SECTION 1

Preface and How to Use This Manual

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TO ALL USERS:

This Medi-Cal Administrative Activities (MAA) manual is to help Local Governmental Agencies (LGA) implement their MAA program. The requirements of the MAA program are contained in the federal statute and regulations, the "Agreement between the federal Health Care Financing Administration and the Department of Health Services" (executed on November 28, 1995), and the Welfare and Institutions Code, Section 14132. When the requirements of the MAA program need to be clarified, a DHS Policy and Procedure Letter (PPL) will be issued, as well as updates to this manual.

The LGAs should adhere to the information provided in this manual. If you have any questions or suggestions regarding this information, please contact the claiming analyst assigned to your LGA or the Chief of the Administrative Claiming Operations Unit.

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The Medi-Cal Administrative Activities (MAA) Provider Manual is your primary reference for information about MAA program participation requirements. You should consult this manual before seeking other sources of information.

Organization

The manual is organized into four major divisions:

- Preface, Contents, and How to Use This Manual
- Medi-Cal Background
- Medi-Cal Administrative Activities (MAA)
- Reference Materials

Colored tabs separate the sections.

Section Page Tabs

Section pages have colored and numbered tabs to make it easy to find a specific section in the manual. A table of contents of each section and subsection follows each section page with a colored tab. For example, if you turn to the colored number tab for the MAA Time Survey section (7), you will see the table of contents and the subsections for the MAA Time Survey.

Numbering System

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

Manual Replacement Pages

When changes occur in MAA , the Department of Health Services (DHS) will issue Provider Manual Updates and manual replacement pages. All manual replacement pages will be dated. Each bulletin will contain specific instructions for updating your manual. It is important to insert or replace manual pages when they arrive. This will ensure that all current information remains in your manual. Pages that have been replaced should be maintained in a separate audit file.

Policy and Procedure Letters

DHS-issued Policy and Procedure Letters (PPLs) are an integral part of the MAA/TCM Provider Manual. It is important to insert the PPLs into your manual upon receipt.

Telephone Inquires

If you have any questions about the contents of your provider manual, please telephone DHS, Medi-Cal Benefits Branch, Administrative Claiming and Support Section, (916) 657-1460, or your assigned program analyst.

SECTION 2

Medi-Cal Background

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Overview of the Medicaid Program

The Medicaid Program is a national health care program designed to furnish medical assistance to families; to individuals who are aged, blind, or disabled; and to individuals whose income and resources are insufficient to meet the cost of necessary medical services. The program, which was established under Title XIX of the Social Security Act, is administered by the Centers for Medi-Care and Medicaid Services (CMS) of the federal Department of Health and Human Services (DHHS). Medicaid is a state/federal partnership under which the federal government establishes basic program rules. Each state administers the program based upon those federal rules. However, states are free to develop their own rules and regulations for program administration within the confines of the federal rules.

States must meet certain federal requirements in order to participate in the Medicaid program. However, states that meet these requirements receive federal funding in the form of federal financial participation (FFP) for all Medicaid expenditures. Each state has an established Federal Medical Assistance Percentage (FMAP) amount, which is paid by DHHS for most program expenditures, although that amount may be higher for certain specific types of expenditures. The FMAP for California is 50 percent.

The primary requirements imposed on states that wish to participate in the Medicaid program relate to eligibility for the program and to services covered by the program. Federal Medicaid law defines certain categories of eligible individuals and specific types of health care coverage that must be provided by any state intending to operate a Medicaid program. Title XIX also offers a variety of optional eligibility groups and types of service that a state may choose to cover. In addition, the federal government establishes general standards by which states must operate their Medicaid programs; however, development of program options and the details of program operation and administration are the responsibility of the states themselves.

Eligibility Requirements

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

Eligibility Categories

In general terms, to be eligible for Medicaid, a person must be "linked" to one of the two major public assistance cash grant programs, either California Work Opportunity and Responsibility to Kids (CalWORKs) or Supplemental Security Income (SSI). To be "linked" to CalWORKs, the family must include at least one child who is deprived of parental support or care, generally due to the absence, unemployment, or disability of one parent. Linkage to SSI is based on age (65 years of age or older), blindness, or disability. Virtually all eligibility categories, whether mandatory or optional, include only individuals who have linkage to one of these two programs. Federal law on this issue has expanded in recent years to include many other individuals, primarily low-income pregnant women and children who live in families where there is no deprivation of parental support or care.

In addition to being linked to CalWORKs or SSI, Medicaid eligibility is based on the amount of income and resources held by the individual or family. Eligibility is divided into two broad categories based on the relative poverty of the applicant. Persons whose income and resources are no greater than the income limits established under the cash grant program to which they are linked are "categorically needy." Persons whose income and resources exceed cash grant limits but meet higher limits established by the State are "medically needy." Medically needy individuals or families must meet these higher resource limits in order to remain eligible, but their income may exceed the medically needy income limit. In such cases, the person or family

must “spend down” the excess income in order to become eligible. In California, this spend-down amount is referred to as the “share of cost.”

The primary federal categories of eligibles covered by California’s Medi-Cal program are included in the following list. In the interest of brevity, the list combines certain mandatory and optional coverage groups.

- CalWORKs and SSI/SSP recipients, and individuals eligible for these programs
- Families terminated from CalWORKs due to increased earnings or hours of employment
- Children under age six who meet CalWORKs resource requirements and whose income is less than 133 percent of the federal poverty level
- Pregnant women (until the end of the second month after pregnancy) and infants under one year of age whose resources meet State Medi-Cal requirements and whose income is no greater than 185 percent of the federal poverty level (and up to 200 percent of the poverty level for State-only eligibles)
- Women who were eligible for Medi-Cal while pregnant until the end of the second month after pregnancy (for pregnancy-related services only)
- Children whose mothers were eligible for Medicaid at childbirth, until one year after birth as long as the child resides with the mother
- Children for whom the State makes adoption assistance or foster care maintenance payments under Title IV-E
- Qualified Medi-Care beneficiaries who are entitled to Medi-Care hospital coverage, whose income does not exceed twice the SSI resource standard

- Individuals who are not living in a nursing facility solely because of coverage under a home and community-based waiver

- Certain disabled children who live at home but, if living in a medical institution, would be eligible for SSI/SSP

- Children under age 19 who were born after September 30, 1983, and whose income is no greater than 100 percent of the federal poverty level (new group under OBRA 1990, effective July 1, 1991)

- All other aged, blind, or disabled persons; children; pregnant women; caretaker relatives; and families with dependent children who are not covered by one of the above groups and whose income and resources meet State requirements for the medically needy. In California, children who are not deprived of parental support or care but whose income and resources meet medically needy limits are referred to as "medically indigent."

Financial Responsibility

In determining an individual's eligibility for Medicaid (Medi-Cal) the income and resources of family members are counted under certain circumstances. Spouses are considered financially responsible for spouses. Parents are considered financially responsible for their children if the children are living in their parents' home and if the parents' income and resources must be counted. The only exception is for certain children who would be living in a nursing facility or a medical institution if they were not living at home.

Only the child's (not the parents') income and resources are considered if any of the following is applicable:

- The child is in foster care.

- The child has been detained or placed by a court or court-designated agency under Welfare and Institutions Code Sections 300 or 601.

- The child is not living with a parent or relative and a public agency is assuming responsibility for the child in whole or in part.

- The child is not living with a parent or caretaker relative when parents or public agencies have been contacted to determine whether they will accept legal responsibility for the child.

Resources and Income

For most of the categories of eligibles discussed above, eligibility is based upon the limits established under CalWORKs or SSI/SSP. For certain other categories of eligibles, income eligibility is based upon a percentage of the federal poverty level. Federal poverty levels are as follows (see <http://aspe.hhs.gov/poverty/01poverty.htm>):

1 person	$8,590
2 persons	$11,610
3 persons	$14,630
4 persons	$17,650
5 persons	$20,670
6 persons	$23,690
7 persons	$26,710
8 persons	$29,730

Plus $3,020 for each additional person

Individuals who do not fall into any of these categories must meet resource and income limits for the medically needy. When determining financial eligibility for the medically needy, resources are generally examined first because, as noted above, excess resources will result in ineligibility, while excess income will simply result in the assignment of a spend-down or share of cost. The value of an applicant's resources (or property) must fall below certain property limits for the applicant to become eligible. Some types of property are not counted against the limit (such as a home or one car that is used for work), while other types of property (such as a bank account or non-home real estate) are counted. Medi-Cal regulations specify how to determine the value of every type of property.

