# California Tribal Medi-Cal Administrative Activities Implementation Plan

**Department of Health Care Services**

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# I. PREFACE

This document describes the Implementation Plan for the State of California's Tribal Medi-Cal Administrative Activities (MAA) program. It is designed to be used by the State's federally recognized Tribes and Tribal Organizations that participate in the Tribal MAA program. This plan has been developed by the California Department of Health Care Services (DHCS) in consultation with the California Rural Indian Health Board (CRIHB) and the federal Centers for Medicare and Medicaid Services (CMS).

The purpose of the Tribal MAA program is to:

- Form a partnership between DHCS and participating federally recognized Tribes and Tribal Organizations;
- Share in the responsibility for promoting access to Medi-Cal health care for Native American Indians/Alaskan Natives (AI/AN); and
- Reimburse Tribes and Tribal Organizations for performing administrative activities allowed by Tribal MAA.

This program is intended to assist in the building and coordination of existing Tribal community resources that serve Tribal members, non-tribal members, and Tribal children and families.

It is the goal of DHCS to implement Tribal MAA consistent with CMS directives in order for Tribes and Tribal Organizations to access allowable federal administrative programs.

# II. GOVERNMENT-TO-GOVERNMENT RELATIONS

## A. The Federal Government and Indian Nations

The United States Constitution recognizes Indian sovereignty by classing Indian treaties among the "supreme law of the land," and establishes Indian affairs as a unique area of federal concern. Early U.S. Supreme Court cases held that since the United States chose to relegate Tribes to a dependent status in terms of Tribal dealings with other nations, the federal government, then, also assumed a "Trust" responsibility toward the Tribes and their members, commonly known as a "Federal Trust Responsibility". This trust responsibility requires that medical services be provided to federally recognized Indian Tribes, and that the federal government, not the state, has that responsibility.

In keeping with the obligation to carry out the federal trust responsibility in accordance with the government-to-government relationship set forth under federal Indian law, CMS policy requires it to consult with Indian Tribes around all issues that may impact the Tribe (See Appendix A: American Indian and Alaska Native Beneficiaries, Consultation, CMS's Consultation Strategy).

## B. The State of California and Indian Nations

State Senate Bill (SB) 308, Chapter 253, Statutes of 2003, modifies California Welfare and Institutions (W&I) Code § 14132.47 (West Supp. 2007) to include Native American Indian Tribes, Tribal Organizations, and Tribal subgroups as participants in the MAA program. This modification allows Native American Indian Tribes, Tribal Organizations, and subgroups of Tribes or Tribal Organizations within the definition of a Local Governmental Agency to contract for administrative activities. California has 107 federally recognized Tribes and about 12 Tribal Organizations. At this time, only federally recognized Tribes and eligible Tribal Organizations may claim MAA.

## C. American Indian/Alaska Native Health Disparities in California[1]

Health services for Native AI/AN are based on a special historical legal responsibility identified in treaties with the Federal Government. California accepted this responsibility in 1954 with the adoption of Public Law 83-280, which allowed for concurrent State jurisdiction of Indian affairs. The current legislative authority for the program was entered into law in 1983 by SB 1117, and codified in 1995 in the Health and Safety Code as Sections 124575–124595 by SB 1360.

In 2000, a total of 2.5 million persons (0.9 percent of the U.S. population) classified themselves as AI/AN alone and 4.1 million (1.5 percent) classified themselves as AI/AN alone or in combination with another race. Approximately 26 percent of

[1] Information for this section is taken from the DHCS Indian Health Program (IHP) website: http://www.dhcs.ca.gov/services/rural/Pages/IndianHealthProgram.aspx

AI/AN lived in poverty, which is twice the national rate and the highest poverty rate of all racial/ethnic populations. AI/AN experience persistent socioeconomic burdens and significant health disparities in their rates of diabetes, cancer, injuries, and pulmonary diseases. Statistics that reflect the overall low health status of AI/AN in California include:

- 16 percent of American Indian births in 2002 were to teen moms compared to 10 percent for Whites.
- There were 8.1 deaths per 1000 American Indian live births in 2001 compared to 4.7 for Whites. This rate discrepancy was probably even higher though as it does not include the finding of an Indian Health Program (IHP) study that showed misclassification on death certificates for American Indian children under age 15 was three to four times greater than reported in State mortality data.
- 74 percent of American Indian mothers in 2001 received first trimester prenatal care as compared to 90 percent for Whites.
- Diabetes prevalence for ages 50-64 is consistently higher among AI/AN (19.6 percent) as compared to Whites (8 percent).
- AI/AN with diabetes have a high incidence of diabetes complications such as eye, kidney, lower extremity amputations, and cardiovascular disease. Cardiovascular disease was the leading cause of death in AI/AN and diabetes is a high contributing risk factor for cardiovascular disease.
- Diabetes mellitus is one of the most serious health challenges facing AI/AN in the United States today. Diabetes contributes to several of the leading causes of death in American Indians - heart disease, cerebrovascular disease, pneumonia, and influenza. On average, AI/AN are 2.6 times as likely to have diabetes as non-Hispanic whites of a similar age.
- From 1999 through 2001, AI/AN had significantly higher average death rates due to chronic liver disease and cirrhosis.
- From 1999 through 2001, AI/AN females in California had the highest average death rate from accidents. Injuries cause 75 percent of all deaths among Native Americans age 19 and younger. The overall death rate from preventable injuries remains nearly twice as high for native people as for the general population.

Existing law directs DHCS to address the comparatively low health status of American Indians through the IHP, which include the following:

- Technical and financial assistance to local agencies concerned with the health of American Indians and their families. The IHP provides assistance to 30 American Indian primary care clinics located in rural and urban areas throughout California. Assistance includes funding as well as standards compliance reviews, program planning, and evaluation.

- Studies of the health and health services available to American Indians and their families throughout the state. The IHP assisted with the completion of a congressionally mandated statewide report regarding the health status of nonfederal recognized Indians. The IHP participated in a study of racial misclassification on death certificates. The misclassification study, published in the American Journal of Public Health in 1997, demonstrates a 200-300-percent error rate in classification of deaths to American Indian children. These findings are significant in terms of planning and evaluation of the impact/success of public health children's services to American Indians. The IHP also serves as the lead California agency for a national study regarding the impact of managed care on Indian health service delivery systems.
- Coordination with similar programs of the Federal Government, other states, and voluntary agencies.
- American Indian Health Policy Panel (AIHPP). The AIHPP provides advice to the Director/Department and the program on issues regarding Indian health. It is composed of four members representing rural areas, four members representing urban areas, and two community members at-large. Panel members are selected by the Director and serve a two-year term.
- Traditional Indian Health Education. IHP administers two contracts that provide forums for clinic medical, dental, and public health nursing providers, and community members to learn about traditional Indian health beliefs and practices. Forums are held in Spring, and there is a gathering in Northern and Southern California.

## D. California Rural Indian Health Board (CRIHB) and its role in Tribal MAA

California Rural Indian Health Board Inc. was founded in 1969 by Tribal Governments in California to serve as the central coordinating point for the planning and development of an Indian-controlled health care delivery system. The first notable success in this mission was the acquisition of earmarked funding in the Indian Health Service (IHS) appropriation for 1973. This award provided funds directly to CRIHB for the purpose of establishing tribally operated health programs in California. In 1983 CRIHB was awarded its first PL 93-638 Indian Self Determination and Education Assistance Act (ISDEAA) contract to provide IHS funded comprehensive health care services through a unique subcontracting process. CRIHB thereby attained the status of a tribal organization, a status that has been continually maintained into the present. Today, CRIHB also operates a number of non-IHS funded programs from federal, state and philanthropic sources to provide services on a statewide basis. These programs variously fund direct care services through an internet based voucher process, a sub-grant process, or directly provide support and technical assistance services to Tribes, Tribal Organizations, or the Indian community more generally.

The practice of using CRIHB as an umbrella organization for the benefit of Tribes, Tribal Health Programs, and the general community is both central to CRIHB's mission and an established process that well fits the structure and organization of

the California Indian community. The IHS in California strives to provide comprehensive health care services to 107 federally recognized Tribes and the surrounding Native American populations located in 37 mostly rural counties. According to the U.S. Census and the IHS, approximately 188,000 American Indians and Alaska Natives currently reside in these counties. In California all IHS services are provided through ISDEAA contracts through 38 different contractors. The largest of these contractors serves over 12,000 clients and the smallest serves only two. Out of the service area population of 188,000, only 80,000 are unduplicated clients that are considered active users of an IHS-funded system of care. This nets an average active user population of 2,000 per Tribal contractor. Most Tribal contractors (25 out of 38) are individual Tribes serving an average 770 clients each while the remaining 13 Tribal Organizations serve an average 4,670 clients each. In short, most IHS-funded services in California are provided through consortia of Tribes which are organized as Tribal Organizations under resolutions from Tribal governments. These Tribal Organizations hold contracts under the ISDA. This task of providing IHS-funded services in California is made more difficult by the fact that this active-user population is spread across a broad area that has a population density of less than 1.5 Indians per square mile. Given the large number of Tribal Governments (107), the vast service area (123,510 square miles), the role of Tribal consortia in the provision of health services, the wide disparity in the size and, the administrative capacity of both Tribes and Tribal Organizations, CRIHB continues to provide a useful means of achieving critical mass and economies of scale for health service programming in California.

CRIHB has been instrumental in the extension of the Medicaid Administrative Match (MAM) program to Tribes and Tribal Organizations in California. In the year 2000 at a meeting sponsored by the National Indian Health Board, CRIHB leadership first heard of the success of the MAM program in Washington State and Alaska in expanding Medicaid coverage to eligible American Indians in those states. After consulting with California officials, an effort was undertaken by CRIHB to add a Section to the state W&I Code that would allow Tribes and Tribal Organizations to participate in the California MAA Program on the same basis as local governmental agencies. The bill was passed by the Legislature and signed into law in 2003. That same legislation, in recognition of the historic organization of health services to California Indians, specifically authorized subcontracting between Tribes and Tribal Organizations and other Tribes and Tribal Organizations to carry out these activities. To date, eight Tribal Governments and nine Tribal Organizations have signed agreements to participate in a CRIHB-based MAA subcontracting process. Nothing in the enabling statute requires the State to contract with CRIHB or prevents other Tribal Organizations or Tribes from approaching and contracting with the State directly.

The Tribal Governments and Tribal Organizations currently performing MAA and seeking reimbursement are:

<u>Tribal Organizations</u>

1. California Rural Indian Health Board (CRIHB)

2. Consolidated Tribal Health Project
3. Feather River Tribal Health, Inc.
4. Lake County Tribal Health Consortium, Inc.
5. M.A.C.T. Health Board (Mariposa, Amador, Calaveras, Tuolumne)
6. Modoc Indian Health Project (Cedarville Rancheria)
7. Northern Valley Indian Health
8. Sonoma County Indian Health Project
9. Toiyabe Indian Health Project, Inc.
10. United Indian Health Services

Tribal Governments

1. Greenville Rancheria Tribal Health Program
2. Karuk Tribal Health Program
3. Pit River Health Services
4. Redding Rancheria Tribal Health Project
5. Round Valley Indian Health Project (Round Valley Indian Tribes of the Round Valley Reservation, formerly the Covelo Indian Community)
6. Shingle Springs Tribal Health Project
7. Tule River Indian Health Center
8. Warner Mountain Indian Health Program (WMIHP) (Fort Bidwell Reservation)

Note: Each of these entities is either a subgroup of a federally recognized Tribe or a Tribal Organization comprised of federally recognized Tribes.

# III. INTRODUCTION TO TRIBAL MAA

## A. What is Medi-Cal?

Under Title XIX of the Social Security Act, the federal government and states share the cost of funding the Medicaid program, known as Medi-Cal in California, which provides medical assistance to certain low-income individuals. Federal Financial Participation (FFP) is the federal government's share for the state's Medicaid program expenditures. States may claim FFP for providing administrative activities that are found to be necessary by the Secretary of the U.S. Department of Health and Human Services for the proper and efficient administration of the Medi-Cal State Plan.

**Summary: Title XIX is part of the Social Security Act related to Medicaid.**

- It is a federal/state partnership to provide medical coverage for low-income children and families.
- In California, it is more commonly known as the Medi-Cal State Plan.

## B. Medi-Cal Administrative Activities (MAA)

Medicaid Administrative Match (MAM), or MAA in California, is a federal reimbursement program for costs of "administrative activities" that directly support efforts to identify, and/or enroll children/individuals in the Medi-Cal program or to assist those already enrolled in Medi-Cal to access services. The overarching policy for MAA is that allowable administrative costs must be directly related to the Medi-Cal State Plan or waiver service, if administering a Medicaid waiver, and is "found necessary for the proper and efficient administration of the Medi-Cal State Plan."

**Examples of reimbursable administrative activities include:**

1. Medi-Cal outreach;
2. Facilitating Medi-Cal application;
3. Medi-Cal related referral;
4. Medi-Cal related program planning and policy development;
5. Providing transportation to Medi-Cal services; and
6. General administrative activities.

The MAA program is administered through DHCS.

