in no case should a program or claiming unit in a local jurisdiction be reimbursed more than the actual cost of that program or claiming unit, including state, local, and federal funds.

LECs/LGAs and claiming units are reimbursed FFP for costs that have already been paid for by allowable CPE. The LEC/LGA and claiming units may not draw down the same FFP reimbursement for identical costs from more than one FFP program. Claims for reimbursement shall not be duplicated, in whole, or part. LECs/LGAs and claiming units are required to verify that claims for reimbursement of Medi-Cal program expenditures have not previously been, or shall not subsequently be, used for federal match through an alternate funding source. Receiving reimbursement for the costs of Medi-Cal program activities or services that should be paid through an alternate funding source is also not allowed. Payments for SMAA shall not duplicate payments made to any public or private entities under other program authorities for the same purpose.

LECs/LGAs and claiming units are required to submit claims for reimbursement to the appropriate FFP programs.

The LEC/LGA and LEA must certify that they have ensured no duplication of its claims. Public agencies may not make a profit by claiming for reimbursement for estimated costs which could exceed actual costs incurred during a fiscal year. The LEC/LGA and claiming units may not request reimbursement for more than the actual costs incurred during the fiscal year. Public agencies may not receive duplicate reimbursement for public expenditures through a claiming mechanism beyond the appropriate claiming mechanism. Any misrepresentation relating to the filing of claims for federal funds constitutes a violation of the Federal False Claims Act.

As a quality assurance measure to avoid duplication, activity codes are paired to capture 100 percent of time sampled for both reimbursable and non-reimbursable activities. (See table below).

Parallel Codes	
Non-Reimbursable	Reimbursable
<u>Code 3</u> Non-Medi-Cal Outreach	<u>Code 4</u> Medi-Cal Outreach
<u>Code 5</u> Facilitating Application for non-Medi-Cal Programs	<u>Code 6</u> Facilitating Medi-Cal Application
<u>Code 7</u> Referral, Coordination, and Monitoring of non-Medi-Cal Services	<u>Code 8</u> Referral, Coordination, and Monitoring of Medi-Cal Services
<u>Code 9</u> Transportation for non-Medi-Cal Services	<u>Code 10</u> Arranging Transportation in Support of Medi-Cal Services
<u>Code 11</u> Non-Medi-Cal Translation	<u>Code 12</u> Translation Related to Medi-Cal Services
<u>Code 13</u> Program Planning, Policy Development, and Interagency Coordination Related to non-Medi-Cal Services	<u>Code 14</u> Program Planning, Policy Development, and Interagency Coordination Related to Medi-Cal Services
Non Parallel Codes	
<u>Code 1</u> School-Related, Educational, and Other Activities	<u>Code 15</u> Medi-Cal Claims Administration, Coordination and Training
<u>Code 2</u> Direct Medical Services	<u>Code 16</u> General Administration/Paid Time Off

Coordinating Activities

Claiming unit staff must not claim for activities that are already being offered or should be provided by other entities or through other programs. Claims for duplicate activities can be avoided by close coordination between the school claiming units, COEs, DHCS, State Department of Education, providers, the County Health Care Agency, community and non-profit organizations, and other entities related to the activities performed.

Activities provided/conducted by another governmental entity shall also be excluded from claims. For example, CHDP educational materials that have already been developed such as pamphlets and flyers must not be claimed as SMAA if they are redeveloped by schools. Staff from school claiming units must coordinate and consult with EPSDT/CHDP to determine the appropriate activities related to EPSDT/CHDP and to determine the availability of existing materials.

Allocable Share of Costs

According to 45 CFR 75, “a cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received.”

Allowable SMAA might or might not be directed solely toward the Medi-Cal population. Therefore, some of the costs associated with allowable SMAA might require discounting. The DHCS-approved discounting methodology is the Actual Client Count (a.k.a., DHCS Tape Match), based on the ratio of the total number of Medi-Cal eligibles to the total number of all individuals served by the claiming unit.

Unallowable Costs

Costs that may not be included in the claim are:

- Direct costs related to staff that are not in the TSP universe, not including direct charge; (i.e., costs related to teachers, cafeteria, transportation, and all other non-School Based administrative areas);
- Costs that are paid with 100 percent federal funds;
- Any costs that have already been fully paid by other revenue sources (federal, state/federal, recoveries, etc.);
- Costs included in the indirect cost rate work sheet (indirect costs numerator) calculation; and
- Any costs funded out of function codes 7120, 7190, 7200-7600, 7700, 8100-8400 and 8700. These costs are included in the Indirect Cost Rate (ICR) numerator.

Provider Participation in the Medi-Cal Program

Reimbursement for the cost of performing administrative activities that support medical services is available only when the following requirements are met:

1. The medical services are provided to a Medi-Cal eligible individual.
2. The medical services are reimbursable under Medi-Cal.
3. The medical services are furnished by a Medi-Cal provider who bills, or will bill, for the services. Such billable services include those provided through the LEA Medi-Cal Billing Option.

A claiming unit does not have to be a participating Medi-Cal provider to claim FFP for referring students to a Medi-Cal-covered service in the community. As long as the provider who renders such services participates in Medi-Cal and the service itself is Medi-Cal-reimbursable, the claiming unit can receive FFP for the administrative costs related to making the referrals. As long as the referral is made to a participating Medi-Cal provider, the two activities—referral and provision of the service—are not linked for administrative billing purposes.

If a claiming unit provider is not participating or chooses not to bill Medi-Cal for the service, then the service cannot be reimbursed and the administrative expenditures related to the service are not allowable. In California, virtually all medical services for children are Medi-Cal-eligible services; therefore, as long as a referral is made for medical reasons, SMAA time is allowable. If LEAs are not involved in the LEA Medi-Cal Billing Option, they will be subject to a discount for district-employed medical providers who are not participating in the billing for services rendered.

Here are examples:

1. A school is a Medi-Cal-participating provider. The school provides and bills for LEA-billable medical services listed in Medi-Cal-eligible children's IEP/IFSP that are covered under the California Medi-Cal state plan. Expenditures for school administrative activities related to school children's medical services for LEA and community Medi-Cal providers billed to Medi-Cal are allowable. The activities would be reported under Code 8, "Referral, Coordination, and Monitoring of Medi-Cal Services."
2. A school is not a Medi-Cal-participating provider through the LEA billing program and, consequently, even though it provides medical services (such as speech/language and OT), it does not bill for any direct medical services, including those listed in children's IEPs/IFSPs. In this example, the costs of the administrative activities performed with respect to the medical services delivered by school medical providers (like speech/language and OT) would not be allowable under the Medi-Cal program, and such activities would be reported under Code 7, "Referral, Coordination, and Monitoring of *Non-Medi-Cal* Services." SMAA time spent referring to outside/non-school Medi-Cal billing

providers is still billable. This will include time spent assisting an individual to obtain transportation to a Medi-Cal-covered service (reported under Code 10).

3. Regardless of whether or not the school is a Medi-Cal participating provider, the school program refers Medi-Cal eligible children to Medi-Cal-participating providers in the community. If the school performs administrative activities related to the services, which are billed to Medi-Cal by community providers, the costs of such activities are allowable under the Medi-Cal program, and such administrative activities would be reported under Code 8, "Ongoing Referral, Coordination, and Monitoring of Medi-Cal Services (PM/50-percent FFP)."
4. Irrespective of whether a school participates in the Medi-Cal program or not, services provided to school children referred to community providers who do not participate in Medi-Cal are not billed to Medi-Cal. In this case, the costs of administrative activities related to medical services would not be allowable under Medi-Cal. These activities would be reported under Code 7, "Ongoing Referral, Coordination, and Monitoring of *Non-Medi-Cal Services*."

Individualized Education Plan (IEP) Activities

Under the provisions of Part B of IDEA, school staff is required to perform a number of education-related activities that can generally be characterized as child find, evaluation (initial) and reevaluation, and development of an IEP. For purposes of the Medi-Cal program, these IDEA/IEP related activities are considered educational activities; therefore, they would not be considered allowable costs under the SMAA program. However, some of these costs are billable as direct-service Medi-Cal when medical evaluations or assessments are conducted to determine a child's health-related needs for purposes of the IEP development. These direct-service activities are claimed under Code 2 on the Time Survey activity form.

Section 411 (k)(13) of the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) amended section 1903(c) of the Act (42 U.S.C. 1396b(c)) to permit Medicaid payment for services provided to children under the Individuals with Disabilities Education Act (IDEA) through an Individualized Education Program (IEP). IDEA provisions require school staff to perform a number of education-related activities that can generally be characterized as child find, evaluation (initial) and reevaluation, and development of an IEP.

The IEP/IDEA related activities conducted by school staff are briefly described below:

"Child Find" All children with disabilities residing in the state who are in need of special education and related services must be identified, located, and evaluated.

"Initial Evaluations and Reevaluation" Before special education and related services are provided, an initial evaluation must be conducted by the state educational agency, another state agency or LEA in order to determine whether a child has a disability, and their special/specific educational needs. A re-

evaluation would be a determination as to whether the child continues to be disabled, and regarding the continuing educational needs of the child.

“Individualized Education Program (IEP).” For those children identified and determined to be disabled in accordance with Section 602 of the IDEA, an IEP must be developed by a team of individuals as defined in section 614. The IEP is statutorily defined as a written statement for each child with a disability that, among other elements includes:

- A statement of the child’s present levels of educational performance;
- A statement of measureable annual goals, including benchmarks or short term objectives;
- A statement of the special education and related services and supplementary aids and services to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided to the child.

Schools are conducting the activities listed above for the purpose of fulfilling education-related mandates under the IDEA; as such, the associated costs of these activities are not allowable as administrative costs under the Medicaid program. For RMTS coders these education-related activities must be coded as non-Medicaid activities.

It is important to distinguish child find activities from Medicaid outreach for the purposes of claiming FFP under Medicaid. In accordance with the IDEA statute, schools conduct child find activities to identify children with disabilities who need special education and related services. Regardless of whether the child find activities result in finding eligible children for whom an IEP is developed, the child find costs are not allowed under Medicaid as administration. This type of outreach can be distinguished from outreach to identify children who might be eligible for Medicaid; such Medicaid outreach activities are allowable.

Various education-related statutes obligate schools to furnish or make payment for services provided in the school setting for which Medicaid payment is not available. While section 1903(c) of the Social Security Act clarifies that Medicaid payment is available for medical services contained in a child’s IEP established under the IDEA (so long as the child is eligible and the services are otherwise reimbursable under Medicaid), no other education-related statutes obligate Medicaid payment. For example, section 504 of the Rehabilitation Act of 1973 requires local school districts to provide or pay for certain services to make education accessible to handicapped children; these services are described in a section 504 plan. The 1903(c) exception is very specific and does not extend to services provided pursuant to a section 504 plan. Because education agencies are required to pay for section 504 services, and there is no provision to make the education agencies secondary to Medicaid, federal Medicaid funds are not available for these services.

Individualized Family Service Plan (IFSP)

A written plan for providing early intervention services to a child eligible under Title 34, Code of Federal Regulations, Section 303.340, and the child's family. The individualized family service plan enables the family and service provider(s) to work together as equal partners in determining the early intervention services that are required for the child with disabilities and the family.

Third Party Liability (TPL), Medi-Cal as Payer of Last Resort

The Medi-Cal program is generally the "payer of last resort." This refers to the principle that Medi-Cal may pay for services and the costs of activities only after other programs or third parties (such as private insurance) have paid for such services or costs of activities. An exception or qualification to this principle relates to medical services contained in a child's IEP/IFSP. Medi-Cal may pay for such services if:

- Such services are contained in the child's IEP/IFSP;
- The child is eligible for Medi-Cal;
- The services are covered by the Medi-Cal program; and
- The TPL requirements have been met (see below).

Another exception is contained in the Maternal and Child Health Services Block Grant Act Title V (e.g., Cal-SAFE) under which Medi-Cal can pay for the allowable care and services for Medi-Cal eligible mothers and infants.

Therefore, except for special circumstances, DHCS cannot reimburse for routine school-based vision and hearing screenings or other primary and preventive services provided free of charge to all students. For Medi-Cal payment to be available for these services, the provider must:

1. Establish a fee for each service that is available;
2. Collect third party insurance information from all those served (Medi-Cal and non-Medi-Cal); and
3. Bill other responsible third party insurers.

This free care policy is relevant to the construction of time survey activity codes and reporting under such codes by time survey participants as it relates to activities that are subject to payment by other programs. If certain activities or services are specifically provided for under a special program, the cost of such administrative activities related to such programs is not allowable as administrative costs in Medi-Cal. Examples of this principle are:

1. California law requires immunizations be provided to all school children, regardless of the child's income status or whether the child is Medi-Cal eligible. In such a case, the administrative activities related to assisting the child to obtain

such immunizations in the school would not be reimbursable as a Medi-Cal administrative cost. Therefore, such an activity would be reported under Code 7, not Code 8.

2. Time spent developing an Individual Health Service Plan (IHSP) or a 504 plan under the requirements of the American Disability Act must be reported under Code 7: Referral, Coordination, and Monitoring of non-Medi-Cal-Covered Services, Unallowable Activities, and not Code 8.
3. Claiming units cannot be reimbursed through SMAA for the cost of providing direct medical services. For example, the services of a school nurse who tends to a Medi-Cal eligible child's sore throat, sprained ankle, or other acute medical problem are direct medical services and are not SMAA. Therefore, such an activity would be reported under Code 2.
4. Medi-Cal will not pay for free care-type activities and preventive care service not specified in a child's IEP/IFSP, if the same service is provided free of charge to non-Medi-Cal eligible students. The administrative activities associated with providing *these* direct services also cannot be billed. Such administrative activities would be reported under Code 7.

Free Care and Other Health Coverage (OHC) Requirements for IEP/IFSP Services

Medi-Cal will not reimburse LEA providers for services provided to Medi-Cal recipients if the same services are offered for free to non-Medi-Cal recipients. Medi-Cal covered services provided under an IEP/IFSP or Title V are exempt from the free care requirement. Although the services are exempt from the free care requirement, the LEA provider still must bill OHC insurers of Medi-Cal students for reimbursement before billing Medi-Cal.

Example: An IEP/IFSP child receives a non-IEP/IFSP service that is free of charge to all students (i.e., a mandated assessment). Medi-Cal must not be billed, because this assessment is given free of charge to any student.

Example: A Medi-Cal eligible student with OHC is provided a service that is documented in the student's IEP/IFSP.

The "free care" principle precludes Medicaid from paying for the costs of Medicaid-coverable services and activities which are generally available to all students without charge, and for which no other sources for reimbursement are pursued. Thus, Medicaid cannot reimburse for routine school-based vision and hearing screenings or other primary and preventive services provided free of charge to all students. In order for Medicaid payment to be available for these services, the provider must:

- 1) establish a fee for each service that is available;
- 2) collect third party insurance information from all those served (Medicaid and non-Medicaid); and
- 3) bill other responsible third party insurers.

Federal legislation provides for exceptions to the above-stated policy with regard to services provided under IDEA, the Women, Infants and Children's (WIC) program and services provided by title V grantees. Thus, Medicaid will pay before the education agency, the WIC program, or title V for Medicaid coverable services provided by those programs to Medicaid eligible children. This is true whether or not the IDEA, WIC or title V provider also charges non-Medicaid beneficiaries of these services. With respect to the title V exception, Medicaid will only reimburse for Medicaid-covered services provided to Medicaid beneficiaries to the extent that title V funds are used or available to the title V provider to provide the services. To the extent that the provider receives other, non-title V funds to provide the services, the title V exception from free care and third party liability does not apply.

The exceptions to the free care and payer of last resort principles are specified in Medicaid statute:

- Section 1902(a)(11)(B) of the Act (42 U.S.C. 1396a(a)(11)(B)), which provides for Medicaid to pay for Medicaid coverable services provided by a Title V grantee in the state.
- Section 1903(c) of the Act (42 U.S.C. 1396b(c)), which allows Medicaid to pay for coverable Medicaid services for children that are included in an IEP or Individualized Family Service Plan (IFSP) under the IDEA.

Medicaid will **not** pay for "EPSDT-type" primary and preventive care services not specified in a child's IEP, if the same service is provided free of charge to non-Medicaid children in the school. For example, the services of a school nurse who attends to a Medicaid child's sore throat, sprained ankle, or other acute medical problem **cannot** be reimbursed by Medicaid if similar services provided by the nurse to non-Medicaid children are not billed. Also, Medicaid coverable medical services that are provided to Medicaid children under a "section 504 plan" in order to make education accessible to these children with disabilities, are not reimbursed by Medicaid. It is the responsibility of the education agency to provide these services, and other third party payers are not generally billed for these services. Costs of related administrative activities for these services are also not allowable under Medicaid.

Medical services specified in a child's IEP, and administrative activities provided in support of those services are treated differently from the other EPSDT-type primary and preventive services or "section 504 plan" services discussed above. Medicaid, as required by 1903(c) of the Act, will pay for IEP- specified medical services and related administrative costs provided to Medicaid children once established, even though non-Medicaid children are generally not billed for them.

This Guide does not change existing third party liability (TPL) requirements for IEP services. Medicaid is primary payer to the education agency for services included in an IEP, but is secondary to any other payer. Medicaid TPL provisions for pursuing all other sources of liability are still required by statute (section 1902(a)(25)(E) of the Act, 42 U.S.C. 1396a(a)(25)(E)) and recovery is sought if there is a liable third party (See also Section VI.,J.).

Example: A screening is provided free of charge to all students. Medicaid would not pay for the screen since it falls under the free care provision. However, the screening may lead to the discovery of a needed service included in a Medicaid enrolled child's IEP. In such a case, Medicaid could pay for the medically necessary service discovered through the screen (assuming the service is not considered free care). Medicaid distinguishes between the screening and the medically necessary service discovered through the screen because the school does not bill any third parties for the provision of the free screening while it does bill for the medical service. The free care provision applies to the particular service in question, and, for this reason, the screening and the service are treated differently for purposes of FFP. Medicaid by law is responsible for paying for the medically necessary services in IEPs, as well as the related administrative activities (i.e., the referral).

It is understood that the free care provision serves to limit the ability of schools to bill Medicaid for covered services provided to Medicaid-eligible children because schools that provide needed health services often provide them to all students free of charge. While there are exceptions to the free care principle for Title V and Medicaid services provided to children with disabilities pursuant to an IEP under IDEA, many schools provide a range of services that would not fall under these exceptions, including services provided by school nurses and school psychologists.

The free care principle is relevant to the assignment of time survey activity codes. To the extent that a medical service is not reimbursable under the Medicaid program due to the free care policy, associated administrative costs also may not be claimed. For example, state laws may require that immunizations be provided to all school children, regardless of the child's income status or whether the child is Medicaid eligible. In such a case the administrative activities related to assisting the child to obtain such immunizations in the school would not be reimbursable as a Medicaid administrative cost. Therefore, such an activity would be reported under Code 7: Referral, Coordination and Monitoring of Non-Medicaid Services.

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SECTION 5

Activity Codes: Descriptions and Examples

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Introduction

When staff performs duties related to the proper administration of the California Medi-Cal program, federal funds may be drawn as reimbursement for the appropriate timesurvey proportion of salary, benefit, and other costs of providing these administrative activities. To identify the cost of providing these activities, a time survey of staff must be conducted. The time survey- identifies the time and subsequent costs spent on Medi-Cal administrative activities that are allowable and reimbursable under the Medi-Cal program. The following coding scheme must be followed by all timesurvey participants:

Staff Activities and Codes. Each code listed in the following pages is followed by an indicator (in parentheses) to show if the code is eligible for reimbursement at the FFP rate, to what extent the code is allowable, and if the Medi-Cal Percentage must be applied.

Application of FFP rate of 50 percent. Refers to an administrative activity that is allowable under the Medi-Cal program and claimable at the 50-percent FFP rate.

Unallowable Activities (U). Refers to an administrative activity that is unallowable under the Medi-Cal program, regardless of whether or not the population served includes Medi-Cal-eligible individuals.

Total Medi-Cal (TM). Refers to an administrative activity that is 100-percent allowable under the Medi-Cal program.

Proportional Medi-Cal (PM). Refers to an administrative activity that is allowable under the Medi-Cal program, but for which the allocable share of costs must be determined by applying the discounted or proportional Medi-Cal share (the Medi-Cal percentage). The Medi-Cal share is determined by calculating the ratio of Medi-Cal-eligible students to total students.

Reallocated Activities (R). Refers to those general administrative activities performed by time survey participants that must be reallocated across the other activity codes on a *pro rata* basis. These reallocated activities are reported under Code 16. Note that certain functions, such as payroll, maintaining inventories, developing budgets, and executive direction are considered overhead; therefore, they are only allowable through the application of an approved indirect cost rate.

Coders should document time spent on each of the following coded activities:

- CODE 1** School-Related, Educational, and Other Activities **(U)**
- CODE 2** Direct Medical Services **(U)**
- CODE 3** Non-Medi-Cal Outreach **(U)**
- CODE 4** Medi-Cal Outreach **(TM/50-percent FFP)**
- CODE 5** Facilitating Application for Non-Medi-Cal Programs **(U)**
- CODE 6** Facilitating Medi-Cal Application **(TM/50-percent FFP)**
- CODE 7** Referral, Coordination, and Monitoring of Non-Medi-Cal Services **(U)**
- CODE 8** Referral, Coordination, and Monitoring of Medi-Cal Services **(PM/50 percent-FFP)**
- CODE 9** Transportation for Non-Medi-Cal Services **(U)**
- CODE 10** Arranging Transportation in Support of Medi-Cal Services **(PM/50-percent FFP)**
- CODE 11** Non-Medi-Cal Translation **(U)**
- CODE 12** Translation Related to Medi-Cal Services **(PM/50-percent FFP)**
- CODE 13** Program Planning, Policy Development, and Interagency Coordination Related to Non-Medi-Cal Services **(U)**
- CODE 14** Program Planning, Policy Development, and Interagency Coordination Related to Medi-Cal Services **(PM/50-percent FFP)**
- CODE 15** Medi-Cal Claims Administration, Coordination, and Training **(TM/50-percent FFP)**
- CODE 16** General Administration/SMAA **(R)**
- CODE 17** **Not Working/Not Paid**
- CODE 18** **Invalid**
- CODE 19** **No Response**

CODE 1. SCHOOL-RELATED, EDUCATIONAL, AND OTHER ACTIVITIES (U)

This code should be used for school-related activities that are not health-related, such as social services, educational services, and teaching services, employment and job training. Examples are in the Code 1 versus Code 16 matrix, in Appendix F. Activities that are specific to education and students, particularly instructional, curriculum and student-focused areas (including attendance reports and all other student records), should be coded here. Include in Code 1 are all clerical and supervisory activities and travel related to these activities. These activities include the development, coordination, and monitoring of a student's education plan that are not health-related.

- a. Providing classroom instruction (including lesson planning).
- b. Testing, correcting papers.
- c. Compiling attendance reports.
- d. Performing activities that are specific to instructional, curriculum, student-focused areas, including those performed by health providers.
- e. Reviewing the education record for students who are new to the school.
- f. Providing general supervision of students (e.g., playground, lunchroom).
- g. Monitoring student academic achievement.
- h. Providing individualized instruction (e.g., math concepts) to a special education student.
- i. Conducting external relations related to school educational issues/matters.
- j. Compiling report cards.
- k. Applying discipline activities.
- l. Performing clerical activities specific to instructional or curriculum areas.
- m. Activities related to the immunization requirements for school attendance. (These activities are considered Free Care and cannot be billed to Medi-Cal.)
- n. Compiling, preparing, and reviewing reports on textbooks or attendance.
- o. Enrolling new students or obtaining registration information.
- p. Conferring with students or parents about discipline, academic matters, or other school-related issues.
- q. Evaluating curriculum and instructional services, policies, and procedures.
- r. Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction).
- s. Performing clerical activities specific to instructional or curriculum areas.
- t. Participating in or coordinating training that improves the delivery of services for programs other than Medi-Cal.
- u. Participating in or coordinating training that enhances IDEA child find programs.
- v. Developing, coordinating, and monitoring that the IEP is conducted, parental sign-off is obtained, the IEP meetings with the parents are scheduled, and the IEP is completed. All time spent in an IEP is an education mandate and is not a claimable administrative activity.
- w. Preparing for and providing behavior management principles to student.

Note: Staff may code time here for activities that do not relate to Medi-Cal or do not meet the definition of any other code category.

CODE 2. DIRECT MEDICAL SERVICES (U)

This code should be used when providing care, treatment, and/or counseling services to an individual to correct or ameliorate a specific condition when performing activities in their duty statement. Activities that are an integral part of or an extension of a medical service (e.g., student follow-up, student assessment, student counseling, student education, consultation and student billing activities) are considered direct medical services. This code also includes all related, paperwork, clerical activities, or staff travel required to perform these activities, including initiating and responding to email and voicemail. This includes Targeted Case Management (TCM) and LEA-billed Medi-Cal services. Examples are in the Code 2 versus Code 8 matrix, in Appendix G.

NOTE: This includes IEP driven Targeted Case management and LEA billed Medi-Cal services. Not all TCM services, provided by staff pool one are eligible for LEA billing if those TCM services are not a part of the students IEP.

- a. Providing health/mental health services contained in an IEP.
- b. Providing medical/health assessment and evaluation as part of the development of an IEP.
- c. Reporting initial health assessment results at IEP.
- d. Conducting medical/health assessments/evaluations and diagnostic testing, and preparing related reports.
- e. Providing health care/personal aide services.
- f. Providing speech, occupational, physical, and other therapies.
- g. Administering first aid.
- h. Administering a prescribed injection or medication, to a student as the result of an IEP.
- i. Providing direct clinical or treatment services.
- j. Performing developmental assessments.
- k. Providing counseling services to treat health, mental health, or substance abuse conditions.
- l. Performing routine or mandated child health screens, including but not limited to vision, hearing, dental, scoliosis, and certain EPSDT/CHDP screens.
- m. Providing immunizations.
- n. Conducting LEA billed TCM Services.
- o. Providing follow-up contact to ensure that a child has received the prescribed medical/mental health services.

CODE 3. NON-MEDI-CAL OUTREACH (U)

This code should be used when performing activities that inform eligible or potentially eligible individuals about non-Medi-Cal social, vocational, and educational programs (including special education). Code 3 should also be used when informing eligible and potential eligible individuals about how to access the programs, describing the range of benefits covered and how to obtain enrollment. Both written and oral methods may be used. Include related paperwork, clerical activities, or staff travel required to perform these activities, including initiating and responding to email and voicemail.

- a. Informing families about wellness programs and how to access these programs.
- b. Scheduling and promoting activities that educate individuals about the benefits of healthy life styles and healthy practices.
- c. Conducting general health education programs or campaigns addressed to the general population.
- d. Conducting outreach campaigns directed toward encouraging persons to access social, educational, legal, or other services not covered by Medi-Cal.
- e. Assisting in the early identification of children with special medical/mental health needs through various IDEA child find activities.
- f. Outreach activities in support of programs that are funded 100 percent by state general revenue.
- g. Participating in or coordinating training that improves the delivery of services for programs other than Medi-Cal.
- h. Participating in or coordinating training that enhances IDEA child find programs.

CODE 4. MEDI-CAL OUTREACH (TM/50-Percent FFP)

This code should be used when performing activities that inform eligible or potentially eligible individuals about Medi-Cal programs and services and how to access them. Initial activities would include: bringing potential eligibles into the Medi-Cal system for the purpose of determining eligibility; and related paperwork, clerical activities, or staff travel required to perform these activities (including initiating and responding to email and voicemail). LEAs can only conduct outreach for the populations served by their schools (i.e., students and their parents or guardians). The following are examples of activities that are considered Medi-Cal outreach:

- a. Providing initial information about Medi-Cal covered services and/or CHDP screenings (e.g., dental, vision) in the schools that will help identify medical conditions that can be corrected or improved by services through Medi-Cal.
- b. Informing Medi-Cal eligible and potential Medi-Cal eligible children and families about the benefits and availability of services provided by Medi-Cal (including preventive, treatment, and screening), including services provided through the EPSDT program.
- c. Informing children and their families on how to effectively access, use, and maintain participation in all health resources under the federal Medi-Cal program.
- d. Assisting in the early identification of children who could benefit from the health services provided by Medi-Cal as part of a Medi-Cal outreach campaign. Not claimable are child find activities that are required under Special Education regulations (use Code 3 Non-Medi-Cal Outreach).

- e. Contacting pregnant and parenting teenagers about the availability of Medi-Cal prenatal and well-baby care programs and services.
- f. Conducting a family planning health education outreach program or campaign if it is targeted specifically to family planning Medi-Cal services that are offered to Medi-Cal eligible individuals.
- g. Participating in/or coordinating outreach trainings that improve access to Medi-Cal services.
- h. Providing information regarding Medi-Cal managed care programs and health plans to individuals and families and how to access that system.

Note: LEAs must submit to DHCS, for approval, all outreach material that provides any information related to activities identified in bullets a-g above. Only distribution of DHCS approved outreach materials shall qualify as a SMAA reimbursable activity. Resource lists that provide contact information for local health facilities do not require DHCS approval, but do qualify for distribution as outreach material. All outreach material must be submitted for approval to the SMAA email box at SMAA@DHCS.CA.GOV. All material will be reviewed for approval within 30 days of submission, and the LEC/LGA will be notified.

Activities that are not considered Medi-Cal outreach under any circumstances are:

- i. General preventive health education programs or campaigns addressed to life-style changes in the general population (e.g., maintaining healthy teeth and gums, anti-smoking, alcohol abstinence, etc.),
- j. Outreach campaigns directed toward encouraging persons to access social, educational, legal, or other services not covered by Medi-Cal.

CODE 5. FACILITATING APPLICATION FOR NON MEDI-CAL PROGRAMS (U)

This code should be used when informing an individual and/or family about programs such as CalWORKS, Food Stamps, WIC, childcare, legal aid, and other social or educational programs, and referring them to the appropriate agency to complete the application. Include related paperwork, clerical activities, or staff travel required to perform these activities, including initiating and responding to email and voicemail.

- a. Explaining the eligibility process for non Medi-Cal programs.
- b. Assisting the individual or family in collecting/gathering information and documents for the non-Medi-Cal program application.
- c. Assisting the individual or family in completing the application.
- d. Developing and verifying initial and continuing eligibility for the National School Lunch Program.
- e. Using client information from Medi-Cal to facilitate the National School Lunch Program application process.

CODE 6. FACILITATING THE MEDI-CAL APPLICATION (TM/50-percent FFP)

This code should be used when assisting an individual and/or family in becoming eligible for Medi-Cal insurance. Include related, paperwork, clerical activities, or staff travel required to perform these activities, including initiating and responding to email and voicemail. This activity does not include the actual determination of Medi-Cal eligibility.

- a. Verifying an individual's current Medi-Cal eligibility status for the purposes of the Medi-Cal program.
- b. Explaining Medi-Cal eligibility rules and the Medi-Cal eligibility process to prospective applicants.
- c. Assisting individuals or families to complete a Medi-Cal application.
- d. Gathering information related to the application and eligibility determination for an individual, including resource information and transaction processing language (TPL) information, as a prelude to submitting a formal Medi-Cal insurance application.
- e. Providing necessary forms and packaging all forms in preparation for the Medi-Cal eligibility determination.
- f. Referring an individual or family to the local Medi-Cal eligibility office to complete the application for Medi-Cal insurance.
- g. Assisting the individual or family in collecting/gathering required information and documents for the Medi-Cal insurance application.
- h. Participating as a Medi-Cal eligibility outreach outstation, but does not include determining eligibility.
- i. Using client information gathered from various programs such as the Child Health and Disability Prevention Program and the Free and Reduced Lunch Program to facilitate the Medi-Cal application process to expand enrollment into Medi-Cal programs and services.

CODE 7. REFERRAL, COORDINATION, AND MONITORING OF NON MEDI-CAL SERVICES (U)

This code should be used when making referrals for, coordinating, and/or monitoring the delivery of non Medi-Cal services, such as educational services. Include related paperwork, clerical activities, or staff travel required to perform these activities, including initiating and responding to email and voicemail.