Medi-Cal property limits are as follows (see Medi-Cal Eligibility Manual):

1 person	$3,000
2 persons	$3,000
3 persons	$3,150
4 persons	$3,300
5 persons	$3,450
6 persons	$3,600
7 persons	$3,750
8 persons	$3,900
9 persons	$4,050
10 or more	$4,200

Unlike resources or property, applicants with income in excess of Medi-Cal income limits are not ineligible for the program. Instead, they are assigned a share of cost equal to the difference between the income limit, called the "maintenance need" in Medi-Cal, and their net non-exempt income. The applicant or family must **pay or obligate** the share of cost amount before being issued a Medi-Cal card. As with resources, certain types of income are not counted (are exempt) in determining an applicant's net income (such as the earned income of a full-time student), while other types of income are counted (such as earned income of parents or income from Social Security).

Monthly maintenance-need income limits are as follows (unchanged from previous years):

1 person	$600
2 persons	$750
3 persons	$934
4 persons	$1,100
5 persons	$1,259
6 persons	$1,417
7 persons	$1,150
8 persons	$1,692
9 persons	$1,825
10 persons	$1,959

SECTION 3

Medi-Cal Administrative Activities (MAA) Glossary

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Advisory Committee	Comprised of County/City and professional organization representatives designated by all Local Governmental Agencies (LGA) participating in the Medi-Cal Administrative Activities (MAA) program; assists the Department of Health Services (DHS) in the formulation of program policy.
Allowable Time	Time spent by identified personnel doing activities that may be claimed as allowable MAA, as determined by time surveys or direct-charge documentation.
Audit File	A file of documentation supporting the LGA's MAA claims. This documentation will be retained for a minimum of three years after the end of the quarter in which the expenditures were incurred.
Case Managers	Individuals performing Targeted Case Management (TCM) and who meet the qualifications as outlined in the California State Plan and the California Code of Regulations Section 51272.
Centers for Medicare and Medicaid Services (CMS)–formerly known as the Health Care Financing Administration (HCFA)	The federal agency that oversees the Medicaid program, a national health care program designed to furnish assistance to families; to aged, blind, and disabled individuals; and to individuals whose income and resources are insufficient to meet the cost of necessary medical services (see Section 2).
Certification Statement	A statement the MAA Coordinator signs stating that the information in the claiming plan is true and correct and that it accurately reflects the performance of MAA activities described in the claiming plan.
Claimable Activities	Activities that may be claimed as allowable under the MAA program.
Claiming Plan	A description of activities claimed as allowable MAA. Each LGA participating in MAA must submit a claiming plan to DHS.
Claiming Unit	An LGA entity, such as a department or subcontractor performing MAA, whose costs can be segregated as a separate budget unit.

Comprehensive Individualized Services Plan	A plan developed by the TCM case manager on behalf of the beneficiary that is reviewed and approved in writing by the case manager's supervisor. The plan shall document the following: The actions required to meet identified service needs; the community programs, persons and/or agencies to whom the beneficiary will be referred; a description of the nature, frequency and duration of the activities and assistance necessary to achieve service outcomes.
Cost Pool	The cost centers that are the base of the MAA claim. The MAA invoice has seven cost pools, aggregating expenditures for Skilled Professional Medical Personnel (SPMP); non-SPMP; Direct Services/Non-Claimable costs; Direct Charge and Allocated Costs.
Cost Report	A TCM annual report due each year for each local county program on or before November 1st of each year. The annual TCM cost report must be submitted to DHS for determination of the rate in the current fiscal year. The report shall reflect only allowable TCM costs and shall include all costs for the prior fiscal year.
County/Charter City Match	Monies from the local governmental agency's General Fund, or from any other funds allowed under the federal law and regulation, for TCM services performed pursuant to Welfare and Institutions Code Section 14132.44(f).
Direct Charge	Direct invoicing of certain costs identified as 100 percent allowable. These costs are entered in the Direct Charge section of the MAA invoice. Some Direct Charge costs must be discounted by the Medi-Cal percentage. Direct charges must be itemized and explained in back-up documentation to be included in the audit file.
Documented Assessment	A component of TCM service that identifies the beneficiary's needs and supports the selection of activities and assistance necessary to meet the assessed needs.
Encounter	A face-to-face contact or a significant telephone contact with or on behalf of the Medi-Cal-eligible person for the purpose of rendering one or more TCM service components by a case manager.

Encounter Log	A log used by case managers to record the necessary encounter information required to support claims to the Medi-Cal program for reimbursement and kept for audit purposes.
Encounter Rate	The annual encounter rate developed for each local county/city program providing services to Medicaid-eligible persons who meet the target population criteria. The rate is calculated by dividing the cost of providing TCM services in the prior fiscal year by the total number of encounters (both Medicaid and non-Medicaid) in that fiscal year. LGAs may only claim the federal share of the costs of providing TCM services to Medicaid-eligible persons, less the required county/charter city match. See Federal Financial Participation.
Enhanced Functions	Those MAA performed by an SPMP and that require the medical expertise of an SPMP. Currently the only enhanced function is Program Planning and Policy Development. The cost of time spent by an SPMP performing these activities is reimbursed at the enhanced rate of 75 percent.
Federal Financial Participation (FFP) Rate	The proportion of allowable cost to be reimbursed by the federal government.
High-Risk Persons	Persons who have failed to take advantage of necessary health care services; who do not comply with their medical regimen; or who need coordination of multiple medical, social, and other services because they have an unstable medical condition that needs stabilization; they have a substance abuse problem; or they are victims of abuse, neglect, or violence.
Host County	The LGA designated by all LGAs participating in the MAA/TCM programs to be the administrative and fiscal intermediary between the Department and all participating LGAs.
Invoice	The set of claim forms submitted by the LGAs to DHS to obtain reimbursement for the cost of allowable MAA/TCM.
Local Governmental Agency	A county or chartered city.
MAA/TCM Coordinator	The person designated by the LGA to coordinate the MAA/TCM programs.

Medi-Cal Administrative Activities (MAA)	A program that allows LGAs to draw down federal reimbursement for activities necessary for the proper and efficient administration of the Medi-Cal State Plan.
Medi-Cal Administrative Activities Contract	The legal document or contract between DHS and the LGA that authorizes participation in the MAA program.
Medi-Cal Percentage	The proportion of a population who are Medi-Cal beneficiaries.
Periodic Review	A component of TCM service that includes a review of the beneficiary's progress toward achieving the objectives identified in the service plan to determine whether current services should be continued, modified, or disconnected.
Provider Agreement	An agreement between the state and an LGA to provide TCM services as a covered Medi-Cal benefit to various identified targeted populations and to claim federal Medicaid reimbursement. The agreement enrolls the LGA as a TCM Medi-Cal provider.
Quarterly Summary Invoice	The summary or aggregate of costs on each quarterly MAA detail invoice. Prepared by an LGA on behalf of all claiming entities or programs within its jurisdiction; it is submitted on the agency's letterhead and is the amount to be subject to FFP reimbursed to the LGA for the quarter.
Revenue	Funding received by an LGA or program.
Revenue Offset	The required deduction from an LGA's claim for allowable MAA. The Revenue Offset Worksheet provides a systematic approach to calculating the dollars that must be offset from the claim.
Single State Agency	A state agency charged with administering the Medicaid program. In California, the single state agency is the Department of Health Services.
Skilled Professional Medical Personnel (SPMP)	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.