**The goals of the MAA program are to:**

1. Facilitate outreach to potential Medi-Cal enrollees;
2. Assist children and families in accessing needed Medi-Cal services;
3. Assist and support Tribes and Tribal Organizations to prepare appropriate claims for administrative costs under the Medi-Cal program; and
4. Administer an effective, efficient statewide MAA program.

**Other examples of MAA activities include:**

1. Discussing access to health care with Tribal members, families, and others;
2. Assisting in early identification of children who could benefit from health services provided by Medi-Cal;
3. Contacting pregnant and parenting teens about the availability of Medi-Cal prenatal and well baby care programs and services such as maternity support services; and
4. Providing referral assistance to Tribal members, families, and others where Medi-Cal services can be provided.

In 2003, CMS developed the "Medicaid School-Based Administrative Claiming Guide". This guide is the only guide that has been developed by CMS, and, in general, is applicable to all Medicaid administrative claiming programs. This Plan describes issues specific to Tribal MAA. The Guide can be found on the DHCS MAA web page at http://www.dhcs.ca.gov/provgovpart/Pages/SMAAManual.aspx

In summary, the CMS Guide:

1. Provides a framework for states to use when implementing MAA programs;
2. Provides guidelines for preparation of appropriate claims for MAA;
3. Ensures reimbursement/payment is for appropriate activities which support effective and efficient administration of the Medi-Cal State Plan;
4. Promotes flexibility for program development and implementation;
5. Ensures consistency with application of MAA requirements across regions and states;
6. Assists with implementation of claiming and oversight functions; and
7. Provides technical assistance.

## C. MAA Program Principles

1. Activities must be found necessary for the proper and efficient administration of the Medi-Cal State Plan;
2. Time survey methodology must capture 100% of time for participating staff for the period being measured;
3. Parallel coding for Medi-Cal and non-Medi-Cal activities is required to clearly identify those activities directly related to Medi-Cal;
4. There is monitoring for potential of "duplicative" payments;
5. Coordination of activities is expected and encouraged between Tribes and /or Tribal Organizations, other governmental entities, DHCS, Providers, community non-profits and other agencies related to activities performed;
6. There must be clear delineation between direct services and administrative activities;
7. There must be allocable share of costs (proportional share of costs based on the Medi-Cal Percentage (MCP) and non-discounted activities). Outreach and facilitating Medi-Cal application are not discounted; they are reimbursed as 100% Medi-Cal share at 50% FFP. Translation, referral, program policy and program development, and transportation related

activities are discounted and reimbursed at the MCP (or Transportation Medi-Cal Percentage (TMCP) Medi-Cal share at 50% FFP;

8. The federal government and the states share the costs of providing MAA-allowable administrative activities;
9. Provider participation – referrals must be to a Medi-Cal provider;
10. CMS reviews and approves programs and codes as meeting regulatory requirements as set forth in this Plan;
11. Free care principle precludes Medi-Cal from paying for the costs of Medi-Cal coverable services and activities that are available to all in the general population without charge.

## D. Tribal MAA

The Tribal MAA program was created to address a number of concerns. These include improving the relatively low rate of AI/AN enrollment in Medi-Cal and assisting AI/AN enrollees in accessing Medi-Cal services, thereby helping to address Indian health disparities by linking AI/AN people with Medi-Cal in the face of compelling health needs and inadequate IHS funding.

By contracting for MAA, federally recognized Tribes, as well as eligible Tribal Organizations, can be reimbursed for the costs of performing MAA. This Plan will describe the CMS approved time-study methodology that Tribes and eligible Tribal Organizations must use to document their MAA costs. Many Tribes and Tribal Organizations are already providing these activities, but are not being reimbursed for them. DHCS, in concert with the federal government and the participating Tribes and Tribal Organizations, has created a strategy by which Tribes and Tribal Organizations can claim administrative costs, not otherwise reimbursed, for providing services that are directly related to the .

Tribes and Tribal Organizations are in a unique position to participate in this program. Due to federal IHS policy, Tribes must provide information about the Medi-Cal program, and assist those enrolled in Medi-Cal in gaining access to services and benefits. Through MAA, the related administrative costs can be reimbursed at a 50% match rate.

Federally recognized Tribes and eligible Tribal Organizations contracting with DHCS for MAA, referred to as Tribal MAA contractors in this plan, may enter into contracts with organizations performing MAA with preference given to Native American Indian Tribes or Tribal Organizations in support of the contractor claiming administrative reimbursement. Such subcontractors that are federally recognized Tribes or eligible Tribal Organizations are referred to as Tribal MAA subcontractors in this Plan.

## E. Who qualifies to do Tribal MAA?

Any federally recognized Native American Indian Tribe, eligible Tribal Organization, or subgroup of a federally recognized Native American Indian Tribe and eligible Tribal Organization that wishes to participate in MAA is eligible. For

interested Tribes and Tribal Organizations, DHCS will provide necessary training, consultation, and on-going technical assistance. DHCS will contract either directly with those Tribes and eligible Tribal Organizations that wish to participate in the MAA program, or Tribes and eligible Tribal Organizations may also subcontract with another Tribe or Tribal Organization with an existing contractual relationship with DHCS for Tribal MAA.

Tribal Organizations eligible to participate are those meeting the requirements as specified in the CMS State Medicaid Director Letters 05-004 and 06-014.

## F. Where Does Tribal MAA Take Place?

MAA may take place anywhere Medi-Cal eligible Tribal members, non-tribal members, families and/or children and contracted Tribal personnel may interact. This could be in an office, school, clinic, and/or center, or during a home visit, as well as by telephone and at a meeting.

Tribes or Tribal Organizations may offer a variety of programs other than those located in a clinic in which staff may perform activities eligible for MAA claiming. The most likely circumstances where MAA claiming would be allowed is when Tribal staff assist Medi-Cal eligible individuals in enrolling in Medi-Cal by facilitating the Medi-Cal application; or in referring individuals already enrolled in the Medi-Cal program to other Medi-Cal services. Any Tribal “outreach-related” service with the goal of informing individuals about the Medi-Cal program and getting them to apply for Medi-Cal would also qualify as a MAA reimbursable activity.

A Tribal program participating in MAA does not have to be a Medi-Cal provider in order to claim FFP, if the program is providing Medi-Cal-related outreach or facilitating application and/or refers clients to Medi-Cal-covered services.

Tribal programs that may be able to claim MAA for outreach, facilitating the Medi-Cal application, and for referral to Medi-Cal-covered services include, but are not limited to:

- Tribal Temporary Assistance for Needy Families
- Elder/Senior services programs
- Childcare programs
- Maternity support services (pregnancy outreach, education, and nutrition services)
- Food assistance programs
- Diabetes programs
- Indian Child Welfare
- Indian Health Service Contract Health Services program
- Indian Health Service Community Health Representative program
- Social services

DHCS will not pay for outreach to programs other than Medi-Cal. All California Tribal MAA claiming must be in accordance with the DHCS Tribal MAA Program contract. It should be noted that, in general, federal funds provided to Tribes and Tribal Organizations which are not part of PL 93-638 Indian Self Determination and Education Assistance Act contract award may not be used as “certified public expenditure” (CPE) eligible funds.

## G. Non-Claimable Activities

Activities that are considered integral to, or an extension of, a specified Medi-Cal-covered service could be termed “provider-extender” activities. Such activities are included in the rate set for the direct service, and therefore they should not be claimed as a Medi-Cal administrative expense. For example, the cost of any related consultations between medical professionals that may occur is already reflected in the payment rate for medical assistance services and may not be claimed separately as an administrative cost.

MAA claiming is also not allowable for Medi-Cal-related case management services.

# IV. PRINCIPLES OF ADMINISTRATIVE CLAIMING

## A. General Information

Tribal employees may perform administrative activities that support the Medi-Cal program. Some or all of the costs of these administrative activities may be reimbursable under Medi-Cal; however, an appropriate claiming mechanism must be used. The time survey is the primary mechanism for identifying and categorizing MAA performed by Tribal employees. The time survey also serves as the primary basis for developing claims for the personnel costs of administrative activities that may be properly reimbursed under Medi-Cal.

The time survey, including the activity codes, should represent the actual duties and responsibilities of participating Tribal employees, consistent with the claiming principles discussed below. Tribal MAA activity codes will be used to allocate most personnel administrative costs for purposes of making claims under the Medi-Cal program.

Certain personnel costs may be claimed as a direct charge based on the actual time spent on MAA as is consistent with other approved MAA programs in California. For these specifically identified personnel costs, direct charge may provide a more accurate reimbursement than the time survey methodology. All direct charge costs must be supported with documentation, easily identifiable and tracked on an ongoing basis.

California provides reimbursement for medically necessary, medical (specialized), non-emergency transportation as a California service to Medi-Cal recipients. The provision of all other non-medical, non-emergency transportation has been delegated to the counties, and in this case to Tribes and Tribal Organizations, to provide administratively. The Medi-Cal State Plan provides the assurance that transportation to and from providers is reimbursable. 42 CFR parts 431.53(a) and 440.170(2) states, “If other arrangements are made to assure transportation under Section 431.53 of this subchapter, FFP is available as an administrative cost.” Since California does not provide separate reimbursement for non-emergency, non-medical transportation as a direct benefit, these costs are properly reimbursed as MAA. For Tribes or Tribal Organizations operating Tribal health facilities with funding authorized by Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law 93-638, as amended), informally referred to as “638” clinics, no other method of Medi-Cal reimbursements of these administrative costs is available in California. These costs will be claimed as described in Section VI. part B, 1.c),”Non-Emergency, Non-Medical (Non-Specialized) Transportation.”

## B. Operational Principles of Activity Codes

### 1) Proper and Efficient Administration of the Medi-Cal State Plan.

In order for the cost of any activities to be allowable and reimbursable under Medi-Cal, the activities will be those that are "found necessary by the Secretary for the proper and efficient administration of the plan" (referring to the Medi-Cal State Plan).

**2) Capture 100 Percent of Time**

In order to ascertain the portion of time and activities that are related to administering the Medi-Cal program, an allocation methodology, or time survey, will be used. The time survey incorporates a comprehensive list of the activities performed by staff whose costs are to be claimed under Medi-Cal. That is, the time survey reflects all of the time and activities (whether allowable or unallowable for Medi-Cal administrative claiming) performed by employees participating in the MAA program. The time survey mechanism entails careful documentation of all work performed by certain Tribal staff over a set period of time and is used to identify, measure and allocate the Tribal staff time that is attributable to Medi-Cal reimbursable activities. The unique responsibilities and functions performed by the time survey participants, as well as the special factors and programs applicable to Tribes or Tribal Organizations, are accounted for and included in the time survey codes.

**3) Parallel Coding Structure: Medi-Cal and Non- Medi-Cal Codes for Each Activity**

The time survey activity codes capture 100% of the activities performed by the time survey participants, and distinguish Medi-Cal activities from similar activities that are not Medi-Cal reimbursable. The codes also distinguish between those services that are covered under the Medi-Cal program and other medical or health care services that are provided by Tribal health programs but are not covered by Medi-Cal. These distinctions are accomplished through the use of "parallel" time survey activity codes. All staff will be trained on proper coding procedures, including reporting activities under the parallel codes, before the time survey period begins.

**4) Assure No Duplicate Payments**

Federal, state and local governmental resources should 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. That is, Tribes or Tribal Organizations may not claim FFP for the costs of allowable administrative activities that have been or should have been reimbursed through an alternative available funding source.

**Examples of activities for which the costs are not claimable as Medi-Cal administration when the activity is reimbursed as part of a medical service due to the potential for duplicate payments:**

- Activities that are integral parts or extensions of direct medical services (including patient follow-up, patient assessment, patient education, or counseling). In addition, the cost of any related consultations between medical professionals that may occur is already reflected in the payment rate for medical assistance services and may not be claimed separately as an administrative cost;
- Activities that have been, or could be, paid for as a Medi-Cal -covered service;
- Activities that have been, or will be, paid for as a service not covered by Medi-Cal;
- Activities that have been, or will be, paid for as a Medi-Cal administrative cost other than by claiming MAA reimbursement; and
- Activities that are included as part of a managed care rate and are reimbursed by the managed care organization.

**5) Coordination of Activities**

In addition to avoiding duplicate payments, as discussed above in Principle 4, duplicate performance of activities should also be avoided. Under Principle 1, allowable administrative activities must be necessary "for the proper and efficient administration of the Medi-Cal State Plan," as well as for the operation of all governmental programs. Therefore, it is important in the design of Tribal claiming programs that the Tribe or Tribal Organization does not perform activities that are already being provided or should be provided by other entities, or through other programs.

**6) Direct Services vs. Administrative Activities**

The time survey and activity codes must capture and clearly distinguish direct services from administrative activities. Typically, direct services have specific funding sources, claiming mechanisms, and documentation requirements related to the particular program or type of activity, and therefore should not be claimed as an administrative expense. Because the time survey must capture 100 percent of the time (see Principle 2, above) spent by Tribal employees, activity codes are designed to reflect all administrative activities and direct services that may be performed, only some of which are reimbursable under Medi-Cal. The time survey methodology should identify the costs of medical and other direct services and ensure that those costs are not included in the claims for Medi-Cal administrative activities. The activity codes used in the time survey must distinguish among different types of activities and direct services, as well as whether or not they are Medi-Cal-related activities. Activities that are considered integral to, or an extension of, a Medi-Cal-covered service are included in the rate set for the direct service, and therefore they should not be claimed as a Medi-Cal administrative expense.