- a. Making referrals for and coordinating access to social and educational services such as childcare, employment, job training, and housing.
- b. Making referrals for, coordinating, and/or monitoring the delivery of state education agency mandated immunizations and child health screens (vision, hearing, scoliosis).
- c. Making referrals for, coordinating, and/or monitoring the delivery of scholastic, vocational, and other non-health-related examinations including making referrals to community organizations (i.e. Lions club for glasses). Gathering any information that may be required in advance of these non-Medi-Cal-related referrals.

- d. Participating in a meeting/discussion to coordinate or review a student's need for scholastic, vocational, and non health-related services not covered by Medi-Cal.
- e. Monitoring and evaluating the non-medical components of the individualized plan as appropriate.
- f. Monitoring and evaluating the non-Medi-Cal-covered service components as appropriate.
- g. Providing information to other staff on the child's related medical/mental health services and plans.

Note: Case Managers participating in the LEA Medi-Cal Billing Option for IEP case management cannot be coded for, SMAA Referral, Coordination, and Monitoring. Case manager time should be coded under Code 2, Direct Medical Service as TCM billing includes Referral, Coordination, and Monitoring.

CODE 8. REFERRAL, COORDINATION, AND MONITORING OF MEDI-CAL SERVICES (PM/50-percent FFP)

This code should be used when making referrals for, coordinating, and/or monitoring the delivery of Medi-Cal covered services. Include related paperwork, clerical activities, or staff travel necessary to perform these activities, initiating and responding to email and voicemail.

Activities that are an integral part of or an extension of a medical service (e.g., student follow-up, student assessment, student counseling, student education, consultation and student billing activities) are considered direct medical services. This includes Targeted Case Management (TCM) and LEA-billed Medi-Cal services should be reported under Code 2, Direct Medi-Cal Services. Activities that include student health billing are also reported under Code 2. Developing, coordinating, and monitoring that the IEP is conducted, parental sign-off is obtained, the IEP meetings with the parents are scheduled, and the IEP is completed should be reported under Code 1. *Note: IEP meetings are part of an education mandate and referral and coordination for the IEP services must not be claimed as Medi-Cal administration. Once an IEP is established monitoring and coordination of services is allowable.*

- a. Making referrals for and/or coordinating medical or physical examinations and necessary medical/mental health evaluations.
- b. Making referrals for and/or scheduling certain Medi-Cal covered CHDP screens, inter-periodic screens, and appropriate immunizations, but do not include the state-mandated health services. **(See Section 2 – Medicaid in the School Setting – Page 2-2).**
- c. Referring students for necessary medical, mental health, or substance abuse services covered by Medi-Cal.
- d. Arranging for any Medi-Cal-covered medical/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/mental health condition.
- e. Gathering any information that may be required in advance of these referrals.

- f. Providing follow-up contact to ensure that a child has received the prescribed medical/mental health services
- g. Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medi-Cal service providers as may be required to provide continuity of care.
- h. -
- i. Coordinating the delivery of interdistrict and community-based medical/mental health services for children with special/severe health care needs.
- j. Coordinating medical/mental health service provisions with managed care plans as appropriate.
- k. Providing initial referral assistance to families where Medi-Cal services can be provided.
- l. Identifying and referring adolescents who may be in need of Medi-Cal family planning services

*Note: Case Managers participating in the LEA Medi-Cal Billing Option for IEP case management **cannot** be coded for SMAA Referral, Coordination, and Monitoring. Case managers time should be coded under Code 2, Direct Medical Service as TCM billing includes Referral, Coordination, and Monitoring.*

CODE 9. TRANSPORTATION FOR NON MEDI-CAL SERVICES (U)

This code should be used when assisting an individual to obtain transportation to services not covered by Medi-Cal, or accompanying the individual to services not covered by Medi-Cal. Include related paperwork, clerical activities, or staff travel required to perform these activities, including initiating and responding to email and voicemail.

- a. Scheduling or arranging transportation to social, vocational, educational, and/or any other non Medi-Cal services, programs, and activities.
- b. Actual cost of transportation is not considered SMAA, only scheduling or arranging transportation is considered SMAA.

CODE 10. ARRANGING TRANSPORTATION IN SUPPORT OF MEDI-CAL SERVICES (PM/50-PERCENT FFP)

This code should be used when **assisting** an individual or family to obtain transportation to the site where services covered by Medi-Cal are provided. This activity includes:

- a. Scheduling or arranging transportation to Medi-Cal covered services (Actual cost of transportation is not SMAA)
- b. A transportation supervisor and staff time coordinating IEP transportation.
- c. **Reviewing routes and maps**
- d. **Troubleshooting early and late pick-ups**

This code does not include the following activities :

- a. The costs of the actual transportation service.

- b. Activities that contribute to the actual billing of transportation as a medical service such as with the LEA Medi-Cal Billing Option program.
- c. Accompanying the Medi-Cal eligible individual to Medi-Cal services as an administrative activity.
- d. Arranging campus security or medical transportation (such as an ambulance).

Note: Case Managers participating in the LEA Medi-Cal Billing Option cannot duplicate their time here. Case managers should be coded under Code 2, Direct Medical Service.

CODE 11. NON MEDI-CAL TRANSLATION (U)

This code should be used when school employees who provide translation services for non Medi-Cal activities. Include related paperwork, clerical activities or staff travel required to perform these activities, including initiating and responding to email and voicemail.

- a. Arranging for or providing translation services (oral or written signing services) that assist the individual to access and understand social, educational, and vocational services.
- b. Arranging for or providing translation services that assist the individual to access and understand the state education or state-mandated health screenings (e.g., vision, hearing, scoliosis) and general health education outreach campaigns intended for the student population.

CODE 12. TRANSLATION RELATED TO MEDI-CAL SERVICES (PM/50-PERCENT FFP)

Translation may be allowable as an administrative activity if it is not included and paid for as part of a medical assistance service. However, translation must be provided by a third party translator or by separate employees performing translation functions for the school and it must facilitate access to Medi-Cal covered services. In other words, time samples from Medi-Cal providers who are translating their own work cannot be dual coded as a direct service and translation because they are not a third party translator. Please note that a school district does not need to have a separate administrative claiming unit for translation.

This code should be used for school employees who provide Medi-Cal translation services. Include related paperwork, clerical activities, or staff travel required to perform these activities, including initiating and responding to email and voicemail.

- a. Arranging for or providing translation services (oral, written, and signing) that assist the individual to access and understand necessary care or treatment covered by Medi-Cal.
- b. Arranging for or providing translation to student/parent to understand how to access the application process for Medi-Cal.

Note: Case Managers participating in the LEA Medi-Cal Billing Option cannot duplicate their time here. Case managers should be coded under Code 2, Direct Medical

Service as TCM billing. TCM Billing Includes Referral, Coordination, and Monitoring.

CODE 13. PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO NON MEDICAL SERVICES (U)

This code should be used when performing collaborative activities with other agencies associated with the development of strategies to improve the coordination and delivery of non-medical/non-mental health services to students and their families. This typically involves large scale collaborative projects which are across schools, schools departments within a district, and/or between the school/ district and outside agencies. Non-medical services may include social, educational, and vocational services. Only employees whose position descriptions include program planning, policy development, and interagency coordination should use this code. This code should include related, paperwork, clerical activities, or travel required to perform these activities, including initiating and responding to email and voicemail.

- a. Identifying gaps or duplication of other non-medical services (e.g., social, vocational, and educational programs) to students and their families, and developing strategies to improve the delivery and coordination of these services.
- b. Developing strategies to assess or increase the capacity of non-medical school programs.
- c. Monitoring the non-medical delivery systems in schools.
- d. Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services.
- e. Evaluating the need for non-medical services in relation to specific populations or geographic areas.
- f. Analyzing non-medical data related to a specific program, population, or geographic area.
- g. Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems.
- h. Defining the scope of each agency's non-medical service in relation to the other.
- i. Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services to the school populations.
- j. Developing non-medical referral sources.
- k. Coordinating with interagency committees to identify, promote, and develop non-medical services in the school system.
- l. Developing and processing non-medical MOUs, contracts, and agreements.
- m. Planning and policy development, interagency coordination for mandated medical/dental or mental health services.

CODE 14. PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO MEDI-CAL SERVICES (PM/50-PERCENT FFP)

This code should be used when performing activities associated with the development of strategies to improve the coordination and delivery of Medi-Cal covered medical/dental/mental health services to students and their families, and also when performing collaborative activities with other agencies and/or providers. This typically involves large scale collaborative projects which are across schools, schools departments within a district, and/or between the school/district and outside agencies. Only employees whose position descriptions explicitly include program planning, policy development, and interagency coordination for services related to Medi-Cal should use this code. Staff surveying under this code should include related paperwork, clerical activities or travel required to perform these activities, including initiating and responding to email and voicemail.

- a. Identifying gaps or duplication of medical/dental/mental health services to students and their families and developing strategies to improve the delivery and coordination of these services.
- b. Developing strategies to assess or increase the capacity of non-mandated school medical/dental/mental health programs.
- c. Monitoring the non-mandated medical/mental health delivery systems in schools.
- d. Developing procedures for tracking families' requests for assistance with Medi-Cal-covered services and providers. (This does not include the actual tracking of requests for Medi-Cal services).
- e. Evaluating the need for Medi-Cal services in relation to specific populations or geographic areas.
- f. Analyzing Medi-Cal data related to a specific program, population, or geographic area.
- g. Working with other agencies and/or providers that provide Medi-Cal services, to expand access to specific populations of Medi-Cal eligibles, and to improve collaboration around the early identification of medical problems.
- h. Defining the scope of each agency's Medi-Cal service in relation to the other.
- i. Working with Medi-Cal resources, such as the managed care plans, to make good faith efforts to locate and develop health services referral relationships.
- j. Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of Medi-Cal care services to the school populations.
- k. Developing medical referral sources, such as directories of Medi-Cal providers and managed care plans, which will provide services to targeted population groups such as Medi-Cal and/or CHDP children.
- l. Coordinating with interagency committees to identify, promote, and develop Medi-Cal and/or CHDP services in the school system.
- m. Negotiating and processing MOUs and special agreements that support interagency coordination to improve the delivery of Medi-Cal services.

- n. Participating in or coordinating training that enhances early identification, intervention, screening, and referral of students with special health needs to Medi-Cal services. (This is distinguished from IDEA child find programs.)

CODE 15. MEDI-CAL CLAIMS ADMINISTRATION, COORDINATION, AND TRAINING (TM/50-PERCENT FFP)

This code should be used for LEA, LEC, and LGA coordinators when performing activities that are directly related to Medi-Cal Administrative Activities claims administration and coordination, and training activities. Include related paperwork, clerical activities, or staff travel necessary to perform these activities, including initiating and responding to email and voicemail. Do not code time for initial or annual training or time spent completing LEA Medi-Cal Billing Option forms or analysis of LEA Medi-Cal Billing Option information.

- a. Drafting, revising, and submitting SMAA operational plans.
- b. Serving as liaison for regional and local SMAA claiming programs and with the State and Federal Governments on Medi-Cal administration (i.e., LEC/LGA Coordinators or their designees).
- c. Monitoring the performance of SMAA claiming programs.
- d. Administering SMAA, including overseeing, preparing, compiling, revising, and submitting claims.
- e. Training program and subcontractor staff on state, federal, and local requirements for SMAA claiming.
- f. Ensuring that SMAA claims do not duplicate Medi-Cal claims for the same activities from other providers.
- g. Attending meetings and conferences that involve SMAA for LEA or LEC/LGA coordinators.
- h. Initial and/or annual claiming for time survey training continues to be disallowed.

CODE 16. GENERAL ADMINISTRATION/ SMAA-PAID TIME OFF(R)

This code should be used for General Administration, and paid time off. General Administration duties are more specific to general administrative/clerical activities related to facilities, district functions and operations.

Certain functions, such as payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead; therefore, they are ONLY allowable through the approved indirect cost rate.

Below are typical examples of general administrative activities, but they are not all-inclusive:

- a. Staff should use this code for participating in RMTS.
- b. General supervision of staff or facilities, including staff performance reviews, and personnel management.

- c. Reviewing non-instructional school policies, procedures, or rules.
- d. Attending or facilitating school, unit staff meetings, or board meetings.
- e. Completing personal mileage and expense claims.

CODE 17. NOT WORKING / NOT PAID (U)

This code should be used when a TSP responds to a moment and indicates they were not working at the time of the moment, or they were on an unpaid lunch break or other unpaid time off.

CODE 18. INVALID MOMENT (U)

This code is used when a TSP vacates their position and there is no direct replacement for the specific job classification. Vacating a position is defined as not returning to the position either with or without notice, and/or retirement.

CODE 19 NO RESPONSE

This code should be used when the TSP fails to provide a response to an assigned moment within the required five student attendance day response time.

DRAFT

California School-Based SMAA Manual
SECTION 6
SMAA Time Survey

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Time Survey Methodology

The purpose of the time survey is to identify the proportion of administrative time allowable and reimbursable under the SMAA program. The federal government has developed an established tradition of using time surveys as an acceptable methodology. DHCS oversees these time surveys on a quarterly basis in order for claiming units to be able to participate in the SMAA program. A time survey is not designed to show how much of a certain activity a worker performs; rather, it reflects how time is allocated among different activities.

In most claiming units, it is uncommon to find staff whose activities are limited to just one or two specific functions. Staff members normally perform a number of activities, some of which are related to the direct covered services and some of which are administrative. Sorting out the portion of the activity that is related to these direct covered services and to all other functions requires an allocation methodology that is objective and empirical (i.e., based on documented data). Staff time has been accepted as the basis for allocating staff cost. The federal government has developed an established tradition of using time surveys as an acceptable basis for cost allocation.

Random Moment Time Survey (RMTS)

Beginning January 1, 2015, the state implemented a Random Moment Time survey (RMTS) methodology which all claiming units that choose to participate in SMAA will be required to utilize.

To ensure LECs, LGAs, and claiming units can accurately account for the amount of time a qualified Time Survey Participant (TSP) spends performing Medi-Cal program eligible activities, California will utilize a statistically valid time survey methodology that is in compliance with 45 CFR 75, as required by the Medicaid Administrative Claiming (MAC) agreement. SSMAA time survey participants will use the California RMTS methodology.

Local Educational Agencies (LEA) are not required to participate in their respective LEC/LGA RMTS; however, LEAs may not implement and operate an RMTS at the district level independent from their LEC/LGA. Los Angeles Unified School District (LAUSD) is the only exception, as their individual RMTS plan was previously approved by the Centers for Medicare & Medicaid Services (CMS).

What is RMTS

RMTS will be the time survey methodology California and DHCS will implement for school claiming units. RMTS is a time sampling methodology for claiming through a LEC or LGA for Medi-Cal Administrative Activities (SMAA) reimbursement in California. DHCS has established an RMTS plan describing the processes and procedures of participation.

The RMTS method polls selected TSPs on an individual basis at random time intervals on a quarterly basis and totals the results to determine the work effort for the entire population of

TSPs over that quarter. Each RMTS moment is randomly assigned and each TSP has equal opportunity to be selected. Some TSPs may be selected multiple times in a quarter and others may not be selected at all.

The RMTS process is a web-based system. An RMTS-paper-based method will only be accepted for claiming units that do not have access to electronic information systems (EIS) or that have policies that restrict the use of such systems.

Administrative Structures for RMTS Participation

DHCS reserves the right for final approval of all RMTS Administrative Units in the state. The state will require three types of Administrative Units: one for LECs; one for LGAs; and one for LAUSD. Each LEC/LGA in the state that participates in the SMAA program will maintain a viable universe of potential TSPs in order to establish a sample pool or pools of TSPs from which a statistically valid random sample can be derived. LECs/LGAs will work with the claiming units to identify the appropriate staff for inclusion in the universe of potential TSPs according to DHCS policy.

Some LECs may choose to join together with other LECs and some LGAs may choose to join together with other LGAs in groups known as “consortia” in order to share the costs and duties of preparing the quarterly time surveys. LECs may not join together with LGAs and LGAs may not join together with LECs for the purpose of creating a consortium. If a consortium is formed, a single point of contact will need to be identified to communicate with DHCS on all matters concerning the consortium’s RMTS issues. The member LECs/LGAs of each consortium will need to develop and maintain a sample pool(s) consisting of all eligible staff from all of the participating claiming units within the consortium. All consortia must be developed and identified three months prior to the beginning of the State Fiscal Year (SFY). DHCS must receive the notice of the details of each consortium no later than April 1 and must submit notification of approval no later than July 1. A consortium will not be approved in any other quarter. Should the consortia dissolve at any time, the single point of contact must notify DHCS within 60 days. All DHCS notifications of approval shall automatically renew annually unless a consortium has provided a 60 day notice to dissolve the consortia.

Before the beginning of the fiscal year, LECs/LGAs must submit a Condition for Consortium RMTS Participation (Condition) letter agreeing to all processes and procedures described in this plan if they wish to participate. Upon DHCS review and approval, the Condition letter will be accepted as a complete collaborative RMTS plan and the LEC/LGA will be considered a qualified participant of the RMTS methodology.

The condition letter to be submitted to DHCS must include:

- The specific LECs/LGAs participating in the consortium
- The individual designated as the single point of contact for DHCS
- All contracts between entities, including sub-recipient entities
- The process for oversight of all RMTS activities
- A detailed list of all job classifications that comprise each sample pool

While a consortium will combine LECs or LGAs for the purpose of creating a viable sample pool that can create a statistically valid random sample of moments, the claiming units will continue to individually invoice DHCS through their respective LEC/LGA. DHCS will continue to enter into signed agreements with the individual LECs/LGAs and not enter into any agreement(s) with any consortium as a whole.

Each quarter's survey moments will be randomly distributed among the consortium's claiming unit participants. All of the claiming units within the consortium that have satisfied the established participation standards, will use the quarter's RMTS results for calculations on their individual claiming invoice to be submitted to DHCS.

Implementation of RMTS

Each LEC/LGA or consortia, and LAUSD are responsible to staff their individual RMTS programs with administrators and a minimum of two central coders and one senior coder. LEC or LGA may collectively choose to design and implement their own RMTS system software platform or may contract with Consulting Firms / Vendors of their choice to assist in the development of an RMTS system design and the implementation of the RMTS processes. The following are examples of necessary components for an RMTS system designed by LEC/LGA staff or Consulting Firms are:

- Establish a compliant web-based random moment generation and sampling system.
- Establish a system for manual, or hard copy, participant responses for use in claiming units that do not have access to, or have policies preventing the use of, Electronic Information Systems (EIS).
- Develop an online participant tutorial that will be fully operational prior to the first quarter of implementation.
- Develop training materials for participants who must use the hard copy system.
- Develop, implement, and complete a training plan for the Central Coders regarding the mechanics of coding.
- Establish efficient and effective RMTS office operations, including inter-coder reliability and quality assurance procedures.

Prior to the first quarter of a new system platform, pre-testing the RMTS system will be done prior to the first quarter. Testing of the sampling process will be designed to resolve any misinterpretations or system problems before the official time survey is conducted. The steps taken for pre-testing the RMTS system performance will be well documented and placed in the audit binder.

RMTS System Software Platform

RMTS is a computer-based system that utilizes the Internet to generate and catalog time survey moments. The computer software that is used for RMTS is referred to as a system software platform (SSP). DHCS reserves the right for final approval of all RMTS SSPs in the state. The state will approve three SSP types: one type for all LECs; one type for all LGAs; and one type for the Los Angeles Unified School District (LAUSD). All claiming units will utilize the SSP approved by their respective LEC/LGA or consortia. LAUSD will maintain its own independent SSP.

Before the LEC/LGA can begin their RMTS system, they will identify how many claiming units will participate, the estimated number of eligible SMAA participants in each claiming unit, and the method of contact from the RMTS staff to each claiming unit personnel department for verification of human resource, payroll and electronic information systems access issues. At this stage, as many of the variables as possible will be identified so that subsequent modifications to the system design are kept to a minimum.

SSP Standards

The standards for the SSP software include but are not limited to:

- Software must accommodate real time access for senior coder(s) to correct any errors.
- Must be able to provide DHCS real-time access to system operations and all RMTS data;
- Must be an Internet-based system and include the ability to generate a hard copy moment and the ability to manually input the hard copy moment responses into the system;
- Must provide a standardized reporting format;
- Must provide a built-in locking mechanism for time survey samples generated by participants, all coding activity, and all communications between coders and participants regarding clarifying questions.

Time Survey Participants (TSP)

All claiming units that participate in the time survey will identify allowable Medi-Cal direct service and administrative costs within a given claiming unit by having staff who spend their time performing reimbursable activities participate in a quarterly time survey. For purposes of this implementation plan, individuals receiving compensation from claiming units for their services are termed TSPs. TSPs may not include individuals such as parents or other volunteers who receive no compensation for their work. This is referred to as “in-kind compensation.”

DHCS has identified and approved appropriate job classifications as TSPs for inclusion in the RMTS. Additions to the list will be dependent upon job duty equivalency, similar credential, licenses, or certification and will require DHCS approval. LECs/LGAs will develop and submit a TSP equivalency list to DHCS no later than 45 calendar days prior to the beginning of a new quarterly time survey.

Beginning with the January 2015 Quarter, the LEC/LGA will begin using the two participant pool methodology. All claiming unit staff in the Participant Universe will be reported into one of two participant pools: Participant Pool 1 “Direct Service and Administrative Providers” and Participant Pool 2 “Administrative Services Providers Only”. **The two participant pools are mutually exclusive, i.e., no claiming unit staff should be included in both pools.**

The following pages provide an overview of the eligible job categories in each cost pool. As a part of their regular job functions, the claiming unit staff with job classifications listed in Participant Pool 1 are eligible to provide Direct School-Based Services through the LEA Medi-Cal Billing Option Program as well as activities reimbursable under the SMAA Program. The individuals listed in Participant Pool 1 will meet the provider credential and license requirements necessary to provide direct School-Based services.

Claiming unit staff with job titles in both Participant Pool 1 and 2 are not automatically included in the time survey as a TSP. A claiming unit must determine whether the individual performs SMAA reimbursable activities and if they are less than 100% federally funded. Individuals that are 100% federally funded (excluding resource 5640) will be excluded from the time survey.

Mutually exclusive time survey will be conducted for Participant Pool 1 and 2. Although some staff may perform both direct services and SMAA related activities, they will only be allowed to participate in one of the two pools. Each time survey has two (2) Participant pools that are made up as follows:

- Participant Pool 1 is comprised of direct service staff, including those who conduct both, direct services and administrative claiming activities as well as direct service only staff, and the respective costs for these staff. These costs include staff time spent on billing activities related to direct services.
- Participant Pool 2 is comprised of administrative claiming staff only and the respective costs for these staff. Staff should be included in Cost Pool 2 only if they perform allowable Medicaid administrative activities on a regular basis.

Participant Pool 1 (Direct Service & Administrative Providers)

1. Audiologist with a valid credential
2. Certified nurse practitioner
3. Credentialed school counselor
4. Credentialed school psychologist
5. Credentialed school social worker
6. Licensed audiologist
7. Licensed clinical social worker
8. Licensed educational psychologist
9. Licensed marriage and family therapist
10. Licensed optometrist
11. Licensed physician/psychiatrist
12. Licensed physical therapist
13. Licensed psychologist
14. Licensed registered nurse, including registered credentialed school nurse and certified public health nurse
15. Licensed speech-language pathologist
16. Licensed vocational nurse
17. Program specialist
18. Registered school audiometrist
19. Registered occupational therapist
20. Speech-language pathologist with a valid credential
21. Trained health care aide
22. Other positions approved by CMS for the LEA Medi-Cal Billing Program State Plan Amendment

Participant Pool 2 (Administrative Service Providers Only)

1. Coordinator- various selected positions (Medi-Cal, Mental Health, Speech, Nursing, etc.)
2. Director- various selected positions (Mental Health, Speech, Nursing, etc.)
3. Education Aides
4. Health Care Advocate
5. Health Center Manager
6. Health Services Special Education Teachers
7. Instructor, Orientation and Mobility (visually handicapped)
8. Interpreters & Interpreter Assistants
9. Medical Administrative Coordinator / Assistant
10. Medical Assistant
11. Medical Interns
12. Office Technician, Sr. Office Technician
13. Organization Facilitator
14. Orientation & Mobility Specialist

15. Parent Community Facilitator / Liaison
16. Placement Assistant
17. Principal and /or Assistant Principal
18. Principal at Special Education Schools
19. Professional Expert
20. Pupil Support Services Administrators
21. Pupil Support – Technicians
22. School Bilingual Assistants
23. Secretary, Sr. Secretary
24. Sign Language Interpreter
25. Special Education Administrators
26. Special Education Assistant
27. Special Education – Support Technicians
28. Student Support Services Coordinator / Case Manager
29. Teacher- various selected positions (special ed, alternative ed, resource, SDC)
30. Translator; Sr. Translator
31. Transportation Planner / Router
32. Other groups/individuals that may be approved by DHCS

Part of the LEC/LGA review process is to ensure that all of the eligible claiming unit staff are included in the universe of potential TSPs. Each quarter the claiming units will certify and upload the universe of potential TSPs to the PCG software and will submit to the LECs/LGAs a TSP roster of staff eligible to participate in the RMTS process. . The LEC/LGA will also certify each TSP. Each eligible staff member is placed into the appropriate participant pool. The entire list of eligible claiming unit staff from all participating claiming units in a particular LEC/LGA is included in the universe of potential TSPs. Claiming units can only claim costs for TSPs that were included in the approved universe of TSPs. For TSPs not on the approved list, see PPL 15-025 and Appendix D.

Prior to the beginning of a quarterly time survey, DHCS will access the SSP and review the list of all TSPs for a given LEC/LGA or Consortium. If all job classifications comply with federal regulations, DHCS will issue an approval letter at least 14 calendar days prior to the beginning of the next quarterly time survey. If specific job classifications do not comply with federal regulations, DHCS will request a justification be submitted by the LEC/LGA or Consortium for the non-compliant job classifications before the TSP list can be certified for the next quarterly time survey. Once DHCS has approved a TSP list, the LEC/LGA or Consortium must certify the TSP list in the software system prior to the beginning of the next quarterly time survey.

At the end of the quarter, a financial schedule is sent to the claiming units to report allowable costs for all eligible staff. The list sent to the claiming units will only include the eligible staff that were identified and approved at the beginning of the claiming process. Claiming units can only claim costs for TSPs that were included in the approved universe of potential TSPs. The LEC/LGA can compare the lists of eligible claiming unit staff against the list used in the

universe of potential TSPs. This list should be a match since all TSPs submitted by the claiming units are included in the universe of potential TSPs.

TSP Equivalency Lists

The TSP Equivalency list will identify specific job classifications that perform duties that are substantially similar to those job classifications on the approved TSP lists. DHCS will have final approval of requests for exceptions to the list of approved job classifications. Requests for exceptions to the list of approved job classification must be submitted or made available to DHCS no later than forty-five (45) calendar days prior to the beginning of a new quarterly time survey. A completed TSP Equivalency form that includes a detailed justification must be submitted along with copies of any duty statements to meet the requirements of the job categories listed on the approved job classifications list. The TSP Equivalency Form can be found in Appendix H. Each LEC and LGA will maintain an equivalency list for the LEAs within its service region for job classifications that are substantially similar in duties and responsibilities to those listed in Participant Pools 1 & 2. DHCS will issue quarterly reports to CMS no later than 6 months after the end of the quarter regarding all exceptions to the approved job classification list. This report will include a listing of each claiming unit that is operating with approved exceptions, as well as the number and type of positions for each approved exception.

Roster Report

Claiming units must submit an annual roster report along with quarterly updates to their respective LEC/LGA RMTS representative. Copies of the annual Roster Report and associated quarterly updates must be maintained in the audit file for that particular claiming unit. The roster report must be updated and approved quarterly prior to the beginning of each RMTS quarter. If changes are necessary for the annual roster report, modifications to this report may be made on a quarterly basis. The LEC/LGA must establish a deadline for claiming units to submit their quarterly roster reports (modified or unmodified) prior to the beginning of each quarter in order to have sufficient time to calculate the universe of eligible moments for each quarter. Fourteen calendar days prior to the beginning of the next quarter, the roster report for that quarter is closed and no further modifications to a claiming unit's roster may be made. The roster report includes, but is not limited to, the following information:

- Participant's base work schedule—all work days and hours;
- Participant Names;
- Employee ID#'s- employee number (if applicable);
- Job classification;
- Email addresses- must be district email, not private email;
- School Calendar;

Time survey Start and End Dates

All paid work days that students are in regular session are included in the potential days to be chosen for RMTS. Each quarter, district calendars will be reviewed by the LEC/LGA to determine those dates that the schools pay for their staff to work, and those dates will be included in the RMTS sample. School calendars will be evaluated on an annual basis and the sample dates will be determined and documented.

Sampling Requirements (RMTS)

In order to achieve statistical validity, maintain program efficiencies and, reduce unnecessary claiming unit administrative burden, a consistent sampling methodology for all activity codes and groups will be used. The RMTS sampling methodology is constructed to achieve a level of precision of +/- 2% (two percent) with a 95% (ninety-five percent) confidence level for activities. This is in accordance with the CMS Medicaid School-Based Administrative Claiming Guide of May 2003.

Statistical calculations show that a minimum sample of 2,401 completed moments each quarter, per cost pool, is adequate to obtain this precision when the total pool of moments is greater than 3,839,197. The minimum sample of 2,401 moments plus a fifteen percent oversample for a total of 2,761 moments per participant pool will be the threshold to establish a viable pool of sample moments for all Administrative Units.

Additional moments are selected each quarter to account for any invalid moments in order to ensure each Administrative Unit achieves the 85% compliance rate of valid moments necessary for a statistically valid sample. Invalid moments are moments in which a TSP did not provide a response within the 5 student attendance day timeline.

The following formula is used to calculate the number of moments sampled for each time survey cost pool:

$$ss = \frac{Z^2 * (P) * (1-P)}{c^2}$$

Where: Z = Z value (e.g. 1.96 for 95% confidence level)
p = percentage picking a choice, expressed as decimal
(.5 used for sample size needed)
c = confidence interval, expressed as decimal
(e.g., .02 = + or - 2)

CORRECTION FOR FINITE POPULATION

Where:

pop = population

$$\text{new ss} = \frac{ss}{1 + \frac{ss-1}{pop}}$$

N is equal to the total pool of “moments” within the time survey and is represented by calculating the number of working days in the sample period, times the number of work hours of each day, times the number of minutes per hour, and times the number of participants within the time survey. The total pool of moments for the quarter is reduced by the exclusion of weekends, holidays and hours during which employees are not scheduled to work.

The following table shows the sample sizes necessary to ensure statistical validity at a 95% confidence level and tolerable error level of 2%. Additional moments will be selected to account for unusable moments, as previously defined. An over sample of 15% will be used to account for unusable moments.

N=	Sample Size Required	Sample Size plus 15% Oversample
100,000	2345	2697
200,000	2373	2729
300,000	2382	2739
400,000	2387	2745
500,000	2390	2749
750,000	2393	2752
1,000,000	2395	2754
3,000,000	2399	2759
>3,839,197	2401	2761

RMTS Process and Notification

The RMTS process is described here as four steps:

1. Identify total pool of TSPs;
2. Identify total pool of time survey moments;
3. Randomly select moments and randomly match each moment to a TSP;
4. Notify TSPs about their Selected Moments.

Identify Total Pool of Time Survey Participants - The TSP Universe

At least 14 calendar days prior to the beginning of quarter two and each subsequent quarter, LECs/LGAs and LAUSD must certify to DHCS, a staff roster providing a comprehensive list of all claiming unit staff eligible to participate in the RMTS. This list of names will be known as the TSP Universe.

The TSP Universe will be grouped into job categories (that describe the job function), and each job category will be assigned into one of two mutually exclusive participant pools for each claiming unit participating in the time survey. The TSP Universe must be approved by DHCS prior to a claiming unit’s participation in RMTS for that quarter.

The TSP Universe document must be submitted, or made available electronically, to DHCS no later than 14 calendar days before the quarter begins.

Identify Total Pool of Time Survey Moments

The total pool of “moments” within the time survey is represented by calculating the number of working days students are in session in the sample period, times the number of work hours of each day, times the number of minutes per hour, and times the number of TSPs within the TSP Universe. The total pool of moments for the quarter is reduced by the exclusion of weekends, holidays and hours during which employees are not scheduled to work.

The Total Pool of Time Survey Moments document must be submitted, or made available electronically, to DHCS no later than 14 calendar days before the quarter begins.

