The State of California
Department of Health Care Services

Time Survey Methodology for the County-Based Medi-Cal Administrative Activities and Targeted Case Management Programs and

County-Based Medi-Cal Administrative Activities Program Operational Plan

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TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

I. PREFACE

This document defines the State of California Department of Health Care Services (DHCS) Time Survey Methodology for the County Based Medi-Cal Administrative Activities (CMAA) and Targeted Case Management (TCM) programs and also outlines the DHCS CMAA Program Operational Plan.

The Time Survey Methodology portion provides guidance and instruction to the Local Governmental Agencies (LGA) and the Local Public Entities (LPE) that participate in the CMAA and TCM programs and the Community-Based Organizations (CBO) that participate in the CMAA program to properly account for the claimable time and to allocate costs related to the administrative activities and/or services they perform that are necessary for the proper and efficient administration of the Medi-Cal program.

The CMAA Program Operational Plan portion provides guidance and assistance to entities participating in the CMAA program regarding the proper processes and procedures to construct an appropriate method to claim federal reimbursement for the cost of providing MAA in a county setting.

DHCS, in cooperation with the LGA Consortium, constructed this CMAA/TCM Time Survey Methodology and CMAA Operational Plan document to develop acceptable claiming processes and procedures to support allowable federal claiming through the CMAA and TCM programs. The original requirements in this document were defined in the Medicaid Administrative Claiming (MAC) Agreement between the Health Care Financing Administration and the DHCS, dated September 27, 1995.

Entities adhering to this CMAA/TCM Time Survey Methodology and CMAA Operational Plan document must also comply with all other applicable State and federal codes, laws, rules, regulations, and policies; including, but not limited to, the Centers for Medicare and Medicaid Services (CMS) regulations and policies, including pertinent State Medicaid Director letters, California Welfare and Institutions (W&I) Codes, federal Medicaid claiming requirements, Office of Management and Budgets (OMB) Circular A-87, The Medi-Cal Administrative Claiming (MAC) Agreement, the 2003 Medicaid School-Based Administrative Claiming Guide, DHCS issued policy and procedure letters, and other DHCS guidance as applicable.

A. The County Structure of California

California is the United States' most populous state with more than 37 million people. This diverse State is comprised of 58 counties ranging in size from Los Angeles County with a population exceeding ten million to Alpine County with a population of just over one thousand. Geographically, California encompasses over 163,000 square miles, making it the third largest state in terms of land area (behind Alaska and Texas).

Counties in California are the default "unit of local government" and are mandated by State law to provide such services as: law enforcement, healthcare, property tax collection, and road maintenance. California counties act as agents of the State and, as such, are subject to extensive State administrative supervision and regulation. In 1991, landmark legislation passed throughout California which shifted the fiscal and funding responsibilities for health, mental health, and various other social services programs from the State of California to the individual counties. This legislation, generally referred to as "Realignment" provided counties with dedicated tax revenues from sales tax and vehicle license fees to cover the cost of shifting programs from the State to the individual counties. These funds assist in covering the cost of health care services that were shifted to the counties.

B. Medicaid within the County Structure of California – "Medi-Cal"

Medicaid is a federal system of health insurance for those requiring financial assistance. Within the U.S., states have a partnership with the federal government in which the federal government establishes the basic Medicaid program rules and the States administer the Medicaid program. States meeting Medicaid program requirements may be eligible to receive federal reimbursement of the states' actual public expenditures associated with the services and administration of the Medicaid program. The Medicaid program in California is referred to as Medi-Cal.

Counties and chartered cities, defined as LGAs in California, provide a wide range of health care administration and related services, which may or may not be reimbursable under the Medi-Cal program. California covers all mandatory Medicaid groups and the vast majority of optional groups. CMAA and TCM are two of many Medi-Cal programs provided by counties.

Pursuant to W&I Code §14132.44 and §14132.47, CMAA and TCM became covered Medi-Cal benefits on January 1, 1995. CMAA relates to the activities performed that are necessary for the proper and efficient administration of the Medi-Cal program. TCM provides services as defined in the State Medicaid Plan. Under California's Medicaid State Plan agreement with CMS, DHCS has been designated the "single State agency" responsible for the administration and oversight of the Medi-Cal program. The LGA is the local entity that administers the CMAA and TCM programs to perform activities and provide services to the Medi-Cal eligible populations.

1. The CMAA Program within the County Structure of California

LGAs participating in the CMAA program are eligible to receive federal reimbursement for the cost of performing administrative activities that directly support efforts to identify and enroll potential eligible individuals into Medi-Cal. Through the CMAA program, DHCS and individual county agencies promote access to health care for clients in the county public health system, minimizing both health care costs and long-term health care needs for at risk populations, and coordinating clients' health care needs with other providers. Reimbursable CMAA activities include, but are not limited to, conducting Medi-Cal outreach, facilitating Medi-Cal eligibility determinations, Medi-Cal program planning, and Medi-Cal contract administration.

A "claiming unit" is defined as a part of an LGA, such as a public agency, or is a private CBO contracted by an LGA to perform CMAA whose costs are identifiable as a separate budget unit. Therefore, reimbursements for CMAA are based on certified public expenditures for the provision of MAA as disclosed in the claiming units' quarterly invoice. Each LGA determines the number of claiming units participating in CMAA.

NOTE: For the purpose of this document "claiming units" will be referred to as budget units.

2. The TCM Program within the County Structure of California

LGAs participating in the TCM program are eligible to receive federal reimbursement for the cost of providing services that directly support services covered under the State Medicaid Plan. LGAs provide TCM to Medi-Cal eligible individuals in California. The TCM program helps ensure the changing needs of Medi-Cal eligible individuals are addressed on an ongoing basis and appropriate choices are provided among the widest array of options for meeting those needs. Reimbursable TCM services are provided to Medi-Cal eligible clients in designated targeted populations. The TCM service components and procedures for constructing an appropriate process for claiming federal reimbursement are specified in the California State Medicaid Plan.

Reimbursements for TCM are based on the public expenditures for the provision of TCM as disclosed in the LGA's annual TCM cost report. This report may include costs for multiple participating budget units. The number of participating staff in a TCM budget unit may range from less than 5 to over 100 staff. TCM budget units may also participate in CMAA, with some staff participating in both programs. Claims for TCM are paid using the unit-of-service, or encounter rate, established through the annual TCM cost report. LGAs make a combined claim for TCM services provided within each quarter for all budget units.

The TCM cost report identifies costs for providing TCM to all clients, not just those who are Medi-Cal eligible. These costs are divided by the number of encounters provided to all clients to establish a per-encounter rate. However, reimbursement at this rate is only made for services provided to Medi-Cal clients. Consequently, all TCM reimbursement codes are identified as 'Total Medi-Cal' rather than 'Partial Medi-Cal'.

C. Federal Reimbursement for Medi-Cal Program Expenditures

Since Medi-Cal is a federal "reimbursement" program and not a federal "matching" or "grant" program, LGAs that meet Medi-Cal program requirements and claim qualified expenditures associated with the administration and provision of services for the Medi-Cal program may be eligible to receive reimbursement from the federal government for a portion of the expenditures.

1. Federal Financial Participation (FFP)

The reimbursement LGAs receive for their Medi-Cal program expenditures is known as Federal Financial Participation (FFP). Section 433.51 of Title 42 of the Code of Federal Regulations (CFR) provides that the amount expended for providing medical assistance must be ". . . certified by the contributing public agency as representing expenditures eligible for FFP".

Section 1903(a) of Title XIX of the Social Security Act also provides language indicating states may receive an enhancement to the FFP.

Section 1903(a)(2) of the Act specifically indicates federal matching at 75 percent is attributable to the compensation and/or training of skilled professional medical personnel (SPMP), and staff directly supporting such personnel of the State agency or any other public agency.

For example, when the amounts expended for providing medical assistance "are attributable to the compensation or training of skilled professional medical personnel (SPMP), and staff directly supporting such personnel", the FFP rate shall be 75 percent. Therefore, the FFP rate for an LGA claim with eligible and certified Medi-Cal expenditures performed by an SPMP, or staff directly supporting an SPMP, in the amount of $100 would be $75 ($100 x .75 = $75).

Per 42 CFR, Chapter IV, Section 432.50, in order for the enhanced matching rate of 75 percent to be available for expenditures for salary or other compensation, fringe benefits, travel, per diem, and training for SPMPs, or staff directly supporting such personnel, the following requirements must be met:

- The activities performed by the SPMP, or staff directly supporting such personnel, must be necessary for the proper and efficient administration of the State plan and must not include expenditures for medical assistance.
- The staff designated as SPMP must have completed a two year program leading to an academic degree or certificate in a medically related program or have professional education and training in the field of medical care or an appropriate medical practice.
- The activities performed by the SPMP must require the use of their professional medical knowledge, training, and/or expertise.
- The directly supporting staff are secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that are directly necessary for the completion of the professional medical responsibilities and functions of the skilled professional medical staff. The skilled professional

medical staff must directly supervise the supporting staff and the performance of the supporting staff's work.

- The SPMP, and staff directly supporting such personnel, must have a documented employer-employee relationship with the State Medicaid agency (SMA).

- The public agency must have a written agreement with the Medicaid agency to verify that the requirements listed above are met.

All LGA contracts with DHCS and LGA contracts with the budget/claiming units include only those activities approved by CMS as necessary for the proper and efficient administration of the State plan. Details of SPMP qualifications, the SPMP activities performed, proof of SPMP supporting staff relationships, and assurances of an appropriate employer-employee relationship between DHCS and the LGA and/or budget/claiming unit level staff (indicating when, where, and how the LGA and/or budget/claiming unit staff work) are contained in the claiming plan documents that must be submitted to, and approved by, DHCS before the LGA and/or budget/claiming unit may begin submitting claims for reimbursement. The LGA and/or budget/claiming unit contracts and claiming plan documents are described in detail in forthcoming sections of this document.

2. Federal Medical Assistance Percentage (FMAP)

The FFP amount, or 'rate', an LGA receives is dependent on California's Federal Medical Assistance Percentage (FMAP). Section 1903(a) of Title XIX of the Social Security Act provides, in part, that the Federal Government shall pay to the State a percentage "of the total amount expended" for providing medical assistance. The current FMAP rate for the state of California is 50 percent; therefore, the FFP rate for an LGA claim with eligible and certified Medi-Cal expenditures in the amount of $100 would be $50 ($100 x .50 = $50).

3. Certified Public Expenditures (CPE)

In order to meet CPE requirements and receive federal financial participation (FFP), LGAs must obtain and maintain supporting documentation verifying:

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

The contributing public agency must certify to their allowable expenditures for the actual costs of providing services and/or activities. CBOs may not utilize their private funds or certify costs. CBOs may only utilize allowable CPE contributed by a Public Agency for the actual costs related to Medi-Cal eligible services and/or activities. If an LGA has a question regarding eligible CPE or actual costs at the claiming unit or CBO level, they should contact DHCS.

4. Non-Duplication of FFP

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

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

In addition, claims for reimbursement of any Medi-Cal program activity that is provided as part of, or an extension of, a direct medical service is not claimable in either program. For example, medical professionals may not report time to Outreach or Referral, Coordination, and Monitoring when performing a direct medical service. Under certain circumstances, for CMAA, clinic schedules and/or other documentation must be retained in the audit file to indicate time spent both in a clinical environment and outside a clinical environment. A log will be used to track the participants who receive CMAA, the CMAA performed, and the initials of the worker providing the CMAA in a clinical setting. A sample CMAA Clinician Log with instructions is included with this implementation plan proposal as **Appendix A**.

5. FFP Exclusions

Per Section 1905(a) of the Social Security Act and 42 CFR 435.1009, when a person is an inmate of a public institution, FFP is not available until the inmate is about to be released from the public institution. However, FFP may be available under certain specific circumstances. Providing Medi-Cal eligibility intake administrative activities to an inmate to facilitate their enrollment into Medi-Cal within thirty (30) days of their release date is exempt from the FFP exclusion; although, no other administrative activities or direct Medi-Cal services are allowable for inmates of public institutions. This activity is “proper and efficient for the administration of the State Plan.”

In each circumstance, claims for FFP reimbursement must comply with the policies and procedures of the FFP program. Any claims that are not in compliance will be denied. Once the inmate is released from the State institution, Medi-Cal program activities or services can be performed and the exclusion described above no longer applies.

6. Application of FFP Rate

a. CMAA

i. Basic Rate: 50 percent

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

ii. Enhanced Rate: 75 percent

Refers to an administrative activity that is allowable under the Medi-Cal program, is performed by a staff member qualified as a Skilled Professional Medical Personnel (SPMP) or staff directly supporting an SPMP, and is claimable at the 75 percent FFP rate.

b. TCM

i. FMAP:

The FFP is determined by multiplying the total cost of TCM services by California's FMAP for the applicable claiming period.

II. The Time Survey Methodology for the CMAA and TCM Programs

A. Allowability or Non-Allowability and Proportional Medi-Cal Share Designations

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

Total Medi-Cal - TM
Refers to an administrative activity or TCM services that is 100 percent allowable under the Medi-Cal program.

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

Reallocated Activities - R
Refers to the activities that must be reallocated across other activity codes on a proportional basis. The reallocated activities are reported under General Administration and/or Paid Time Off.

1. Activity Codes

The following table (**Table 1**) summarizes the Medi-Cal activities and/or services that are eligible or not eligible for federal reimbursement, the application of the FFP rate, the allowability or non-allowability designation, and the proportional Medi-Cal share (detailed explanations of the information in **Table 1** are included subsequent to the table).

Table 1

Activity Code	Activity Description	FFP Rate
1	Other Programs/Activities***	U
2	Direct Patient Care***	U
3	Outreach to Non Medi-Cal Programs	U
4	Medi-Cal Outreach*	TM
5	Referral, Coordination, and Monitoring of Non Medi-Cal Services	U
6	Referral, Coordination, and Monitoring of Medi-Cal Services*	PM
7	Facilitating Non Medi-Cal Application	U
8	Facilitating Medi-Cal Application*	TM
9	Arranging and/or Providing Non-Emergency, Non-Medical Transportation to a Non Medi-Cal covered Service	U
10	Arranging and/or Providing Non-Emergency, Non-Medical Transportation to a Medi-Cal covered Service*	PM
11	Contract Administration for Non Medi-Cal Services	U
12	Contract Administration (A) for Medi-Cal Services specific for Medi-Cal populations*	TM
13	Contract Administration (B) for Medi-Cal services specific for Medi-Cal and Non Medi-Cal populations*	PM
14	Program Planning and Policy Development for Non Medi-Cal Services	U
15	Program Planning and Policy Development (A) (Non-Enhanced) for Medi-Cal services for Medi-Cal clients*	TM
16	Program Planning and Policy Development Skilled Professional Medical Personnel (SPMP) (A) (Enhanced) for Medi-Cal services for Medi-Cal clients*	TM
17	Program Planning and Policy Development (B) (Non- Enhanced) for Medi-Cal services for Medi-Cal and Non Medi-Cal clients *	PM
18	Program Planning and Policy Development (SPMP) (B) (Enhanced) for Medi-Cal services for Medi-Cal and Non Medi-Cal clients*	PM
19	MAA/TCM Coordination and Claims Administration*	TM
20	MAA/TCM Implementation Training*	TM
21	General Administration***	R
22	Paid Time Off (PTO)***	R
23	Non-Targeted Case Management	U
24	Providing TCM Service Components**	TM
25	TCM Encounter –Related Activities**	TM
26	Travel Related to Providing TCM**	TM
27	Supervision of Case Managers**	TM
28	Encounter Entry into TCM On-Line System**	TM
29	TCM Data Systems and Claiming Coordination**	TM
30	TCM Quality Assurance/Performance Monitoring**	TM
31	TCM Subcontract Administration**	TM
32	TCM Program Planning and Policy Development**	TM

*Reimbursable to CMAA only.