State Plan	A comprehensive written statement submitted by the State describing the nature and the scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific federal requirements. The State Plan serves as a basis for federal financial participation (FFP) in the program.
State Plan Amendments (SPAs)	The vehicle used to amend, add, or delete material from the California State Plan.
Target Group	A defined and specific group of Medi-Cal beneficiaries defined in a State Plan Amendment to whom TCM services can be provided.
Targeted Case Management (TCM)	Services that assist a Medi-Cal-eligible individual in a defined target population to gain access to needed medical, social, educational, and other services. TCM is comprised of components that include needs assessment, setting of objectives related to needs, individual service planning, service scheduling, crisis assistance planning, and periodic evaluation of service effectiveness.
Targeted Case Management Cap	The total, or maximum, dollar amount that may be claimed in the current fiscal year. The TCM cap is calculated by multiplying the per-encounter reimbursement rate by the projected number of Medi-Cal encounters.
Targeted Case Management Provider	In accordance with Section 14132.44, Welfare and Institutions Code, an LGA under contract with DHS to provide TCM services and enrolled as a TCM provider in the Medi-Cal program.
Time Survey	The approved methodology to determine the percentage of costs that are allocable to each MAA activity claimed by the LGA.

SECTION 4

Medi-Cal Administrative Activities (MAA)

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MEDI-CAL ADMINISTRATIVE ACTIVITIES OVERVIEW

Pursuant to Welfare and Institutions Code, Section 14132.47, Medi-Cal Administrative Activities (MAA) became a covered Medicaid benefit effective January 1, 1995. MAA are administrative activities necessary for the proper and efficient administration of the Medi-Cal program.

To participate in MAA, each LGA must enter into a contract with DHS. As part of the contract, the LGA must submit a comprehensive claiming plan for each claiming unit performing MAA. The claiming unit is an entity within the LGA that performs MAA. The MAA claiming plan must describe in detail: each category of MAA the LGA is claiming, the claiming units for which claims will be submitted, the supporting documentation the claiming unit will maintain, and the development and documentation of the costs relating to MAA. The claiming plan is reviewed and approved by DHS and HFCA. Once approved, the claiming plan becomes a part of the contract between the LGA and DHS. Costs for MAA are only claimable when the activities are identified in an approved MAA claiming plan.

The claiming plan remains in effect from year to year until amended by the LGA. A claiming plan must be amended each time the scope of MAA is significantly changed, a new claiming unit is established, a new type of activity is undertaken, or a claiming unit is no longer participating. All claiming plan amendments are subject to DHS and CMS review and approval. An LGA may submit amendments to its claiming plan at any time. The effective date of the amendment is the first day of the quarter in which the amendment is submitted.

Allowable MAA may or may not be directed solely to the Medi-Cal population. Therefore, the costs associated with allowable MAA may be discounted. The method of calculating the discount is to take an actual “head count” or to derive a percentage based on the total number of Medi-Cal recipients and the total number of all individuals served by the LGA. Countywide averages or other methods approved by DHS and CMS may be used to calculate the Medi-Cal percentage discount. The Medi-Cal discounting methodology must be identified in the MAA claiming plan. See Section 5, Determining the Medi-Cal Percentage, for further information.

In general, costs associated with MAA are matched at the federal financial participation (FFP) rate. DHS requires LGAs to certify the availability and expenditure of 100 percent of the non-federal share of the cost of performing MAA. The funds expended for this purpose must be from the LGA’s general fund or from funds allowed under federal law and regulation.

Each year, DHS will designate a MAA time survey month within the first quarter of the fiscal year. The purpose of conducting the time survey is to identify the amount of time spent on the performance of MAA. The time survey is completed by individuals performing MAA. The month of the time survey will vary to ensure a valid basis from which to claim costs for the current fiscal year. LGAs have two options regarding how often to perform time surveys for the MAA program: the LGA can use the results of the time survey conducted in the designated month of the first quarter for the entire fiscal year, or it can conduct an additional time survey in a subsequent quarter of the fiscal year. The activity percentages must be used for that quarter and all subsequent quarters during that fiscal year until another time survey is conducted. If an LGA intends to perform an additional time survey, it must provide written notification to DHS at least thirty (30) days before the beginning of the quarter in which the survey will be conducted. The new time survey, if approved by DHS, will be in effect from the first day of the quarter in which it is conducted and will remain in effect until it is superseded by a subsequent time survey in that fiscal year. Once a new time survey has been approved by DHS, it must be performed by the LGA and the result must be used to prepare the MAA quarterly invoice. Once an additional time survey is approved by DHS, an LGA cannot claim MAA based on the results of a previous time survey.

Claims for MAA reimbursement are submitted by the LGA to DHS. Each claim for MAA costs is prepared on a separate detailed quarterly invoice for each program, clinic, non-governmental entity, or contractor. The LGA will also prepare and submit a quarterly summary invoice, which is an aggregate of all detailed invoices for each program. The form for the detailed invoice blends the cost and revenue data into one spreadsheet that allows for the computation of the claim, adjusting for all necessary revenues and applying activity and Medi-Cal discount percentages. The LGA must provide DHS with complete invoice and expenditure information no later than eighteen (18) months after the end of the quarter for which a claim is being submitted. DHS will approve the claim, return the claim for revision, or deny the claim. An LGA can request a reconsideration of the DHS decision to deny a claim. The request must be filed in writing and within thirty (30) days from the receipt of the written notice of denial. This review is limited to a programmatic or accounting reconsideration based upon additional supporting documentation submitted to DHS.

DHS has delegated authority to the Department of Mental Health (DMH) through an interagency agreement to administer the MAA program when allowable MAA are performed by participating county mental health programs. Participating county mental health programs will submit their MAA claiming plan directly to DMH. DMH will review the claiming plan, and upon approval, will forward each claiming plan to DHS and CMS for additional review and approval. Participating county mental health programs will also submit MAA invoices directly to DMH for processing. Invoices approved by DMH will be submitted to DHS for payment.

The following activities are allowable MAA for a more detailed description of these activities, please see Section 5 (MAA Claiming Plan) of the manual.

Medi-Cal Outreach

This activity brings potential eligibles into the Medi-Cal system and helps all eligible individuals obtain Medi-Cal services. Medi-Cal Outreach is divided into two sections: Medi-Cal Outreach A and Medi-Cal Outreach B.

Medi-Cal Outreach A

This activity is a campaign or program directed toward the general population for the purpose of providing information about the Medi-Cal program in order to encourage those individuals who may be eligible for Medi-Cal to apply for Medi-Cal.

It can also be a campaign or program directed toward bringing Medi-Cal eligibles into specific Medi-Cal-covered services. These are service campaigns, targeted specifically to Medi-Cal services.

Medi-Cal Outreach B

This activity is a campaign or program directed toward bringing specific high-risk populations into health care services covered by Medi-Cal, targeting both Medi-Cal and non-Medi-Cal eligibles.

Facilitating Medi-Cal Application

This activity explains the Medi-Cal eligibility process and rules to prospective applicants, helps an applicant complete a Medi-Cal eligibility application, and gathers information related to the Medi-Cal application and to the eligibility determination and redetermination process. This does not include rendering the Medi-Cal eligibility determination itself.

Medi-Cal Non-Emergency Non-Medical Transportation

This activity includes arranging and providing non-emergency non-medical transportation of Medi-Cal eligibles to Medi-Cal-covered services provided by an enrolled Medi-Cal provider. When medically necessary, this activity may include the cost of accompanying Medi-Cal eligibles to Medi-Cal services.

Contracting for Medi-Cal Services

This activity involves the coordinating contracts with community-based organizations or other provider agencies to provide Medi-Cal services and/or MAA.

Program Planning and Policy Development	This activity develops strategies to increase the capacity of the Medi-Cal system and to close gaps in Medi-Cal service. This activity also includes interagency coordination to improve the delivery of Medi-Cal services and to develop resource directories for Medi-Cal services and providers.
MAA/TCM Coordination and Local Governmental Agency Claims Administration	This activity involves the administration of MAA, which includes but is not limited to: drafting, revising, and submitting MAA claiming plans; serving as liaison with claiming programs within the Local Governmental Agency (LGA); and ensuring that MAA claims do not duplicate Medi-Cal claims for the same activities from other providers.
Training	This activity may be given or received, including training in general Medi-Cal program overview. Training must be related to the performance of MAA and must be claimed to the activity it relates to.
General Administration	This activity involves the general program administrative functions that are eligible for cost distribution on the Office of Management and Budget Circular A-87 on an approved cost allocation basis. These activities include but are not limited to: attending or conducting general non-medical staff meetings; and developing and monitoring program budgets, site management, and supervision of staff. General Administration is not directly claimable to MAA. However, the costs are allocated on the MAA Invoice.

