Provider Billing Forum
Part 1

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

August 2026

Medicaid Claiming

DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES

August 2026

Certified Public Expenditure (CPE)

- Public entities certify that the funds spent on Medicaid services are eligible for federal matching funds.
- Key program components for compliance:
  - Certify costs of providing services via the Cost and Reimbursement Comparison Schedule (CRCS)
  - Match nonfederal dollars for federal reimbursement
  - Audit to confirm the final amount

CPE Comparison

Standard Fee-For-Service

- Provider receives flat reimbursement rate
- Payment may not reflect true staff or service cost
- Limited ability to capture administrative effort
- No cost reconciliation, payment is final amount

Certified Public Expenditure

- Reimbursement based on actual Medi-Cal allowable costs
  - Based on incurred staff costs, contractor costs and health-related support costs.
  - May include transportation costs, when applicable.
  - Includes an allocation of indirect costs.
- Requires transparency: costs must be documented, certified, and audit ready.

The LEA BOP Payment Cycle

Claiming for Interim Reimbursement

- LEAs may submit claims for interim reimbursement throughout the FY.
- Billing Limit:
  - 12 months from the service date
- LEAs will be paid interim reimbursements based on the approved claim submissions.
- Reference: Local Educational Agency (LEA) Billing and Reimbursement Overview

LEA BOP Billing Requirements

- For a service to be eligible for billing under LEA BOP, the following criteria must be met:
  - Student is Medi-Cal enrolled.
  - Service is provided by a qualified practitioner.
  - Supervision is documented, if necessary.
  - Authorization for services are in place by prescription, referral, or recommendation.
  - Service is documented appropriately (e.g., assessments, progress/case notes).
  - Parental consent to bill Medi-Cal requirements are met, when required.
  - Billed Other Health Coverage (OHC), when required.

Federal Medical Assistance Percentage (FMAP)

- FMAP: The percentage of Medicaid costs that the federal government will pay.
- California's FMAP is typically 50 percent, meaning the federal government will cover 50% of Medicaid costs.
- May be increased based on program, benefit, or population (e.g., SCHIP eligible members is 65%).