**Reimbursable to TCM only.

***Common to both CMAA and TCM.

2. Activity Code Descriptions and Examples

The following activity code descriptions and examples outline the specific activities and/or services related to the proper administration of the Medi-Cal program that are eligible for federal reimbursement. However, if any activity listed below is provided as part of, or as an extension of, a direct medical service, it may not be claimed as MAA or TCM.

Code 1 – Other Programs/Activities - U

Description: Other Programs/Activities means providing a service that is not medical or Medi-Cal related, including non Medi-Cal health and wellness activities, social services, educational services, teaching services, employment and job training.

Examples:

Providing or administering Education Programs or a Lead Poisoning Prevention Program, etc.

Educating individuals about the benefits of healthy lifestyles and practices.

Placing clients into a licensed community care setting.

Providing or administering MAA to an inmate in a public institution. (Excluding public institutions designated as medical institutions, such as an Institutions for Mental Diseases).

Providing Case Management services to an inmate incarcerated in a local jail.

Performing School Based service activities; such as conducting, attending, or participating in an IEP meeting that is focused on improving the educational opportunities for one specific child.

Code 2 – Direct Patient Care - U

Description: Direct Patient Care includes providing direct care, treatment, and/or counseling services to an individual. This code also includes administrative activities that are an integral part of or extension of a medical service.

Examples:

Providing Medical exams and medical or mental health diagnosis, etc.

Counseling a client on his/her substance abuse issues.

Providing medical/dental/mental health/chemical dependency counseling treatment services.

Providing speech, occupational, physical, and other therapies.

Providing clinical nursing services covered by Medi-Cal.

Providing a referral to a specialist during a physical exam.

Time spent updating patient records related to direct patient care.

Code 3 – Outreach to Non Medi-Cal Programs - U

Description: Outreach to Non Medi-Cal programs includes general preventive health education programs or campaigns addressed to lifestyle changes in the general population. This also includes outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medi-Cal.

Examples:

Providing information regarding the Women, Infants, and Children (WIC) program at the health fair.

Informing families about wellness programs and how to access these programs.

Scheduling and promoting activities that educate individuals about the benefits of healthy lifestyles and healthy practices.

Overseeing the creation of the non-Medi-Cal portion of a general outreach campaign.

Code 4 – Medi-Cal Outreach - TM

Description: Outreach may consist of discrete campaigns or may be an ongoing activity, such as: sending teams of employees into the community to contact homeless alcoholics or drug abusers; establishing a telephone or walk-in service for referring persons to Medi-Cal services or eligibility offices; operating a drop-in community center for underserved populations, such as minority teenagers, where Medi-Cal eligibility and service information is disseminated.

The only allowable Medi-Cal Outreach for purposes of Medi-Cal administrative claiming is to groups or individuals targeted to two goals:

- Bringing potential eligible into the Medi-Cal system for the purpose of determining Medi-Cal eligibility; and
- Bringing Medi-Cal eligible people into Medi-Cal services.

Examples:

Providing information to Medi-Cal eligible people about Medi-Cal covered services at a health fair.

Informing Medi-Cal-eligible and potential Medi-Cal-eligible children and families about the benefits and availability of services provided by Medi-Cal (including preventive treatment and screenings), including services provided through the EPSDT program.

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

Informing individuals or the general public about the benefits and services that the Medi-Cal program offers and encouraging and referring them to apply for Medi-Cal benefits.

Providing initial referral assistance to families to Medi-Cal services.

Code 5 – Referral, Coordination, and Monitoring of Non Medi-Cal Services - U

Description: Referral, Coordination, and Monitoring of Non Medi-Cal Services includes making referrals for, coordinating, and/or monitoring the delivery of non-medical activities or medical services not covered by Medi-Cal. This also includes non-medical case management for social, educational, or vocational needs that are not part of a separately reimbursed comprehensive TCM program.

Example:

Making referrals for, coordinating, and/or monitoring the delivery of State-education-agency-mandated child health screens (vision, hearing, and scoliosis).

Code 6 – Referral, Coordination, and Monitoring of Medi-Cal Services - PM

Description: Referral, Coordination, and Monitoring of Medi-Cal Services includes making referrals for, coordinating, and/or monitoring the delivery of Medi-Cal covered services.

Examples:

A Public Health Nurse making a client referral to a local public, mental health provider.

Referring adolescents who may be in need of Medi-Cal family planning services.

Making referrals and/or coordinating medical or physical examinations for necessary medical/dental/mental health evaluations.

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

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

Code 7 – Facilitating Non Medi-Cal Application - U

Description: Facilitating Non Medi-Cal Application activities include informing an individual(s) about programs such as Temporary Assistance for Needy Families (TANF), Food Stamps, WIC, legal, and other social or educational programs and referring them to the appropriate agency to make application.

Examples:

Assisting a client to complete the food stamp eligibility application.

Explaining the eligibility process for non Medi-Cal programs.

Providing and/or packaging all necessary forms in preparation for the non Medi-Cal eligibility determination.

Code 8 – Facilitating Medi-Cal Application - TM

Description: Facilitating Medi-Cal Application includes the following tasks separately or in combination:

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

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

Examples:

Assisting a client to complete the Medi-Cal eligibility application.

Verifying a client's Medi-Cal status.

Explaining Medi-Cal eligibility rules and the eligibility process to clients and their families.

Providing all forms and packaging the forms in preparation for the Medi-Cal determination process.

Code 9 – Arranging and/or providing Non-Emergency, Non-Medical Transportation to a Non-Medi-Cal Covered Service - U

Description: Arranging and/or providing Non-Emergency, Non-Medical Transportation to a Non Medi-Cal Covered Service includes assisting an individual to obtain transportation to services not covered by Medi-Cal and/or accompanying the individual to services not covered by Medi-Cal.

Examples:

Arranging and/or providing transportation for individuals to visit a community center.

Providing transportation to a diabetes luncheon, sobriety camp, swimming program, gym, or court hearing, etc...

Code 10 – Arranging and/or providing Non-Emergency, Non-Medical Transportation to a Medi-Cal Covered Service - PM

Description: Arranging and/or providing non-emergency, non-medical transportation for a Medi-Cal eligible client who does not have a physical or mental limitation to a Medi-Cal provider for a Medi-Cal covered service when medically necessary. Arranging and/or providing non-emergency, non-medical transportation and accompaniment by an attendant, for a Medi-Cal eligible client who has a physical or mental limitation to a Medi-Cal provider for a Medi-Cal covered service when medically necessary. If the Medi-Cal eligible client does not have a physical or mental limitation, the contractor or governmental unit may provide transportation services, but is unable to accompany the client to the Medi-Cal covered service appointment. However, **LGAs may not claim arranging transportation as CMAA when performed by a TCM Case Manager.** The cost of this time will be included in the TCM encounter rate and is not claimable separately through MAA (MAC Agreement, page 23).

NOTE: The term "non-medical" transportation does not refer to the type of vehicle used, but to the condition of the transportation recipient. As stated in "California's Title XIX State Plan for Assurance of Transportation," non-medical transportation indicates that the "recipient does not qualify for medical transportation." Nonetheless, the State is obligated to "assure access to Medi-Cal services for Medi-Cal eligibles" and may, therefore, claim the cost of non-emergency, non-medical transportation (MAC Agreement, Attachment 5, page 3).

Examples:

Providing transportation services to a Medi-Cal eligible individual to a Medi-Cal service provider.

Scheduling or arranging transportation to Medi-Cal covered services.

Accompanying clients (elderly, young, disabled) at a Medi-Cal provider medical appointment because the client has physical limitations, pursuant to 42 CFR part 440.170.

Code 11 – Contract Administration for Non Medi-Cal Services - U

Description: Contract Administration for Non Medi-Cal Services involves entering into contracts with CBOs or other provider agencies for the provision of non Medi-Cal services.

Example:

Administering a contract with a service provider to install security alarms within the building.

Code 12 – Contract Administration (A) for Medi-Cal Services Specific for Medi-Cal Populations - TM

Description. Contract Administration (A) for Medi-Cal Services Specific for Medi-Cal Populations involves entering into contracts with CBOs or other provider agencies for the provision of Medi-Cal services and/or CMAA, other than TCM. The costs of TCM subcontractor administration should be included in the TCM rate.

Contracting for Medi-Cal services and/or MAA is only claimable as CMAA under this activity when the administration of those contracts meets all of the following criteria:

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

Examples:

Administering a contract with a service provider to serve only Medi-Cal eligibles.

Monitoring and oversight of a service provider contract that serves only Medi-Cal eligibles.

Code 13 – Contract Administration (B) for Medi-Cal Services Specific for Medi-Cal and Non Medi-Cal Populations - PM

Description: Contract Administration (B) for Medi-Cal Services Specific for Medi-Cal and Non Medi-Cal Populations involves entering into contracts with CBOs or other provider agencies for the provision of Medi-Cal services and/or CMAA.

Example:

Administering a contract with a community service agency that serves both Medi-Cal and non-Medi-Cal eligibles.

Code 14 – Program Planning and Policy Development for Non Medi-Cal Services - U

Description: Program Planning and Policy Development for Non Medi-Cal Services includes time associated with developing strategies to improve the delivery of non-Medi-Cal services.

Examples:

Developing strategies for expanding the CalWORKs program.

Identifying gaps or duplication of other non-medical services (e.g., social, vocational, and educational programs) to clients and their families, and developing strategies to improve the delivery and coordination of these services.

Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services.

Code 15 – Program Planning and Policy Development (A) (Non-Enhanced) for Medi-Cal Services for Medi-Cal Clients - TM

Description: Program Planning and Policy Development (A) (Non-Enhanced) for Medi-Cal Services for Medi-Cal Clients includes time spent developing strategies to increase Medi-Cal system capacity and close Medi-Cal service gaps; including analyzing Medi-Cal data related to a specific Medi-Cal program or a specific Medi-Cal eligible group, interagency coordination to improve delivery of Medi-Cal services, or developing resource directories of Medi-Cal services/providers. In counties with county wide managed care arrangements, program planning and policy development activities are claimable as Medi-Cal administration only for those services which are excluded from the managed care contracts. (MAC agreement, Section III, Administrative Claiming Process, page 25).

Examples:

Analyzing Medi-Cal data for planning purposes to close Medi-Cal service gaps for Medi-Cal clients.

Identifying gaps or duplication of medical/dental/mental health/chemical dependency counseling services provided to Medi-Cal clients and developing strategies to improve the delivery and coordination of these services to Medi-Cal clients.

Developing strategies to assess or increase the capacity of medical/dental/mental health/chemical dependency counseling programs to Medi-Cal clients, including planning staff training to implement strategies.

Monitoring the medical/dental/mental health/chemical dependency counseling service delivery systems specific to Medi-Cal clients.

Evaluating the need for medical/dental/mental health/chemical dependency counseling services in relation to specific Medi-Cal populations or geographic areas.

Description: Program Planning and Policy Development Skilled Professional Medical Personnel (SPMP) (A) (Enhanced) for Medi-Cal Services for Medi-Cal Clients includes time spent developing strategies to increase Medi-Cal system capacity and close Medi-Cal service gaps; including analyzing Medi-Cal data related to a specific Medi-Cal program or a specific Medi-Cal eligible group, interagency coordination to improve delivery of Medi-Cal services, or developing resource directories of Medi-Cal services/providers. The activity must require the professional medical knowledge and skills of an SPMP and must be performed by an SPMP or staff directly supporting the SPMP. In counties with county wide managed care arrangements, program planning and policy development activities are claimable as Medi-Cal administration only for those services which are excluded from the managed care contracts. (MAC agreement, Section III, Administrative Claiming Process, page 25).

NOTE: To be eligible for enhanced claiming, all SPMP PP&PD activities must adhere to the requirements of 42 CFR 432.50 and Section 1903(a)(2) of Title XIX of the Social Security Act (outlined in the "Federal Financial Participation (FFP)" section of this document).

Examples:

A Public Health Nurse (SPMP) attends a meeting to develop strategies for assessing and treating increased occurrences of methicillin resistant staph infections in Medi-Cal patients with the goal of disseminating the findings to other local governmental agencies.

A Licensed Clinical Social Worker (SPMP) spends time analyzing Medi-Cal data related to the county's mental health clinical practice guidelines with the intention of improving the delivery of Medi-Cal services and sharing the results with other local governmental agencies so that they may work on improving the delivery of Medi-Cal services within their own mental health clinical practice guidelines as well.

A Psychiatrist (SPMP) spends time analyzing Medi-Cal data related to the cost effectiveness of multiple drug treatments for Medi-Cal patients suffering from bipolar disorder and summarizes the data results with the goal of disseminating the findings to other local governmental agencies.

Code 17 – Program Planning and Policy Development (B) (Non-Enhanced) for Medi-Cal Services for Medi-Cal and Non Medi-Cal Clients - PM

Description: Program Planning and Policy Development (B) (Non-Enhanced) for Medi-Cal Services for Medi-Cal and Non Medi-Cal Clients includes time spent developing strategies to increase Medi-Cal system capacity and close Medi-Cal service gaps; including analyzing Medi-Cal data related to a specific program or specific group, interagency coordination to improve delivery of Medi-Cal services, or developing resource directories of Medi-Cal services/providers. In counties with county wide managed care arrangements, program planning and policy development activities are claimable as Medi-Cal administration only for those services which are excluded from the managed care contracts. (MAC agreement, Section III, Administrative Claiming Process, page 25).

Examples:

Attending a meeting with countywide agencies to coordinate health service agreements for low income families.

Performing a cost-benefit analysis on whether or not to open a new clinic in the community.

Prepare for attending a board of supervisors meeting at which the expansion and/or improvement of existing healthcare services are discussed and, potentially, voted on.

Attend/facilitate planning meetings with community partners and other agencies, which work with clients, interested in increasing access and decreasing barriers for Medi-Cal covered services.

Plan and develop resource and referral guides to be used by clients when accessing Medi-Cal covered services.

Code 18 – Program Planning and Policy Development (SPMP) (B) (Enhanced) for Medi-Cal Services for Medi-Cal and Non-Medi-Cal Clients – PM

Description: Program Planning and Policy Development (SPMP) (B) (Enhanced) for Medi-Cal Services for Medi-Cal and Non Medi-Cal Clients includes time spent developing strategies to increase Medi-Cal system capacity and close Medi-Cal service gaps; including analyzing Medi-Cal data related to a specific program or specific group, interagency coordination to improve delivery of Medi-Cal services, or developing resource directories of Medi-Cal services/providers. The activity must require the professional medical knowledge and skills of an SPMP and must be performed by an SPMP or staff directly supporting the SPMP. In counties with county wide managed care arrangements, program planning and policy development activities are claimable as Medi-Cal administration only for those services which are excluded from the managed care contracts. (MAC agreement, Section III, Administrative Claiming Process, page 25).

NOTE: To be eligible for enhanced claiming, all SPMP PP&PD activities must adhere to the requirements of 42 CFR 432.50 and Section 1903(a)(2) of Title XIX of the Social Security Act (outlined in the "Federal Financial Participation (FFP)" section of this document).

Examples:

A Nurse (SPMP) attends a planning development meeting for a new clinic that will serve a population of Medi-Cal and Non Medi-Cal eligible individuals to assist in developing strategies related to infection control with the goal of disseminating the outcomes to other local governmental agencies.

A Medical Director (SPMP) spends time analyzing the health department's physician Medi-Cal and Non Medi-Cal billing data with the intention of improving the delivery of services and sharing the results with other local governmental agencies so that they may work on improving the delivery of services within their own clinical practice as well.

A Registered Nurse (SPMP) attends an interagency meeting to discuss improving clinical protocols for Medi-Cal and Non Medi-Cal patients suffering from sexually transmitted diseases with the intention of sharing the results with other local governmental agencies so that they may work on improving clinical protocols for patients suffering from sexually transmitted diseases within their own clinics as well.