SECTION 5

Medi-Cal Administrative Activities Claiming Plan

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MEDI-CAL ADMINISTRATIVE ACTIVITIES CLAIMING PLAN OVERVIEW

Section five, subsection two, of this manual contains the Department of Health Services (DHS) publication "Preparing the Medi-Cal Administrative Activities Claiming Plan," which includes the standardized formats, descriptions, and instructions for Local Governmental Agencies (LGAs) to use when claiming Federal Financial Participation (FFP) for administrative activities. These administrative activities, known as Medi-Cal Administrative Activities (MAA), are defined therein. The federal Centers for Medi-Care and Medicaid Services (CMS) and the State agree that these MAA are allowable administrative activities, the costs of which will be matched by CMS, so long as the rules outlined in the publication are adhered to.

Each LGA that intends to claim for the costs of MAA must submit a comprehensive MAA claiming plan to DHS. Claiming plans and subsequent claiming plan amendments will become effective the first month of the quarter in which they were submitted. Such a claiming plan shall describe in detail all of the following:

- The categories of MAA that the LGA intends to claim;
- The location and scope-of-work of the claiming unit(s) and the types (SPMP or non-SPMP) of employees involved;
- The supporting documentation the claiming unit will maintain to support its claim;
- How the related costs of implementing MAA are generated; and
- How these costs will be documented.

For certain categories of MAA, additional documentation must be submitted with the claiming plan, as explained in the publication.

Once submitted to DHS, each LGA's claiming plan will be reviewed in a timely manner by DHS and, after approval, submitted to CMS. CMS agrees to review, provide comment, and approve acceptable plans in a timely manner. Once approved by DHS and CMS, these MAA claiming plans will become annual agreements between the LGAs and DHS and will form the basis for claiming MAA. Claims submitted to DHS without an approved claiming plan or claims that do not agree with the approved claiming plan will be rejected. A claiming plan will remain in effect from year to year until amended. An LGA may submit amendments to its claiming plan at any time. These amendments will be subject to the approval process described above. For example, an outreach claiming plan must be amended each time a new outreach campaign or program is implemented. An amendment is also required when a new claiming unit is established, when a new MAA activity is claimed, or when a claiming unit is no longer participating.

To assist the LGAs in the preparation and submission of MAA Claiming Plan Amendments, a MAA Claiming Plan Amendment Checklist has been developed (see Section 5-4-1 of this manual). The checklist must be completed and submitted with each Claiming Plan Amendment. The checklist is not an all-inclusive listing of claiming plan amendment situations. If circumstances arise that are not listed on the checklist, please detail the situation under item 30 of the checklist or attach an additional explanation. Amendments should be submitted as a comprehensive package for the entire LGA and must contain a revised Certification Statement with a new date and signature. Only the pages that are changing in the existing MAA Claiming Plan need to be amended. Please do not resubmit the entire MAA Claiming Plan. Number the amended pages by using the original page number and consecutive letters. For example, for each subsequent amendment, a Public Health Claiming Unit would amend its original page PH-8 as follows: PH-8a, PH-8b, and PH-8c. The pages must be easily identifiable by the LGA, DHS, and CMS.

Two copies of the Claiming Plan Amendment package must be submitted. The original copy is for DHS review, and the second copy is for CMS review. Please note that if the proposed Claiming Plan Amendment requires the claiming unit to conduct a time survey, the LGA must request authorization from DHS to conduct the time survey thirty (30) days before the beginning of the quarter in which the time survey will be conducted.

PREPARING THE MEDI-CAL ADMINISTRATIVE ACTIVITIES CLAIMING PLAN

(Standardized Formats Including Descriptions and Instructions)

DEPARTMENT OF HEALTH SERVICES
MEDI-CAL BENEFITS BRANCH
MEDI-CAL POLICY DIVISION
714 P Street, Room 1640
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-1460

TO ALL USERS:

In accordance with the Welfare and Institutions Code, Section 14132.47, all local governmental agencies (LGAs) participating in the Administrative Claiming Process program, more commonly referred to as MAA, are required to prepare a claiming plan. Claiming plans must contain comprehensive information on each of the MAA performed and are to be prepared for each claiming unit engaged in the performance of MAA.

Completed claiming plans are to be submitted to DHS for review. DHS reviews the claiming plans to determine whether the information provided clearly describes the MAA performed and that the information is provided in accordance with the format and instructions contained in this publication. Once approved by DHS, the claiming plans are submitted to the federal Health Care Financing Administration for their approval. LGAs are notified in writing by DHS of the approval/disapproval of their claiming plan. After receiving approval of their claiming plan, LGAs may invoice DHS for reimbursement of the costs of performing MAA. DHS will issue separate instructions for completing the MAA Invoice. LGA invoices must be submitted in accordance with the MAA invoice instructions.

LGAs are advised to follow the standardized format and instructions provided in this section when preparing claiming plans. To request additional copies of these forms, please submit your request in writing to:

Department of Health Services
Administrative Claiming Operations Unit
714 P Street, Room 1640
Sacramento, CA 95814

Sincerely,

Marianne Lewis, Chief
Medi-Cal Benefits Branch

ACKNOWLEDGEMENTS

The Department of Health Services would like to acknowledge the following individuals for contributing their expertise and knowledge of Medi-Cal Administrative Activities claiming to the development of the claiming plan format and instructions. Representing the federal Health Care Financing Administration, Linda Minamoto; representing the Department of Health Services, Patricia Morrison and Georgia Rivers; representing the Local Governmental Agencies' Advisory Committee, Jim DeAlba; and Host County Liaison, Cathleen Gentry.

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CERTIFICATION STATEMENT
(See requirements and instructions on reverse.)

(1) Local Governmental Agency (LGA) (County or Chartered City)	
(2) LGA Address	(3) LGA Medi-Cal Administrative Activities Coordinator's Phone Number

In signing this certification, I am certifying that the information provided herein is true and correct and accurately reflects the performance of the Medi-Cal Administrative Activities (MAA) described in this claiming plan.

I am also certifying that invoices submitted to the state Department of Health Services for reimbursement shall be based on the approved claiming plan and shall be submitted in accordance with the MAA invoice instructions. Any knowing misrepresentation of the activities described herein may constitute violation of the federal False Claims Act.

I understand that this claiming plan shall be subject to the review and approval of the state Department of Health Services and the federal Health Care Financing Administration.

.....(4) Typed Name (Medi-Cal Administrative Activities Coordinator)	(5) Signature (Medi-Cal Administrative Activities Coordinator)
(6) Title	(7) Date

MEDI-CAL ADMINISTRATIVE ACTIVITIES TO BE CLAIMED

(Refer to Attached Pages _____ to _____)

CLAIMING PLAN REQUIREMENTS

In order for Local Governmental Agencies (LGA) to receive federal matching funds for performing allowable Medi-Cal Administrative Activities (MAA), each LGA is required to submit a comprehensive MAA claiming plan package to the Department of Health Services (DHS) for review and approval by DHS and the Centers for Medi-Care and Medicaid Services (CMS). A claiming plan package consists of separate claiming plans for each claiming unit performing MAA. LGAs must submit two copies of the claiming plan package to DHS. One package must be submitted in a three-ring binder. The second package will be forwarded to CMS for their review.

A claiming plan and any subsequent amendments will remain in effect from year to year. A claiming plan must be amended each time the scope of MAA is significantly changed or a new type of activity is undertaken. For example, a claiming plan must be amended when a new outreach campaign or program is instituted or a new claiming unit performing MAA is created. An LGA may submit amendments to any of its claiming plans at any time. Amendments are subject to DHS and CMS approval. DHS will notify each LGA in writing of the approval or disapproval of all its amendments. Claims should only be made under amended claiming plans when these have been approved and are effective for the period claimed.

The effective date of the approved claiming plan and any subsequent amendments shall be no earlier than the first day of the calendar quarter in which the claiming plan is submitted.

To facilitate the review process, a standardized claiming plan format has been developed and is included with the instructions. LGAs intending to claim MAA must use this format.