Randomly Select Moments and Randomly Match Each Moment to a Participant

Once compiled, each participant pool is sampled to match TSPs with moments in the RMTS time survey. The sample is selected from each participant pool, along with the total number of eligible time survey moments for the quarter. Using a statistically valid random sampling technique, the desired number of random moments is selected from the total pool of moments. Next, each randomly selected moment is matched up, using a statistically valid random sampling technique, with a TSP in the TSP Universe.

Each time the selection of a minute and the selection of a name occurs, both the minute and the name are returned to the overall sample pool to be available for selection again. In other words, the random selection process is done with replacement so that each minute and each person are available to be selected each time a selection occurs. This step guarantees the randomness of the selection process.

Each selected moment is defined as a specific one-minute unit of a specific day from the total pool of time survey moments and is assigned to a specific TSP. Each moment selected from the pool is included in the time survey and coded according to the documentation submitted by the TSP.

The sampling period is defined as the three-month period comprising each quarter of the SFY calendar. The following are the quarters followed for the SMAA program:

- Quarter 1 = July 1 – September 30 (Average of Q2 – Q4)
- Quarter 2 = October 1 – December 31
- Quarter 3 = January 1 – March 31
- Quarter 4 = April 1 – June 30

Moments pulled and matched with TSPs for each quarter will be referred to as the Master Moments List. This will include the claiming unit identifying information, the name of each participant selected for the time survey and the date and time of the moment selected for that participant. LECs/LGAs/Consortia will maintain this list in a secure location for each claiming unit. In addition, each Master Moment List will be submitted by the LEC/LGA and LAUSD to DHCS when it is generated, in advance of the start of the quarter and no later than the first day of the quarter, for DHCS quality assurance and monitoring purposes.

The majority of claiming unit staff work a traditional school year. Since the time survey results captured during a traditional time survey are reflective of any other activities that would be performed during the summer quarter, a summer quarter time survey will not be conducted. Claiming units will use an average of the three (3) previous quarters (Quarter 2, October-December, Quarter 3, January-March, and Quarter 4, April-June) time survey results to calculate a claim for the Quarter 1 (July-September) period. This is in accordance with the May 2003 CMS Medicaid School-Based Administrative Claiming Guide, page 42. Specifically:

“...the results of the time survey performed during the regular school year would be applied to allocate the associated salary costs paid during the summer. In general, this is acceptable if administrative activities are not actually performed during the summer break, but salaries (reflecting activities performed during the regular school year) are prorated over the year and paid during the summer break.”

Notify TSPs about their Selected Moments

Email is the standard method by which TSPs are notified of their requirement to participate in the time survey and of their sampled moment. TSPs will be notified of their sampled moment no more than five (5) student attendance days prior to the sampled moment. After the occurrence of the moment, each TSP is asked to record and submit his/her activity for that particular moment. Throughout this entire process, the claiming unit's SMAA coordinators and DHCS have real-time access in the SSP to view their TSP roster, the dates/times of their TSP's moments, and whether or not the moment has been completed. Moments close after 5 student attendance days, which means TSPs will not be able to complete their moment after that time. If the return rate of valid moments is less than 85% then a sufficient number of invalid moments will be coded as non-reimbursable in order to achieve the minimum of 2,401 moments for a valid sample and to achieve the 85% compliance rate..

The LECs/LGAs and DHCS will have the ability to run real time compliance reports that are comprehensible and provide individual claiming unit compliance rates, overall time survey results, moment status and other required information for program compliance . A validity check of the time survey results is completed each quarter prior to the calculation of the claim. The validity check ensures that the minimum number of responses is received each quarter to meet the required RMTS confidence level. The number of completed and returned time survey moments is analyzed to confirm that the confidence level requirements have been met. Once the validity of the sample has been confirmed, the time survey results are calculated and prepared for the calculation of the quarterly claim.

RMTS Hard Copy Option

Subject to LEC/LGA approval, claiming units that have TSPs who cannot access email due to district policy or lack of Internet access, equipment or software, will be given the option to access a hard copy RMTS moment. This will also apply if there is a disruption to internet access that will impede the participants' ability to respond. The LEC/LGA must be informed of a TSP's need to receive a hard copy RMTS moment when a claiming unit submits their TSP Universe to ensure approval and delivery of the printed moment to the TSP, if selected. In order to ensure the moment response is entered into the SSP within the required 5 student attendance day timeline, the moment, certified by the TSP, must be returned to the LEC/LGA within 3 student attendance days of the moment. This provides sufficient time to input the response into the SSP. Communication of the certified moment between the TSP and the LEC/LGA may be accomplished via fax, telephone, or in-person. Whichever method of communication is selected, the LEC/LGA/LEA must maintain a record of the hard copy moment, and the actual date and time the certified moment was delivered. Regardless of the method of communication, all information must be input into the system by the LEC/LGA no later than 5 student attendance days from the occurrence of the moment.

Training and Overview

LEA SMAA Coordinator Training (RMTS)

DHCS must approve all RMTS training material used by the LEC/LGA. The LECs/LGAs will perform annual training for the claiming unit SMAA coordinators, which will include an overview of the RMTS software system and information on how to access and input information into the system. It is essential for the SMAA coordinators to understand the purpose of the time survey process, the completion of the RMTS methodology, the timeframes and deadlines for participation, and that their role is crucial to the success of the program. In addition, the annual training will cover topics SMAA such as SMAA program updates, process modifications and compliance issues. All training materials will be accessible to SMAA coordinators.

Central Coding Staff Training (Activity Coding)

DHCS will provide annual training for the Central Coding staff. The training will include an overview of the activity codes and a set of sample responses for each code. Additionally, training will include a detailed description of the similarities and differences in parallel and non-parallel codes discussed in Section 4, SMAA Overview. Central Coder training will also include a discussion of the proper procedure for contacting the TSPs timely for clarifying questions for unclear responses, and an understanding of the importance of avoiding leading questions when asking those clarifying questions.

TSP Training

time survey Training for TSPs will be incorporated into the moment documentation portion of the RMTS SSP so sampled staff will have to review the information prior to documentation of their sampled moment. The TSP training will not include an overview of activity codes since all coding will be completed by Central Coders. The following items must be included in TSP training:

- Overview of the SMAA program;
- Overview of the required process to participate in RMTS;
- Review the standards for RMTS documentation submitted by TSP; and
- Response process by TSP to respond to a clarifying question.

Documentation of Sampled Moments

All documentation of sampled moments must be sufficient to provide answers to the time survey questions needed for accurate coding:

- Who were you with? (**Remember not to list proper names*)
- What were you doing?
- Why were you performing this activity?

In addition, each TSP will certify the accuracy of their response prior to submission. TSPs are assigned a unique identifier from the RMTS web link that connects the TSP to the moment. After answering the documentation questions, they are shown their responses and asked to certify that the information they are submitting is accurate. Their moment is not completed unless and until they certify the accuracy of the information. Since the TSP only has access to their information, this conforms to the electronic signature policy and allows them to verify that their information is accurate. Once the TSP has certified their moment, the sample is locked in the SSP and cannot be altered. The TSP may provide clarification through the SSP to a coder if requested, but the initial sample is never altered.

Time Survey Return Compliance

DHCS will require an 85% response rate from all TSPs within a particular RMTS universe within the approved timeframe. If the return rate of valid moments is less than 85% then, a sufficient number of invalid moments will be pulled and coded as non-allowable (Code 1) to achieve the minimum number of moments to attain a valid sample. To ensure that enough moments are received to have a statistically valid sample, each LEC/LGA/Consortia must over sample at fifteen percent (15 %) more moments than needed for a valid sample size. TSPs must submit completed moments within five student attendance days after the sampled moment has passed.

If a claiming unit has 5 or fewer TSPs and more than 50% of their total moments for a quarter are returned as invalid, the LEA Coordinator will receive a warning letter from their LEC/LGA noting the non-compliance and possible sanctions that may be imposed by the LEC/LGA. The

claiming unit's Superintendent or equivalent will be copied on all warning letters sent to the LEA Coordinator.

Allowability	Allocable	Description
Application of FFP rate	50 percent	Refers to an activity that is allowable as administration under the Medi-Cal program and claimable at the 50 percent non-enhanced FFP rate.
Allowability & Application of Medicaid Share	U	Unallowable – refers to an activity that is unallowable as administration under the Medi-Cal program. This is regardless of whether or not the population served includes Medi-Cal eligible individuals.
	TM	Total Medicaid – refers to an activity that is 100 percent allowable as administration under the Medi-Cal program.
	PM	Proportional Medi-Cal – refers to an activity, which is allowable as Medi-Cal administration under the Medi-Cal program, but for which the allocable share of costs must be determined by the application of the proportional Medi-Cal share (the Medi-Cal percentage). The Medi-Cal share is determined as the ratio of Medi-Cal eligible students to total students.
	R	Reallocated – refers to those general administrative activities which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under Code 16, General Administration.

The following time survey codes are to be used for the Random Moment Time survey:

Time Survey Activity Code Table	
Code	Activity
CODE 1	School-Related, Educational, and Other Activities (U)
CODE 2	Direct Medical Services (U)
CODE 3	Non-Medi-Cal Outreach (U)
CODE 4	Medi-Cal Outreach (TM/50-percent FFP)
CODE 5	Facilitating Application for Non-Medi-Cal Programs (U)
CODE 6	Facilitating Medi-Cal Application (TM/50-percent FFP)
CODE 7	Referral, Coordination, and Monitoring of Non-Medi-Cal Services (U)
CODE 8	Referral, Coordination, and Monitoring of Medi-Cal Services (PM/50 percent-FFP)
CODE 9	Transportation for Non-Medi-Cal Services (U)
CODE 10	Arranging Transportation in Support of Medi-Cal Services (PM/50-percent FFP)
CODE 11	Non-Medi-Cal Translation (U)
CODE 12	Translation (PM/50-percent FFP)
CODE 13	Program Planning, Policy Development, and Interagency Coordination Related to Non-Medi-Cal Services (U)
CODE 14	Program Planning, Policy Development, and Interagency Coordination Related to Medi-Cal Services (PM/50-percent FFP)
CODE 15	Medi-Cal Claims Administration, Coordination (TM/50-percent FFP)
CODE 16	General Administration/Paid Time Off (R)
CODE 17	Not Working / Not Paid (U)
CODE 18	Invalid (U)
Code 19	No Response (U)

Coding of Random Moments

The LEC/LGA will utilize a centralized coding methodology. Under that methodology, the TSP will not code his or her moment. The TSP is asked to document their activity for that moment by answering the specific questions. After answering the questions, the TSP is asked to certify their documentation and submit.

The Central Coding Staff must be LEC/LGA employees or be employed by the LECs/LGAs under a personal services contract (PSC), or be employed by an agency or organization that holds a service contract with the LEC/LGA to provide RMTS Coding services. If Central Coding Staff are employed by the LECs/LGAs under a PSC, the individual(s) may not hold or be employed by an agency that holds any other contracts that relate to RMTS or the RMTS process. An agency or organization that holds a service contract with the LEC/LGA to provide RMTS Coding services, may not hold any other contracts with the LEC/LGA that relate to RMTS or the RMTS process. The methodology followed by LEC/LGA in the use of Centralized Coders will be a two-tier, two-coder system, comprised of, at a minimum, two primary coders (Tier 1) and one senior coder (Tier 2). The purpose of the two-tier, two-coder system is to have independent review of the moment responses to verify coding. A senior staff member (senior coder) is required to verify the results and resolve any differences in the codes assigned by the primary coders. The LEC/LGA will assign the primary coders, whose roles will be to review the moment response of the TSP and use the information provided to determine the appropriate activity code to assign to the moment response. The primary coders will not communicate with each other during the primary coding assignment.

The senior coder is a more experienced staff member and is also assigned by the LEC/LGA. The role of the senior coder is to:

1. Review a minimum 10% random sample of moment response(s) of the TSP and the code(s) assigned by the primary coders to ensure the correct code was assigned to the moment response; however, the senior coder could override the codes of the primary coders at any time he/she identifies a coding error prior to invoicing. Software must accommodate real time access to allow senior coder(s) to correct any errors.
2. Resolve any discrepancies with code assignments; and
3. Review all clarifying questions to ensure the questions do not lead the TSP to a specific response.
4. The senior coder could override a code assignment even if the two central coders agree on a code.

The senior coder will inform the primary coders of any moments they feel were coded incorrectly. If the senior coder does not feel there is enough information to determine the activity code then the senior coder may contact the TSP for additional information; however, TSPs may only be contacted twice per moment response for clarification. Clarifying Questions

(CQs) by the senior coder will be issued to the TSP within 15 LEC/LGA business days of the moment response from the date the time survey participant completed their moment response. All moments are coded using the activity codes and examples as outlined in this plan in Section 5 and on the Time Survey Activities Codes Table in Section 6-15. All communications between central coding staff and TSPs related to coding of moments must be through the System Software Platform (SSP) and be included with the sample and coding.

Note: Coders should be mindful of LEA calendars and time frames when sending CQs

Random Moment Time Study (RMTS) Clarifying Question (CQ) Procedure

The methodology adopted by LEC/LGA in the use of Centralized Coders will be a two-tier, two-coder system, comprised of, at a minimum, two primary coders (Tier 1) and one senior coder (Tier 2). The purpose of the two-tier, two-coder system is to have multiple sets of eyes independently reviewing the moment responses to verify coding. The LEC/LGA will assign the primary coders, whose roles will be to review the moment response of the Time Study Participant (TSP). The primary coders will use the information provided by TSP to determine the appropriate activity code to assign to the moment response. The primary coders will not communicate with each other during the primary coding assignment. A senior coder is a more experienced staff member and is also assigned by LEC/LGA. The senior coder is required to verify the results and resolve any differences in the codes assigned by the primary coders. The senior coder could override the codes of the primary coders at any time when a coding error is identified.

The role of the senior coder is to:

1. Review a minimum 10% random sample of moment response(s) of the TSP and the code(s) assigned by the primary coders to ensure the correct code was assigned to the moment response;
2. Resolve any discrepancies with code assignments; and
3. Review and submit all clarifying questions to ensure the questions do not lead the TSP to a specific response.

The senior coder will inform the primary coders of any moments they feel were coded incorrectly. If the senior coder does not feel there is enough information to determine the activity code then the senior coder may contact the TSP for additional information; however, TSPs may only be contacted twice per moment response for clarification. Clarifying Questions (CQs) by the senior coder will be issued to the TSP within 15 calendar days from the date the TSP completed their moment response. All moments are coded using the activity codes and examples as outlined in this manual in Section 5. All communications between central coding staff and TSPs must be through the System Software Platform (SSP) and be included with the sample and coding.

Note: Coders should be mindful of summer break timeframes when sending CQs in the 4th quarter

Clarifying Questions

CQs must be open-ended questions and not leading questions that encourage a specific response from the TSP. The senior coder may pose no more than two (2) CQs per-moment response. In the event a TSP does not provide enough information to determine the appropriate activity code, a CQ may be posed to the TSP by the senior coder and must be relayed to the TSP through the SSP. CQs are posed to the TSP in order for the TSP to provide additional information about the activity performed at the time of the sampled moment so coding can be completed.

Clarifying Question (CQ) Procedure

1. Primary coder A reviews the moment response, assigns an activity code if the TSP response provides sufficient information. If necessary, the primary coder suggests a CQ within the system for the senior coder.

Primary coder B reviews the moment response, assigns an activity code if the TSP response provides sufficient information. If necessary, the primary coder suggests a CQ within the system for the senior coder.

Note: If the primary coders assign codes that match and a CQ is not necessary, coding for that moment response is complete. The primary coders DO NOT have access to view the codes assigned by other primary coders.

2. Once both primary coders have reviewed the moment and either assigned a code or entered a CQ into the system, the moment is available for the senior coder to make a determination if the assigned codes do not agree or one of the primary coders have suggested a CQ.
3. The senior coder reviews the moment response and any suggested CQs entered into the system by the primary coders and either assigns a code from the information that is available or sends a CQ to the TSP.
4. Once the TSP responds to the CQ(s) or the CQ expires the moment is placed back into the coding queue for the primary coders to review and code.
5. Primary coder A reviews the moment response and assigns an activity code if the moment response and the CQ response provides sufficient information. If necessary, the Primary Coder A enters a final CQ suggestion into the system.

Primary coder B reviews the moment response and assigns an activity code if the moment response and the CQ response provides sufficient information. If necessary, Primary Coder B enters a final CQ suggestion into the system.

6. Once both primary coders have reviewed the moment response and either assigned a code or entered a CQ into the system, the moment is available for the senior coder to make a determination if the assigned codes do not agree or one of the primary coders have suggested a CQ.
7. The senior coder reviews the moment response and the CQ responses and any additional CQs suggested by the primary coders and either assigns a code from the information that is available or sends the final CQ to the TSP. The TSP shall not receive more than two CQs per moment.
8. Primary coder A reviews the moment response and assigns an activity code.

Primary coder B reviews the moment response and assigns an activity code.

Once both coders have reviewed the moment response and assigned a code, the moment is available for the senior coder to make a determination if the assigned codes do not agree.

9. The code assigned by the senior coder is the final code (subject to review by the LEAs and final approval by DHCS).
10. The TSP must respond to CQ(s) within 5 student attendance days from the date the CQ was transmitted.

Note: All CQs must be transmitted during normal business hours - 8:00am to 5:00pm Monday through Friday.

11. If the TSP does not respond to the CQ(s) within 5 student attendance days and the primary coders do not agree, the senior coder will determine the final code based on the information available.

The RMTS web-based system will collect and store all RMTS moments. The LEC/LGA are responsible for monitoring the moments ensuring that they are responded to, completed, and coded in a timely manner but no later than 15 calendar days after the end of the quarter. Central coders will access completed moments and assign the appropriate activity codes described above. DHCS will have real-time access to the RMTS system to spot check coding activity, the quality of clarifying questions, and coding accuracy.

1. Activity Codes

The California SSMAA program captures activities performed by selected participants. The activities are allocated into (17) 19 activity codes; both reimbursable and non-reimbursable.

2. Avoiding Duplication of Payment

All LECs/LGAs are required to provide assurances of non-duplication to DHCS that they do not claim Federal Financial Participation (FFP) for the costs of allowable administrative activities that have been or should have been reimbursed through an alternative mechanism or funding source.

3. Coding Responsibilities

The RMTS design has removed the responsibility of assigning sample activities to the correct activity code from the participant and placed the responsibility upon the central coding team. The central coding team will consist of at least two RMTS staff who will individually code each random moment separately, known as dual coding, to ensure that sample moments are assigned to the correct activity code. Central coders will log in to a secure RMTS system using their unique, authorized user identification and password to access and code the sample moments. All activities made by any user to a sample moment must be documented and maintained in the RMTS system for tracking purposes. A response completed within the required time frame, and linked to the participant's paid time is considered a valid moment. All valid moments must be used to calculate the time survey results for the quarter.

When the LEC/LGA is calculating the quarterly RMTS results, the denominator for determining the percentage of time reported to each code will be all valid responses linked to paid employee time. The numerator will be the number of valid random moments reported.

Invalid moments are moments not received within the required time frame (5 student attendance days). The RMTS system will not allow participants to answer the standard three questions after the sample expiration deadline; however, the sample moment may be categorized by the LEC/LGA/LEA Coordinator prior to moment expiration as one of the following:

- 1) Working and did not respond timely
- 2) Was on paid time off
- 3) Was on unpaid time off

Verification of paid/unpaid time off must be reconciled, after the occurrence of the moment or before final invoicing, with the specific district's payroll systems and supporting documentation retained. If paid/unpaid time off is unverifiable, the response will be coded as invalid, thus making it an invalid moment. If the 85% compliance rate is not met, a sufficient number of invalid moments will be coded as non-reimbursable in order to achieve the minimum of 2,401 moments for a valid sample.

Moments that occur during a participant's unpaid time off, cannot be counted in the RMTS results because they are not attached to an employee's costs and must be coded as

invalid. An additional activity code specifically for moments that fall within a participant's unpaid time off was created (code 17) in the RMTS coding matrix for tracking purposes.

4. Central coders have these duties and guidelines to follow:
- All coding will be consistent with the reasonableness standards contained in Title 2 Code of Federal Regulations (CFR) Part 225 Appendix A (C)(2), the California SMAA manual and adhere to all State approved activity codes.
 - All central coders will review the information provided in the responses to the questions by the sampled RMTS participant and determine the appropriate activity code.
 - For the purposes of quality control, all completed random moments will be dually coded by two central coders. Discrepancies in coding will be identified, reviewed, and resolved by the senior coder or RMTS Administrators.
 - If insufficient information is provided to determine the appropriate activity code, the senior coder will contact the participant via the SSP, to pose a clarifying question about the moment. For manual system users the coder will contact the participant's supervisor to have the question passed on to the participant.
 - Senior coders must ensure they do not lead participant responses when asking clarifying questions.
 - Central coders must ensure that all contacts and actions made regarding a moment are electronically recorded and stored.
 - Once a clarifying question has been answered, the moment is coded and included in the final time survey percentage calculation.

Quality Assurance Process

LEC/LGA Review Process

The RMTS system will randomly select, at a minimum, 10% of all coded moments and clarifying questions each quarter for quality assurance code reviews by the LEC/LGA. Quarterly quality assurance sample reviews must be conducted prior to finalizing the quarterly results. Reviews entail 1) that the TSP answered their moment completely; 2) the accuracy of the assigned code; 3) any coding errors are corrected by the senior coder; and 4) the coders are not posing leading questions to the participants.

Each LEC/LGA will submit the quarterly quality assurance sample results to DHCS prior to finalizing the results

For quality assurance measures, the LEC/LGA and DHCS has the discretion to sample a greater percentage of randomly selected coded moments or clarifying questions. Further actions to ensure coder reliability may be required if the LEC/LGA and DHCS finds that more frequent comprehensive quality assurance reviews are needed.

The LEC/LGA will also conduct quality assurance reviews on at least 10% of the clarifying questions asked by the central coders to ensure participants were not asked leading questions. Each quarter a summary report of the LEC/LGA quality assurance reviews will be prepared, placed in the LEC/LGA audit file, and submitted to DHCS. DHCS and CMS may

review the electronic RMTS records, summary reports, participants' responses, clarifying questions, and the assigned code for any random moments throughout the quarterly time survey process.

It is the LEC/LGA responsibility to ensure that the RMTS process is effectively promoted throughout their region/county claiming units to establish a well-supported RMTS foundation and to secure the RMTS process's longevity. Claiming unit participation is essential to the quarterly invoice. Each claiming unit is dependent on all other participating claiming units within their LEC/LGA Consortium to respond timely in order for activities to be included in the SMAA invoice.

The LECs/LGAs are also required to review the invoice and perform cost analyses of all invoice documents to ensure that all costs that are input into the invoice meet the standards for Certified Public Expenditures and are composed of the nonfederal share of all salary and benefit costs.

LEC/LGA Reporting of Coding Data

For each quarterly time survey period for which random moments are assigned, within 30 days of coding being finalized for the quarter, each LEC/LGA will make available to the claiming units in their region that make up the participant universe the results of the claiming unit's TSP responses to the random moments that were generated and the final codes that were assigned to each response by the TSPs in that claiming unit. Each claiming unit will have 30 days to review the coding data to ensure accuracy, and submit corrections to the LEC/LGA. For any specific coding assignment for which the claiming unit and LEC/LGA are unable to resolve the appeals process may be utilized. LEC/LGA will have 30 days to respond to any appeals submitted. The appeals process may be found on the SMAA website at ; http://www.dhcs.ca.gov/provgovpart/Documents/ACLSS/SMAA/SMAA_Appeal_PPL_14-006.pdf

DHCS Review Process

In order to ensure the quality assurance process is applied with statewide consistency, DHCS will randomly select a minimum 10% sample of all coded responses and clarifying questions issued during the quarter. The random nature of the selection of coded moments and clarifying questions helps to maintain the consistent application of the quality assurance process statewide. A representative from DHCS will validate the 10% subsample. The validation process will consist of reviewing the TSP responses, the corresponding code assigned by LEC/LGA, primary coders and/or senior coders and the clarifying questions asked by the coders to determine: 1) if the assigned code accurately reflects the activities performed by the TSP; 2) if the activities performed were necessary for proper administration of the state plan; 3) that no direct medical services provided were coded to a SMAA reimbursable code; and 4) that the clarifying questions posed to participants were not leading questions. When all of the subsample responses and coding have been verified, DHCS will identify and discuss any disagreements with the LEC/LGA. After the discussion on coding, a consensus must be

met in order for the code to be approved by DHCS. DHCS holds final approval for all coding decisions. .

At the end of each quarter, once all random moment data has been received and time survey results have been calculated, and approved by DHCS, statistical compliance reports will be generated by the LECs/LGAs to serve as documentation that the sample results have met the necessary statistical requirements.

Site Visits/Desk Reviews - DHCS will perform site visits on a minimum of three LECs and three LGAs each year. These Site Visits consist of a review of two claiming units and invoices for two fiscal years and include SMAA Coordinator, central coder, and fiscal staff in-person interviews, and a complete review of the audit binders for all invoices covered by the review. When state budget restrictions prohibit staff travel, desk reviews will be substituted for site reviews and use the same criteria.

Invoice Analysis – DHCS reviews each invoice submitted for reimbursement. The review process involves scrutiny of the Activities and Medi-Cal Percentages Worksheet, the Roster Report, the Cost and Revenue Worksheet, the Payroll Data Collection Worksheet, to ensure compliance with the standards set in the SSMAA Manual. If DHCS determines that an invoice does not comply with the standards set out in the SSMAA manual, the invoice will be returned to the LEC/LGA for further LEA review and compliance and federal funds will not be claimed.

Claiming Unit / LEA Participation Standards

A key factor to a successful RMTS is having the full support of the District Superintendents or other Executive Administrative Officials for the process. It has been demonstrated that with District Officials promoting RMTS, eligible SMAA staff are reminded of the significance of their role and importance of their participation in the process which provides increased incentive to respond to their moment. This support alone will help maximize the return response rate, therefore increasing funding to reimburse the schools.

The LEA SMAA Coordinator needs to develop a process to ensure each TSP is aware of the date and time of their moment and the benefits of their participation to their school. If an TSP has been selected for random moments and does not participate, they cannot submit an invoice for that quarter due to non-participation in the quarterly time survey. They may still be included in the next quarter sample universe if the LEA wants to continue RMTS participation. The SMAA Coordinator may need to provide additional training or outreach to their TSPs to ensure compliance.

However, if an LEA continues to have a high non-response rate, they may be rejected to participate in RMTS by their LEC/LGA beginning the next fiscal year. The LEA must assure the LEC/LGA that efforts have been made to increase participant compliance to be considered to participate in the next RMTS cycle.

Averaging

The sample universe is limited to student attendance days. Since the first quarter of the fiscal year, July 1-September 30, is traditionally the bulk of the summer vacation for most school districts, this quarter must be an averaged quarter when using the RMTS methodology. The first quarter averaged invoice will include the time survey results from the previous three quarters of the prior fiscal year. Random moments should not be generated during the first quarter at any time, except for testing purposes only and are not to be included in the quarterly invoice.

Since the first quarter is an averaged quarter for RMTS, a claiming unit cannot begin participation in the RMTS TSP universe until the second quarter of that SFY. Claiming units that did not participate in RMTS during the previous three quarters of the previous fiscal year cannot submit a first quarter averaged invoice.

Note: During the transition from worker log to RMTS, claiming units may submit their own averaged first quarter invoice using the prior three worker-log quarters to claim for SMAA reimbursement only if none of the three were averaged quarters.

Financial Data

The financial data to be included in the calculation of the SMAA claim are to be based on actual expenditures incurred during the quarter. These costs must be obtained from actual detailed expenditure reports generated by the claiming unit's financial accounting system. 45 CFR 7545 CFR Part 75 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards specifically defines the types of costs that can be included in the program (direct costs, indirect costs, and allocable costs). These principles can be applied when establishing the allowability or unallowability of certain items of cost, and whether a cost is treated as direct or indirect. The following items are considered allowable costs as defined in 45 CFR 75.

Direct Costs

- Compensation (salary and benefits) of employees
- Cost of materials acquired, consumed, or expended
- Equipment
- Travel expenses incurred

Indirect Costs

The indirect cost rate is developed by the claiming units' state cognizant agency, the California Department of Education (CDE), and is updated annually. The methodology used by the respective state cognizant agency to develop the indirect rates has been approved by the cognizant federal agency, as required by the CMS guide. Indirect costs are applied to the total SMAA allowable costs. The LEC/LGA will ensure that costs included in the SMAA financial data are not included in the district's indirect cost rate, and no costs will be accounted for more than once.

Non-SMAA Cost Pool

Costs that may not be included in the claim are:

- Direct costs related to staff that are not identified as eligible TSPs (i.e., costs related to teachers, cafeteria, transportation, and all other non-School Based administrative areas)
- Costs that are paid with 100 percent federal funds, excluding SACS resource code 5640 that is used for reporting the allocation of federal revenue, by DHCS, to seek reimbursement for cost of Medi-Cal covered services delivered by LEA providers for the LEA Medi-Cal billing Option Program.
- Costs included in the indirect cost rate work sheet (Indirect Costs Numerator) calculation.
- Any costs funded out of function codes 7120, 7190, 7200-7600, 7700, 8100-8400 and 8700. These costs are already included in the Indirect Cost Rate (ICR) numerator.

Allocated Cost Pool

Costs include general and administrative staff in the claiming unit who were not included in the time survey moments, whose costs are not direct charged, and by the nature of their work support the staff in the other cost pools.

Revenue Offsets

The purpose of offsetting revenue or funding against cost is to ensure that the Federal Government participates in its share of the costs only once. Failure to offset federal revenues and state/local matches of federal programs against the costs incurred would result in these costs also being applied to the claim for FFP. The claiming agency would be participating in less than its share by supplanting its share of costs with the federal or other unallowable revenue.

In general, funds that do not require offset include claiming unit general funds, other local public funds, and SMAA reimbursements. The following rules govern which revenues received by a program must be offset against costs before a federal match is determined.

1. **Federal Revenues**. All federally funded costs shall be offset against claimed costs. Including these amounts in the costs claimed for reimbursement will cause the Federal Government to not only fund these costs, but to also pay the Medi-Cal percentage on those amounts, and therefore pay for the same costs twice, which is prohibited by 45 CFR 75 .
2. **Matching Revenues**. Claimed costs funded by state/local matching funds required by a federal grant must be offset. 45 CFR 75 stipulates that a cost used to meet a matching or cost-sharing requirement of one federal grant may not also be included as a cost against any other federal grant. State/local match funds become federal monies, carry the same restrictions as the federal funds, and must be identified accordingly.

3. Previously Matched Revenues. All costs funded by State General Fund monies previously matched by the Federal Government must be offset because the Federal Government has already funded these costs. This includes Medi-Cal fee-for-service money, similar to item 2.
4. Private Health Insurance. Insurance collected from nongovernmental (private health insurance) sources for the delivery of direct client services may not be used as the local share of a federal match for administrative activities. These funds must be offset if the related expenses are included in the SMAA invoice.

Essentially, revenue offsets are costs funded by one of the above revenue sources that may not be claimed for reimbursement from the Federal Government because the Federal Government has already directly or indirectly funded those costs. Therefore, these costs must be removed to avoid billing the Federal Government twice for the same cost.

Claiming units will only be reimbursed the non-federal share of any SMAA billings. The Chief Financial Officer (CFO), Chief Executive Officer (CEO), Executive Director (ED), Superintendent (SI) or other individual designated as the authorized signer by the claiming unit will be required to certify the accuracy of the submitted claim and the availability of matching funds necessary. The certification statement is part of the invoice and will meet the requirements of 42 CFR 433.51.

Claiming units are required to maintain documentation that appropriately identifies the certified funds used for SMAA claiming. The documentation must also clearly illustrate that the funds used for certification have not been used to match other federal funds. Failure to appropriately document the certified funds could result in non-payment of claims.

Documentation Requirements

It is required that all SMAA claiming units maintain documentation supporting the administrative claim. The claiming units must maintain and have available upon request the contract with the LEC/LGA to participate in the SMAA program. Documentation must be available upon request by the LEC/LGA, state or federal entities. The quarterly requirements are outlined below.