TCM services are included in state Medicaid programs as an optional service, and are pre-approved by CMS. TCM enables states to target case management services to specific classes of individuals and/or to individuals residing in specified areas. Case management services are referred to as TCM services when the services are not furnished in accordance with requirements pertaining to state wideness or comparability. If an individual is receiving any TCM service through another provider, extra care must be taken by the Tribe or Tribal Organization to ensure that there is no duplication of services, or duplicate claim for payment. Some case management service provided by the Tribal claiming unit would be reported under either activity Code 7, Referral, Coordination, and Monitoring of non-Medi-Cal services or Activity Code 8a and 8b, Ongoing Referral, Coordination, and Monitoring of Medi-Cal Service as applicable. Medical case management that is part of a direct service would be reported under Activity Code 2, Direct Medical Services.

At this time, Tribes and Tribal Organizations are not approved to claim TCM in California.

### 7) Allocable Share of Costs

Since many Tribal-based medical activities are provided both to Medi-Cal and non-Medi-Cal eligible individuals, the costs applicable to these activities must be allocated to both groups. This allocation of costs involves the determination and application of the proportional share of Medi-Cal individuals to the total number of individuals for each site whose cost may be segregated as a budget unit or claiming unit, usually each Tribal health facility. Development of the proportional Medi-Cal share, which will be referred to as the MCP in this Plan, is an aggregated statewide percentage. The proportional Medi-Cal share is then applied to the total costs of a specific activity for which the Tribal claiming unit is submitting claims for FFP, thereby discounting a portion of the costs. This process is necessary to ensure that only the costs related to Medi-Cal eligible individuals are claimed to Medi-Cal. Note: not all activities are subject to the MCP; activities such as outreach and facilitating Medi-Cal application are not discounted.

Through the use of time studies that contain specific activity codes, the costs of Tribal personnel are distributed to certain activities (identified by time survey codes) to determine the administrative costs allocable to the Medi-Cal program. The universe of activity codes used in the time survey as a group must capture the following categories of costs:

**(U)** **U**nallowable: the activity is unallowable as administration under the Medi-Cal program;

**(TM)** **T**otal **M**edi-Cal: the activity is solely attributable to the Medi-Cal program and as such is not subject to the application of the Medi-Cal share percentage (this is sometimes referred to as “not discounted”);

**(PM)** **P**roportional **M**edi-Cal Share: the activity is allowable as administration under the Medi-Cal program, but the allocable share of costs must be determined by applying the percentage of the Medi-Cal eligible population that has been determined statewide.

**(R)** **R**eallocated Activities: the activities which are reallocated across other codes based on the percentage of time spent on allowable/unallowable administrative activities.

To establish the proportional Medi-Cal share, the number of Medi-Cal eligible individuals must be determined statewide for which an invoice is submitted. This number serves as the numerator in a fraction, with the denominator being the total number of individuals served. This fractional value is then applied to the total costs applicable to the Proportional Medi-Cal Share (PM) time codes to determine the costs applicable to MAA. Note that the number of Medi-Cal eligible individuals and the total number of individuals served must be identified for the same time period. For example, the total number of individuals seen in the 3rd quarter cannot be used as the numerator for the MCP for the 4th quarter invoice.

Tribal MAA contractors may perform activities that affect subcontractors performing MAA, such as Tribal Organizations performing program planning and policy development. When this is the case, the proportional Medi-Cal share will be determined from the ratio of Medi-Cal eligible individuals to all individuals served by the subcontractors. An alternate method may be proposed for approval by DHCS and CMS.

(MCP = The number of unduplicated Medi-Cal-enrolled individuals provided with any services in that quarter, divided by the total number of unduplicated individuals provided with any services that quarter).

**EXAMPLE OF PROPORTIONATE MEDI-CAL SHARE**

The following example establishes how the Medi-Cal share of the costs related to the activity should be proportionately allocated to Medi-Cal. The amount of FFP is then determined based on the activity costs that are allocable to Medi-Cal.

Example:
Number of unduplicated Medi-Cal-enrolled individuals. = 1,000
Number of unduplicated individuals served by Tribal claiming unit = 5,000
MCP: Number of Medi-Cal -enrolled individuals served/total individuals served = 1,000/5,000 = 20 percent

Activity = (referral, coordination, and monitoring of Medi-Cal services)
(Proportional Medi-Cal / 50 Percent FFP)
Gross activity costs = $1,500
MCP (20 percent)

$1,500 X 20% = $300
Gross MAA claimable amount = $300
FFP rate (50 %): $300 X 50% = $150
Net FFP claimable amount $150

**EXAMPLE OF REALLOCATED COSTS**

The following example establishes how the costs of reallocated activities are calculated. The reallocated costs are subject to the MCP. The amount of FFP is then determined based on the activity costs that are allocable to Medi-Cal.

Total activity costs = $100,000
MCP = 23%
Percentage of paid activities that are to be reallocated = 25%
Percentage of paid activities solely attributable to Medi-Cal (TM) = 6%
Percentage of paid activities that are proportionately Medi-Cal (PM) = 19%

Percentage of paid activities that are not MAA-allowable = 50%
Percentage of reallocated activities allowable for claiming
= 25*((6+19)/(6+19+50)) = 8.33
Gross MAA claimable costs of reallocated activities = $100,000 X 8.33% = $8,333
Discounted for the MCP: = $8,333 X 23% = $1,916.59
FFP Rate (50 %): = $1,916.59 X 50% = $958.30
Net FFP claimable amount: = $958.30

**8) Provider Participation in the Medi-Cal Program**

Administrative activities performed in support of medical services that are not coverable or reimbursable under the Medi-Cal program would not be allowable as Medi-Cal administration. In order for the medical service to be reimbursable under the Medicaid state plan, the following requirements must be met:

a). The medical service must be furnished to a Medi-Cal eligible individual;
b). The medical service must be included in the Medi-Cal State Plan;
c). The medical service is not provided free-of-charge to non- Medi-Cal eligibles; and
d). The provider must furnish services as a participating provider in the Medi-Cal program, with a provider agreement and a Medi-Cal provider identification number; or must furnish such services as a provider for Medi-Cal enrollees of a Medi-Cal managed care plan.

Referral activities allowable for MAA claiming must be aimed at assisting the Medi-Cal-enrolled patient in making a referral to a willing Medi-Cal provider for a Medi-Cal-covered service. Allowable MAA referral activities provided by

Tribal health programs include the time spent in searching for a willing provider and may include time spent in unsuccessful contacts with providers.

**9) No Free Care**

The “no free care” principle precludes Medi-Cal from paying for the costs of Medi-Cal-coverable services and activities which are generally available to all individuals without charge, and for which no other sources for reimbursement are pursued. In order for Medi-Cal payment to be available for services, the provider must:

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

Federal policy provides for an exception to the “no free care” principle with regard to services provided through the Indian Health Service (IHS). IHS is the payer of last resort, after Medicaid, to eligible persons, pursuant to 42 CFR part 136.61.

**10) Federal and State Financial Participation**

The Federal Government and the State share the costs of performing Tribal MAA. Title XIX of the Social Security Act, Section 1903(a), provides for FFP reimbursements to the State for part of the State’s “proper and efficient” administration of the Medi-Cal State Plan.

42 CFR part 433.51(a), specifies that public funds may be considered as the State’s share in claiming FFP if these funds meet the following conditions:

- The public funds are appropriated directly to the state or local Medicaid agency, or transferred from other public agencies [including federally recognized AI/AN Tribes] to the state, or certified by the contributing public agency as representing expenditures eligible for FFP; and
- The public funds are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds.

Tribal MAA contractors, specifically federally recognized Tribes (as public entities) and eligible Tribal Organizations, certify to DHCS that they expended funds totaling 100 percent of the cost of performing the MAA they are claiming. DHCS then pays the Tribal MAA the FFP amount of their claim.

For purposes of Tribal MAA, Tribes certify the expenditures that constitute the “state reimbursement” portion. By contracting for MAA, they are able to be reimbursed for the federal share of the costs associated with performing allowable MAA. Subcontractors that are not federally recognized Tribes or Tribal Organizations cannot certify to their costs. However, federally

recognized Tribes or Tribal Organizations can certify their public expenditures to subcontractors

**11) Time Survey Staff Training**

All Tribal staff participating in MAA will complete the required time survey quarterly. Staff will receive adequate training before participating in their first time survey. Training should be conducted close to the week prior to the time survey, with signed documentation as evidence of such training. Once trained, all staff who time-survey will participate in an annual time survey training. Attendance at the annual time survey training session cannot be claimed during any survey weeks by the Tribal MAA coordinator or by the time survey participants**.** Staff will understand clearly how to complete the time survey form; know how to report activities under the appropriate time survey codes; understand the difference between Medi-Cal covered and other activities; and know where to obtain technical assistance if there are questions. Professional staff will understand the distinctions between the performance of administrative activities and direct medical services and those administrative activities that are an inherent part of the direct medical service. The Tribal MAA contractor must have a mechanism in place to assess how often training is necessary and to revise the training schedule, if appropriate. To ensure consistent application, all training documentation will be maintained and available for site review and audit purposes. Documentation will show the content of the training provided to participating MAA staff and the frequency of training. The frequency of training should take into account staff turnover.

**12) Monitoring Process**

In order to ensure that the time survey is statistically valid as specified in Section V. part C, “Tribal MAA Time Survey”, DHCS will monitor the compliance of Tribal claiming units with the requirements of the time survey methodology and activity codes each quarter. Tribal claiming units will establish a rate of MAA activities each quarter, per participating staff, by completing a random time survey period. DHCS will monitor the claim each quarter by review and analysis of the invoice. Additionally, DHCS has dedicated resources for audit staff to regularly conduct financial and compliance audits to support meeting federal requirements. (See Sections V. part B, Claiming, “Documentation” and VII, “Performance Standards/Program Oversight and Monitoring”, and Appendix E).

**13) Offset of Revenues**

A government program may not be reimbursed in excess of its actual costs, i.e., make a profit. Allocated costs must be offset by the amount of other funding sources in order to assure there is no duplication of payment for administrative activities. To the extent that other funding sources have paid

or would pay for the costs of performing Tribal MAA, federal reimbursements are not available, and the costs must be removed from the total reported costs of performing Tribal MAA. See Office of Management and Budgets OMB Circular A-87 (OMB A-87), Attachment A, part C, item 4. The following are some of the funding categories that must be offset against unallowable costs:

- All “non-authorized” federal funds.
- All State expenditures that have previously been matched by the Federal Government (i.e., most State grants).
- All State grants that are a pass-through of federal funds.

Federal funding to Native American Indian Tribes and Tribal Organizations under the ISDEAA is specifically allowable as match for federal funds under Section 106(j) of Public Law 93-638, as amended. Also see 25 U.S.C. § 450j-1 and 25 U.S.C. § 458aaa-11 (d)

**14) Timely Filing Requirements**

The State must file claims for FFP within a two-year period that begins on the first day of the calendar quarter immediately following the quarter in which the expenditure was made. The implementing regulations for timely filing are at 45 CFR Subtitle A and provide specific guidelines for determining when expenditure is said to have been made, so as to initiate the two-year filing period. Federal regulations at 45 CFR part 95.13(d) indicate that a state agency's expenditure for administration is considered to have been made in the quarter the payment was actually made by the state agency.

Further, 45 CFR part 95.4 identifies a state agency as any agency of the state, including the state Medicaid agency, its fiscal agents, a state health agency, or any other state or local organization which incurs expenses. Tribes and Tribal Organizations are an example of a qualifying local organization.

Example: A Tribal Organization incurs MAA-reimbursable expenditure in January 2002. The end of the calendar quarter in which the expenditure occurs would be March 31, 2002. In order to meet the two-year timely filing limit, DHCS must file a claim with CMS within two years after the calendar quarter in which the expenditure occurred, or by March 31, 2004.

In determining the two-year filing limit, the state agency must give consideration to the expenditure reporting cycle. The expenditure is not considered "filed" until it is received by CMS on the CMS-64 Expenditure Report, which is required to be filed 30 days after the end of a reporting quarter.

## 15) No Contingency Fees

Medi-Cal claims for the costs of administrative activities and direct medical services may not include fees for consultant or contracted services that are based on, or include, contingency fee arrangements. Thus, if payments to consultants by Tribes or Tribal Organizations are contingent upon payment by Medi-Cal, the consultant fees may not be claimed. With regard to the use of the services of consultants, OMB A-87 Attachment B, part 33.a, states 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."

# V. CALIFORNIA TRIBAL MAA CLAIMING METHODOLOGY

## A. Comprehensive Activity Codes

The following activity codes will be used for Tribal MAA. Staff must document time spent on each of the following coded activities using the Native American Tribal Program Time Survey for Employees Performing Medi-Cal Administrative Activities and/or Targeted Case Management (Appendix B):

FFP is provided at 50% of the amount determined to be the Medicaid share.

