California School-Based Medi-Cal Administrative Activities Manual

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FORWARD

This California School-Based Medi-Cal Administrative Activities (MAA) Manual (hereinafter referred to as “the School 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). Department of Health Care Services (DHCS), formerly known as 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 School Manual. Each year, DHCS and the LEC/LGA committee will revise the School Manual to update any changes and provide further clarification.

The School 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 MAA Manual

SECTION 1

How to Use This Manual

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How to Use This Manual

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

The School Manual is your primary reference for information about MAA program participation requirements. You should consult this manual before seeking other sources of information.

For the purposes of this manual, the term Local Educational Consortium (LEC) represents the one school district or County Office of Education (COE) within each region holding a contract with DHCS to coordinate the MAA program for school districts and county offices within its region. The Local Educational Agency (LEA) represents the claiming unit, which is typically a school district, or program within a district or COE like Healthy Start, Special Education, or California School-Age Families Education (Cal-SAFE). The term Local Governmental Agency (LGA) is included with LECs when an LEA contracts with the LGA to invoice for MAA. Therefore, MAA school-based claiming policies and procedures apply to LECs, LEAs, and LGAs.

Organization

The School Manual is organized into four topic areas:

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

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 School Manual is updated.

School Manual Updates/Policy and Procedure Letters

Annually, DHCS issues and updates the School Manual. Throughout the year, when changes occur in the MAA 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 School Manual. Changes in federal requirements are reflected in the School Manual every fiscal year based on the State's approved process. The School Manual represents the California method of meeting federal requirements and applies to the applicable fiscal year being claimed.

The current School Manual can be found online atwww.dhcs.ca.gov/provgovpart/Pages/SMAAManual.aspx. Changes to any text in this manual are identified by a vertical line in the left hand border. Policy and Procedure Letters can be found online at www.dhs.ca.gov/maa/WebPages-PPL's/ppl_index.htm.

Telephone Inquiries

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

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SECTION 2

Medi-Cal Background

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Overview

Throughout the School-Based MAA Manual, the terms "school" and/or "school district" are used to represent all types of school-related administrative claiming units (e.g., LEAs, consortia).

The Medicaid program is a national health care program designed to furnish medical assistance to families; to 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 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, it 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 for MAA is 50 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.

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 screening, dental, vision, and hearing services; and report EPSDT performance information annually to CMS. For more information about EPSDT, please refer to the CMS Medicaid website at www.cms.gov.

Administrative activities discussed in the School Manual that are claimable to Medicaid must be those associated with or in support of the provision of Medicaid-coverable medical services. The coverable 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: these include conducting Medicaid outreach; facilitating Medicaid eligibility determinations; and providing medical/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 to provide 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.

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SECTION 3

MAA Glossary

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MAA Glossary

Actual Client Count (ACC)/Tape Match	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 MAA activities as determined by time surveys or direct charge documentation.
Annual Time Survey Training	All participants that time survey must attend annual Time Survey training according to the California School-Based MAA Manual. Annual is the school fiscal year, which begins on July 1 and ends on June 30.
Audit File	The documents and records that the LEA/LEC/LGA develops and maintains in support of MAA invoice(s). This file is used to support the invoice during site reviews and audits.
Averaging Form	Quarter Averaging Worksheet (QAW) Participation hours for each MAA Code must be entered manually; the worksheet then automatically calculates the average.
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 program. Medicaid is a national health care program designed to assist families; aged, blind, and disabled persons; and individuals whose income and resources are insufficient to meet the costs of necessary medical services.

Certification Statement	A statement on the Claiming Unit Functions Grid (the Grid) certifying that the information in the operational plan is true and correct and accurately reflects the performance of MAA activities. This statement, located at the bottom of the form, is signed by the LEC/LGA Coordinator and the LEA Coordinator.
Certified Public Expenditure	An expenditure by a public entity (a government/public agency, including public schools) for providing MAA or TCM services. Certified public expenditures include only those expenditures made by an LEC, LGA, LEA, or other governmental non-federal source 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 MAA Program.
Claiming Plan	(Replaced by the term “Operational Plan.”)
Community-Based Organizations (CBO)	Organizations based/located in the LEC’s/LGA’s local community providing support services to families in accessing medical services, including programs and services covered by Medi-Cal.
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 a MAA invoice.
Cost Pool(s) (CP)	Cost Pools are the basis of MAA claims (invoices). All costs for a claiming unit must be included in one of the Cost Pools or on the Direct Charge Worksheet.
Department of Health Care Services (DHCS)	The single state agency for the administration of the Medicaid program in California.

DHCS Tape Match/ Actual Client Count	Referenced as both the DHCS Tape Match and the ACC, LEAs that participate in the LEA Medi-Cal Billing Option program have access to tape matches of school enrollments with Medi-Cal eligibility data. Produced by DHCS, these matches 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 identified as 100-percent allowable. These costs are entered in the Direct Charge section of the MAA invoice.
Duty Statement	Document describing the current duties and responsibilities assigned to a specific position and how they relate to MAA. 1) Specific employment classification; 2) necessary knowledge, skills, abilities, education, certification and minimum qualifications; 3) scope of work, the variety and complexity of general tasks performed; 4) type of supervision exercised and/or received as they relate to MAA; 5) the proper MAA code identifying the MAA activity, as applicable.
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 Medicaid eligibles and their parents or guardians effectively use these resources.
Enhanced Funding	The enhanced federal financial funding rate of 75 percent is no longer claimable effective January 1, 2003.
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 Families	Low-cost insurance that provides health, dental, and vision coverage to children who do not have insurance and do not qualify for no-cost Medi-Cal. Offered to children whose family income is at or below 250 percent of the Federal Poverty Income Guidelines.
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.
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 instruction that is specially designed to meet each student's unique needs. See Appendix D.
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.
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 MAA Detail Invoice with supporting worksheets and the MAA Summary Invoice are to be used for the MAA claiming process. The invoice package claiming documents that must be included and submitted to DHCS in the following order are: 1) MAA Summary Invoice, 2) Invoice Variance Form, 3) Activities and Medi-Cal Percentages Worksheet, 4) Time Survey Summary Report, 5) Direct Charges Worksheet, 6) Payroll Data Collection Worksheet, 7) Payroll Data Collection & Other Summary Sheet (maintain actual staff ledger reports for audit purposes), 8) Costs and Revenues Worksheet, 9) Supporting Documentation, 10) Claiming Units Function Grid, 11) Checklist for preparing the MAA Detail Invoice, and 12) Checklist for preparing the MAA Summary Invoice.
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 MAA for an LEA.
LEA Medi-Cal Billing Option	A mechanism for LEAs to bill Medi-Cal for specific health and 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)	An LEA coordinating MAA services for one specific region. Each LEC represents one of the 11 service regions of the California County Superintendents Educational Services Association (CCSESA), and each regional coordinator serves on an advisory committee to DHCS.
Local Governmental Agency (LGA)	Local public health office or county agency that oversees the MAA program for its county.
LEC/LGA Coordinator	An individual who administers the MAA program for the region or county according to DHCS interpretation of MAA regulations.
Managed Care Organizations (MCO)	Health maintenance organization designed to oversee services and costs for individual clients.
MAA Contract	For an LEC/LGA to claim reimbursement for MAA, Welfare and Institutions Code Section 14132.47(b) requires that a contract be in place between DHCS and the LEC/LGA.
Medi-Cal Administrative Activities (MAA)	Activities necessary for the proper and efficient administration of the Medi-Cal program.
Medi-Cal Discount	The Medi-Cal percentage used to discount costs on the MAA invoice. The approved method to calculate the discount is the DHCS Tape Match/Actual Client Count.
Medi-Cal Eligible	An individual who is currently eligible to receive Medi-Cal benefits and health services.
Medi-Cal Percentage	The fraction of a population that consists of actual recipients of the Medi-Cal program.
Non-Public Schools	A nonpublic, nonsectarian school, certified by the state, that enrolls individuals with exceptional needs pursuant to IEP (EC Sec. 56034).
Nonspecific Contract	The contract does **not** clearly describe the MAA to be performed or specifically identify the amount to be paid for each allowable activity.
Office of Management and Budget (OMB) Circular A-87	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.
Operational Plan (OP)	Documentation the claiming unit uses to perform MAA and that includes the audit file documentation that supports the invoice.
Participation Fee	LECs/LGAs participating in MAA are required to pay a fee to cover additional costs related to program administration.

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 MAA 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.
Policy and Procedure Letter (PPL)	Notification from DHCS to all LEC/LGA coordinators of new procedures or to clarify policy and procedural issues.
Professional Day	Time survey recording based on contract language allowing for flexible hours worked. Often used by management personnel.
Quarterly Summary Invoice	The summary or aggregate of costs for each claiming unit on each quarterly MAA 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.
Revenue	Funding received by an LEC/LGA or program.
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.
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 MAA.
Service Providers	A provider of Medi-Cal services in California.
Single State Agency	The state agency charged with administering the Medicaid program. In California, the single state agency is DHCS and the Medicaid program is called Medi-Cal.
Specific Contract	A contract that describes the MAA to be performed and the specific amount to be paid for each activity.
Subcontractor	An agency that enters into a contract with the LEA/LEC/LGA to perform MAA-related services.
Time Survey	The approved methodology for determining the percentage of costs allowable for each MAA activity.
Vendor	A vendor may be used by LEAs to help them administer the MAA program.
504 Accommodations	The section of the Rehabilitation Act of 1973 that requires school districts to provide or pay for certain services to make education accessible to handicapped children.

California School-Based MAA Manual

SECTION 4

MAA Overview

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Overview

DHCS and individual school 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. In the School Manual, a "school claiming unit" refers to a school-sponsored program administered by an LEA, which is a school district, COE, 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 MAA claiming. The primary purpose of the MAA program is to reimburse school claiming units for these activities, where allowed as described in the School Manual. 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 MAA time survey. The term "activities" typically refers to MAA time, which is not claimable through the LEA Billing Option, but is claimable through MAA.

Definition

The MAA 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 LEA Medi-Cal Billing Option or under other Medi-Cal. In general, the cost of school-based health and outreach activities reimbursed under MAA 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. OMB Circular A-87 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 MAA program. However, it is necessary to determine the amount of time school staff spend performing MAA. Time spent by school staff on MAA is identified using a time survey. The results of the time survey is then used in a series of calculations to determine the percentage of school costs that can be claimed under MAA. MAA reimbursement to school claiming units is made from federal Medicaid funds.

Participating in MAA

To participate in MAA, all LEAs, must contract through only their California County Superintendents Educational Services Association (CCSESA), regional LEC or county LGA, time survey, complete the Grid, invoice, and maintain an audit file. The Grid, submitted with the invoice, reflects changes to the Operational Plan (OP) and is supported by the audit file.

Constructing Time Activity Codes

School employees may engage in activities that involve furnishing direct services and/or performing other administrative activities required and covered by education programs, other social programs, and the Medi-Cal program. Some or all of the costs of these services and administrative activities may be claimed under these programs; however, an appropriate claiming mechanism must be used. The time survey identifies and categorizes activities performed by school employees and is used to develop claims for the costs of these administrative activities that may be properly reimbursed under these programs.

The time survey must reflect all of the paid time and activities (whether allowable or unallowable) performed by employees participating in the MAA claiming program. The time survey identifies direct medical and other services and ensures that those costs are not included in the claims for administrative activities. Time survey codes distinguish between each activity an employee is engaged in during a time survey period. The time survey is considered a legal document representing the actual time the person spends performing the MAA activities reported in the invoice.

Each year, DHCS will designate a one-week MAA Time Survey period for quarters one, two, three, and four. During each quarter, the designated one-week period for the time survey will vary to ensure a valid basis from which current fiscal year costs are claimed. Claiming Units that time-survey during three quarters may create their remaining quarter time survey results by averaging the results of three quarters (see Section 6 for further details on the averaging option).

If a claiming unit wishes to participate, the LEC/LGA must provide training prior to the time survey. A training log must be maintained with the training date, location, name of trainer, participants printed legal name, and signature to verify that the participant was trained. This time survey will be used for processing the invoice from the first day of the quarter in which the time survey is conducted and will remain in effect until the next required time survey period. Unless averaging for the quarter, a time survey must be performed by staff for each quarter in order for the claiming unit to claim reimbursement.

Invoicing for MAA

Claims for MAA reimbursement are submitted by the LEC/LGA to DHCS. Each invoice is prepared on a separate detailed quarterly invoice for each claiming unit, as defined in the Grid. Certain costs are entered in the Direct Charge section. Some direct charge costs must be discounted by the Medi-Cal percentage. Direct charges must be itemized and explained in documentation to be included in the audit file. (See page 6-8.)

The LEC/LGA must prepare and submit a quarterly summary invoice for each claiming unit's detailed invoice. The form for the detailed invoice blends the cost and revenue data into one spreadsheet, which is used to compute the invoice, adjust for all necessary revenues, and apply activity and Medi-Cal discount percentages, 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 MAA were performed.

Contingency Fees

The costs of contingency fee contracts shall not be claimed under the MAA program. Many school districts or local educational agencies have chosen to use the services of consultants. The OMB Circular A-87 states in item 32.a, of Attachment B, Selected Items of Costs, that:

> Cost of professional and consultant services rendered by persons or organizations that are members of a particular profession or possess a special skill, whether or not officers or employees of the governmental unit, are allowable, subject to section 14 when reasonable in relation to the services rendered and when not contingent upon recovery of the costs from the Federal Government.

Medi-Cal claims for the costs of administrative activities and direct medical services may 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.

LEAs may directly contract with consultants to administer parts of the MAA 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 federal regulations. LEAs may not reimburse vendors on a contingency fee basis and claim that cost on their MAA invoices. If LEAs reimburse vendors using a flat fee schedule, they may claim that cost on their MAA invoices. (See Section 9 for explanation of allowable fees.)

Duplicate Payments

Federal, State, and local governmental resources must be expended in the most cost-effective manner possible. In determining the administrative costs that are reimbursable under Medi-Cal, duplicate payments are not allowable. 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.

Coordinating Activities

LEA 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 MAA 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

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

In general, local costs associated with MAA are reimbursed at the FFP rate. DHCS requires LEAs to certify the availability and expenditure of 100 percent of the cost of performing MAA. The funds expended for this purpose must be from the LEA claiming unit funds allowed under State and federal law and regulations (per Title 42, Code of Federal Regulations [CFR], Section 433.51: the expenditure must come from a public entity). When a MAA activity code is identified as proportional or discounted, the activity costs claimed for reimbursement must be allocated to both the Medi-Cal and the non-Medi-Cal eligible students. The proportion of Medi-Cal-eligible students to the total number of students served by the claiming unit represents the Medi-Cal percentage, which is applied to total costs. The discounted costs then represent proper administrative claims, as required by OMB Circular A-87, which states: “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.”

Provider Participation in the Medi-Cal Program

Reimbursement for the cost of performing administrative activities that support medical services is available only when each of the following requirements is 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.

An LEA 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 school 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 an LEA 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, MAA time can be counted. 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.

Examples of this principle are:

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." MAA 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, "Referral, Coordination, and Monitoring of Medi-Cal Services."
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, "Referral, Coordination, and Monitoring of Non-Medi-Cal Services."

Individualized Education Plan (IEP) Activities

Under the provisions of Part B of IDEA, school staff are 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 MAA 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.

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 Payor of Last Resort

The Medi-Cal program is generally the "payor 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. LEAs cannot be reimbursed through MAA for the cost of providing direct medical services. For example, the services of a school nurse who attends to a Medi-Cal child's sore throat, sprained ankle, or other acute medical problem are direct medical services and are not MAA. 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 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 LEA provider must pursue recovery from the OHC insurers for reimbursement before billing Medi-Cal.

Training for School Administrative Claiming

School staff that perform MAA must be knowledgeable of which activities are eligible for reimbursement under the MAA program. Staff must be familiar with the time survey methodology and how to complete the DHCS-approved time survey form. All school staff intended to be included in an OP must participate in training annually to gain an understanding of the definitions of all 100-percent-Medi-Cal-reimbursable activities, partially reimbursable (proportional Medi-Cal) activities, and nonreimbursable activities that are on the time survey form. Staff added to an OP during the fiscal year must also be provided training by the local/regional MAA coordinator prior to time-surveying. **(See Section 6 – MAA Time Survey – Time Survey Training – Page 6-3)**

Trainings will include detailed training regarding completing the time survey form and the appropriate methods of capturing the costs of specific activities reimbursed at 50 percent. DHCS, in conjunction with the LEC/LGA Committee, will:

1. Develop a DHCS-approved training of trainers presentation;
2. Conduct a training of trainers annually for LECs and LGAs and their designated agents; and
3. Provide ongoing training and support to each claiming unit on time surveys, OPs, and invoices.

Attendance will be mandatory for LEC and LGA coordinators for these annual MAA training-of-trainers sessions. LECs and LGAs, along with their designated agents, will be allowed to develop additional training materials and offer training sessions to their respective claiming units, based on the DHCS statewide training materials. DHCS and CMS staff will attend random trainings offered by LECs and LGAs to their regional claiming units.

Transportation as Administration

MAA transportation activities include only the arranging for the student's transportation to and from a location where he or she will receive a Medi-Cal provided and billable service. These activities are captured in Code 10. (See Section 5 for more information regarding Code 10).

Time spent arranging LEA-billed transportation during the MAA survey week is to be included under Code 2, Direct Medical Services.

A claiming unit cannot bill for arranging transportation through both TCM and MAA. This is considered duplicate billing.

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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 time-studied proportion of salary, benefit, and other costs of providing these administrative activities. To identify the cost of providing these activities, a time study of staff must be conducted. The time study 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 time-study participants.

Staff Activities and Codes. Each code 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 study 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.

Staff 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	Initial 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	Ongoing Referral, Coordination, and Monitoring of Non-Medi-Cal Services **(U)**
CODE 8	Ongoing 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, and Training **(TM/50-percent FFP)**
CODE 16	General Administration/Paid Time Off **(R)**

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 H. Performing 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 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 is 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.

w. Preparing for and providing behavior management principles to student.

Note: *Activities that do not relate to Medi-Cal, are not administrative in nature or do not meet the definition of any other code category.*

CODE 2. DIRECT MEDICAL SERVICES (U)

School staff should use this code 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, including arranging and coordinating IEP meetings) 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 TCM- and LEA-billed Medi-Cal services.

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, or a prescribed injection or medication, to a student.

h. Providing direct clinical or treatment services.

i. Performing developmental assessments.

j. Providing counseling services to treat health, mental health, or substance abuse conditions.

k. Performing routine or mandated child health screens, including but not limited to vision, hearing, dental, scoliosis, and certain EPSDT/CHDP screens.

l. Providing immunizations.

m. Conducting TCM Services.

n. Activities that are medical services or components of medical services.

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

This code should be used by all school staff when performing activities that inform eligible or potentially eligible individuals about non-Medi-Cal social, vocational, and educational programs (including special education) and how to access them, describing the range of benefits covered and how to obtain them. 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/dental/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. INITIAL MEDI-CAL OUTREACH (TM/50-Percent FFP)

This code should be used by school staff when performing initial 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 eligible's into the Medi-Cal system for the purpose of determining eligibility and initially arranging for the provision of Medi-Cal services. Include related paperwork, clerical activities, or staff travel required to perform these activities (including initiating and responding to email and voicemail). LEAs 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. Identifying and referring adolescents who may be in need of Medi-Cal family planning services.

c. 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.

d. Informing children and their families on how to effectively access, use, and maintain participation in all health resources under the federal Medi-Cal/Healthy Families program.

e. Assisting in the early identification of children who could benefit from the health services provided by Medi-Cal as part of a Medi-Cal/Healthy Families outreach campaign. Not claimable are child find activities that are required under Special Education regulations (use Code 3 Non-Medi-Cal Outreach).

f. Contacting pregnant and parenting teenagers about the availability of Medi-Cal prenatal and well-baby care programs and services.

g. 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.

h. Providing initial referral assistance to families where Medi-Cal services can be provided.

i. Participating in/or coordinating outreach trainings that improve the delivery of Medi-Cal services.

j. Providing information regarding Medi-Cal managed care programs and health plans to individuals and families and how to access that system.