A Psychiatrist (SPMP) spends time analyzing Medi-Cal data related to the cost effectiveness of multiple drug treatments for Medi-Cal and Non Medi-Cal patients suffering from bipolar disorder and summarizes the data results with the goal of disseminating the findings to other local governmental agencies.

Code 19 – MAA/TCM Coordination and Claims Administration – TM

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

- Drafting, revising, and submitting MAA claiming plans, TCM cost reports, and performance monitoring plans.
- Serving as liaison to claiming units within the LGA and with the State and Federal Governments on MAA/TCM to monitor the performance of claiming units.
- Administering LGA claiming, including overseeing, preparing, compiling, revising, and submitting MAA/TCM claims on an LGA-wide basis to the State.
- Attending training sessions, meetings, and conferences involving MAA/TCM.
- Training LGA program and subcontractor staff on State, federal, and local requirements for MAA/TCM claiming.
- Ensuring that MAA/TCM claims do not duplicate Medi-Cal claims for the same activities from other providers. This includes ensuring there is no duplication of services when a Medi-Cal beneficiary receives TCM services from more than one case manager.

Examples:

Reviewing time survey results to ensure accurate claiming.

Drafting, revising, and submitting MAA claiming plan documents.

Serving as liaison to claiming units in the LGA to ensure accurate claiming.

Ensuring there are no duplicate claims for the same activities from other providers.

Monitoring subcontractor capacity and availability.

Code 20 – MAA/TCM Implementation Training - TM

Description: MAA/TCM Implementation Training includes time spent providing or attending training related to the performance of MAA or TCM. Reasonable time spent on related paperwork, clerical activities, staff travel time necessary to perform these activities including initiating and responding to email and voicemail.

Examples:

Participating in the MAA/TCM Time Survey Training.

Providing MAA/TCM Time Survey Training.

Code 21 – General Administration - R

Description: General Administration relates to the activities of being an employee, but not tasks performed for a specific program. These activities include, but are not limited to, attending or conducting general, non-medical staff meetings, developing and monitoring program budgets and/or site management, and general non-program supervision of staff. This also includes staff break time and any time spent filling out a Time Survey Form.

Examples:

Attending general meetings, breaks, training, etc. unrelated to MAA/ TCM or other programs, e.g. WIC.

Developing and monitoring a program budget.

Providing instructional leadership, site management, or participating in employee performance review.

Reviewing departmental or unit procedures and rules.

The 15 minutes that a time survey participant spent filling out the Time Survey Form at the end of the work day.

Code 22 – Paid Time Off - R

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

Example:

Vacation, sick leave, paid holiday time, paid jury duty, and any other paid employee time off.

Code 23 – Non-Targeted Case Management - U

Description: Non-Targeted Case Management includes time spent providing or supporting case management services to clients that do not meet the definition of the TCM targeted population.

Example:

Providing a referral to needed medical services for a Multipurpose Senior Services Program client.

Code 24 – Providing Targeted Case Management (TCM) Service Components - TM

Description: TCM service components are defined as services furnished to assist individuals, eligible under a specific targeted population, to gain access to needed medical, social, educational, and other services. TCM service components must be performed as face-to-face contact with the beneficiary. The service components are:

- Comprehensive assessment and periodic reassessment of an individual's needs.
- Development (and periodic revision) of a specific care plan.
- Referral and related activities.
- Monitoring and follow-up activities.

When provided to clients who are members of Medi-Cal Managed Care health plans, this activity is claimable only when within the scope of TCM's defined role in the CMS-approved managed care health plan/LGA TCM coordination protocols.

Case management services do not include activities that are an essential part of Medicaid administration such as outreach, intake processing, or eligibility determination.

***Examples*:**

Case Manager takes a client history to develop a comprehensive assessment.

Case Manager develops a care plan to address the client's assessed needs.

Case Manager arranges client transportation and appointments.

Case manager arranges translation activities and/or providing translation as part of a TCM service.

Case manager follows-up on a referral to the food bank, as identified as a need, in the client's comprehensive needs assessment.

Code: 25 - TCM Encounter-Related Activities - TM

Description: TCM encounter – related activities include time spent performing tasks that directly support TCM face-to-face encounters for Medi-Cal and Non-Medi-Cal clients before, during, and after the encounter.

When supporting encounter-related activities for clients who are members of Medi-Cal Managed Care health plans, this activity is claimable only when the encounter-related activity supports the scope of TCM's defined role in the CMS-approved managed care health plan/LGA TCM coordination protocols.

***Examples*:**

Staffing cases through team meetings and interagency coordination time.

Making an appointment for a face-to-face visit with a TCM client.

Preparing and documenting case records.

Case manager non-SPMP training.

Code 26: Travel Related to Providing TCM - TM

Description: Staff travel time to provide TCM services and any TCM related activities to a TCM eligible recipient. However, only the proportionate time spent on TCM services and TCM related activities at a specific location are applicable to travel.

***Example*:**

A Case Manager drives to and from client's home for a face-to-face encounter at a clients home, 50% of the case manager time was spent on TCM related activities and 50% on client education. Only 50% of the case manager travel time can be coded to Code 26. Therefore, the other 50% should be coded to other codes as applicable.

Code 27: Supervision of Case Managers - TM

Description: Supervision of case managers in the performance of TCM related services.

When supervising the provision of TCM for clients who are members of Medi-Cal Managed Care health plans, this activity is claimable only when the service supervised is within the scope of TCM's defined role in the CMS-approved managed care health plan/LGA TCM coordination protocols.

***Example*:**

A case manager's supervisor reviews the client's goals and needs assessment and care plan to ensure appropriate actions are taken to meet the client's goals and needs.

Code 28: Encounter Entry into TCM On-Line System - TM

Description: TCM service provider entry of encounters into the TCM On-Line System from the Encounter Logs.

***Examples*:**

Maintenance of Encounter Log(s) and related encounter activities.

Entry of Medi-Cal data from the Encounter Log into the TCM data collection system.

Code 29: TCM Data Systems and Claiming Coordination - TM

Description: Review of all of the Medi-Cal data submitted by the TCM service provider. This includes validation of summary invoice before submission to DHCS for reimbursement. This activity cannot be performed by a Case Manager.

***Examples*:**

Reconciliation of TCM Medi-Cal encounter claims reported as rejected by the State.

Maintaining and analyzing Medi-Cal TCM management information systems.

Preparing, reviewing, and revising TCM claims.

Code 30: TCM Quality Assurance/Performance Monitoring - TM

Description: TCM provider monitors Medi-Cal services providers to insure quality, capacity, and availability of services. TCM provider develops and maintains a TCM Performance Monitoring Plan to prevent countywide duplication of services. This activity cannot be performed by a Case Manager.

In LGAs with county-wide managed care arrangements, TCM quality assurance provider monitoring activities are claimable only when related to the case management services that are within the scope of TCM's defined role in the CMS-approved managed care health plan/LGA TCM coordination protocols.

***Examples*:**

TCM case documentation compliance.

TCM 'free care' and TPL compliance.

Preventing duplication of services and ensuring continuity of care when a Medi-Cal recipient receives services from two or more programs.

Monitoring Medi-Cal TCM provider agency capacity and availability.

Code 31: TCM Subcontract Administration - TM

Description: Administering subcontracts for TCM providers of services. This activity cannot be performed by a Case Manager.

***Examples*:**

Identify and recruit community agencies as TCM contract providers.

Develop and negotiate TCM provider subcontractor performance to ensure appropriate delivery of TCM services to eligible beneficiaries.

Monitor TCM provider subcontracts to ensure compliance with Medi-Cal regulations.

Provide technical assistance to TCM subcontractors regarding county, federal, and State regulations.

Code 32: TCM Program Planning and Policy Development - TM

Description: Program Planning and Policy Development for TCM services for Medi-Cal and Non Medi-Cal clients includes time spent developing strategies to increase TCM services to capacity and close gaps in resources.

In LGAs with county-wide managed care arrangements, TCM program planning and policy development activities are claimable only for those case management services that are within the scope of TCM's defined role in the CMS-approved managed care health plan/LGA TCM coordination protocols.

***Examples*:**

Planning to increase TCM system capacity and close gaps.

Interagency coordination to improve TCM service delivery.

Developing policies and protocols for TCM.

Developing TCM resource directories.

B. Accounting for the Time Spent Performing Medi-Cal Program Eligible Activities and/or Services

LGAs are eligible to receive federal reimbursement for the specific salary, benefit, and non-salary costs of the staff that spend time providing Medi-Cal program activities and/or services related to the proper administration of the Medi-Cal program. However, the amount of federal reimbursement an LGA may receive must be directly proportional to the amount of time qualified staff members spend performing Medi-Cal program eligible activities and/or services. LGAs can account for the amount of time qualified staff members spent performing Medi-Cal program eligible activities and/or services using the Worker Log Time Survey Methodology or via direct charging.

1. Accurately Accounting for Medi-Cal Program Eligible Time versus Non Medi-Cal Program Eligible Time

The time survey must capture 100 percent of the activities and/or services performed by the time survey participant during the designated time survey period. “Parallel” activity codes have been established to distinguish the Medi-Cal program eligible activities and/or services from the Non Medi-Cal program eligible activities and/or services. This parallel coding captures 100 percent of the participating staff member’s work time and ensures that both the Medi-Cal program eligible time and Non Medi-Cal program eligible time is accurately accounted for and allocated to the appropriate program (2003 CMS Medicaid School-Based Administrative Claiming Guide, page 9). The parallel and non-parallel codes for the CMAA and TCM programs are provided in the tables (**Table 2** and **Table 3**) below.

Table 2

Parallel Codes	
Non-Reimbursable	**Reimbursable**
Code 3 Outreach for Non Medi-Cal Programs	Code 4 Medi-Cal Outreach
Code 5 Referral, Coordination, and Monitoring of Non Medi-Cal Services	Code 6 Referral, Coordination, and Monitoring of Medi-Cal Services
Code 7 Facilitating Non Medi-Cal Application	Code 8 Facilitating Medi-Cal Application
Code 9 Arranging and/or Providing Non-Emergency, Non-Medical Transportation to a Non Medi-Cal Covered Service	Code 10 Arranging and/or Providing Non-Emergency, Non-Medical Transportation to a Medi-Cal covered Service
Code 11 Contract Administration for Non Medi-Cal Services	Code 12 Contract Administration (A) for Medi-Cal Services Specific for Medi-Cal Populations Code 13 Contract Administration (B) for Medi-Cal Services Specific for Medi-Cal and Non Medi-Cal Populations
Code 14 Program Planning and Policy Development for Non Medi-Cal Services	Code 15 Program Planning and Policy Development (A) (Non-Enhanced) for Medi-Cal Services for Medi-Cal Clients Code 16 Program Planning and Policy Development Skilled Professional Medical Personnel (SPMP) (A) (Enhanced) for Medi-Cal Services for Medi-Cal Clients Code 17 Program Planning and Policy Development (B) (Non-Enhanced) for Medi-Cal Services for Medi-Cal and Non-Medi-Cal Clients Code 18 Program Planning and Policy Development (SPMP) (B) (Enhanced) for Medi-Cal Services for Medi-Cal and Non-Medi-Cal Clients
Code 23 Non-Targeted Case Management	Code 24 Providing TCM Service Components Code 25 TCM Encounter –Related Activities Code 26 Travel Related to Providing TCM Code 27 Supervision of Case Managers Code 28 Encounter Entry into TCM On-Line System Code 29 TCM Data Systems and Claiming Coordination Code 30 TCM Quality Assurance/Performance Monitoring Code 31 TCM Subcontract Administration Code 32 TCM Program Planning and Policy Development

Table 3

Non-Parallel Codes
Code 1 (Non-Reimbursable) Other Programs/ Activities
Code 2 (Non-Reimbursable) Direct Patient Care
Code 19 (Reimbursable) MAA/TCM Coordination and Claims Administration
Code 20 (Reimbursable) MAA/TCM Implementation Training
Code 21 (Reallocated) General Administration
Code 22 (Reallocated) Paid Time Off

C. Implementing a Statistically Valid Time Survey Methodology

To ensure LGAs can accurately account for the amount of time a qualified staff member spends performing Medi-Cal program eligible activities and/or services, CMS has mandated that California must implement a statistically valid time survey methodology that is in compliance with OMB Circular A-87, as required by the MAC agreement. California's 'Worker Log Time Survey' methodology includes provisions for qualified staff members who will track their time on a perpetual or daily basis or for qualified staff members who will track their time within a specific statistically valid sample size.

1. California's 'Worker Log Time Survey' Methodology

To accommodate the CMS mandate to implement a statistically valid time survey methodology, California is employing a 'Worker Log Time Survey' methodology. The Worker Log Time Survey methodology includes processes and procedures for determining the percentage of time a staff member spends performing allowable Medi-Cal eligible services and/or activities against the amount of time a staff member spends performing unallowable activities. The staff time spent performing certain activities, such as General Administration or Paid Time Off, is proportionately reallocated to all other activity codes so that all activities encompass the proportionate share of the General Administration or Paid Time Off.

The data collected through the Worker Log Time Survey methodology also provides a basis for allocating salaries and benefit costs. The statistical results of the Worker Log Time Survey methodology demonstrate a true and accurate representation of the costs and subsequent staff time spent performing Medi-Cal eligible services and/or activities that are allowable and reimbursable through the Medi-Cal program. A sample Worker Log Time Survey form is included as **Appendix B**.

a. Direct Charging for MAA

Some LGAs may employ the method of 'Direct Charging' to report MAA costs for staff that perform Medi-Cal eligible activities either 100 percent of the time or in distinct and documented blocks of time. Staff who perform Medi-Cal eligible activities either 100 percent of the time or in distinct blocks of time must document the time spent on these activities in a log and must complete a "Staff Certification of Direct Charge Time" (**Appendix N**) to certify that the percentage of claimable direct charge time is accurate, true, and correct. LGAs may also utilize the staff classification and payroll coding documents to verify the reimbursable costs for staff that perform Medi-Cal eligible services and/or activities 100 percent of the time.

Direct charging is also permitted for non-salary and/or overhead costs associated with MAA specific reimbursable activities (designated as 'non-salary costs'); such as, travel, training, printing, computer, or other equipment costs. LGA's must provide supporting documentation to substantiate any non-salary and/or overhead direct charges.

2. The Worker Log Time Survey within the CMAA and TCM Programs

LGA budget units that elect to participate in the CMAA and/or TCM programs are required to conduct time surveys to account for staff time spent performing Medi-Cal and non Medi-Cal eligible services and/or activities. The time survey results are used in the determination of allowable Medi-Cal costs. In the event the LGA budget unit subcontracts, the LGA budget unit must ensure that the local public entities, MAA CBOs, or any other MAA subcontractors adopt and apply the processes and procedures of the Worker Log Time Survey to account for the costs and subsequent staff time spent performing Medi-Cal eligible services and/or activities. The CMAA claiming units use the Worker Log Time Survey results to prepare quarterly invoices; whereas, the TCM budget units use the Worker Log Time Survey results to allocate costs between TCM and non-TCM services and/or activities on their annual TCM cost reports.

TCM non-governmental contract providers will follow the guidance provided in the CMS approved "Allowable Models for LGA Subcontracts for TCM Services" methodology, as applicable (per the TCM Cost Report State Plan Amendment (SPA) 10-010).

a. MAA Worker Log Time Survey Participant Eligibility Information

Prior to each claiming period, the LGA must identify all eligible MAA staff classifications within each budget unit that contribute to the cost and subsequent staff time spent performing Medi-Cal eligible activities. To establish and confirm participant eligibility, the LGA must:

- Identify each staff classification that performs the Medi-Cal eligible activities,
- Ensure the staff classification duty statement reflects all of the Medi-Cal eligible activities performed,
- Ensure that participating staff within that classification will perform the Medi-Cal eligible activities during the claiming period, and
- Establish a list of eligible participating staff classifications for each claiming period and submit it to DHCS prior to the start of the claiming period.