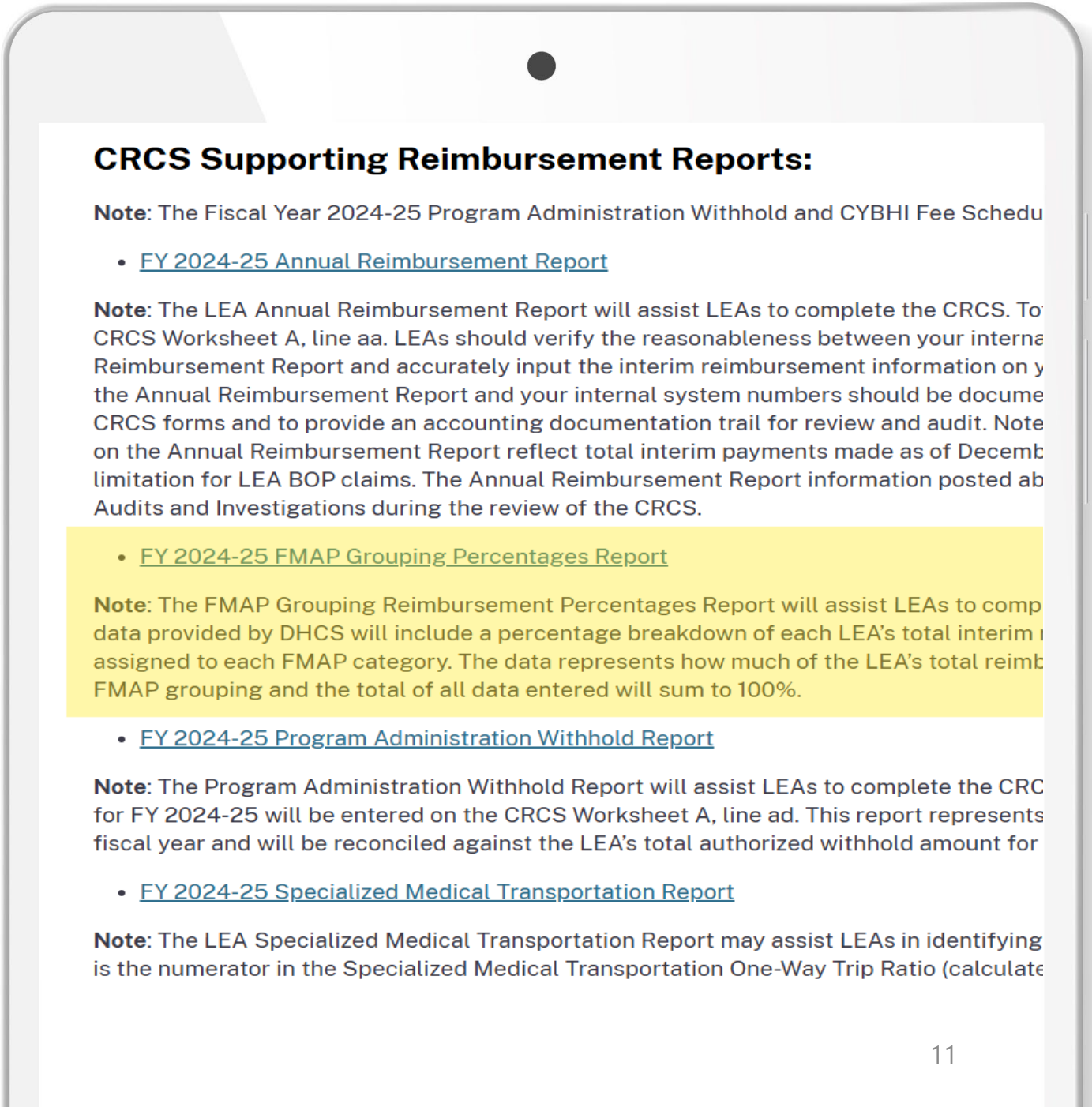
LEA	FMAP
50%	50%

FMAP (cont'd.)

- The LEA BOP federal share is funded through:
  - Title XIX (50% FMAP)
  - Title XIX Enhanced (90% FMAP)
  - Title XXI Funds (65% FMAP)
- All LEA BOP claims are paid at the standard 50% FMAP.
- The CRCS is used to generate additional funding for students associated with the enhanced FMAP amounts.

FMAP (cont'd.)

- FMAP applied at cost reconciliation, not during interim reimbursement.
- Example – LEA USD:
  - Title XIX (50%): 82% interim claims
  - Title XXI: 17% of interim claims
  - Title XIX-Enhanced: 1% of interim claims
  - 82% + 17% + 1% = 100%
- The LEA's total FFP will increase since some of their claims were associated with members that qualify for enhanced FMAP.



Documentation of Services

- The Centers for Medicare and Medicaid Services (CMS) Guidance states :
  - To claim federal funds for services provided to Medi-Cal–enrolled students, documentation is required for each claim.
  - School-based providers should include required information in their care plans, Individualized Education Program (IEPs), or other templates or software used for clinical service documentation.

Minimum Required Documentation

Required documentation must include	Required for Medicaid Claiming	Required by IDEA*
Date of service	✓	
Name of recipient	✓	✓
Medicaid identification number (of student)	✓	
Provider agency and person providing the service	✓	✓
Nature, extent, or units of service	✓	✓
Place of service	✓	✓
Eligibility for IDEA* services		✓

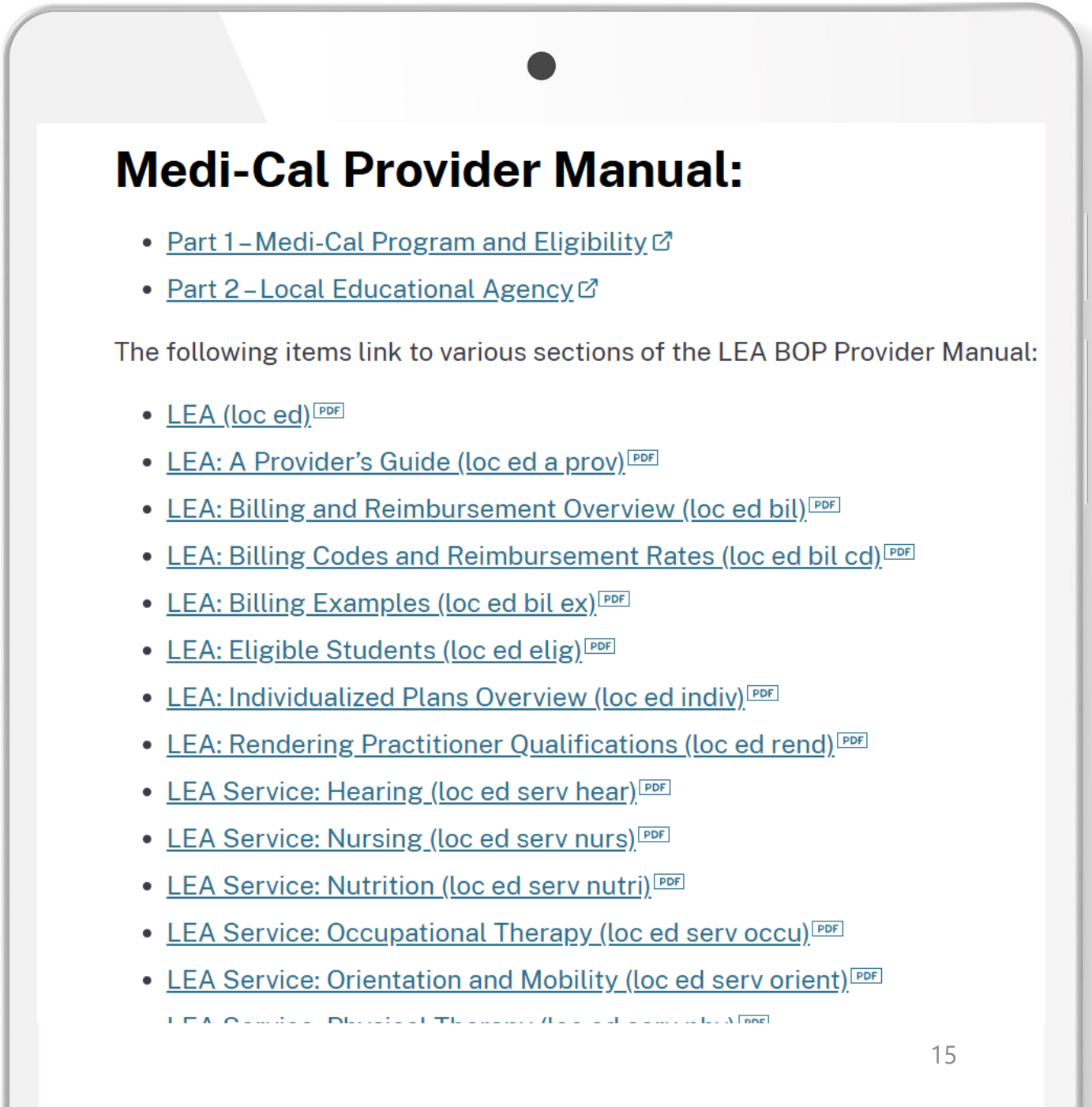
*Individuals with Disabilities Education Act