Each participating claiming unit will maintain a quarterly file in a ready-to-review format containing, at a minimum, the following information:

- A roster of eligible individuals, by participant pool, submitted for inclusion in the TSP Universe;
- Financial data used to develop the expenditures and revenues for the claim calculations including state/local match used for certification;
- Documentation of the district's approved indirect rate (if applicable);
- A copy of the completed and signed invoices; and
- Documentation supporting the calculations for the Medi-Cal percentage.

LECs/LGAs are required to use and distribute any materials provided by DHCS regarding the time survey. LECs/LGAs will maintain a quarterly audit file containing, at a minimum, the following information:

- List of centralized coders used in the RMTS with certified training verification;
- RMTS Master Moment list identifying each moment by participant name and job class;
- Electronic documentation of completed random moments including all communication with TSPs;
- Calculation of RMTS response rate;
- RMTS results data; and
 - Report of corrected coded moments
 - Records of appealed moments and outcomes
- Quarterly reports on quality assurance review of a minimum of 10% sample and clarifying questions.

Record Retention

Federal regulations require that all records in support of the SMAA invoice must be maintained for a minimum of five fiscal years after the end of the quarter in which the LEC/LGA receives reimbursement from the DHCS for the expenditures incurred. If an audit is in progress, or is identified as forthcoming, all records relevant to the audit must be retained throughout the audit's duration, or the final resolution of all audit exceptions, deferrals, and/or disallowances whichever is greater. All records retained must be stored ready-to-review in an Audit File-sorted by quarter; these files must be available to LEC/LGA, State and federal reviewers and auditors upon request in accordance with record retention requirements set forth under Title 42 of the Code of Federal Regulations (CFR), Section 433.32. Similarly, the documents that support the construction of a SMAA claim must be kept five years after the last claim revision.

Oversight and Monitoring

Federal guidelines require the oversight and monitoring of the administrative claiming programs. This oversight and monitoring must be done at the DHCS, LEC/LGA and claiming unit level.

DHCS Level Oversight and Monitoring

DHCS is charged with performing appropriate oversight and monitoring of the time survey moments and SMAA program to ensure compliance with state and federal guidelines and to ensure the program is implemented consistently across the State. DHCS has a contract with the LEC/LGA. The contract will clearly state all parties' responsibilities.

DHCS will monitor and review various components of the SMAA program operating in the State. The review includes, but not limited to:

- TSP Universe List – To ensure only eligible staff are reported on the TSP Universe list based on the approved RMTS cost pools in the implementation plan.
- RMTS Time survey – sampling methodology, the sample, and time survey results.
- Master Moment List – review of Master Moment list submitted for each Administrative Unit prior to the initiation of the quarter and compare with the RMTS time survey results to assess alignment with reported participant and moment selection and actual reported samples.
- RMTS Central Coding – review at a minimum a 10% sample per quarter of the completed coding and clarifying questions for all RMTS universes.
- Training – Compliance with training requirements for TSPs, program coordinators, and central coders.
- Financial Reporting – Costs are only reported for eligible cost categories and meet reporting requirements.
- Documentation compliance.

Frequency

DHCS will have real-time read-only access to all RMTS software. LECs/LGAs will be continuously monitored through the RMTS software. DHCS will conduct site visits or desk reviews at least once every three (3) years. For this monitoring process, two claiming units and invoices for two fiscal years will be selected for in-depth review. Participating LECs/LGAs will be required to fully cooperate in providing information and access to necessary staff in a timely manner to facilitate these efforts.

For all quarters, trends will be examined (e.g. total costs in the claim, time survey results, and reimbursement levels).

LEC/LGA Level Oversight and Monitoring

Training regarding RMTS

- Ensure claiming unit SMAA Coordinator has participated in required RMTS training.
- Review of RMTS compliance rate, ensure each claiming unit meets the 85% compliance level requirement.
- Ensure claiming unit coordinator understands how critical response rate is per claiming unit and that the claiming unit is aware of non-compliance consequences.

Roster

- Receive electronic updated roster from claiming unit.
- Review updated roster to validate TSPs are accurately placed in the correct cost pools.

- Ensure that the individual claiming unit rosters are updated and maintained quarterly into a SSP with all other participating claiming units.

Time Survey Tasks

- Randomly select TSPs from the participant universe of eligible participants and assign each TSP to an individual moment from the pool of eligible moments to establish a Master Moments list.
- Maintain confidentiality of Master Moment List.
- Notify selected TSPs no sooner than five student attendance days prior to their selected moment and on the day of the moment.
- Timely review of TSP responses to the random moment questions and assign SMAA codes.
- Develop and send clarifying questions to TSPs if necessary for the determination of the appropriate time survey code.
- Quality check coded time survey data through a random sample review.
- Review all time survey for the quarterly report. .

Financial Tasks

- Conduct financial training with claiming units, as needed.
- Advise claiming unit to maintain all source documentation for the invoice(s).
- If necessary, resubmit invoice to LEC/LGA for revisions.

Miscellaneous Tasks

- Participate in LEC/LGA and DHCS Advisory Committee meetings.
- Answer general questions from claiming units throughout the quarter.
- Submit quarterly SMAA claim to DHCS to conduct quality assurance reviews to assure program integrity.
- Serve as liaison between claiming units and DHCS.

Local-Claiming Unit Level Oversight and Monitoring

Each claiming unit participating in the SMAA program must take appropriate oversight and monitoring actions that will ensure compliance with SMAA program requirements.

Actions must be taken to ensure, at a minimum, that:

- The time survey is performed according to DHCS guidelines and requirements.
- The time survey responses are completed in the required timeline.
- The financial data submitted is true and correct.
- Appropriate documentation is maintained to support the time survey and the claim.

Roster

- Prepare and submit rosters to the LEC/LGA as required. Failure to provide this information in the time frame allowed will result in the claiming unit not being able to participate for that quarter

Financial Tasks

- Prepare and submit financial information for the SMAA claim to LEC/LGA
- Obtain annual indirect cost rate (ICR) from the CDE
- Obtain Medi-Cal Percentage (MP) (Semiannually) from DHCS.

Required Personnel

Each claiming unit must designate a claiming unit employee as the claiming unit's coordinator or SMAA program contact. This single individual is designated within the claiming unit to provide oversight for the implementation of the time survey and to ensure that policy decisions are implemented appropriately. The claiming unit coordinator cannot be affiliated with or employed by a consultant/consulting firm or vendor.

Direct-Charging in Lieu of Time-Surveying

Staff that perform SMAA Program Coordination, Claims Administration and Fiscal Coordination (Code 15) are not required to time-survey. However, to qualify for direct charge reimbursement, participants must certify 100 percent of their time spent on these activities and be able to provide documentation that supports this percentage. Documentation should include the method of keeping time records. Ongoing time records or logs would provide a good audit trail and would allow the claiming unit to claim for actual costs, which might vary each quarter. All direct charge certification documentation/calendars, must be tracked on an on-going basis and must be signed by the direct charge participant and the direct charge participant's supervisor. These costs are separately itemized on the Direct Charge Worksheet and included in the audit file maintained by the LEA.

An overhead or indirect rate, established according to 45 CFR 75 principles, may be applied to personnel expenses. *Note: Staff who perform multiple SMAA activities other than the administration of the program cannot direct charge.*

The SMAA Operational Plan (OP) requires the retention of job descriptions showing that SMAA Medi-Cal Coordination, Claims Administration are part of the job of persons whose costs are direct-charged. Claiming units that have "generic" job descriptions for job classifications are required to justify the specific SMAA-related responsibilities. Related operating expenses can also be direct-charged. Examples might include travel to SMAA-related training, computer equipment or programming expenses, or training materials. Claiming units using service bureaus or consultants to assist in SMAA Coordination, Claims

Administration may direct-charge these expenses. These items must be included in the SMAA OP.

Note: Costs that are direct-charged on the SMAA invoice must not be included in other sections of a SMAA claim.

Indirect Costs

Indirect costs for LEAs

Per 45 CFR 75, indirect costs are those: (a) incurred for a common or joint purpose benefiting more than one cost objective; and (b) not readily assignable to the cost objectives specifically benefited, without effort disproportionate to the results achieved. The term “indirect costs” as used herein, applies to costs of this type originating in the grantee department, as well as those incurred by other departments in supplying goods, services, and facilities. To facilitate equitable distribution of indirect expenses to the cost objectives served, it may be necessary to establish a number of pools of indirect costs within a governmental unit department or in other agencies providing services to a governmental unit department. Indirect costs pools should be distributed to benefited cost objectives on basis that will produce an equitable result in consideration of relative benefits derived.

DHCS will provide oversight and monitoring of indirect cost rates to ensure that costs are allowable according to 45 CFR 75. In cases where the indirect cost rate is greater than 10 percent, DHCS will conduct a review to determine whether the indirect cost rate is reasonable and allowable and maintain documentation of the review. DHCS may limit the indirect cost rate to 10 percent if the costs included in the indirect cost rate are unreasonable, unallowable, and/or contain formulas in calculating the indirect cost rate that are flawed.

Indirect costs may only be claimed if there is an indirect cost rate approved by the cognizant agency responsible for approving such rates. With respect to school-based administrative costs, the cognizant agency is the U.S. Department of Education or its delegate. The United States Department of Education (ED) has approved a delegation agreement with the California Department of Education (CDE) that authorizes the CDE, as the cognizant agency, to establish indirect cost rates for California's local educational agencies (LEAs). These rates are established annually after LEAs submit their year-end financial data. The rates for each LEA are published on the CDE website (<http://www.cde.ca.gov/fg/ac/ic/>).

The invoice used by all LEAs in California to claim federal reimbursement for their SMAA activities limits the amount of indirect costs that may be claimed to the percentage approved annually by the CDE. There are no other indirect cost rates applied to the invoice, and no other indirect costs are claimed except for what is captured through the application of the indirect cost rate.

California School-Based SMAA Manual

SECTION

Audit File

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Record Keeping and Retention

Overview

The foundation of SMAA claiming is the time survey sampling. Federal regulations require that all records in support of allowable SMAA activities must be retained for a minimum of five fiscal years after the date of payment for that claim. This documentation includes time survey documentation, secondary documentation, and direct charge certification. Similarly, those documents that support the construction of a SMAA claim must also be kept for five fiscal years after the date of payment for that claim. These documents include the documentation that supports the Medi-Cal percentage, the basis of the cost pools, and job descriptions/duty statements for all staff performing SMAA. All records retained must be stored ready-to-review in an Audit File/Operational Plan (OP). The time survey documentation and OP must be kept at the claiming unit that is easily accessible.

If an audit is in progress, or is identified as forthcoming, all records relevant to the audit must be retained throughout the audit's duration, or the final resolution of all audit exceptions, deferrals, and/or disallowances whichever is later. These records must be available to State and federal reviewers and auditors upon request in accordance with record retention requirements set forth under Title 42 of the Code of Federal Regulations (CFR), Section 433.32. .
SMAASMAA

Building and Maintaining an Audit File/Operational Plan

Each claiming unit must develop an Audit File/Operational Plan beginning the first quarter in which a time survey is conducted. A checklist, found in Page 7-2, has been developed to assist the claiming unit in this task. Documentation is necessary to respond to audit inquiries, especially in the absence of the specific staff who were responsible for the time survey or the SMAA claim.

Documents to Include in the Audit File/Operational Plan

This section provides information on how to prepare and assemble the required documentation for each claiming unit's Audit File/Operational Plan. The term "operational plan" (OP) replaces the term "claiming plan" and includes the audit documents in support of each invoice.

Pursuant to 45 CFR 75, each claiming unit must develop and maintain an audit file of comprehensive documents in support of the invoice prior to its submission to DHCS. The OP components are subject to review by the LEC/LGA, DHCS, and/or CMS upon submission of the invoice. The OP becomes the audit file and must include but is not limited to:

- **Copies of the annual Roster Report and associated quarterly updates.**
- **Job Descriptions /Duty Statements** that match the job classifications identified on the Roster Report.
- **Medi-Cal Percentage** documentation used in the discounted codes.

- **Contracts/MOUs** for SMAA services provided by personnel who are included on the Roster Report and/or whose costs will be included in the invoice, all Vendor contracts, and the LEC/LGA SMAA contract.
- **Invoice Documents** to support all claims on the invoice, including paid time off (PTO).
- **Organization Charts** that show the relationships of TSPs, as entered in the invoice.
- **Resource Directories** used to help participants access Medi-Cal services.
- **DHCS approved outreach material and a copy of the DHCS approval letter.**

Audit File/Operational Plan Checklist

The checklist on the following page provides a guide to determine what to include in the audit file when claiming SMAA. The list is general in nature and is not intended to be all-inclusive.

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RMTS Training Materials	
LEC/LGA	Evidence of SMAA training for SMAA Coordinators including training materials and attendance sheets
LEC/LGA	Evidence of annual training for Central Coders indicating the date, location, and trainers
LEA	Copy of online tutorial for RMTS participants
RMTS Time Survey Data	
LEC/LEA	Participant list, by job class, included in the RMTS and time survey cost pool of the invoice (i.e., sample universe of employees)
LEC	List of centralized coders used in the RMTS
LEC	RMTS master list identifying each moment by participant name and job class
LEA	Documentation of completed random moments
LEC	(same documents below)
LEC	Documentation for shift/work hours for participants
LEC	RMTS results data
LEC	Quarterly report on quality assurance review of 10% sample
Duty Statements	
LEA	A duty statement describing the current duties and responsibilities for each job class in the RMTS sample universe that describes their approved scope of work, including SMAA and non-SMAA activities
Invoice Documents	
Both	SMAA Summary Invoice and detailed invoice including the following:
Both	Activities Percentages and Medi-Cal Eligibility Rate Worksheet
Both	Time Survey Summary Report
Both	Copy of the Indirect Cost Rate from the CDE website
Both	Direct Charges Worksheet
Both	Documentation of direct charges
Both	Payroll Data Collection Worksheet
Both	Payroll Data Collection & Other Summary Sheet (maintain actual staff ledger reports)
Both	Costs and Revenues Worksheet
Both	Supporting documentation
Both	Roster Report (Olive: What are the contents of this Roster Report? Or is only a change in name?)
Both	SMAA
Both	SMAA
Both	Tape match calculations
Contracts	
Both	Contract or Memorandum of Understanding (MOU) between the LEA and the LEC/LGA for SMAA participation
Both	Contract or Memorandums of Understanding (MOUs) with contracting agencies and providers, including personal service contracts
Agency Documents	
LEA	Organizational charts that show the supervision responsibility of staff in SMAA claiming down to the level of the clerical staff whose costs are included in the invoice

Both	School calendar(s)
Resource Directories	
Both	Documents used to promote Medi-Cal that directly relate to surveyed time for such activities. Should include DHCS approved flyers, announcements & other materials pertaining to Medi-Cal. Provide a statement that gives the locations where these materials will be maintained for future DHCS and CMS review

Quality Control

The Claiming Unit Coordinator is the first level of review to ensure that the OP is complete and accurate. This includes ensuring the completeness and accuracy of the invoices, and thorough documentation to support the OP.

The LEC/LGA SMAA Coordinator is the second level of review. Review at this level should include continuous training, site visits, desk reviews, and review of the claiming unit OP to ensure accuracy, reasonableness, and completeness. The LEC/LGA SMAA Coordinator is also responsible for receiving all invoices in his or her region/county, checking to ensure accuracy, reasonableness, completeness, and submitting them to DHCS.

DHCS is the third level of review and will monitor and review various components of the SMAA program operating in the state. The areas of review include, but are not limited to:

- TSP Universe List – ensure only eligible cost pools of staff are reported on the TSP Universe list based on the approved RMTS cost pools in the implementation plan.
- RMTS Time Study – sampling methodology, the sample, and time study results.
- RMTS Central Coding – review at a minimum a 10% sample per quarter of the completed coding.
- Training – Compliance with training requirements: program contact, central coder and claiming unit staff.
- Financial Reporting – Costs are only reported for eligible cost categories and meet reporting requirements.
- Documentation compliance.

Frequency

DHCS will have real-time read only access to all RMTS software.

LECs/LGAs will be monitored at least once every three (3) years. This monitoring will consist of either an on-site, desk, or combination review. For this monitoring process, two claiming units and invoices for two fiscal years will be selected for in-depth review. Participating LECs/LGAs will be required to fully cooperate in providing information and access to necessary staff in a timely manner to facilitate these efforts.

All quarters, trends will be examined (e.g. total costs in the claim, time study results, and reimbursement levels).

- Desk reviews will be conducted periodically. These may include any combination of the following, and the backup documentation to support it:
 - Training Materials
 - Time Survey Materials
 - The Roster Report(s)
 - Job Descriptions
 - Medi-Cal Eligibility Rate
 - Contracts/MOUs
 - Backup Documentation to the Invoice
 - Organization Charts
 - Resource Directories

Site reviews may be scheduled as a result of findings from desk reviews.

- Site reviews will be conducted on a rotational basis. DHCS will perform a site review in a minimum of three LECs and three LGAs annually. These will be extensive, and will include, OP reviews, Roster Report(s) reviews, and invoice reviews. DHCS will review documentation that supports the invoice – which may include, but is not limited to, all of the items on the Audit File/Operational Plan Checklist.

If a review results in an invoice overpayment, DHCS will require a check from the claiming unit in the amount of the overpayment. Additional steps may be required, such as additional training, procedure changes, and internal audits.

California School-Based SMAA Manual

SECTION 8

SMAA Contracts

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Contract Requirements

For a LEC/LGA to claim reimbursement for SMAA, Welfare and Institutions Code 14132.47(b) requires that the LEC/LGA have a contract with DHCS, the single state agency for administering the Medicaid program. This document is called the SMAA Contract.

Lateral Agreements/Memorandums of Understanding

The SMAA contract is designed so the LEC/LGA may act on behalf of claiming units claiming reimbursement for SMAA. Claiming unit's intending to seek reimbursement through SMAA must have a similar agreement or contract with the LEC/LGA that holds the DHCS contract. Its language mirrors the DHCS contract so that other participating agencies may be held to the same terms and conditions set forth in the contract between DHCS and the LEC/LGA. A claiming unit may only contract with the regional LEC or LGA. A cohort/offsite program of a community college must bill through the region in which its fiscal agent is located.

Administrative Fees Charged to Claiming Units

LECs and LGAs participating in the SMAA program must monitor invoices to ensure that administrative fees they charged to their claiming units are not reported by both the LEC/LGA and claiming unit. The cost of activities included on the SMAA invoice may only be claimed by one entity if they are on the LEC/LGA invoice; they must not be claimed on other invoices, such as the claiming unit or subcontractor claiming unit invoices. If they are claimed on the individual claiming unit or subcontractor invoices, they must not also be claimed on the LEC/LGA invoice. Allowable administrative costs are described in this manual, in the Medi-Cal Claims Administration, Coordination, and Training section (Code 15)

<http://www.dhcs.ca.gov/formsandpubs/Documents/ACLSS%20PPLs/2006/pp106-001%202-06-2006.pdf>

(See PPL 06-001, available at)

<http://www.dhcs.ca.gov/formsandpubs/Pages/2006PPLs.aspx>.)

Including such fees or activities in more than one entity's invoice would result in duplication of claims for federal financial participation. An example of sound oversight to safeguard against duplication would be:

1. A LEC/LGA conducts SMAA Coordination and Claims Administration and contracts with claiming units/subcontractors that conduct SMAA.
2. The LEC/LGA charges the claiming units/subcontractors an administrative fee for the SMAA costs of its own staff that are associated with the coordination. These costs are claimed on the LEC/LGA invoice.
3. While reviewing the claiming unit/subcontractor invoices, the LEC/LGA notices that the claiming unit/subcontractors include the administrative fee as SMAA

Coordination Costs on the Direct Charges Worksheet, Line 31(d) (School-Based SMAA invoice) or as Other Costs in Cost Pool 6, Line H (SMAA invoice).

4. The LEC/LGA had already identified and included the costs of the activities associated with these administrative fees in its own SMAA invoice.
5. The LEC/LGA returns the SMAA invoice to the claiming unit/subcontractor for correction to delete the administrative fee cost. The administrative fee expense cannot be reported as an expense on the claiming unit/subcontractor invoice.

Alternatively, if the LEC/LGA allows its claiming unit/subcontractors to include in their SMAA invoices the cost of administrative fees charged by the LEC/LGA, then the LEC/LGA must not include in its own SMAA invoice the cost of activities associated with these administrative fees. An example of sound oversight to safeguard against duplication would be:

1. The LEC/LGA conducts SMAA Coordination and Claims Administration and contracts with claiming unit/subcontractors that conduct SMAA.
2. The LEC/LGA charges the claiming unit/subcontractors an administrative fee for the SMAA costs of its own staff that are associated with the coordination.
3. While reviewing the claiming unit/subcontractor invoices, the LEC/LGA notices that the claiming unit/subcontractors include the administrative fee as SMAA Coordination Costs on Direct Charges Worksheet, Line 31(d) (School-Based SMAA invoice) or as Other Costs in Cost Pool 6, Line H (County-Based SMAA invoice).
4. The LEC/LGA does not include in its own SMAA invoice the costs of the activities associated with these administrative fees.

Contract Agencies

LEC/LGAs and claiming units may deliver their services through contract providers or community-based organizations (CBOs). The contract language must reflect the intent of the contract agency to perform some or all of the allowable SMAA activities. Local matching funds that support claims for reimbursement of the cost of providing SMAA must constitute Certified Public Expenditures (CPE); that is, they must come from county or city governments, schools or any other public entities. They may not come from CBOs that are nongovernmental or private agencies. To qualify as a federally reimbursable SMAA expense, the LEC/LGA or claiming unit must have made a CPE in support of SMAA being claimed. CPE can be generally defined as an expenditure of non-federal public funds (defined in federal regulation 42 CFR §433.51) that support the provision of SMAA activities within the claiming unit.

Host Entity: DHCS Contract

The Host Entity, if applicable, is the designated administrative and fiscal intermediary for all LEC/LGA contracts with DHCS to perform administrative activities. DHCS determines each year the staffing requirements upon which the DHCS-projected costs are based. The projected costs include the anticipated salaries, benefits, overhead, operating expenses, and equipment necessary to administer the SMAA program.

The contract requires the host entity to submit invoices to and collect from each LEC/LGA, its portion of the payment for the DHCS-projected administrative costs for which each participating LEC/LGA is liable. Funds are disbursed to DHCS to reimburse the costs incurred by DHCS for the performance of administrative activities. The payments are remitted to the department within 60 days of receipt of the DHCS invoice to the host entity.

Host Entity: LEC/LGA Contract

The Host Entity, if applicable, contracts with the participating LEC/LGA and invoices the LEC/LGA for the annual participating fee. The contract specifies the responsibility of the Host Entity contractors.

Personal Services Contracts

Personal Services Contracts are agreements/contracts for an entity (non-employee) whose contract language does not specify performing SMAA. These staff are treated like district-employed staff and must time-survey. Their job classifications must be identified on the Roster Report(s) and must include a separate duty statement if it differs from those of other claiming staff on the Roster Report(s).

Subcontractor Contracts

Subcontractor contracts are agreements/contracts for entities (non-employees) who conduct specific SMAA on behalf of the claiming unit. The contract must specify the SMAA being conducted and the projected amount of time and cost to perform such activities. When such language exists, staff does not need to time-survey and services can be direct-charged. All subcontractor contracts must include the Catalog of Federal Domestic Assistance (CFDA) number 93.778.

Consultant(s)/Consulting Firms/Vendor(s) Contracts

All costs associated with consultants/ consulting firms/vendor(s) being claimed for reimbursement must be directly attributable to School-Based Medi-Cal Administrative Activities (SMAA).

Contract Amendments

Contracts with DHCS to provide school-based SMAA may be amended.

The required amendment forms must be submitted to DHCS at least 90 days prior to the end of the fiscal year in which the contracted activities were conducted.

These forms must be requested in a timely manner by email or letter addressed to:

Department of Health Care Services
Safety Net Financing - SMAA, MS 4603
P.O. Box 997436, Ste. 71.3024
Sacramento, CA 95899-7436

Department of Health Care Services
Medi-Cal Administrative Claiming Section
School-Based Medi-Cal Administrative Activities Unit
P.O. Box 997436, MS 4603
Attn: (Program Analyst)
Sacramento, CA 95899-7436

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California School-Based SMAA Manual

SECTION 9

Determining the Medi-Cal Eligibility Rate

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Overview of the Approved Methodology	9-1

Definition of the Medi-Cal Eligibility Rate

The Medi-Cal **Eligibility Rate (MER)** is the fraction of a total population that consists of Medi-Cal beneficiaries, as identified on the DHCS Tape Match. The numerator is the number of students that are Medi-Cal beneficiaries, and the denominator is the total number of students.

The only approved methodology is the actual client count (as determined by the DHCS Tape Match). This methodology is described below. The Medi-Cal Eligibility Rate must be calculated **at least** twice per year, once in the 1st and 3rd quarters or once in the 2nd and 4th quarters; this percentage must be reflected in the invoices for those quarters.

(Note: All claiming units that obtain the Medi-Cal Eligibility Rate on a monthly basis should average the MERs within the respective quarters. However, the MER used in the invoice must only be calculated twice per year, either in the 1st and 3rd quarter or the 2nd and 4th quarter.)

Actual Client Count/DHCS Tape Match

The actual client count (obtained through the DHCS Tape Match) is determined by dividing the total number of Medi-Cal beneficiaries by the total number of all individuals served by the claiming unit. The total number of all individuals served by the claiming unit is defined in the operational plan as the target population. The Medi-Cal **Eligibility Rate** is the fraction of a claiming unit's target population that consists of Medi-Cal beneficiaries. To use this methodology, the claiming unit must define the population "served" and identify the Medi-Cal eligibility status of each person.

Overview of the Approved Methodology

The portion of costs that can be claimed as allowable for some SMAA is based on the Medi-Cal **Eligibility Rate**. Costs are reduced or "discounted" by the Medi-Cal **Eligibility Rate** when the activity benefits or involves both Medi-Cal and non-Medi-Cal populations. The Medi-Cal **Eligibility Rate** must be calculated at **no more than twice** per year, once in the 1st and 3rd quarters or once in the 2nd and 4th quarters; this percentage must be reflected in the invoices for those quarters.

The following SMAA codes require discounting by the Medi-Cal **Eligibility Rate**:

- CODE 8 Referral, Coordination, and Monitoring of Medi-Cal Covered Services
- CODE 10 Transportation-Related Activities in Support of Medi-Cal Covered Services
- CODE 12 Translation-Related to Medi-Cal Covered Services
- CODE 14 Program Planning and Policy Development, and Interagency Coordination (PPPD&IC) Related to Medi-Cal Services

$$\text{Medicaid Costs} = \left[\frac{\text{Total Number of MediCal Students}}{\text{Total Number of Students}} \right] \times \text{Costs to be Allocated}$$

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The California School-Based SMAA Manual

SECTION 10

Instructions for Preparing The SMAA Detail Invoice and The SMAA Summary Invoice

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Introduction

The instructions for the SMAA Detail Invoice, with supporting worksheets, and the SMAA Summary Invoice are to be used for the SMAA claiming process. The results of the SMAA Detail Invoice flow into the SMAA Summary Invoice, which is submitted along with the SMAA Detail Invoice. A sample SMAA Invoice is in Appendix B. The SMAA Detail Invoice includes the following documents:

- Moment Count Worksheet
- Activities **Percentages** and Medi-Cal **Eligibility Rate** Worksheet
- Direct Charges Worksheet (participant pool 1)
- Direct Charges Worksheet (participant pool 2)
- Payroll Data Collection Worksheet
- Costs and Revenues Worksheet (participant pool 1)
- Costs and Revenues Worksheet (participant pool 2)
- SMAA Summary Invoice Page
- **Averaging Quarter** Worksheet (participant pool 1)
- **Averaging Quarter** Worksheet (participant pool 2)

The SMAA Detail Invoice integrates the costs and the funding source elements that must be offset to derive the amount of FFP. The amount to be reimbursed is determined when the net costs are factored by the appropriate Medi-Cal **eligibility rate** and activity percentages determined from the time survey.

Before preparing the invoice, review the following documents to ensure you are using the most current information:

- Policy and Procedure Letters (PPLs)
- Operational Plans
- Applicable SMAA Contracts
- The School-Based Medi-Cal Administration Activities (SSMAA) Manual

Before submitting the SMAA Detail Invoice and the SMAA Summary Invoice, the operational plan must be completed and all required materials maintained in an audit file (see Section 7). The information entered on the SMAA Detail Invoice must be consistent with that found on the Roster Report(s) (TSP List) **and Time Survey Summary Report**.

The SMAA Detail Invoice includes a total of four cost pools which are:

1. Time Survey Cost Pool 1 (Participant Pool 1) Direct Service and Administrative Providers
- Time Survey Cost Pool 2 (Participant Pool 2) Administrative Service Providers
2. Non-SMAA Cost Pool
3. Allocated Cost Pool
4. Direct Charge Cost Pool

The first three cost pools are identified on the **Payroll Data Collection Worksheets and subsequently flows into the Costs and Revenues**

Worksheets and the fourth is identified on the Direct Charge Worksheets **and also subsequently flows into the Costs and Revenues Worksheets**. All costs for the claiming unit must be reported on these worksheets. A separate detail invoice must be developed and submitted for each **Claiming Unit**.

*Note: All personal services **and** subcontractor contracts must be noted in the Claiming Unit's operational plan, and the associated costs must be tracked separately if they are coded as a contract service.*

The specific **Medi-Cal Eligibility Rate** and the Time Survey Results Percentages are reported on the Activities **Percentages** and Medi-Cal **Eligibility Rate** Worksheet.

Data should only be entered where indicated by these instructions. Data should **NEVER** be entered in the shaded areas. Doing so will alter the spreadsheet and, therefore, incorrectly calculate the components of the claim, resulting in an erroneous amount of reimbursement. Data to be input is obtained from external sources, such as accounting system reports, **ledgers**, spreadsheets, journals, and payroll records. Only those costs and funding sources applicable to the claiming entity should be included. Once all the **required data** are entered, the spreadsheet will automatically calculate the amount of **reimbursement**.

When prompted to input data into cells of the SMAA Detail Invoice and the data for the claiming unit is zero, the claiming unit should enter "0".

All data entered on the invoice must include documented evidence linking it to the specified cost pool(s) or funding source designation and must be maintained in the audit file. For example, salaries and benefits assigned to staff by entry into either of the time survey cost (participant) pools should be evidenced by payroll documentation to show the expenditure of such salaries and benefits.

How To Enter Percentages

The worksheet cells in which a percentage must be entered are pre-formatted to display as a percent. Use the decimal form when entering percentages. For example:

- 35 percent should be entered as "35"
- 5.5 percent should be entered as "5.5"
- 100 percent should be entered as "100"
- **0.01 percent should be entered as "0.01"**

Rounding

All numbers should be rounded to two decimal points. If the third decimal place is a "5" or higher, round up. Otherwise, round down. For example:

- 35.674 percent should be entered as "35.67"
- 12.075 percent should be entered as "12.08"
- 49.463 percent should be entered as "49.46"

Constructing Cost Pools

For each claimed period, all costs and funding sources of the claiming entity either must be assigned to one of the cost/funding pools or must be direct-charged. The claiming unit has the option of either including all costs and funding for a program or including only those costs and funding amounts for the unit performing SMAA. The second option is only permissible if the costs are in a separate budget unit and can be separately identified. An example might be claiming for school nurses who perform SMAA and whose costs are in a separate budget unit and can be separately identified.

Costs of certain functions, such as payroll, maintaining inventories, developing budgets, executive directions, etc., are overhead and are only allowable through the application of an indirect cost rate. Therefore, they **must not** be included in either the Time Survey Cost (Participant) Pools or the Direct Charge Cost Pool.

Time Survey Cost Pools

Claiming unit staff whose costs should be included in the Time Survey Cost (Participant) Pools consist of the following:

- **Any percentage** of the non-federally funded costs of staff included in the universe of RMTS participants.
(For example, a TSP's salary and benefit costs are 70-percent federally funded and 30-percent funded by other state or local sources. For that TSP, only 30 percent of the salary and benefit costs may be included in the relevant Time Survey Cost Pool.)
- The non-federally funded costs of Personal Services Contractors who time-survey to determine SMAA costs because the contract language is nonspecific as to the SMAA to be performed.