Staff who meet the requirements above and are present for a portion of the claiming period are eligible for inclusion in the universe of eligible participants to the extent they were present during the claiming period. Staff who do not meet the MAA participant eligibility requirements or do not contribute to the cost and subsequent time spent performing Medi-Cal eligible services and/or activities must be excluded from the universe of eligible participants (for example, employees who do not work during an entire claiming period). Also, once the list of eligible participant staff classifications is established, the LGA may not amend, revise, or change the list at any time during the claiming period.

b. TCM Worker Log Time Survey Participant Eligibility Information

For TCM, all case managers, supervisors of case managers, and support staff to case managers must complete a time survey to account for the specific amount of time they spent performing that services and /or activity.

TCM participants who are present for a portion of the claiming period are eligible for inclusion in the universe of eligible participants to the extent they were present during the claiming period. TCM staff who do not contribute to the cost and subsequent time spent performing Medi-Cal eligible services and/or activities must be excluded from the universe of eligible participants (for example, employees who do not work during an entire claiming period).

3. Ensuring the Statistical Validity of the Worker Log Time Survey

The basic processes and procedures of the Worker Log Time Survey are consistent for all LGA budget units participating in the CMAA and/or TCM programs; however, to ensure the statistical validity of the time survey results, the number of consecutive work days each participating staff member is required to time survey varies. (For the purpose of surveying staff time using the Worker Log Time Survey, 5 consecutive work days is equivalent to one staff work week, 10 consecutive work days is equivalent to two staff work weeks, and 20 consecutive days is equivalent to four staff work weeks.)

A one-week survey of staff work time per quarter meets the minimum statistical criteria necessary to represent 100 percent of all participating workers' time if there are at least 400 participants. Therefore, to ensure the Worker Log Time Survey methodology is statistically valid and meets the 95 percent confidence level, the time survey sample size must consist of at least 400 staff work weeks per quarter. Consequently, an LGA with 400 participating staff members would be required to obtain a one-week time survey from all 400 staff members each quarter to achieve statistical validity. However, in instances where an LGA does not have 400 participating staff members, the LGA can maintain statistical integrity as long as the LGA collects 400 staff work weeks' worth of time surveys per quarter. Therefore, an LGA with 200 participating staff members would be required to obtain a two-week time survey from all 200 staff members each quarter, an LGA with 100 participating staff members would be required to obtain a four-week time survey from all 100 staff members each quarter, and an LGA with less than 100 participating staff members would be required to obtain a perpetual or 'daily' time survey from all participating staff members each quarter.

4. The Time Survey Frequency Requirements

The frequency in which a participating staff member must time survey is dependent on the total number of participating staff within each individual LGA budget unit. The following table (**Table 4**) summarizes the time survey frequency requirements depending on the number of participants in each LGA budget unit (detailed explanations of the information in **Table 4** are included subsequent to the table).

Table 4

Number of Participants in Budget Unit	Time Survey Frequency Per Quarter
1 to 99	Each Work Day
100 to 199	20 Consecutive Work Days
200 to 399	10 Consecutive Work Days
400+	5 Consecutive Work Days

Any budget unit, regardless of the number of participants, may opt to time survey on a perpetual basis instead of surveying on their required 20, 10, or 5 day minimum. LGAs have the option of requiring participants to complete the time survey more frequently as long as the minimum standards described in this section are met. However, the duration of the more frequent time survey period must be consistent with the 5 consecutive days, 10 consecutive days, 20 consecutive days, or perpetual time survey frequency. LGAs cannot utilize a time survey frequency that does not meet the standards set in this methodology.

For budget units that time survey on a perpetual basis, an employee new to the budget unit within the claiming period, may time survey after completing the required training. Upon completion of training, the participant's time and associated costs can be included in the claimable costs from the date of training forward.

For budget units that do not perpetually time survey, an employee, who is new to the budget unit within the claiming period and replaces another employee in the same position and classification (meeting the same duties), may time survey after completing the required training. Upon completion of training, the participant's time and associated costs can be included in the claimable costs from the date of training forward.

The required time survey period of a claiming unit may be increased based on a decrease in the number of staff within the claiming unit. However, the time survey frequency utilized due to the decrease in the number of staff must be determined by the number of participants required to time survey either on the first day of the claiming quarter or by the first day of the time survey period. The time survey frequency cannot be changed during the time survey period. Also, under no circumstances can an increase of new participants during the claiming period be used to decrease the time survey frequency requirements of the budget unit during that claiming period.

a. LGA Budget Units with Less than 100 Participants

LGA budget units participating in the CMAA and/or TCM programs with less than 100 total participants must complete a time survey on a perpetual or 'daily' basis. Therefore, the participants are required to complete a time survey or functional time sheet, or equivalent, every work day of each quarter to capture 100 percent of their time. A functional time sheet collects all information relative to the program claim by tracking and delineating (by function or program) an employee's work time and the amount of time the employee spends performing a specific service and/or activity on a daily basis.

It is anticipated that the majority of LGA budget units participating in the CMAA and/or TCM programs in California will have fewer than 100 participants; therefore the majority of participants will complete the time survey each working day.

b. LGA Budget Units with 100 to 199 Participants

LGA budget units participating in the CMAA and/or TCM programs with 100 to 199 participants must complete a time survey for 20 consecutive work days. Therefore, the participants are required to complete a time survey or functional time card, or equivalent, for 20 consecutive work days of each quarter to capture 100 percent of their time.

c. LGA Budget Units with 200 to 399 Participants

LGA budget units participating in the CMAA and/or TCM programs with 200 to 399 participants must complete a time survey for 10 consecutive work days. Therefore, the participants are required to complete a time survey or functional time card, or equivalent, for 10 consecutive work days of each quarter to capture 100 percent of their time.

d. LGA Budget Units with 400 or More Participants

LGA budget units participating in the CMAA and/or TCM programs with 400 or more participants must complete a time survey for 5 consecutive work days. Therefore, the participants are required to complete a time survey or functional time card, or equivalent, for 5 consecutive work days of each quarter to capture 100 percent of their time.

5. The Worker Log Time Survey Start Date

Another technique to ensure the statistical validity of the Worker Log Time Survey methodology involves standardizing the time survey start date procedures for all participating staff members within each claiming quarter. Therefore, the Worker Log Time Survey methodology ensures that all participants are given the same randomly selected time survey start date; a start date that corresponds with a Monday through Friday work day and allows each participant, regardless of frequency, to complete a comprehensive time survey within the quarter.

a. The Time Survey Timetable for LGA Budget Units with Less than 100 Participants

LGA budget units with less than 100 participants are required to complete a time survey on a perpetual or ‘daily’ basis; therefore, the time survey period will begin on the first working day of the claiming quarter and continue through to the last working day of the claiming quarter. For example, for the first claiming quarter within each fiscal year, the first day of the perpetual time survey will be on July 1 (or the first working day of the month) through September 30 (or the last working day of the month).

b. The Time Survey Start Date for LGA Budget Units with 100 or More Participants

All LGA budget units with 100 or more participants will use the same random start date. The first day of the time survey will be the same date for every participant, regardless of whether they are participating in the 20, 10, or 5 consecutive work day time survey. The start date will also provide participants with sufficient time to complete the consecutive 20, 10, or 5 work days of their time survey prior to the end of the quarter.

c. Determining the Worker Log Time Survey Random Start Date

DHCS will employ the use of a random number generator to determine the quarterly time survey start dates. However, the universe of dates eligible for selection will consist of Mondays through Fridays, excluding major holidays and the last 30 days of each quarter. Utilizing a Monday through Friday start date accounts for all potential work schedules and excluding the last 30 days allows all participants who are required to complete a 20 consecutive work day time survey time to complete the survey prior to the end of the claiming quarter.

i. Notification from DHCS to the MAA/TCM Coordinators

To ensure all time survey participants are properly notified of the random quarterly time survey start date, the Worker Log Time Survey methodology includes notification procedures and timelines for DHCS to notify the LGA CMAA and/or TCM program coordinators (MAA/TCM Coordinators) and for the MAA/TCM Coordinators to notify the participants.

DHCS will establish the random quarterly time survey start date and issue a Policy & Procedure Letter (PPL) to all participating LGAs 21 days prior to the time survey start date. The PPL will include the random time survey start date, the timeline requirements for the MAA/TCM Coordinators to provide notification to the participants, and all documentation requirements for the time survey.

ii. Notification from the MAA/TCM Coordinators to the Participants

The MAA/TCM Coordinators will notify all participants required to complete a time survey at least 5 days prior to the selected random time survey start date. The MAA/TCM Coordinators must provide the required time survey participants with the information from the DHCS PPL and any other information intended to inform them of the critical elements of the Worker Log Time Survey processes and procedures, including, but not limited to:

- the time survey start date,
- the necessary Worker Log Time Survey documents,
- a request of the participant to place a calendar reminder of their time survey start and end date, and
- a reminder to the participant to utilize the time survey start date as the first day of their specific 5, 10, or 20 consecutive work day time survey period.

To ensure prompt and efficient communication, all contact regarding the Worker Log Time Survey start date between the MAA/TCM Coordinators and the required participants will be via email or telephone.

d. The Processes and Procedures of the Worker Log Time Survey Methodology

The Worker Log Time Survey methodology consists of several guidelines, concepts, and parameters that must be applied and followed in order to yield true and accurate results and ensure statistical validity of the methodology. Any deviation or discrepancy to following the processes and procedures of the Worker Log Time Survey may adversely affect the outcome. The example (**Example 1**) and table (**Table 5**) below provide specific information regarding the application of those requirements.

i. Example 1 – The Worker Log Time Survey Frequency, Start Date, and Notification

The following example illustrates how the Worker Log Time Survey frequency, start date, and notification would be implemented for one LGA:

An LGA currently has fifty-two budget units participating in CMAA and TCM. The number of participants in each of the budget units varies greatly. For instance, the LGA has one budget unit with 400 or more participants, two budget units with 200 to 399 participants, and forty-nine budget units with less than 100 participants. (CBO budget units would only count MAA participants; whereas, TCM non-governmental contract providers will follow the guidance provided in the CMS approved "Allowable Models for LGA Subcontracts for TCM Services" methodology, as applicable (per the TCM Cost Report State Plan Amendment (SPA) 10-010)).

In the event Monday, August 15th was randomly selected as the Worker Log Time Survey start date for quarter one, on July 25th DHCS would issue a PPL providing the time survey start date and all other necessary time survey information to the LGA MAA/TCM Coordinator. On August 10th the LGA MAA/TCM Coordinator would notify all participating budget unit staff who are required to time survey of the time survey start date and provide them with any other necessary information.

On Monday, August 15th, all staff that are required to time survey would begin the time survey process. The participants in the claiming unit with 400 or more participants would begin the time survey process and continue for 5 consecutive work days. The participants in the claiming units with 200 to 399 participants would begin the time survey process and continue for 10 consecutive work days. The participants in the claiming unit with 100 to199 participants would begin the time survey process and continue for 20 consecutive work days.

However, the participants in the forty-nine LGA budget units with less than 100 participants would be required to time survey on a perpetual or 'daily' basis for the entire first quarter. Therefore, they would begin the time survey process on July 1st and time survey for each work day within the quarter until September 30th.

Table 5*

Number of Budget Unit Participants	Time Survey Frequency	Notification Date for DHCS	Notification Date for the LGA	Time Survey Start Date	Time Survey End Date
400 or more	5 Consecutive Work Days	July 25th	August 10th	August 15th	August 19th
200 to 399	10 Consecutive Work Days	July 25th	August 10th	August 15th	August 26th
100 to 199	20 Consecutive Work Days	July 25th	August 10th	August 15th	September 9th
0 to 99	Every Work Day	N/A - Perpetual	N/A - Perpetual	July 1st	September 30th

*the information included in this table assumes that the August 15th time survey start date falls on a Monday and that all of the participants have a regular Monday through Friday work week.
NOTE: For samples of the Worker Log Time Surveys reflecting the information contained in **Example 1** and **Table 5**, please see **Appendices B1, B2, B3,** and **B4**.

6. Documenting Time on the Worker Log Time Survey

Time survey participants are required to account for 100 percent of their productive and non-productive work time on the Worker Log Time Survey to differentiate the amount of time they spend performing allowable Medi-Cal eligible services and/or activities against the amount of time they spend performing unallowable services and/or activities. For example, if a participant with a 40 hour work week is required to complete a 5 day time survey and he/she worked 32 hours and took 8 hours vacation during the Worker Log Time Survey period, he/she would code all 40 hours of his/her time on the Worker Log Time Survey document.

Time is documented on the Worker Log Time Survey in 15 minute increments; therefore, the minimum amount of time a participant may log to a particular Medi-Cal eligible service and/or activity on any given day is 15 minutes. In the event a participant performs a Medi-Cal eligible service or activity for 8 minutes or more (up to 15 minutes), the participant would log 15 minutes to that Medi-Cal eligible service or activity; however, if a participant performs a Medi-Cal eligible service or activity for less than 8 total minutes for the day (0 to 7 minutes), the participant would not log any time to that Medi-Cal eligible service or activity. In the event a participant performs multiple Medi-Cal eligible services and/or activities within a 15 minute period, the participant should log time to the Medi-Cal eligible services or activity they performed for the majority of the 15 minute period (e.g., 8 minutes or more).

If a participant performs a specific Medi-Cal eligible service and/or activity throughout the day in non-consecutive increments of time, the participant may be eligible to 'roll up' the amount of time they spent performing a particular Medi-Cal eligible service and/or activity for the entire day. For example, if a participant performs a specific Medi-Cal eligible service and/or activity for 5 minutes within three separate hours of the day, the participant may 'roll up' each of those instances to account for 15 minutes of time spent performing that specific Medi-Cal eligible service and/or activity. The 'roll up' reflects a summary of the time spent performing the specific Medi-Cal eligible services and/or activities for the entire day. The option to 'roll up' time for performing a particular Medi-Cal eligible service and/or activity must only be applied to instances where the separate increments of time spent performing the Medi-Cal eligible service and/or activity are less than 8 minutes. A participant may not 'roll up' separate increments of time that have already been 'rounded up' to the 15 minute minimum.

7. The Components of a Worker Log Time Survey Document

A sample Worker Log Time Survey form is included (**Appendix B**); however, LGAs are not required to utilize this specific form. LGAs may utilize their own documents to account for time survey participant time as long as the LGA documents utilized meet the following guidelines.

- Only one participant must be identified per Worker Log Time Survey document.
- Participants are required to provide a daily account for all time spent during the Worker Log Time Survey period; however, they are not required to account for their daily activities beyond the Worker Log Time Survey period.
- All time must be recorded in 15 minute increments.
- The total number of hours a participant records on the Worker Log Time Survey document must match the total number of hours on the participant time card and budget unit payroll records.
- Participants are required to complete, sign, and date the document on the last working day of the time survey period and give the document to their supervisor.
    - Any deviation to the signature requirement must be accompanied by a documented justification.
- Participants may use an ink pen or electronic means to track time.
    - Paper Worker Log Time Survey documents must be certified with the participant's signature in BLUE ink.
    - Electronic Worker Log Time Survey documents may only be certified via an electronic signature when the following criteria is met:
        - The budget/claiming unit has a policy and procedures in place regarding the use of electronic signatures,
        - The electronic document identifies the individual signing the document by name and title,
        - There are assurances the document cannot be altered after the signature has been affixed, and
        - There are assurances that the signer cannot claim the electronic signature is invalid and/or counterfeit.
- If corrections are made, they must be notated using a single strike out and must be initialed by the participant with non-black ink.
- By signing the completed Worker Log Time Survey documents, the participant is certifying that they have read and understand requirements of the program in which they participate (CMAA and/or TCM), they understand their role in the program in which they participate (CMAA and/or TCM), and that all of the information contained in the Worker Log Time Survey is true, accurate, and correct.
- Participants who complete DHCS time survey entries on a 5, 10, or 20 consecutive work day bases are also **REQUIRED** to complete a Time Survey Activity Description document (included with **Appendix B**).
- The Time Survey Activity Description document must include:
    - The name of the LGA
    - The name of the budget/claiming unit
    - The name and classification of the time survey participant
    - The activity code and/or description of the activity performed
    - The date the activity was performed
    - The location where the activity was performed
    - The recipient of the activity (if applicable)
    - A detailed description of the purpose for the activity

- The Time Survey Activity Description document must also include a description for each separate occurrence of each type of activity performed as indicated on the Worker Log Time Survey. In instances where a participant performed an activity on more than one occasion, a minimum of two written descriptions of two separate occurrences must be included to support the time indicated on the Worker Log Time Survey. If a participant only performs an activity only once during the time survey period, documentation of one occurrence is sufficient.