**(U)** Unallowable: the activity is not allowable as administration under the Medi-Cal program.

**(TM)** Total Medi-Cal Administration 100% Medi-Cal Share: this administrative activity is wholly attributable to the Medi-Cal program and as such is not subject to the application of discounting by the proportional Medi-Cal share percentage or MCP.

**(PM)** Proportional Medi-Cal Share: the activity is allowable as administration under the Medi-Cal program, but the Medi-Cal share of costs must be determined by applying the Medi-Cal percentage of the service population that has been determined for the Tribal claiming unit. This discounts the costs by the proportional Medi-Cal share or MCP.

**(R)** Reallocated Activities: those activities which are reallocated across other codes based on the percentage of all other time spent on allowable/unallowable administrative activities. FFP is provided at 50% of the reallocated proportionate Medi-Cal share. A single calculation of reallocation is made for the entire quarterly claim, based on the total MAA-claimable costs of all Tribal staff who participated in that quarter's time survey.

| | |
|---|---|
| CODE 1 | Other Programs/Activities - U |
| CODE 2 | Direct Medical Services - U |
| CODE 3 | Non-Medi-Cal Outreach - U |
| CODE 4a | Initial Medi-Cal Outreach **(Tribal Health Program Office)** – TM |
| CODE 4b | Initial Medi-Cal Outreach **(Other Locations)** – TM |
| CODE 5 | Facilitating Application for Non-Medi-Cal Programs - U |
| CODE 6a | Facilitating Medi-Cal Application **(Tribal Health Program Office)** - TM |
| CODE 6b | Facilitating Medi-Cal Application **(Other Locations)** - TM |
| CODE 7 | Referral, Coordination, and Monitoring of Non-Medi-Cal Services - U |
| CODE 8a | Ongoing Referral, Coordination & Monitoring of Medi-Cal Services **(Tribal Health Program Office)** - PM |
| CODE 8b | Ongoing Referral, Coordination & Monitoring of Medi-Cal Services **(Other Locations)** - PM |
| CODE 9 | Arranging Transportation for Non-Medi-Cal Services - U |

| | |
|---|---|
| CODE 10 | Arranging Transportation for Medi-Cal Services - PM |
| CODE 11 | Providing Transportation for Non-Medi-Cal Services - U |
| CODE 12 | Providing Transportation for Medi-Cal Services - PM |
| CODE 13 | Non-Medi-Cal Translation Services - U |
| CODE 14 | Translation Related to Medi-Cal Services - PM |
| CODE 15 | Program Planning, Policy Development & Interagency Coordination (PPPD) Related to Non-Medi-Cal Services - U |
| CODE 16 | PPPD Related to Medi-Cal Services – PM |
| CODE 17 | Medi-Cal Administrative Activities (MAA) Coordination and Claims Administration - R |
| CODE 18 | General Administration & Paid Time Off - R |
| CODE 19 | Targeted Case Management - U |

For all the activity codes and examples listed below, if an activity is provided as part of, or an extension of, a direct medical service, it may not be claimed as MAA. Any staff activity involved in directly providing medical and/or Medi-Cal-covered services should be assigned to Code 2. Direct Medical Services.

All activities may include related paperwork, clerical activities, staff travel, and related training required to perform these activities, including initiating and responding to email and voicemail. These activities may be performed in a manner that is culturally relevant and particularly suited to and/or suitably located for access by members of Native American Indian Tribes.

**CODE 1 OTHER PROGRAMS/ACTIVITIES - U**

This code is used when performing activities that are not medical or Medi-Cal-related, including non-Medi-Cal health and wellness activities, social services, educational services, teaching services, employment and job training. Tribal services not related to Medi-Cal or to direct medical services can be reported in two ways: As a separate non-Medi-Cal code (Code 1) or as an example within one or more non-Medi-Cal activity codes. Activities may include, but are not limited to:

1. Providing non-Medi-Cal health and wellness programs and services, such as exercise classes, cooking for diabetes management, meals on wheels, etc.
2. Educating individuals about the benefits of healthy life-styles and practices.
3. Educating individuals and families about general health or life-style (e.g., dental prevention, anti-smoking, alcohol reduction, etc.).
4. Providing social, educational, legal or other non-medical services.
5. Other facility functions not applicable to other activity codes.

**CODE 2 DIRECT MEDICAL SERVICES - U**

This code is used when providing direct care, medical/dental treatment, and/or clinical counseling services to an individual. This includes medical case management when part of a direct medical service. Activities may include, but are not limited to:

1. Providing medical/dental/mental health/chemical dependency counseling treatment services.
2. Conducting medical/dental/mental health/chemical dependency assessments/evaluations and diagnostic testing and preparing related reports.
3. Providing personal aide services covered by Medi-Cal.
4. Providing speech, occupational, physical and other therapies.
5. Providing clinical nursing services covered by Medi-Cal.
6. Developing a treatment plan (medical plan of care) for a patient if provided as part of a medical or service.
7. Medical (specialized) transportation (if covered as a service under Medi-Cal).
8. Activities that are services, or components of services, listed in the state's Medicaid plan.
9. Participating in or providing training to enhance the knowledge and skills needed for provision of the above services.

**CODE 3 NON-MEDI-CAL OUTREACH - U**

This code is used when performing activities that inform individuals about their eligibility for non-Medi-Cal, social, vocational and educational programs and how to access them; and/or describing the range of benefits covered under these programs and how to obtain them. Both written and oral methods may be used. Activities may include, but are not limited to:

1. Informing families about non-Medi-Cal health and wellness programs and how to access these programs and services, such as exercise classes, cooking for diabetes management, Women, Infants, and Children (WIC), etc.
2. Informing families about activities that educate individuals about the benefits of healthy life-styles and practices.
3. Informing individuals and families about general health education programs or campaigns that address life-style changes in the general population (e.g., dental prevention, anti-smoking, alcohol reduction, etc.).
4. Conducting outreach campaigns that encourage persons to access social, educational, legal or other non-medical services.
5. Outreach activities in support of medical programs that are funded only by state general revenue.
6. Developing outreach materials such as brochures or handbooks for social, educational, or vocational programs.
7. Distributing outreach materials regarding the benefits and availability of social, educational, or vocational programs.

**CODE 4a INITIAL MEDI-CAL OUTREACH (Tribal Health Program Office) - TM/50 Percent FFP**

This code is used when performing initial outreach activities at a Tribal Health Program Office that inform eligible or potentially eligible individuals about Medi-Cal programs and services and how to access them. Initial outreach activities include bringing potential eligible individuals into the Medi-Cal system for the purpose of determining eligibility and initially arranging for the provision of Medi-Cal services. Initial outreach activities directed

to non-specific groups do not have to be discounted by the MCP. Activities may include, but are not limited to:

1. Providing initial information about services that will help identify medical conditions that can be corrected or improved by services through Medi-Cal.
2. Informing individuals initially on how to effectively access, use, and maintain participation in all health resources under the federal Medi-Cal program.
3. Providing initial referral assistance to families where Medi-Cal services can be provided.
4. Providing information regarding Medi-Cal managed care programs and health plans to individuals and families and how to access that system.

**CODE 4b INITIAL MEDI-CAL OUTREACH (Other Locations) – TM/50 Percent FFP**

This code is used when performing initial outreach activities in other locations that inform eligible or potentially eligible individuals about Medi-Cal programs and services and how to access them. Initial activities include bringing potential eligible individuals into the Medi-Cal system for the purpose of determining eligibility and initially arranging for the provision of Medi-Cal services. Initial outreach activities directed to non-specific groups do not have to be discounted by the MCP. Activities may include all the activities listed under "CODE 4a" plus the following:

1. Conducting a family planning health education outreach program or campaign that is targeted specifically to family planning Medi-Cal services that are offered to Medi-Cal eligible individuals.
2. Participating in or coordinating trainings that improve the delivery of Medi-Cal services.

**CODE 5 FACILITATING APPLICATION FOR NON-MEDI-CAL PROGRAMS - U**

This code is used when informing an individual or family about programs not covered by Medi-Cal, such as County Medical Services Program (CMSP)/Medically Indigent Adult, Genetically Handicapped Person's Program (GHPP), Children's Medical Services (CMS), food stamps, WIC, day care, legal aid, and other social or educational programs, as well as health and wellness programs not covered by Medi-Cal, such as exercise programs, and referring them to the appropriate agency to make application. Activities may include, but are not limited to:

1. Explaining the eligibility process for non- Medi-Cal programs, including health and wellness programs not covered by Medi-Cal.
2. Assisting the individual or family to collect/gather information and documents for a non-Medi-Cal program application.
3. Assisting the individual or family in completing the non-Medi-Cal application, including necessary translation activities.
4. Developing and verifying initial and continuing eligibility for non- Medi-Cal programs.
5. Providing necessary forms and packaging all forms in preparation for the eligibility determination for a non- Medi-Cal program.

## CODE 6a FACILITATING MEDI-CAL APPLICATION (Tribal Health Program Office) - TM/50 Percent FFP

This code is used at a Tribal Health Program Office when explaining the Medi-Cal eligibility rules and process to prospective applicants, assisting an applicant complete the Medi-Cal eligibility application, and gathering related information. This activity includes helping the client gather information about the eligibility determination or re-determination, including resource information and third party liability information, as a prelude to submitting a formal Medi-Cal application; and/or providing necessary forms and packaging all forms in preparation for the Medi-Cal eligibility determination. This activity does not include the eligibility determination itself. Activities may include, but are not limited to:

1. Verifying an individual's current Medi-Cal eligibility status.
2. Explaining Medi-Cal eligibility rules and the Medi-Cal eligibility process to prospective applicants.
3. Assisting individuals or families to complete a Medi-Cal eligibility application, including the joint Medi-Cal/Healthy Families application unless the applicant has indicated on the application that he/she does not want Medi-Cal.
4. Gathering information related to the application and eligibility determination for an individual, including resource information and third party liability information, as a prelude to submitting a formal Medi-Cal application, including the Medi-Cal portion of the joint Medi-Cal/ Healthy Families application.
5. Providing necessary forms and packaging all forms in preparation for the Medi-Cal eligibility determination.
6. Referring an individual or family to the local Medi-Cal or joint Medi-Cal/Healthy Families eligibility office to complete an application for Medi-Cal benefits.
7. Assisting the individual or family in collecting/gathering required information and documents for the Medi-Cal application, including the Medi-Cal portion of a joint Medi-Cal/Healthy Families application.

Assisting individuals with the joint Medi-Cal/Healthy Families application is allowable only when the applicant has not marked the box "I do not want Medi-Cal" on the application.

## CODE 6b FACILITATING MEDI-CAL APPLICATION (Other Locations) – TM/50 Percent FFP

This code is used at other locations when explaining the Medi-Cal eligibility rules and process to prospective applicants, assisting an applicant in completing the Medi-Cal eligibility application, and gathering related information. This activity includes helping the client gather information about the eligibility determination or re-determination, including resource information and third party liability information, as a prelude to submitting a formal Medi-Cal application to the county social services department, and/or providing necessary forms and packaging all forms in preparation for the Medi-Cal eligibility determination. This activity does not include the eligibility determination itself. Activities may include all the activities listed under "CODE 6a" plus the following:

1. Staff traveling to assist in gathering the required documents for eligibility determination or to assist the client in applying in person if required by the State or local jurisdiction
2. Participating at a Medi-Cal or joint Medi-Cal/Healthy Families eligibility outreach outstation, but does not include determining eligibility.

### CODE 7 REFERRAL, COORDINATION, AND MONITORING OF NON-MEDI-CAL SERVICES - U

This code is used when making referrals for, coordinating, and/or monitoring the delivery of non-medical activities or medical services not covered by Medi-Cal. This includes non-medical case management for social, educational, or vocational needs not part of a separately reimbursed comprehensive TCM program. Activities may include, but are not limited to:

1. Making referrals for and coordinating access to medical and other healthcare services not covered by Medi-Cal (e.g. exercise programs, WIC, parenting classes, etc).
2. Making referrals for and coordinating access to social and educational services such as child care, employment, job training, and housing.
3. Making referrals for coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.
4. Gathering any information that may be required in advance of these non-Medi-Cal related referrals.
5. Participating in a meeting/discussion to coordinate or review a patient/Tribal member's need for services not covered by Medi-Cal.

**Case Management:** Note that case management as an administrative activity involves the facilitation, access and coordination of program services. Such activities may be provided under the term Case Management or may also be referred to as Referral, Coordination, and Monitoring of non-Medi-Cal Services. Case management may also be provided as an integral part of the service and as such, would be included in the service cost, and cannot be reimbursed separately.

### CODE 8a ONGOING REFERRAL, COORDINATION & MONITORING OF MEDI-CAL SERVICES (Tribal Health Program Office) - PM/50 Percent FFP

This code is used at a Tribal Health Program Office when making ongoing referrals for coordinating, and/or monitoring the delivery of Medi-Cal-covered services. This activity is performed after an initial referral is made. The costs of these activities are claimable but must be discounted by the statewide MCP. Activities may include, but are not limited to:

1. Making referrals for and/or coordinating medical or physical examinations and necessary medical/mental health evaluations.
2. Making referrals for and/or scheduling certain Child Health and Disability Prevention screens, inter-periodic screens, and appropriate immunization.