Following the submission of claiming plans or amendments to DHS, DHS will review the claiming plans or amendments and forward the results of its review along with one set of the claiming plans or amendments to CMS for its review. CMS will notify DHS in writing of the results of its review. DHS will notify the LGAs in writing of the approval or disapproval of their claiming plans or amendments. DHS will provide technical assistance to LGAs, upon request, in the event of disapproval.

Invoices will be rejected that are submitted to DHS without an approved claiming plan, that do not agree with the approved claiming plan, or that do not agree with the MAA invoice instructions.

INSTRUCTIONS FOR LOCAL GOVERNMENTAL AGENCIES (COUNTY OR CHARTERED CITY)

Attach to the front of the entire claiming plan:

1. A table of contents, listing by section each claiming unit included in the claiming plans.
2. A complete Certification Statement by entering the following:

    (1) The name of the LGA.
    (2) The LGA's address.
    (3) The MAA/TCM Coordinators phone number.
    (4) The typed name of the MAA/TCM Coordinator.
    (5) The signature of the MAA/TCM Coordinator.
    (6) The title of the MAA/TCM Coordinator
    (7) The date the claiming plan package is signed.

Claiming plan packages are to be submitted to:

Department of Health Services
Administrative Claiming Operations Unit
714 P Street, Room 1640
Sacramento, CA 95814

NOTE: It is recommended that claiming plan packages be submitted by express mail service in order to ensure delivery.

CLAIMING UNIT FUNCTIONS

(1) LOCAL GOVERNMENTAL AGENCY: _____ SUBMITTAL DATE: _____
(COUNTY OR CHARTERED CITY)

(2) NAME OF CLAIMING UNIT:	(3) NO. OF STAFF:
(4) ADDRESS:	
(5) CONTACT PERSON:	
(6) ADDRESS : (If different than above)	(7) PHONE NUMBER:
(8) DESCRIPTION OF CLAIMING UNIT FUNCTIONS:	

(9) STAFF JOB CLASSIFICATIONS	(10) NUMBER OF STAFF		(11) MEDI-CAL ADMINISTRATIVE ACTIVITIES (ENTER NUMBER OF STAFF UNDER EACH ACTIVITY)								
	SPMP	Non-SPMP	A	B1	B2	B3	C	D	E	F	G

A = Medi-Cal Outreach A (Not Discounted)
B1 = Medi-Cal Outreach B (Discounted)
B2 = Medi-Cal Outreach B (Discounted)
B3 = Medi-Cal Outreach B (Discounted)
C = Facilitating Medi-Cal Application (Not Discounted)
D = Medi-Cal Non-Emergency, Non-Medical Transportation
E = Contracting for Medi-Cal Services
F = Program Planning and Policy Development
G= MAA Coordination and Claims Administration

DHS USE ONLY

CP Reference No. _____ **Original Approval Date:** **Amendment Approval Date:**

INSTRUCTIONS FOR CLAIMING UNIT

Methods for Allocating Costs

In order for the local governmental agencies (LGAs) to claim the costs of Medi-Cal Administrative Activities (MAA) performed by the reporting claiming units, the following methods for allocating costs have been approved by the Department of Health Services (DHS):

1. Employee time surveys.
2. Direct charges. Direct-charging based on employee salaries must be supported by a signed certification statement (included on the direct charges worksheet). Direct-charging for non-salaried costs must be supported by receipts for actual costs incurred.

Using the Standardized Claiming Plan Format

On the following pages, forms for each of the allowable MAA are provided. A description of the MAA and instructions for preparing the claiming plan are on the reverse of each form. The forms may be used by claiming units to prepare claiming plans. The claiming plan information must be presented in the same order as requested in the instructions.

Each claiming unit must provide the information requested beginning on page 3 of the standardized claiming plan format. (The numbers shown below correspond to the numbers shown on page 3 of the standardized claiming plan format). Complete page 3 of the standardized claiming plan by entering:

1. The name of the LGA and the claiming plan submittal date.
2. The name of the claiming unit performing MAA.
3. The total number of staff employed in the claiming unit.
4. The claiming unit's address.
5. The name of the claiming unit contact person.
6. The address of the claiming unit contact person.
7. The phone number of the claiming unit contact person.
8. A brief description of the specific functions performed by the claiming unit.
9. The job classifications for each of the staff who completed a time survey or whose costs will be direct-charged for the performance of MAA and for which an invoice will be submitted. If some staff in a classification are considered skilled professional medical personnel (SPMP) and other staff are considered non-SPMP, enter the information for SPMP staff on one line and enter the information for non-SPMP staff in the same job classification on a separate line.
10. The number of staff who are SPMP or non-SPMP.
11. The number of staff performing MAA by type of activity.

Each Claiming unit must attach to its claiming plan:

1. The documents required to support each of the MAA that the LGA claiming unit intends to claim for federal matching funds. The documents required are listed on the instructions provided for each MAA. Identify the activities supported by each document by placing on the front of each document the letter assigned to the MAA. The letters assigned to the MAA are listed at the bottom of page 3. For example A = Medi-Cal Outreach A, B = Medi-Cal Outreach B, C = Facilitating Medi-Cal Application, etc. Next to the MAA letter place the number of the document. For example if three documents are submitted to support the activity Medi-Cal Outreach A, separately number the documents as A-1, A-2, and A-3.

2. Position descriptions and/or duty statements for each staff performing the MAA identified in the claiming plan. These must clearly show the performance of the MAA identified in the claiming plan as being part or all of the employees' duties. The MAA duties described on the position descriptions and/or duty statements must be clearly identified. To clearly identify the MAA duty, place next to each MAA duty the letter assigned to the MAA. The letters assigned to the MAA are listed at the bottom of page 3. For example A = Medi-Cal Outreach A, B = Medi-Cal Outreach B, C = Facilitating Medi-Cal Applications, etc.

(A) MEDI-CAL OUTREACH A
- NOT DISCOUNTED -
(**Attach additional pages if needed. See description and instructions on reverse side.)**

Claiming Unit: **Submittal Date:**

Local Governmental Agency:

DHS USE ONLY

CP Reference No. _____ **Original Approval Date:** **Amendment Approval Date:**

MEDI-CAL OUTREACH A
- NOT DISCOUNTED -

DESCRIPTION

Medi-Cal Outreach A is a campaign, program, or ongoing activity that is targeted to:

1. Bringing potential eligibles into the Medi-Cal system to determine their Medi-Cal eligibility.
2. Bringing Medi-Cal-eligible people into Medi-Cal services.

Medi-Cal Outreach A is a campaign or program that is directed toward:

1. The general population for the purpose of providing information about the Medi-Cal program in order to encourage those individuals who may be eligible for Medi-Cal to apply for Medi-Cal.
2. Bringing Medi-Cal eligibles into specific Medi-Cal-covered services, such as Early and Periodic Screening, Diagnosis and Treatment [EPSDT] (known in California as Child Health and Disability Prevention Program [CHDP]). In such campaigns the language should clearly indicate that the message is directed only to persons eligible for Medi-Cal and not to the general public. These campaigns are service campaigns, targeted specifically to Medi-Cal services.

NOTE:

- Public health campaigns that contain a discrete segment targeted only to bringing Medi-Cal eligibles into Medi-Cal-covered services may be claimed as Outreach A only for the targeted segment.
- Information and referral activity are allowable as Outreach A when it involves referring Medi-Cal eligibles to Medi-Cal providers, or referring potential Medi-Cal eligibles exclusively to Medi-Cal eligibility workers.
- Targeted Case Management (TCM) case managers, except in local educational agencies (LEAs) may perform Outreach A activities, as well as TCM provided there is an accurate accounting and reporting of the time spent on each.

Subcontracting

The Local Governmental Agency (LGA) may subcontract with non-governmental agencies or programs to conduct Outreach A. If the LGA chooses to direct-charge the Outreach A performed by subcontractors, the contracts must clearly describe the Outreach A to be performed, the method used for determining direct-charge claiming, and the dollar amount to be paid to the subcontractor.

Individual employees of subcontractors, including LEAs, may not claim for the performance of both TCM and MAA.