Claiming unit staff whose salary and benefits are 100-percent funded by federal programs **must not be included** in the Time Survey Cost (Participant) Pools. Also, staff positions which costs are included in the numerator of the Indirect Cost Rate (ICR) **MUST** not be included in the Time Survey Cost (Participant) Pools. This includes the costs of salaries and benefits coded to **SACS** Functions 7120, 7190, 7200-7600, 7700, 8100-8400 and 8700. **The Time Survey Costs (Participant) are entered in the Payroll Data Collection Worksheet.**

A TSP may include any individual who may have direct contact with students and provides a SMAA service. This could include, for example, a bilingual school employee who provides interpretation related to Medi-Cal for a non-English-speaking student or a school psychologist who refers students to Medi-Cal-covered services.

Direct Charge Cost Pool

Includes the non-federally funded costs associated with staff **that** did NOT participate in the time survey, and are NOT included in any of the other cost pools. Direct charge costs are entered on the Direct Charge Worksheet and included in the Claiming Unit's Operational Plan. Typically, items to be direct-charged include those items for which the associated costs can be easily identified and tracked on an ongoing basis.

Examples include:

- a. A subcontractor/Personal Services Contractor contract that specifically defines the SMAA activities to be performed and the costs associated with each of those activities.
- b. The costs associated with an employee who may perform only one of the SMAA allowable activities 100 percent of the time.
- c. The costs associated with an employee who may perform multiple allowable SMAA activities, each of which can be easily tracked and identified.
- d. The costs associated with SMAA Coordinators.

Claiming unit staff position/costs are included in the numerator of the ICR MUST not be included in the Direct Charge Cost Pool. This includes the costs of salaries and benefits coded to **SACS** Functions 7120, 7190, 7200-7600, 7700, 8100-8400 and 8700.

Non-SMAA Cost Pool

Includes the costs associated with staff **that** did not participate in the time survey, are not included in any other cost pool, and are not included in the Direct Charge Cost Pool. **Non-SMAA costs are entered on the Payroll Data Collection Worksheet.** Typically, this includes staff providing direct medical services and classroom instruction and staff that are included in the Claiming Unit's indirect cost rate calculation.

Allocated Cost Pool

Costs include **school** and general administrative staff in the claiming unit who did not time survey, whose costs are not direct charged, and by the nature of their work, support the staff in the other cost pools. **These costs are entered in the Payroll Data Collection Worksheet.**

Staff included in the Allocated Cost Pool may include management, secretarial, fiscal, supervisory and clerical staff not included in any other cost pools. Their costs will be allocated to each of the other three cost pools based on each cost pool's ratio of personnel costs to the total personnel costs of those three cost pools.

Invoice Information

The following section contains detailed instructions for completing the school-based SMAA Invoice. The invoice **was created in** an excel workbook and **consists of** eleven tabs. A separate **school-based SMAA** invoice must be **created** and submitted for each **Claiming Unit**. Each tab (numbered 1 through 11) is labeled as follows:

- TAB 1 Moment Count Worksheet
- TAB 2 Activities and Medi-Cal **Percentages** Worksheet
- TAB 3 Direct Charges Worksheet (Participant Pool 1)
- TAB 4 Direct Charges Worksheet (Participant Pool 2)
- TAB 5 Payroll Data Collection Worksheet
- TAB 6 Costs and Revenues Worksheet (Participant Pool 1)
- TAB 7 Costs and Revenues Worksheet (Participant Pool 2)
- TAB 8 SMAA Summary Invoice Worksheet (LEC)
- TAB 9 SMAA Summary Invoice Worksheet (LGA)

- TAB 10 **Averaging Quarter** Supplemental Worksheet (Required for the Averaging Quarter Invoice) (Participant Pool 1)
- TAB 11 **Averaging Quarter** Supplemental Worksheet (Required for the Averaging Quarter Invoice) (Participant Pool 2)

See Appendix B for an example of the SMAA Invoice. **Moment Count Worksheet (TAB 1)**

This worksheet is a moment count summary and breaks down the number of moments sampled by code.

For Participant Pool 1:

1. Enter 2761 for the Total Number of Moments Selected Randomly Prior to the Start of the Quarter.
2. Enter the number of Total Invalid Moments. The Total Valid Moments and the Compliance Percentage will auto populate after steps 1 and 2 are complete.
3. Enter the number of moments for each code. The code percentages will auto populate once all moments have been entered. Please be sure to check that the Total Moments count is equal to the Total Valid Moments count calculated in step 2.

Activities and Medi-Cal Percentages Worksheet (TAB 2)

Rows 1–9: Enter the required information in the unshaded areas.

Row 1: Claiming Unit Name and CDS Code

Note: The name of the Claiming Unit on the SMAA Detail Invoice and attachments must match the name on the Operational Plan.

Row 2: DHCS Contractor (Region)

Row 3: LEC/LGA State Contract number

Row 4: Name of person preparing the form **SMAA**

Row 5: Title of person preparing the form

Row 6: Phone number of person preparing the form

Row 7: Date

Row 8: Contract year/quarter

Row 9: Time Survey Period

Column C, Row 12: Enter the Medi-Cal Eligibility Rate (MER). This MER represents a ratio of Medi-Cal students to total students in the claiming unit. The approved method to calculate the discount percentage is the Actual Client Count (ACC), which the claiming unit must obtain from DHCS in the form of a Tape Match that provides the

actual count of Medi-Cal students **for** a particular claiming unit. The claiming unit must determine this percentage at least twice per year, once in the 1st and 3rd quarters or once in the 2nd and 4th quarters; this percentage must be reflected in the invoices for those quarters. **(Note: All claiming units that obtain the Medi-Cal Eligibility Rate on a monthly basis should average the MERs within the respective quarters. However, the MER used in the invoice must only be calculated twice per year, either in the 1st and 3rd quarter or the 2nd and 4th quarter.** See Section 9 and Appendix C of this manual for additional information on determining a Claiming Unit's Medi-Cal **Eligibility Rate**.

Time Surveys

The purpose of the time survey is to identify the proportion of administrative time allowable and reimbursable under the SMAA program. LECs and LGAs conduct time surveys on a quarterly basis in order for their respective claiming units to be able to participate in the SMAA program. A time survey reflects how workers' time is distributed across a range of activities. It is not designed to show how much of a certain activity a worker performs; rather, it reflects how time is allocated among different activities. Beginning January 1, 2015, the state implemented a Random Moment Time Survey (RMTS) methodology which all claiming units that choose to participate in SMAA will be required to utilize.

Averaging Quarter

The sample universe is limited to every working day that students are in session and considered a paid day for staff. Since the first quarter of the fiscal year, July 1-September 30, is traditionally the bulk of the summer vacation for most school districts, this quarter must be an averaged quarter when using the RMTS methodology. The first quarter averaged invoice will include the time survey results from the previous three quarters of the prior fiscal year. Random moments should not be generated during the first quarter at any time, except for testing purposes only and are not to be included in the quarterly invoice.

Claiming units may join in the RMTS TSP universe with their respective LEC/LGA prior to the second, third or fourth quarter if they meet the quarterly participant submission deadline issued by their LEC/LGA. The claiming unit must provide the LEC/LGA their roster report with all required information and provide assurance they will meet the standards of participation.

Column D: Enter the results of the time survey for **Participant Pool 1** from the LEC/LGA Region or Consortium that represents your LEA by Activity and Code in the unshaded areas of **Rows 10–25**. **Row 26 total percentage** must equal 100%. **If a percentage error occurs, increase or decrease only the Code 1 percentage in order to derive 100% in row 26.** The **formulas in the invoice worksheet** will calculate all other cells automatically.

Column E: Enter the results of the time survey for **Participant Pool 2** from the LEC/LGA Region or Consortium that represents your LEA by Activity and Code in the unshaded areas of **Rows 10–25**. **Row 26** total **percentage** must equal 100%. **If a percentage error occurs, increase or decrease only the Code 1 percentage in order to derive 100% in row 26**. The **formulas in the invoice worksheet** will calculate all other cells automatically.

Row 27: Column D - Enter the number of **Participant Pool 1** TSPs participating in the time survey period.

Row 27: Column E – Enter the number of Participant Pool 2 TSPs participating in the time survey period

Row 28: Enter the Claiming Unit's State Approved Indirect Cost Rate for **the fiscal year covering** the current **time survey** period.

Direct Charges Worksheet (TAB 3 Pool 1 & TAB 4 Pool 2)

Allowable costs for time and resources related to SMAA are determined through either RMTS or separately identified and direct-charged. The purpose of the Direct Charge Worksheet is to capture costs determined through methodologies other than RMTS.

A claiming unit may direct-charge costs only if it identifies those costs in its SMAA Operational Plan. Unlike the costs captured through RMTS, costs to be direct-charged must be tracked on an on-going basis throughout the fiscal year. These costs are separately itemized on the Direct Charge Worksheet and included in the audit file maintained by the claiming unit.

Clerical and supervisory support staff may only be included if they either direct charge or time survey. All participants who direct charge must be included on the Roster Report(s) and TSP list

Seven cost categories of activities may be direct-charged. The type of activity determines whether the Medi-Cal Discount Percentage applies. The seven activities, and whether the Medi-Cal Discount Percentage applies, are as follows:

Non-discounted Direct Charge Activities

1. Medi-Cal Outreach – Code 4 (Row 29 A). Direct charging is allowed for Medi-Cal outreach when performing activities that inform eligible, or potentially eligible, Medi-Cal individuals about Medi-Cal and how to access the program. Examples include, but are not limited to, informing individuals about the Medi-Cal program, developing materials to inform individuals about the Medi-Cal program and how and where to obtain those benefits, or distributing literature about the Medi-Cal program.
2. Facilitating the Medi-Cal Application – Code 6 (Row 30 A). Direct charging is permitted for this activity when helping an individual to become eligible for the Medi-

Cal program. This includes, among other things, related paperwork, clerical activities, training, and travel required to accomplish this end.

Medi-Cal Claims Administration and Coordination only by claiming unit, LEC and LGA – Code 15 (Row 31 A). Direct charging is permitted for the costs of staff performing Medi-Cal Administration, Coordination, and Claims Administration. This includes the time that SMAA claiming unit coordinators and LEC/LGA coordinators spend in training, conferences, or meetings related to the SMAA program. In addition, this category includes administration, such as overseeing, compiling, revising and submitting claims and operational plans; and coordination related to the SMAA program. Similarly, all related paperwork, clerical duties and necessary staff travel is included.

Discounted Direct Charge Activities

3. Referral, Coordination, and Monitoring of Medi-Cal Covered Services – Code 8 (Row 32 A –needs to be corrected when correction is made to the Direct Charges Worksheet). Direct charging should be used to report costs for staff that make referrals for the delivery of Medi-Cal services and who coordinate and monitor the delivery of those services. Related paperwork, clerical activities, and staff travel to perform these activities are also included.
4. Arranging Transportation in Support of Medi-Cal Covered Services – Code 10 (Row 33 A –needs to be corrected when correction is made to the Direct Charges Worksheet). The actual cost of arranging for Medi-Cal Non-Emergency, Non-Medical transportation may be direct-charged. These costs include bus tokens, taxi fares, mileage, etc. Costs reimbursed cover the administrative activities involved in scheduling or arranging specialized transportation. Related paperwork, clerical activities, and staff travel to perform these activities are also included.
5. Translation Related to Medi-Cal Services – Code 12 (Row 34 A –needs to be corrected when correction is made to the Direct Charges Worksheet). Direct charging is allowed for translation-related Medi-Cal services when arranging or providing for translation services to help individuals access and understand treatment and plans of care covered by the Medi-Cal program. Translation services must be provided by or arranged with an individual specifically performing translation functions for the school and it must facilitate access to Medi-Cal covered services. Related paperwork, clerical activities, and staff travel to perform these activities are also included.
6. Medi-Cal Program Planning, Policy Development, and Interagency Coordination – Code 14 (Row 35 A –needs to be corrected when correction is made to the Direct Charges Worksheet). The claiming unit should direct-charge the costs of staff that perform Program Planning and Policy Development 100 percent of their paid time. If performed less than 100 percent, the costs must be determined through the time survey. This activity would include staff time when performing duties associated with the development of strategies to improve the coordination and delivery of medical, dental, and mental health services to school-aged children and when performing collaborative activities with other agencies or providers. Related

paperwork, clerical activities, and staff travel to perform these activities are also included.

7. Medi-Cal Claims Administration and Coordination only by claiming unit, LEC and LGA – Code 15 (**Row 31 A –needs to be corrected when correction is made to the Direct Charges Worksheet**). Direct charging is permitted for the costs of staff performing Medi-Cal Administration, Coordination, and Claims Administration. This includes the time that SMAA claiming unit coordinators and LEC/LGA coordinators spend in training, conferences, or meetings related to the SMAA program. In addition, this category includes administration, such as overseeing, compiling, revising and submitting claims and operational plans; and coordination related to the SMAA program. Similarly, all related paperwork, clerical duties and necessary staff travel is included.

Direct charges for each of the activities above may consist of the following types of costs:

- **Staff Salary.** For the billing period, 100 percent non-federally funded costs of the staff member's salary costs must be identified, as well as the percent of time (Medi-Cal Certified Time Factor) spent on the particular SMAA activity.
- **Staff Benefits.** For the billing period, 100 percent non-federally funded costs of the staff member's benefits must be identified, as well as the percent of time (Medi-Cal Certified Time Factor) spent on the particular SMAA activity.
- **Personal Services Contracts.** If the contract specifically defines the SMAA activity to be performed and the cost for each SMAA activity, the cost for that contract should be direct-charged. Otherwise the contractor should time survey.
- **Other Costs.** The normal day-to-day and monthly operating expenses of the claiming unit that are easily identifiable and tracked on an ongoing basis. Examples include, but are not limited to, items such as supplies, utilities, travel, transportation, training, or printing costs.

When determining which costs are to be direct-charged, remember that those costs cannot appear anywhere else on the SMAA Detail Invoice as this would result in duplicate claiming. In addition, direct charge costs must be identified in the claiming unit's operational plan; otherwise, it may not be direct-charged.

Entering Costs in the Direct Charges Worksheet

All costs to be direct-charged are entered on this worksheet. Data from this worksheet automatically transfers to the Direct Charge Cost Pool on the Costs and Revenues Worksheet.

Tab 3 is for Participant Pool 1 costs only and Tab 4 is for Participant Pool 2 costs only.

Enter costs in the unshaded cells in the appropriate cost column. Separate columns have been provided to record the costs of salaries, benefits, personal services contracts, and other costs as described earlier in this section.

The Medi-Cal Discount Percentage will be automatically applied to the appropriate costs entered on this worksheet based on the activity for which the costs apply.

Personnel Costs

- **Column A:** List the description of each staff member for whom salary and benefits will be direct-charged under the appropriate SMAA activity as defined in the Roster Report(s) and TSP list. For example, enter the costs to be direct-charged for a staff member performing Medi-Cal Outreach in **Row 29a** and a staff member to be direct-charged for facilitating the Medi-Cal application should be entered in **Row 30a**. Also provide a description of each personal service contract charge in this column under the appropriate activity.
- **Column B:** Enter the total gross salary of each staff member for the billing period.
- **Column C:** Enter the Medi-Cal Certified Time Factor for each staff member. The Medi-Cal Certified Time Factor represents the actual amount of time spent by the staff member on the particular activity. The Medi-Cal Certified Time Factor entered for Salary costs will automatically be entered for the corresponding Benefit costs of the staff member.
- **Column G:** Enter the total Gross Benefits of each staff member for the billing period.

Note: The claimable and nonclaimable portion of Salary and Benefit costs will be automatically calculated based on the Medi-Cal Certified Time Factor and the Medi-Cal Discount Percentage where appropriate based on the SMAA activity charged.

Personal Service Contracts

- **Column L:** Enter the costs of personal service contracts to be direct-charged for the billing period in the row corresponding to its description under the appropriate SMAA activity. Claimable and Nonclaimable costs will be calculated automatically based on the Medi-Cal Discount Percentage where appropriate, based on the SMAA activity charged.

Other Costs

- **Column P:** Enter the Other Costs to be direct charged for the billing period in the row corresponding to its description under the appropriate SMAA activity. The invoice automatically calculates Claimable and Nonclaimable costs based on the Medi-Cal Discount Percentage where appropriate, based on the SMAA activity charged.

Payroll Data Collection Worksheet (TAB 5)

The Federal Government requires that actual expenses be reported and may not be based on estimates or encumbrances. Expenses claimed in an invoice must be recognized in a manner consistent with expense recognition method used in an LEA's general ledger.

Identifying total costs for a billing period will require the claiming unit to use and rely on its financial information system and the uniformity of the State's standardized account code structure (SACS). The SACS coding structure will allow the Claiming Unit's costs

to be separated into each of the four cost pools utilizing the four-digit SACS Function code as follows:

Salary and Benefit costs are separated by Participant Pool 1 (Columns A, C & E) and Participant Pool 2 (Columns B, D & F). Participant Pool 1 and Participant Pool 2 costs should not be duplicated.

1. Determining Total Salary Costs

- a. Produce an expenditure report of the claiming unit's salary costs (Objects 1000–2999) for the billing period using only Function codes 1000–9999, excluding **SACS** Function codes 2700 and 7000–7199 and excluding Federal series of **SACS** Resources 3000-5639 and 5650-5999. **Enter the total in Row 36, Column A for Participant Pool 1 and enter the total in Row 36, Column B for Participant Pool 2.** This combination of Object and Function codes will provide the amount of gross nonclaimable salary expenditures for the billing period that belong to the Non-SMAA Cost Pool before **determining** which portion pertains to the Time Survey Cost (Participant) Pool and the Direct Charge Cost Pool.
- b. Produce an expenditure report of the claiming unit's salary costs (Objects 1000–2999) for the billing period using only **SACS** Function codes 2700 and 7000–7199 and excluding Federal series of **SACS** Resources 3000-5639 and 5650-5999. **Enter the total in Row 41, Column A for Participant Pool 1 and enter the total in Row 40, Column B for Participant Pool 2.** This combination of Object and Function codes will provide the amount of gross **school and general administrative** salary expenditures that belong to the Allocated Cost Pool before **determining** which portion pertains to the Time Survey Cost (Participant) Pools and the Direct Charge Cost Pool.
- c. Identify salary costs of the claiming unit's employees SMAA included in the participant universe, excluding Federal series of **SACS** Resources 3000-5639 and 5650-5999. Once these costs are identified, determine which portion of these costs are coded with **SACS** Function codes 1000–9999, excluding **SACS** Function codes 2700 and 7000–7199 (see Page 11-3 Time Survey Cost (Participant) Pools for specific criteria). Enter the result in **Row 37, Column A for Participant Pool 1 and enter the result in Row 38, Column B for Participant Pool 2.** The balance of the costs for employees in the participant universe represents **SACS** Function codes 2700 and 7000–7199 and should be entered in **Row 42, Column A for Participant Pool 1 and Row 43, Column B for Participant Pool 2.**
- d. Identify Claiming Unit's salary costs to be direct-charged, excluding Federal series of **SACS** Resources 3000-5639 and 5650-5999. Once these costs are identified, determine which portion of these costs are coded with **SACS** Function codes 1000–9999, excluding **SACS** Function codes 2700 and 7000–7199 (refer to Page 11-3 Time Survey Cost Pool for specific criteria). Enter the result in **Row 38, Column A.** The balance of the direct charge salary costs represents salary cost coded with **SACS** Function codes 2700 and 7000–7199 and should be

entered in **Row 44, Column A for Participant Pool 1 and Row 44, Column B for Participant Pool 2.**

2. Determining Total Benefit Costs

- a. Produce an expenditure report of the Claiming Unit's benefit costs (Objects 3000–3999) for the billing period using only **SACS** Function codes 1000–9999, excluding **SACS** Function codes 2700 and 7000–7199 and excluding Federal series of **SACS** Resources 3000-5639 and 5650-5999. **Enter the total in Row 36, Column C for Participant Pool 1 and enter the total in Row 36, Column D for Cost Pool 2.** This combination of Object and Function codes will provide the amount of gross nonclaimable benefit expenditures for the billing period that belong to the Non-SMAA Cost Pool before **determining** which portion pertains to the Time Survey Cost (Participant) Pools and the Direct Charge Cost Pool.
- b. Produce an expenditure report of the Claiming Unit's benefit costs (Objects 3000–3999) for the billing period using only **SACS** Function codes 2700 and 7000–7199 and excluding Federal series of **SACS** Resources 3000-5639 and 5650-5999. **Enter the total in Row 40, Column C for Cost Pool 1 and enter the total in Row 40, Column D for Cost Pool 2.** This combination of Object and Function codes will provide the amount of gross school and general administrative benefit expenditures that belong to the Allocated Cost Pool before **determining** which portion pertains to the Time Survey Cost (Participant) Pools and the Direct Charge Cost Pool.
- c. Identify benefit costs of the Claiming Unit's employees **included in the participant universe**, excluding Federal series of **SACS** Resources 3000-5639 and 5650-5999. Once these costs are identified, determine which portion of these costs are coded with **SACS** Function codes 1000–9999, excluding Function codes **SACS** 2700 and 7000–7199 (see Page 11-3 Time Survey Costs (Participant) Pools for specific criteria). Enter the result in **Row 37, Column C for Cost Pool 1 and enter the result in Row 38, Column D for Cost Pool 2.** The balance of the costs for those participating in the time survey should be entered in **Row 42, Column C for Cost Pool 1 and Row 43 Column D for Cost Pool 2.**
- d. Identify Claiming Unit's benefit costs to be direct-charged, excluding Federal series of **SACS** Resources 3000-5639 and 5650-5999. Once these costs are identified, determine which portion of these costs are coded with **SACS** Function codes 1000–9999, excluding **SACS** Function codes 2700 and 7000–7199 (refer to Page 11-3 Time Survey Cost Pools for specific criteria). Enter the result in **Row 38, Column B.** The balance of the direct charge salary costs represents salary cost coded with **SACS** Function codes 2700 and 7000–7199 and should be entered in **Row 44, Column C for Cost Pool 1 and in Row 44 Column D for Cost Pool 2.**

When the above costs have been entered as indicated on the Payroll Data Collection Worksheet, the appropriate costs will be automatically calculated and transferred to the corresponding cost pool on the Costs and Revenues Worksheet.

In addition, all accounting reports, fiscal reports, spreadsheets, and other schedules used to complete the Payroll Data Collection Worksheet should be retained in the audit file.

Note: The above salary and benefit expenditures should represent costs across all Funds of the Claiming Unit (e.g., general fund, adult education fund, child development fund, etc.). Any expenditures existing in any of the Claiming Unit's Funds considered "not-claimable" under the SMAA program will be appropriately filtered utilizing the appropriate SACS Function code where indicated in this manual.

A summary copy of the claiming unit's general ledger supporting the amount entered in Row 36, Columns A-D and Row 41, Columns A-D must be submitted with the SMAA Detail Invoice and SMAA Summary Invoice. Invoices submitted without this documentation will not be processed or paid by DHCS.

Cost and Revenues Worksheet (TAB 6 Pool 1 & TAB 7 Pool 2)

The Cost and Revenues Worksheet is separated by Participant Pool 1 (Tab 6) and Participant Pool 2 (Tab 7). Participant Pool 1 and Participant Pool 2 costs should not be duplicated.

Personnel Costs

Rows 44–46: These rows automatically calculate the claiming unit's total personnel costs based upon cost information entered on the Direct Charge Worksheet and the Payroll Data Collection Worksheet. Do not enter data into these rows.

Revenue Offsets

The purpose of offsetting revenue or funding against cost is to ensure that the Federal Government participates in its share of the costs only once. Failure to offset federal revenues and state/local matches of federal programs against the costs incurred would result in these costs also being applied to the claim for FFP. The claiming agency would be participating in less than its share by supplanting its share of costs with the federal or other unallowable revenue.

In general, funds that do not require offset include claiming unit general funds, other local public funds, and SMAA reimbursements. The following rules govern which revenues received by a program must be offset against costs before a federal match is determined.

1. **Federal Revenues.** All federally funded costs shall be offset against claimed costs. Including these amounts in the costs claimed for reimbursement will cause the

Federal Government to not only fund these costs, but to also pay the Medi-Cal percentage on those amounts, and therefore pay for the same costs twice, which is prohibited by 45 CFR 75.

2. Matching Revenues. Claimed costs funded by state/local matching funds required by a federal grant must be offset. 45 CFR 75 stipulates that a cost used to meet a matching or cost-sharing requirement of one federal grant may not also be included as a cost against any other federal grant. State/local match funds become federal monies, carry the same restrictions as the federal funds, and must be identified accordingly.
3. Previously Matched Revenues. All costs funded by State General Fund monies previously matched by the Federal Government must be offset because the Federal Government has already funded these costs. This includes Medi-Cal fee-for-service money. Similar to item 2.
4. Private Health Insurance. Insurance collected from nongovernmental (private health insurance) sources for the delivery of direct client services may not be used as the local share of a federal match for administrative activities. These funds must be offset if the related expenses are included in the SMAA invoice.

Essentially, revenue offsets are costs funded by one of the above revenue sources that may not be claimed for reimbursement from the Federal Government because the Federal Government has already directly or indirectly funded those costs. Therefore, these costs must be removed to avoid billing the Federal Government twice for the same cost.

Row 47: Enter the amount of federally funded costs included in the Direct Charge cost pool (**Column E**) identified in the Personnel Cost section. Be careful to offset costs only to the extent that the personnel costs included in the “claimable” column of the Direct Charge cost pool are funded through federal sources. Enter the balance of federal revenues in **Column H** as non-offset revenue.

*Note: Because local matching funds are usually combined and recorded with federal funds, typically only Row 47 **must be** entered as “offset revenue”.*

Row 49: Enter the amount of Other State Revenue funded costs included in the Direct Charge cost pool (**Column E**) identified in the Personnel Cost Section that must be offset. Generally, this includes the State match portion of federally funded programs. Be careful to offset costs only to the extent that personnel costs included in the “claimable” column of the Direct Charge cost pool are funded by Other State Revenue sources required to be offset. Enter the balance of Other State Revenue in **Column H** as non-offset revenue.

Rows 47–52: Enter the total amount of all other revenues for each row that are not to be offset, in **Column H**. All revenues must be identified whether or not they are to be offset. (For more information on Funding Sources [Revenue], claiming unit **should** refer to the PPLs issued under separate cover.)

Row 55: This row automatically calculates percentages used to allocate Other Costs and costs included in the Allocated Cost Pool across the Time Survey, Direct Charge, and Non-SMAA cost pools based on their percentage of personnel costs to total personnel costs of the three cost pools. The costs are allocated in **Rows 58 and 59**. The Allocated Cost Pool is not considered in this calculation because total costs in the Allocated Cost Pool are subsequently allocated to the remaining cost pools based on the same percentage.

Non-Salary Costs

Non-salary costs are costs, other than salaries and benefits, necessary for the proper and efficient administration of Medi-Cal. While many non-salary costs are claimable, some are not. Non-salary costs are claimable only if they do not support non-claimable costs. The repair and maintenance of an X-ray machine is not claimable because it does not support an allowable cost.

Following is a list of claimable non-salary costs. This list is an example and is not comprehensive. These costs are claimable costs only if they do not relate to non-claimable categories of cost:

Claimable Non-Salary 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
- Travel
- Property and liability insurance (excluding malpractice insurance)
- Professional association/affiliation dues
- Legal representation for the agency
- Indirect costs determined to be in accordance with 45 CFR 75

Other Costs and Allocations

Row 56: Enter the costs for **nonspecific** personal service contracts (PSC) that participate in the time survey and are not direct charge contracts in **Row 56, Column A**.

Nonspecific contracts are those contracts that do not specifically define the SMAA activity to be performed or the cost for each SMAA activity.

Specific contracts are those contracts that do specifically define the SMAA activity to be performed and the cost for each SMAA activity. The costs for these contracts should be direct-charged on the Direct Charge Worksheet. For example, this may include a contract to provide a specific SMAA service, such as creating and distributing Medi-Cal literature or advertising for Outreach services for a specific cost.

Identify the amount of the Personal Service Contract costs in **Row 56, Columns C–F** that are also included in the Other Costs determined at **Row 58, Column J**. Enter the result in **Row 56, Column I**.

Row 57: Identify the amount of the Direct Charge Other Costs in **Row 57, Columns E–F** that are also included in the Other Costs determined at **Row 58, Column J**. Enter the result in **Row 57, Column I**.

Row 56: Using the claiming unit’s financial information system, produce an expenditure report for Objects 4000–5999, **SACS** Functions 2700 and 7000–7199 (Other General Administration), and excluding the Federal series of **SACS** Resource codes 3000–5999 and other costs coded to functions 7120, 7190, 7200-7600, 7700, 8100-8400, and 8700 across all Funds of the Claiming Unit (**e.g.**, general fund, adult education fund, child development fund, etc.) for the billing period and enter the result in **Row 58, Column J**. The result represents the claiming unit’s net claimable Other Costs, excluding federally funded costs, which may be allocated across the Time Survey, Direct Charge, and Non-SMAA cost pools. Not including federally funded costs in this total ensures that the Federal government participates in only its share of program costs.

After analyzing the costs identified in the expenditure report above, enter any other unallowable costs noted by the claiming unit in **Row 59, Column J** that is included in the amount at **Row 58, Column J**. Claiming unit Note: The expenditure report should be analyzed to ensure that the costs identified in this expenditure report are not duplicated in any other cost pools, such as, direct charge costs for Personal Service Contracts (PSC) or any unallowable costs.

This cell may also be used to add allowable costs that may not be maintained in a claiming unit’s financial system. For example, OMB A-87 **does not** allow reimbursement for capital expenditures (i.e. equipment or buildings, land is not allowable because it is not depreciated) which are coded to SACS Objects 6700-6999. Fortunately, OMB A-87 does provide that reimbursement of capital expenditures is permitted through the application of depreciation. For SMAA purposes, the SACS Function and Resource coding for the depreciation expense, which in almost all cases is tracked using an off-system method, must match the coding required for Other Costs entered at

Row 58, Column J. If this option is utilized, the amount entered for depreciation expense at **Row 59, Column J**, should be entered as a negative amount to cause an increase at **Row 60, Column J**.

Total Other Costs will first be reduced by the total Personal Service Contract costs entered in **Row 58, Column I**, and Direct Charge Other Costs in **Row 59, Column I**, to avoid duplicate billing of costs because the Claiming Unit has determined these costs to be a component of the claiming unit's Other Costs in **Row 60, Column J** through an analysis of these costs. The invoice will automatically allocate the remaining costs across the Time Survey, Direct Charge, and Non-SMAA cost pools based on their percentage of personnel costs to total personnel costs of the three cost pools. **Row 57** calculates these percentages and the allocation is calculated across **Row 60**. The Allocated Cost Pool is not considered in this allocation because total costs in the Allocated Cost Pool are subsequently allocated to the remaining cost pools based on the same percentage. Generally, Other Costs include the normal day-to-day and monthly operating expenses necessary to run the claiming unit.

Row 61: This row calculates the allocation of School and General Administrative costs in the Allocated Cost Pool based on the percentages calculated in **Row 57**.

Row 62: This row calculates subtotal of costs before applying the claiming unit's indirect cost rate.

Row 63: This row calculates the costs of applying the Claiming Unit's indirect cost rate to the sub-total in **Row 62**.

Row 64: This row calculates the totals for each column.

A summary copy of the claiming unit's general ledger supporting the amount entered in **Row 58, Column J** must be submitted with the SMAA Detail and SMAA Summary Invoice. Invoices submitted without this documentation will not be processed or paid by DHCS.

FFP Calculations

Rows 65–67: Do not enter data in these rows. These rows calculate the FFP based upon data entered on this worksheet and each of the previous three worksheets.

Row 65: These amounts represent the claimable portion of the Time Survey and Direct Charge costs (**Columns C and E**).

Row 66: This row applies the Medi-Cal Federal Financial Participation percentage (50%) to the claimable costs (**Claimable Costs X FFP Percentage**) to arrive at the federal share of costs for each cost pool.

Rows 67: Adds **Columns C and E** of **Row 64** to arrive at the “Total Federal Share” of the SMAA costs for the billing period. The Invoice automatically transfers this amount to the SMAA Summary Invoice for billing.