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

k. General preventive health education programs or campaigns addressed to life-style changes in the general population (e.g., dental prevention, anti-smoking, alcohol reduction, etc.), and

l. 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 by school staff when informing an individual 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 make 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. When a school employee is verifying a student's eligibility or continuing eligibility for Medi-Cal/Healthy Families to develop, ascertain, or continue eligibility under the National School Lunch Program, report that activity under this code.

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

School staff should use this code when assisting an individual in becoming eligible for Medi-Cal/Healthy Families. 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/Healthy Families eligibility status for the purposes of Medi-Cal program.

b. Explaining Medi-Cal/Healthy Families eligibility rules and the Medi-Cal/Healthy Families eligibility process to prospective applicants.

c. Assisting individuals or families to complete a Medi-Cal/Healthy Families eligibility application.

d. Gathering information related to the application and eligibility determination for an individual, including resource information and TPL information, as a prelude to submitting a formal Medi-Cal/Healthy Families application.

e. Providing necessary forms and packaging all forms in preparation for the Medi-Cal/Healthy Families eligibility determination.

f. Referring an individual or family to the local Medi-Cal/Healthy Families eligibility office to make application for Medi-Cal/Healthy Families.

g. Assisting the individual or family in collecting/gathering required information and documents for the Medi-Cal/Healthy Families application.

h. Participating as a Medi-Cal/Healthy Families eligibility outreach outstation, but does not include determining eligibility.

i. Using client information gathered from various programs such as CHDP and the Free and Reduced Lunch Program to facilitate the Medi-Cal/Healthy Families application process and expand enrollment into Medi-Cal programs and services.

Note: Healthy Family outreach is claimable unless the eligibility application form box is marked: "I do not want Medi-Cal".

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

School staff should use this code when making ongoing 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, and 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.

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

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

School staff should use this code when making ongoing referrals for, coordinating, and/or monitoring the delivery of Medi-Cal-covered services. This code is used after an initial referral is made. Referral, coordination, and monitoring activities related to services in an IEP are reported in this code. Activities that are part of a direct service are not claimable as an administrative service. Furthermore, 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 coordinating IEP meetings) should be reported under Code 2, Direct Medi-Cal Services. Include related paperwork, clerical activities, or staff travel necessary to perform these activities, including initiating and responding to email and voicemail.

School staff should use this code when making ongoing referrals for, coordinating, and/or monitoring the delivery of Medi-Cal-covered services.

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 not to include the state-mandated health services. **(See Section 2 – Medicaid in the School Setting – Page 2-1).**

c. Referring students for necessary medical health, mental health, or substance abuse services covered by Medi-Cal.

d. 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.

e. Gathering any information that may be required in advance of these referrals.

f. Participating in a meeting/discussion to coordinate or review student(s') needs for health-related services covered by Medi-Cal.

g. Providing follow-up contact to ensure that a child has received the prescribed medical/dental/mental health services.

h. 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.

i. Providing information to other staff on the child's related medical/dental/mental health services and plans, such as IEPs and/or IFSPs.

j. Coordinating the delivery of medical/dental/mental health services for children with special/severe health care needs.

k. Monitoring and evaluating the Medi-Cal-covered service components of the IEP as appropriate.

l. Coordinating medical/dental/mental health service provisions with managed care plans as appropriate.

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

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

School employees should use this code 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 MAA.

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

School employees should use this code when **assisting** an individual or family to obtain Transportation to services covered by Medi-Cal. This does not include:

a. The costs of the actual transportation service, but rather the administrative activities involved in scheduling or arranging specialized transportation.

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.

Include related paperwork, clerical activities, or staff travel required to perform these activities, including initiating and responding to email and voicemail.

d. Scheduling or arranging transportation to Medi-Cal-covered services.

e. A transportation supervisor and staff time coordinating IEP transportation.

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

CODE 11. NON-MEDI-CAL TRANSLATION (U)

School employees who provide translation services for non-Medi-Cal activities should use this code. 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 signing services) that assist the individual to access and understand social, educational, and vocational services.

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

CODE 12. TRANSLATION (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. Please note that a school district does not need to have a separate administrative claiming unit for translation.

School employees who provide Medi-Cal translation services should use this code. 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/Healthy Families.

Note: Case Managers participating in the LEA Medi-Cal Billing Option cannot duplicate their time here. Staff should claim time 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-MEDI-CAL SERVICES (U)

This code should be used by school staff 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. 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. Staff time-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 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.

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

This code should be used by school staff when performing collaborative activities within districts, with community agencies, and with other LEAs 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. Only employees whose duty statements include program planning, policy development, and interagency coordination 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 school medical/dental/mental health programs.

c. Monitoring the medical/dental/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 perform 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 by LEA, LEC, and LGA coordinators and time survey participants when performing activities that are directly related to Medi-Cal claims administration and coordination, and training activities. Staff who time survey should use this code for time spent after initial or annual training in reviewing how to document relevant MAA through the time survey process. Reasonable time spent reviewing how to survey and working with others to complete the survey is acceptable. 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 MAA operational plans.

b. Serving as liaison for regional and local MAA 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 claiming programs.

d. Administering MAA, including overseeing, preparing, compiling, revising, and submitting claims.

e. Training program and subcontractor staff on state, federal, and local requirements for MAA claiming.

f. Ensuring that MAA claims do not duplicate Medi-Cal claims for the same activities from other providers.

g. Attending meetings and conferences that involve MAA for LEA or LEC/LGA coordinators.

h. Initial and/or annual claiming for time survey training continues to be disallowed.

ADDITIONAL NOTE:

According to OMB Circular A-87, Attachment A, Section C, 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. Therefore, invoices must only include data from the participant's time surveys that document MAA-reimbursable time.

For example, if a person does not perform any claimable school-based MAA activity (Codes 4, 6, 8, 10, 12, 14) during the survey week, they cannot charge any time to Code 15 for only completing the time survey. Similarly, if a person does not perform

any claimable school-based MAA activity during the survey week, they cannot charge any time to Code 16. This also means a person cannot time survey to only Code 16 and charge time to Code 15 for only completing the time survey. Exceptions would be a LEC, LGA or LEA MAA staff member on paid absence or leave who typically performs MAA as demonstrated through previous time surveys and the duty statement.

DHCS advises the LECs/LGAs/LEAs to review their time surveys and invoices to assess reasonableness of time. Can the Code 15 time be explained and justified adequately to an auditor? If not, the LECs/LGAs/LEAs are advised to revise any invoices that do not meet these criteria. All records in support of allowable MAA activities must be maintained in an audit file for a minimum of three fiscal years and made available to State and the federal reviewers and auditor upon request, in accordance with Title 42 of the Code of Federal Regulations, Section 433.32. DHCS Audits and Investigation Division, the Centers for Medicare and Medicaid Services, and the federal Office of the Inspector General will reference OMB A-87 to verify supportable and allowable costs.

The LEA is responsible to ensure that time survey results are supportable. The LEA is also responsible for any audit disallowances.

CODE 16. GENERAL ADMINISTRATION/ 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.

Time recorded under this code will be apportioned appropriately to MAA and non-MAA. Paid time off is when you are being paid, but you're not at work. This includes paid vacation days, jury duty, sick leave, etc. If you are not paid for your time off, you can't record that time here. Unpaid time off should be left blank on your time survey.

When not included in the indirect rate, the general operation of LEA such as accounting, budgeting, payroll, purchasing and data processing may be recorded under this code. (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. General supervision of staff or facilities, including staff performance reviews, and personnel management.
b. Reviewing non-instructional school policies, procedures, or rules.
c. Attending or facilitating school or unit staff meetings, board meetings.
d. Completing personal mileage and expense claims.

California School-Based MAA Manual

SECTION 6

MAA Time Survey

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Determining Which Staff Should Time-Survey

To determine which LEA staff might time-survey, two factors must be considered:

1. Determine which staff perform MAA, and
2. Ensure that appropriate nonfederal funds are expended for MAA in order to receive federal reimbursement.

To determine which staff performs MAA, it is necessary to work with the relevant LEA management and/or administrative staff to discuss both claimable MAA and the various activities performed by staff under the various district or COE programs. It is important to match up the various LEA activities with MAA to ensure that the appropriate staff members are selected. A staff listing or organization chart is helpful to identify LEA functions, staff classifications, and lines of supervision.

Once the potential staff classifications are selected, ensure that sufficient appropriate nonfederal funds are expended to receive federal reimbursement for the costs of the selected staff. Staff positions that are funded 100-percent by federal dollars may not participate in the MAA program, because the Federal Government is already paying its share of costs. Staff may not participate in the MAA program in the proportion of which their positions are federally funded.

When a staff member performs MAA for multiple claiming units, they must have only one original time survey form. The original must include all paid time and related activities during the survey period. Each claiming unit's time must be clearly identified on the original form, and all time survey review standards must be met. Copies of the original time survey form must be labeled as copies. The original must be maintained with one claiming unit's audit records. Copies are added to additional claiming unit audit records, with reference to placement of the original.

When staff members perform MAA, in an entire fiscal year, the LEA must either time-survey four quarters or time-survey three quarters and average one quarter. Staff must time-survey to be included in the invoice. If the staff member is not going to perform MAA, but provides support to staff who time-survey to MAA, the costs of the supporting staff member whose salaries and benefits are coded with SACS function codes 2700 and 700-7199 (School Administration and General Administration) are claimable on an allocated basis through the allocated cost pool. Otherwise, if the costs of the supporting staff member are not coded in the School Administration and General Administration function range, then his or her salary and benefits will not be claimable and will fall into the non-MAA Cost Pool.

Time Survey Process

The MAA time survey is the basis of the claim for federal funds, and its completion must be done with strict controls on how it is conducted and how time is recorded.

The time survey is a representative sample of staff's work, which is to be used as the basis of the MAA claim. MAA activities should be random and should not be scheduled during the time survey period only. To claim for an entire year, the LEA must time survey, with the survey time periods randomly selected by DHCS. The LEC/LGA shall be notified no later than the first day in May annually of the first-quarter time survey period. The DHCS-selected second-, third-, and fourth-quarter survey weeks will be reported to the LEC/LGA 45 days before the beginning of the new quarter.

The LEA can average the time survey results of any quarter in a fiscal year. Only individual positions that participate in MAA, and have been included in the 3 non-averaged invoices may be included in the averaging quarter. The LEA may only average one quarter per year. The averaging quarter cannot be chosen after surveys are completed. Completed surveys must be used for that quarter. For example, if an LEA time surveys for a particular quarter, the LEA cannot choose to use the average for that quarter. Staff who replace other staff in the same position, are trained, and survey, may have their results used in an averaging quarter.

To submit averaged invoices you must either submit all four invoices to DHCS at one time or you must have previously submitted invoices that will be used for the averaged quarter.

Averaged Quarter Invoicing Methodology

If the LEA chooses to average a quarter, a weighted average will be used to calculate claims for the averaged quarter. The time survey results for all staff in a claiming unit that surveyed three quarters will be averaged by the claiming unit. Those individual staff positions that are not time surveyed for three quarters must time survey in the averaged quarter in order to be included in the averaged quarter invoice. When both time survey results and averaged results are included in a quarterly invoice, two Claiming Unit Functions Grids are required. The results would be averaged using a weighted average. For instance, a claiming unit consists of five staff. Three staff time surveyed the first 3 quarters, Staff person #4 hasn't time surveyed at all, and Staff person #5 time surveyed the second and third quarter. Staff persons' #4 & #5 must time survey the fourth quarter. Their results would then be averaged into results from the existing average for quarters 1, 2, and 3, using a weighted average. See below for example:

Staff	1	2	3	4	5
Time Survey	1st, 2nd, 3rd qtr.	1st, 2nd, 3rd qtr.	1st, 2nd, 3rd qtr.	Hasn't time surveyed 1st, 2nd, or 3rd quarter	Time surveyed 2nd and 3rd quarter
MAA time for one activity	Average 11.2 hours	Average 11.2 hours	Average 11.2 hours	15.5 hours	21 hours

Weighted Average	11.2+11.2+11.2+15.5+21 = 70.1; 70.1/5=14.02 hrs. for one activity; 14.02 /40 (40 in this example is the average paid hours for included staff)= 35.02%

This calculation must be performed for all activities, MAA and non-MAA. The total time recorded on the survey must total to 100 percent of the staff member's work hours. Claiming units may begin claiming during any quarter of the fiscal year if they participate in the time survey week. If a claiming unit wishes to begin claiming during the averaged quarter, they must time-survey during the randomly selected fourth-quarter time survey week.

Time Survey Training

Time Survey training enables time survey participants to accurately and correctly record their paid time and the activities they perform during that time. Annual time survey training for those trained the preceding year must be completed before the 3rd time survey week each fiscal year, regardless of the quarter averaged. Staff new to the MAA program must participate in annual training before beginning the time survey. Each time survey participant must complete the required annual training prior to reporting paid time and activities on the MAA Time Survey.

Training should be conducted close to the week prior to the time survey. Training must be focused on changes and updates to administrative claiming categories and activities. Annual training time may not be claimed during any time survey week.

Time Survey Form

Only the DHCS approved time survey form shall be used. In each time survey week, all participants must use the current version of the time survey, either the hard copy format or the electronic format. If the claiming unit chooses the hard copy format, participants may complete it in pencil; however, each time survey must be signed in BLUE INK. Electronic time surveys must also be signed in BLUE INK. The time participants enter on the time survey must be paid time only, and sufficient supporting documentation must be maintained that verifies that the hours participants were paid equals the amount of time they surveyed. Staff should time-survey daily to ensure accuracy.

Time survey participants may make corrections to the time survey until the results are entered into the invoice. Once the results are entered into the invoice, no further time survey changes may be made. Do not use whiteout on the time survey: all errors must be thoroughly erased or stricken through, and initialed.

If there is any question regarding the accuracy of data entered on the form (e.g., the form is incomplete, provided sample activities are not claimable, the local/regional MAA coordinator must contact the individual completing the form and obtain clarification. If clarification cannot be obtained, the data entered for that sample must be discarded and not included in the tabulation of the claim data.

Time Survey Documentation

Each participant identified on the Claiming Unit Functions Grid, whose costs are not direct charged, must time-survey for five days during the designated quarterly time survey week.

- When students are in session, participants must time survey for five consecutive days excluding Saturdays, Sundays and Holidays.

- When students are out of session for fewer than thirty (30) calendar days, participants must time survey on the first (1) day when the school year resumes and students are in session, for five (5) consecutive days, excluding Saturdays, Sundays and Holidays.

- When students are out of session for thirty (30) or more calendar days, then participants must time survey on the sixth (6) day from when the school year resumes and students are in session, for five (5) consecutive days, excluding Saturdays, Sundays and Holidays.

The time survey activities found in Section 5 require that each participant code only the hours paid according to their contract during the five-day survey week, capturing all activities and using the correct codes. (For example, a participant works a 10-hour day but is only paid for eight hours. The participant should only Code 8 hours, starting with the first paid hour of the work day.) Although hours worked might exceed the paid hours MAA is reimbursement only for paid hours. Each participant must provide a minimum of two specific samples on the back of the survey of any activities they performed in Codes 4, 6, 8, 10, 12, 14, 15, and 16. The original time survey will be retained in each claiming unit audit file.

Local and regional MAA coordinators are responsible for ensuring that staff completes Time Surveys during the time survey period. Coordinators must also help staff complete their Time Survey forms accurately and verify via the sample documentation that the forms have been completed correctly before placement in the audit file. Audit files are subject to state and federal review.

Time Survey Administration

The responsibility for proper administration of MAA Time Surveys is shared by the individual participant, the participant's supervisor, the LEA MAA Coordinator, the LEC/LGA MAA Coordinator, and DHCS.

The time survey process, form, and training summary have been approved by CMS. Significant changes in the MAA program require prior review by CMS.

DHCS designates the time survey periods, issues the time survey form and training materials, trains LEC/LGA MAA Coordinators, and reviews time survey forms and the operational plan and/or the audit file during site visits.

LEC/LGA MAA Coordinators assist DHCS by training LEA MAA Coordinators on the MAA program, time survey, and audit file. They provide DHCS materials and updates to the local coordinators.

LEA MAA Coordinators are responsible for training all time survey participants, reviewing each time survey form for completion and correctness, ensuring that the surveyed activities are claimable, and maintaining the original time survey forms in the claiming unit audit file. The supervisor of the time survey participant verifies that the number of paid hours recorded are the actual hours paid and that the activities are within the participant's job classification. Each time survey participant attends time survey training to learn which MAA activities are within their scope of work and how to properly document their paid time. Each individual is responsible for completing the form as instructed.

Time Survey Review Process

For compliance assurance, DHCS requires the three-step process before inclusion in the invoice.

1. Site Supervisors of Time Survey Staff
   The first review will be by the Supervisor. He/she will review for the following:

   (1) Samples are completed for MAA codes;

   (2) Hours indicated are the employees paid workday; and

   (3) All totals are accurate and complete.

   If the Supervisor finds problems with a survey they must be corrected by the participant and returned to the Supervisor. Once approved by the Supervisor they are forwarded to the LEA MAA Coordinator.

2. LEA MAA Coordinators and Surveying Staff Site Supervisors
   The second review is more comprehensive and includes the careful review of samples, training dates, job description and other elements which must align with the Operational Plan (OP). When problems are found which require correction or further training the LEA Coordinator contacts the individual participant. The surveying participant must correct their survey, and/or be provided with additional training as necessary. Only the survey participant can provide samples of the activity performed and any necessary corrections in relation to the clarification of sample activities and/or amount of time per code. If the survey cannot be corrected and is invalid, it must be removed from the time survey results. *Sample activity descriptions on each time survey form must maintain a minimum of 80% accuracy for the unit to meet audit compliance.* Time surveys that have not been corrected

prior to inclusion into that quarterly invoice *must* be removed from that quarter invoice.

3. LEC/LGA MAA Coordinators
   It is the responsibility of the LEC/LGA Coordinators who signs the invoice and claiming grid(s) to assure the accuracy and reasonableness of the time surveys, and compliance with the School-Based claiming MAA provider manual. **Each LEC/LGA will conduct reviews of all LEA claiming units every 3 years**. These reviews should consist of desk and field reviews of all completed time surveys and any training materials used by the LEA. This review function shall be performed by the LEC/LGA, and cannot be subcontracted.

   The following must be performed by the LEC/LGA Coordinator:

   - Attend time survey trainings conducted by or for LEAs.
   - Hold LEA Coordinator meetings following time survey periods to enhance LEA Coordinator review of surveys.
   - Develop, coordinate or provide additional time survey training as necessary before each quarter.
   - Identify regional/county time survey questions and seek clarification through the LEC Committee and approval through the DHCS.
   - Identify random LEAs for operational plan review and audit file compliance.

Role of Vendors

Vendors may be used by LEAs to help them administer the MAA program.