D. Assuring Worker Log Time Survey Methodology Compliance

To ensure continued compliance of the Worker Log Time Survey methodology, certain responsibilities are required of DHCS, the LGAs, the individual budget units, and the participants. Each of the entities that utilize the Worker Log Time Survey methodology must be properly trained, must comply with the 85% Worker Log Time Survey completion rate requirement for 5, 10, and 20 day time surveys, must ensure there are no instances of duplication of payments, and must ensure all Worker Log Time Survey documentation is properly maintained.

E. Worker Log Time Survey Methodology Training

To prevent inaccuracies within the Time Survey Methodology, each participant must be properly trained prior to participating in the Worker Log Time Survey process. The responsibility to ensure the Worker Log Time Survey participants receive proper training is shared between DHCS and the LGA MAA/TCM Coordinators. However, the participants are also responsible for ensuring they have been properly trained prior to participating.

1. The Time Survey Training Responsibilities of DHCS and the LGA MAA/TCM Coordinators

DHCS has the primary responsibility to develop a Worker Log Time Survey Training; however, DHCS works in conjunction with the LGA Consortium, a representative body of all participating LGA MAA/TCM coordinators, to develop training on an annual basis. The training is formatted as a 'Train the Trainers' presentation; wherein, DHCS presents the Worker Log Time Survey Training to the LGA MAA/TCM Coordinators and the LGA MAA/TCM Coordinators then present the training to the LGA MAA/TCM budget units and their participants. DHCS typically conducts the 'Train the Trainers' presentation well before the beginning of each new fiscal year to ensure that the LGA MAA/TCM Coordinators have time to present the training to the LGA MAA/TCM budget units and their participants prior to the beginning of each new fiscal year.

LGAs that do not have a LGA MAA/TCM Coordinator, or an authorized alternate, attend the annual 'Train the Trainers' presentation must complete a DHCS approved training alternative before the LGA will be allowed to participate in the Worker Log Time Survey process for that fiscal year.

The 'Train the Trainer' presentation includes detailed instructions to ensure consistent application of the Worker Log Time Survey processes to all participants and stresses the importance of properly logging time worked to the appropriate Medi-Cal eligible service and/or activity and maintaining relevant documentation for audit purposes. All Worker Log Time Survey participants must be properly trained prior to participating in the Worker Log Time Survey process. Since the LGA MAA/TCM coordinator, or an authorized alternate, is responsible for training the Worker Log Time Survey participants, attendance to the DHCS 'Train the Trainer' presentation is mandatory for all participating LGA MAA/TCM coordinators or their authorized alternates.

The ‘Train the Trainer’ presentation must include detailed instructions that explain how to properly complete the Worker Log Time Survey documentation, how to report time to the appropriate Medi-Cal eligible services and/or activities, and how to distinguish between Medi-Cal eligible services and/or activities, direct medical services, and unallowable activities.

A sample of the DHCS ‘Train the Trainer’ presentation materials is included with this document as **Appendix C**.

2. The Responsibilities of the Time Survey Training Participants

Although LGA MAA/TCM coordinators are required to attend the annual ‘Train the Trainers’ presentation, the individual budget unit participants are not. The individual budget unit participants are required to attend a Worker Log Time Survey training presentation at least once prior to the beginning of each new fiscal year. However, participants that are granted eligibility to participate after the beginning of a new fiscal year must attend a Worker Log Time Survey training presentation prior to completing a time survey. Budget unit participants are not allowed to time survey until they have completed the prescribed and approved Worker Log Time Survey training. If a participant fails to complete the required Worker Log Time Survey training prior to the appropriate time survey period, all reported participant time and associated personnel costs must be excluded from the entire claiming period. However, if a participant receives training during the appropriate time survey period, the participant costs may be included in the claiming period beginning with the first date the participant was trained. All the costs associated to the participant prior to meeting training compliance must be excluded.

Prior to time surveying, budget unit participants must have a clear and accurate understanding of the proper procedures for coding time to the approved CMAA and/or TCM Medi-Cal eligible services and/or activities. Participants must also be able to accurately recognize the distinctions between the CMAA and/or TCM Medi-Cal eligible services and/or activities, direct medical services, and unallowable activities. In addition, the participants must understand the overall purpose of the Worker Log Time Survey, recognize the importance of completing the documentation in an expedient and timely manner, and be aware of how crucial their role is related to the CMAA and/or TCM programs.

3. The 85% Worker Log Time Survey Completion Rate Requirement

To determine the validity of the LGA budget/claiming unit MAA/TCM time survey submissions, the accuracy of the time survey coding and/or the total number of time surveys submitted is evaluated. The evaluation criteria used to determine the accuracy of the time survey coding requires that 100% of the time survey forms submitted are coded correctly (based on the participant’s time survey activity description documents). The evaluation criteria used to determine the accuracy of the total number of time survey submissions requires that 100% of the LGA budget/claiming unit MAA/TCM participants who are required to submit a time survey form have submitted a time survey form. The 85% Worker Log Time Survey completion rate requirement mandates that all LGA budget/claiming unit MAA/TCM time survey submissions are at least 85% valid.

The time survey participant has the primary responsibility of validating that the time survey form is coded correctly based on the activity performed and the description of the activity performed in any supporting documents. The time survey participant should make every effort to ensure the validity of the time survey form prior to submitting it to the MAA/TCM Claims Coordinator. If the time survey participant discovers any instances of incorrect coding, the time survey form should be corrected prior to submitting it to the MAA/TCM Claims Coordinator.

The MAA/TCM Claims Coordinator has the secondary responsibility of validating that the participant time survey form is coded correctly based on the description of the activity performed in any supporting documents. The MAA/TCM Claims Coordinator should make every effort to ensure the validity of the time survey form prior to using the time survey data to prepare and submit an invoice to DHCS. If the MAA/TCM Claims Coordinator discovers any instances of incorrect coding, the time survey form should be returned to the participant for correction before it can be included in the invoice to DHCS.

For budget/claiming units that time survey on a perpetual basis, any time survey forms not accurately completed and subsequently resubmitted to the MAA/TCM Claims Coordinator will not be included in the time survey universe used to create the invoice.

For budget/claiming units that time survey on a 5, 10, or 20 consecutive work day basis, any time survey forms not accurately completed and subsequently resubmitted to the MAA/TCM Claims Coordinator will not be included in the invoice unless the total number of valid time survey forms for the budget/claiming unit is 85% or greater. If the total number of valid time survey forms for the budget/claiming unit is 85% or greater, all invalid or unreturned time survey forms may be excluded from the universe of time survey results. However, if the total number of valid time survey forms for the budget/claiming unit is less than 85%, then all unreturned or invalid time survey forms must be included in the universe of time survey results and coded indicating no eligible MAA and/or TCM activity time.

In all instances, the universe of valid time surveys used to prepare and submit an invoice to DHCS must meet the time survey frequency requirements as determined by the number of time survey participants in the budget/claiming unit. Therefore, in order to maintain statistical validity, budget/claiming units that time survey on a 5, 10, or 20 consecutive work day basis must have enough time surveys in the universe of time survey results to qualify for the time survey frequency utilized. The 85% Worker Log Time Survey completion rate requirement is not applicable when the number of valid time survey results changes the statistical validity of the time survey frequency utilized.

For example, if a budget/claiming unit with 405 participants follows the 5 consecutive work day time survey frequency requirement, that budget/claiming unit must use at least 400 time surveys in the universe of time survey results to qualify for the 5 consecutive work day time survey frequency. If the number of valid time surveys falls below 400 in a claiming quarter, the entire time survey is considered invalid. In an instance when the budget/claiming unit suspects the number of valid time surveys to fall below 400 in a claiming quarter, the budget/claiming unit may increase the time survey frequency to maintain statistical validity. However, if the budget/claiming unit does not adjust the time survey frequency to maintain statistical validity, they must use at least 400 time surveys in the universe of time survey results. Therefore, if the

budget/claiming unit only has 398 valid time surveys in the universe of time survey results, the budget/claiming unit must include at least 2 more time surveys coded indicating no eligible MAA and/or TCM activity time into the universe of time surveys to maintain statistical validity.

Since CMAA program claiming is conducted on a quarterly basis within each fiscal year, any CMAA claiming unit with 100 MAA/TCM or more participants that does not meet the 85% Worker Log Time Survey completion rate requirement within any claiming quarter must exclude all reported participant time and associated personnel costs from the entire claiming quarter.

A TCM budget unit with 100 MAA/TCM or more participants that does not meet the 85% Worker Log Time Survey completion rate requirement within any quarter must exclude all reported participant time and associated personnel costs for that quarter from the annual Cost Report. The average number of hours computed from the remaining compliant quarters will be used as the number of hours in the non-compliant quarter, with all time being considered non-claimable for that quarter.

To ensure that claiming units are meeting the 85% Worker Log Time Survey completion rate requirement, the time survey submission percentages will be monitored and analyzed by DHCS. Any LGA claiming and/or budget unit that fails to meet the 85% MAA/TCM Worker Log Time Survey completion rate requirement for two consecutive quarters will be required to have all participants complete a perpetual time survey beginning with the subsequent quarter and continuing for each consecutive quarter forward. However, the requirement to perpetually survey may be lifted at the discretion of DHCS.

4. Avoiding Duplication of Payment

A crucial component to maintaining the validity of the Worker Log Time Survey methodology is ensuring there are no instances of duplication of payment. Therefore, the eligible participants and the LGA Coordinators must adhere to the Worker Log Time Survey methodology instructions, guidelines, and processes to ensure accurate CMAA and/or TCM program claiming.

Each eligible participant must utilize the same time survey tracking method and documents for the entire claiming quarter. Also, each participant must ensure that the information on the Worker Log Time Survey documentation accurately represents the amount of time the participant actually spent performing those specific activities and/or services.

a. Consistency in Reporting Time for Activities

If the budget unit has staff who participate in both MAA and TCM, any activity that qualifies as either MAA or TCM must be reported consistently throughout the budget unit to the same code by all participants. However, the provision of all TCM service components must always be reported to Code 24 when provided to TCM clients, irrespective of whether the activity may also conform to the definition of a MAA activity.

For example, if a Targeted Case Manager performs ‘referral and related activities’, that activity must be coded to TCM Code 24 (Providing TCM Service Components) instead of the CMAA Code 6 (Referral, Coordination, and Monitoring of Medi-Cal Services) when provided to a TCM client.

When the activity qualifies as either MAA or TCM and does not meet the conditions for participants that provide TCM service components to TCM clients, the coding determination will be made by the budget unit. However, the determination shall be documented and actively overseen and reviewed by DHCS or any other oversight or audit agency prior to approval of claims for reimbursement.

For example, Program Planning and Policy Development (PP&PD) for the TCM program may be reported to either MAA Code 15 or TCM Code 32. However, all budget unit staff who participate in both MAA and TCM must report their time for this activity to the same code consistently throughout the claiming period, not interchangeably. MAA participants may only code time to activities they have been approved to perform.

All time specific to the shared activity codes, such as General Administration (Code 21) or Paid Time Off (Code 22), are claimed to both programs since the General Administration or Paid Time Off is proportionately reallocated to all other activity codes within each program's reimbursement mechanism.

F. Maintaining Proper Worker Log Time Survey Documentation

Pursuant to the Office of Management and Budgets (OMB) Circular A-87, each budget/claiming unit must maintain comprehensive documentation of all costs claimed. Therefore, documentation related to the Worker Log Time Survey must be maintained in an audit file on site and must be made available to agents of the federal and State governments or their authorized representatives upon request. When applicable, the documentation must also include proof that the activities and/or services identified within the Worker Log Time Survey documentation were performed.

LGAs are required to substantiate all time surveyed for MAA/TCM claims for Federal Financial Participation. LGAs are responsible for the documentation of all costs claimed, including those associated with personnel time. The nature and amount of all activities time-surveyed must be supported with sufficient documentation. Each LGA is responsible to determine what specific documentation it can provide to demonstrate the validity of its costs. A clear audit trail must exist from time survey to documentation.

Existing regulations and agreements have required and continue to require documentation that demonstrates compliance with all MAA and TCM program requirements. These regulations and agreements include, but are not limited to: MAA Contracts and TCM Participation Agreements; OMB Circular A-87; and 42 CFR Sections 413.20, 413.24, 433.32, and 433.51.

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

This documentation must be retained in the program's audit files and available for review throughout the required retention period. Costs not substantiated by source documents may be disallowed by DHCS, CMS, or any other auditing agencies.

Documentation may include, but is not limited to, a detailed description of the time survey activity performed, file notes, copies of a calendar pages with notations, announcements of events the staff member participated in, or event sign-in logs. For TCM, the documentation may also be a copy of a case manager's client case notes completed during the survey period. If documentation is associated with a specific client and the client identifier has been excluded for confidentiality, the audit trail to the time survey must still be present.

III. The County Based Medi-Cal Administrative Activities (CMAA) Program Operational Plan

A. Introduction

DHCS is designated as the "single State agency" responsible for the administration and oversight of all California Medicaid (Medi-Cal) programs per the Medicaid State Plan agreement between California and CMS. As such, the remaining sections of this document are designed to provide guidance and instruction to the LGAs, LPEs, chartered cities, and CBOs that participate in the CMAA program regarding the proper processes and procedures to claim federal reimbursement for the cost of providing MAA. Operational information for LGAs, LPEs, chartered cities, and CBOs that participate in the TCM program can be found in the Medicaid State Plan.

As noted in the preface of this document, the requirements of the DHCS CMAA Program Operational Plan were previously defined in the Medicaid Administrative Claiming (MAC) Agreement between the Health Care Financing Administration and the DHCS, dated September 27, 1995. However, all entities participating in the CMAA program must also comply with all other applicable State and federal codes, laws, rules, regulations, and policies; including, but not limited to, the Centers for Medicare and Medicaid Services (CMS) regulations and policies, including pertinent State Medicaid Director letters, California Welfare and Institutions (W&I) Codes, federal Medicaid claiming requirements, Office of Management and Budgets (OMB) Circular A-87, and the 2003 Medicaid School-Based Administrative Claiming Guide as applicable. The CMAA specific guidelines from the MAC Agreement are included with this document as **Appendix D**.

B. An Overview of the CMAA Program

Medicaid Administrative Match (MAM), or MAA in California, is a federal program that provides certain entities reimbursement for the costs of administrative activities that directly support efforts to identify and/or enroll individuals in the Medi-Cal program or to assist those already enrolled to access services. To be eligible for reimbursement, the allowable administrative costs must be directly related to the Medi-Cal State Plan and must be found necessary for the proper and efficient administration of the Medi-Cal State Plan.

CMAA became a covered Medi-Cal benefit on January 1, 1995, per W&I Code §14132.44 and §14132.47. The CMAA program provides a mechanism for the state to provide federal reimbursement to LGAs for the MAA they perform. Through the CMAA program, DHCS and individual county agencies promote access to health care for clients in the county public health system, minimizing both health care costs and long-term health care needs for at risk populations and coordinating clients' health care needs with other providers.