Documentation Needed to Support Costs Without Claims

- If the LEA reports practitioners on the CRCS without interim billing, the LEA must be able to support costs with documented covered services.
  - ✓ Did the practitioner meet the qualifications ***to bill for the covered service*** per LEA BOP requirements found in the Provider Manual? *(See* Local Educational Agency (LEA) Rendering Practitioner Qualifications (loc ed rend) *for additional requirements.)*
  - ✓ Was the practitioner supervised, if necessary? Is this documented?
  - ✓ Did the practitioner record services (in a portal or hard copy)?
  - ✓ Did the practitioner document to the extent required for billing purposes?
    - ❖ Please see the September 2025 General and Code 2A Documentation Training for more information.
  - ✓ In an audit, could the LEA support that the practitioner provided covered LEA BOP services? Could they readily locate supporting documentation?
- **If NO to any of the above**, do not include these practitioner costs on the CRCS!

Qualified Practitioners

- For a rendered service to be billable, it must be provided by a qualified direct service practitioner.
- Reference: Local Educational Agency (LEA) Rendering Practitioner Qualifications
- Look in the various LEA BOP Provider Manual Services Section for Qualified Practitioners.



Qualified Practitioners (example)

Page updated: October 2021

Rendering Practitioners: Reimbursable Services

‹‹The following chart indicates the services that are reimbursable to LEAs when performed by the indicated qualified practitioners.››

‹‹Reimbursable Services for Qualified Practitioners››

Qualified Practitioners	Reimbursable Services
‹‹Licensed speech-language pathologist Credentialed speech-language pathologist››	‹‹IEP/IFSP speech-language assessments (evaluations) Developmental assessments and hearing assessments (non-IEP/IFSP; includes screening test, pure tone and pure tone audiometry, threshold)›› Speech therapy treatments, including individual and group treatments
‹‹Speech-language pathology assistant (SLPA)	Speech therapy treatments under the supervision of a licensed speech-language pathologist or a credentialed speech-language pathologist, including individual and group treatments (group consists of two to eight students)››

- Local Educational Agency (LEA) Service: Speech Therapy
- Qualified Practitioners is located under "Speech Therapy," subsection "Rendering Practitioners: Reimbursable Services"
- Additional guidance:
  - Supervision Requirements – outline how certain practitioners must be overseen when delivering services.
  - Service Limitations – noting any boundaries or restrictions on what can be billed.
  - ORP Requirements – explain when an ORP provider is needed.

Supervision Requirements

- Pre-licensed practitioners require clinical supervision as part of their certification, registration, or licensure.
- Practitioners working in an educational setting who do not hold a Pupil Personnel Services (PPS) credential must be supervised by a PPS credentialed practitioner.
  - This requirement comes from Education Code § 49426 and is separate from licensure-related supervision.
- These requirements are outlined in the LEA BOP Provider Manual under LEA Rendering Practitioner Qualification or within the specific services section.