INSTRUCTIONS FOR PREPARING THE MEDI-CAL OUTREACH A CLAIMING PLAN

For *each* campaign, program, or ongoing outreach, provide the following information, and identify it using the same numbering sequence as shown below:

1. Identify the type of Outreach A performed. (Select from 1 and/or 2 shown above).
2. Provide a clear description of how each Outreach A activity will be performed to achieve the objective.
3. Identify the population targeted.
4. Provide the length of time of the Outreach A activity, i.e. days and/or hours.
5. Provide the location(s) where the Outreach A activity will be conducted.
6. Provide the number of times Outreach A will be conducted during the fiscal year, or indicate if Outreach A is an ongoing activity.
7. If using other than time surveys, describe how the costs of Outreach A will be developed and documented.
8. Provide the name(s) of the subcontractor(s), if applicable.

Documents Required

Attach to the claiming plan the following documents:

1. Flyers, announcements, or any materials that describe the Outreach A campaigns. If materials are unavailable when the claiming plan is submitted to DHS, provide a statement that gives the location of where materials will be maintained for future DHS and CMS review.
2. A list of subcontractors, if direct-charge invoices will be submitted.
   Copies of those sections of contracts that clearly describe the Outreach A to be performed, how the time spent performing Outreach A will be documented, and that show the effective date of the contract. If direct-charging, the contract must clearly show the method used for determining direct-charge claiming (including application of the Medi-Cal percentage discount) and the dollar amount to be paid to the contractor.

(B1) MEDI-CAL OUTREACH B1
- DISCOUNTED -

CLIENT COUNT OR OTHER METHOD

(Attach additional pages if needed. See description and instructions on reverse.)

Claiming Unit: **Submittal Date:**

Local Governmental Agency:

Methodology Approved for Calculating the Medi-Cal Discount: (Place checkmark next to methodology to be used.)

_____Client Count _____Check here if submitting unapproved methodology.
Explain methodology below:

DHS USE ONLY

CP Reference No. _____ **Original Approval Date:** **Amendment Approval Date:**

MEDI-CAL OUTREACH B1
- DISCOUNTED -
CLIENT COUNT OR OTHER METHOD

DESCRIPTION

Medi-Cal Outreach B1 is a campaign, program, or ongoing activity that is directed toward bringing both Medi-Cal and non-Medi-Cal persons into health care services. Since these campaigns are only allowable to the extent they bring Medi-Cal eligibles into Medi-Cal services, the following outreach activities must be discounted by the Medi-Cal percentage:

1. Campaigns directed toward bringing specific high-risk populations into health care services.
   For example: Media or direct contact Outreach B campaigns directed to high-risk populations, such as low-income or substance-abusing pregnant women, diabetics, HIV-positive persons, TB cases, etc., when these campaigns target both Medi-Cal and non-Medi-Cal eligibles and the health care services are covered by Medi-Cal.
2. Telephone, walk-in, or drop-in services for the purpose of informing or referring persons, including Medi-Cal eligibles, to services covered by Medi-Cal.
3. Conducting specific Medi-Cal health education programs that are included as part of a broader general health education program. The Medi-Cal portion may be allowable if the cost of the general health education program is discounted according to the Medi-Cal percentage.

The approved methods to calculate the discount for Outreach B1 is the Medi-Cal actual client count. Local governmental agencies (LGAs) may use other reasonable methods to calculate the discount. The Department of Health Services (DHS) and the Centers for Medi-Care and Medicaid Services (CMS) will review the methods during the review of the claiming plan. Please refer to Outreach B2 if using the countywide Medi-Cal average method.

NOTE: Targeted Case Management (TCM) case managers, except in local governmental agencies (LGAs), may perform Outreach B1 activities, as well as TCM, provided there is an accurate accounting and reporting of the time spent on each.

Subcontracting
The LGA may subcontract with non-governmental agencies or programs to conduct Outreach B1. If the LGA chooses to direct-charge the Outreach B1 performed by subcontractors, the contracts must clearly describe the Outreach B1 to be performed, the method used for determining direct-charge claiming, and the dollar amount to be paid to the subcontractor.

Individual employees of subcontractors, including LEAs may not claim for the performance of both TCM and MAA.

INSTRUCTIONS FOR PREPARING THE MEDI-CAL OUTREACH B1 CLAIMING PLAN

For *each* campaign, program, or ongoing Outreach B1, provide the following information in the order requested. Identify the information by using the same numbering sequence as shown below:

1. Identify the type of Outreach B1 performed. (Select from 1., 2., and/or 3. shown above.)
2. Provide a clear description of how each Outreach B1 activity will be performed to achieve the objective.
3. Identify the population targeted.
4. Provide the method for calculating the Medi-Cal discount.
5. Provide the length of time of the Outreach B1, i.e. days and/or hours.
6. Provide the location(s) where the Outreach B1 will be conducted.
7. Provide the number of times the Outreach B1 will be conducted during the fiscal year, or indicate if Outreach B1 is an ongoing activity.
8. If using other than time surveys, describe how the costs of Outreach B1 will be developed and documented.
9. Provide the name(s) of the subcontractor(s), if applicable.

Documents Required

Attach to the claiming plan the following documents:
1. Flyers, announcements, or any materials that describe the Outreach B1 campaigns. If materials are unavailable when the claiming plan is submitted to DHS, provide a statement that gives the location of where materials will be maintained for future DHS and CMS review.
2. A list of subcontractors, if direct-charge invoices will be submitted.
3. Copies of those sections of contracts that clearly describe the Outreach B1 to be performed, how the time spent performing Outreach B1 will be documented, and that show the effective date of the contract. If direct-charging, the contract must clearly show the method used for determining direct-charge claiming (including application of the Medi-Cal percentage discount) and the dollar amount to be paid to the contractor.

(B2) MEDI-CAL OUTREACH B2
- DISCOUNTED -

COUNTYWIDE MEDI-CAL AVERAGE

(Attach additional pages if needed. See description and instructions on reverse.)

Claiming Unit: **Submittal Date:**

Local Governmental Agency:

_____Countywide Medi-Cal Average. Used for Calculating the Medi-Cal Discount.

DHS USE ONLY

CP Reference No. _____ **Original Approval Date:** **Amendment Approval Date:**

MEDI-CAL OUTREACH B2
- DISCOUNTED –
COUNTYWIDE MEDI-CAL AVERAGE

DESCRIPTION

Medi-Cal Outreach B2 is a campaign, program, or ongoing activity that is directed toward bringing both Medi-Cal and non-Medi-Cal persons into health care services. Since these campaigns are only allowable to the extent they bring Medi-Cal eligibles into Medi-Cal services, the following outreach activities must be discounted by the Medi-Cal percentage:

1. Campaigns directed toward bringing specific high-risk populations into health care services.
   For example: Media or direct contact Outreach B2 campaigns directed to high-risk populations, such as low-income or substance-abusing pregnant women, diabetics, HIV-positive persons, TB cases, etc., when these campaigns target both Medi-Cal and non-Medi-Cal eligibles and the health care services are covered by Medi-Cal.
2. Telephone, walk-in, or drop-in services for the purpose of informing or referring persons, including Medi-Cal eligibles, to services covered by Medi-Cal.
3. Conducting specific Medi-Cal health education programs that are included as part of a broader general health education program. The Medi-Cal portion may be allowable if the cost of the general health education program is discounted according to the Medi-Cal percentage.

The approved method to calculate the discount for Outreach B2 is the countywide Medi-Cal average. Please refer to Outreach B1 if using the Medi-Cal actual client count or any other reasonable methods to calculate the discount.

NOTE: Targeted Case Management (TCM) case managers, except in local governmental agencies (LGAs) may perform Outreach B2 activities, as well as TCM, provided there is an accurate accounting and reporting of the time spent on each.

Subcontracting

The LGA may subcontract with non-governmental agencies or programs to conduct Outreach B2. If the LGA chooses to direct-charge the Outreach B2 performed by subcontractors, the contracts must clearly describe the Outreach B2 to be performed, the method used for determining direct-charge claiming, and the dollar amount to be paid to the subcontractor.

Individual employees of subcontractors, including LEAs, may not claim for the performance of both TCM and MAA.