3. Referring individuals for necessary medical health, mental health, or substance abuse services covered by Medi-Cal.
4. Arranging for any medical/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/mental health condition.
5. Gathering any information that may be required in advance of referrals.
6. Providing information to other staff on an individual's medical/dental/mental health/chemical dependency services and plans, provided that such participation is not an extension of a direct service.

Activities that are part of a direct service or covered under a managed care plan are not claimable as an administrative service. Furthermore, activities that are an integral part of or an extension of a medical service (e.g., patient follow-up, patient assessment, patient counseling, patient education or consultation and patient billing activities) are not allowable as MAA. The costs of medical consultations between medical professionals are not claimable as MAA.

**CODE 8b ONGOING REFERRAL, COORDINATION & MONITORING OF MEDI-CAL SERVICES (Other Locations) – PM/50 Percent FFP**

This code is used at other locations when making ongoing referrals for coordinating, and/or monitoring the delivery of Medi-Cal covered services. This activity is performed after an initial referral is made. The costs of these activities are claimable but must be discounted by the statewide MCP. Activities may include all the activities listed under "CODE 8a" plus the following:

1. Participating in a meeting/discussion to coordinate or review and individual's needs for health-related services covered by Medi-Cal in a non-clinical setting not reimbursed through an all-inclusive rate or other billable fee-for-service mechanism.
2. Providing follow-up contact to ensure that an individual has received the prescribed medical/mental health services.
3. Coordinating the completion of the prescribed services, termination of services, and the referral of the individual to other Medi-Cal service providers as may be required to provide continuity of care.
4. Coordinating the delivery of medical/mental health services for an individual with special/severe health care needs.

**CODE 9 ARRANGING TRANSPORTATION FOR NON-MEDI-CAL SERVICES - U**

This code is used when assisting an individual in obtaining transportation to social, vocational, and/or educational programs and/or medical, health and wellness services not covered by Medi-Cal. Activities may include, but are not limited to:

1. Arranging transportation to a diabetics' luncheon, sobriety camp, swimming program, gym, court hearing, GED class or office to complete an application for food stamps, etc.

**CODE 10 ARRANGING TRANSPORTATION FOR MEDI-CAL SERVICES - PM/50 Percent FFP**

This code is used when arranging transportation to Medi-Cal-covered services. This activity includes assistance in securing transportation for an individual or family. The costs of these activities are claimable but must be discounted by the statewide MCP. See Section VI. part B, "Allowable Costs" for details. Activities may include, but are not limited to:

1. Arranging transportation to a medical appointment for the delivery of medical services.

**CODE 11 PROVIDING TRANSPORTATION FOR NON-MEDI-CAL SERVICES - U**

This code is used when providing transportation to social, vocational, and/or educational programs and/or medical, health and wellness services not covered by Medi-Cal. Activities may include, but are not limited to:

1. Providing transportation to a diabetics' luncheon, sobriety camp, swimming program, gym, court hearing, GED class, office to make application for food stamps, etc.
2. Accompanying a client as an attendant to a swimming program, gym, court hearing, GED class, etc.

**CODE 12 PROVIDING TRANSPORTATION FOR MEDI-CAL SERVICES - PM/50 Percent FFP**

This code is used when providing individuals with non-emergency, non-medical transportation to Medi-Cal covered services. This activity includes accompanying an individual or family when necessary. The attendant may not be a family member. The costs of these activities are claimable. The costs of these activities are claimable but must be discounted using a methodology that accounts for the percentage of Medi-Cal clients transported to medical services in proportion to all clients transported to medical services. This will be calculated on a facility by facility basis. See Section VI. part B, "Allowable Costs" for details. Activities may include, but are not limited to:

1. Providing non-emergency, non-medical transportation to a medical appointment for the delivery of medical services.
2. Accompanying a client as an attendant, to medical services, if necessary, pursuant to 42 CFR part 440.170.

**CODE 13 NON-MEDI-CAL TRANSLATION SERVICES - U**

The code is used when providing translation services for non-medical activities or medical services not covered by Medi-Cal should use this code. Non-Medi-Cal translation can be reported in two ways: As a separate non-Medi-Cal code (Code 13) or as an example within one or more other non-Medi-Cal activity codes. Activities may include, but are not limited to:

1. Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand medical and healthcare services not covered by Medi-Cal, as well as for social, educational, and vocational services.
2. Developing translation materials that assist individuals to access and understand social, educational, and vocational and non-Medi-Cal medical and healthcare services.

**CODE 14 TRANSLATION RELATED TO MEDI-CAL SERVICES - PM/50 Percent FFP**

This code is used when providing translation related to Medi-Cal-covered services. 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 separate units or by separate employees performing translation functions and it must facilitate access to medical services covered by Medi-Cal. The costs of these activities are claimable but must be discounted by the statewide MCP. Activities may include, but are not limited to:

1. Arranging for or providing translation services (oral and signing) that assist the individual to access and understand necessary care or treatment for medical services covered by Medi-Cal.

2. Developing translation materials that assist individuals to access and understand necessary care or treatment for medical services covered by Medi-Cal.

**CODE 15 PROGRAM PLANNING, POLICY DEVELOPMENT & INTERAGENCY COORDINATION (PPPD) RELATED TO NON-MEDI-CAL SERVICES - U**

This code is used when performing activities associated with developing strategies to improve the coordination and delivery of non-medical services provided to patients/Tribal members. Non-Medi-Cal services include social services, educational services, and vocational services, as well as medical and other healthcare services that are not covered by Medi-Cal. Only employees whose position descriptions include program planning, policy development and interagency coordination may use this code. Activities may include, but are not limited to:

1. Identifying gaps or duplication of non-medical services (e.g., social, vocational, educational and state mandated medical and general health care programs) available to patients/Tribal members, and developing strategies to improve the delivery and coordination of these services.
2. Developing strategies to assess or increase the capacity of non-medical programs.
3. Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services.
4. Evaluating the need for non-medical services in relation to specific populations or geographic areas.
5. Analyzing non-medical data related to a specific program, population, or geographic area.

6. 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 problems not addressed by programs and services.
7. Defining the relationship of each agency's non-Medi-Cal services to one another.
8. Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services.
9. Developing non-medical referral sources.
10. Coordinating with interagency committees to identify, promote and develop non-medical services.

**CODE 16 PPPD RELATED TO MEDI-CAL SERVICES - PM/50 Percent FFP**

This code is used when performing collaborative activities with other agencies associated with the development of strategies to improve the coordination and delivery of Medi-Cal-covered services by contractor employees or subcontractors whose tasks officially involve PPPD. This activity's tasks must be specifically identified in the employee's position description/duty statement. The costs of these activities are claimable but must be discounted by the statewide MCP. Activities may include, but are not limited to:

1. Identifying gaps or duplication of medical/dental/mental health/chemical dependency counseling services provided to patients/Tribal members and developing strategies to improve the delivery and coordination of these services.
2. Developing strategies to assess or increase the capacity of medical/dental/mental health/chemical dependency counseling programs, including planning staff training to implement strategies.
3. Monitoring the medical/dental/mental health/chemical dependency counseling service delivery systems.
4. Developing procedures for tracking families' requests for assistance with accessing medical/dental/mental health/chemical dependency counseling services and providers, including Medi-Cal. (This does not include the actual tracking of referral to Medi-Cal services, which would be coded under Code 8a and 8b.)
5. Evaluating the need for medical/dental/mental health/chemical dependency counseling services in relation to specific populations or geographic areas.
6. Analyzing Medi-Cal data related to a specific program, population, or geographic area.
7. Working with other agencies and/or providers that provide medical/dental/mental health/chemical dependency counseling services, to improve the coordination and delivery of services, to expand access to specific populations of Medi-Cal eligible individuals, and to increase provider participation and improve provider relations.
8. Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental health/chemical dependency problems.
9. Developing strategies to assess or increase the cost effectiveness of medical/dental/mental health/chemical dependency counseling programs.
10. Defining the relationship of each agency's Medi-Cal services to one another.
11. Working with Medicaid resources, such as the Medicaid agency and Medicaid managed care plans, to make good faith efforts to locate and develop health services referral relationships.
12. Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services.

13. Working with the Medi-Cal agency to identify, recruit and promote the enrollment of potential Medi-Cal providers.
14. Developing medical referral sources such as directories of Medi-Cal providers and managed care plans, which will provide services to targeted population groups.
15. Program planning and interagency coordination concerned with implementation of the Medi-Cal program, such as meetings with DHCS to develop strategies for extending coverage of mental health services to family members of the Medi-Cal enrollee.

This activity is not reimbursable if staff performing this function is employed full-time in a service provider setting, such as a clinical environment. The full costs of the employee's salary are assumed to be included in the billable fee-for-service or all-inclusive rate and separate MAA claiming is not allowed.

This activity is not reimbursable if staff who deliver services part-time in a service provider setting, such as a clinical environment, are performing PPPD activities relating to the service provider setting in which they deliver services.

**CODE 17 MEDI-CAL ADMINISTRATIVE ACTIVITIES (MAA) COORDINATION AND CLAIMS ADMINISTRATION - R**

This code is used by Tribal MAA coordinators and claims administration staff when performing activities that are directly related to MAA coordination and claims administration. This time will be reallocated across other codes based on the percentage of all other time spent on allowable/unallowable administrative activities claimed. Activities under this code must be detailed in the Claiming Plan. Activities may include, but are not limited to:

1. Drafting, revising and submitting MAA Claiming Plans.
2. Serving as liaison for regional and local MAA claiming programs and with the State and Federal Governments on Medicaid administrative claiming (i.e., Tribal MAA Coordinators or their designees).
3. Monitoring the performance of claiming programs.
4. Administering MAA, including overseeing, preparing, compiling, revising and submitting claims.
5. Ensuring that MAA claims do not duplicate Medi-Cal claims for the same activities from other programs and managed care plans.
6. Entering into contracts with organizations performing MAA with preference given to Native American Indian Tribes and/or Tribal Organizations.
7. Recruiting and contracting with organizations performing MAA with preference given to Native American Indian Tribes and/or Tribal Organizations as Medi-Cal contract providers.
8. Monitoring subcontractor capacity and availability.
9. Ensuring compliance with the terms of the contract.

**CODE 18 GENERAL ADMINISTRATION & PAID TIME OFF - R**

This code is used when performing activities that cannot directly be assigned to other program activities and are eligible for cost distribution on an OMB A-87 approved cost allocation basis. Note that certain functions, such as payroll, maintaining inventories,

developing budgets, executive direction, etc., are considered overhead; and therefore, are only allowable through the application of an approved Indirect Cost Rate (ICR). This activity is to be used by all staff involved in MAA to record usage of paid leave, including vacation, sick leave, holiday time and any other employee time off that is paid. These costs are to be distributed proportionately to all of the activities performed. Activities may include, but are not limited to:

1. Attend or conduct general, non-medical staff meetings.
2. Develop and monitoring a program budget.
3. Provide instructional leadership, site management, supervise staff, or participate in employee performance review.
4. Review departmental or unit procedures and rules.
5. Present or participate in, in-service orientations and programs.
6. Participate in health promotion activities for employees of the Contractor.
7. General training on MAA and/or conducting MAA time surveys and training activities.
8. Attendance at training on MAA and/or how to document relevant activities through the time survey process.
9. Training program and subcontractor staff on state, federal and local requirements for Medi-Cal administrative claiming.
10. Attending training sessions, meetings and conferences involving MAA.
11. Completing the Tribal MAA time survey form.

Tribal staff who do not perform any claimable MAA activity (codes 4a, 4b, 6a, 6b, 8a, 8b, 10, 12, 14, 16 and 17) during the time survey weeks cannot charge any time to “General Administration & Paid Time Off”. Exceptions would be a Tribal facility staff member on paid absence or leave who typically performs MAA as demonstrated through previous time surveys and the duty statement.

**CODE 19 TARGETED CASE MANAGEMENT - U**

This code is used when providing comprehensive case management services in accordance with Section 1915(g) of the Social Security Act and the Medi-Cal State Plan which includes needs assessment, individualized service plans, linkage and consultation, assistance with accessing services, crisis assistance planning, and periodic review. Services should be time surveyed to this activity only if they are being separately reimbursed for TCM. Activities may include, but are not limited to:

1. Perform a comprehensive documented needs assessment which identifies the client’s medical, educational, social, and other needs as relevant.
2. Develop a written comprehensive individualized service plan based on the documented assessment.
3. Provide the client with linkage and consultation and with referral to service providers and placement activities, including follow-up as quickly as indicated by the need no later than 30 days after the referral.
4. Assist the client in accessing services identified in the individualized service plan.
5. Providing crisis assistance planning to help the client access needed services.
6. Perform a follow-up re-evaluation of the client’s progress toward achieving the objectives in the service plan at least every six months.

## B. Claiming

- **Documentation**

Tribes and Tribal Organizations must maintain records and be able to support the claims submitted to the state. Tribal MAA contractors are responsible for the documentation of all costs claimed, including those associated with personnel time pursuant to OMB A-87; and 42 CFR parts 413.20(a), 413.24(a), and 433.32(a)-(d). Additionally, Centers for Medicare and Medicaid Services (CMS) Publication 15-1, Sections 2300 and 2304 require that the Tribal MAA contractors provide adequate cost data based on financial and statistical records to support all of their reimbursable costs.