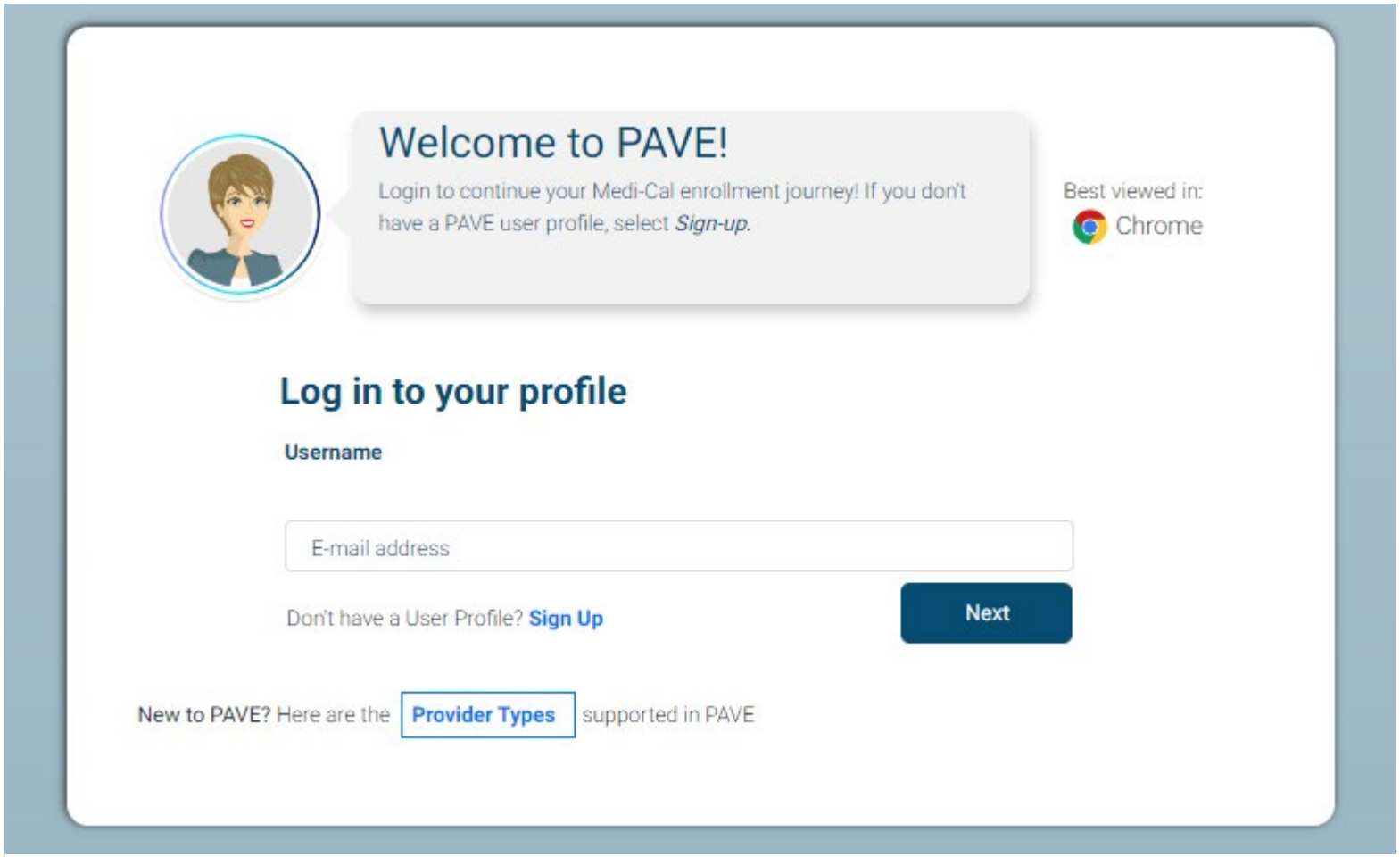
Authorization for Services Prescription, Referral or Recommendation

- All LEA treatment services require a prescription, referral, or recommendation from a qualified medical care practitioner.
- **Prescription**: A written order from a licensed physician, podiatrist or dentist for specialized treatment services - 22 CCR § 51476(d).
- **Referral**: Less formal than a prescription, but meets certain documentation standards (i.e., student name, date, reason for referral, name and signature of practitioner).
- **Recommendation**: May consist of a note in the student's file that indicates the observation/reason for assessment, practitioner type, name and signature.
  - A parent, teacher or registered credentialed school nurse can request an evaluation as well. If the parent is making the referral for assessment, the written request should be included in the student's file and should include the parent's signature and date.
  - Prescriptions, referrals and recommendations must be documented in the student's file.

Ordering, Referring, or Prescribing (ORP) Requirements

- Each service section of the LEA BOP Provider Manual defines which practitioners are authorized to ORP services.
- Practitioners may enroll to ORP for two different purposes:
  - To meet the federal ORP enrollment requirement – enrolled but do not bill Medi-Cal to ORP LEA services.
  - To actively ORP LEA BOP services – requires meeting the practitioner qualifications defined in the manual.
- ORP practitioners must have an NPI Type 1 and be individually enrolled as a Medi-Cal ORP provider.
- All claim submissions for treatment services must include the NPI of the medical professional who ordered, referred, or prescribed the treatment service in box 76 of the claim form.

Enrolling in Medi-Cal as an ORP Practitioner



- Submit an enrollment application through the Provider Application and Validation for Enrollment (PAVE) Portal
- https://pave.dhcs.ca.gov/sso/login.do?

Parental Consent for IDEA Students

- For IDEA students, one of the following must be completed before accessing public benefits or insurance for the first time (34 CFR Section 300.154(d)):
  - Obtain a one-time written consent from the parent/guardian.
  - Provide written notification to the child's parent/guardian (completed before obtaining one-time written consent, and annually thereafter).

Note: Parental consent may be revoked at any time.

Parental Consent for Non-IDEA Students

- For Non-IDEA students, the Medi-Cal application provides the consent to bill.
- However, LEAs should check with their school district legal counsel to ensure that they are in compliance with FERPA requirements, prior to submitting claims to Medi-Cal.
- The 2023 CMS guide encourages LEAs to establish parental consent protocol in place for non-IDEA services.