Examples of what vendors may do:

- Conduct training for time survey, operational plan and invoice.
- Prepare LEA invoices for LEA signature.
- Review time surveys only at the LEA level.

Examples of what vendors may not do:

- Perform LEA site reviews at the LEC/LGA level.
- Perform LEA time survey reviews at the LEC/LGA level.
- Retain LEA audit file.

The LEA is ultimately responsible for all claims, deferrals, and disallowances.

DHCS School-Based MAA Unit Reviews

Quarterly, randomly selected LECs and LGAs will be required to submit the sign-in sheets from the LEC/LGA time survey training and 50 completed time surveys. DHCS will perform an initial desk review followed by site reviews as warranted. Upon timely conclusion of the review a final written report reflecting positive and negative findings and recommendations for improved performance will be issued to the LEC and LGA Coordinators.

Time Survey Review Standards

At each level of review, verification of compliance will include but not be limited to:

- Clean, legible recording of hours or portions of hours for the entire paid workday.
- Correct totaling of MAA and Non-MAA hours.
- Correct sample descriptions for MAA activities. The MAA activity must be referenced in staff duty statement.
- Signature and date of participant and supervisor *before submitting an invoice.*

Each level of review will conduct field reviews that include the following:

- Matching the individual's job classification on the time survey to their job classification on the claiming grid(s).
- Training rosters showing date survey staff was trained.
- Comparison of paid contract hours with surveyed hours.
- Review of Audit File/Operational Plan binders.

Non-Compliant Surveys

Time surveys that do not meet the above standards will not be allowed for claiming in that invoice quarter, and cannot be used to average the remaining quarter results.

Unit Review Findings

Summary of Findings (SOF)

Upon timely conclusion of the review, a written report reflecting positive and negative findings, recommendations for improved performance, and any required actions for program compliance will be issued to the LEC and LGA Coordinators. The written report is known as Summary of Findings (SOF).

Corrective Action Plan (CAP)

If the Summary of Findings specifies there are required actions for program compliance, the LEC/LGA may be requested to submit a corrective action plan to DHCS in a timely manner. The LEC/LGA may also be requested to submit a revised invoice based on the findings from the site/desk review. DHCS will review the CAP and provide the LEC/LGA

a response through written correspondence indicating whether or not further action is required to meet program compliance.

Appeal Process
If there are remaining actions required of the LEC/LGA and they disagree with these actions, they may submit an appeal letter to the Administrative Claiming Local Schools & Services Branch (ACLSSB) Branch Chief, as directed in the correspondence letter. The appeal letter must contain the issues being appealed, reasonable evidence to support the appeal, and the suggested course of action for consideration. DHCS will consider the appeal letter and make the appropriate final decision to meet program compliance based upon State and federal guidelines. Notification of this decision will be sent to the LEC/LGA in a final correspondence letter.

LEA MAA Time Survey Form

The LEA MAA Time Survey Form has been developed using MS Office/Excel and can be downloaded from the MAA website at http://www.dhcs.ca.gov/provgovpart/Pages/SMAATimeSurveyForms.aspx . The hard copy format of the form is available in Appendix G. Only the DHCS-approved Time Survey form may be used. Diskettes with forms may be provided to claiming units so that staff may use the electronic version, print it out when completed, sign it in blue ink, and turn it in to the appropriate supervisor for signature and maintenance in the local audit file.

Direct-Charging in Lieu of Time-Surveying

Staff that performs MAA Medi-Cal Coordination, Claims Administration, Training and Fiscal Coordination may not be required to time-survey and can direct charge. However, to qualify for direct charge reimbursement, participants must certify 100 percent of their time spent 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. An overhead or indirect rate, established according to OMB A-87 principles, may be applied to personnel expenses. Staff duty statements must show that these activities are part of their job.

Note: Staff who perform MAA Medi-Cal Coordination, Claims Administration, and Training and who also perform other MAA must time-survey.

The MAA OP requires the retention of position descriptions showing that MAA Medi-Cal Coordination, Claims Administration, and Training are part of the job of persons whose costs are direct-charged. LEAs that have “generic” position descriptions for job

classifications are required to include duty statements describing the specific MAA-related responsibilities.

Related operating expenses can also be direct-charged. Examples might include travel to MAA-related training, computer equipment or programming expenses, or training materials. Claiming units using service bureaus or consultants to assist in MAA Coordination, Claims Administration, and Training may direct-charge these expenses. These items must be included in the MAA OP. Assigning a MAA account number may be useful in isolating these expenses. Direct-charging some smaller expenses, such as printing time survey forms, may not be worth the effort as all direct-charge expenses must be subtracted from overhead costs.

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

Examples of Medi-Cal Providers Supporting Schools

The list of providers are often referred to when performing activities related to MAA Outreach, Referral, Coordination, and Monitoring; Arranging Transportation; and Program Planning, Policy Development, and Interagency Coordination.

Audiologist
Child Health and Disability Prevention Providers (CHDP)
Clinical Laboratories or Laboratories
Perinatal Services Program & Teen Pregnancy Services
County Mental Health/Rehabilitation Services Including Short-Doyle Providers (*School and public health counselors with appropriate credentials and/or licenses)*
Dentists and Dental School Clinics
Dietitians
Dispensing Opticians
Early and Periodic Screening, Diagnosis, and Treatment Providers (EPSDT)
Hearing Aid Dispensers
Home Health Agencies
Hospitals
Incontinence Medical Supply Dealers
Intermediate Care Facilities including Nurse Facilities
Local Educational Agency School Providers
Medical Specialists
Nurse Services including Anesthetists, Midwives Practitioners
Nurses Licensed Visiting/Vocational Nurse (LVN) and Registered Nurse (RN)
Occupational Therapists, including California Children Services (CCS)
Optometrists and Ophthalmologists
Orthodontists
Organized Drug Detoxification Providers
Organized Outpatient Clinics (PH Clinics, Community Clinics)
Personal Care Service Providers
Pharmacies/Pharmacists

Physical Therapists including California Children Services (CCS)
Physicians
Podiatrists
Providers of Medical Transportation
Psychologists
Respiratory Therapists
Regional Center Health Services
Rehabilitation Centers
Renal Dialysis Centers and Community Hemodialysis Units
Rural Health Clinics
School Counselors with Appropriate Credentials/Licenses
Social Workers with Appropriate Credentials/Licenses
Short-Doyle Medi-Cal Providers (Mental Health Division)
Skilled Nursing Facilities
Speech-Language Pathologists and Therapists
Supplemental EPSDT Providers (Mental Health)
Trained Health Care Aide Services and Physician Assistant

California School-Based MAA Manual

SECTION 7

Operational Plan Overview

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Claiming Unit Functions Grid	7-3

Overview

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

Pursuant to OMB Circular A-87, 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 certification signature on the Claiming Unit Functions Grid(s) (the Grid) indicates such preparation has occurred. 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 might not be limited to:

- **Training Materials** and information describing when and where time survey training was conducted, who conducted the training, and who attended. A training log must be maintained with the training date, location, name of trainer, participants printed legal name, and signature to verify that the participant was trained.
- **Time Survey Materials** that support the training of staff who time-surveyed.
- **The Grid(s)** (signed by both the LEC/LGA Coordinator and the LEA Coordinator) for each quarter claimed in support of the invoice.
- **Duty Statements** that match the position classifications identified on the Grid.
- **Medi-Cal Percentage** documentation used in the discounted codes.
- **Contracts/MOUs** for MAA services provided by personnel who are included on the claiming grid(s) and/or whose costs will be included in the invoice.
- **Invoice Documents** to support all claims on the invoice.
- **Organization Charts** that show the relationships of time-surveying staff, as entered in the invoice.
- **Resource Directories** used to help participants access Medi-Cal services.

All changes reflected on the claiming grid(s) and claimed for in the invoice must be documented and maintained in the audit file.

Grids and invoices are submitted together each quarter to the LEC/LGA for review and submission to DHCS. Once the invoice is approved by DHCS, the OP is approved contingent upon a DHCS/CMS review that reflects compliance. This OP supports the requirements defined in the contract between the LEC/LGA and DHCS and forms the basis for Medi-Cal administrative claiming. An LEA/ LEC/LGA may submit changes to its Grid(s) once per quarter when the invoice is submitted.

Claiming Unit Functions Grid(s)

The Grid(s) provide DHCS with a summary of the claiming unit staff participating in MAA and the certification that all documentation in support of the invoice is on file and available for review. The Grid(s) are submitted each quarter with the invoice and must

include all staff that are included in your invoice whether they time-surveyed or direct-charged.

Two grids must be submitted to DHCS with an invoice that includes averaged and time surveyed participants in the same quarter. One grid must reflect the averaged time only and the second grid must reflect time survey activity only. LEAs must enter “D” for direct charge under each activity in number 14 of the Claiming Unit Functions Grid. For a copy of this form please see the next page.

CLAIMING UNIT FUNCTIONS GRID (rev 6/1/2011)

(1) LEC/LGA:	**(2) INVOICE NUMBER (from Summary Invoice):**
(3) NAME OF CLAIMING UNIT:	**(4) NO. OF CLAIMING STAFF:(sum of item13, No. of Staff):**
(5) COUNTY DISTRICT SCHOOL (CDS) CODE:	**(6) LEC/LGA CONTRACT #**
(7) CLAIMING UNIT ADDRESS:	
(8) CLAIMING UNIT COORDINATOR:	
(9) TELEPHONE:	**(10) E-MAIL:**
(11) AUDIT FILE LOCATION (ADDRESS):	

(12) STAFF JOB CLASSIFICATIONS: (Identified by duty statement/job description – *please indicate if the staff is the MAA Coordinator or MAA assistant.*	**(13) NUMBER OF STAFF:**	**(14) MEDI-CAL ADMINISTRATIVE ACTIVITIES (ENTER "D" FOR DIRECT CHARGE UNDER EACH ACTIVITY):**							
		Code 4	**Code 6**	**Code 8**	**Code 10**	**Code 12**	**Code 14**	**Code 15**	**Code 16**

Code 4 = Initial Medi-Cal Outreach
Code 6 = Facilitating Medi-Cal Application
Code 8 = Ongoing Referral, Coordination, and Monitoring
Code 10 = Arranging Transportation in Support of Medi-Cal Covered Services
Code 12 = Translation Related to Medi-Cal Covered Services
Code 14 = Program Planning, Policy Development, and Interagency Coordination
Code 15 = Medi-Cal Claims Administration, Coordination and Training
Code 16 = General Administration/Paid Time Off

CERTIFICATION STATEMENT

My signature below certifies that the information provided herein is true and correct and accurately reflects the performance of the MAA OP described in the invoices and time surveys related to this grid. I hereby certify that, to the best of my knowledge and belief, this report is true and correct and all data have been compiled and reported in accordance with state and federal laws and regulations and the instructions for this report.

LEC/LGA Coordinator Date LEA Coordinator Date

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SECTION 8

Audit File

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Record Keeping and Retention

Overview

The foundation of MAA claiming is the time survey. Federal regulations require that all records in support of allowable MAA activities must be maintained for a minimum of three fiscal years after the end of the quarter in which the LEC or LGA receives reimbursement from the Department of Health Care Services (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/Operational Plan sorted by program; these files 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. This documentation includes all original time survey documentation, secondary documentation, and direct charge certification. The time survey documentation and OP must be kept at the LEA that is easily accessible.

Similarly, the documents that support the construction of a MAA claim must be kept three years after the last claim revision. These documents include the documentation that supports the Medi-Cal percentage, the basis of the cost pools, and position descriptions and/or duty statements for all staff performing MAA.

Building and Maintaining an Audit File/Operational Plan

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

Audit File/Operational Plan Checklist

The following list is provided as a guide to determine what to include in the audit file when claiming for Medi-Cal Administrative Activities (MAA). The list is general in nature and is not intended to be all-inclusive.

Training Materials:	
	Copies of coordinator training materials indicating dates, locations, trainers, and attendance lists.
	Copies of all time survey trainings, dates, locations, trainers, and original attendance lists.
	A training log must be maintained with the training date, location, name of trainer, participants printed legal name, and signature to verify that the participant was trained.
Time Survey Materials:	
	Participant's original time surveys signed by the employee and the employee's supervisor.
	Attendance summaries may be requested.
	Time Survey listing all participants and their hours worked and percentages.
	Time surveys (as above) if contractors are time surveying.
The Claiming Unit Functions Grid(s)	
Duty Statements:	
	Duty Statements for staff performing MAA. A duty statement describes the current duties and responsibilities assigned to a specific position. The MAA activity is referenced in the position's duty statement. Each duty statement is required to include, in a single document, both the full scope of work and the approved MAA activities.
Invoice Documents:	
	MAA Summary Invoice
	Invoice Variance Form
	Activities and Medi-Cal Percentages Worksheet
	Copy of the Indirect Cost Rate from the CDE website
	Time Survey Summary Report
	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
	Averaging Worksheet that corresponds with the claiming unit grid. Two separate grids are required if participants are averaging and time surveying in the same quarter.
	Supporting Documentation
	Claiming Units Function Grid(s)
	Checklist for preparing the MAA Detail Invoice
	Checklist for preparing the MAA Summary Invoice
	Tape Match Calculations

Audit File/Operational Plan Checklist, cont.

Contracts:	
	The contract between the Department of Health Care Services (DHCS) and the LEC or LGA
	Contracts or sub-contracts between any LEA/LEC/LGA participating in MAA.
	Contracts or Memorandums of Understanding (MOUs) with contracting agencies and providers including personal contracts.
	The contract with the Host Entity (if applicable), or DHCS.
Agency Documents:	
	Charts that show the supervision responsibility of staff involved in MAA claiming down to the level of clerical staff whose costs are included in the invoice.
	School Calendar
Resource Directories:	
	Copies of documents used to promote Medi-Cal that directly relate to surveyed time for such activities. Should include flyers, announcements and 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 LEA Coordinator is the first level of review to ensure that the OP is complete and accurate. This includes ensuring the accuracy of the time surveys for all staff in the claiming unit, the completeness and accuracy of the invoices, and thorough documentation to support the OP.

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

DHCS is the third level of review. DHCS will be conducting different reviews:

- Desk reviews will be conducted on a minimum of 100 invoices per year. These may include any combination of the following, and the backup documentation to support it:
    - Training Materials
    - Time Survey Materials
    - The Grid(s)
    - Position Descriptions/Duty Statements
    - Medi-Cal Percentage
    - 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 time survey reviews, OP reviews, claiming unit function grid(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.

For further details, see Section 6, page 6-4, Time Survey Review Process.

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SECTION 9

MAA Contracts

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Contract Requirements

For a LEC/LGA to claim reimbursement for MAA, 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 MAA Contract.

Lateral Agreements/Memorandums of Understanding

The MAA Contract is designed so the LEC/LGA may act on behalf of LEAs claiming reimbursement for MAA. LEAs intending to seek reimbursement through MAA 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. An LEA may only contract with the regional LEC or local county LGA. Claiming units must be fiscally affiliated with an LEA or COE to claim. 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 MAA program must monitor invoices to ensure that administrative fees they charged to their LEAs or claiming units are not reported by both the LEC/LGA and LEA claiming unit. The cost of activities included on the MAA invoice may only be claimed by one entity if they are on the LEC/LGA invoice; they may not be claimed on other invoices, such as the LEA or subcontractor claiming unit invoices. If they are claimed on the individual LEA or subcontractor invoices, they may not also be claimed on the LEC/LEA invoice. Allowable administrative costs are described in this manual, in the Medi-Cal Claims Administration, Coordination, and Training section (Code 15) and in the County-Based MAA Provider Manual in the MAA/TCM Coordination and Claims Administration section (Activity G). These manuals are available at http://www.dhcs.ca.gov/provgovpart/Pages/CMAAManual.aspx. (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 MAA Coordination and Claims Administration and contracts with LEAs/subcontractors that conduct MAA.
2. The LEC/LGA charges the LEAs/subcontractors an administrative fee for the MAA costs of its own staff that are associated with the coordination. These costs are claimed on the LEC/LEA invoice.
3. While reviewing the LEA/subcontractor invoices, the LEC/LGA notices that the LEAs/subcontractors include the administrative fee as MAA Coordination Costs on the Direct Charges Worksheet, Line 31(d) (School-Based MAA invoice) or as Other Costs in Cost Pool 6, Line H (County-Based MAA invoice).

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

Alternatively, if the LEC/LGA allows its LEAs/subcontractors to include in their MAA invoices the cost of administrative fees charged by the LEC/LEA, then the LEC/LGA must not include in its own MAA 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 MAA Coordination and Claims Administration and contracts with LEAs/subcontractors that conduct MAA.
2. The LEC/LGA charges the LEAs/subcontractors an administrative fee for the MAA costs of its own staff that are associated with the coordination.
3. While reviewing the LEA/subcontractor invoices, the LEC/LGA notices that the LEAs/subcontractors include the administrative fee as MAA Coordination Costs on Direct Charges Worksheet, Line 31(d) (School-Based MAA invoice) or as Other Costs in Cost Pool 6, Line H (County-Based MAA invoice).
4. The LEC/LGA does not include in its own MAA invoice the costs of the activities associated with these administrative fees.

Contract Agencies

LEC/LGAs and LEAs may deliver their services through contract providers. These contract agencies, or community-based organizations (CBOs), may also participate in MAA. The contract language must reflect the intent of the contract agency to perform some or all of the allowable MAA.

Local matching funds that support claims for reimbursement of the cost of providing school-based MAA must constitute Certified Public Expenditures; 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 MAA expense, the LEC/LGA or LEA must have made a certified public expenditure (CPE) in support of MAA 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 MAA activities within the claiming unit. For further information, refer to PPL 05-005.

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 MAA 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 MAA. These staff are treated like district-employed staff and must time-survey. Their job classifications must be identified on the Grid(s) and must include a separate duty statement if it differs from those of other claiming staff on the Grid.

Subcontractor Contracts

Subcontractor contracts are agreements/contracts for entities (non-employees) who conduct specific MAA on behalf of the claiming unit. The contract must specify the MAA 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.

Contract Amendments

Contracts with DHCS to provide school-based MAA may be amended. The required amendment forms must be submitted to DHCS within 90 days of 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:

California Department of Health Care Services
Safety Net Financing Division
Administrative Claiming Local and Schools Services Branch
1501 Capitol Avenue, MS 4603
P.O. Box 997436
Sacramento, CA 95899-7436

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SECTION 10

Determining the Medi-Cal Percentage

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Definition of the Medi-Cal Percentage

The Medi-Cal percentage 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 percentage must be calculated twice per year, once in the 1st or 2nd quarters and once in the 3rd or 4th quarters; this percentage must be reflected in the invoices for those quarters.

Actual Client Count/DHCS Tape Match

The actual client count (as determined by 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 percentage 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 MAA is based on the Medi-Cal percentage. Costs are reduced or "discounted" by the Medi-Cal percentage when the activity benefits or involves both Medi-Cal and non-Medi-Cal populations. The Medi-Cal percentage must be calculated twice per year, once in the 1st or 2nd quarters and once in the 3rd or 4th quarters; this percentage must be reflected in the invoices for those quarters.