Claiming For Subcontractors

The costs for subcontractors providing SMAA-related services should be billed in a manner similar to personal services contracts and included in the invoice for the claiming unit as follows:

Specific Contracts

If the contract is "specific," meaning that the contract specifically defines the SMAA to be performed and the cost for each activity, the costs should be direct-charged and entered in the Direct Charges Worksheet (Tab 3) or tab 4 for cost pool 2 under the “Personal Services Contracts” column (**Column L**) on the row corresponding to the appropriate activity.

Non-Specific Contracts

If the contract is "nonspecific," meaning that the contract does not specifically define the SMAA activities to be performed and the cost for each allowable activity, the contractor’s staff must time survey and include those costs in the Time Survey Cost Pool in **Row 58, Column A** of the Costs and Revenues Worksheet (tab 6, cost pool 1, tab 1 cost pool 2).

Activities and Medi-Cal Percentages Worksheet

Conduct the time survey and determine the Claiming Unit’s Medi-Cal Discount Percentage and its indirect cost rate. Enter the Medi-Cal **Eligibility Rate** in **Row 12, Column C** and the indirect cost rate in **Row 28, Column I**. Enter the results of the time survey in **Rows 10–25, Column D**.

Direct Charges Worksheet

Enter costs into this worksheet where indicated and as directed under the standard methodology discussed in the preceding pages of this section.

Payroll Data Collection Worksheet

Salary Costs: Enter 100 percent of the claiming unit’s salary costs in **Row 36, Column A**. Enter 100 percent of the salary costs SMAA staff included in the approved participant universe in **Row 37, Column A**. Enter 100 percent of salary costs to be direct-charged in **Row 38, Column A**.

Benefit Costs: Enter 100 percent of the claiming unit’s benefit costs in **Row 36, Column B**. Enter 100 percent of the benefit costs for staff included in the approved participant universe SMAA in **Row 37, Column B**. Enter 100 percent of benefit costs to be direct-charged in **Row 38, Column B**.

No costs should be entered in **Rows 40–42**.

Costs and Revenues Worksheet

Enter costs into this worksheet where indicated and as directed under the standard methodology discussed in the preceding pages of this section.

SMAA Summary Invoice Worksheet (TAB 8-LEC and TAB 9-LGA)

It is the responsibility of the LEC/LGA and claiming unit SMAA Coordinators to review all invoices for completeness and accuracy prior to submitting them to DHCS. Invoices submitted using an incorrect format will be returned without being reviewed. To expedite the review and payment process, it is necessary to follow all the instructions. The following items must be included:

- SMAA Summary Invoice
- Activities and Medi-Cal Percentages Worksheet
- Time Survey Summary Report – not necessary if only direct charging
- Direct Charges Worksheet
- Payroll Data Collection Worksheet
- Payroll Data Collection & Other Summary Sheet (Maintain actual staff ledger reports for audit purposes)
- Costs and Revenues Worksheet
- Supporting Documentation
- Roster Report(s)

The original SMAA Summary Invoice, SMAA Detail Invoice, Roster Report(s), documentation supporting the time survey results, summary general ledger reports as indicated on the SMAA Detail Invoice Checklist (pages 10-23 and 10-24) must be submitted to DHCS for each quarter billed. Claiming units must submit its invoices to its appropriate LEC/LGA.

Payment Process

SMAA claims are submitted to DHCS, Administrative Claiming Local & Schools Services Branch (ACLSSB). The invoices are reviewed for fiscal integrity and compared to the Roster Report(s). If the invoice is accepted, reviewed and approved by the ACLSSB, the invoice will be forwarded to the Accounting Office for payment processing. The Accounting Office will prepare the invoices for payment and forward them to the State Controller's Office (SCO) for payment. Warrants are made payable to the LEC/LGA Treasurer.

All LEC/LGA invoices must be submitted to DHCS within 15 months of the end of the quarter claimed.

Invoices submitted after these dates **may** not be paid. Many claiming units wait until the last moment to submit claims, creating a peak workload demand that can delay review and payment of invoices that have been submitted timely to DHCS.

If the LEC or LGA anticipates a delay in submitting invoices by the above due dates, the LEC/LGA Coordinator must sign and submit a "Late Invoice Submission Request" at claiming unit two weeks before the due date. Appendix E provides a sample request.

If an invoice is denied, a LEC/LGA can request reconsideration of the DHCS decision to deny an invoice. The request must be filed in writing and within 30 days after the receipt of the written notice of denial. The review process is limited to a programmatic

or accounting reconsideration based upon additional supporting documentation requested by and submitted to DHCS. Revisions to previously paid invoices must follow DHCS guidelines.

Correction and/or Additional Information

Effective 03/12/07, DHCS adopted a Three-Step Review Policy (PPL-07-005), for requesting corrections and/or additional information to support time surveys, invoices, contracts and documentation in support of their operational plans. SMAA invoices will no longer be held indefinitely while waiting for the essential corrections or backup information from the LEC/LGA SMAA Coordinators).

Step 1: The SMAA analysts will review time surveys, invoices, contracts, and operational plan supporting documents for each respective claiming unit, and shall notify the **LEC/LGA** SMAA Coordinator by e-mail if corrections and/or additional information are necessary. The analyst shall request that the corrections and/or additional information from the **LEC/LGA** SMAA Coordinator be sent within five (5) business days from the date of the e-mail message.

Step 2: If the LEC/LGA SMAA Coordinator does not respond within five (5) business days or sends incomplete information, the SMAA analyst shall notify the LEC/LGA SMAA Coordinator a second time both by e-mail and telephone, and the co-chairs and/or their designee will be cc'd. An additional five (5) business days will be given for a response.

Step 3: If the LEC/LGA SMAA Coordinator does not respond or sends incomplete information by the end of the second five (5) business days, the SSMAA analyst shall return the related invoice package and/or contract. The SSMAA invoice will be denied as it is not adequately documented to be eligible for federal reimbursement.

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 the LGA or LEC SMAA Coordinators. An e-mail explaining the situation must be sent to the DHCS SMAA analyst, the SMAA Unit Manager, and the Section Manager.

Examples of costs that are not claimable as Medi-Cal administration:

- Activities that are an integral part or extension of direct medical services, such as patient assessment, education, or counseling. In addition, the cost of any consultations between medical professionals is already reflected in the payment rate for medical assistance services and may not be claimed separately as an administrative cost. However, the time spent by the student's designated IEP case manager in coordinating and monitoring consultations between professionals may be allowable SMAA time under activity Code 8 (Referral, Coordination, and Monitoring of Medi-Cal Covered Services).
- Overhead costs of operating a provider facility.

- An activity that has been, or will be, paid as a medical assistance service (or as a service of another non-Medi-Cal program) shall not be paid again as a Medi-Cal administrative cost.
- An activity that has been, or will be, paid as a Medi-Cal administrative cost shall not be claimed again.
- An activity that is included as part of a managed care rate and is reimbursed by the managed care organization, shall not be claimed as Medi-Cal administration or through a fee-for-service payment rate.
- Cost of elected officials.

SMAA providers must distinguish between duplicate payments for the same activity and the inefficient use of resources, which may result in the unnecessary duplication of an activity. Duplication of services or administrative activities can be avoided by coordinating activities and staff. If the same Medi-Cal eligible child received IEP services from both a school and a medical care organization (MCO), there must be a concerted effort to ensure that Medi-Cal is not paying for the same services twice, once to the MCO and again to the school.

Submitting Corrections and Revisions

Corrections: All invoices submitted for payment are reviewed by DHCS staff. If errors are found or additional documentation is required, please refer to the above three-step process for corrections.

When the LEC/LGA corrects and returns the rejected invoice, it must identify the resubmitted invoice as a Corrected Invoice. The corrected invoice must be identified as a "Correct Invoice" in the transmittal letter and also 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 corrections (C-2), etc. For instance the invoice number for first corrected invoice of the second quarter of fiscal year 2014/15 should read as "14/15-2-C-1" (fiscal year–quarter–correction number).

A LEC/LGA may discover the need to correct the invoice before the invoice has been paid. In these situations, the LEC/LGA must submit the corrected invoice identifying it as a "Correct Invoice" in the transmittal letter and also in the invoice number.

Revisions: Sometimes, after an invoice has been processed and paid, a LEC/LGA may discover the need to revise the invoice. In these situations, the invoice should be recomputed and resubmitted along with a copy of the original paid invoice summary sheet. The revised invoice must be identified as a "Revised Invoice" in the transmittal letter and also in the invoice number (i.e., R-1). If the revision results in a DHCS credit invoice, the LEC/LGA must submit a check for the amount of the **difference** along with a copy of the original invoice and the revised invoice.

The invoice number for the second revised invoice of the third quarter of fiscal year 2014/15 should read as "14/15-3-R-2" (fiscal year–quarter–revision number).

Credits: Every credit Revised Invoice submitted to DHCS must be accompanied with a check from the respective entity in the amount of the revision (i.e., the **difference** between the original amount and the revised amount).

Note: Corrections and Revisions require a new SMAA Summary Invoice and all supporting documentation.

Averaging Quarter Supplemental Worksheet (TAB 10 Pool 1 & TAB 11 Pool 2)

When a claiming unit averages the first quarter of each fiscal year they must submit with their invoice an Averaging Quarter Worksheet.

Additionally, all claiming units are required to complete the Time Survey Summary Worksheet. The Time Survey Summary worksheet must be kept onsite in the operational plan. **These supplemental averaging worksheets are a requirement for invoices submitted beginning fiscal year 2005/2006 First Quarter.**

- **Averaging:** The claiming unit must average the time survey results for the first quarter in a fiscal year using the results of quarters two, three, and four from the previous year.

How to Average:

1. Compile the time survey results for each of the three quarters for each Participant Pool to arrive at new recalculated time survey percentages.
2. The compiled percentages should be added and divided by three. This will give you the averaged quarter averaging percentages.
3. Be sure to make your calculations clear and well documented in the event of an audit or site visit.
4. These worksheets must be submitted with each invoice that you have chosen to average.

A summary copy of the LEC/LGA Region's or Consortia's non-averaged quarter time survey results in invoice order (Tab 2, Column D for Pool 1 and Tab 2, Column E for Pool 2) must be submitted with the SMAA Detail and SMAA Summary Invoice. Invoices submitted without this documentation will not be processed or paid by DHCS.

Summary of SACS-Based Financial Reports

Activities and Medi-Cal Percentages Worksheet: No SACS financial reports required.

Direct Charges Worksheets: No SACS financial reports required.

Payroll Data Collection Worksheet:

Column A Pool 1 and Column B Pool 2:

Row 36 – Include Objects 1000–2999, **SACS** Functions 1000–2699, 2800–6999 and 7200–9999. Include only non-federal **SACS** resources 0000-2999, 5640-5649, and 6000-9999.

Row 41 – Include Objects 1000–2999, **SACS** Functions 2700 and 7000–7199. Include only non-federal **SACS** resources 0000-2999, 5640-5649, and 6000-9999.

Column C Pool 1 and Column D Pool 2:

Row 36 – Include Objects 3000–3999, **SACS** Functions 1000–2699, 2800–6999 and 7200–9999. Include only non-federal **SACS** resources 0000-2999, 5640-5649, and 6000-9999.

Row 41 – Include Objects 3000–3999, **SACS** Functions 2700 and 7000–7199. Include only non-federal **SACS** resources 0000-2999, 5640-5649, and 6000-9999.

Costs and Revenues Worksheet:

Row 49 – Federal Revenues, include Objects 8100–8299.

Row 50 – State Revenue Limit Sources, include Objects 8010–8099.

Row 51 – Other State Revenues include Objects 8300–8599.

Row 52 – Other Local Revenues include Objects 8600–8799.

Row 53 – Other Financing Sources include Objects 8910–8979.

Row 54 – Contributions to Restricted Programs, include Objects 8980–8999

Row 58, Column J –Other Costs Net of Federally Funded expenditures, include Objects 4000-5999, **SACS** Functions 2700 and 7000–7199. Also, exclude Federal **SACS** resource series 3000-5639 and 5650-5999.

APPENDIX A

Abbreviations and Acronyms

DRAFT

Abbreviation/ Acronym	Term
ACC	Actual Client Count (a.k.a., DHS Tape Match)
Cal-SAFE	California School Age Families Education
CBO	Community Based Organizations
CFR	Code of Federal Regulations
CHDP	Child Health and Disability Prevention
CMS	Centers for Medicare & Medicaid Services
COE	County Office of Education
CPSP	Comprehensive Perinatal Services Program
DHCS	Department of Health Care Services
DHHS	Federal Department of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FFP	Federal Financial Participation
HCFA	Health Care Financing Administration
IDEA	Individuals with Disabilities Education Act of 1997
IEP	Individualized Education Program (or Plan)
IFSP	Individualized Family Service Plan
IHSP	Individualized Health Service Plan
ISP	Individualized Service Plan
LEA	Local Educational Agency
LEC	Local Educational Consortium
LGA	Local Governmental Agency
LVN	Licensed Vocational Nurse
MAA	Medi-Cal Administrative Activities
MCO	Managed Care Organizations
MOU	Memorandum of Understanding
OMB A-87	Office of Management and Budget Circular A-87
OP	Operational Plan
PPL	Policy and Procedure Letter
PPPD&IC	Program Planning and Policy Development, and Interagency Coordination
RN	Registered Nurse
SMAA Manual	California School-Based Medi-Cal Administrative Activities Manual
SELPA	Special Education Local Plan Area
TPL	Third Party Liability

APPENDIX B

Sample MAA Invoice

DRAFT

Claiming Unit: _____
 Period of Service: _____

Participant Pool 1: Direct Service & Administrative Providers

8/1/15

Total Number of Moments Selected Randomly Prior to the Start of the Quarter:
 Total Number of Invalid Moments:
 Total Valid Moments
 Compliance Percentage:

Pool 1:	Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10	Code 11	Code 12	Code 13	Code 14	Code 15	Code 16	Total Moments
Moments:																	-

SUMMARY FOR INVOICING ONLY																	
	4	6	15	8	10	12	14	1	2	3	5	7	9	11	13	16	Total
	#DIV/0!																

Claiming Unit _____
 Period of Service: _____

Participant Pool 2: Administrative Providers Only

Total Number of Moments Selected Randomly Prior to the Start of the Quarter:
 Total Number of Invalid Moments:
 Total Valid Moments
 Compliance Percentage:

Pool 2:	Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10	Code 11	Code 12	Code 13	Code 14	Code 15	Code 16	Total Moments
Moments:																	-

SUMMARY FOR INVOICING ONLY																	
	4	6	15	8	10	12	14	1	2	3	5	7	9	11	13	16	Total
	#DIV/0!																

**RANDOM MOMENT TIME SURVEY (RMTS)
SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA)**

II. RMTS - ACTIVITIES AND MEDI-CAL PERCENTAGES WORKSHEET: Pool 1 and Pool 2

RMTS INVOICE INFORMATION	
Claiming Unit Name	
CDS Code	
DHCS Contractor (Region)	
Contract #	
Prepared by	
Title	
Phone #	
Date	
Contract year/quarter	
Period of Service	

A	B	C	RANDOM MOMENT TIME SURVEY RESULTS					
			D	E	F	G	H	I
Type of Activity	Code	Medi-Cal Discount %	Participant Pool 1: Direct Service & Administrative Providers (RMTS Results) (a)	Participant Pool 2: Administrative Providers Only (RMTS Results) (a)	Pool 1: Allocate Gen. Admin./Paid Time Off (Code 16)	Pool 2: Allocate Gen. Admin./Paid Time Off (Code 16)	Pool 1 - RMTS Results: Apply Medi-Cal Discount % (Col. C X Col. H)	Pool 2 - RMTS Results: Apply Medi-Cal Discount % (Col. C X Col. I)
Non-Discounted:								
Medi-Cal Outreach	4	100.00%			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Facilitating Medi-Cal Application	6	100.00%			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Medi-Cal Claims Administration, Coordination & Training	15	100.00%			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Discounted:								
Referral, Coordination, and Monitoring of Medi-Cal Services	8				#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Arranging Transportation in Support of Medi-Cal Services	10	0.00%			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Translation to Access Medi-Cal Services	12	0.00%			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Program Planning, Policy Development & Interagency Coord. Related to Medi-Cal Services	14	0.00%			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Non-claimable:								
School-Related, Education, and Other Activities	1				#DIV/0!	#DIV/0!		
Direct Medical Services	2				#DIV/0!	#DIV/0!		
Non-Medi-Cal Outreach	3				#DIV/0!	#DIV/0!		
Facilitating Application for Non-Medi-Cal Programs	5				#DIV/0!	#DIV/0!		
Referral, Coordination, and Monitoring of Non-Medi-Cal Services	7				#DIV/0!	#DIV/0!		
Transportation for Non-Medi-Cal Programs	9				#DIV/0!	#DIV/0!		
Non-Medi-Cal Translation	11				#DIV/0!	#DIV/0!		
Program Planning, Policy Development & Interagency Coord. Related to Non-Medi-Cal Services	13				#DIV/0!	#DIV/0!		
Allocated:								
General Administration/Paid Time Off	16				Allocated	Allocated		
TOTAL TIME			0.00%	0.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Number of Claiming Unit Staff Included in each Participant Pool								
State Approved Indirect Cost Rate for the Current Billing Period								

(a) The summary report (Tab 6) supporting amounts entered in these columns are required to be completed and submitted with the invoice. Invoices will not be processed or paid by DHCS without this supporting documentation.

RANDOM MOMENT TIME SURVEY (RMTS)

III. DIRECT CHARGES WORKSHEET - Pool 1

Claiming Unit Name _____
 DHCS Contractor (Region) _____
 Contract # _____

Date _____
 Contract Year/Qtr. _____
 Period of Service _____

8/1/15

A		B C D E F					G H I J K					L M N O				P Q R S			
		SALARIES (Object 1000-2999)					BENEFITS (Object 3000-3999)					PERSONAL SERVICE CONTRACTS (Object 5800)				OTHER COSTS (Object 4000-5999)			
PARTICIPANT POOL 1: COST CATEGORY	MAA ACTIVITY CODE	GROSS STAFF SALARIES	Medi-Cal Certified Time Factor	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE	GROSS STAFF BENEFITS	Medi-Cal Certified Time Factor	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE	Contract Costs	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE	Total Other Costs	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE
29	Medi-Cal Outreach	4																	
a		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	0
b		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	0
c		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	0
d		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	0
	TOTAL	0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	0
30	Facilitating Medi-Cal Application	6																	
a		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	0
b		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	0
c		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	0
d		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	0
	TOTAL	0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	0
31	Medi-Cal Claims Admin., Coord. & Training	15																	
a		0	0.00%																
b		0	0.00%																
c		0	0.00%																
d		0	0.00%																
	TOTAL	0	0.00%																
	NON-DISCOUNTED SUB-TOTAL	0														0			0
32	Referral, Coord. and Monitoring of Medi-Cal Svcs	8																	
a		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
b		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
c		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
d		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
	TOTAL	0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
33	Arranging Transportation in Support of Medi-Cal Services	10																	
a		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
b		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
c		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
d		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
	TOTAL	0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
34	Translation to Access Medi-Cal Svcs	12																	
a		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
b		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
c		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
d		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
	TOTAL	0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
35	Program Planning, Policy Dev. & Interagency Coord Related to M/C Svcs	14																	
a		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
b		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
c		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
d		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
	TOTAL	0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
	DISCOUNTED SUB-TOTAL	0			0	0	0			0	0	0		0		0		0	0
	TOTAL SALARY COSTS	0			0	0	-			-	-	0		0		0		0	0

RANDOM MOMENT TIME SURVEY (RMTS)

III. DIRECT CHARGES WORKSHEET - Participant Pool 2

8/1/15

Claiming Unit Name _____
 DHCS Contractor (Region) _____
 Contract # _____

Date _____
 Contract Year/Qty. _____
 Period of Service _____

PARTICIPANT POOL 2 COST CATEGORY	MAA ACTIVITY CODE	SALARIES (Object 1000-2999)				BENEFITS (Object 3000-3999)					PERSONAL SERVICE CONTRACTS (Object 5800)				OTHER COSTS (Object 4000-5999)				
		GROSS STAFF SALARIES	Medi-Cal Certified Time Factor	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE	GROSS STAFF BENEFITS	Medi-Cal Certified Time Factor	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE	Contract Costs	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE	Total Other Costs	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE
29 Medi-Cal Outreach	4																		
a		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	
b		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	
c		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	
d		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	
TOTAL		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	
30 Facilitating Medi-Cal Application	6																		
a		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	
b		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	
c		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	
d		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	
TOTAL		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	
31 Medi-Cal Claims Admin., Coord. & Training	15																		
a		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	
b			0.00%					0.00%		0	0	0		0		0		0	
c		0	0.00%				0	0.00%		0	0	0		0		0		0	
d		0	0.00%				0	0.00%		0	0	0		0		0		0	
TOTAL		0	0.00%		0	0	0	0.00%		0	0	0		0		0		0	
NON-DISCOUNTED SUB-TOTAL		0										0		0		0		0	
32 Referral, Coord. and Monitoring of Medi-Cal Svcs	8																		
a		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
b		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
c		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
d		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
TOTAL		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
33 Arranging Transportation in Support of Medi-Cal Services	10																		
a		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
b		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
c		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
d		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
TOTAL		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
34 Translation to Access Medi-Cal Svcs	12																		
a		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
b		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
c		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
d		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
TOTAL		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
35 Program Planning, Policy Dev. & Interagency Coord Related to M/C Svcs	14																		
a		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
b		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
c		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
d		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
TOTAL		0	0.00%	0.00%	0	0	0	0.00%	0.00%	0	0	0	0.00%	0	0	0	0.00%	0	0
DISCOUNTED SUB-TOTAL		0			0	0	0			0	0	0		0	0	0		0	0
TOTAL SALARY COSTS		0			0	0	-			-	-	0		0	0	0		0	0

RANDOM MOMENT TIME SURVEY (RMTS)

8/1/15

IV. PAYROLL DATA COLLECTION WORKSHEET

Claiming Unit Name
DHCS Contractor (Region)
Contract #

Date _____
Contract year/qtr _____
0 _____

	A			C		E	F
	Functions	Functions		Functions	Functions		
SALARIES (Objects 1000-2999):	Participant Pool 1: Direct Service & Administrative Providers 1000- 9999, excluding 2700 & 7000-7199	Participant Pool 2: Administrative Providers Only 1000-9999, excluding 2700 & 7000-7199	BENEFITS (Objects 3000-3999):	Participant Pool 1: Direct Service & Administrative Providers 1000- 9999, excluding 2700 & 7000-7199	Participant Pool 2: Administrative Providers Only 1000-9999, excluding 2700 & 7000-7199	Participant Pool 1: Total Claiming Unit Salaries & Benefits	Participant Pool 2: Total Claiming Unit Salaries & Benefits
36 Total Non-Federally Funded Claiming Unit Salaries (b)			Total Non-Federally Funded Claiming Unit Benefits (b)			-	-
37 Less: Time Survey Participants in Pool 1 (Employee) Salary Costs			Less: Time Survey Participant in Pool 1 (Employee) Benefit Costs				
38 Less: Time Survey Participants in Pool 2 (Employee) Salary Costs			Less: Time Survey Participant in Pool 2 (Employee) Salary Costs				
39 Less: Direct Charge Salary Costs in Participant Pools 1 and/ or 2			Less: Direct Charge Benefit Costs in Participant Pools 1 and 2				
40 TO NON-MAA COST POOL (P.4, Line 44, Col. G)			TO NON-MAA COST POOL (P. 4, Line 45, Col. G)				
School Administration and General Administration	Functions 2700 & 7000-7199	Functions 2700 & 7000-7199	School Administration and General Administration	Functions 2700 & 7000-7199	Functions 2700 & 7000-7199		
41 Total Non-Federally Funded Claiming Unit Salaries (b)			Total Non-Federally Funded Claiming Unit Benefits (b)			-	-
42 Less: Time Survey Participants in Pool 1 (Employee) Salary Costs			Less: Time Survey Participants in Pool 1 (Employee) Benefit Costs				
43 Less: Time Survey Participants in Pool 2 (Employee) Salary Costs			Less: Time Survey Participants in Pool 2 (Employee) Benefit Costs				
44 Less: Direct Charge Salary Costs in Participant Pools 1 and/or 2			Less: Direct Charge Benefit Costs in Participant Pools 1 and 2				
45 TO ALLOCATED COST POOL (P. 4, Line 44, Col. H)			TO ALLOCATED COST POOL (P. 4, Line 45, Col. H)			-	-

(b) A summary general ledger report supporting amounts entered in these cells (Row 36, Column A & B and Row 40, Column A & B) are required to be submitted with the invoice. Invoices submitted without this documentation will not be processed or paid by DHCS.

V. COSTS AND REVENUES WORKSHEET - Participant Pool 1

Claiming Unit Name _____
 DHCS Contractor (Region) _____
 Contract # _____

Date _____
 Contract year/qr _____
 0 _____

PARTICIPANT POOL 1: CATEGORY (OBJECTS)	TIME SURVEY				DIRECT CHARGE		NON-MAA	ALLOCATED	CONTROL TOTAL
	Participant	MAA Time Survey Percentage	Equals MAA Funded Costs (A X B)	Non-Claimable Time Survey Costs (A - C)	Claimable	NON-CLAIMABLE	NON CLAIMABLE (Funct. 1000-9999 excluding 2700 and 7000-7199)	GENERAL & ADMIN. (Funct. 2700 & 7000-7199)	
PERSONNEL COSTS									
	\$		\$		\$	\$	\$	\$	\$
46 Salaries (1000-2999)	0	#DIV/0!	#DIV/0!	#DIV/0!	-	-	-	-	#DIV/0!
47 Benefits (3000-3999)	0	#DIV/0!	#DIV/0!	#DIV/0!	-	-	-	-	#DIV/0!
48 SUBTOTAL PERSONNEL	0	#DIV/0!	#DIV/0!	#DIV/0!	-	-	-	-	#DIV/0!
REVENUE OFFSETS									
Non-Offset									
49 Federal Revenues (8100-8299)					0	0		0	-
50 State Revenue Limit Sources (8010-8099)								0	-
51 Other State Revenues (8300-8599)					0	0		0	-
52 Other Local Revenues (8600-8799)								0	-
53 Other Financing Sources (8910-8979)								0	0
54 Contributions to Restricted Programs (8980-8999)								0	0
55 Total Revenues					0	0		0	0
56 Personnel Costs less Revenue Offsets			#DIV/0!	#DIV/0!	0	0	0		
57 Allocation Percentages			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!
OTHER COSTS AND ALLOCATIONS									
									Enter Amount of Other Costs from Columns C thru F included in Column J
58 Personal Service Contracts		#DIV/0!	#DIV/0!	#DIV/0!	0	0			0
59 Direct Charge Other Costs					0	-			0
60 ALLOCATION OF OTHER COSTS:			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		
61 ALLOCATION OF GENERAL & ADMIN.			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		
62 Subtotal Costs			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!
63 Indirect Rate Applied			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
64 TOTAL COSTS			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
FFP CALCULATIONS									
65 MAA CLAIMABLE COSTS			#DIV/0!		#DIV/0!				#DIV/0!
66 Apply FFP Percentage (50%)			#DIV/0!						#DIV/0!
67 TOTAL FEDERAL SHARE			#DIV/0!						#DIV/0!

J
 CLAIMING UNIT OTHER COSTS - NET OF FEDERALLY FUNDED EXPENDITURES (b) (Objects 4000-5999, Functions 2700 & 7000-7199, and excluding Resources 3000-5999)

Less Other Unallowable Costs

K

Prior Year Corresponding Quarter Variance Check	Prior Quarter Variance Check
Enter PY Same Quarter's Reimbursement => _____	Enter Prior Quarter's Reimbursement => _____
Displayed is Percent Change from PY Same Quarter => 0.00%	Displayed is Percent Change from Prior Quarter => 0.00%

Typed Name of Preparer _____

Title _____

Telephone # _____

Typed Name of Authorized LEA Business Official _____

Title _____

Signature of Authorized LEA Business Official _____ (Blue Ink Only)

Date _____

I certify under penalty of perjury that the information provided on this invoice is true and correct, based on actual expenditures of the claiming unit for the period claimed, that the funds/contributions have been expended as necessary for federal matching funds pursuant to the requirements of 42 CFR 433.51 for allowable activities and that these claimed expenditures have not previously been, nor will subsequently be, used for the federal match for this or any other program. Furthermore, I certify that the revenue sources identified in this invoice represent accurate and identifiable costs for the program/claiming entity and that the direct charges have been properly identified and allocated. I have notice that this information is to be used for filing of a claim with the Federal government for federal funds and that knowing misrepresentation constitutes a violation of the Federal False Claims Act.

V. COSTS AND REVENUES WORKSHEET - Participant Pool 2

Claiming Unit Name _____
 CDS Code _____
 Contract # _____

Date _____
 Contract year/qtr _____
 0 _____

PARTICIPANT POOL 2: CATEGORY (OBJECTS)	TIME SURVEY				DIRECT CHARGE		NON-MAA	ALLOCATED	CONTROL TOTAL
	Participant	MAA Time Survey Percentage	Equals MAA Funded Costs (A X B)	Non-Claimable Time Survey Costs (A - C)	Claimable	NON-CLAIMABLE	NON CLAIMABLE (Funct. 1000-9999 excluding 2700 and 7000-7199)	GENERAL & ADMIN. (Funct. 2700 & 7000-7199)	
PERSONNEL COSTS									
	\$	\$	\$	\$	\$	\$	\$	\$	\$
46 Salaries (1000-2999)	0	#DIV/0!	#DIV/0!	#DIV/0!	-	-	-	-	#DIV/0!
47 Benefits (3000-3999)	0	#DIV/0!	#DIV/0!	#DIV/0!	-	-	-	-	#DIV/0!
48 SUBTOTAL PERSONNEL	0	#DIV/0!	#DIV/0!	#DIV/0!	-	-	-	-	#DIV/0!
REVENUE OFFSETS									
Non-Offset									
49 Federal Revenues (8100-8299)					0	0		0	-
50 State Revenue Limit Sources (8010-8099)								0	-
51 Other State Revenues (8300-8599)					0	0		0	-
52 Other Local Revenues (8600-8799)								0	-
53 Other Financing Sources (8910-8979)								0	0
54 Contributions to Restricted Programs (8980-8999)								0	0
55 Total Revenues					0	0		0	0
56 Personnel Costs less Revenue Offsets			#DIV/0!	#DIV/0!	0	0	0		
57 Allocation Percentages			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!
OTHER COSTS AND ALLOCATIONS									
58 Personal Service Contracts		#DIV/0!	#DIV/0!	#DIV/0!	0	0			0
59 Direct Charge Other Costs					0	-			0
60 ALLOCATION OF OTHER COSTS:			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		-
61 ALLOCATION OF GENERAL & ADMIN.			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		
62 Subtotal Costs			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!
63 Indirect Rate Applied			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
64 TOTAL COSTS			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
FFP CALCULATIONS									
65 MAA CLAIMABLE COSTS			#DIV/0!		#DIV/0!				
66 Apply FFP Percentage (50%)			#DIV/0!		#DIV/0!				#DIV/0!
67 TOTAL FEDERAL SHARE			#DIV/0!		#DIV/0!				#DIV/0!

J
 CLAIMING UNIT OTHER COSTS - NET OF FEDERALLY FUNDED EXPENDITURES (b)
 (Objects 4000-5999, Functions 2700 & 7000-7199, and excluding Resources 3000-5999)

Less Other Unallowable Costs

K

Prior Year Corresponding Quarter Variance Check		Prior Quarter Variance Check	
Enter PY Same Quarter's Reimbursement =>		Enter Prior Quarter's Reimbursement =>	-
Displayed is Percent Change from PY Same Quarter =>	0.00%	Displayed is Percent Change from Prior Quarter =>	0.00%

Typed Name of Preparer _____

Title _____

Telephone # _____

Typed Name of Authorized LEA Business Official _____

Title _____

Signature of Authorized LEA Business Official _____ (Blue Ink Only)

Date _____

I certify under penalty of perjury that the information provided on this invoice is true and correct, based on actual expenditures of the claiming unit for the period claimed, that the funds/contributions have been expended as necessary for federal matching funds pursuant to the requirements of 42 CFR 433.51 for allowable activities and that these claimed expenditures have not previously been, nor will subsequently be, used for the federal match for this or any other program. Furthermore, I certify that the revenue sources identified in this invoice represent accurate and identifiable costs for the program/claiming entity and that the direct charges have been properly identified and allocated. I have notice that this information is to be used for filing of a claim with the Federal government for federal funds and that knowing misrepresentation constitutes a violation of the Federal False Claims Act.