INSTRUCTIONS FOR PREPARING THE MEDI-CAL OUTREACH B2 CLAIMING PLAN

For *each* campaign, program, or ongoing Outreach B2, provide the following information in the order requested. Identify the information by using the same numbering sequence as shown below:

1. Identify the type of Outreach B2 performed. (Select from 1., 2., and/or 3. shown above.)
2. Provide a clear description of how each Outreach B2 activity will be performed to achieve the objective.
3. Identify the population targeted.
4. Provide the length of time of the Outreach B2, i.e. days and/or hours.
5. Provide the location(s) where the Outreach B2 will be conducted.
6. Provide the number of times the Outreach B2 will be conducted during the fiscal year or indicate if Outreach B2 is ongoing activity.
7. If using other than time surveys, describe how the costs of Outreach B2 will be developed and documented.
8. Provide the name(s) of the subcontractor(s), if applicable.

Documents Required

Attach to the claiming plan the following documents:

1. Flyers, announcements, or any materials that describe the Outreach B2 campaigns. If materials are unavailable when the claiming plan is submitted to DHS, provide a statement that gives the location of where materials will be maintained for future DHS and CMS review.
2. A list of subcontractors, if direct-charge invoices will be submitted.
3. Copies of those sections of contracts that clearly describe the Outreach B2 to be performed, how the time spent performing Outreach B2 will be documented, and that show the effective date of the contract. If direct-charging, the contract must clearly show the method used for determining direct-charge claiming (including application of the Medi-Cal percentage discount) and the dollar amount to be paid to the contractor.

(C) FACILITATING MEDI-CAL APPLICATION (ELIGIBILITY INTAKE)
(Attach additional pages if needed. See description and instructions on reverse.)

Claiming Unit **Submittal Date:**

Local Governmental Agency:

DHS USE ONLY

CP Reference No. _____ **Original Approval Date:** **Amendment Approval Date:**

FACILITATING MEDI-CAL APPLICATION (ELIGIBILITY INTAKE)

DESCRIPTION

This activity includes the following tasks separately or in combination: **NOTE:** This activity does not include the eligibility determination itself.

1. Explaining Medi-Cal eligibility rules and the Medi-Cal eligibility process to prospective applicants.

2. Assisting an applicant to fill out a Medi-Cal eligibility application.

3. Gathering information related to the application and eligibility determination/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 welfare department.

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

NOTE: Targeted Case Management (TCM) case managers, except in local governmental agencies (LGAs), may perform Eligibility Intake activities, as well as TCM, provided there is an accurate accounting and reporting of the time spent on each.

Subcontracting

The LGA may subcontract with non-governmental agencies or programs to conduct Eligibility Intake. If the LGA chooses to direct-charge the Eligibility Intake performed by subcontractors, the contracts must clearly describe the Eligibility Intake to be performed, the method used for determining direct-charge claiming, and the dollar amount to be paid to the subcontractor.

Individual employees of subcontractors, including LEAs, may not claim for the performance of both TCM and Medi-Cal Administrative Activities (MAA).

The LGA may subcontract with non-governmental agencies or programs to conduct eligibility intake activities. TCM case managers, except in LEAs, may conduct eligibility intake, so long as there is an accurate accounting and reporting of the time spent on each. Individual employees of subcontractors may not perform both TCM and MAA.

INSTRUCTIONS FOR PREPARING THE FACILITATING MEDI-CAL APPLICATION (ELIGIBILITY INTAKE) CLAIMING PLAN

Provide the information listed below. Identify the information by using the same numbering sequence as shown below:

1. Identify the Eligibility Intake objective. (Select from 1., 2., 3., and/or 4. shown above).
2. Provide a clear description of how the Eligibility Intake activity will be performed to achieve the objective. For example, identify the staff performing the activity, describe what is performed, indicate when and where it is performed, and explain the purpose of performing it.
3. Indicate whether the Eligibility Intake is performed by the LGA's subcontractors or by claiming unit staff.
4. Provide the name(s) and address(es) of the subcontractor(s), if applicable.
5. If using other than time surveys, describe how the costs of the Eligibility Intake will be developed and documented.

Documents Required

Attach to the claiming plan the following documents:

1. Copies of any materials unique to or designed by the claiming unit for use in conjunction with this activity.
2. A list of subcontractors, if direct-charge invoices will be submitted.
3. Copies of those sections of contracts that clearly describe the Eligibility Intake to be performed, how the time spent performing the Eligibility Intake will be documented, and that show the effective date of the contract. If direct-charging, the contract must clearly show the method used for determining direct-charge claiming (including application of the Medi-Cal percentage discount) and the dollar amount to be paid to the contractor.

(D) MEDI-CAL NON-EMERGENCY, NON-MEDICAL TRANSPORTATION
(Attach additional pages if needed. See description and instructions on reverse.)

Claiming Unit: **Submittal Date:**

Local Governmental Agency:

DHS USE ONLY

CP Reference No. _____ **Original Approval Date:** **Amendment Approval Date**:

MEDI-CAL NON-EMERGENCY, NON-MEDICAL TRANSPORTATION

DESCRIPTION

This activity includes arranging and/or providing non-emergency, non-medical transportation of Medi-Cal eligibles to Medi-Cal services, and when medically necessary, accompaniment by an attendant. This activity is claimable only if the Local Governmental Agency (LGA) incurs actual allowable costs, such as taxi vouchers, bus tokens, mileage, vans, drivers, etc. If no actual cost is borne, the activity cannot be claimed.

NOTE: This activity cannot be claimed if it is performed by a Targeted Case Management (TCM) case manager. The TCM rate includes the costs incurred by case managers for arranging and/or providing transportation for, and/or accompanying Medi-Cal eligibles to Medi-Cal services.

In situations where an LGA operates a separate transportation unit or contracts for the provision of transportation services, the costs of the unit or the contractor of actually providing the Medi-Cal non-emergency, non-medical transportation services for Medi-Cal eligibles to Medi-Cal services is an allowable Medi-Cal administrative cost. Costs may be calculated on a per-mile or per-trip basis for each Medi-Cal client transported or by any other reasonable method (to be reviewed for approval by DHS).

INSTRUCTIONS FOR PREPARING THE MEDI-CAL NON-EMERGENCY, NON-MEDICAL TRANSPORTATION CLAIMING PLAN

For *each* type of transportation performed, provide the following information. Identify the information by using the same numbering sequence as shown below.

1. Individually list and clearly describe each allowable type of transportation activity: (a) Arranging non-emergency, non-medical transportation; (b) Providing non-emergency, non-medical transportation; and (c) Accompanying Medi-Cal eligibles to Medi-Cal services.

2. Provide a clear and specific description of how each type of transportation activity will be performed to achieve the objective.

3. Provide the name(s) of the subcontractor(s) performing the transportation, if applicable.

4. Provide the method used to determine time and costs when the activity is performed by claiming unit staff or by subcontractors, and how the cost is calculated.

5. Provide the method for calculating the Medi-Cal discount.

Documents Required

Attach to the claiming plan the following documents:

1. Copies of those sections of contracts that clearly describe the transportation to be performed; how the time spent performing the transportation will be documented; how the transportation will be charged, e.g., per mile, per trip, etc.; how the rate is calculated; and that show the effective date of the contract.

2. Documents that support the calculation of transportation costs. For example: sales receipts for vans, salary schedules for drivers, etc.

(E) CONTRACTING FOR MEDI-CAL SERVICES AND MEDI-CAL ADMINISTRATIVE ACTIVITIES
(Attach additional pages if needed. See description and instructions on reverse.)

Claiming Unit: **Submittal Date:**

Local Governmental Agency:

DHS USE ONLY

CP Reference No. _____ **Original Approval Date:** **Amendment Approval Date**:

CONTRACTING FOR MEDI-CAL SERVICES AND MEDI-CAL ADMINISTRATIVE ACTIVITIES

DESCRIPTION

This activity involves entering into contracts with community-based organizations or other provider agencies for the provision of Medi-Cal services and/or Medi-Cal Administrative Activities (MAA), other than Targeted Case Management (TCM). The costs of TCM subcontractor administration should be included in the TCM rate.

NOTE: Local Governmental Agencies (LGAs) have the option of claiming the costs of contract administration for allowable MAA, such as Outreach, under that activity, or the costs may be claimed under Contract Administration. Under no circumstances are the costs of contract administration for allowable MAA to be claimed under both Contract Administration and the activity, such as Outreach. Contracting for Medi-Cal Services may only be claimed under Contract Administration.