Other Health Coverage (OHC) Requirements

Insurance Status	Services Authorized in an IEP or IFSP	Services Authorized in an IHSP or Other Care Plan
Medi-Cal Only	Bill Medi-Cal	Bill Medi-Cal
Medi-Cal and OHC	Bill Medi-Cal	Bill OHC, then Medi-Cal

* Per the Provider Manual, if a response from the OHC carrier is not received within 90 days of the provider's billing date, the provider may bill Medi-Cal. A copy of the completed and dated insurance claim form must accompany the Medi-Cal claim. LEA must state "90-day response delay" on the claim.

Cost Settlement

- LEAs submit the annual CRCS to certify costs.
- The CRCS is used to compare each LEA's actual costs for LEA BOP covered services to the interim Medi-Cal reimbursement for the respective fiscal year.
- DHCS audits the costs on the CRCS to determine the final total reimbursement amount.
  - DHCS pays an LEA more when interim reimbursements are lower than the audited settlement, and recoups funds when interim reimbursements are higher than the audited settlement by withholding future payments.
- When an LEA does not receive a final settlement within 12 months of the March 1 CRCS due date, they will receive an interim settlement.
  - When an interim settlement is issued, the final settlement will be completed within 18 months of when the CRCS was submitted.

Questions?

Resources

- LEA BOP Webpage
  https://www.dhcs.ca.gov/provgovpart/Pages/LEA.aspx
- LEA BOP Provider Manual
  https://www.dhcs.ca.gov/provgovpart/Pages/LEAProviderManual.aspx

Random Moment Time Study (RMTS) Overview

DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

August 2026

How RMTS Impacts LEA Funding

How Does RMTS Impact Your LEA?

- The RMTS is one of the key components for determining federal reimbursement for administrative and direct services since it is part of the payment methodology for both programs.
- **LEA BOP:** The RMTS results determine the Direct Medical Services Percentage (or DMSP) which is applied on the annual LEA BOP cost report.
- **SMAA:** The RMTS results determine the RMTS percentages which are applied to the quarterly SMAA invoice.

RMTS → **DMSP & RMTS Percentage** → **Reimbursement**

Impact of RMTS Results: LEA BOP Direct Medical Services Percentage (DMSP)

- The DMSP is calculated at the RMTS Administrative Unit (AU) level and applied to all LEAs within the region:
  - Uses the percentage of 2A moment results and allocates a portion of LEA administrative time (code 16).
  - Higher DMSPs result in a higher proportion of allowable costs.
- The DMSP is one of the major allocation factors that drives the proportion of reimbursable costs!

Example:
$500,000 Total Net Personnel Costs x 55% (DMSP) x 65% (MER) x 50% (FMAP) = $89,375 owed to LEA

$500,000 Total Net Personnel Costs x 62% (DMSP) x 65% (MER) x 50% (FMAP) x 65% = $100,750 owed to LEA

LEA Impact of RMTS

- LEAs may only claim costs for:
  - The quarters in which the LEA participates in the RMTS (i.e., submits a TSP List to the RMTS AU).
  - The individual TSPs included on the quarter's TSP List.
- If the LEA does not participate in a quarter, they cannot be reimbursed for **any costs associated with their employed practitioners** that were incurred during that quarter.
- If a LEA did not include someone on the TSP List for a quarter, they cannot be reimbursed for **the TSP's** costs incurred that quarter.

Who you include matters for reimbursement:
Employed practitioners cannot be on the CRCS unless they are on the TSP list!

Regional Impact of RMTS

- For both LEA BOP and SMAA reimbursement, RMTS results are applied at the RMTS AU level to all LEAs within the region.

- Since the results are based on a random sample, each LEA within a region may not be represented in the sample.
  - **LEA experience may vary.** The sample represents a group, not every individual participant. A LEA's staff experience may not look exactly like what the sample shows.
  - **The sample is still highly reliable**. It is designed using standard statistical methods, which means if we repeated this process many times, we'd expect results to fall very close to the true population experience most of the time.