C. Participating in the CMAA Program

As well as complying with State and federal law, LGAs participating in the CMAA program must follow specific DHCS guidelines and procedures to ensure proper reimbursement for the costs of performing MAA. The CMAA program operational details include information regarding the Memorandum of Understanding/Contract requirements, the CMAA claiming plan components, eligible MAA Job Classifications, CMAA specific CPE requirements, a detailed explanation of the CMAA invoice, timely filing requirements, proper supporting documentation, site review expectations, and program auditing guidelines.

D. Memoranda of Understanding/Interagency Agreements/Subcontracts

DHCS administers contracts with LGAs to share in the responsibility for promoting access to health care for the Medi-Cal population in California. LGAs must have a signed contract with DHCS to claim federal reimbursement.

The contract for CMAA between DHCS and an LGA allows the LGA to act on behalf of other governmental agencies and CBOs within its geographic region to claim reimbursement for the cost of performing MAA. CBOs are non-governmental entities that provide programs and services within the LGA's geographical region. For these entities to participate in the CMAA program, the LGA must establish a subcontract, lateral agreement, or memorandum of understanding (MOU). LGAs may directly provide services or subcontract with CBOs or other local public entities providing services within their geographical region. A sample DHCS and LGA CMAA contract template is included with this Operational Plan proposal as **Appendix E**. A sample of the LGA and claiming unit contract template is also included with this Operational Plan proposal as **Appendix F**. A sample of the LGA and CBO contract template is also included with this Operational Plan proposal as **Appendix G**.

E. The CMAA Claiming Plan

An LGA must have a comprehensive CMAA claiming plan for each claiming unit that performs CMAA. The CMAA claiming plan is the basis for determining allowable costs and activities for which LGAs claim federal reimbursement. LGAs participating in the CMAA program for the first time will be required to submit all claiming plan documents to DHCS for review and approval prior to submitting claims for reimbursement. An approved claiming plan will become the ongoing agreement between the LGA, claiming unit and DHCS that will form the basis for claiming CMAA reimbursement through the CMAA program. Any changes and/or amendments to an LGA's CMAA claiming plan must adhere to the guidelines specified in the "CMAA Document Submission Requirements" Section III (K) of this Operational Plan. However, DHCS, at its discretion, may require an LGA to submit claiming plan documents on a more frequent basis to ensure CMAA program compliance.

The CMAA claiming plan must include:

1. An LGA Comprehensive Claiming Unit(s) Grid

The LGA Comprehensive Claiming Unit(s) Grid (CCUG) is specific to each individual LGA. The CCUG lists all of the LGAs active claiming units and provides DHCS with a listing of all claiming units authorized to submit MAA claims through the CMAA program. The CCUG also identifies the time survey frequency assigned to each claiming unit or indicates that the entire claiming unit utilizes direct charging to account for participant time. A sample LGA CCUG is included with this Operation Plan as **Appendix H**.

2. An LGA Claiming Unit Functions Grid

The LGA Claiming Unit Functions Grid (CUFG) is specific to each individual LGA claiming unit. The CUFG lists all of the employee classifications that participate in MAA, the number of participants in each employee classification, and indicates the MAA activities that are performed by each classification. The CUFG also indicates which employee classifications will be direct charged and which employee classifications are designated as SPMP for enhanced FFP claiming. A sample LGA CUFG is included with this Operational Plan as **Appendix I**.

3. All applicable LGA Activity Sheets

The LGA Activity Sheets are specific to each MAA performed by staff classifications within each claiming unit. The activity sheets provide a variety of information to describe exactly how the claiming unit staff member intends to perform the specific MAA. The information includes, but is not limited to; describing the MAA, describing how the MAA will be performed, identifying the target population, the length of time the MAA may take, the location where the MAA will be performed, a designation of how frequent the MAA will be performed, a description of how the MAA costs will be developed and documented, the names of any subcontractors who will be also performing the MAA, and examples of supporting documentation. Samples of the LGA Activity Sheets are included with this Operational Plan as **Appendix J**.

4. All applicable Duty Statements

The Duty Statements are specific to staff member job classifications designated to perform MAA on behalf of the claiming unit. The duty statement must include a description of all of the job functions, duties, tasks, and responsibilities the staff members in the specific classification must perform. However, the functions, duties, tasks, and responsibilities that are specific to the performance of MAA must be clearly identified. The MAA must be identified by placing the designated activity code number next to each activity that it is related to. The duty statement must also be signed by the employee to ensure the employee understands the MAA specific performance expectations. A sample of a claiming unit duty statement is included with this Operational Plan as **Appendix K**.

5. Skilled Professional Medical Personnel (SPMP) Questionnaire

The SPMP Questionnaire is specific to each qualified SPMP staff member that is designated to perform MAA on behalf of the claiming unit. The questionnaire is designed to validate a staff members SPMP status for MAA claiming and is only required when MAA claiming includes expenditures for staff designated as SPMP. The questionnaire must be completed in its entirety. A sample SPMP Questionnaire is included with this Operational Plan as **Appendix L**.

F. Eligible CMAA Worker Log Time Survey Job Classifications

To receive federal reimbursement for the proportional salary, benefit, and non-salary costs of the staff that spend time providing MAA, LGAs participating in the CMAA program must comply with the DHCS Worker Log Time Survey Methodology requirements.

The Worker Log Time Survey participant eligibility requirements indicate "to establish and confirm participant eligibility an LGA must":

- Identify each employee that performs the MAA,
- Ensure the employee duty statement reflects all of the MAA they perform, and
- Establish a list of eligible participants for each claiming period prior to the start of the claiming period.

Through the execution of an LGA CMAA claiming plan, LGAs participating in the CMAA program are able to confirm and establish the eligibility of all staff members within each claiming unit that contribute to the cost and time spent performing MAA. The job classifications for staff who will complete a time survey for the performance of MAA are a part of the claiming plan and the duty statements for each staff job classification clearly shows the performance of MAA as a part or all of the staff member's duties.

Specific to CMAA program participation, the following guidelines must also be used in determining eligible Worker Log Time Survey participants:

- Worker Log Time Survey participants may be any direct employee of the county, contract employee, subcontractor employee, part time employee, temporary employee, and any other category of individuals receiving compensation from the county. This does not include volunteers who receive no compensation for their work or in-kind contributions.
- Staff positions that are funded 100 percent by non-allowable federal dollars may not participate in the CMAA program because the federal government is already paying its share of costs. Staff may only participate in the CMAA program in the proportion of which their positions are funded by allowable federal or other funding dollars.
- Only staff that perform any of the following activities as part of their routine work tasks will complete the time survey:
    - Medi-Cal Outreach
    - Referral, Coordination, and Monitoring of Medi-Cal Services
    - Facilitating Medi-Cal Application
    - Arranging and/or Providing Non-Emergency, Non-Medical Transportation
    - Contract Administration for Medi-Cal Services
    - Program Planning, Policy Development, for Medi-Cal Services
    - Targeted Case Management
    - MAA/TCM Coordination, and Claims Administration
    - MAA/TCM Implementation Training

The following job classifications have been evaluated using the above criteria and are currently participating in CMAA. This list includes, but is not limited to:

1. **Examples of Non-SPMP job classifications:**

    1. Accountant
    2. Administrative Analyst
    3. Administrative Secretary
    4. Administrative Services Officer
    5. Administrator
    6. Benefits Analyst
    7. Chief Financial Officer
    8. Communication Technician
    9. Community Health Planner
    10. Community Worker
    11. Contract Specialist
    12. Contract Administrator
    13. Departmental Analyst
    14. Financial Services Manager
    15. Fiscal Support Technician
    16. Fiscal Support Supervisor
    17. Health Care Planning Assistant
    18. Health Information Services Specialist
    19. Healthcare Application Analyst
    20. Health Services Manager
    21. Management Analyst
    22. Medical Services Assistant
    23. Office Services Assistant
    24. Office Specialist
    25. Outreach Worker
    26. Patient Services Assistant
    27. Program Coordinator
    28. Program Specialist
    29. Public Health Aide
    30. Public Health Analyst
    31. Senior Accountant
    32. Systems Analyst

2. **Examples of SPMP job classifications:**

    1. Assistant Director of Public Health Nursing
    2. Chief Medical Officer
    3. Clinical Director
    4. Public Health Officer
    5. Deputy Public Health Officer
    6. Licensed Clinical Social Worker
    7. Public Health Nurse
    8. Registered Nurse
    9. Staff Nurse
    10. Nurse Practitioner
    11. Staff Physician

G. LGA Reimbursement to CBOs for the Performance of MAA

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

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

1. CBOs may <u>not</u> claim for Contract Administration for Medi-Cal Services Specific for Medi-Cal and/or Non-Medi-Cal Populations (Codes 12 and 13).
2. CBOs may <u>only</u> claim for "support activities" under Program Planning and Policy Development (PP&PD), such as:

    - Developing Resource Directories
    - Preparing Medi-Cal Data Reports
    - Conducting Needs Assessments
    - Preparing Proposals for expansion of Medi-Cal services.

CBOs can claim for MAA in one of two ways:

1. A county can engage a CBO in a MAA specific contract that would allow for a direct charge. As an example, if a county were to pay a CBO $30,000 for performing MAA Outreach, the $30,000 cost to the county could be claimed in the county's MAA claim via a direct charge for Medi-Cal Outreach. This approach does not require that the CBO time survey. However, the LGA must obtain and maintain documentation from the CBO indicating that the entire $30,000 is directly related to providing MAA as agreed to in the contract. An LGA is only eligible for reimbursement of CBO costs that are directly related to providing Medi-Cal eligible activities and/or services stipulated in the contract.

2. The CBO would conduct a time survey. In this option, the CBO would have a CMAA claiming plan indicating who would time survey. Allowable revenue sources that may be used as CPE include, but are not limited to; county general funds and state general funds. A sample LGA and CBO CMAA Contract template has been included with this Operational plan proposal as **Appendix G**.

Note: The reimbursement is limited to actual costs. The only entities that claim MAA are Counties, Chartered Cities, Local Public Entities, and CBOs.

H. CMAA CPE Requirements

The payment structure of expenditures by the LGAs to CBOs must correspond to the CMAA activities identified in the CMAA claiming plan. The LGA or contributing public agency must make payments for approved expenditures to the CBOs with CPE funds prior to invoicing DHCS. The LGAs must also certify or attest that the expenditures were incurred for CMAA and submit invoices with supporting documentation to DHCS for reimbursement.

To verify acceptable CPEs for LGAs pursuant to 42 CFR 433.51 for FFP, the following steps must be taken:

- The CPE must be supported by auditable documentation that identifies the relevant category of expenditure under the State plan.
- The CPE documentation must demonstrate the actual expenditures incurred by the LGA or contributing public agency in providing MAA.
- The payments must be made by the LGA or contributing public agency to the claiming unit for CMAA identified in the CMAA claiming plan.
- The CMAA Contracts and Memorandums of Understanding (MOU) must incorporate CMAA specific language and indicate scope of performance.
- The LGA must verify that the aggregate time coded to CMAA corresponds to the approved claiming plan using the Worker Log Time Survey methodology or direct charge.
- The LGA or contributing public agency must certify that the expenditures were made to provide CMAA for Medi-Cal beneficiaries.
- The LGA or contributing public agency should also include and identify expenditures for CMAA in their general ledgers.
- The LGA or contributing public agency must make payments to claiming units for expenditures specific to CMAA prior to invoicing DHCS.
- The LGA must submit invoices and other supporting documentation to DHCS to properly claim for CMAA reimbursement.

I. CMAA Claiming

To claim reimbursement, LGAs will prepare quarterly invoices and other supporting documents (**see Appendix M for templates and instructions**) in accordance with all federal and State requirements. All costs and funding sources of each claiming unit are assigned to one of the allowable costs pools defined below. Actual costs include salaries, benefits, personal services contracts, and non-salary costs. Funding sources include revenue offsets and non-offsets used to determine the net MAA costs eligible for federal reimbursement. LGAs certify that the information provided on the invoice meets federal requirements.

1. Cost Pools

For each period claimed, all costs and funding sources for the claiming unit are assigned to one of seven allowable cost pools. The allowable cost pools include Skilled Professional Medical Personnel (SPMP), Non-SPMP, Non-Claimable, Non-Claimable (Direct Charge), Direct Charges Enhanced, Direct Charges Non-Enhanced, and Allocated Costs and Revenues. Each cost pool is explained in detail below.

a. SPMP (Cost Pool 1)

An SPMP is an employee of a public agency who has completed a two-year or longer program leading to an academic degree or certification in a medically related profession and who is in a position that has duties and responsibilities requiring that professional medical knowledge and skills (MAC Agreement, Pages 4, 23, 25, and Attachment 3, Page 3). The cost of CMAA performed by SPMPs is only eligible for enhanced reimbursement when the CMAA requires SPMP level skills (42 CFR 432.45).

Staff whose costs should be included in SPMP include:

- SPMP who participated in the time survey, or
- Clerical staff who work for, are supervised by, and provide “direct clerical support” to the SPMP in the SPMP cost pool, as shown in the organizational chart, or
- Supervisors of the SPMP in the SPMP cost pool, as shown in the organizational chart.

b. Non-SPMP (Cost Pool 2)

Staff whose costs should be included in Non-SPMP include:

- All Non-SPMP staff who participated in the time survey, or
- Clerical staff who work for the staff in the Non-SPMP cost pool, as shown in the organizational chart, or
- Supervisors of staff in the Non-SPMP cost pool, as shown in the organizational chart, or
- Personal services contractors regardless of SPMP status.

c. Non-Claimable (Cost Pool 3a)

This cost pool includes costs associated with staff who:

- Do not perform CMAA and are not included in any of the other cost pools. This typically includes staff who provide treatment, counseling, clinical services, lab services, or other non-claimable activities, or
- Perform CMAA, were present during the time survey period, and did not participate in the time survey.

d. Non-Claimable (Direct Charge) (Cost Pool 3b)

This cost pool includes Direct Charge costs that are not claimable.

e. Direct Charges Enhanced (Cost Pool 4)

This cost pool includes costs associated with SPMP staff that did NOT participate in the time survey but performed CMAA activities, and are NOT included in the SPMP cost pool. Expenditures that are direct charged are associated with the portion of personnel or non-salary costs that are 100% attributable to a single Medi-Cal eligible activity.

SPMP staff that perform Medi-Cal eligible activities either 100 percent of the time or in distinct and documented blocks of time must document the time spent on these activities in a log. Also, staff whose costs are direct charged must complete a “Staff Certification of Direct Charge Time” (**Appendix N**) to certify that the percentage of claimable direct charge time is accurate, true, and correct. LGA’s must also provide supporting documentation to substantiate any non-salary and/or overhead direct charges.

f. Direct Charges Non-Enhanced (Cost Pool 5)

This cost pool includes costs associated with Non-SPMP staff that did NOT participate in the time survey but performed CMAA activities, and are NOT included in the Non-SPMP cost pool. Expenditures that are direct charged are associated with the portion of personnel or non-salary costs that are 100% attributable to a single Medi-Cal eligible activity. In this cost pool, all participants are reimbursed at the Non-SPMP rate, without exception.

Non-SPMP staff that perform Medi-Cal eligible activities either 100 percent of the time or in distinct and documented blocks of time must document the time spent on these activities in a log. Also, staff whose costs are direct charged must complete a "Staff Certification of Direct Charge Time" (**Appendix N**) to certify that the percentage of claimable direct charge time is accurate, true, and correct. LGA's must also provide supporting documentation to substantiate any non-salary and/or overhead direct charges.