The documentation for administrative activities must clearly demonstrate that the activities/services directly support the administration of the Medi-Cal program. The administrative claiming records must be made available for review by state and federal staff upon request during normal working hours (section 1902(a) (4) of the Act, implemented at 42 CFR part 431.17). Documentation maintained in support of administrative claims must be sufficiently detailed to permit state and federal staff to determine whether the activities are necessary for the proper and efficient administration of the Medi-Cal State Plan. For most activities, the activity is self-evident in the detailed coding scheme.

For staff not working solely on a single federal award, additional standards for payroll documentation apply regarding time distribution pursuant to OMB A-87, Attachment B, part 11.h, "(4) Where employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation which meets the standards in subsection (5) unless a statistical sampling system (see subsection (6)) or other substitute system has been approved by the cognizant Federal agency."

For the select staff performing multiple activities whose personnel costs are approved for direct charging, the salary distributions will be supported pursuant to OMB A-87, Attachment B, part 11.h, (5), as stated:

> "(5) Personnel activity reports or equivalent documentation must meet the following standards: (a) They must reflect an after the fact distribution of the actual activity of each employee, (b) They must account for the total activity for which each employee is compensated, (c) They must be prepared at least monthly and must coincide with one or more pay periods, and (d) They must be signed by the employee."

The CMS School-Based Administrative Claiming Guide states, "OMB A-87 permits the use of "substitute systems" for allocating salaries and wages to federal awards to be used in place of activity reports when employees work

on multiple activities or cost objectives. Any such system must be approved by the funding agency. These sampling systems (time studies) may include but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort or outcome." Standards for time distributions personnel costs for staff participating in the substitute system (time study or survey) in OMB A-87, Attachment B, part 11.h (6) apply:

> "Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limited to, random moment sampling, case counts, or other quantifiable measures of employee effort. (a) Substitute systems which use sampling methods (primarily for Aid to Families with Dependent Children (AFDC) , Medicaid, and other public assistance programs) must meet acceptable statistical sampling standards including: (i) The sampling universe must include all of the employees whose salaries and wages are to be allocated based on sample results except as provided in subsection (c); (ii) The entire time period involved must be covered by the sample; and (iii) The results must be statistically valid and applied to the period being sampled. (b) Allocating charges for the sampled employees' supervisors, clerical and support staffs, based on the results of the sampled employees, will be acceptable."

As an additional level of documentation, all staff who time survey are required to complete two specific samples of any activities they perform for Medi-Cal reimbursable activities. This requirement is in addition to the documentation requirements cited above.

During the time survey period, the time study participant must document on a daily basis the name of each client they provide MAA activities to on the secondary documentation form.

The samples provided with the time survey for each activity code should accurately reflect the activity code definition. Samples must meet a minimum of 85% accuracy to meet program compliance. This percentage is the ratio of accurate samples to all samples provided on each time survey. If the ratio is below 85% for any time survey, that time survey will be removed and associated staff person's salary and benefits will not be apportioned by the summary time survey results, and will not be included in the reimbursement calculation of the invoice.

The requirement to document costs at least monthly does not necessarily mean that time studies must be conducted monthly. OMB A-87 makes a distinction between documentation of costs and the methods/mechanisms for allocating such costs. While costs must be documented at least on a monthly basis, time studies, which are conducted for purposes of allocating costs, can occur on a quarterly basis or some other statistically valid time frame. In this

Implementation Plan, Tribal claiming units will complete a two-week per quarter time survey. ASMB C-10, the U.S. Department of Health and Human Services' implementation guide for OMB A-87, provides further guidance on the requirements and circumstances dictating the frequency of time and effort reporting.

The required documentation to be maintained in the audit file includes but is not limited to:

- Original time survey forms and secondary documentation;
- Documentation supporting the calculation of the time survey percentages used to compile the invoice;
- During the time survey period, the time study participant must document on a daily basis the name of each client they provide MAA activities to on the secondary documentation form.
- Copies of the original invoice worksheets and templates;
- Documentation related to salaries and wages, including personnel activity reports;
- Documentation supporting the calculation of the MCP/TMCP;
- Documentation demonstrating Direct Charges that are allocable to Medi-Cal;
- Documentation of the calculation of the Indirect Rate;
- Accounting records supported by source documentation such as canceled checks, paid bills, payrolls, contract, and sub-grant award documents;
- Documentation detailing and supporting Indirect Costs; and
- Adequate documentation for personnel costs.

## C. Tribal MAA Time Survey

- **Tribal Time Survey Methodology**

### a) Method

The CMS School-Based Administrative Activities Claiming Guide requires an assured randomized time period with a large enough sample of Tribal staff service-wide for each Tribal MAA contractor to ensure that the time survey is statistically valid at the 95 percent or higher confidence level for a 5 percent error level. DHCS will monitor the compliance of the Tribal MAA contractor with the requirements of the following time survey methodology each quarter. (See Section VII. "Performance Standards/Program Oversight and Monitoring for details of the monitoring process".)

- A time survey shall be conducted for each Tribal claiming unit for two weeks of every quarter consisting of ten consecutive business days. The two-week time survey period shall be randomly selected by DHCS and accepted as representative of Tribal MAA for that quarter. Statewide quarterly results will be aggregated. The total statewide

aggregated percentages for each activity will be used for claiming for each claiming unit.

- Tribal MAA contractors are notified no later than the first day in May annually of the first-quarter time survey period. The second-, third-, and fourth-quarter survey periods will be reported to the Tribal MAA contractor via a Policy and Procedure Letter within 45 days before the beginning of the new quarter. These dates will be shared only by MAA coordinators and necessary management staff on an as-needed basis until DHCS releases this information on the DHCS website. The time survey dates will be posted on the DHCS website no sooner than five business days before the first day of the time survey period.

- Every staff person, contracted staff, or sub-contractor claiming personnel costs under this contract through the time survey methodology shall complete and sign a record of the actual activities engaged in by that person for all paid time throughout the work day during the period of the time survey, by means of a detailed time survey that breaks each hour of the working day into 15-minute increments. The time survey shall record all activities, and shall document not only Medi-Cal outreach and linkage activities, but also time spent in the provision of medical services, paid time off, and other non-reimbursable time, resulting in a complete picture of that person's activities. When multiple activities are performed in a 15-minute period, the activity performed for the greater amount of time should be coded to that 15-minute increment.

- This signed documentation shall include, at minimum: 1) the name of the employee completing the time survey and performing the allowable activities; 2) the employee's department or program and the employee's job title and/or job description; 3) the dates covered by the time survey; and 4) the activity code applicable to each 15-minute increment of time during the work day. **Appendix B** displays the required time survey form. Time surveys that do not meet the above standards may not be used for claiming in that quarter's invoice.

- A random selection of 10% of the time surveys will be validated by DHCS staff within 90 days of the end of the time survey period. The validation will consist of reviewing the participant responses and the corresponding code assigned by the participant to determine if the code was accurate. The State will review the results and independently code the activity and compare it to the activity recorded by the participant. The State will communicate validation results to the contractor and will require the contractor to revise the time survey results by removing the incorrect time survey. If the contractor has invoiced, the invoice must be revised to reflect the corrected time survey results.

- DHCS will ensure that Tribal claiming units receive the necessary Time Survey training annually.

**b) Time Survey Conditions/Exceptions**

- Staff must time survey for ten consecutive days, excluding Saturdays, Sundays, holidays, and other dates when the facility is closed. Should the time survey period occur during an unanticipated event or circumstances beyond the control of the Tribal claiming unit (i.e. illness of key staff, facility closure, elder's funeral, etc.), the claiming unit may be allowed to begin or continue the time-survey process beginning the first day of their return to business. Documentation for all excluded days must be kept in the claiming unit's audit file.

**c) Secondary Method**

- DHCS may propose an alternate, statistically valid time survey methodology. Implementation will be contingent upon CMS approval. Approval by CMS for any alternate methodology must be obtained prior to implementation.

## D. Calculating the Medi-Cal Percentage (MCP)

The Medi-Cal Percentage refers to the proportion of Medi-Cal enrollees in the client population. A participating Tribal health facility must verify and document each client's Medi-Cal eligibility and maintain that documentation for review by DHCS and CMS upon request.

Each Tribal claiming unit will track both the unduplicated number of Medi-Cal-enrolled individuals provided with services during the quarter, and the total unduplicated number of individuals served during the quarter. Tribal claiming units shall determine these numbers each quarter and may use Tribal databases and other resources, such as IHS RPMS (Resource & Patient Management System). The total statewide aggregated percentages for each activity will be used for claiming for each claiming unit.

The statewide MCP must be calculated and documented according to the following formula:

The total unduplicated number of Medi-Cal-enrolled individuals provided with services, divided by the total unduplicated number of all individuals provided with services.

This ratio represents the rate of utilization by Medi-Cal eligibles as compared to that of the entire population served.

Please see Section IV. part B.7, “Allocable Share of Costs” for an example of the calculation of the MCP.

The documentation for the MCP must be kept in the audit file for state and federal review.

## VI. BILLING AND PAYMENT PROCEDURES

### A. Federal Financial Participation

1. Federal funds shall not be used as matching funds unless otherwise allowed by statute. The Tribal MAA contractor shall ensure that its monetary share of costs for MAA is non-federal monies, eligible federal monies, or Tribal funds allowable as state match by regulation, and which has not been used and will not be used as match for other federal money.

2. In no case should a Tribal health program or other Tribal claiming unit be reimbursed more than the actual costs incurred by that program or claiming unit. In the event the Tribal claiming unit receives funds, other than funds received from Indian Health Services or under this Cost Allocation Plan, that are earmarked for outreach services for Medi-Cal, or for other administrative activities claimed under MAA, such funds shall be offset from the Medi-Cal administrative reimbursements.

### B. Allowable Costs

As a cost-based reimbursement program eligible for Federal Financial Participation, the allowed composition of the California Tribal MAA program costs are defined by OMB A-87 which establishes principles and standards for determining costs for federal awards.

Total costs eligible for reimbursement are defined as in OMB A-87, Attachment A, part D, item 1, “The total cost of Federal awards is comprised of the allowable direct cost of the program, plus its allocable portion of allowable indirect costs, less applicable credits,” with allowable direct and indirect costs defined in OMB A-87, Attachment A, Parts E and F.

In order to claim Tribal Agency indirect costs, the Native American Indian Tribe or Tribal Organization must have an ICR, or an approved CAP negotiated by the Native American Indian Tribe or Tribal Organization with the Inspector General, United States Department of the Interior or other appropriate federal cognizant agency. If the Tribal Agency does not have an approved ICR or CAP by the federal cognizant agency, a ten percent “default” ICR will be used to claim administrative activities reimbursement. These three methodologies will be hereinafter referred to as the Indirect Rate.

Per OMB A-87 Attachment A, part C, item 3.A, “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.” Costs must be allocated to all other Federal programs and/or non-Federal funded programs that benefit from the cost before any cost can be included in cost pools on the Tribal MAA invoice. This applies to Tribal Government, Tribal Organization, and subcontracted costs.

## 1. Direct Costs:

**General-** Direct costs are those that can be identified specifically with a particular final cost objective.

- Personnel Costs
- Staff Travel Expenses
- Transportation Mileage Reimbursement

### a.) Personnel Costs

Allowable costs include personnel costs for those activities defined in Section V. part A, “Comprehensive Activity Codes”, as allowable reimbursable MAA activities. Personnel costs associated with the performance of MAA are direct costs per OMB A-87 as, “Compensation of employees for the time devoted and identified specifically to the performance of those awards.” For purposes of MAA claiming, the Tribal MAA contractor shall limit calculation of personnel costs to salary plus benefits using payroll documents. Salary costs for the quarter must be readily determinable and based on data available from the Tribal accounting office. The data shall tie to the quarterly payroll tax reports, providing a good audit trail for what is claimed as salary paid to the individual staff person for whom costs are claimed. In addition to salary, personnel costs shall include payroll taxes and fringe benefits. Personnel costs for contracted staff shall consist only of the compensation paid to or for that person, as documented by the Tribal accounting office.

Total claiming unit personnel costs for the quarter will be segregated into allowable direct and unallowable cost pools. For those staff who perform allowable MAA activities and report time on the quarterly time survey, their total personnel costs will be multiplied by the quarterly aggregate statewide total percentage of time reported on the time survey for that quarter for each allowable reimbursable activity. For activities defined as total MAA, resulting personnel costs will be assigned to the allowable direct cost pool as will those defined as proportional after the application of the MCP. For activities defined as reallocable, resulting costs will be assigned to both the allowable direct and unallowable costs pools based on the proportion of time survey percentages in each cost pool. Per OMB A-87 Attachment A, part C, item 3.A, “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.”

For those staff whose personnel costs are direct charged, costs are assigned to cost pools in the same manner as prescribed for costs for staff who report time on the time survey.

### b.) Staff Travel Expenses

Staff travel costs associated with the performance of MAA is direct costs per OMB A-87 Attachment A, part E, item 2.d, as, “Travel expenses incurred specifically to carry out the award.” The Tribal MAA contractor may claim allowable staff travel expenses as a direct cost. Quarterly costs associated with staff travel time are captured through the quarterly time survey process as described in Section V. part A, “Comprehensive Activity Codes.” Staff travel time should be reported on the time survey to the activity code for which the travel was incurred.