**LEC SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA)
RANDOM MOMENT SUMMARY INVOICE
Participant Pool 1 & 2**

Claiming Unit Name: _____
 DHCS Contractor (Region) _____
 Contract # _____

Date _____
 Contract year/quarter _____
 Period of Service _____

Type of Invoice (check one):

Original Invoice
Revised Invoice
Corrected Invoice

Participant Pool 1 _____

Participant Pool 2 _____

Enter the Total Amount Previously Reimbursed for the Period of Service \$ _____

Amount Previously Over or Under Reimbursed for the Period of Service \$ _____ 0

TOTAL to be Reimbursed by Federal Government Representing 50% Share \$ _____ 0

I certify under penalty of perjury that the information provided on this invoice is true and correct, based on actual expenditures of the claiming unit incurred for the period claimed, and that the funds/contributions expended, as necessary for federal matching funds pursuant to the requirement of 42 CFR 433.51, allowable administrative activities and that these claimed expenditures have not previously been nor shall not subsequently be used for federal match in this or any other program. I have notice that this information is to be used for filing of a claim with the Federal government for Federal funds and that knowing misrepresentation constitutes violation of the Federal False Claims Act.

 Typed Name of Signer

 LEC Coordinator Signature

 Title

 Date

For DHCS Program Use Only

I hereby certify to the best of my knowledge and belief that the claims submitted and attached herein, are claims for the Medicaid program under Title XIX of the Social Security Act (the Act), and as applicable, under the State Children's Health Insurance Program (SCHIP) under Title XXI of the Act, and are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies, and the state plan (including any approved waivers of the state plan) approved by the Secretary and in effect at the corresponding time commensurate with the claims aforementioned and furthermore, I certify that federal matching funds are not being claimed for any expenditure under Medicaid and/or SCHIP state plan amendment that was submitted after January 2, 2001, and that has not been approved by the Secretary effective for the applicable quarter associated with the claims aforementioned. Further, I direct the Accounting Section to process the attached claims for payment certifying to the best of my knowledge and belief that the payee has met the contractual conditions for such payment(s) and the following accounting codes are appropriate for such payment(s). This invoice has been checked against our records and found to be the original one presented for payment and has not previously been paid. We have recorded this payment so as to prevent a later duplicate payment.

 Signed

SSMI

 Title

 Date

 Analyst Initials

CALSTARS Code 1 -95929-9912-702-42-60 LEC

**Department of Health Care Services
 Safety Net Financing Division
 School-Based Medi-Cal Administrative Activities
 1501 Capitol Ave., MS 4603
 PO Box 997413
 Sacramento, CA 95899-7413**

**LGA SCHOOL-BASED MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA)
RANDOM MOMENT SUMMARY INVOICE
Participant Pool 1 & 2**

Claiming Unit Name: _____
CDS Code _____
Contract # _____

Date _____
Contract year/quarter _____
Period of Service _____

Type of Invoice (check one):

Original Invoice
Revised Invoice
Corrected Invoice

Participant Pool 1 _____
Participant Pool 2 _____

Enter the Total Amount Previously Reimbursed for the Period of Service \$ _____

Amount Previously Over or Under Reimbursed for the Period of Service \$ _____ 0

TOTAL to be Reimbursed by Federal Government Representing 50% Share \$ _____ 0

I certify under penalty of perjury that the information provided on this invoice is true and correct, based on actual expenditures of the claiming unit incurred for the period claimed, and that the funds/contributions expended, as necessary for federal matching funds pursuant to the requirement of 42 CFR 433.51, allowable administrative activities and that these claimed expenditures have not previously been nor shall not subsequently be used for federal match in this or any other program. I have notice that this information is to be used for filing of a claim with the Federal government for Federal funds and that knowing misrepresentation constitutes violation of the Federal False Claims Act.

Typed Name of Signer

LGA Coordinator Signature

Title

Date

For DHCS Program Use Only

I hereby certify to the best of my knowledge and belief that the claims submitted and attached herein, are claims for the Medicaid program under Title XIX of the Social Security Act (the Act), and as applicable, under the State Children's Health Insurance Program (SCHIP) under Title XXI of the Act, and are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies, and the state plan (including any approved waivers of the state plan) approved by the Secretary and in effect at the corresponding time commensurate with the claims aforementioned and furthermore, I certify that federal matching funds are not being claimed for any expenditure under Medicaid and/or SCHIP state plan amendment that was submitted after January 2, 2001, and that has not been approved by the Secretary effective for the applicable quarter associated with the claims aforementioned. Further, I direct the Accounting Section to process the attached claims for payment certifying to the best of my knowledge and belief that the payee has met the contractual conditions for such payment(s) and the following accounting codes are appropriate for such payment(s). This invoice has been checked against our records and found to be the original one presented for payment and has not previously been paid. We have recorded this payment so as to prevent a later duplicate payment.

Signed

SSMI
Title

Date

Analyst Initials

CALSTARS Code 1 ___-95910-9912-702-42-60 LGA

**Department of Health Care Services
Safety Net Financing Division
School-Based Medi-Cal Administrative Activities
1501 Capitol Ave., MS 4603
PO Box 997413
Sacramento, CA 95899-7413**

SMAA Averaging Quarter Worksheet Participant Pool 1

(Required for Averaging Quarter Invoice)

Quarter 2

Total Number of Moments Selected Randomly Prior to the Start of the Quarter:

Total Number of Invalid Moments:

Total Valid Moments

Compliance Percentage:

8/1/15

Pool 1:	Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10	Code 11	Code 12	Code 13	Code 14	Code 15	Code 16	Total Moments
Moments:																	-

SUMMARY FOR INVOICING ONLY																	
	4	6	15	8	10	12	14	1	2	3	5	7	9	11	13	16	Total
	#DIV/0!																

Quarter 3

Total Number of Moments Selected Randomly Prior to the Start of the Quarter:

Total Number of Invalid Moments:

Total Valid Moments

Compliance Percentage:

Pool 1:	Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10	Code 11	Code 12	Code 13	Code 14	Code 15	Code 16	Total Moments
Moments:																	-

SUMMARY FOR INVOICING ONLY																	
	4	6	15	8	10	12	14	1	2	3	5	7	9	11	13	16	Total
	#DIV/0!																

Quarter 4

Total Number of Moments Selected Randomly Prior to the Start of the Quarter:

Total Number of Invalid Moments:

Total Valid Moments

Compliance Percentage:

Pool 1:	Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10	Code 11	Code 12	Code 13	Code 14	Code 15	Code 16	Total Moments
Moments:																	-

SUMMARY FOR INVOICING ONLY																	
	4	6	15	8	10	12	14	1	2	3	5	7	9	11	13	16	Total
	#DIV/0!																

Quarter Average (Averaging by %)

	Code 4	Code 6	Code 15	Code 8	Code 10	Code 12	Code 14	Code 1	Code 2	Code 3	Code 5	Code 7	Code 9	Code 11	Code 13	Code 16
Qtrs	#DIV/0!															
2	#DIV/0!															
3	#DIV/0!															
4	#DIV/0!															
Average	#DIV/0!															
Enter on Tab 2																
Line#	10D	11D	12D	13D	14D	15D	16D	17D	18D	19D	20D	21D	22D	23D	24D	25D

SMAA Averaging Quarter Worksheet Participant Pool 2

(Required for Averaging Quarter Invoice)

Quarter 2

Total Number of Moments Selected Randomly Prior to the Start of the Quarter:

Total Number of Invalid Moments:

Total Valid Moments

Compliance Percentage:

8/1/15

Pool 2:	Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10	Code 11	Code 12	Code 13	Code 14	Code 15	Code 16	Total Moments
Moments:																	-

SUMMARY FOR INVOICING ONLY																	
	4	6	15	8	10	12	14	1	2	3	5	7	9	11	13	16	Total
	#DIV/0!																

Quarter 3

Total Number of Moments Selected Randomly Prior to the Start of the Quarter:

Total Number of Invalid Moments:

Total Valid Moments

Compliance Percentage:

Pool 2:	Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10	Code 11	Code 12	Code 13	Code 14	Code 15	Code 16	Total Moments
Moments:																	-

SUMMARY FOR INVOICING ONLY																	
	4	6	15	8	10	12	14	1	2	3	5	7	9	11	13	16	Total
	#DIV/0!																

Quarter 4

Total Number of Moments Selected Randomly Prior to the Start of the Quarter:

Total Number of Invalid Moments:

Total Valid Moments

Compliance Percentage:

Pool 2:	Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10	Code 11	Code 12	Code 13	Code 14	Code 15	Code 16	Total Moments
Moments:																	-

SUMMARY FOR INVOICING ONLY																	
	4	6	15	8	10	12	14	1	2	3	5	7	9	11	13	16	Total
	#DIV/0!																

Quarter Average (Averaging by %)

Qtrs	Code 4	Code 6	Code 15	Code 8	Code 10	Code 12	Code 14	Code 1	Code 2	Code 3	Code 5	Code 7	Code 9	Code 11	Code 13	Code 16
2	#DIV/0!															
3	#DIV/0!															
4	#DIV/0!															
Average	#DIV/0!															
Enter on Tab 2																
Line#	10E	11E	12E	13E	14E	15E	16E	17E	18E	19E	20E	21E	22E	23E	24E	25E

APPENDIX C

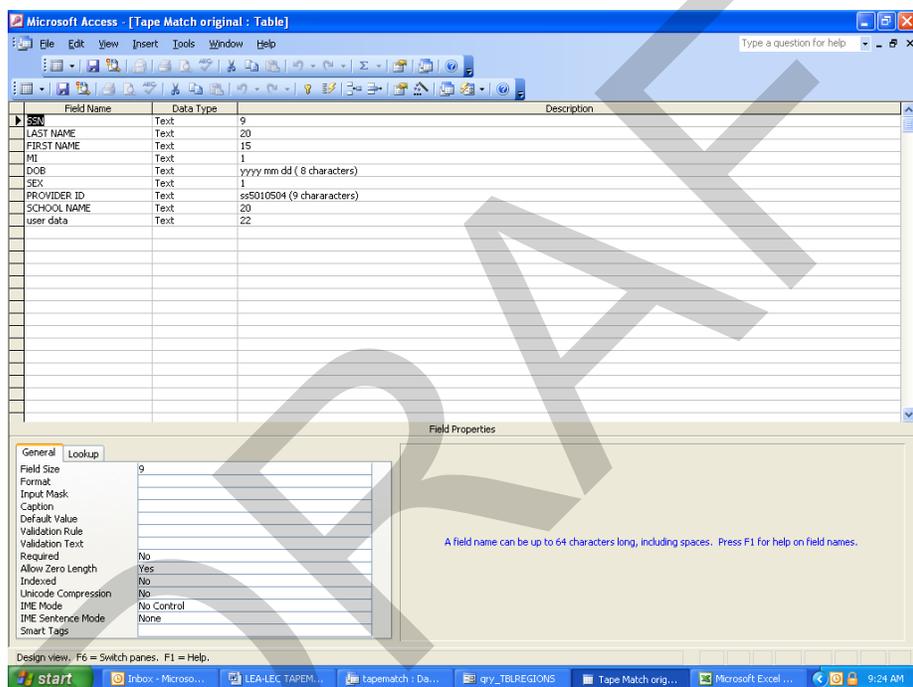
LEA-LEC Tape Match Procedures

DRAFT

LEA/LEC TAPE MATCH INSTRUCTIONS (PC environment with Microsoft ACCESS)

- 1.) Download PGP software and establish a Key and Password
- 2.) Request a “provider id” number from DHCS; apply at <http://www.dhcs.ca.gov/provgovpart/Pages/LEAProviderEnrollment.aspx>
- 3.) Open Microsoft ACCESS and create a new database. Within the database create a new table and call it “DHCS Tape Match”.
- 4.) Following are the name, type and length of the fields that *must be in the database*:

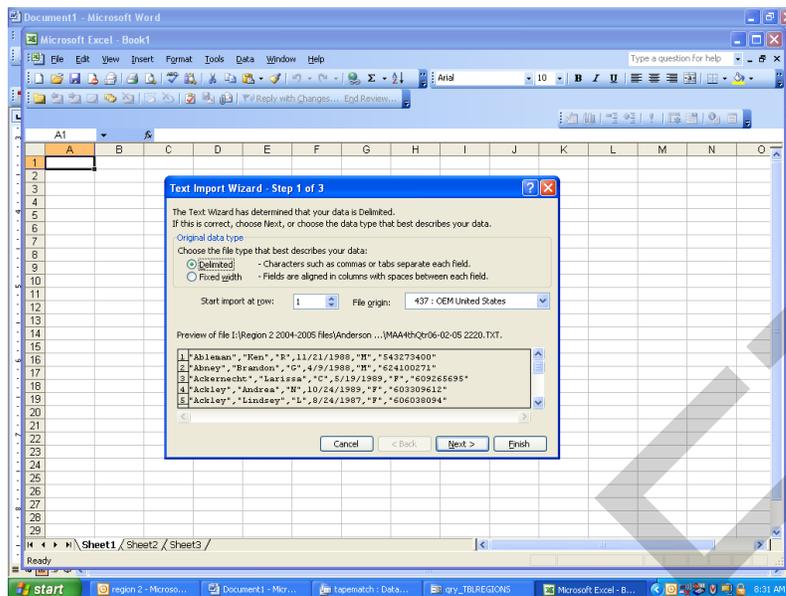
SSN Text 9; LAST NAME Text 20; FIRST NAME Text 15; MI Text 1; DOB Text 8;
SEX Text 1; PROVIDER ID Text 9; SCHOOL NAME Text 20; USER DATA Text 22.



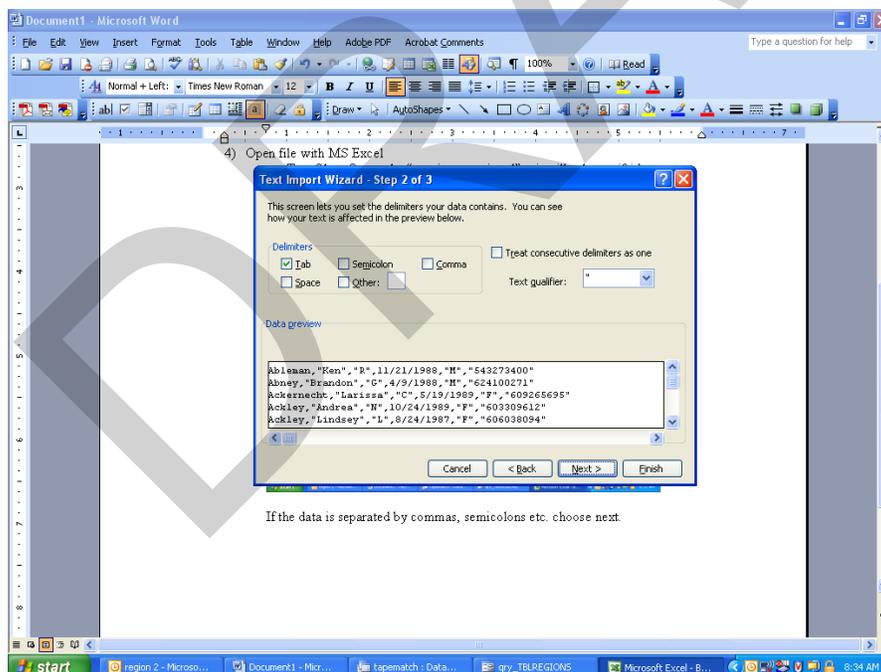
- a.) Close and save the table. Close and save the database.
- 5) Download or output a student population data file (the total number of individuals served by the claiming unit,) from district system as a text or MS EXCEL file. This data file must be from the 1st and 3rd or 2nd and 4th fiscal quarters.

6.) Open the file with MS EXCEL

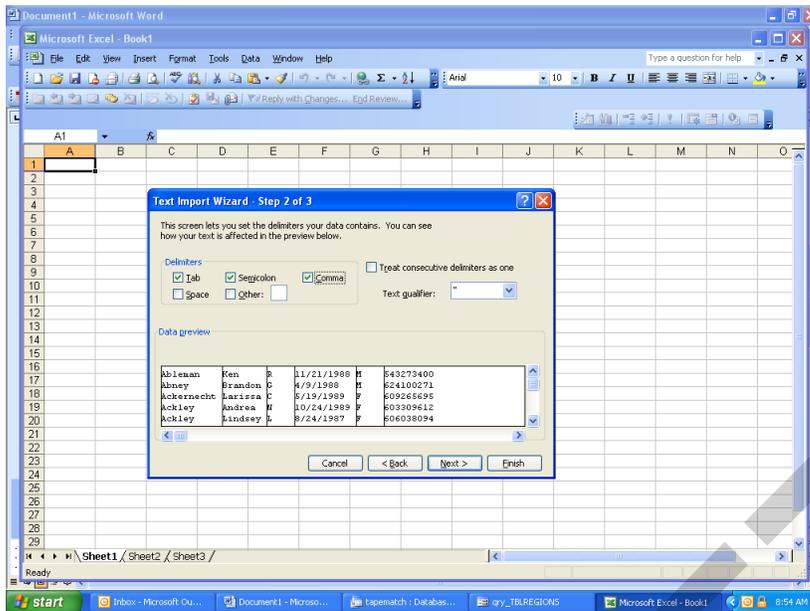
a.) Text file – Opens the “text import wizard” – it will ask you if it’s delimited or fixed width (in the case of fixed width it will have lines dividing the columns and you click finish).



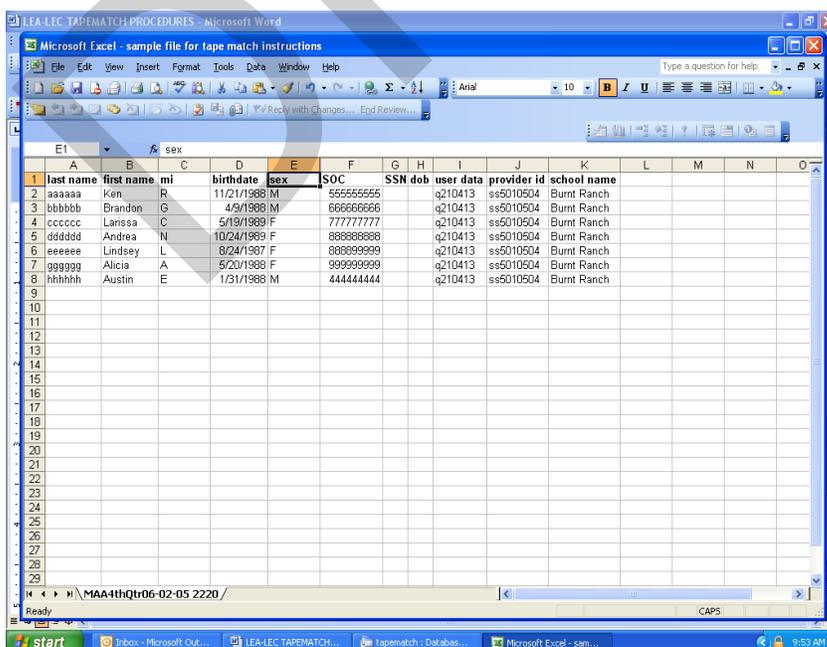
b.) If the data is separated by commas, semicolons, etc., select “Next”. That will give you the opportunity to define the separators.



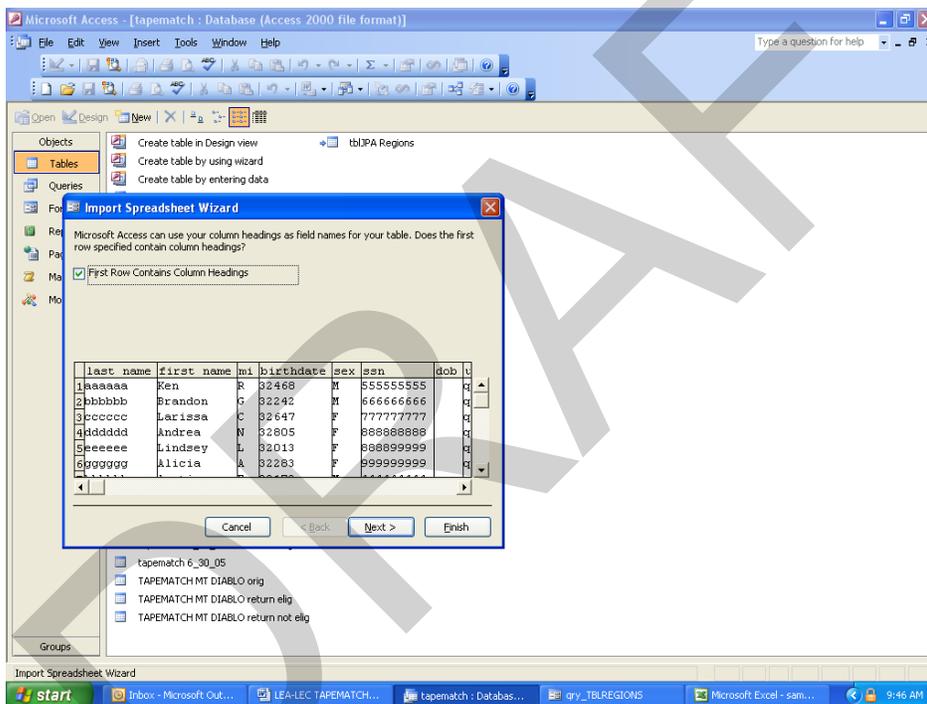
c.) In this case, choose semicolon and comma and the result is the data lined up in columns:



- d.) Click finish and you will have finished the text file import into MS EXCEL.
- e.) Insert a row at the top and label the columns as indicated: Last name, first name, mi, birthdate, social security number and sex.
- f.) **Insert these additional fields: SSN, DOB, user data, provider id and school name. (Even if the Social Security column is labeled SSN, re-label SOC and add a new column SSN.)**
 (Note: User data can be any locally defined information you would like. E.g.: use the CDS number and a quarter identifier, i.e. q461507)
- g.) Fill in the user data, provider id and school name, copying and pasting as necessary to fill entire column for each name in the file, for instance, Q210413, ss5010504, Burnt Ranch.



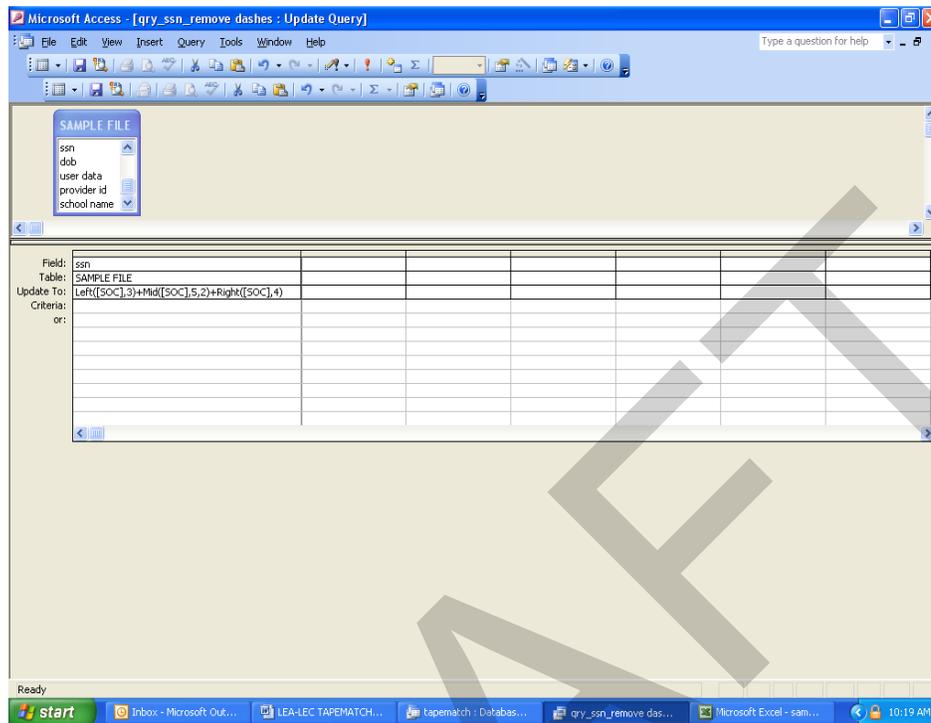
- h.) Save this file as an “MS EXCEL Worksheet” and close.
- 7.) MS EXCEL file – if the file is already in an MS EXCEL format, open and insert a row for labels and/or re-label the columns making sure they are labeled precisely as indicated in step above: **Last Name, First Name, MI, Birthdate, Sex (not gender) and SOC, adding a DOB, SSN, user data, provider id and school name column.**
 - 8.) Fill in the user data, provider id and school name as in step 5 above. Save and close this file.
 - 9.) Open the “database” you created in step 3.
 - 10.) On the File menu choose GET EXTERNAL DATA, IMPORT. This will open a find file box. Locate the MS EXCEL file you had created above, highlight the file and then click IMPORT. This opens the Microsoft ACCESS IMPORT SPREADSHEET wizard.



- a.) Click on the “First row contains column headings” and FINISH. This file will import with the worksheet name as a new table so you might want to rename the table; left click, choose “rename” and give the table a new name, for instance “District”. (Do not call it TAPE MATCH). You will receive a confirmation message of how many records were saved.

(Import Errors: sometimes import errors will occur and a second table will be created. These records are OK in your District or main table, Microsoft ACCESS is just alerting you that an expected configuration wasn't found, for instance, a birthdate field was empty. You can look at the import error table and compare the field number to your main table if you'd like to see the problems.)

- f.) Choose “SSN” from the table list and double click.
- g.) Go to the menu across the top of the database and click on query.
- h.) Click on “update” query. You will now see an update line in the grid.
- i.) In update to: type **Left([SOC],3)+Mid([SOC],5,2)+Right([SOC],4)**

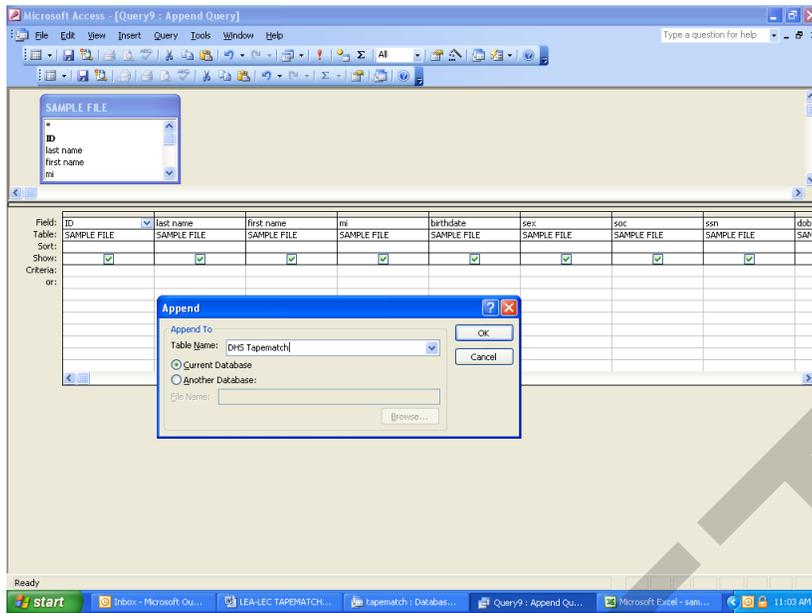


- j.) Go to the file menu and QUERY, RUN or use the ! button. This process will verify that you updated the records in your table. (Your original SOC field is left intact and the SSN field becomes the DHCS acceptable SSN format.
- k.) Close and save the query, calling it “Qry to update SSN”.
- l.) Go to the Tables tab and open the district table to verify the conversion occurred.
- m.) Close

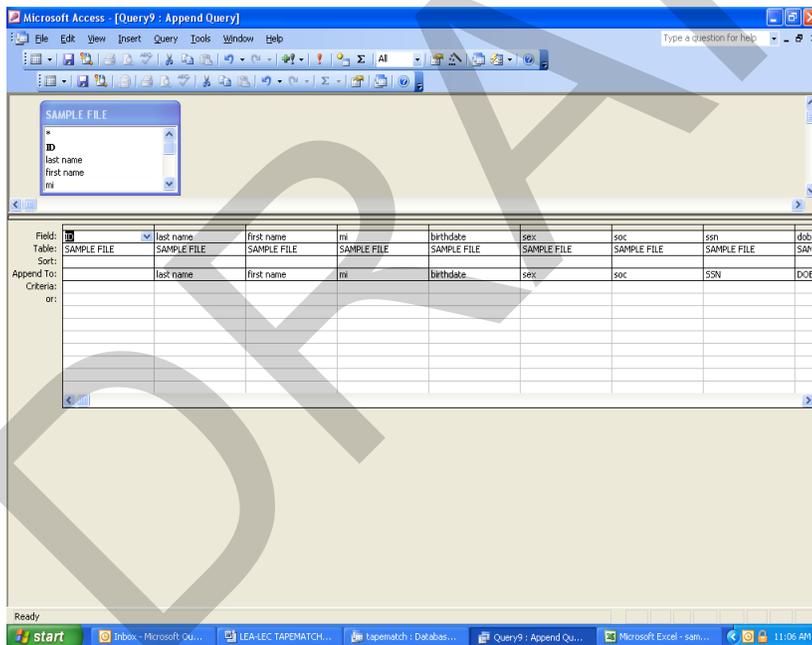
13.) Placing the file into the DHCS Tape Match format

Your file may have some extra information, for instance, middle names instead of middle initial or an ID field. This step enables you to append the “district” table data into the DHCS Tape Match file in exactly the format DHCS requires.

- a.) Go to the Queries tab.
- b.) Create a new query in design view.
- c.) In the Show Table box, highlight your “district” table and click “Add”.
- d.) Close the box.
- e.) Double click on the blue in the table box and drag down to the grid or add each field into the query by double clicking on it.
- f.) Go to the menu across the top of the database and click on query.
- g.) Click on “append” query. A box will open allowing you to choose the table to append to.
- h.) Using the arrow, choose the “DHCS Tape Match” table and click OK.



- i.) After clicking OK, a new line appears that says “Append To” and the names of the fields that you will be appending from your district table into the DHCS Tape Match file will be visible.

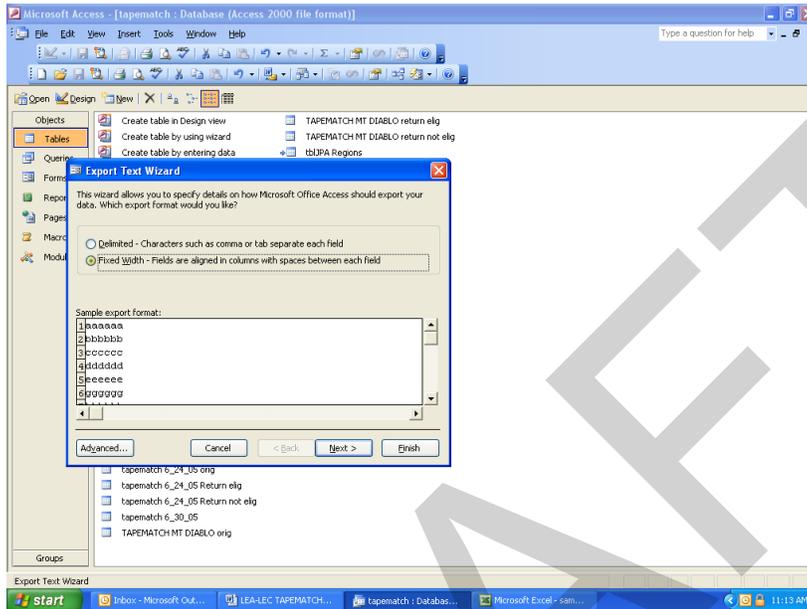


- j.) Go to file menu QUERY and RUN or use the ! . You will get a confirmation that so many records have been appended to the table “DHCS Tape Match”.
- k.) Close the query and save as “Qry to append to Tape Match file”.