Typically, items to be direct charged include those items for which the associated costs can be easily identified and tracked on an ongoing basis. Examples include:

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

Direct Charge staff titles and assignments differ from county to county. The following is only an example and is not intended to contain all possible direct charge staff:

Accountant
Chief Financial Officer
Contract Specialist
Departmental Analyst
Management Analyst
Fiscal Support Technician
Program Specialist
Senior Accountant

NOTE: The sample classifications listed above are not indicative of classifications that work solely on Medi-Cal or are qualified to direct charge 100% of their time to a single Medi-Cal eligible activity. Classifications that work solely on Medi-Cal and are qualified to direct charge 100% of their time to a single Medi-Cal eligible activity are uncommon for CMAA claiming.

g. Allocated Costs and Revenues (Cost Pool 6)

This cost pool includes general or administrative staff who:

- Did not complete a time survey, or
- Were not included in any department/program (internal) or in the countywide (external) indirect rate, or
- Were not direct charged, or
- By the nature of their work, support the staff in the other cost pools.

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

2. Revenue Offsets

Certain revenues must be offset against allocated costs in order to reduce the total amount of LGA costs that are eligible for reimbursement by the federal government. Revenue offsets include federal funds and State/local matches of federal funds that have directly or indirectly funded costs that may not be claimed for reimbursement. If a participant's direct costs are completely funded by unallowable federal funds, they will not participate in CMAA. However, if a participant's direct costs are only partially federally funded, the costs that are federally funded must be offset.

An example would be a case manager whose costs are paid 20% by Ryan White federal funds and 80% by local general funds. 100% of the participant's costs would be placed on the MAA Detail Invoice (in cost pool 1 or cost pool 2, dependent on SPMP status). However, 20% of the revenue for that participant would be placed in an offset category on the MAA Detail Invoice "Funding (Revenue) Sources" page so that 20% of the costs would be offset.

3. Allocation of Time Survey Results

The CMAA/TCM Worker Log time survey is the basis for allocating the time and costs of claiming units between CMAA and non-CMAA activities. The time survey results serve as the basis for allocating the salary and benefit costs of the staff in the SPMP and Non-SPMP cost pools. Time survey results for a claiming unit are aggregated to determine the percentage of time in each activity code and separated into claimable, non-claimable, and allocated costs.

4. Calculation of the CMAA Medi-Cal Percentages

For some activities, claiming units claim allowable costs based on how many Medi-Cal beneficiaries exist in their target population. This is referred to as the "Medi-Cal percentage." The Medi-Cal percentage represents the cost of serving **only** Medi-Cal beneficiaries. Codes 6, 10, 13, 17, and 18 require calculated Medi-Cal percentages. To calculate an activity's Medi-Cal percentage as a fraction, the numerator is the number of Medi-Cal clients served per activity by a claiming unit within a quarter and the denominator is the total number of clients served per activity by the claiming unit within a quarter.

The CMAA program as approved by CMS provides two methods of calculation: actual client count (ACC), and countywide average (CWA). For claiming CMAA, claiming units must use ACC, as it is the default methodology to determine the Medi-Cal percentage. To define the Medi-Cal percentage of an activity using the ACC methodology, a claiming unit must identify the population served, the total number of clients served within the claiming quarter, and the number of Medi-Cal beneficiaries within that population. If a claiming unit cannot calculate an ACC, it must use CWA. DHCS annually releases CWA data through a policy and procedure letter.

5. CWA, Single and Multiple Discount Justifications

LGAs with claiming units that are unable to utilize an ACC methodology must submit a justification requesting authorization to use CWA to DHCS prior to the start of the claiming year. DHCS will provide a written response of approval or denial. Those approved must apply the CWA when submitting claims for allowable costs. DHCS will retain records of those claiming units eligible to utilize the CWA.

a. Utilizing Medi-Cal Percentage Methodologies (ACC and CWA)

Claiming units must determine an ACC percentage for each applicable activity. However, circumstances may exist in which a claiming unit cannot establish an ACC percentage for one or more activities, necessitating the use of CWA for such activities. The term “multiple Medi-Cal percentage methodologies” refers to the usage of varying ACCs or combining ACC(s) and CWA, for different activities within an invoice.

Claiming units that utilize multiple Medi-Cal percentage methodologies must individually track the number of clients served to develop separate ACCs for codes 6 and 10. The Medi-Cal eligibility status for those clients must be determined and used to develop an ACC. However, codes 13, 17, and 18 may refer to a potential group of Medi-Cal beneficiaries, identified within a target population that the claiming unit serves. For codes 13, 17 and 18, the claiming unit must identify the target population(s) and the number of Medi-Cal beneficiaries within that group. For example, to claim for code(s) 17 and/or 18, Program Planning and Policy Development specifically to reduce service gaps for children under 5 years old, documentation supporting the ACC must include the total number of children under 5 years old served in a claiming quarter, as well as the number of Medi-Cal beneficiaries under 5 years old served within the target population. Another code 17 and/or 18 example; for a claiming unit that works to reduce service gaps for all Medi-Cal eligible people within their county, the documentation supporting their ACC would include the total number of clients served within the claiming quarter and the number of Medi-Cal beneficiaries within that population served. If a claiming unit is unable to provide this information, it must request use of CWA for that activity.

Other circumstances may exist in which claiming units may use a single ACC percentage for more than one applicable activity. In this situation, these claiming units must also provide a justification as to why they are using one percentage and how that percentage will be developed.

LGAs must submit a justification packet for claiming units to utilize single or multiple Medi-Cal percentage methodologies prior to the start of the claiming year. The packet must include both a justification letter explaining why and how the claiming unit will utilize their intended Medi-Cal discount percentages, and activity sheets for the activities a claiming unit intends to provide to clients. A Medi-Cal percentage methodologies' justification letter must include the following:

- County letterhead
- Description of how the Medi-Cal percentage is developed for each activity
- Description of internal procedures/mechanisms in place to record client data and how that information will be separated by activity
- List of the intended Medi-Cal percentage methodology to be utilized per activity (i.e., CWA and/or ACC)
- List of the sources used to collect and/or confirm the client data for developing the Medi-Cal percentage for each activity
- If the claiming unit serves multiple programs and/or populations, list those programs and individually list the specific populations served
- Sign the justification letter in blue ink, scan it in color and submit the complete packet to your assigned analyst.
    - Claiming units unable to scan documents in color and email their complete packet, can submit hard copies to:

      Department of Health Care Services
      CMAA Unit, MS 4603
      P.O. Box 997436
      Sacramento, CA 95899-7436

DHCS will respond to an LGA's submission of a complete justification packet within thirty (30) calendar days. A complete packet's activity sheets must provide detailed information about the claiming unit's operation and development of their Medi-Cal percentages. LGAs cannot change the DHCS approved Medi-Cal percentage methodologies within the fiscal year, without proof of extenuating circumstances. DHCS will review any exceptions on a case-by-case basis.

Note: LGAs that email their packets will need to retain their original signed copies in their audit binders.

6. Non-Salary Costs

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

Following is a list of claimable non-salary costs and a list of non-claimable non-salary costs. Both lists are examples and are not comprehensive. These costs are claimable costs only if they do not relate to non-claimable categories of cost. As part of the invoice submission, LGAs are required to provide a detailed list of all non-salary costs that are included in the invoice.

Claimable Non-Salary Costs:

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

The State follows federal guidelines regarding the depreciation of non-salary equipment costs (42 CFR 413.134; CMS Pub. 15-1, Chapter 1). Therefore, if an LGA includes non-salary costs related to equipment in the claim, the LGA must factor the depreciation and useful life of that equipment into the claiming process. For example, if an LGA includes the non-salary cost of a computer in the claim, the useful life of the computer (3 years) must be factored into claiming. Therefore, the costs of the computer would be claimed over a three year period.

Non-Claimable Non-Salary Costs (include in Cost Pool 3):

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

7. Treatment of Indirect Costs

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

The federal Office of Management and Budgets (OMB) issued OMB Circular A-87 guidelines for federally subsidized programs to use in claiming indirect costs.

- LGAs submit external indirect cost rate plans or countywide cost allocation plans, usually prepared through the county/city Auditor-Controller's Office, to the State Controller's Office for review and approval.
- LGAs must prepare and maintain internal indirect cost rate plans with the LGA's audit file for each claiming unit. These plans must be prepared in accordance with OMB Circular A-87.
- LGAs must certify that costs claimed as direct costs do not duplicate those costs reimbursed through application of the indirect cost rate.

Per OMB Circular A-87, indirect costs are those: (a) incurred for a common or joint purpose benefiting more than one cost objective, and (b) not readily assignable to the cost objectives specifically benefited, without effort disproportionate to the results achieved. The term "indirect costs", as used herein, applies to costs of this type originating in the grantee department, as well as those incurred by other departments in supplying goods, services, and facilities. To facilitate equitable distribution of indirect expenses to the cost objectives served, it may be necessary to establish a number of pools of indirect costs within a governmental unit department or in other agencies providing services to a governmental unit department. Indirect costs pools should be distributed to benefited cost objectives on bases that will produce an equitable result in consideration of relative benefits derived.

DHCS will provide oversight and monitoring of indirect cost rates to ensure that costs are allowable according to OMB Circular A-87. In cases where the indirect cost rate is greater than 10 percent, DHCS will conduct a review to determine whether the indirect cost rate is reasonable and allowable and maintain documentation of the review. DHCS may limit the indirect cost rate to 10 percent if the costs included in the indirect cost rate are unreasonable, unallowable, and/or contain formulas in calculating the indirect cost rate that are flawed.

J. Medi-Cal Administrative Activities (MAA) Detail Invoice

All LGAs in California participating in the CMAA program must use the MAA Detail Invoice (**see Appendix M for templates and instructions**). The MAA Detail Invoice provides a place to report actual costs, funding sources, time survey results, and Medi-Cal percentages. The MAA Detail Invoice calculates the total costs and offsets those costs with qualified funding. Adjusted or net costs are multiplied by the percentage of claimable activity, appropriate Medi-Cal percentage and FFP to determine the amount to be reimbursed.

1. CMAA Claim Calculation

The amount of Federal Share in the LGA's quarterly MAA Detail Invoice is determined by calculating Total Adjusted Costs, multiplying by the Adjusted Activity Results and the Medi-Cal percentage, and applying the appropriate FFP rate.

A Total Adjusted Costs:

Salary, Benefits, Personal Service Contracts, and Non-Salary Costs are entered into Page 1 of the CMAA Detail Invoice for SPMP (Cost Pool 1), Non-SPMP (Cost Pool 2), Non-Claimable (Cost Pool 3), and Allocated Costs and Revenues (Cost Pool 6). Direct Charges for Cost Pool 4 and Cost Pool 5 are transferred from the Direct Charge Worksheet. The total of all costs for Cost Pool 6 are redistributed to Cost Pool 1, Cost Pool 2, Cost Pool 3, Cost Pool 4, and Cost Pool 5 based on the Personnel costs of these Cost Pools. Total Costs are then reduced by Funding Sources (Offsets) to arrive at Total Adjusted Costs.

F = Subtotal Personnel (Salary, Benefits, Personal Service Contracts)
G = Non-Salary Costs
H = Direct Charges
I = Redistributed Cost Pool 6
J = Funding Sources (offsets)

(F + G + H + I) – J = A (Total Adjusted Costs)

EXAMPLE OF TOTAL ADJUSTED COSTS

Subtotal Personnel (from Cost Pool 2 Non-SPMP) = $25,000
Non-Salary Costs = $5,000
Direct Charges = $1,000
Redistributed Cost Pool 6 = $2,000
Funding Sources (offsets) = $28,000
($25,000 + $5,000 + $1,000 + $2,000) - $28,000 = **$5,000**
Total Adjusted Costs = $4,000 (Cost Pool 2) + $1,000 (Direct Charge) = **$5,000**

B Adjusted Time Survey Activity Results:

The Activity Results Percentages for Each Activity are calculated from the completed time surveys and entered into Page 1 of the CMAA Detail Invoice. General Administration and Paid Time Off are reallocated to all other time survey activity codes to determine the Adjusted Time Survey Activity Results.
K = Activity Results Percentage for Each Activity
L = Total Activity Results Percentages (Total Time Page 1)
M = General Administration
N = Paid Time Off

$$\frac{K}{L - (M + N)} = \textbf{B (Adjusted Time Survey Activity Results)}$$

EXAMPLE OF ADJUSTED TIME SURVEY ACTIVITY RESULTS

Activity Results Percentage for Referral, Coordination, and Monitoring of Medi-Cal Services (Non-SPMP) = 20%
Total Activity Results Percentages = 100%
General Administration = 8%
Paid Time Off = 12%

$$\frac{20\%}{100\% - (8\% + 12\%)} = \textbf{25\%}$$

C Medi-Cal Percentage

To calculate the Medi-Cal percentage, the number of clients served per activity by a claiming unit that are Medi-Cal beneficiaries is divided by the total number of clients served per activity by the claiming unit. To determine the number of clients served, LGAs are required to use ACC. If ACC is unavailable, LGAs must use the CWA for their county if given approval by DHCS. Calculate a Medi-Cal percentage (ACC), for applicable activities, as follows:

$$\frac{\text{Total Number of Medi-Cal Clients Served}}{\text{Total Number of Clients Served}} = \textbf{C (Medi-Cal Percentage)}$$

EXAMPLE OF MEDI-CAL PERCENTAGE

Total Number of Medi-Cal Clients Served (ACC) = 1,000
Total Number of Clients Served = 5,000

$$\frac{1,000}{5,000} = \textbf{20\%}$$

D Federal Financial Participation (FFP) Rate (50%/75%)

The allowable FFP rate for CMAA is either 50% or 75%. The FFP rate is applied to the total claimable CMAA costs to determine the claim amount. This is the last step of the claim calculation.

E Federal Share

A = Total Adjusted Costs
B = Adjusted Time Survey Activity Results
C = Medi-Cal Percentage
D = Federal Financial Participation (FFP) Rate
E = Federal Share

(A x B x C x D = E)

K. CMAA Document Submission Requirements

1. Claiming Plan Documents:

LGAs with claiming units participating in the CMAA program for the first time are required to submit all claiming plan documents to DHCS for review and approval prior to submitting claims for reimbursement, as mentioned in Section III (I), "The CMAA Claiming Plan" portion of this Operational Plan. However, LGAs continuing their participation are only required to submit specific portions of the CMAA claiming plan documents to DHCS on an ongoing basis for amendments.

a. Submitting the Comprehensive Claiming Unit Grid

Each LGA must submit a CCUG to DHCS for any claiming plan amendments (i.e., any time the LGA adds, deletes, or renames a claiming unit or increases or decreases the time survey frequency of a claiming unit). DHCS must receive amended CCUGs prior to the beginning of the claiming year the changes affect. DHCS will reject claims submitted that do not agree with the CCUG. LGA CMAA Coordinators must sign and certify the CCUG. The claiming units included on the CCUG must have accurate and complete CUFGs included in their claiming plan.

b. Submitting the Claiming Unit Functions Grid

Each LGA must submit a CUFG to DHCS any time a claiming unit increases or decreases the number of activity codes they claim, add or remove staff or subcontractors, or change the claiming unit description. LGAs must submit all amended CUFGs prior to the beginning of each claiming year. The CUFG must identify all staff who will be included in the quarterly invoice by their employment classifications and indicate which CMAA activities each participant intends to perform regardless of whether the participant will time survey or direct charge. The CUFG must also indicate the number of SPMP staff in each classification that will be included in the quarterly invoice. Changes made within a claiming unit not included on an approved CUFG before the claiming year begins, must not be included in the quarterly invoice. Therefore, if a claiming unit changes the CUFG, the LGA must submit a revised claiming plan prior to the beginning of the claiming year. Exceptions will be allowed for new claiming units being added during a claiming year. However, new claiming units must be added to a claiming plan prior to the start of a claiming quarter. DHCS will reject claims submitted that do not agree with the CUFG. LGA CMAA Coordinators must sign and certify the CUFG.