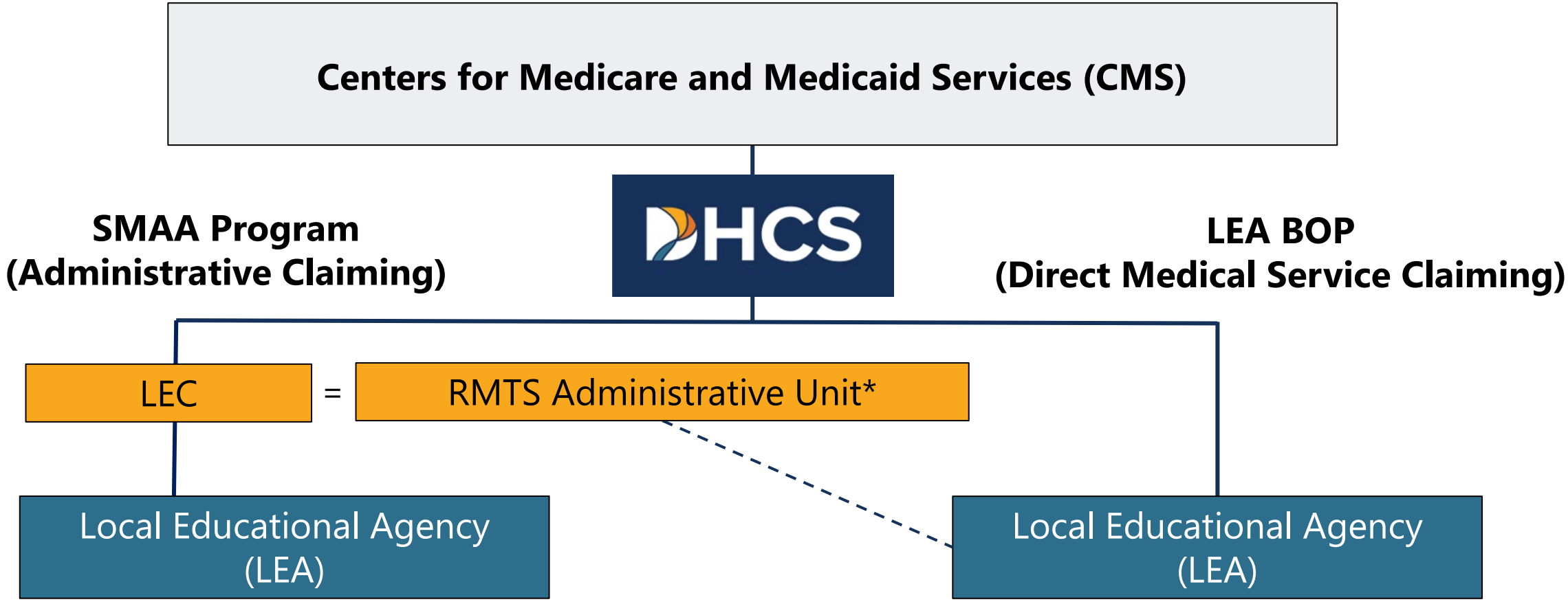
Summary: How Does RMTS Impact Your LEA?

- Detailed moment responses are used to calculate quarterly results.
- The RMTS helps determine federal reimbursement for both LEA BOP and SMAA.
- While your LEA's TSPs may not always be selected, LEA participation in the RMTS is required to meet compliance requirements.
- RMTS reduces administrative burden by allowing results from a small sample to represent the broader population.

Questions?

RMTS Basics

School-Based Medicaid Agency Oversight



***Local Educational Consortium (LEC) should be referred to as RMTS Administrative Unit (RMTS AU) to align with the TSIP *for the purposes of RMTS*.**

What Is RMTS?

- The Random Moment Time Study (RMTS) is a federally approved, **statistically valid** web-based time study **methodology** used to determine how staff allocate time to Medicaid reimbursable activities.
- Under RMTS, Time Study Participants (TSPs) are randomly selected and asked what they are doing during their assigned moment, a duration of one minute.
  - Moments are then coded as a reimbursable or non-reimbursable activity **or service** based on the TSP's response.
- The RMTS supports cost allocation for both the LEA BOP and the SMAA Program.

Why Use RMTS?

- LEA BOP and SMAA are **cost-based reimbursement programs**, which require a way to allocate a portion of total costs to Medicaid.
- RMTS is a **CMS-approved time study methodology** used to calculate the federally reimbursable share of costs.
- **Statistically valid sampling** allows results to be extrapolated from the RMTS sample to represent all participating LEAs within the RMTS AU.
- **Without a sampling approach**, LEAs would need to track all Medicaid time at **the individual staff level** to determine each time study participant's reimbursable costs.

Who Is Included in RMTS? Time Study Participant (TSP) List

- Eligible staff that potentially perform direct services and administrative activities.
  - **Participant Pool 1:** Employed practitioners that perform direct medical services.
  - **Participant Pool 2:** Employed staff or SMAA contractors that perform activities that support the administration of the Medicaid State Plan.

- TSP Lists support claiming of costs on the LEA BOP cost report and the SMAA invoice.
- A randomly selected subset of TSPs are selected to respond to a moment, however all TSPs are eligible to be selected.

Reminder! *A TSP* ***cannot*** *be listed in both Participant Pools.*

RMTS Timing

- The RMTS is run on a **quarterly basis** by each of the RMTS AUs for their participating LEAs.
  - Four time studies are conducted each school year:
    - Quarter 1: July 1 – September 30
    - Quarter 2: October 1 – December 31
    - Quarter 3: January 1 – March 31
    - Quarter 4: April 1 – June 30
- Each quarter the RMTS re-sets and a new pool of TSPs are randomly selected to respond to the quarterly time study.
- LEAs may only claim costs for TSPs that participate in the quarter's RMTS (e.g., Staff are included on the TSP List).