In order to claim Tribal Agency indirect costs (or administrative costs), the Native American Indian Tribe or Tribal Organization must have an Indirect Rate. Only materials, equipment, or capital expenditures that have been approved as part of the indirect rate will receive federal reimbursement.

Non-personnel travel expenses are allowable as incurred by staff in connection with their MAA. MAA-allowable non-personnel travel expenses are limited to actual costs of travel, including, per diem and mileage plus documented transportation and hotel expenses and shall be claimed at no greater than prevailing federal General Service Administration (GSA) rate.

Allowable non-personnel travel costs must have taken place during the quarter, must have been incurred in conducting MAA, and must be documented at the individual staff person level.

Non-personnel travel costs for activities defined as total MAA will be assigned to the allowable direct cost pool as will those defined as proportional MAA after the application of the MCP. For example, staff traveling to a community health fair to perform Medicaid Outreach only would be staff travel which is not discounted. For activities defined as reallocable, resulting costs will be assigned to both the allowable direct and unallowable costs pools based on the proportion of time survey percentages in each cost pool. Per OMB A-87 Attachment A, part C, item 3.a, “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.” Full documentation of costs claimed must be maintained and available on request.

### c.) Non-Emergency, Non-Medical (Non-Specialized) Transportation

The Tribal MAA program in California has an acute need to provide non-medical transportation to medically necessary non emergent Medi-Cal funded health care services due to the rural nature of the community served and the lack of automobile ownership. The overall rate for American Indian households without vehicles in the Tribal Health Program service areas is 12%. The overall rate for White households in the same geography is 6%. As an example, the Warner Mountain Indian Health Program (WMIHP) demonstrates the intersection of isolation and lack of vehicle ownership. At that Tribal Health Program, 22% of the American Indian households served own no automobile. The program located on the Fort Bidwell Indian reservation is the only medical service available on the reservation. The closest community with an alternative source medical service is Surprise Valley California approximately 23 miles away. The WMIHP, although open five days a week, is staffed with a certified Family Practice Nurse Practitioner whose supervising physician is on site one day a month. Both providers routinely make referrals for follow up services to Alturas which is 51 miles one way, Reno which is 247 miles one way, and Redding which is 248 miles one way. Transportation services are generally provided to WMIHP Indian clients via a GSA leased vehicle and a staff Transportation Aide at federal government established mileage rates.

The cost of providing transportation for Medi-Cal clients to Medi-Cal providers may be claimed as administration. 42 CFR part 440.170(2) states, “If other arrangements are made to assure transportation under Section 431.53 of this subchapter, FFP is available as an administrative cost.” OMB A-87, Attachment A, part E, item 2, states “(a) Compensation of employees for the time devoted and identified specifically to the performance of those awards. (b) Cost of materials acquired, consumed, or expended specifically for the purpose of those awards. (c) Equipment and other approved capital expenditures. (d) Travel expenses incurred specifically to carry out the award.” In California, the actual cost of providing non-emergency, non-medical (non-specialized) transportation of Medi-Cal eligible individuals to services is properly reimbursed as MAA.

For those staff who arrange or provide transportation, are not part of a separate transportation unit and report time on the quarterly time survey, their quarterly personnel costs will be assigned as described above for personnel costs. For quarterly transportation costs associated with a separate transportation unit, all costs for the transportation unit will be assigned to the allowable direct cost pool after the application of the applicable Medi-Cal eligibility percentage for transportation (TMCP).

The actual cost of providing non-emergency, non-medical (non-specialized) transportation of Medi-Cal eligible individuals to services is limited to:

1. Actual personnel cost of providing transportation, or accompanying as an attendant if necessary. This personnel cost will be allocated by time survey. However, if the Tribal claiming unit operates a separate transportation unit whose staff performs no other MAA, personnel costs may be direct charged, including personnel costs for the transportation unit staff who arrange transportation.
2. Actual cost of meals and lodging at no greater rate than at the prevailing federal GSA rate for eligible individuals and/or an attendant when necessary. (For example, when staff spend more than eight hours away from their place of employment providing transportation for an eligible individual and/or acting as an attendant when necessary.)
3. Actual cost of taxi, bus, etc. (i.e. vouchers, tokens).
4. Actual transportation costs per mile at the prevailing federal GSA rate. The vehicle cost is limited to reimbursement through a mileage rate at the prevailing federal GSA rate.
5. Actual transportation cost where a Tribal facility contracts with non-Tribal health facilities for the provision of transportation services.
6. Tribal Organizations or Tribal entities must assure that all of the MAA costs are assigned and entered into the invoice as a direct charge and discounted to account for contracts that are for Medi-Cal populations only or for a combination of Medi-Cal and non-Medi-Cal populations served.

Individuals needing transportation to medical services is a subset of all individuals served at Tribal facilities, drawing more heavily from those of lower economic means. Applying the MCP to transportation costs will significantly under represent the Medi-Cal eligible individuals to whom transportation is provided. Tribal claiming units will instead use the ratio of Medi-Cal eligible individuals transported to Medi-Cal-covered services to all individuals transported. This ratio will be applied to all costs of providing non-emergency, non-medical transportation to Medi-Cal-covered services to determine costs that may be properly reimbursed as MAA. The method used to compute the TMCP will be the same as is used for computing the MCP, but instead with the applicable transportation related client counts on a facility-by-facility basis.

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## 2. Indirect Costs

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

In order to claim Tribal Agency indirect costs (or administrative costs), the Native American Indian Tribe or Tribal Organization must have an Indirect Rate. Only materials, equipment, or capital expenditures that have been approved as part of the indirect rate will receive federal reimbursement.

The Tribal agency administrative Indirect Rate must comply with provisions of OMB A-87, and Federal Publication ASMB C-10.

The Tribe or Tribal Organization must assure that costs claimed as direct costs (claimed through the time survey process or direct charged) do not duplicate costs claimed through the application of the Indirect Rate.
The applicable Indirect Rate will be applied to each time survey period of claiming within the applicable fiscal year. If the Tribe or Tribal Organization does not have an approved Indirect Rate for the current fiscal year, the most recently approved Indirect Rate may be used.

The Tribe or Tribal Organization must ensure that costs claimed do not duplicate costs claimed through the application of any Indirect Rate, or through reimbursement for direct medical services.

## 3. Other Direct Cost (Subcontract Costs)

Per OMB A-87 Attachment A, part C, Item 3.a, “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.” The “Other Direct Cost” that would be claimed as MAA is the cost of any subcontracts (such as transportation services) that Tribal organizations or Tribal entities enter into for the performance of MAA. Tribal Organizations or Tribal entities must assure that all of the MAA costs are assigned and entered into the invoice as a direct charge and discounted to account for contracts that are for Medi-Cal populations only or for a combination of Medi-Cal and non-Medi-Cal populations served. This amount will be determined by the MCP or TMCP as applicable. Costs may be claimed in the quarter in which

they are paid. Providers must submit all claims no later than 12 months from the end of the quarter in which the activity occurred. Full documentation of costs claimed must be maintained and available on request.

Full documentation of costs claimed must be maintained and available on request. All costs included in a claiming unit's applicable budget unit where the MAA costs are incurred will be entered into the invoice so as to allow clear documentation of all costs from the Tribal claiming unit's general ledger. Costs will be assigned to cost pools as allowable costs direct or unallowable as described in this section and will be entered as such in the Native American Tribal Medi-Cal Administrative Activities Invoice. Section V. part A, "Comprehensive Activity Codes", defines what allowable direct personnel costs are eligible for total MAA, proportional MAA, and reallocable FFP reimbursement. The invoice process will apportion or reallocate all proportional the allowable direct or unallowable cost pools as applicable as described in this section.

## C. Payment for Tribal MAA Contracts

- The FFP amount for the MAA which the Tribe or Tribal Organization provides under this Plan is 50% of the total allowable costs that are attributable to MAA.

2. The Tribal MAA contractor shall ensure that its monetary share of costs for MAA is non-federal monies, or eligible federal monies, or that they are Tribal funds allowable as state match by regulation, and which have not been used and will not be used by the Tribe or Tribal Organization as match for other Federal money. Accordingly, each Native American Tribal Medi-Cal Administrative Activities Invoice shall be signed by the Tribal MAA contractor's representative and shall include the current DHCS MAA certification statement.

3. Payment for work under Tribal MAA contracts shall be subject to all the provisions of the contract and this Plan. The Tribal MAA contractor may bill DHCS for MAA performed during the contracted period of performance, provided there is adequate documentation of activities to substantiate the services claimed for reimbursement.

4. DHCS will not pay any amount in excess of the maximum compensation amount contracted. DHCS will pay only for work performed after the beginning date or before the expiration date of the contract, including properly executed amendments and extensions. Tribal Organizations or Tribal entities must assure that all of the MAA costs are assigned and entered into the invoice as a direct charge and discounted to account for contracts that are for Medi-Cal populations only or for a combination of Medi-Cal and non-Medi-Cal populations served.

5. The Tribal MAA contractor shall submit claims only for MAA allowable activities. Medi-Cal does not pay for administrative expenditures related to, or

in support of, services that are not allowable for reimbursement by Medi-Cal and which are not included in the Medi-Cal State Plan. In addition, Medi-Cal does not pay for health care services that are rendered free of charge to the general population, except for services rendered to Native Americans and to people of close social or economic ties to the Native American people, who are authorized under contract or by the Tribe or Tribal Organization IHS direct care facility to receive such services. Thus, any administrative activity, other than Medi-Cal outreach and application assistance, that supports the referral, coordination, planning, or other services that are provided free to the general non-tribal population, would not be considered as Medi-Cal administration.

6. The Tribal MAA contractor contracted with DHCS for MAA shall submit its claim for payment to DHCS within twelve (12) months of the end of the quarter claimed. Claims must be submitted in accordance with time limitations as outlined by federal guidelines.

7. The Tribal MAA contractor shall determine the amount of MAA claimable costs according to the formulas below:

   - For costs that are specifically Medi-Cal focused (i.e., not discounted):

     The actual time spent by each staff person on allowable MAA activities divided by total time spent by that person for all paid activities [i.e., this yields a percentage amount of paid time] multiplied by that person's allowable wages and fringe benefits or contract fees. Related costs are included.

   - For costs that are claimable for reimbursement as MAA only insofar as they are provided to Medi-Cal participants; i.e., discounted by the MCP. Thus, claimable costs are calculated as:

     The actual time spent by each staff person on allowable MAA divided by the total time spent by that person for all paid activities multiplied by that person's allowable wages and fringe benefits or contract fees multiplied by the MCP. Related costs are also included and multiplied by the MCP.

   - The invoice or calculating costs submitted to DHCS must clearly demonstrate claimable costs that are allowable for FFP at 50%, as well as discounted and non-discounted rates, and a calculation of reallocated time.

8. DHCS shall reimburse the Tribal MAA contractor on a quarterly basis for the total amount of FFP billed for allowable Medi-Cal administrative costs.

9. The Tribal MAA contractor contracting with DHCS for MAA shall accept responsibility for any disallowances and/or penalties that CMS may determine during an audit, resulting from claims which DHCS submitted on behalf of the

Tribal MAA contractor billing of Medi-Cal. If the Tribal MAA contractor is paid for MAA reimbursements for services or activities that are later found to be undelivered, ineligible for MAA reimbursements, or not delivered in accordance with applicable standards, the Tribal MAA contractor shall be responsible for any disallowances and/or penalties and shall fully cooperate in the recovery of funds.

10. The Tribal MAA contractor shall provide DHCS an itemized billing for MAA activities using the Native American Tribal Medi-Cal Administrative Activities Invoice for each Tribal claiming unit claiming.

11. The Tribal MAA contractor shall bill DHCS quarterly, for the total allowable reimbursement attributable to MAA.

12. If the State Budget Act does not appropriate sufficient funds for the program, the State shall have no liability to pay any funds whatsoever to a Tribal MAA contractor or to furnish any other considerations. If funding for any fiscal year is reduced or deleted by the State Budget Act for purposes of this program, the State shall have no liability.

# VII. PERFORMANCE STANDARDS/PROGRAM OVERSIGHT AND MONITORING

## A. Roles and Responsibilities

The responsibility for proper administration of the MAA program is shared between DHCS, the Tribal MAA contractor, Tribal MAA Coordinators and Site Coordinators. The responsibility for administering the time surveys is shared by the individual participant, the participant's supervisor, the Tribal MAA Coordinator, the Site Coordinator, and DHCS. DHCS designates the time survey periods, issues the time survey forms and training materials, trains Tribal MAA coordinators and participants, and reviews the audit file in its entirety during site visits.

Tribal MAA Coordinators assist DHCS by training Site Coordinators on the MAA program, time survey, claiming plan, invoice and audit file requirements. They provide DHCS materials and updates to the Site Coordinators.

Site Coordinators are responsible for the following, including but not limited to:

1) Training all time survey participants;
2) Reviewing each time survey form and secondary documentation for completion and accuracy;
3) Ensuring that the surveyed activities are claimable;
4) Ensuring secondary documentation meets the compliance requirements; and
5) Maintaining the original time survey forms and secondary documentation in the claiming unit audit file.