2. Invoice Documents:

LGAs participating in the CMAA program that incur reimbursable costs must prepare quarterly claims to receive reimbursement. Invoices must be submitted to DHCS for each quarter billed. DHCS, in turn, reviews, approves and certifies the invoices.

Claims for reimbursement must be submitted in accordance with the requirements laid out in the CMAA Manual using the CMAA Detail Invoice and any other forms required by DHCS (**see Appendix M for templates and instructions**). It is the responsibility of the LGA MAA/TCM Coordinators to review all invoices for completeness and accuracy prior to submitting them to DHCS. By signing and submitting the CMAA Detail Invoice to DHCS for payment, the LGA MAA/TCM Coordinator certifies that:

- The invoiced amount satisfies the requirements of 42 CFR 433.51 for allowable administrative activities and that the claimed expenditures have not previously been or shall not subsequently be used for federal match in this or any other program.
- The expenditures do not duplicate, in whole or part, claims made for the costs of direct patient care.

- The financial data and resource documents provided in the invoice package are accurate and comply with State and federal law and regulations and OMB Circular A-87 standards.

Any misrepresentation relating to the filing of claims for federal funds constitutes a violation of the Federal False Claims Act.

a. Timely Filing Requirements

LGAs must submit quarterly invoices and supporting documents to DHCS for review and approval no later than 15 months after the end of the quarter claimed to allow DHCS staff adequate time to complete the review and approval of quarterly invoices. All paid invoices are reported to CMS each quarter using the Quarterly Medicaid Statement of Expenditures, Form CMS 64. The table below (**Table 6**) outlines the 15 month submission timeline.

Table 6

Months	Jul-Sep 2011	Oct-Dec 2011	Jan-Mar 2012	Apr-Jun 2012	Jul-Sep 2012	Oct-Dec 2012	Jan-Mar 2013	Apr-Jun 2013
Invoice to DHCS	Dec 2012	Mar 2013	Jun 2013	Sept 2013	Dec 2013	Mar 2014	Jun 2014	Sept 2014

Section 1132(a) of the Social Security Act requires that a claim for FFP must be filed 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. For quarterly invoices received within the two-year period but not approved by DHCS for payment, DHCS is allowed to submit a placeholder claim to CMS. However, DHCS cannot claim additional FFP once a placeholder claim is entered on the CMS 64. For invoices submitted 15 months after the end of the quarter claimed, LGAs are at risk of not receiving full reimbursement due to the two year claiming limit. The table below (**Table 7**) outlines the 2 year claiming limit timeline.

Table 7

Months	Jul-Sep 2011	Oct-Dec 2011	Jan-Mar 2012	Apr-Jun 2012	Jul-Sep 2012	Oct-Dec 2012	Jan-Mar 2013	Apr-Jun 2013
Invoice to DHCS	Sep 2013	Dec 20113	Mar 2014	Jun 2014	Sep 2014	Dec 2014	Mar 2015	Jun 2015

L. CMAA Program Claims Oversight

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

M. The Audit File

Pursuant to OMB Circular A-87, each CMAA claiming unit must maintain an audit file of comprehensive documents in support of MAA claiming prior to the submission of an invoice to DHCS. The certification signatures on the CCUG and CUFG indicate that the LGA has prepared, collected, and filed all appropriate claiming plan supporting documents. LGAs must also prepare, collect, and file documentation regarding all MAA costs claimed; including those associated with personnel time. The nature and amount of all activities time surveyed must be supported by sufficient documentation. All components of the LGA and individual claiming units related to MAA claiming are subject to review by the DHCS, and/or CMS upon submission of the invoice. The audit file must include, but is not limited to, containing the supporting documentation detailed below.

1. Supporting Documentation

Contract/Memorandum of Understanding Documents:

- CMAA specific contracts between DHCS and the LGA to include all CMAA specific exhibits and attachments.
- CMAA specific contracts between the LGA and the Claiming Unit or CBO to include all CMAA specific exhibits and attachments.

Claiming Plan Documents:

- The complete history of CCUGs signed by the LGA coordinator or their appointee.
- The complete history of CUFGs signed by the LGA coordinator or their appointee for each quarter claimed.
- All applicable LGA activity sheets related to the activities indicated on the CUFGs and claimed for each quarter.
- All signed duty statements related to the classifications indicated on the CUFGs and claimed for each quarter.
- All applicable licenses and/or certifications indicating the SPMP eligibility of the classifications/staff claimed for each quarter.
- All applicable time survey results or direct charge documents related to the staff time claimed for each quarter.

CPE Documents:

- Payment documentation from the LGA to the Claiming Unit or CBO showing where the public funds were expended 100% prior to invoicing DHCS.
- When applicable, certification documents attesting to the CPE eligibility of LGA and/or claiming unit revenue.
- General ledger documentation demonstrating the expenditures were made to provide eligible MAA to Medi-Cal beneficiaries.

The CMAA Detail Invoice:

- All CMAA detail invoice documents submitted by the LGA to DHCS for CMAA reimbursement claiming.
- All applicable remittance advice details from DHCS to the LGA for CMAA reimbursement claiming.
- All original time survey documentation and staff certification of direct charge time.
- Documentation supporting the Medi-Cal percentage.
- Documentation supporting the basis of claiming to specific cost pools.

A CMAA Audit File Reference Guide is included as **Appendix O**. This document may be helpful to LGAs when setting up and/or maintaining an audit file; however, the information on the reference guide should not be interpreted as an all-inclusive list.

2. CMAA Audit File Retention Guidelines

Federal regulations require that all records in support of allowable CMAA claims must be maintained for a minimum of three fiscal years after the end of the quarter in which the LGA receives reimbursement from DHCS for the incurred expenditures. Similarly, the documents that support the construction of a CMAA Detail Invoice must be kept three years after the last claim revision.

The State will maintain claims documentation submitted by each LGA. All LGA and State documentation must be capable of being audited and must be maintained for a period of three years or greater as required by State and federal law and/or Program directive, whichever is the most restrictive.

N. CMAA Program Compliance Responsibilities

Each entity within the CMAA program claiming process has a responsibility to ensure CMAA program claiming compliance. The first level of review is done at the claiming unit or 'local' level. The local level review includes a review of the CMAA claiming plan documents, the time survey and/or direct charge documents, and the quarterly invoice documents to ensure they are accurate and complete. The local level review must also ensure that all training guidelines are met.

The second level of review is done at the LGA MAA Coordinator level. Review at this level includes a secondary review of all local level responsibilities; however, the LGA MAA Coordinator also has primary responsibility to comply with all training, site visit, desk review, and claiming plan requirements to ensure accuracy and completeness regarding CMAA claiming. The LGA MAA Coordinator is responsible for ensuring accuracy and completeness regarding all CMAA program related documents and guidelines. The LGA MAA Coordinator is also responsible for the submission of MAA claiming invoices to DHCS.

The third and final level of review is performed by DHCS. Review at this level includes a final review of all local and LGA level responsibilities. DHCS will conduct ongoing reviews of all CMAA claiming documents, processes, procedures, and guidelines. In the event deficiencies are discovered, DHCS will take whatever steps necessary to ensure the integrity of the CMAA program and its funding. If a review identifies an invoice

overpayment, DHCS will recover the overpayment amount from the LGA. If warranted, DHCS may also conduct additional training, implement procedural changes, and/or perform provider audits and reviews. In the even an audit or review is necessary, DHCS will, upon conclusion of the audit or review, issue a final written report reflecting findings and required corrective actions and identify any required recovery amounts if applicable.

O. CMAA Program Site Review

As required by CMS, DHCS will conduct program site reviews of each LGA participating in the CMAA program at least once every four years. The purpose of the site visit is to verify that the MAA claiming by the LGAs for the approved claiming units are in compliance with state and federal laws, rules, and regulations. The claiming units included in the review will be a representative sample of all of the claiming units within each LGA. DHCS will analyze the following documents during the review:

Time Survey Documentation

- Original time survey forms
- Copies of time cards or time sheets for the time survey period
- Secondary Documentation (only for 5, 10, & 20 day time survey budget units)
- Staff Certification of Direct Charge Time forms (If applicable)

Invoice Documentation

- Copies of salaries and benefits information used for those costs associated with the invoices (such as payroll registers, general ledgers, budget reports, etc.)
- Non-salary costs backup documentation
- Methodology for Cost Pool 6 determination
- Supporting documentation for CPE (if applicable)
- Supporting documentation for Actual Client Count (if applicable)
- Supporting documentation for Direct Charge (if applicable)

Claiming Plan Documentation (as applicable)

- Flyers, announcements, or other materials
- Materials unique to, or designed by, the claiming unit
- Documents that support the calculation of transportation costs
- Copies of contracts/MOUs between the LGA and the Claiming Unit
- Copies of contracts/MOUs between the Claiming Unit and any subcontractors
- Documentation that supports Claiming Plan Methodology for determining direct charge claiming and the dollar amount to be paid to the subcontractor and/or LGA staff
- Sample(s) of Resource Directories
- Full and complete duty statements
- Time Survey Training Presentation and sign-in sheets

SPMP Designation Documentation (as applicable)

- Copies of SPMP supporting documentation, i.e. copies of the SPMP license
- Organization Chart showing the relationship of SPMP clerical staff to SPMPs charged in Cost Pool
- Substantiation that the clinical expertise is required to perform the activity for which SPMP was claimed.

1. The CMAA Program Site Review Process

The CMAA program site review consists of several aspects of LGA documentation, process, procedure, and guidelines review. DHCS will conduct LGA site reviews based on a four-year review cycle, as mandated by CMS. The basic structure and processes of the site review are outlined below.

Approximately 60 days prior to the date of the review, DHCS staff will contact the LGA coordinator of the designated LGA to schedule the site review. DHCS, in collaboration with the LGA coordinator, will identify a representative sample of claiming units within the LGA to be included in the site review. The representative sample will consist of 10% of the total number of claiming units within that LGA. However, the representative sample must contain a minimum of three claiming units unless the LGA has less than three claiming units total. In the event an LGA has less than three claiming units, all claiming units will be selected for review. The LGA will be required to furnish CMAA claiming documentation and records for the selected claiming units for the current and prior fiscal year.

Once the representative sample of claiming units is identified, DHCS, in collaboration with the LGA coordinator, will identify a representative sample of participating staff to interview regarding the CMAA program and appropriate CMAA claiming practices. The representative sample of participating staff will consist of 10% of the total number of participating staff within each claiming unit. However, the representative sample will not exceed 20 participating staff. In the event the claiming unit has less than 20 participating staff, DHCS will interview a minimum of four participants. However, if a claiming unit has less than four participating staff, all staff will be interviewed.

Approximately 30 days prior to the site review, DHCS will send the LGA Coordinator an Entrance Letter (**Appendix P**) that includes:

- The date and time of the site review,
- The address the site review will be taking place,
- The fiscal years being reviewed,
- The claiming units selected for review,
- A CMAA Site Visit Documentation Checklist (**Appendix Q**),
- A CMAA Unit Site Visit Tool Worksheet (**Appendix R**),
- The CMAA Time Survey Participant Interview Questions (**Appendix S**), and
- The participating staff Interview Schedule (**Appendix T**).

On the day of the site review, DHCS staff will arrive at the designated address. The site review will begin with DHCS staff conducting an entrance conference with the LGA coordinator and any pertinent LGA or claiming unit staff that wish to be present. The entrance conference will explain the DHCS site review process and provide an opportunity for the staff in attendance to ask questions prior to the review.

Upon conclusion of the entrance conference, DHCS staff typically begin the interview process with the selected participating staff. However, the interviews are conducted in consideration of the claiming unit's staff schedules, therefore, the interviews may be conducted sporadically throughout the site review. Either after the interviews or immediately following the entrance conference, DHCS staff will begin review of the LGA claiming unit documentation. The LGA coordinator is permitted to be present during the documentation review; although, it is not a requirement. However, the LGA coordinator must be available to DHCS staff to answer any questions regarding the documentation.

DHCS staff will utilize the CMAA Unit Site Visit Tool Worksheet to conduct the documentation review. The CMAA Unit Site Visit Tool Worksheet provides a series of questions that DHCS staff intend to answer in relation to the several areas of documentation under review (see **Appendix R** for a detailed description). All LGA documentation, processes, procedures, and guidelines must be reasonable and appropriate for billing and/or reimbursement.

Once the on-site review has been concluded, the DHCS staff will conduct an exit conference with the LGA coordinator and any pertinent LGA or claiming unit staff that wish to be present. The exit conference will explain the results of the DHCS site review, detail the corrective measures that may be needed, if any, and provide an opportunity for the staff in attendance to ask questions regarding the site review findings.

Within 30 days following the site review, the LGA Coordinator will receive a written Summary of Findings (SOF) Report (**Appendix U**) from DHCS. The SOF Report will provide a detailed analysis of the site review, and will either indicate that the LGA is in compliance with the CMAA claiming standards, or will indicate that the LGA is required to develop a Corrective Action Plan (CAP) to correct any issues that were discovered during the site review. The SOF will also give the LGA Coordinator a deadline for submitting the CAP to DHCS. DHCS must review and approve the CAP prior to the LGA Coordinator submitting any corrections and/or revisions. Once the CAP is approved by DHCS, the LGA Coordinator will be sent an Approval Letter (**Appendix V**) and the DHCS CMAA Analyst will work with the LGA Coordinator to ensure all identified corrections and/or revisions are resolved. In the event the CAP is not approved, the DHCS CMAA Analyst will provide technical assistance to the LGA Coordinator to ensure the CAP meets the standards for CMAA claiming.

DHCS will maintain copies of any monitoring tools, the Summary of Findings, all corrective action plan responses, and technical assistance documents (if applicable).

2. Reviewing Supporting Documentation for the Invoice

As previously indicated, DHCS will conduct LGA site reviews based on a four-year review cycle; however, in the interim between site reviews, DHCS will periodically require LGAs to submit more thorough and complete supporting documentation for invoices; including, but not limited to, time survey and/or cost justification documentation. As with the site review, all documentation in support of the invoice must be reasonable and appropriate for billing and/or reimbursement. DHCS will also conduct periodic on-site technical assistance reviews on an as needed or requested basis in the interim between site reviews.

In the event DHCS has questions regarding the reasonability or appropriateness of the supporting documentation, the LGA Coordinator may be required to provide written justification of the supporting documentation.

3. Recurring Compliance Issues

Repetitive deficiencies or compliance issues within an LGA may be cause for DHCS to conduct more frequent site visits, desk reviews, or technical assistance visits. DHCS will also require the LGA to regularly submit more thorough and complete supporting documentation for invoices. In extreme cases, DHCS will conduct site reviews, desk reviews, or technical assistance visits every two years, instead of every four years, to ensure adequate oversight and monitoring.

Appendices (A – V)

- **A.** CMAA Clinicians Log
- **B.** DHCS Worker Log Time Survey Samples
- **C.** CMAA/TCM Training Presentation
- **D.** CMAA Specific MAC Agreement Guidelines
- **E.** DHCS and LGA CMAA Contract Templates
- **F.** CMAA LGA and County Claiming Units Contract Template
- **G.** CMAA LGA and CBO Contract Template
- **H.** CMAA Comprehensive Claiming Unit Grid Template
- **I.** CMAA Claiming Unit Functions Grid Template
- **J.** CMAA Activity Sheets
- **K.** CMAA LGA Duty Statement Sample
- **L.** Skilled Professional Medical Personnel (SPMP) Questionnaire
- **M.** CMAA Invoice Instructions and CMAA Invoice Template
- **N.** Staff Certification of Direct Charge Time
- **O.** CMAA Audit File Reference Guide
- **P.** Site Review Entrance Letter
- **Q.** CMAA Site Visit Documentation Checklist
- **R.** CMAA Unit Site Visit Tool Worksheet
- **S.** CMAA Time Survey Participant Interview Questions
- **T.** Participating Staff Interview Schedule
- **U.** Summary of Findings (SOF) Report
- **V.** Corrective Action Plan Approval Letter