Updates to RMTS

- Effective **July 1, 2026**, the RMTS was updated to align with the 2023 CMS Guidance.
- Updated RMTS requirements are outlined in the **Time Study Implementation Plan (TSIP)**, linked on the DHCS website.
- All updates are pending CMS approval.
- RMTS updates include (but are not limited to):
  - Revising Pool 1 moment "Pre-Question" to be a "Post-Question"
  - Implementing a Quarter 1 RMTS (currently in process for July – September 2026)
  - Adding newly eligible practitioners (LPCCs, APCCs, CWCs, CHWs)
  - Reducing TSP moment response time from 4 student attendance days to 3 LEA working days
  - Using Paid Working Days (vs. Student Attendance Days) to develop LEA calendars

Time Study Moment Questions: Updates

Time Study Questions

1. Were you working at the time of your moment? *(Multiple choice)*
2. Who were you working with during this sample moment? *(Narrative)*
3. Describe in detail the activity you were performing during your sampled moment. *(Narrative)*
4. Describe in detail why you were doing this activity during your sampled moment. *(Narrative)*
5. Participant Pool 1 Only: Is the activity in your response (including pre-and post service time) being performed as part of the student's plan of care? *(Multiple choice)*

New! Post-Narrative Question

- Direct service practitioners (Pool 1) receive the final question to help determine if the activity is reimbursable under LEA BOP.
- This "post-question" was previously a "pre-question".
  - Language has been revised for clarity.
  - TSP will select the plan of care, when relevant.
- Post-question goal is to improve TSP accuracy of identifying whether the activity described in the narrative is (or is not) related to a plan of care.

Direct Service Practitioners: Pre-Question → Post Question

Post-Question Details

Post-Question (Pool 1 Only): *"Is the activity in your response (including pre- and post-service time) being performed as part of the student's plan of care?*

Response options include:

- **Yes, this confirms the activity was performed in accordance with one of the following (select one):**
  - The student's IEP/IFSP.
  - The student's other type of care plan, such as a 504 plan, a student health plan, or a nursing plan.
  - The student's behavioral health plan.
  - Doctor's orders/prescription.
  - The student's vision/hearing screening or assessment.
  - The student's physical, mental, or behavioral health screening or assessment.
  - Required Immunization, or other covered EPSDT (Early and Periodic Screening, Diagnostic, and Treatment) services.
- **No, the activity was not applicable to any of the above.**

Responding to Post-Question

Post-Question (Pool 1 Only): *"Is the activity in your response (including pre- and post-service time) being performed as part of the student's plan of care?*

- Plan of care is not limited to IEP / IFSP.
- Plan of care is a medical management tool used to identify medically necessary services.
- In addition to IEPs/IFSPs, TSPs should select "yes" if their activity is pursuant to:
  - **Another plan of care (504 Plan, Nursing Plan, Health Plan,**
  - **Behavioral Health Plan**
  - **Doctors Orders / Prescriptions**
  - **Results from a screening or assessment (including crisis / risk assessments)**
  - **Preventive EPSDT mandated services for students (i.e., hearing / vision screens)**

Pre- and Post-Service Time

Post-Question (Pool 1 Only): *"Is the activity in your response* ***(including pre- and post-service time)*** *being performed as part of the student's plan of care?*

- **Definition:** Time spent before or after a service that is directly related to providing a medically necessary direct care service, when a student is *not* present.
  - This time is considered an extension of the direct service.
  - Moments occurring during this time should answer "yes" to the Post-Question.
- **Examples** of pre- and post-service time:
  - Driving to / from a service.
  - Setting up / breaking down equipment for the service.
  - Completing documentation of the service (i.e., progress notes, treatment logs).
  - Completing billing activities for the service.

Aligning Moment Narrative & Post-Question

- **Moment narrative response** provides details of the service/activity and insight into whether the moment qualifies as reimbursable.
- **Post-question response** validates the moment narrative response to confirm a plan of care is in place, when required for reimbursement.
- Moving from a pre-question to post-question is intended promote stronger alignment between narrative and post-question responses.
- **If the narrative response contradicts the post-question response**, a Clarifying Question will be sent to the TSP.

Questions?

RMTS:
California's First Quarter 1 Time Study and What's Next

Implementing Quarter 1 Time Study

- CMS requires a RMTS be conducted for any quarter in which services are being rendered for the LEA to claim costs.
- Since traditional school years start before October 1, a Quarter 1 RMTS is required to claim ***any*** costs incurred between July 1 and September 30.
- LEAs wanting to claim costs incurred during a quarter *must* participate in the quarter's RMTS.

If a LEA did not participate in RMTS for Quarter 1 (in process), they cannot include costs for Q1 on their FY 26-27 LEA BOP cost report or SMAA Q1 invoice.

What Happens After Quarter 1 Closes?

- The FY 26-27 Quarter 1 closes on September 30, 2026.
- After Q1 closes there is still work to be done to determine the quarter's RMTS results, including:
  - RMTS AUs finish **coding all Q1 moment** responses.
  - RMTS AUs run **statistical compliance reports** to ensure enough TSPs responded to moments in Q1 to the meet TSIP requirements.
  - LEAs receive the Quarterly Coding Report (QCR) to review coding for their moments. Each LEA with moments must sign a **QCR Coding and Documentation Certification Form** to confirm **they have** appropriate documentation to support their moments.
  - The quarter's **RMTS results** are calculated and **finalized**.

Quarterly Coding Report (QCR) Process

- **RMTS AUs share the QCR and Documentation Certification Form** with every LEA that received at least 1 moment during the quarter.