The following MAA codes require discounting by the Medi-Cal percentage:

CODE 8 Ongoing 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

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

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SECTION 11

Instructions for Preparing the LEA MAA Detail Invoice and the LEA MAA Summary Invoice

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INTRODUCTION

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

- Activities and Medi-Cal Percentages Worksheet
- Direct Charges Worksheet
- Payroll Data Collection Worksheet
- Costs and Revenues Worksheet
- Summary Invoice
- Quarter Averaging Worksheet

The MAA 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 discount percentage 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:

- PPLs
- Operational Plans
- Applicable MAA Contracts
- The School-Based Manual

Before submitting the MAA Detail Invoice and the MAA Summary Invoice, the operational plan must be completed and all required materials maintained in an audit file (see Section 8). The information entered on the MAA Detail Invoice must be consistent with that found on the Grid(s).

The MAA Detail Invoice includes four cost pools, three of which are identified on the Costs and Revenues Worksheet and one of which is identified on the Direct Charge Worksheet. All costs for the claiming unit must be reported on these worksheets. The cost pools are described later in this section and are named:

- Time Survey Cost Pool
- Direct Charge Cost Pool
- Non-MAA Cost Pool
- Allocated Cost Pool

*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 Discount Percentage and the results of the time survey are reported on the Activities and Medi-Cal Percentages 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, spreadsheets, journals, and payroll records. Only those costs and funding sources applicable to the claiming entity should be included. Once all the items are entered, the spreadsheet will automatically calculate the remainder of the claim.

When prompted to input data into cells of the MAA 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 or funding source designation and must be maintained in the audit file. For example, salaries and benefits assigned to staff by entry into the Time Survey Cost Pool 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"

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 LEA 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 the MAA. 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 MAA and whose costs are In a separate budget unit and can be separately identified.

Note: Costs of certain functions, such as payroll, maintaining inventories, developing budgets, executive directions, etc., are overheard and are only allowable through the application of an indirect cost rate. Therefore, they may not be included in the Time Survey Cost Pool or the Direct Charge Cost Pool.

Time Survey Cost Pool

Staff whose costs should be included in the Time Survey Cost Pool consists of the following:

- One-hundred percent of the non-federally funded costs of staff who participated in the time survey (Participant).

  (For example, a time survey participant's salary and benefit costs are 70-percent federally funded and 30-percent funded by other state or local sources. For that participant, only 30 percent of the salary and benefit costs may be included in the Time Survey Cost Pool.)

- The non-federally funded costs of Personal Services Contractors who time-survey to determine MAA costs because the contract language is nonspecific as to the MAA to be performed.

Claiming Unit staff whose salary and benefits are 100-percent funded by federal programs may not be included in the Time Survey Cost Pool. Also, staff positions whose costs are included in the numerator of the Indirect Cost Rate (ICR) MUST not be included in the Time Survey Cost Pool. This includes the costs of salaries and benefits coded to Functions 7120, 7190, 7200-7600, 7700, 8100-8400 and 8700.

A participant in the time survey may include any individual who may have direct contact with students and provide a MAA service. This could include, for example, a bilingual school janitor 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 should be 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 MAA 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 MAA allowable activities 100 percent of the time.
c. The costs associated with an employee who may perform multiple allowable MAA activities, each of which can be easily tracked and identified.
d. The costs associated with MAA Coordinators.

All direct charge costs that are included in the ICR MUST NOT be included in Direct Charge Cost Pools. This includes the costs coded to Functions 7120, 7190, 7200-7600, 7700, 8100-8400 and 8700.

Non-MAA 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 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 general and 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.

Staff included in the Allocated Cost Pool may include management, secretarial, fiscal, supervisory and clerical staff not included in any other cost pool. 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 MAA Invoice. The invoice consists of an excel workbook with six worksheets/tabs within the workbook. Each worksheet/tab (numbered 1 through 6) is labeled as follows:

TAB 1 Activities and Medi-Cal Percentages Worksheet

TAB 2 Direct Charges Worksheet

TAB 3 Payroll Data Collection Worksheet

TAB 4 Costs and Revenues Worksheet

TAB 5 MAA Summary Invoice Worksheet

TAB 6 Quarter Averaging Supplemental Worksheet (Required for the Averaging Quarter Invoice).

See Appendix B for an example of the SBMAA Invoice.

ACTIVITIES AND MEDI-CAL PERCENTAGES WORKSHEET (TAB 1)

Rows 1–9: Enter the information as indicated in the unshaded areas

Row 1: Claiming Unit Name and CDS Code

Note: The name of the Claiming Unit on the MAA 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

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: Period of service

Medi-Cal Percentages

The Medi-Cal Discount Percentage 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 at a particular Claiming Unit. The Claiming Unit must determine this percentage twice per year, once in the 1st or 2nd quarter and once in the 3rd or 4th quarters; this percentage must be reflected in the invoices for those quarters. See Section 10 and Appendix C of this manual for additional information on determining a Claiming Unit's Medi-Cal Discount Percentage.

Time Surveys

To claim for a full fiscal year time surveys will be conducted a minimum of three times each year. DHCS will designate a one-week MAA Time Survey period for each quarter. During each quarter, the designated one-week period will vary to ensure a valid basis

from which current fiscal year costs are claimed. The time survey is the basis for allocating the time and costs of the Claiming Unit's staff between the different MAA and non-MAA activities. This survey serves as the basis for allocating the salary and benefit costs of the staff included in the Time Survey Cost Pool.

Averaging Quarter

An LEA can average the time survey results of any quarter in a fiscal year. The LEA must only average one quarter per fiscal year. Averaging only applies if the individual positions' time survey results and costs were included in three non-averaged quarters in that fiscal year. The averaging quarter cannot be chosen after time surveys are completed. Only time surveys with reimbursable MAA time can be used for that quarter. When both time survey results and averaged results are included in a quarterly invoice, two Claiming Unit Functions Grids are required. If an LEA time surveys for a particular quarter, the LEA cannot choose to use the average for that quarter. Please see the QUARTER AVERAGING SUPPLEMENTAL WORKSHEET (TAB 6) which is **required** to be submitted with an Averaging Quarter Invoice.

Example: *A Claiming Unit with five employees chooses to average its time survey results for the averaging quarter. Only three of the Claiming Unit's staff participated in each of the first, second, and third time surveys and the remaining two staff participated in only one of the previous time surveys. The Claiming Unit may average the results of the three staff participating in each of the previous three quarters and enter the average in* ***Column E****. The remaining two staff who did not participate in all three time surveys must participate in the averaging quarter time survey and enter the results in* ***Column D****.*

After entering the number of staff included in the averaging quarter and the number of staff participating in the averaging quarter time survey in ***Row 27****, the weighted-average of the two results will be calculated automatically in* ***Column F****.*

Column C: Enter the Medi-Cal Discount Percentage for the period being claimed in **Row 13**. Once entered here, the discount percentage will be transferred to the other worksheets of the MAA Detailed Invoice where necessary.

Column D: Enter the results of the time survey by Activity and Code in the unshaded areas of **Rows 10–25**. Row 26 total time must equal 100%. If a time error occurs, you must increase or decrease the Code 1 (only) percentage accordingly in order to total 100% in row 26. This often occurs due to a rounding disparity created by the use of multiple database programs used to generate the survey results percentages. See Section 5 for a detailed description of each Activity and its associated Code. The invoice will calculate all other cells automatically.

Column E: Enter the results of the averaged quarter by Activity and Code in the unshaded areas of **Rows 10–25**. Row 26 total time must equal 100%. If a

time error occurs, you must increase or decrease the Code 1 (only) percentage accordingly in order to total 100% in row 26. This often occurs due to a rounding disparity created by the use of multiple database programs used to generate the survey results percentages. (For details on how to calculate an average see page 11-23)

Column H: Enter the State-approved indirect cost rate.

Row 27: Column D – For the non-averaged quarter. Enter the number of Claiming Unit Staff participating in the time survey period. This is a required field for every time survey period. Unless it's the averaging quarter, during which no separate time survey is performed.

Row 27: Column E – Enter the number of Claiming Unit staff included in the averaged period per the Time Survey Summary Worksheet (TAB 5). This field is only required for the averaging quarter invoice.

Row 28: Enter the Claiming Unit's State Approved Indirect Cost Rate for the current billing period.

DIRECT CHARGES WORKSHEET (TAB 2)

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

A Claiming Unit may direct-charge costs only if it identifies those costs in its MAA Operational Plan. Unlike the costs captured through the time survey, 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 LEA. *(Please refer t0 11-4 for Function Code criteria).*

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 Grid(s). LEAs must enter "D" for direct charge under each activity in number 14 of the Claiming Unit Functions Grid.

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.

3. Medi-Cal Claims Administration and Coordination by LEA, 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 MAA claiming unit coordinators and LEC/LGA coordinators spend in training, conferences, or meetings related to the MAA program. In addition, this category includes administration, such as overseeing, compiling, revising and submitting claims and operational plans; and coordination related to the MAA program. Similarly, all related paperwork, clerical duties and necessary staff travel is included.

Discounted Direct Charge Activities

4. Referral, Coordination, and Monitoring of Medi-Cal Covered Services – Code 8 (Row 32 A). Direct charging should be used to reports 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.

5. Arranging Transportation in Support of Medi-Cal Covered Services – Code 10 (Row 33 A). 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.

6. Translation Related to Medi-Cal Services – Code 12 (Row 34 A). 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.

7. Medi-Cal Program Planning, Policy Development, and Interagency Coordination – Code 14 (Row 35 A). 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.

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 MAA 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 MAA activity.
- **Personal Services Contracts.** If the contract specifically defines the MAA activity to be performed and the cost for each MAA 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 MAA 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.

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 <u>each</u> staff member for whom salary and benefits will be direct-charged under the appropriate MAA activity as defined in the Grid(s). 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 non-claimable 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 MAA 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 MAA activity. Claimable and Non-claimable costs will be calculated automatically based on the Medi-Cal Discount Percentage where appropriate, based on the MAA 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 MAA activity. The invoice automatically calculates Claimable and Non-claimable costs based on the Medi-Cal Discount Percentage where appropriate, based on the MAA activity charged.

PAYROLL DATA COLLECTION WORKSHEET (TAB 3)

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:

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 Function codes 2700 and 7000–719 and excluding Resources 3000-5639 and 5650-5999. **Enter the total in Row 36, Column A.** This combination of Object and Function codes will provide the amount of gross non-claimable salary expenditures for the billing period that belong to the Non-MAA Cost Pool before we consider which portion pertains to the Time Survey Cost 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 Function codes 2700 and 7000–7199 and excluding Resources 3000-5639 and 5650-5999. **Enter the total in Row 40, Column A.** This combination of Object and Function codes will provide the amount of gross general and administrative salary expenditures that belong to the Allocated Cost Pool before we consider which portion pertains to the Time Survey Cost Pool and the Direct Charge Cost Pool.

c. Identify 100 percent of the non-federally funded salary costs of the Claiming Unit's employees participating in the time survey. Once these costs are identified, determine which portion of these costs are coded with Function codes 1000–9999, excluding Function codes 2700 and 7000–7199 (see Page 11-3 Time Survey Cost Pool for specific criteria). Enter the result in **Row 37, Column A.** The balance of the costs for those participating in the time survey represents Function codes 2700 and 7000–7199 and should be entered in **Row 41, Column A.**

d. Identify 100 percent of non-federally funded Claiming Unit's salary costs to be direct-charged. Once these costs are identified, determine which portion of these costs are coded with Function codes 1000–9999, excluding 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 Function codes 2700 and 7000–7199 and should be entered in **Row 42, Column A.**

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 Function codes 1000–9999, excluding Function codes 2700 and 7000–7199 and excluding Resources 3000-5639 and 5650-5999. **Enter the total in Row 36, Column B.** This combination of Object and Function codes will provide the amount of gross non-claimable benefit expenditures for the billing period that belong to the Non-MAA Cost Pool before we consider which portion pertains to the Time Survey Cost Pool 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 Function codes 2700 and 7000–7199 and excluding Resources 3000-5639 and 5650-5999. **Enter the total in Row 40, Column B.** This combination of Object and Function codes will provide the amount of gross general and administrative benefit expenditures that belong to the Allocated Cost Pool before we consider which portion pertains to the Time Survey Cost Pool and the Direct Charge Cost Pool.

c. Identify 100 percent of the non-federally funded benefit costs of the Claiming Unit's employees participating in the time survey. Once these costs are identified, determine which portion of these costs are coded with Function codes 1000–9999, excluding Function codes 2700 and 7000–7199 (see Page 11-3 Time Survey Costs Pool for specific criteria). Enter the result in **Row 37, Column B.** The balance of the costs for those participating in the time survey should be entered in **Row 41, Column B.**

d. Identify 100 percent of the non-federally funded Claiming Unit's benefit costs to be direct-charged. Once these costs are identified, determine which portion of these costs are coded with Function codes 1000–9999, excluding 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 B.** The balance of the direct charge salary costs represents salary cost coded with Function codes 2700 and 7000–7199 and should be entered in **Row 42, Column B.**

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 MAA 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 & B and Row 40, Columns A & B must be submitted with the MAA Detail Invoice and MAA Summary Invoice. Invoices submitted without this documentation will not be processed or paid by DHCS.

COSTS AND REVENUES WORKSHEET (TAB 4)

Personnel Costs

Rows 44–46: These rows 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 LEA/Claiming Unit general funds, other local public funds, and MAA 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 OMB Circular A-87.

2. Matching Revenues. Claimed costs funded by state/local matching funds required by a federal grant must be offset. OMB Circular A-87 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 MAA 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], please 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-MAA 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.

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 MAA activity to be performed or the cost for each MAA activity.

Specific contracts are those contracts that do specifically define the MAA activity to be performed and the cost for each MAA 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 MAA 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, Functions 2700 and 7000–7199 (Other General Administration), and excluding the Federal series of Resource codes 3000–5639 and 5650-5999 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 56, 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-MAA 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 57, Column J that** is **i**ncluded in the amount at **Row 56, Column J**.

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 MAA purposes, the SACS Function and Resource coding for the depreciation expense, which is almost all cases is tracked using an off-system method, must match the coding required for Other Costs entered at **Row 56, Column J**. If this option is utilized, the amount entered for depreciation expense at **Row 57, Column J,** should be entered as a negative amount to cause an increase at **Row 58, Column J**.

Total Other Costs will first be reduced by the total Personal Service Contract costs entered in **Row 56, Column I,** and Direct Charge Other Costs in **Row 57, 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 58, Column J** through an analysis of these costs. The invoice will automatically allocate the remaining costs across the Time Survey, Direct

Charge, and Non-MAA cost pools based on their percentage of personnel costs to total personnel costs of the three cost pools. **Row 55** calculates these percentages and the allocation is calculated across **Row 58**. 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 59: This row calculates the allocation of General and Administrative costs in the Allocated Cost Pool based on the percentages calculated in **Row 55**.

Row 60: This row calculates a subtotal of costs before applying the Claiming Unit's indirect cost rate.

Row 61: This row calculates the costs of applying the Claiming Unit's indirect cost rate to the sub-total in **Row 60**.

Row 62: This row calculates the totals for each column.

A summary copy of the Claiming Unit's general ledger supporting the amount entered in **Row 56, Column J** must be submitted with the MAA Detail and MAA Summary Invoice. Invoices submitted without this documentation will not be processed or paid by DHCS.

FFP Calculations

Rows 63–65: 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 63: These amounts represent the claimable portion of the Time Survey and Direct Charge costs (**Columns C and E**).

Row 64: 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.

Row 64I: Enter the Prior Year corresponding Quarter invoice reimbursement amount. This cell is used to determine if a 20% Invoice Percentage Variance Form needs to be submitted with the invoice. If the message "Must Submit 20% Variance Form" appears, then you must submit the form. (See Appendix F)

Row 64K: Enter the Current Year Prior Quarter Invoice reimbursement amount. This cell is used to determine if a 20% Invoice Percentage Variance Form needs to be submitted with the invoice. If the message "Must Submit 20% Variance Form" appears, then you must submit this form. (See Appendix F)

Rows 65: Adds **Columns C and E** of **Row 64** to arrive at the "Total Federal Share" of the MAA costs for the billing period. The Invoice automatically transfers this amount to the MAA Summary Invoice for billing.

CLAIMING FOR SUBCONTRACTORS

The costs for subcontractors providing MAA-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 MAA to be performed and the cost for each activity, the costs should be direct-charged and entered in the Direct Charges Worksheet (Tab 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 MAA 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 56, Column A** of the Costs and Revenues Worksheet (Tab 4).

ALTERNATIVE CLAIMING METHODOLOGY

A Claiming Unit may choose the following methodology as an alternative to claiming for MAA costs. Although this methodology is less administratively burdensome, it results in a reduced reimbursement when compared to the standard methodology discussed in the preceding pages of this section. Each Claiming Unit should carefully analyze each methodology before deciding which alternative is best suitable for its situation.

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 Discount Percentage in **Row 13, Column C** and the indirect cost rate in **Row 28, Column H**. 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 for those participating in the time survey 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 those participating in the time survey 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.

Note: Under the alternative methodology, claimable costs are lower when compared to the standard methodology because the costs that would be accumulated under the Allocated Cost Pool under the standard methodology are now being accumulated in the Non-MAA Cost Pool under the alternative methodology. Therefore, costs in each of the "claimable" cost pools is lower by the amount of allocable costs not allocated, which also results in a reduced base when applying the Claiming Unit's indirect cost rate. However, the Claiming Unit is relieved of the administrative responsibility of sorting the costs included in the Time Survey and Direct Charge costs pools as directed on the Payroll Data Collection Worksheet (Tab 3).

MAA SUMMARY INVOICE WORKSHEET (TAB 5)

It is the responsibility of the LEC/LGA and LEA MAA 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:

- MAA Summary Invoice
- Invoice Variance Form
- 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
- Claiming Units Function Grid(s)
- Checklist for preparing MAA Detail Invoice
- Checklist for preparing MAA Summary Invoice

The original MAA Summary Invoice, MAA Detail Invoice, Grid(s), documentation supporting the time survey results, summary general ledger reports as indicated on the MAA Detail Invoice Checklist (pages 11-23 and 11-24) must be submitted to DHCS for each quarter billed. Claiming Unit's must submit its invoices to its appropriate LEC/LGA.

PAYMENT PROCESS

MAA claims are submitted to DHCS, Administrative Claiming Local & Schools Services Section (ACLSS). The invoices are reviewed for fiscal integrity and compared to the Grid(s). If the invoice is accepted, reviewed and approved by the ACLSS, 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 least two weeks before the due date. Addendum 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 has 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 MAA 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 MAA 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 MAA Coordinator be sent within five (5) business days from the date of the e-mail message.

Step 2: If the LEC/LGA MAA Coordinator does not respond within five (5) business days or sends incomplete information, the SMAA analyst shall notify the LEC/LGA MAA 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 response.

Step 3: If the LEC/LGA MAA Coordinator does not respond or sends incomplete information by the end of the second five (5) business days, the SMAA analyst shall return the related invoice package and/or contract. The SMAA 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 MAA 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 MAA 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.

MAA 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 2005/06 should read as “05/06-2-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 2005/06 should read as “05/06-3–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 MAA Summary Invoice and all supporting documentation.

QUARTER AVERAGING SUPPLEMENTAL WORKSHEET (TAB 6)

If a claiming unit chooses to average a particular quarter, they must submit with their invoice a Quarter Averaging Worksheet. Enter the number of participants and total hours for each activity code in the worksheet and it will automatically calculate the average.

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: Applies only if individual positions' time survey results and costs were included in the three non-averaged quarter invoices in that fiscal year.** The LEA can average the time survey results of any quarter in a fiscal year. The averaging quarter cannot be chosen after time surveys are completed. Completed surveys must be used for that quarter.