The supervisor of the time survey participant verifies that the number of paid hours recorded is the actual hours paid and that the activities are approved in the claiming plan, in accordance with the job classification and duty statement. Each time survey participant attends time survey training on the MAA program, 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.

It is the responsibility of the Tribal MAA Coordinators who sign the invoice to assure the accuracy of the time surveys, and compliance with the Tribal MAA Implementation Plan, contract, provider manual, and claiming plan. Each Tribal MAA Coordinator will conduct reviews of Tribal claiming units every three years. These reviews should consist of desk and field reviews of the audit file which includes, but is not limited to, completed time surveys, training materials, and invoices (including back up documentation) associated with the claiming unit. This review function shall be performed by the Tribal MAA contractor, and cannot be subcontracted. A Summary of Findings report will be furnished to the claiming unit and a copy will be submitted to DHCS to ensure compliance.

## B. Training

Each Tribal MAA contractor will designate at least one staff member to receive time survey training from DHCS prior to the first quarter of the first time survey of the fiscal year. This staff person will be responsible for training all Tribal staff claiming MAA. DHCS will provide technical assistance and training to Tribal MAA designated staff annually and as additionally requested or on an as needed basis.

DHCS will also provide claiming plan and invoice training if requested or on an as needed basis.

## C. Contract Monitoring Plan

1) Scope of the Monitoring Plan

   This monitoring plan covers all current Tribal contracts for MAA reimbursement for Medi-Cal-related administrative activities including, but not limited to outreach, referral and facilitating Medi-Cal application.

2) Monitoring Coordinator

   DHCS is currently responsible for monitoring Tribal contracts.

3) Risk Factors

   Tribes and Tribal Organizations have multiple funding sources. As a governmental agency, they are covered under the Single Audit Act. Thus, the risk factor of multiple funding sources is reduced. Audit requirements under the Single Audit Act serve as an auxiliary monitoring tool. The Single Audit Act 31 U.S.C. § 7502 (a)(1)(A) requires "each non-Federal entity that expends a total amount of Federal awards equal to or in excess of $300,000 or such other amount specified by the Director under subsection (a)(3) in any fiscal year of such non-Federal entity shall have either a single audit or a program-specific audit made for such fiscal year in accordance with the requirements of this chapter."

4) Monitoring Activities and Schedule

   The following monitoring activities will be conducted for all Tribal MAA claiming units receiving MAA reimbursement by DHCS:

   - Review 100% of time surveys and secondary documentation.
   - Review of invoices submitted for payment.
   - Problem-solve issues/complaints regarding the administrative activities policies and claiming.
   - Respond to e-mail, fax, and phone contacts from contractors.

- On-site monitoring by DHCS Program staff will be provided to each claiming unit at a minimum of once every three years or more frequently if deemed necessary by DHCS.
- Technical assistance will be provided on an as needed or requested basis by DHCS.
- During the site visit, and as Tribes or Tribal Organizations submit invoices for MAA reimbursement, contract performance standards and MAA policies will be reviewed, and claims will be checked for accuracy, compliance and non-duplication of claimed time.
- Regularly conduct financial and compliance audits by DHCS audit staff to support meeting federal requirements as deemed necessary by DHCS Financial Audits Branch.
- A random selection of 10% of the time surveys will be validated by DHCS staff within 90 days of the end of the time survey period. The validation will consist of reviewing the participant responses and the corresponding code assigned by the participant to determine if the code was accurate.
- DHCS will provide to the CMS Regional Office a quarterly report of time reported from time surveys. This will be required in such a manner as to allow for claiming time frames up to 18 months after the end of the applicable quarter. This report will designate the location of where codes 4a, 4b, 6a, 6b, 8a, and 8b are performed.

5) Site Visits and Corrective Action

   Once DHCS conducts a site visit, a Summary of Findings report will be sent to the Tribal MAA contractors and/or Tribal claiming units which will include any identified corrective action items and contractor requirements and deadlines to address all findings. This Summary of Findings report will be furnished to the CMS Regional Office on a quarterly basis.

6) Documentation and Reporting

   DHCS will maintain copies of the monitoring tool and Summary of Findings in the contractor file, including all corrective action plan responses. Documentation of technical assistance visits, training, and billing reviews will be maintained by DHCS.

## D. Tribal MAA Claiming Plan

Each Tribal MAA contractor must provide to DHCS a comprehensive MAA Claiming Plan for each claiming unit describing all activities and costs to be claimed as allowable MAA. A claiming unit is defined as each location or site whose cost may be segregated as a budget unit. The Claiming Plan must be submitted on templates approved by DHCS. The Claiming Plan must be approved by DHCS prior to the submission of MAA invoices.

Once approved by DHCS, these MAA Claiming Plans will become the annual agreements between the Tribal MAA contractor and will form the basis for claiming MAA. Claims submitted to DHCS without an approved Claiming Plan or claims that do not agree with the approved Claiming Plan will be rejected. A Claiming Plan will remain in effect from year to year until amended. A Tribal MAA contractor may submit amendments to its Claiming Plan for review and approval by DHCS no more than once a quarter.

Claiming Plans and subsequent Claiming Plan amendments will become effective the first day of the quarter in which they are submitted for approval.

The Claiming Plan and subsequent Claiming Plan amendments will include (as applicable):

1. A summary of all staff and position classifications for which MAA will be claimed and the MAA activities each classification will perform on a Claiming Unit Functions Grid (referred to as the Grid) as specified and provided by DHCS. This will include what staff will time survey and what activities staff will be approved to perform.
2. Position Descriptions/Duty Statements that match the position classifications for which MAA will be claimed.
3. Organization Charts that show the relationships of time surveying staff, as entered in the invoice.
4. The location and scope-of-work of the Tribal claiming unit(s) for which claims will be submitted, the nature of their work, and their location.
5. Contracts/Memorandum of Understanding for MAA services provided by personnel for which MAA will be claimed and/or whose costs will be included in the invoice.
6. Documentation as to the status of the claiming unit as either a federally-recognized Tribe or Tribal Organization approved by CMS for claiming MAA.
7. Designation of a Tribal MAA Coordinator for the Tribal MAA contractor. This Coordinator will serve as liaison for the Tribal MAA contractor with the State and Federal governments for MAA.
8. Any other documentation or information deemed necessary by DHCS.

# VIII. APPENDICES

## APPENDIX A

### American Indian and Alaska Native Beneficiaries Consultation

**CMS Consultation Strategy**

This Centers for Medicare & Medicaid Services (CMS) policy on consultation with AI/AN Governments responds to the 1998 Executive Order on Government-to-Government Relations with Native American Tribal Governments, directives from the White House Domestic Policy Council Working Group on Indian Affairs, and recommendations from the Departmental Working Group on Consultations with American Indians and Alaska Natives. The guiding principle of the policy is to ensure that, pursuant to the special relationship between the United States Government and the Tribal Governments and to the greatest extent practicable and permitted by law, broad based input is sought by CMS prior to taking actions that have the potential to affect federally recognized Tribes.

CMS acknowledges and accepts the following definition of consultation as developed by the HHS Working Group.

"Consultation is an enhanced form of communication which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process which results in an effective collaboration and informed decision making."

CMS's consultation process will address all policies, regulations, and statutes applicable to the Medicare, Medicaid, and State Children's Health Insurance programs, including but not limited to eligibility, coverage, reimbursement, certification, and quality standards issues. With respect to the Medicaid program, CMS will require State participation in certain critical program change situations; such as, implementation of Statewide health care reform waivers and other waiver programs which clearly affect Indian people. CMS will strongly encourage the inclusion of Tribal groups in the development of other State health program proposals. All consultation processes will be mindful of the Government-to-Government relationship which exists between the Tribes and CMS.

- **Goals of the Consultation Strategy**

CMS has two primary goals for its consultation process:

o Establishing and Maintaining Communications
CMS shall establish improved communication channels with Tribal officials and other AI/AN organizations as appropriate to increase knowledge and understanding of the Medicare, Medicaid, and State Children's Health

Insurance programs. CMS will, in turn, learn from Tribal governments and organizations of the needs and concerns of their members, providers and health care partners serving the AI/AN population. CMS shall consult with Tribes about communication methods.

A variety of methods and mechanisms will be necessary to effect communication with the more than 500 federally recognized Tribes; for example, use of the Internet and other information technology may be necessary and appropriate in many situations. In some cases, face-to-face or other two-way communication will be needed, for example, the introduction of major legislative change in our programs.

- Establishing and Maintaining Ongoing Consultation Mechanisms
  As CMS enhances its communication channels with the Tribes, consultation will occur promptly and effectively and as an acknowledged part of daily business. CMS will share information with the Tribes and seek their input into proposed changes in the operation of the Medicare and Medicaid programs that have the potential to impact the lives of AI/AN individuals. Any proposed program changes will be communicated to the Tribes as early in the process as is practicable and appropriate.

  Inherent in the ongoing consultation processes within CMS is the need for technical assistance to Tribes in realizing the full potential of the Medicare, Medicaid, and State Children's Health Insurance program benefits for AI/AN beneficiaries and for providers of health services. In addition, CMS will strive to resolve problems and issues in a focused manner which is, as always, mindful of the Government-to-Government relationship as well as legal, fiscal and political constraints.

- **Responsibility for Consultation**

  Responsibility for ensuring the consultation strategy is implemented, maintained, and continually improved and adapted to change, is vested in a joint partnership between CMS's headquarters and its regional offices. The Intergovernmental and Tribal Affairs Group (IGTAG), the Director of the Center for Medicaid and State Operations (CMSO), and the Regional Administrators with Seattle as the lead for all field activities, share joint responsibility for establishing effective communication mechanisms with Tribes and for ensuring effective ongoing consultation with Tribes.

- **Implementation Steps**
  - Definition of Core Consultation Issues
    The Regional Office and CMSO, including IGTAG, with consultation from Tribes will develop a core group of issues and activities on which consultation will be sought or the criteria that will be used to identify such issues. Waivers and legislation affecting Tribes are considered critical for consultation.
  - Training of Staff
    CMS staff will participate in a training session on the Consultation Policy

Statement and Agency expectations on a regular basis. The sessions may be by meeting, conference call, other broadcast or video format.

- o Ongoing Consultation with Tribes
  Where feasible, it is assumed that there is great value to both the Tribes and federal staff to conduct regular face-to-face meetings with the Tribes and/or to seek opportunities to participate in meetings conducted for the Tribes by others. These face-to-face meetings will provide additional and more issue-specific opportunities for CMS staff to seek and receive feedback from the Tribes on the consultation process, to provide technical assistance, and to assist in resolving problems and issues. Identification and resolution of issues will take place largely at the Regional level. Central Office personnel will be included in the consultation process and/or the Regional Office will provide information based on consultation in order to inform the policy making process.

- **Additional Policies and Guidance in Consulting with Tribes**
  - o A variety of mechanisms (e.g., Internet Web sites, meetings, telephones, newspapers, magazines and newsletters) will be explored and utilized to ensure timely and consistent exchange of information between the CMS Offices/Staff and the Tribes.
  - o Consultation will occur directly between the CMS and the Tribes. While other interested organizations may also receive information and be asked for input, the primary mechanism for consultation by the CMS will be direct communication with the Tribes.
  - o When consultation is sought from the Tribes, sufficient explanation of the issue and potential for impact on the Tribes will be provided by the CMS Office/Staff. All requests for input by the Tribes will state clearly what advice is requested and the time frame for response. As far as practicable, time frames will be of sufficient duration to allow communication by the Tribal Leaders with their constituency.
  - o Tribes which provide advice or comments back to the CMS during a consultation process will be provided with timely feedback on the disposition of the issue for which consultation was requested. Time frames will be of sufficient duration to allow communication by the Tribal Leaders with their constituency.
  - o CMS will ensure that states notify Tribes of proposed changes to state programs impacting Tribal members. CMS will also strongly encourage the inclusion of Tribal groups in the development of state proposals.
  - o Although no government-to-government relationship exists between the CMS and urban Indian centers, significant numbers of AI/AN beneficiaries receive health services at these locations. Consultation with these centers is also encouraged whenever possible.

**Summary:** Consultation is viewed by the CMS as an evolving process. The joint partnership between the Center for Medicaid and State Operations (CMSO), Intergovernmental and Tribal Affairs Group (IGTAG), and the lead Regional Office will provide leadership for the implementation of the CMS Consultation Policy.

Together the IGTAG and the lead Regional Office will ensure implementation of the Policy, make recommendations for revisions to the Policy based upon periodic assessments, and assure that issues surfaced by the Tribes are addressed promptly.

Attachment: List of Native American Contacts

| Region & State | NAC | Phone, E-mail Address & Fax Number |
|---|---|---|
| Region IX - San Francisco<br><br>American Samoa, Arizona, California, Guam, Hawaii, Nevada, Northern Mariana Islands | Rosella Norris<br>DHHS/CMS<br>90 Seventh Street, Suite 5-300 (5W), San Francisco, CA 94105-7413 | (415) 744-3611<br>rosella.norris@cms.hhs.gov<br>(415) 744-3771 (fax) |