⬇

- **LEAs have 30 calendar days to review the QCR.**
  - If the LEA agrees with coding and has sufficient documentation to support moment codes (Codes 2A and 16), the LEA will sign the Certification Form.

⬇

- **If the LEA and RMTS AU do not agree** on coding correction(s) within 30 days, the **coding decision may be elevated to DHCS** through a coding appeal.

Why is DHCS Oversight of the RMTS Important?

Federal Audits of School-Based Medicaid Programs

- Since 2015, the US Department of Health and Human Services (US DHHS) Office of Inspector General **(OIG) has conducted 15 school-based audits** and one multi-state audit specific to the **vulnerabilities that exist when using RMTS**.
  - OIG has published findings recommending federal share recoupments ranging from ~$400,000 (MA) to over $551 million (PA).
  - OIG audits can be focused on health-service programs (seven audits) or administrative claiming programs (six audits) and may include both programs (two audits).
- OIG findings are based on a sample but are generally extrapolated to LEAs statewide.

Common OIG Findings for RMTS Audits

Common OIG Finding:	Example:
Improper rate methodologies	Payment rate includes unpaid costs / unallowable staff
Insufficient documentation	Service is not supported in a way that meets Medicaid standards
Non-compliant provider qualifications	License of provider was inactive; provider not adequately trained
RMTS and cost allocation errors	Moments lack documentation, sampling errors, cost allocation plan not updated, time study participants identified incorrectly
Unallowable costs	Unsupported allocation ratios resulted in unallowable costs

Why Is DHCS Oversight Important?

- DHCS oversight of and guidance on RMTS is intended to protect LEA funding by:
  - Monitoring that RMTS practices align with federal requirements.
  - Promoting sound coding and documentation practices.
  - Collaborating with LEAs and RMTS AUs to support an understanding of programs.
  - Ensuring that documentation exists to support Medicaid claiming.

RMTS guardrails help promote sustainable funding for LEAs!

Questions?

RMTS: Tips for Success

How LEA RMTS Coordinators Can Support An Effective RMTS

- Each participating LEA is required by the TSIP to designate an LEA RMTS Coordinator.
  - The LEA RMTS Coordinator may also be the LEA BOP or SMAA Program Coordinator.
- The LEA RMTS Coordinator responsibilities include, but are not limited to:
  - Train and support TSPs on responding quickly with clear, complete, and detailed moment responses that are fully supportable.
  - Address common errors through reviewing coded moments and identifying trends.
  - Tailoring your trainings to address deficits.
  - Referring TSPs to the **RMTS Quick Reference Guide.**

Response Best Practice: P.O.I.N.T. Framework

- Primary Focus
  - What was the primary topic or focus of the TSP's activity?
- Objective
  - Why was the TSP completing the activity?
- Insight
  - What insight was provided for the activity that the TSP was performing.
- Necessary Detail
  - Is there any additional detail you can extract from a clarifying question?
- Timely
  - If clarifying questions are required, be sure to ask them in a timely manner (up to two CQs per moment response are allowed within 15 working days from the date the TSP completed their initial moment response).

Source: How to Answer RMTS

RMTS Documentation

- Documentation is an important aspect of claiming Medicaid funding.
- Strong documentation protects your LEA in audits.
- Direct service moments (Code 2A) require specific, service-level documentation.
- Reimbursable administrative moment responses must clearly show that the activity supports access to Medicaid covered services.
- If a moment response lacks detail, it cannot be coded as a Medicaid-reimbursable activity.
- Strong LEA documentation practices = stronger audit readiness and sustainable funding.

Working with Your RMTS Administrative Unit

- Work with your RMTS AU to understand requirements.
  - Contact Information for each region is on the LEA BOP website.
- Understand your RMTS AU's deadlines:
  - When are TSP Lists due?
  - What timing is required to submit TSP equivalency requests?
  - When do you need to submit the QCR Certification Form?
- Attend all RMTS AU Trainings.
- Reach out to your RMTS AU if you have any questions!

Summary: Tips for RMTS Success

- Work closely with your RMTS AU.
- Regularly update and certify your TSP List.
- Coordinator review of moments / assigned codes to understand RMTS training opportunities and support proper moment responses.
- Coordinate with HR, finance, and Chief Business Officer to track staffing and funding sources.
- Maintain sufficient documentation to support moments, when required.

Resources – Supporting LEA BOP

- CRCS Administration and Audit Checklist
- LEA BOP Trainings Webpage
- LEA BOP Webpage
- Technical Assistance Request Form
- Subscribe to the LEA BOP LISTSERV

Resources – RMTS and SMAA

- 2023 CMS Guide to Medicaid Services and Administrative Claiming
- 2026 Draft of California's Proposed Time Study Implementation Plan (TSIP) (pending CMS approval)
- General and Code 2A Documentation Training
- CMS Medicaid SBS Federal Documentation Requirements Guide
- RMTS Administrative Unit Service Regions
- Time Study Participant (TSP) Training Video

QUESTIONS

Please submit additional questions to the RMTS Inbox:
RMTS@dhcs.ca.gov

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Thank You!

If you have any remaining questions, please email LEA@dhcs.ca.gov