How to Average:

1. Identify those individual positions that had time survey results and costs included in each of the three non-averaged quarter invoices in that fiscal year.
2. Compile the time survey results for each of the individual positions identified by Activity Code for each of the three quarters to arrive at a new recalculated time survey percentage.
3. The recalculated percentages should be added together and divided by three. This will give you the averaged quarter averaging percentages.
4. Be sure to make your calculations clear and well documented in the event of an audit or site visit.
5. This worksheet must be submitted with each invoice that you have chosen to average.
6. If a Claiming Unit, wishes to claim for an individual position that did not time survey all three quarters, the position must participate in a separate time survey quarter.

A summary copy of the Claiming Unit's non-averaged quarter time survey results *in invoice order (Tab 1, Column D)* must be submitted with the MAA Detail and MAA Summary Invoice. A Quarter Averaging Worksheet which contains a separate Quarter Time Survey must be submitted with the Averaging Quarter 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 Worksheet: No SACS financial reports required.

Payroll Data Collection Worksheet:

Column A:

Row 36 – Include Objects 1000–2999, Functions 1000–2699, 3000–6999 and 7200–9999. Include only resources 0000-2999, 5640-5649, and 6000-9999. Exclude federal resources 3000-5639 and 5650-5999.

Row 40 – Include Objects 1000–2999, Functions 2700 and 7000–7199. Include only resources 0000-2999, 5640-5649, and 6000-9999. Exclude federal resources 3000-5639 and 5650-5999.

Column B:

Row 36 – Include Objects 3000–3999, Functions 1000–2699, 3000–6999 and 7200–9999. Include only resources 0000-2999, 5640-5649, and 6000-9999. Exclude federal resources 3000-5639 and 5650-5999.

Row 40 – Include Objects 3000–3999, Functions 2700 and 7000–7199. Include only resources 0000-2999, 5640-5649, and 6000-9999. Exclude federal resources 3000-5639 and 5650-5999.

Costs and Revenues Worksheet:

Row 47 – Federal Revenues, include Objects 8100–8299.

Row 48 – State Revenue Limit Sources, include Objects 8010–8099.

Row 49 – Other State Revenues include Objects 8300–8599.

Row 50 – Other Local Revenues include Objects 8600–8799.

Row 51 – Other Financing Sources include Objects 8910–8979.

Row 52 – Contributions to Restricted Programs, include Objects 8980–8999.

Row 56, Column J – Other Costs Net of Federal Revenues, include Objects 4000–5999, Functions 2700 and 7000–7199. Also, to remove federally funded expenditures, include only Resources 0000–2999 and 6000–9999.

CHECKLIST FOR PREPARING THE MAA DETAIL INVOICE

Before the Detail Invoice Packet is submitted for reimbursement, this checklist must be completed to ensure completion of the following requirements. **Incomplete packets will not be processed.** All claims will be reviewed for reasonableness and consistency.

_____ The official and current version of the DHCS invoice is used

_____ The LEC/LGA name and correct contract number are on the invoice

_____ The period of service is correct. If the invoice is a correction, add C-1, C-2, etc. If it is a revision, add R-l, R-2, etc.

_____ There are no "Error" comments on the claim

_____ The same Medi-Cal percentage is used for Quarters 1 and 2

_____ The same Medi-Cal percentage is used for Quarters 3 and 4

_____ Administrative fees are not reported by both the LEA and LEC/LGA

_____ Documentation supporting the time survey results, general ledger reports as indicated on the MAA Detail Invoice

_____ The required supporting documentation is attached:
(A description is only required if the claiming unit deviates from the SACS reporting requirements, such as a Community College or Non Public School.)

_____ The required documents must be signed in blue ink by both the LEC/LGA Coordinator and the LEA Coordinator:

- MAA Summary Invoice (include all worksheets-TABS 1-5)
- Variance form
- Claiming Unit Functions Grid(s)
  - Please Note: When both time survey results and averaged results are included in a quarterly invoice, two Claiming Unit Functions Grids are required.
- Detail and Summary Checklists

_____ The Averaging Quarter invoice includes the Averaged Quarter Worksheet (Tab 6)

_____ The official version of the Claiming Unit Function Grid includes:

- Claiming Unit Name is consistent with the invoice information
- The County-District-School is identified on the Grid
- All job classifications are listed (including the direct charged staff)
- Signed/dated by the LEA MAA Coordinator (in blue ink)

SIGN AND DATE TO INDICATE THAT ALL ABOVE ITEMS HAVE BEEN REVIEWED.

_____ _____

Signature of Invoice Preparer (in blue ink) Date

CHECKLIST FOR SUBMITTING THE MAA SUMMARY INVOICE

Each MAA Summary Invoice sent to DHCS by the LEC/LGA **must be accurate and complete**. To assist DHCS in reviewing and processing your MAA Claims expeditiously, the LEC/LGA must complete this checklist and verify the following items:

_____Include (on LEC/LGA letterhead) the Invoice Variance Form (refer to Appendix F) showing the reason for 20% discrepancy between consecutive quarters and year-to-year quarters

_____ Confirm the MAA Summary Invoice is prepared on the letterhead of the LEC/LGA agency which is under contract with the Department of Health Care Services

_____Confirm the LEC/LGA Name is correct

_____Confirm the contract number is correct

_____ Confirm that the period of service is correct and matches the period of service on the corresponding MAA Detail Invoice

_____ Confirm the Claiming Unit name is the same as the MAA Detail Invoice

_____Verify that the invoice number is the same as the MAA Detail Invoice

_____ Confirm the amount to be reimbursed on the MAA Summary Invoice is the same as the Total Federal Share amount on the FFP Calculations Worksheet

_____ Confirm the MAA Summary Invoice is dated and has an original signature (in blue ink)

SIGN AND DATE TO INDICATE THAT ALL ABOVE ITEMS HAVE BEEN REVIEWED.

_____ _____

Signature of LEC/LGA Coordinator (in blue ink) Date

APPENDIX A

Abbreviations and Acronyms

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
DHHS	Federal Department of Health and Human Services
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
Grid	Claiming Unit Functions Grid
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
PALS	Pregnant and Lactating Students Program
PMP	Pregnant Minors Program
PPL	Policy and Procedure Letter
PPPD&IC	Program Planning and Policy Development, and Interagency Coordination
RN	Registered Nurse
SAPID	School Age Parenting and Infant Development Program
School Manual	California School-Based Medi-Cal Administrative Activities Manual
SELPA	Special Education Local Plan Area
TPL	Third Party Liability

APPENDIX B

Sample MAA Invoice

LEC/LGA SCHOOL MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA) DETAIL INVOICE (7/2011)

I. ACTIVITIES AND MEDI-CAL PERCENTAGES WORKSHEET

	INVOICE INFORMATION	
1	Claiming Unit Name	
	CDS Code	
2	DHCS Contractor (Region)	
3	Contract #	
4	Prepared by	
5	Title	
6	Phone #	
7	Date	
8	Contract year/quarter	
9	Period of Service	

	A	B	C	D	E	F	G	H
	Type of Activity	Code	Medi-Cal Discount %	MAA TIME SURVEY STAFF				
				Survey Results Percentages	Quarter Average Percentages	Total Weighted-Average Survey Results	Allocate Gen. Admin./Paid Time Off (Code 16)	Apply Medi-Cal Discount % (Col. C X Col. G)
	Non-Discounted:				-			
10	Initial Medi-Cal Outreach	4	100.00%			#DIV/0!	#DIV/0!	#DIV/0!
11	Facilitating Medi-Cal Application	6	100.00%			#DIV/0!	#DIV/0!	#DIV/0!
12	Medi-Cal Claims Administration, Coordination & Training	15	100.00%			#DIV/0!	#DIV/0!	#DIV/0!
	Discounted:							
13	Ongoing Referral, Coordination, and Monitoring of Medi-Cal Services	8	0.00%			#DIV/0!	#DIV/0!	#DIV/0!
14	Arranging Transportation in Support of Medi-Cal Services	10	0.00%			#DIV/0!	#DIV/0!	#DIV/0!
15	Translation to Access Medi-Cal Services	12	0.00%			#DIV/0!	#DIV/0!	#DIV/0!
16	Program Planning, Policy Development & Interagency Coord. Related to Medi-Cal Services	14	0.00%			#DIV/0!	#DIV/0!	#DIV/0!
	Non-claimable:							
17	School-Related, Education, and Other Activities	1				#DIV/0!	#DIV/0!	
18	Direct Medical Services	2				#DIV/0!	#DIV/0!	
19	*Non*-Medi-Cal Outreach	3				#DIV/0!	#DIV/0!	
20	Facilitating Application for *Non*-Medi-Cal Programs	5				#DIV/0!	#DIV/0!	
21	Referral, Coordination, and Monitoring of *Non*-Medi-Cal Services	7				#DIV/0!	#DIV/0!	
22	Transportation for *Non*-Medi-Cal Programs	9				#DIV/0!	#DIV/0!	
23	*Non*-Medi-Cal Translation	11				#DIV/0!	#DIV/0!	
24	Prog. Planning, Policy Dev., & Interagency Coord. Related to *Non*-Medi-Cal Services	13				#DIV/0!	#DIV/0!	
	Allocated:							
25	General Administration/Paid Time Off	16				#DIV/0!	Allocated	
26	**TOTAL TIME**			**100.00%**	**100.00%**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
27	Number of Claiming Unit Staff Included in Each Survey							
28	**State Approved Indirect Cost Rate for the Current Billing Period**							

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

LEC/LGA SCHOOL MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA) DETAIL INVOICE

(7/2011)

II. DIRECT CHARGES WORKSHEET

Claiming Unit Name	0	Date	
DHCS Contractor (Region)	0	Contract Year/Qtr.	0
Contract #	0	Period of Service	

	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)			
	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	Initial 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	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	
	NON-DISCOUNTED SUB-TOTAL		0			0	0	-			-	-	0		0		0		0	
32	Ongoing 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**

LEC/LGA SCHOOL MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA) DETAIL INVOICE (7/2011)

III. PAYROLL DATA COLLECTION WORKSHEET

Claiming Unit Name	0	Date	
DHCS Contractor (Region)	0	Contract year/qtr	0
Contract #	0	Period of Service	

	A		B		
	SALARIES (Objects 1000-2999):	Functions 1000-9999, excluding 2700 & 7000-7199	**BENEFITS (Objects 3000-3999):**	Functions 1000-9999, excluding 2700 & 7000-7199	Total Claiming Unit Salaries & Benefits
36	Total Non-Federally Funded Claiming Unit Salaries		Total Non-Federally Funded Claiming Unit Benefits	-	-
37	**Less:** Time Survey Participant (Employee) Salary Costs		**Less:** Time Survey Participant (Employee) Benefit Costs	-	
38	**Less:** Direct Charge Salary Costs		**Less:** Direct Charge Benefit Costs	-	
39	**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	**School Administration and General Administration**	Functions 2700 & 7000-7199	
40	Total Non-Federally Funded Claiming Unit Salaries **(b)**		Total Non-Federally Funded Claiming Unit Benefits **(b)**		-
41	**Less:** Time Survey Participant (Employee) Salary Costs		**Less:** Time Survey Participant (Employee) Benefit Costs		
42	**Less:** Direct Charge Salary Costs		**Less:** Direct Charge Benefit Costs		
43	**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.***

LEC/LGA SCHOOL MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA) DETAIL INVOICE

(7/2011)

IV. COSTS AND REVENUES WORKSHEET

Claiming Unit Name:	0	Date	
DHCS Contractor (Region)	0	Contract year/quarter	0
Contract #:	0	Period of Service	

		A	B	C	D	E	F	G	H	I	J
	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	$		$		$	$	$	$	$	
44	Salaries (1000-2999)	0	#DIV/0!	#DIV/0!	#DIV/0!	-	-	-	-	#DIV/0!	
45	Benefits (3000-3999)	0	#DIV/0!	#DIV/0!	#DIV/0!	-	-	-	-	#DIV/0!	
46	**SUBTOTAL PERSONNEL**	0	#DIV/0!	#DIV/0!	#DIV/0!	-	-	-	-	#DIV/0!	
	REVENUE OFFSETS								Non-Offset		
47	Federal Revenues (8100-8299)					0	0			-	
48	State Revenue Limit Sources (8010-8099)									-	
49	Other State Revenues (8300-8599)					0	0			-	
50	Other Local Revenues (8600-8799)									-	
51	Other Financing Sources (8910-8979)									0	
52	Contributions to Restricted Programs (8980-8999)								0	0	
53	**Total Revenues**					0	0		0	0	
54	**Personnel Costs less Revenue Offsets**			#DIV/0!	#DIV/0!	0	0	0			CLAIMING UNIT OTHER COSTS - NET OF FEDERALLY FUNDED EXPENDITURES (b) (Objects 4000-5999, Functions 2700 & 7000-7199, and excluding Resources 3000-5639 and 5650-5999)
55	**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**	
56	Personal Service Contracts		#DIV/0!	#DIV/0!	#DIV/0!	-	0			0	
57	Direct Charge Other Costs					-	-			0	Less Other Unallowable Costs
58	**ALLOCATION OF OTHER COSTS:**			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		-	-
59	**ALLOCATION OF GENERAL & ADMIN.**			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!			
60	**Subtotal Costs**			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!	
61	**Indirect Rate Applied**			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
62	**TOTAL COSTS**			**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	K
	FFP CALCULATIONS										
63	**MAA CLAIMABLE COSTS**			#DIV/0!		#DIV/0!					
64	**Apply FFP Percentage (50%)**			#DIV/0!		#DIV/0!					
65	**TOTAL FEDERAL SHARE**			**#DIV/0!**							

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%**
#DIV/0!		**#DIV/0!**	

0
Typed Name of Preparer

0
Title

Typed Name of Authorized LEA Business Official

Signature of Authorized LEA Business Official (Blue Ink Only)

0
Telephone #

Title

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 MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA) SUMMARY INVOICE

(7/2011)

Claiming Unit Name:	0	Date	
DHCS Contractor (Region)	0	Contract year/quarter	0
Contract #	0	Period of Service	

Type of Invoice (check one):

Original Invoice ☐

Revised Invoice ☐

Corrected Invoice ☐

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	$ #DIV/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 Medi-Cal Administrative Activities
1501 Capitol Ave., MS 4603
PO Box 997413
Sacramento, CA 95899-7413

LGA SCHOOL MEDI-CAL ADMINISTRATIVE ACTIVITIES (SMAA) SUMMARY INVOICE

(7/2011)

Claiming Unit Name	0	Date	
DHCS Contractor	0	Contract year/quarter	0
Contract #	0	Period of Service	

Type of Invoice (check one):

Original Invoice ☐

Revised Invoice ☐

Corrected Invoice ☐

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	$ #DIV/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 Medi-Cal Administrative Activities
1501 Capitol Ave., MS 4603
PO Box 997413
Sacramento, CA 95899-7413

SMAA Averaging Quarter Worksheet

(Required for Averaging Quarter Invoice)

Quarter Recalculated **0** **(7/2011)**

		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	Total Hours
# Participants	Total Hours																	0.00
	% of Hours	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Quarter Recalculated **0**

		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	Total Hours
# Participants	Total Hours																	0.00
	% of Hours	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Quarter Recalculated **0**

		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	Total Hours
# Participants	Total Hours																	0.00
	% of Hours	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Quarter Average *(Averaging by %)*

Invoice Reimbursement ($)quarter averaging %'s and using same fiscal data as presented in the May 2007 MAA SB Invoice Training Manual

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

27E

Separate Quarter Time Survey (Those staff not part of averaging)

Quarter Recalculated **4**

		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	Total Hours
# Participants	Total Hours																	0.00
	% of Hours	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
		↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	↓	
Enter on Invoice Line#		**10D**	**11D**	**12D**	**13D**	**14D**	**15D**	**16D**	**17D**	**18D**	**19D**	**20D**	**21D**	**22D**	**23D**	**24D**	**25D**	

27D

APPENDIX C

LEA-LEC Tape Match Procedures

LEA/LEC TAPE MATCH INSTRUCTIONS

(PC environment with Microsoft OFFICE including ACCESS installed only)

1.) Download PGP software and establish a password
(be sure and write down your password)

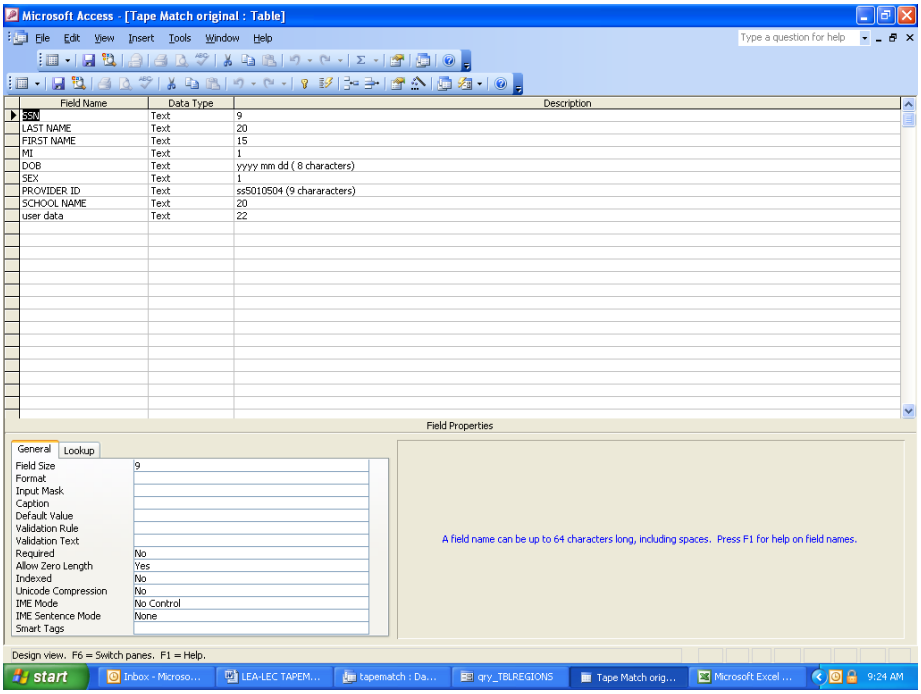
PGP website address - www.pgpi.org/products/pgp/versions/freeware
(call Han Nhan at 916 440-7253 or email hnhan@dhcs.ca.gov for assistance)

2.) Request a "provider id" number from DHCS, apply at
http://www.dhcs.ca.gov/provgovpart/Pages/LEAProviderEnrollment.aspx

3.) In MS OFFICE ACCESS create a new database. Within the database create a new table and call it "DHCS Tape match".

4.) Following is 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.

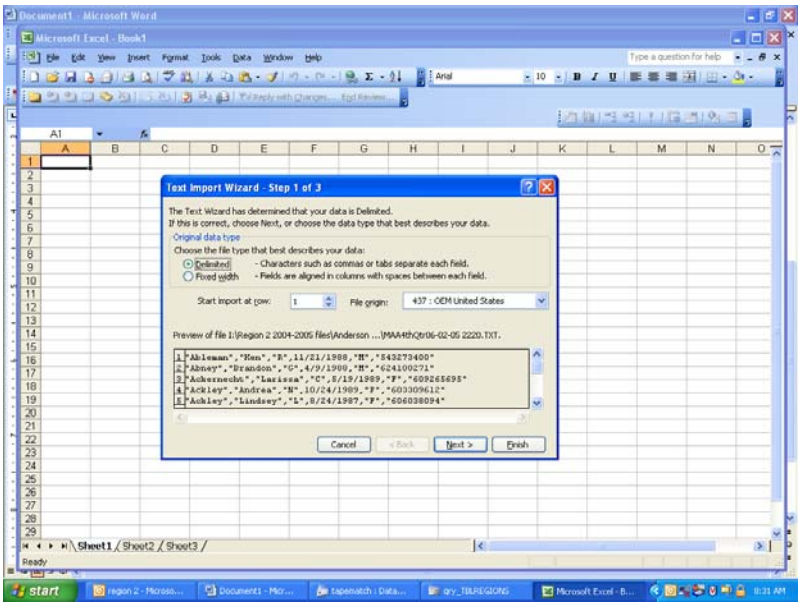


a.) Close and save the table. Close and save the database.