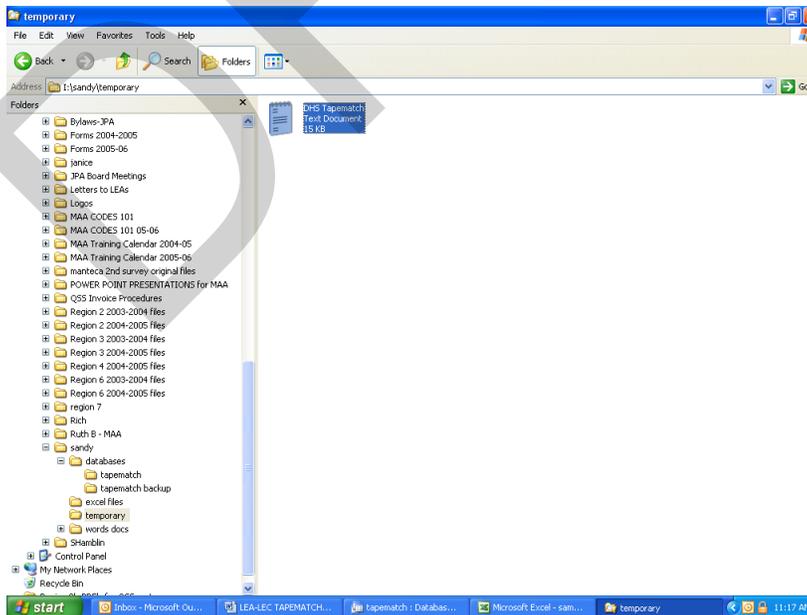
14.) Sending the file to DHCS

- a.) Go to the Tables tab.
- b.) Highlight (click on) the table “DHCS Tape Match”.
- c.) Go to file menu and choose “EXPORT”.

- d.) In the Save as Type file click on the down arrow and choose “text files” (do not use Rich Text Format).
- e.) Once you do that, the file name will automatically appear above the save as type.
- f.) In the Save in: at the top, be sure you remember where you’ve saved the file.
- g.) Click EXPORT.
- h.) In the EXPORT Wizard box choose “Fixed Width” and click Finish.

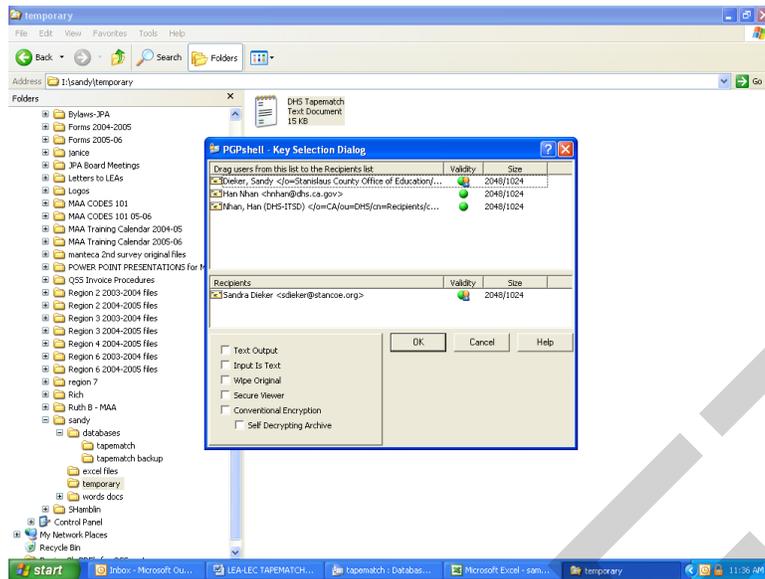


- i.) This step has converted the Microsoft ACCESS table to a text file with the same name as the table, “DHCS Tape Match.txt”.
- j.) Locate the new “DHCS Tape Match” txt file in your directory.
- k.) Highlight the file.

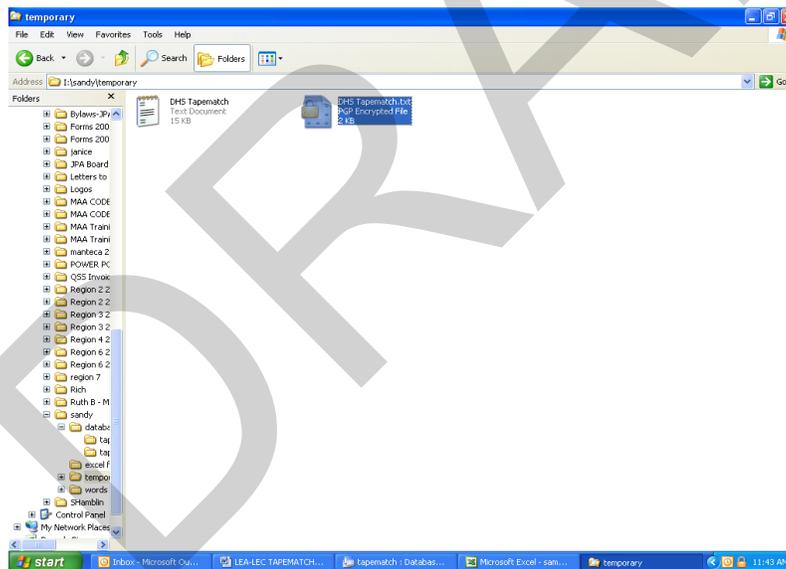


- l.) Left click with your mouse.

- m.) A Box opens that will let you pick some options.
 n.) Find PGP on the list and choose Encrypt. The following box opens:



- o.) Click on the name of the current DHCS assigned key holder name and drag it down to the recipient's box and click OK. You will now have a file created with the same name but the file type is **“PGP Encrypted”**.

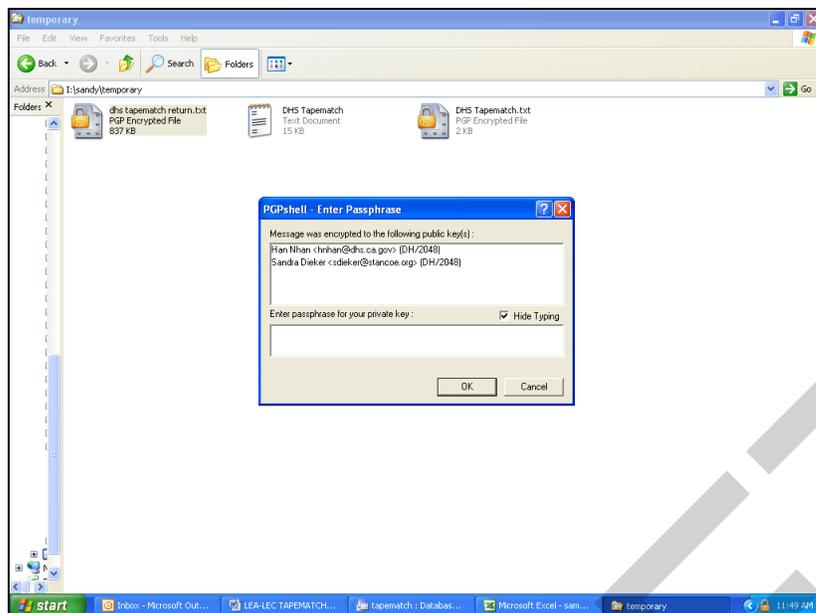


- p.) Choose or highlight the PGP encrypted file, left click and choose send to mail recipient. In the outlook box type in the address of the assigned key holder as noted in Step O. above.

File Returned from DHCS

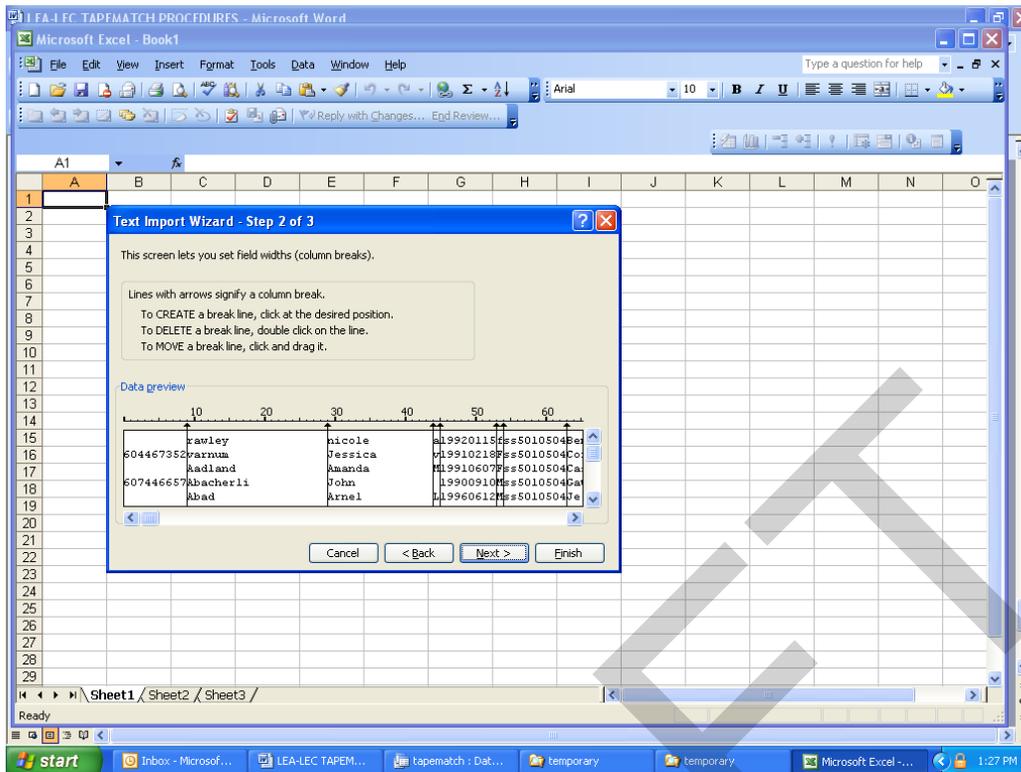
- 1.) Once you receive the file back from DHCS, you will need to decrypt and verify.
- 2.) Double click on the attachment and save the file to your local directory, don't open.
- 3.) Locate the file and left click mouse to get the list of options.

4.) Find PGP and choose “decrypt and verify”. A dialogue box will open.



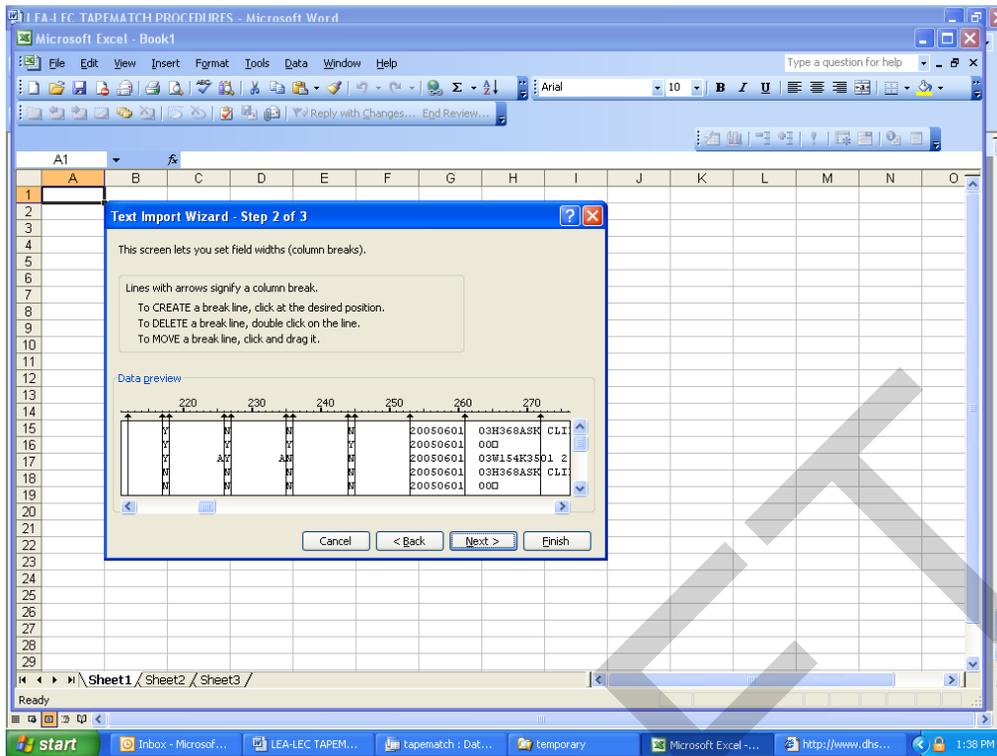
(Note: This step may function differently depending on the PGP version you are using.)

- 5.) In the “Enter passphrase for your private key” type the password you originally set up with DHCS in step 1. The file will automatically save as a Text with the word “return” in the name.
- 6.) Open MS EXCEL, locate this returned file and then double click to open the file.
- 7.) A Text Import Wizard box will open. Choose **Fixed Width and NEXT**.
- 8.) This next step is the most crucial to interpreting the eligibility months. Create, delete or move line breaks according to the DHCS format:



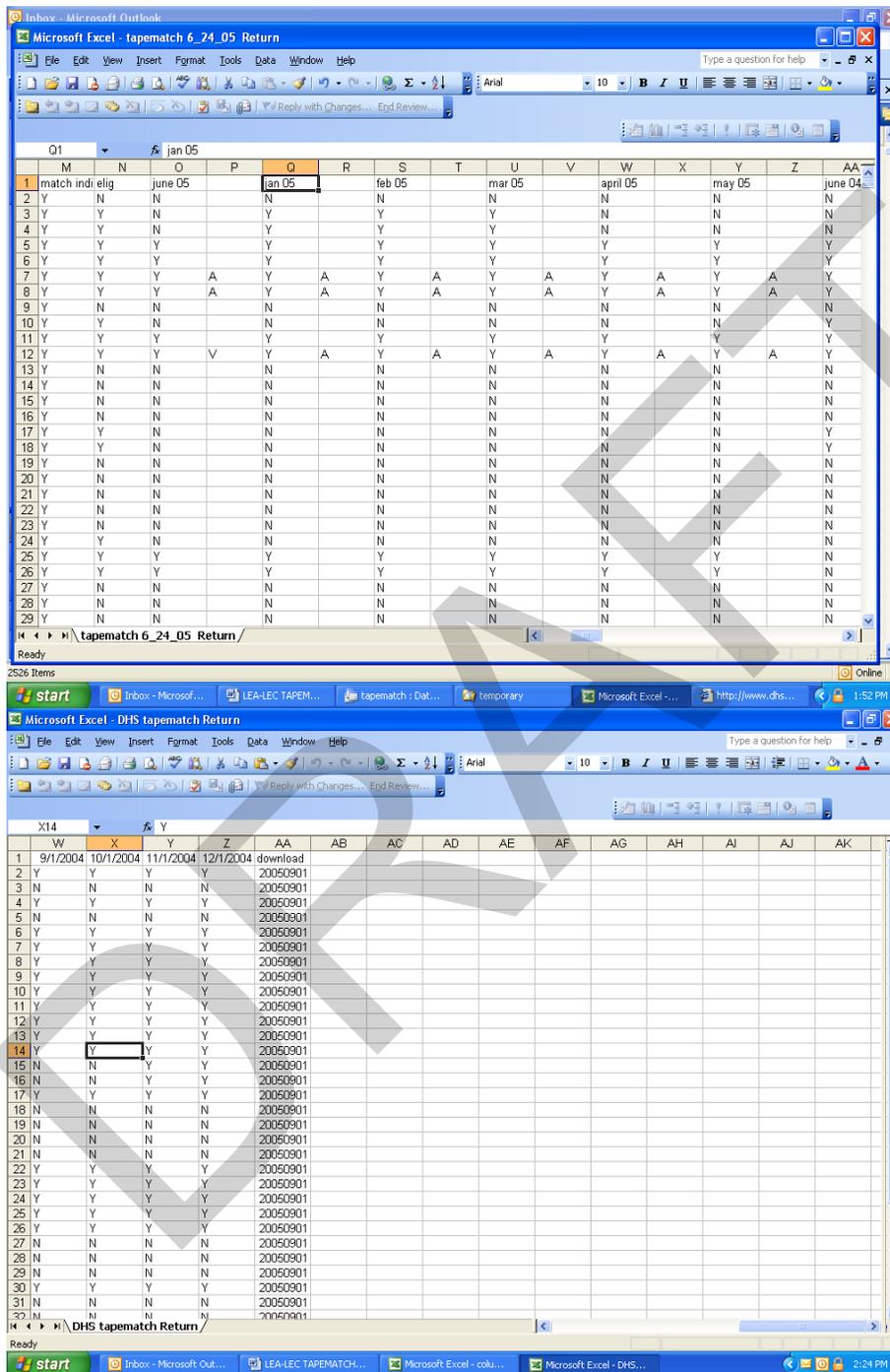
- a.) You'll notice in the Data Preview box that the import wizard has a ruler. Be very careful to make sure you create or delete lines according to the LEA Match Record Layout, if possible. For instance, the SSN number starts at 1 and goes to 9, the last name column starts at 10 and goes to 29, number 30 starts the First Name etc. You will need to create and delete lines all the way to the number 261 which is the Meds Current Date or "download date" from DHCS. You'll notice as you scroll through this ruler and file that a lot of columns consist of Y and N.

Hint: Put a line directly in front of and behind every column with an N or Y. These columns will be your monthly eligibility indicators. An example follows:



- b.) Everything after the “Meds Current Date” is not necessary for our “Tape Match” purposes. Once you get to that point, click Finish.
- 9.) Save this file as an “MS EXCEL Workbook”.
- 10.) Open the MS EXCEL file.
- 11.) Insert a row at the top.
- 12.) Label each column consistent with your names from the original “DHCS Tape Match” file you sent, i.e. SSN, Last Name, First Name etc.
- 13.) After the column that is the Beneficiary ID Card number and Matched Meds ID (it looks like this 94430826A45101622429623) is the match indicator and they should all have Y’s.
- 14.) The next column with Y or N is the Record Eligibility Indicator (if they were eligible in the last 12 months).
- 15.) The next column with Y or N is the current month eligibility indicator, i.e. if your Meds Current Date is 20050601 then that is the Y or N eligibility for June 2005.
- 16.) The next column with a Y or N is the January eligibility indicator, i.e. January 2005 (the same year as the Meds Current Date.)
- 17.) The next column with Y or N after January will be February 05, March 05, April 05, May 05 etc. until you get to the download month, in this case, June 05. Since you already have a June 05 column the next column with a Y or N would be June of the previous year or June 2004.
- 18.) Each column with Y or N after June 2004 would be July 2004, August 2004 all the way to December 2004.

- 19.) December 2004 should be the last Y or N or the 13th column before the Med Current Date. If this doesn't work out, you need to redo the original "returned" file from DHCS and adhere to LEA Match Record Layout. (Note: you may delete any fields like column P in the example below).



- 20.) Once you have these columns all labeled, close and save the file.

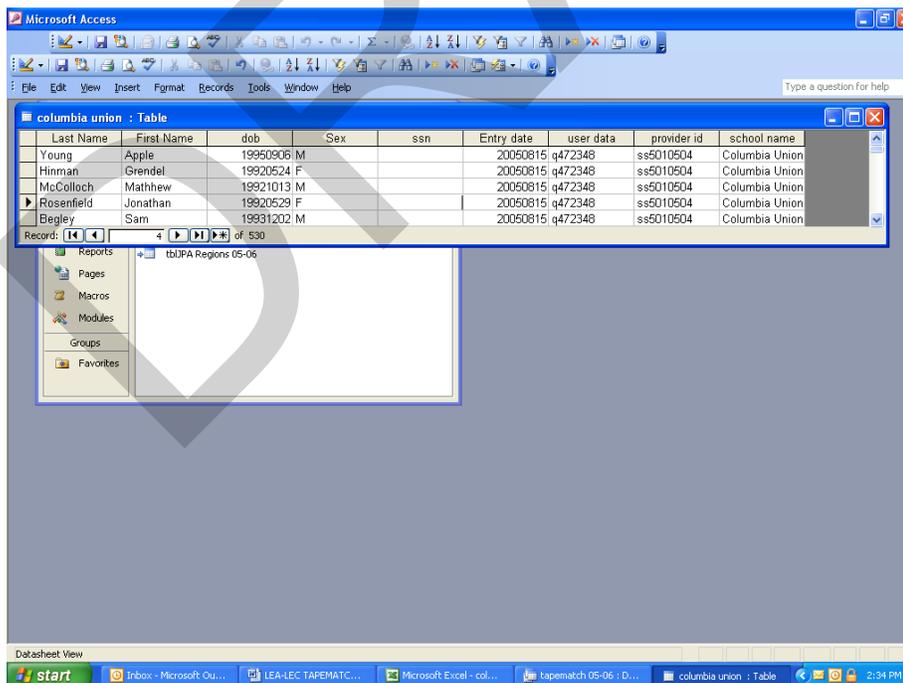
Append the file to Microsoft ACCESS for the Calculation

- 1.) Open the Microsoft ACCESS Tape Match file.
- 2.) Go to FILE, click on GET EXTERNAL DATA, and click on IMPORT.

- 3.) In the dialogue box, find the MS EXCEL FILE that was returned from DHCS, select or highlight and click IMPORT.
- 4.) You may be notified that Microsoft ACCESS will automatically assign field names and the Import Spreadsheet Wizard will open. Be sure and check “first row contains column headings” and then click Finish. You now have a table to perform the Tape Match calculation.

Performing Tape Match calculation

- 1.) Create a new query.
- 2.) Add the user data or school name and each of the months of the quarter you need to match. For instance, if you want to match on a 2nd quarter file then only use those months of eligibility in the file, i.e. Oct. 04, Nov. 04 and Dec. 04.
- 3.) Run the query.
- 4.) Highlight all three columns and sort AZ ascending on the months, i.e. Oct., Nov., and Dec.
- 5.) Scroll or go to the first record that has a Y for one of those months.
- 6.) Place your cursor on the record above it that didn't have any Y's for those three months.
- 7.) In the bottom left hand corner of the query is a record count box. The number in the box is the record number of where your cursor is on the record above the first eligible student. The next number is the total number of records in the table.
- 8.) Subtract the current record number from the total in the file. That is the total number of eligible students for that quarter or students that were eligible in any one month of that quarter.



- 9.) If the original school population sent to DHCS was 1000 and you had 200 returned eligible, the formula is 200 divided 1000 or 20% Tape Match.

APPENDIX D

Participant Exception Form

DRAFT



State of California—Health and Human Services Agency
 Department of Health Care Services



JENNIFER KENT
 DIRECTOR

EDMUND G. BROWN JR.
 GOVERNOR

**School-Based Medi-Cal Administrative Activities Random Moment Time Study (RMTS) Participant Exception
 (Attachment A)**

LEC/LGA/Consortia:				
Claiming Unit	Participant Name	Participant Job Classification	Fiscal Year	Quarter
Print Coordinator Name				
I, the undersigned, state the following: As a public administrator, a public officer, or other public employee of the above named LEC/LGA/Consortia, I am duly authorized or designated to sign this Certification for the Random Moment Time Survey (RMTS) for the fiscal years and quarters noted above. I understand that making false statements for the purpose of filing a false or fraudulent claim is punishable under Welfare and Institutions Code sections 14107, 14107.11, and other applicable provisions of law. This Certification is made under penalty of perjury.				
Coordinator Signature			Date	

Submit forms to: SMAA@DHCS.CA.GOV

APPENDIX E

LATE INVOICE SUBMISSION REQUEST

DRAFT



State of California—Health and Human Services Agency
Department of Health Care Services



Date:

To: DHCS School-Based MAA Chief

From: LEC Coordinator (include Region) or LGA Coordinator (include County)

Subject: Late Invoice Submission Request

Claiming Unit: _____ Invoice Number: _____

We are requesting delayed submission of our invoice for:

Fiscal Year: _____ Quarter: _____

The reason the invoice will not be submitted in a timely manner is: _____

The following steps will be taken to ensure that future invoices are submitted timely:

The invoice will be sent to DHS on: _____ Date

Please contact me if you have any questions or require further information at _____

LEC/LGA Coordinator

Submit forms to: SMAA@DHCS.CA.GOV

APPENDIX F

Code 1 versus Code 16 Matrix

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**School-Based Medi-Cal Administrative Activities
Code 1 and Code 16**

Code 1	Code 16
<u>Education Requirements</u> - Performing administrative or clerical activities specific to instructional, curricular, student-focused areas (e.g., attendance) - Performing activities related to the immunization requirements for school attendance (These activities are considered Free Care and cannot be billed to Medi-Cal.) - Enrolling new students or obtaining registration information - Compiling, preparing, and reviewing reports on textbooks or attendance - Reviewing the education record for students who are new to the school - Conducting external relations related to school/educational issues/matters	<u>Education Requirements</u> - Only Code 1
<u>Instruction</u> - Providing classroom instruction (including lesson planning) - Testing, correcting papers, completing reports - Monitoring student academic achievement	<u>Instruction</u> - Only Code 1
<u>Individualized Education Program</u> - Developing, coordinating, and processing the IEP for a student, which includes ensuring that annual reviews of the IEP are conducted, parental sign-off is obtained, IEP meetings are scheduled, and the IEP is completed	<u>Individualized Education Program</u> - Only Code 1
<u>Operations -</u> <u>- Fulfilling administrative and oversight responsibilities as Assistant Superintendent, Principal, or Assistant Principal</u> - Conducting external relations related to overall general operations (e.g., fiscal, legal, administrative) [previously Code 16] - Performing administrative or clerical activities related to general operations such as accounting, budgeting (including budget development and monitoring of program expenditures), payroll, purchasing and data processing (when these activities are not included in the indirect rate) [previously Code 16] - Compiling, preparing, and reviewing reports related to overall general operations but unrelated to the instructional, curricular, or student information [previously Code 16] - Reviewing technical literature and research articles related to general operations (e.g., fiscal, legal, administrative) [previously Code 16]	<u>Operations</u> - Only Code 1
<u>Meetings and Trainings</u> - Coordinating, participating in, or presenting training related to curriculum or instruction to improve the delivery of student services for programs other than Medi-Cal	<u>Meetings and Trainings</u> - Coordinating, participating in, or presenting training necessary to clarify site and district policy, procedures, or issues related to employees - Attending or facilitating school or unit staff meetings, board meetings, or required in-service trainings and events (not related to curriculum, instruction, or students)
<u>Review and Planning</u> - Reviewing technical literature and research articles related to curriculum and instructional services - Evaluating curriculum and instructional services, student/teacher policies, and procedures as they relate to student instruction for the school site or district	<u>Review and Planning</u> - Reviewing school policies, procedures, or rules
<u>Supervision</u> - Providing general supervision of students (e.g., playground, lunchroom) - Conferring with students/parents about discipline, academic matters, or other school non-health related issues - Applying discipline activities with students	<u>Supervision</u> - Providing general supervision of staff, including supervision of student teachers or classroom volunteers - Evaluation of employee performance (including person being evaluated)
<u>Survey Participant Paperwork</u> -	<u>Survey Participant Paperwork</u> - Completing expense claims as required for work-related travel - Completing time survey form
<u>Paid Time Off</u> - Only Code 16	<u>Paid Time Off</u> - Paid time off (when you are being paid, but you are not at work). This includes vacation days, jury duty, sick leave, breaks, and lunch breaks (if it is paid time)

APPENDIX G

Code 2 versus Code 8 Matrix

DRAFT

School-Based Medi-Cal Administrative Activities Code 2 and Code 8

Code 2	Code 8
Direct Medical Services & Extensions of Direct Medical Services	Referral, Coordination, and Monitoring of Medi-Cal Services
IEP direct service time (such as counseling, speech, OT/PT, and specialized nursing).	Making referrals for and/or coordinating medical or physical examinations and necessary medical/mental health evaluations.
Monitoring/observation of student by the direct service provider to determine what direct service techniques/strategies to further provide.	Gathering any information that may be required in advance of referrals.
Direct service provider activities that are an integral part of or an extension of a medical service (e.g., student follow-up, student assessment, student counseling, student education, consultation and student billing activities, including arranging and coordination IEP meetings) are considered direct medical services.	Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medi-Cal service providers as may be required to provide continuity of care.
Direct service provider research of the health condition, therapy strategies and equipment to use with a student.	Arranging for any Medi-Cal covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition.
Direct service provider consultation with other health providers necessary for implementation of a direct service.	Providing information to other staff on the child's related medical/dental/mental health condition.
Examples of Code 2	Examples of Code 8
Met with student/teacher of family to modify student learning environment as <u>required</u> extension of direct service.	Met with teacher to discuss student progress outside the direct service environment.
Reported on student health assessment results at IEP meeting.	Met with parent to discuss students' on-going progress in M/C covered speech therapy.
Provided and/or received information from other health providers about student condition in order to implement direct services.	Arranging/scheduling ongoing Medi-Cal health services w/providers.
Completing assessment reports and preparing for IEP meeting.	Monitoring the provision of IEP required Medi-Cal covered services.

APPENDIX H

Time Survey Participant Equivalency Form

DRAFT



JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

School-Based Medi-Cal Administrative Activities (SMAA) Time Survey Participant Equivalency Request

LGA/LEC: _____ Submittal Date: _____

Claiming Unit: _____ Fiscal Year and Quarter: _____

Proposed Equivalent Job Classification Title:

Number of Positions that will Participate in MAA Activities _____

Pursuant to the California School-Based Medi-Cal Administrative Activities (SMAA) Manual, each LEC/LGA must ensure claiming unit staff performing MAA activities are included on the authorized Time Study Participant (TSP) list. Please answer to the following questions for the Equivalent Job Classification listed above in order to describe how that job classification complies with the authorized list and performs an equivalent job function. Please attach additional pages as necessary.

(Include a job description and copies of credential, certification or license, if applicable)

1. In which participant pool is this job classification being placed?
 ___ Participant Pool #1 ___ Participant Pool #2
2. To what authorized job classification is this equivalent? (list pool and position number)
3. What are the job functions of this position that makes it equivalent to the authorized job classification?
4. Provide a clear description of the type of activities performed.
5. Provide a clear description of how the activity will be performed to achieve the objective.
6. Identify the target population.

I certify that the information provided herein is true and correct and accurately reflects the performance of Medi-Cal Administrative Activities (MAA). I also certify the information provided complies with 42 Code of Federal Regulations (CFR) 433.15(b)(7) and the Office of Management and Budget (OMB) Circular A-87.

Print Name: _____

Signature: _____ Date: _____

Title: _____

APPENDIX I

Funding Source Change Form

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APPENDIX J

PPL 15-011

DRAFT



JENNIFER KENT
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



EDMUND G. BROWN JR.
GOVERNOR

DATE: May 5, 2015 **PPL No. 15-011**

TO: Local Educational Consortia (LEC) and
Local Governmental Agency Coordinators (LGA)

Subject: Medi-Cal Administrative Activities Related to Individualized Educational
Programs (IEPs)

The purpose of this Policy and Procedure Letter (PPL) is to provide guidance to LECs and LGAs participating in the School-Based Medi-Cal Administrative Activities (SMAA) program regarding individual code assignments for Random Moment Time Study (RMTS) moment responses that are related to the development and/or implementation of an IEP.

According to Centers for Medicaid and Medicare Services (CMS) 2003 Medicaid School-Based Administrative Claiming Guide, Section B 4(b):

The development of an IEP is a requirement of the Individuals with Disabilities Education Act (IDEA), the primary purpose of which is to facilitate the child's education. Because it is an education requirement, Medicaid does not pay for the administrative activities associated with the development of the IEP. Once the IEP is established and implemented, however, Medicaid does pay for administrative activities that are directly related to the provision of those Medicaid covered services that are identified in the IEP, and which are furnished to Medicaid eligible children.

In compliance with CMS guidelines, administrative activities provided in the development of the IEP, including initial assessments, and activities that take place within the IEP meeting itself are not eligible for Medicaid/Medi-Cal reimbursement.

PPL 15-011
Page 2
May 5, 2015

If you have any questions or require further assistance regarding this PPL, please contact Tony Teresi, Chief, School-Based MAA Unit at (916) 552-9049, or Tony.Teresi@dhcs.ca.gov

Sincerely,

ORIGINAL SIGNED BY MICHELLE KRISTOFF

Michelle Kristoff, Chief
Medi-Caid Administrative Activities Section

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