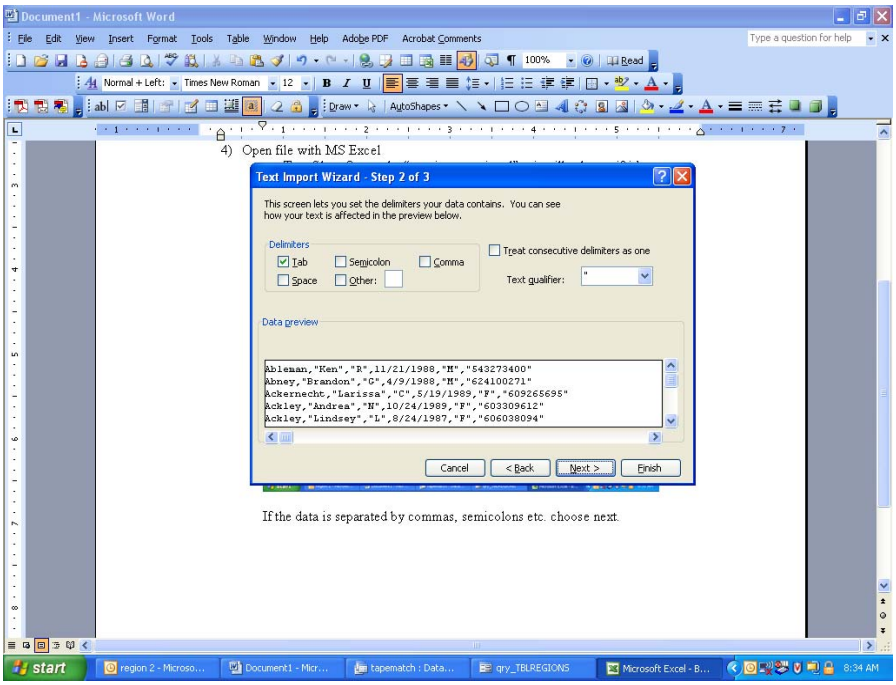
5.) Download or output a student population data file (the total number of individuals served by the claiming unit, DHCS Manual pg.10-1) from district system as a text or excel file. The Medi-Cal percentage must be calculated twice per year, once in the 1st or 2nd quarters and once in the 3rd or 4th quarters; this percentage must be reflected in the invoices for those quarters.

6.) Open the file with MS Excel

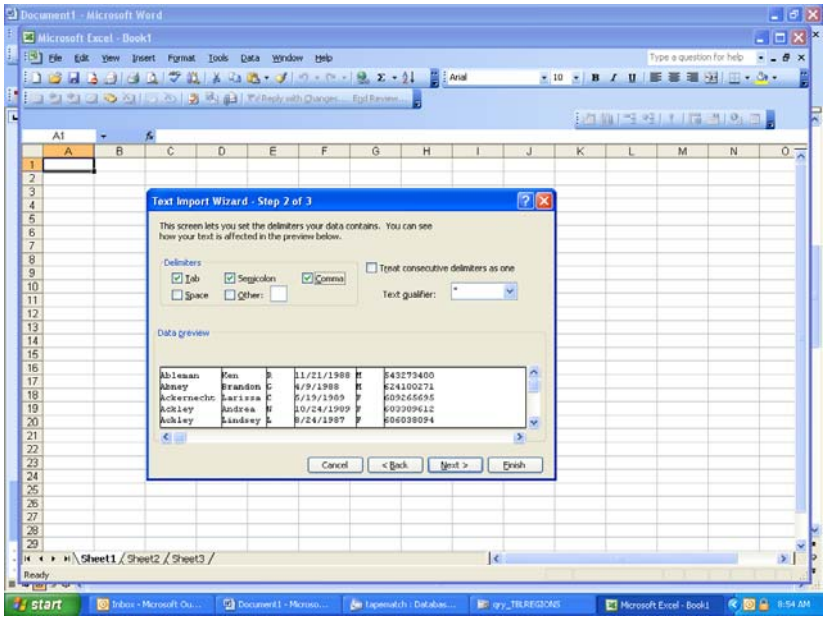
a.) Text file – Opens the “text import wizard” – it will ask you if it’s delimited or fixed width (in the case of fixed width it will have lines dividing the columns and you hit finish).



b.) If the data is separated by commas, semicolons etc. choose next. That will give you the opportunity to define the separators.



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



d.) Click finish at this point and you will have finished the text file import into Excel.

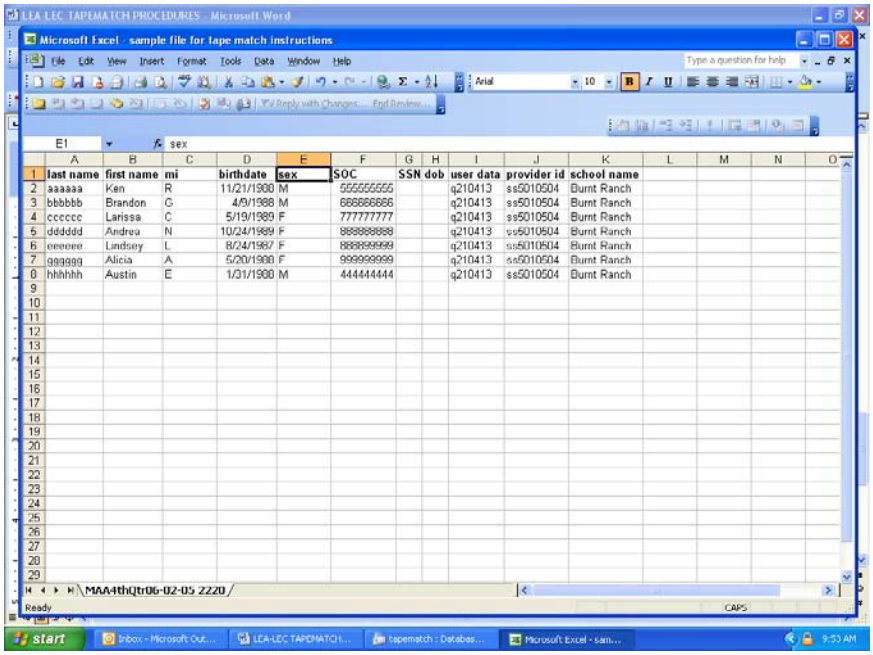
e.) Insert a row at the top and label the columns as indicated:

Last name, first name, mi, birthdate, sex and soc.

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. I 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 the entire columns for each name in the file, for instance, Q210413, ss5010504, Burnt Ranch



last name	first name	mi	birthdate	sex	SOC	SSN	dob	user data	provider id	school name
aaaaaa	Ken	R	11/21/1988	M	555555555			q210413	ss5010504	Burnt Ranch
bbbbbb	Brandon	G	4/9/1988	M	666666666			q210413	ss5010504	Burnt Ranch
cccccc	Larissa	C	5/19/1989	F	777777777			q210413	ss5010504	Burnt Ranch
dddddd	Andrea	N	10/24/1989	F	888888888			q210413	ss5010504	Burnt Ranch
eeeeee	Lindsey	L	8/24/1987	F	888899999			q210413	ss5010504	Burnt Ranch
gggggg	Alicia	A	5/20/1988	F	999999999			q210413	ss5010504	Burnt Ranch
hhhhhh	Austin	E	1/31/1988	M	444444444			q210413	ss5010504	Burnt Ranch

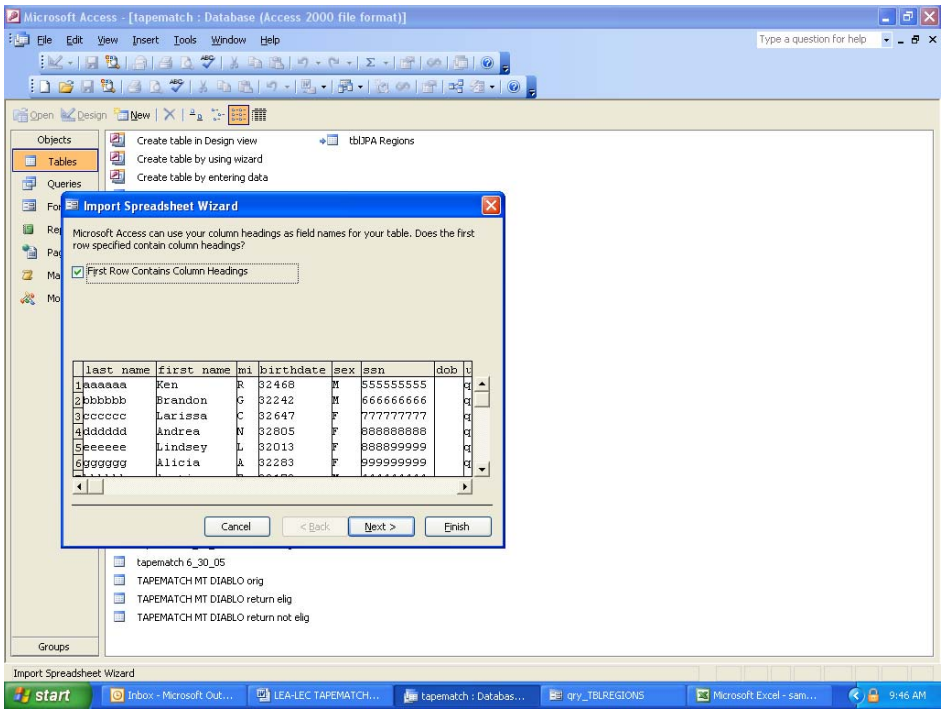
h.) Save this file as an “Excel Worksheet” and close.

7.) EXCEL file – if the file is already in an EXCEL format, open and insert a row for labels and/or relabel the columns making sure they are labeled precisely as indicated as the above step: **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 EXCEL file you had created above, highlight the file and then click IMPORT. This opens the ACCESS IMPORT SPREADSHEET wizard.

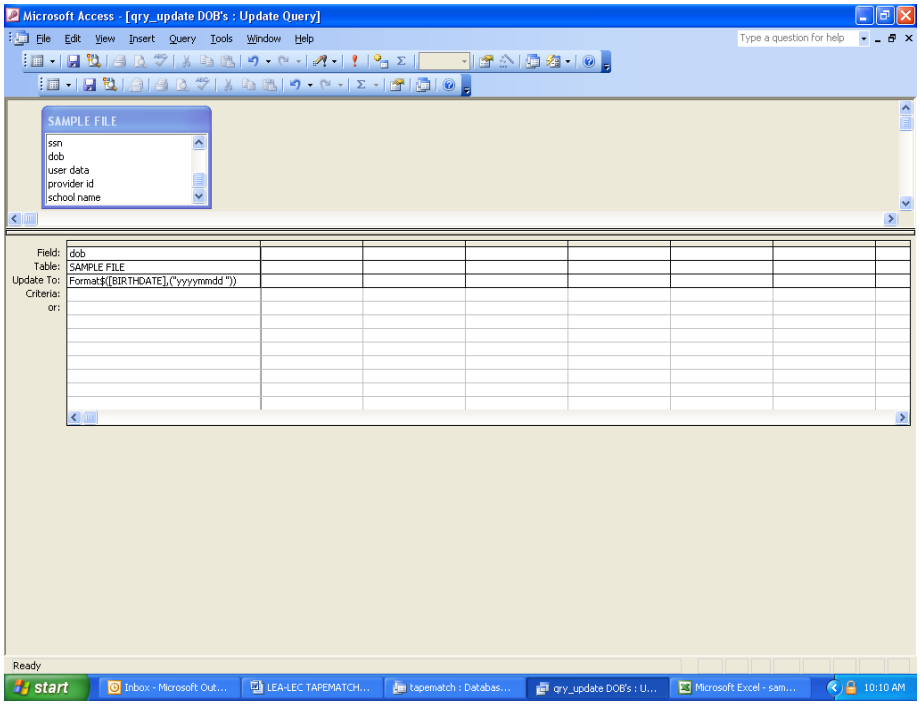


a.) Click on the “First row contains column headings” and FINISH. This file will import with the worksheet name as a new table so you might want to rename the table; left click, choose rename and give the table a new name, for instance “District”. (Do not call it TAPE MATCH). You will receive a confirmation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

11.) Birthdates as mm/dd/yy, i.e. 12/25/99 or mm/dd/yyyy, i.e. 12/25/1999

a.) If the birthdates in the file are structured as anything but **yyyymmdd** (year, month, date), 19991225, then we need to convert them to the DHCS format. (This is why we added a blank column labeled DOB to the excel file)
b.) Go to the queries tab in your database.
c.) Create a query in design view.
d.) In the Show Table box, highlight the district table and click ADD.
e.) Close the box.
f.) Choose “DOB” 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 **Format$([BIRTHDATE],("yyyymmdd "))**

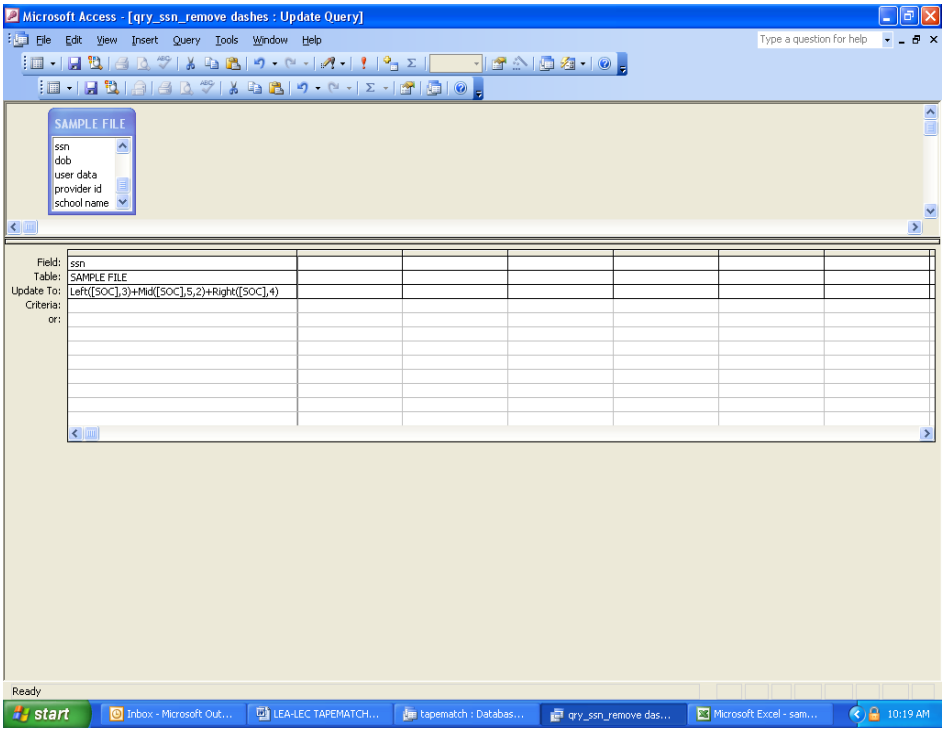


j.) Go to the file menu and QUERY, RUN or use the “!” button. This process will verify that you updated the records in your table. (Your original SOC field is left intact and the SSN field becomes the DHCS acceptable SOC format.
k.) Close and save the query, calling it “Qry to update SSN”.
l.) Go to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

12.) Social Security numbers with dashes

a.) If the Social Security numbers in the file have dashes, we need to remove the dashes. (This is why we added a blank column labeled SSN)
b.) Go to the queries tab in your database.
c.) Create a query in design view.
d.) In the Show Table box, highlight the district table and click ADD.
e.) Close the box.

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)**

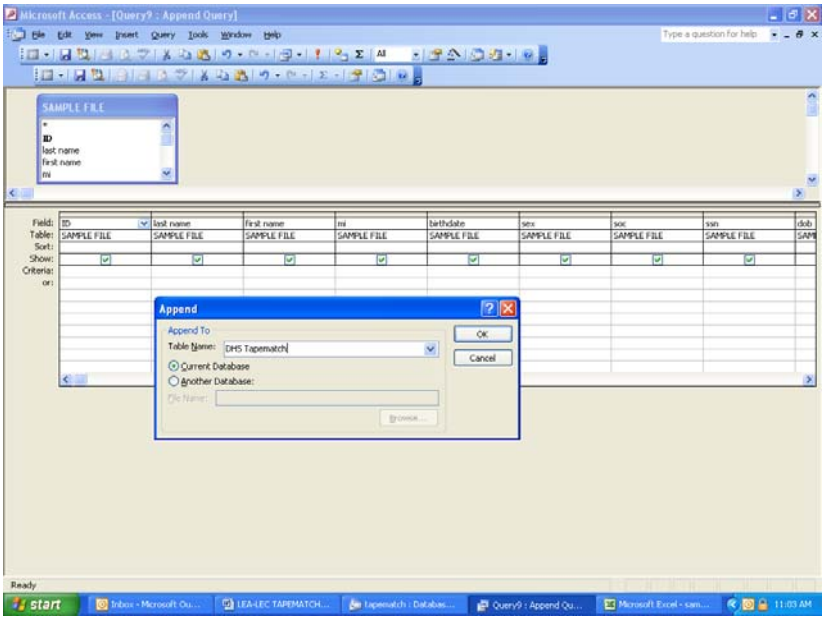


j.) Go to the file menu and QUERY, RUN or use the ! button. This process will verify that you updated the records in your table. (Your original birthdate field is left intact and the DOB field becomes the DHCS acceptable DOB format.
k.) Close and save the query, calling it “Qry to update birthdays”.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

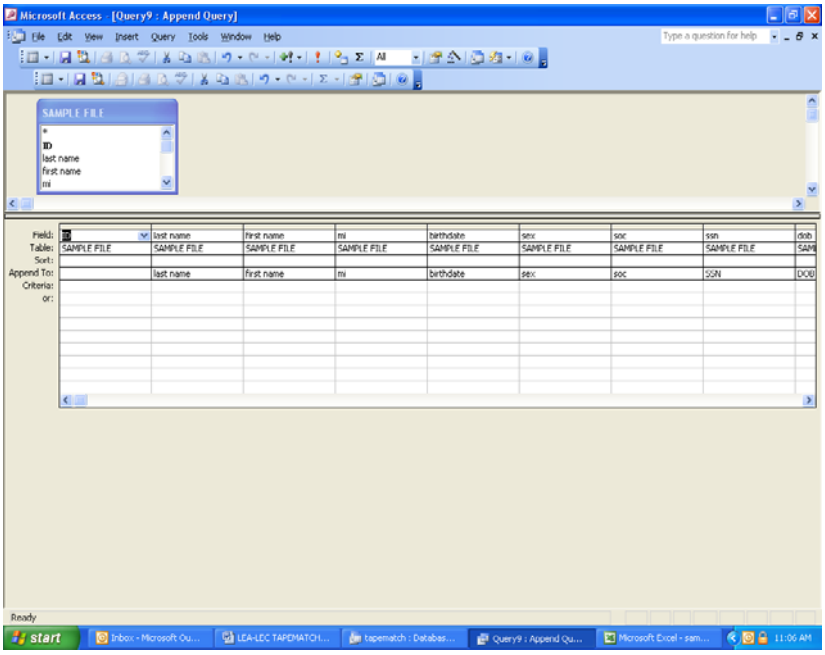
13.) Getting the file into the DHCS Tape match format

Your file may have some extra information, for instance, middle names instead of middle initials or an ID field etc. This step enables us 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 for you to choose the table you want to append to.
h.) Using the arrow, choose the DHCS Tape match table and click OK.



i.) After you say 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”.

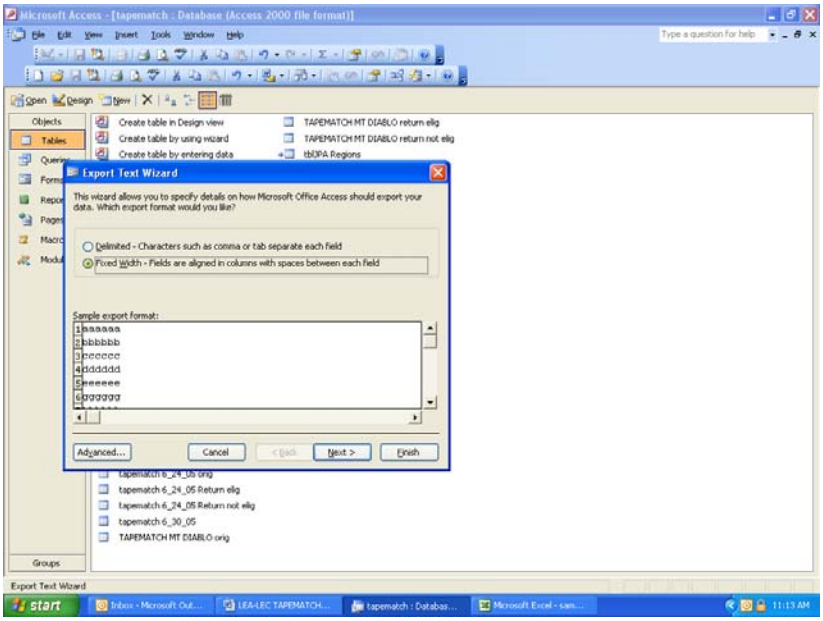
14.) Sending the file to DHCS

a.) Go to the Tables tab.

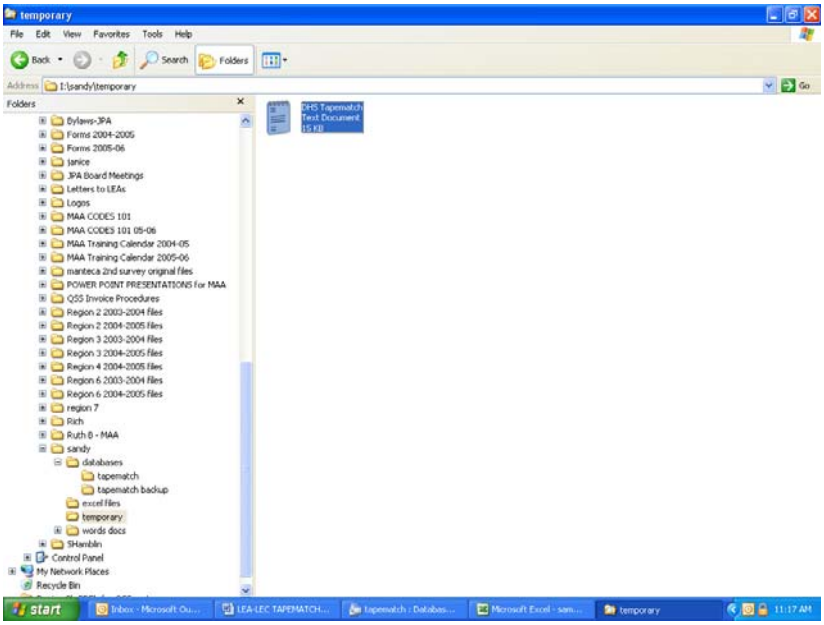
b.) Highlight (click on) the table “DHCS Tape match”.

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.**

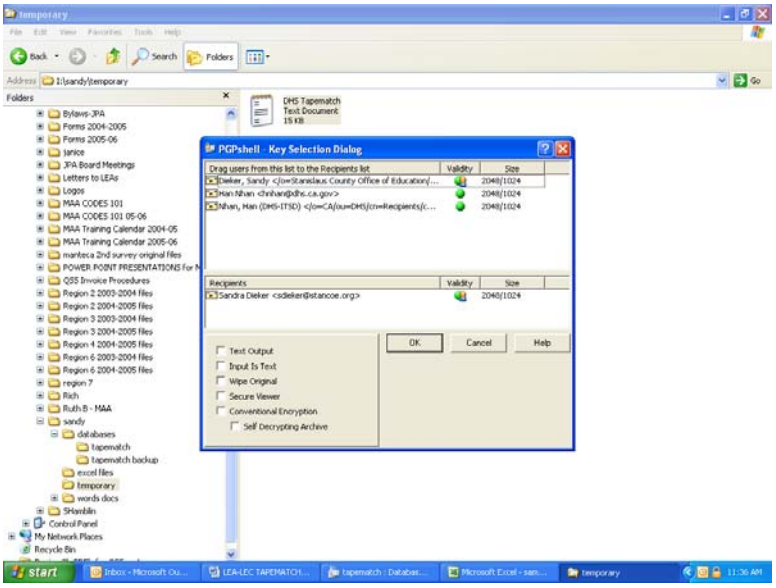


i.) This step has converted the ACCESS table to a text file with the same name as the table, “DHCS Tapematch.txt”.
j.) Locate the new “DHCS Tape match” txt file in your directory.
k.) Highlight the file.

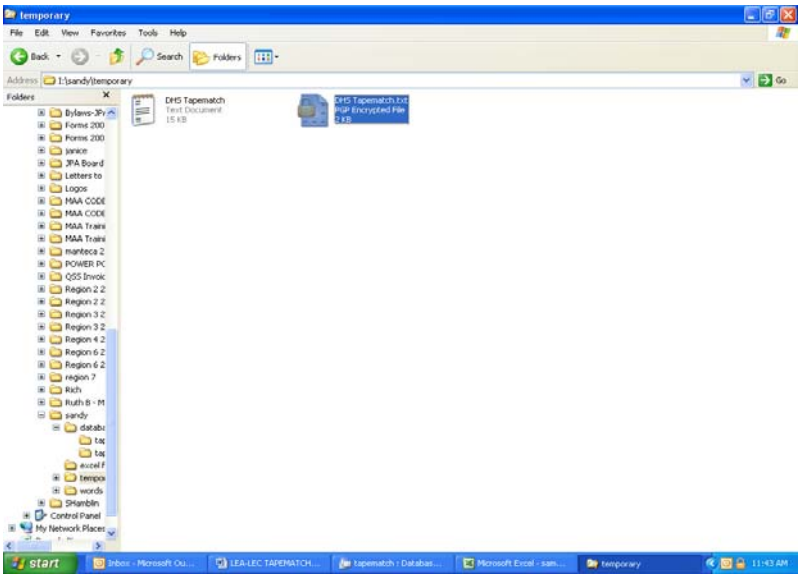


l.) Left click with your mouse.

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 Han Nhan's 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 <u>send to mail recipient</u>. In the outlook box type <u>HNhan@DHCS.ca.gov</u> and send.

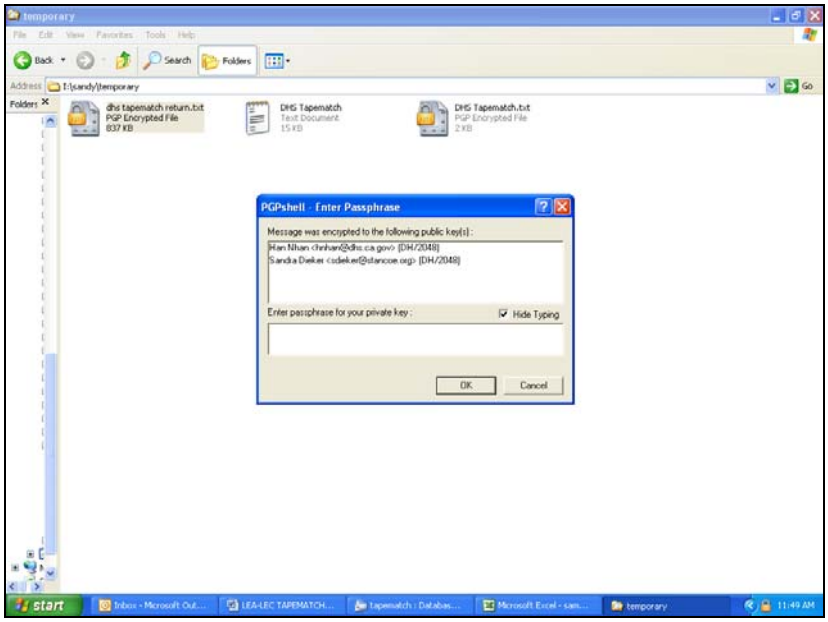
<u>File Returned from DHCS</u>

1.) Once you receive the file back from DHCS (usually the next day) 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.

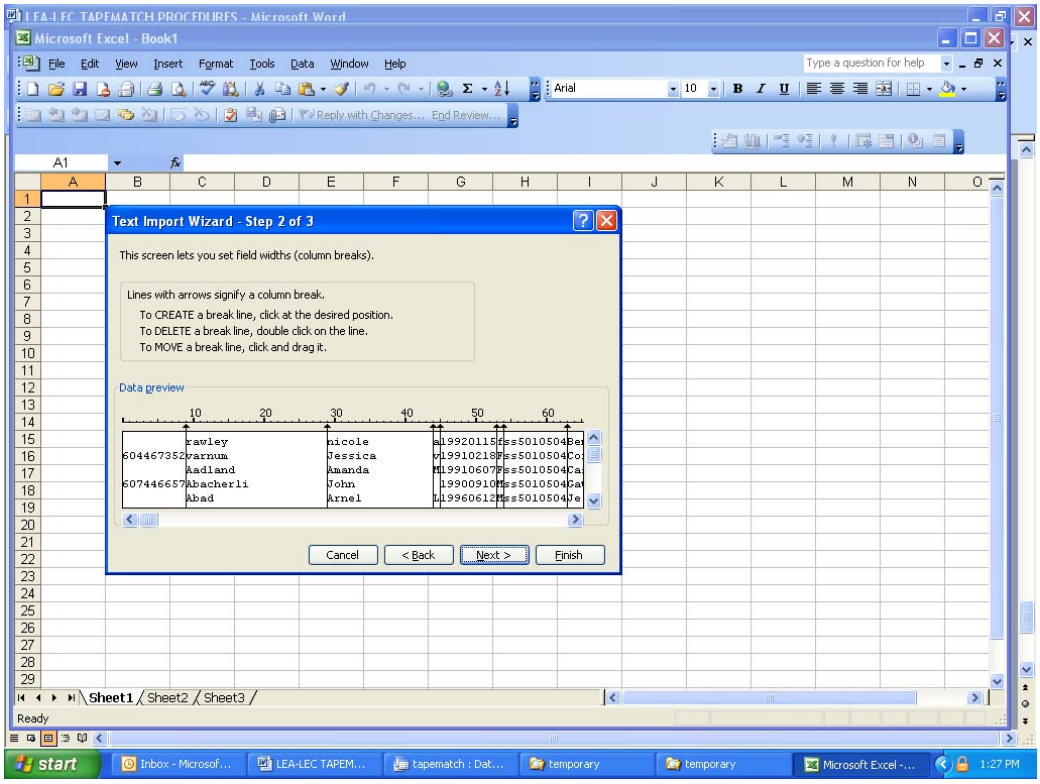


5.) In the "Enter passphrase for your private key" type the password you originally set up with DHCS in step 1. The file will automatically save as a Text with the word return in the name.

6.) Open EXCEL, locate this returned file and then double click to open the file.

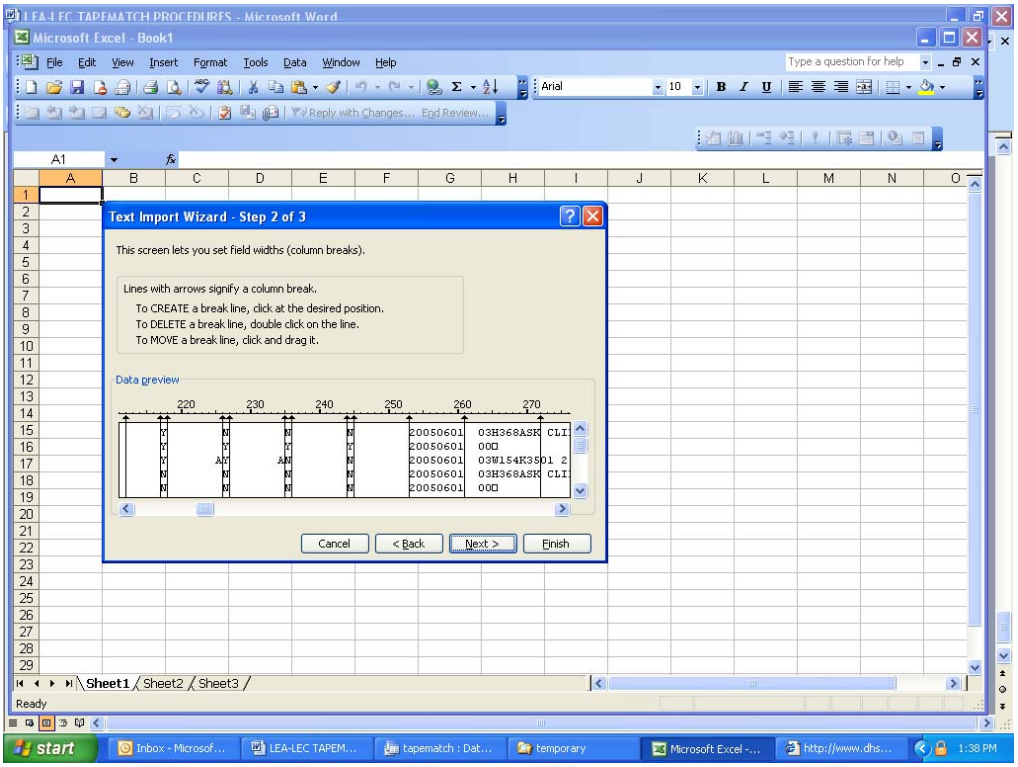
7.) A Text Import Wizard box will open. Choose **Fixed Width and NEXT.**

8.) This next step is the most crucial too 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 <u>LEA Match Record Layout if possible.</u> For instance, the SSN number starts at 1 and goes to 9, the last name column starts at 10 and goes to 29, and 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 "Excel Workbook".

10.) Open the 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).

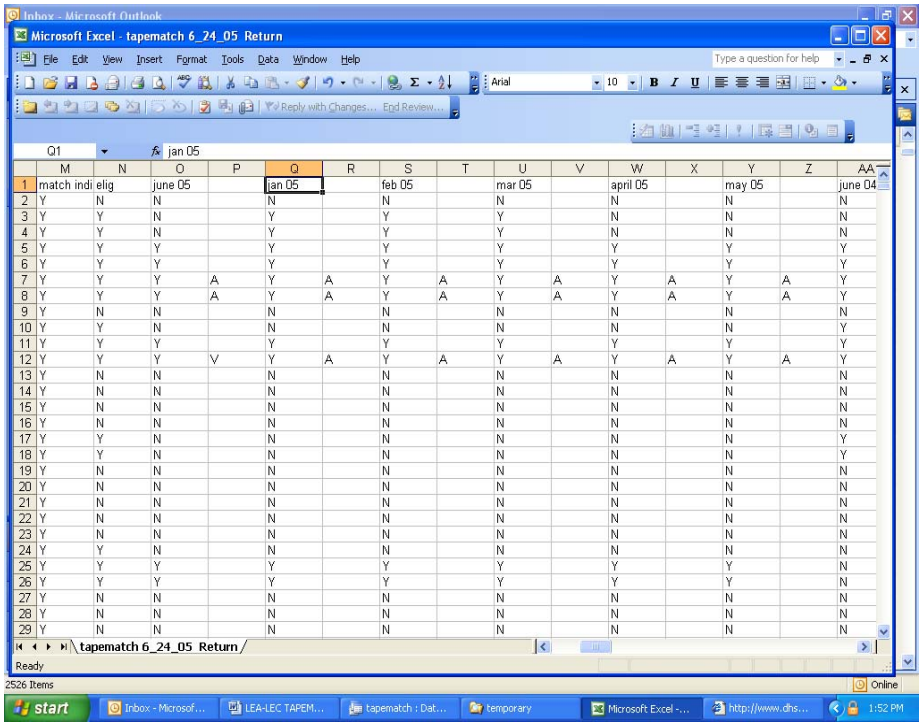
15.) The next column with Y or N is the current month eligibility indicator, i.e. if your Meds Current Date is 20050601 then that is the Y or N eligibility for June 2005.

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.)

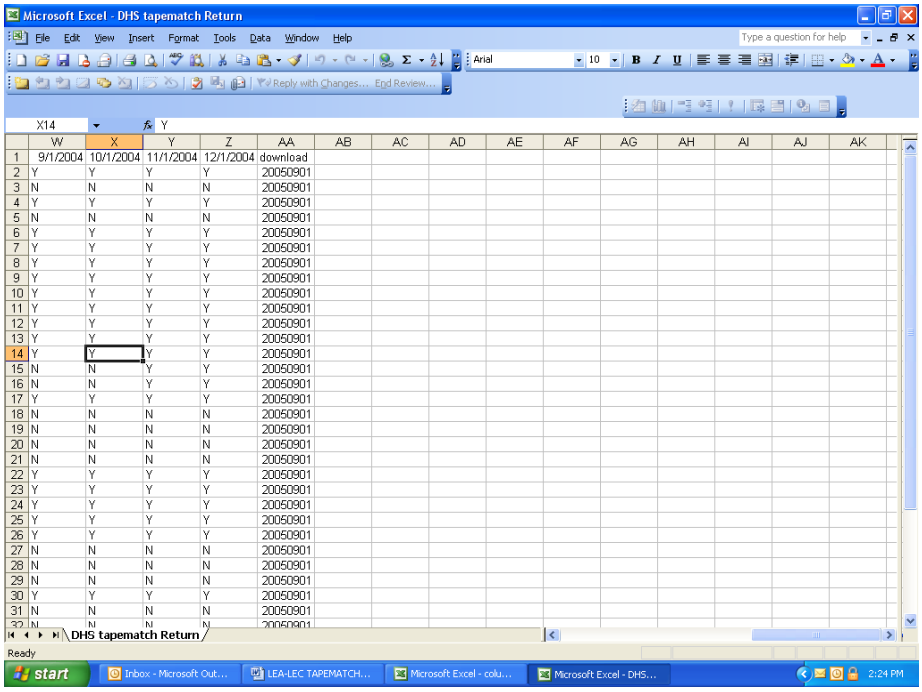
17.) The next column with Y or N after January will be February 05, March 05, April 05, May 05 etc. until you get to the download month, in this case, June 05. Since you already have a June 05 column the next column with a Y or N would be June of the previous year or June 2004.

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 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.



	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA
1	match indi	elig	june 05		jan 05		feb 05		mar 05		april 05		may 05		june 04
2	Y	N	N		N		N		N		N		N		N
3	Y	Y	N		Y		Y		Y		N		N		N
4	Y	Y	N		Y		Y		Y		N		N		N
5	Y	Y	Y		Y		Y		Y		Y		Y		Y
6	Y	Y	Y		Y		Y		Y		Y		Y		Y
7	Y	Y	Y	A	Y	A	Y	A	Y	A	Y	A	Y	A	Y
8	Y	Y	Y	A	Y	A	Y	A	Y	A	Y	A	Y	A	Y
9	Y	N	N		N		N		N		N		N		N
10	Y	Y	N		N		N		N		N		N		Y
11	Y	Y	Y		Y		Y		Y		Y		Y		Y
12	Y	Y	Y	V	Y	A	Y	A	Y	A	Y	A	Y	A	Y
13	Y	N	N		N		N		N		N		N		N
14	Y	N	N		N		N		N		N		N		N
15	Y	N	N		N		N		N		N		N		N
16	Y	N	N		N		N		N		N		N		N
17	Y	Y	N		N		N		N		N		N		Y
18	Y	Y	N		N		N		N		N		N		Y
19	Y	N	N		N		N		N		N		N		N
20	Y	N	N		N		N		N		N		N		N
21	Y	N	N		N		N		N		N		N		N
22	Y	N	N		N		N		N		N		N		N
23	Y	N	N		N		N		N		N		N		N
24	Y	Y	N		N		N		N		N		N		N
25	Y	Y	Y		Y		Y		Y		Y		Y		N
26	Y	Y	Y		Y		Y		Y		Y		Y		N
27	Y	N	N		N		N		N		N		N		N
28	Y	N	N		N		N		N		N		N		N
29	Y	N	N		N		N		N		N		N		N



	W	X	Y	Z	AA
1	9/1/2004	10/1/2004	11/1/2004	12/1/2004	download
2	Y	Y	Y	Y	20050901
3	N	N	N	N	20050901
4	Y	Y	Y	Y	20050901
5	N	N	N	N	20050901
6	Y	Y	Y	Y	20050901
7	Y	Y	Y	Y	20050901
8	Y	Y	Y	Y	20050901
9	Y	Y	Y	Y	20050901
10	Y	Y	Y	Y	20050901
11	Y	Y	Y	Y	20050901
12	Y	Y	Y	Y	20050901
13	Y	Y	Y	Y	20050901
14	Y	Y	Y	Y	20050901
15	N	N	Y	Y	20050901
16	N	N	Y	Y	20050901
17	Y	Y	Y	Y	20050901
18	N	N	N	N	20050901
19	N	N	N	N	20050901
20	N	N	N	N	20050901
21	N	N	N	N	20050901
22	Y	Y	Y	Y	20050901
23	Y	Y	Y	Y	20050901
24	Y	Y	Y	Y	20050901
25	Y	Y	Y	Y	20050901
26	Y	Y	Y	Y	20050901
27	N	N	N	N	20050901
28	N	N	N	N	20050901
29	N	N	N	N	20050901
30	Y	Y	Y	Y	20050901
31	N	N	N	N	20050901

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

Append the file to ACCESS for the Calculation

1.) Open the ACCESS Tape match file.

2.) Go to FILE, click on GET EXTERNAL DATA, and click on IMPORT.

3.) In the dialogue box, find the EXCEL FILE that was returned from DHCS, select or highlight and click IMPORT.

4.) You may be notified that 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.

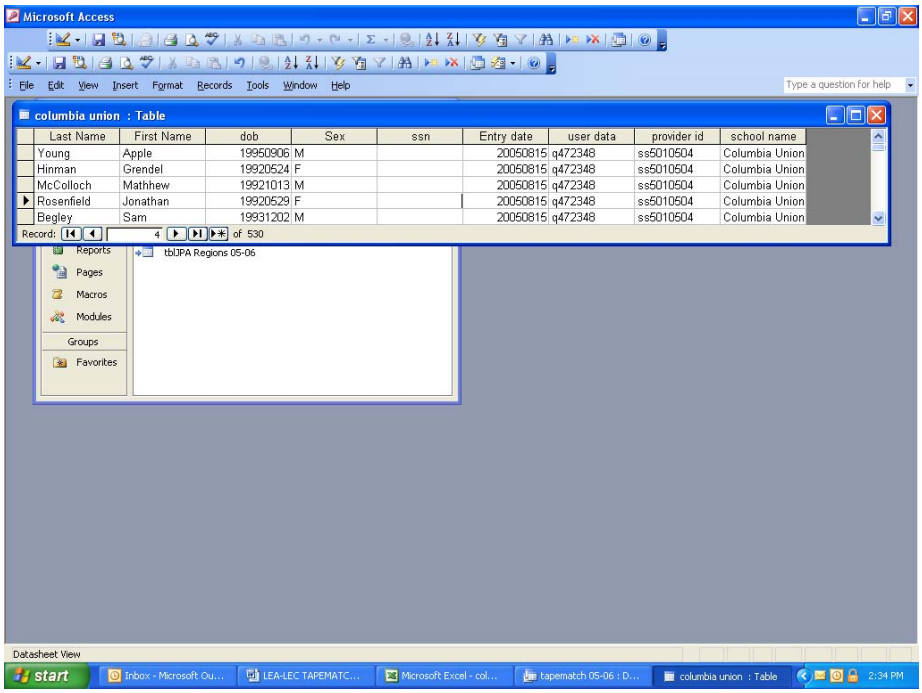
4.) Highlight all three columns and sort AZ ascending on the months, i.e. Oct., Nov., and Dec.

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

IEP Coding

MAA Coding for IEP's and SST's Related to Medi-Cal Services

Note: Medi-Cal services are assumed billed by school or community allowing for MAA.

Student Study Team (SST) type meeting or prior to authorization of health services in an IEP

Teacher/parent meetings to discuss academic concerns	Code 1
Discussion with staff regarding an *initial* referral for student to a Medi-Cal service	Code 4
The first time a parent/student is referred to a Medi-Cal service at school or in the community	Code 4
Arranging for a translator (written or verbal) to inform a parent about Medi-Cal health services	Code 12
Translator time to inform parent/student about Medi-Cal health services	Code 12
Referring & assisting parent/student to Medi-Cal/Healthy Families application assistance	Code 6
Informing parent/student, about Medi-Cal services and the assessment process	Code 1
Obtaining parent permission for Medi-Cal health assessments	Code 1
Performing IEP Medi-Cal health assessment	Code 2
Preparing information and completing assessment reports	Code 1
Providing outreach information in written reports	Code 2

During IEP meetings

Reporting Medi-Cal health assessment results	Code 2
Arranging for translator to explain assessment results	Code 11
The first time a parent/student is referred to a Medi-Cal service at school or in the community	Code 4
Translator time to inform a parent about Medi-Cal health services to be delivered	Code 12
Referring & assisting parent/student to Medi-Cal/Healthy Families application assistance	Code 6
Completing meeting process and obtaining appropriate signatures	Code 1

After health services are authorized by student/parent

Arranging/scheduling ongoing Medi-Cal health services w/providers (speech, OT, counselors)	Code 8
Informing teachers about a student's Medi-Cal health services	Code 8
Researching/directing parent/student to *initial* Medi-Cal health services	Code 4
Directing/referring parent/student to *ongoing* Medi-Cal health services	Code 8
Monitoring the provision of Medi-Cal-covered services	Code 8
Coordinating and reviewing Medi-Cal services	Code 8
Coordinating student transportation to Medi-Cal services	Code 10

Annual, Tri-annual or other IEP or SST meetings to reexamine health services

Coordinating ongoing assessments for Medi-Cal health services	Code 8
Researching/developing new Medi-Cal services for a student	Code 4
Amending the IEP, SST, placement, etc. with new Medi-Cal services	Code 4
Exiting a student from services	Code 1
Transitioning a student/family to ongoing Medi-Cal services outside school environment	Code 8
Completing assessment reports and preparing for meeting	Code 1
Preparing information and completing annual assessment reports for meeting	Code 1
Completing form process and obtaining appropriate signatures	Code1

APPENDIX E

LATE INVOICE SUBMISSION REQUEST

LEC/LGA LETTERHEAD

Date:

To:
DHS County-Based MAA Chief
DHS 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

APPENDIX F

INVOICE VARIANCE FORM

Date: _____

To: _____

From: _____

Subject: Invoice Percentage Variance and Analysis of Variance (if applicable) Documentation
(Between Current Year Prior Quarter and / or Previous Year Corresponding Quarter)

Claiming Unit: _____ Invoice #: _____

Please check the reason for the variance and provide a narrative for those that have a variance of 20% lesser/greater.

PY Corresponding Quarter		Prior Quarter Current Year	
	Corresponding Qtr Prior Fiscal Year		**Prior Qtr Invoice Amount**
	Current Qtr Invoice Amount		**Current Qtr Invoice Amount**
#DIV/0!	**Percentage Corresponding Qtr PFY Variance**	**#DIV/0!**	**Percentage of Current Qtr Invoice Variance**

PY Corresponding Quarter Variance	*Prior Quarter Variance*	Variance Analysis
☐	☐	***Increase/(decrease) in participants. (Explain)*** *Consecutive Qtr:* *Fiscal Year Qtr:*
☐	☐	***Time Survey results were materially different. (Explain)*** *Consecutive Qtr:* *Fiscal Year Qtr:*
☐	☐	***Decrease in other cost pool. (Explain)*** *Consecutive Qtr:* *Fiscal Year Qtr:*
☐	☐	***Change in Medi-Cal percentage. (Explain)*** *Consecutive Qtr:* *Fiscal Year Qtr:*
☐	☐	***Difference in the number of Pay Periods (Explain)*** *Consecutive Qtr:* *Fiscal Year Qtr:*
☐	☐	***Other: (Explain)*** *Consecutive Qtr:* *Fiscal Year Qtr:*

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

Printed Name: _____ Signature: _____

BLUE INK ONLY

Region/County: _____ Title: _____

Instructions: Enter reimbursement amount in Row 27, Column ABC, for the Corresponding quarter of the Prior Year. Enter the amount of the current quarter invoice in Row 28, Column ABC. Enter the reimbursement amount for thePrior Quarter in Row, Column 1

APPENDIX G

Time Survey Form

PROGRAM TIME SURVEY FOR LEA EMPLOYEES PERFORMING MEDI-CAL ADMINISTRATIVE ACTIVITIES **For use after 7/1/2011** **Training Date:** _____

Name (Last, First, MI)	Job Classification	Employee Number	Claiming Unit (District)	School Site

Record 5 consecutive days - Start with first hour paid - Record the type of activity by code in **15-minute increments**	**Date:**								**Date:**								**Date:**								**Date:**								**Date:**								**Date:**								**Total**
	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8					
1) School-Related, Educational, & Other Activities																																													
2) Direct Medical Services																																													
3) **Non-Medi-Cal** Outreach																																													
4) Initial **Medi-Cal** Outreach																																													
5) Facilitating Application for **non-Medi-Cal** Programs																																													
6) Facilitating **Medi-Cal** Application																																													
7) Ongoing Referral, Coordination, & Monitoring of **non-Medi-Cal** Services																																													
8) Ongoing Referral, Coordination, & Monitoring of **Medi-Cal** Services																																													
9) Transportation for **non-Medi-Cal** Services																																													
10) Arranging Transportation in support of **Medi-Cal** Services																																													
11) **Non-Medi-Cal** Translation																																													
12) Translation to Access **Medi-Cal** Services																																													
13) Program Planning, Policy Development, & Interagency Coordination Related to **non-Medi-Cal** Services																																													
14) Program Planning, Policy Development, and/or Interagency Coordination Related to **Medi-Cal Services**																																													
15) **Medi-Cal** Claims Administration, Coordination, and Training																																													
16) General Administration/ Paid Time Off																																													
TOTAL HOURS																																													

EMPLOYEE SIGNATURE: (blue ink only)	DATE:	TELEPHONE NUMBER:	SUPERVISOR SIGNATURE: (blue ink only)	DATE:

1. Include two or three samples of activities performed on lines provided below each code. If the same activity is being routinely performed, indicate such. No more than three samples are required.
2. Complete the survey on a daily basis for the designated time survey period.
3. Draw a vertical line through columns that represent days that are unpaid (unpaid leave).
4. Record time in 15-minute increments using only decimals (0.25, 0.50, 0.75).
5. At the end of the day, total each column in the "Total Hours" column. Each day must equal all hours for which paid that day.
6. Be sure to include each activity for codes 1-16 during the survey period.
7. If hours paid equal more than 8, continue on second survey form.
8. Confirm the sum in bottom right hand corner equals the sum of bottom row. Sign and date your survey the last day worked and give it to your supervisor. If two pages are used, sign the second page also.

NO WHITE OUT ALLOWED

Revised by DHCS July 2011

PROGRAM TIME SURVEY FOR LEA EMPLOYEES PERFORMING MEDI-CAL ADMINISTRATIVE ACTIVITIES **For use after 7/1/2011** **Training Date:**

Name (Last, First, MI)	Job Classification	Employee Number	Claiming Unit (District)	School Site
0				

If more than 8 hours per day, continue from page 1 in hours 9-16. Record the type of activity in 15-minute increments.	**Date:**								**Date:**								**Date:**								**Date:**								**Date:**								**Total**
	9	10	11	12	13	14	15	16	9	10	11	12	13	14	15	16	9	10	11	12	13	14	15	16	9	10	11	12	13	14	15	16	9	10	11	12	13	14	15	16	
1) School-Related, Educational, & Other Activities																																									
2) Direct Medical Services																																									
3) **Non-Medi-Cal** Outreach																																									
4) Initial **Medi-Cal** Outreach																																									
5) Facilitating Application for **non-Medi-Cal** Programs																																									
6) Facilitating **Medi-Cal** Application																																									
7) Ongoing Referral, Coordination, & Monitoring of **non-Medi-Cal** Services																																									
8) Ongoing Referral, Coordination, & Monitoring of **Medi-Cal** Services																																									
9) Transportation for **non-Medi-Cal** Services																																									
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13) Program Planning, Policy Development, & Interagency Coordination Related to **non-Medi-Cal** Services																																									
14) Program Planning, Policy Development, and/or Interagency Coordination Related to **Medi-Cal Services**																																									
15) **Medi-Cal** Claims Administration, Coordination, and Training																																									
16) General Administration/ Paid Time Off																																									
TOTAL HOURS																																									

EMPLOYEE SIGNATURE: (blue ink only)	DATE:	TELEPHONE NUMBER:	SUPERVISOR SIGNATURE: (blue ink)	DATE:

1. Include two or three samples of activities performed on lines provided below each code. If the same activity is being routinely performed, indicate such. No more than three samples are required.
2. Complete the survey on a daily basis for the designated time survey period.
3. Draw a vertical line through columns that represent days that are unpaid (unpaid leave).
4. Record time in 15-minute increments using only decimals (0.25, 0.50, 0.75).
5. At the end of the day, total each column in the "Total Hours" column. Each day must equal all hours for which paid that day.
6. Be sure to include each activity for codes 1-16 during the survey period.
7. If hours paid equal more than 8, continue on second survey form.
8. Confirm the sum in bottom right hand corner equals the sum of bottom row. Sign and date your survey the last day worked and give it to your supervisor. If two pages are used, sign the second page also.

NO WHITE OUT ALLOWED

NO WHITE OUT ALLOWED.

NAME: 0 **QTR:** 0

The following codes are reimbursable under the Medi-Cal Administrative Activities program. As you record time under each of these specific codes, please include two to three samples of the activity performed on lines provided below each code. To maintain confidentiality, avoid using specific names. Some examples have been included as a reference.

Note: 3 lines Maximum

CODE 4. Initial Medi-Cal Outreach: Use this code when initially informing persons about the Medi-Cal program. Examples: informing persons, particularly high risk groups, about Medi-Cal, to determine eligibility; providing referral assistance; participating in or coordinating Medi-Cal trainings/outreach directed toward improving the delivery of Medi-Cal services; and referring students to Medi-Cal-covered services, program screenings, program initiatives, and services; identifying and referring students to Medi-Cal family planning services.

Samples:

CODE 6: Facilitating Medi-Cal Application: Use this code when assisting an individual in becoming eligible for the Medi-Cal program. Examples: informing individuals of eligibility criteria; helping a family gather information and prepare and package forms; and referring the family to the local eligibility office. Use available information to expand enrollment in Medi-Cal.

Samples:

CODE 8: Ongoing Referral, Coordination, and Monitoring of Medi-Cal Services: Use this code for time spent making referrals and coordinating and/or monitoring the delivery of Medi-Cal services. Examples: making referrals for medical/mental health Medi-Cal-covered evaluation/screens (but NOT State-mandated exams), and case-managing medical/mental health evaluations and services in the school and community covered by Medi-Cal.

Samples:

Code 10: Transportation-Related Activities in Support of Medi-Cal-Covered Services: Use this code for administrative time spent assisting an individual to obtain transportation to a Medi-Cal covered service. Example: time coordinating and scheduling IEP specialized transportation to Medi-Cal-covered services. This code does not include time spent billing the provider of the transportation or the actual provision of transportation.

Samples:

Code 12: Translation Related to Medi-Cal Services: Use this code when arranging for or providing translation services to help individuals access and understand treatment and plans of care covered by Medi-Cal. Translation services must be provided, or arranged with a separate unit or separate employee who specifically performs translation functions for the school, and it must facilitate access to Medi-Cal-covered services.

Samples:

Code 14: Program Planning, Policy Development, and/or Interagency Coordination Related to Medi-Cal Services: Only employees whose job description includes Medi-Cal planning, policy development and interagency coordination should use this code. Use this code when when collaborating within the district, with community agencies and with other districts to evaluate a need for Medi-Cal services; monitoring Medi-Cal/mental/dental health delivery in schools.

Samples:

Code 15: Medi-Cal Claims Administration, Coordination, and Training: Reviewing time survey requirements, working with others to appropriately report activities, and completing the time survey forms.

Samples:

Code 16: General Administration/Paid Time Off: This code would be used when performing activities that are not directly assignable to program activities. Does not include tasks that you were specifically hired to do. This code also captures paid time off away from your job.

Samples:

APPENDIX H

Code 1 versus Code 16 Matrix

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

Code 1	Code 16
Education Requirements - 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	*Education Requirements* - Only Code 1
Instruction - Providing classroom instruction (including lesson planning) - Testing, correcting papers, completing reports - Monitoring student academic achievement	*Instruction* - Only Code 1
Individualized Education Program - 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	*Individualized Education Program* - Only Code 1
Operations - - *Fulfilling administrative and oversight responsibilities as Assistant Superintendent, Principal, or Assistant Principal* - 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]	*Operations* - Only Code 1
Meetings and Trainings - Coordinating, participating in, or presenting training related to curriculum or instruction to improve the delivery of student services for programs other than Medi-Cal	*Meetings and Trainings* - 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)
Review and Planning - 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	*Review and Planning* - Reviewing school policies, procedures, or rules
Supervision - 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	*Supervision* - Providing general supervision of staff, including supervision of student teachers or classroom volunteers - Evaluation of employee performance (including person being evaluated)
Survey Participant Paperwork -	*Survey Participant Paperwork* - Completing expense claims as required for work-related travel
Paid Time Off - Only Code 16	*Paid Time Off* - 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)