Contracting for Medi-Cal Services and/or MAA is claimable as MAA under activity "E" when the administration of those contracts meets all of the following criteria:

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

Discounted Costs

The contracts being administered must be for Medi-Cal services and/or MAA and may involve Medi-Cal populations only or may involve Medi-Cal and other indigent, non-Medi-Cal populations. When the contract involves a Medi-Cal and non-Medi-Cal population, the costs of contract administration may be discounted by the Medi-Cal percentage. In addition, another reasonable basis may be used by LGAs to apportion the time of employees who administer contracts involving Medi-Cal and non-Medi-Cal activities and services.

Direct Charge

If employees perform contract administration 100 percent of their time, the activity should be claimed on the direct-charge portion of the MAA invoice.

Not Claimable under MAA

1. TCM case managers and LGA subcontractors, except for school district staff, *cannot* claim contract administration. Contract administration must be an LGA function. Schools may contract for Medi-Cal services in connection with the Local Educational Agency billing option.
2. The costs of contracting for TCM services with non-LGA providers should be claimed as part of the TCM rate. These costs cannot be separately claimed as MAA.
3. The administrative costs of contracting by LGAs as service providers under managed care arrangements may not be claimed as MAA and are considered to be in the capitation payment to the LGA.

INSTRUCTIONS FOR PREPARING THE CONTRACTING FOR MEDI-CAL SERVICES AND MEDI-CAL ADMINISTRATIVE ACTIVITIES CLAIMING PLAN

1. Individually list each type of contract administered by the claiming unit and describe how staff perform contract administration for each contract listed.
2. For each contract, indicate whether the contract is for Medi-Cal populations only or for a combination of Medi-Cal and non-Medi-Cal populations.
3. For those contracts that combine both Medi-Cal and non-Medi-Cal populations, indicate the Medi-Cal population served by each contract and the methodology used for determining the Medi-Cal percentage.
4. For each contract, explain the method for allocating time spent by employees between Medi-Cal and non-Medi-Cal contract functions, if this method of discounting will be used.

Documents Required

Attach to the claiming plan a sample of the contracts being administered.

(F) PROGRAM PLANNING AND POLICY DEVELOPMENT

(Attach additional pages if needed. See description and instructions on reverse.)

Claiming Unit: **Submittal Date:**

Local Governmental Agency:

DHS USE ONLY

CP Reference No. _____ **Original Approval Date:** **Amendment Approval Date:**

(F) PROGRAM PLANNING AND POLICY DEVELOPMENT

This activity is claimable as Medi-Cal Administrative Activities (MAA) when program planning and policy development (PP&PD) is performed, either part-time or full-time, by one or more Local Governmental Agency/Local Education Agency (LGA/LEA) employees and subcontractors whose tasks officially involve PP&PD. LGA/LEA employees performing PP&PD must have the tasks identified in the employees' position descriptions/duty statements. If the programs serve both Medi-Cal and non-Medi-Cal clients, the costs of PP&PD activities must be allocated according to the Medi-Cal percentages being served by the programs.

Direct Charge

Costs may be claimed on the direct-charge portion of the MAA invoice if the employee performs PP&PD activities 100 percent of their paid working time. This activity is claimable ONLY if the administrative amounts being claimed for PP&PD persons and activities are not otherwise included in other claimable cost pools and if the amounts being claimed for such persons employed by ***(and activities taking place in***) a service provider setting are not otherwise being reimbursed through the billable service rate of that provider. Costs for persons performing PP&PD functions less than 100 percent of their time will be based on a time-survey.

In counties with countywide managed care arrangements, PP&PD activities are claimable as MAA only for those services that are excluded from the managed care contracts.

Under the conditions specified above, the following tasks are allowable as MAA under PP&PD:

1. Developing strategies to increase Medi-Cal system capacity and close Medi-Cal service gaps. This includes analyzing Medi-Cal data related to a specific program or specific group.
2. Interagency coordination to improve delivery of Medi-Cal services.
3. Developing resource directories of Medi-Cal services/providers.
4. For subcontractors, some PP&PD support services are allowable, such as developing resource directories, preparing Medi-Cal data reports, conducting needs assessments, or preparing proposals for expansion of Medi-Cal services.

Not Allowable

1. This activity is not allowable if staff performing this function are employed full-time by LGA service providers, such as clinics. The full costs of the employee's salary are assumed to be included in the billable fee-for-service rate, and separate MAA claiming is not allowed.
2. This activity is not allowable if staff who deliver services part-time in an LGA service provider setting, such as a clinic, are performing PP&PD activities relating to the service provider setting in which they deliver services.
3. PP&PD activities are not allowable MAA activities when performed by Targeted Case Management (TCM) case managers.

INSTRUCTIONS FOR PREPARING THE PROGRAM PLANNING AND POLICY DEVELOPMENT CLAIMING PLAN

The LGA must submit a detailed claiming plan that identifies:

1. The units or classifications being claimed and whether or not they are skilled professional medical personnel (SPMP).
2. Each type of allowable PP&PD tasks performed by the staff (individually listed).
3. The health programs involved (if the activity is performed in the LGA's health department).
4. The location(s) where the activity(ies) is performed.
5. Whether staff perform PP&PD activities full-time or part-time. For part-time performance of activities, indicate whether staff deliver direct services part-time in a billable setting and identify the setting.
6. How the Medi-Cal discount percentage will be determined.
7. The method that will be used for claiming, i.e., direct-charge or time studies. Explain the method for determining time and costs.
8. Whether and which PP&PD activities are being performed by contractors and consultants.

Documents Required

Attach to the claiming plan the following documents:

1. List of subcontractors, if applicable
2. Copies of any contracts entered into for the performance of PP&PD that:
   (a) Clearly describe the PP&PD to be performed.
   (b) Describe how the time spent performing PP&PD will be documented,
   (c) The effective date of the contract,
   (d) The method used for determining direct-charge claiming (including application of the Medi-Cal percentage discount), and
   (e) The dollar amount to be paid to the contractor
3. Resource directories, if available.
4. A listing of staff employed in service-provider settings who are involved with the four allowable MAA tasks: developing strategies, interagency coordination, developing resource directories, and contracted support services. As noted above, PP&PD is not allowable if staff performing this function are employed by LGA services providers, such as clinics.

(G) MEDI-CAL ADMINISTRATIVE ACTIVITIES/TARGETED CASE MANAGEMENT COORDINATION AND LOCAL GOVERNMENTAL AGENCY CLAIMS ADMINISTRATION
(Attach additional pages if needed. See description and instructions on reverse.)

Claiming Unit: **Submittal Date:**

Local Governmental Agency:

DHS USE ONLY

CP Reference No. _____ **Original Approval Date:** **Amendment Approval Date:**

MEDI-CAL ADMINISTRATIVE ACTIVITIES/TARGETED CASE MANAGEMENT COORDINATION AND LOCAL GOVERNMENTAL AGENCY CLAIMS ADMINISTRATION

DESCRIPTION

The Medi-Cal Administrative Activities (MAA)/Targeted Case Management (TCM) Coordinator and claims administration staff may claim the costs of the following activities, as well as any other reasonable activities directly related to the local governmental agency (LGA) administration of TCM services and MAA at the LGA-wide level. All of these activities must be detailed in the claiming plan.

1. Drafting, revising, and submitting MAA claiming plans, and TCM performance monitoring plans.
2. Serving as liaison with claiming programs within the LGA and with the state and federal governments on MAA/TCM. Monitoring the performance of claiming programs.
3. Administering LGA claiming, including overseeing, preparing, compiling, revising, and submitting TCM and MAA claims on an LGA-wide basis to the state.
4. Attending training sessions, meetings, and conferences involving TCM and/or MAA.
5. Training LGA program and subcontractor staff on state, federal, and local requirements for MAA/TCM claiming.
6. Ensuring that MAA and TCM claims do not duplicate Medi-Cal claims for the same activities from other providers. This includes ensuring that services are not duplicated when a Medi-Cal beneficiary receives TCM services from more than one case manager.

Direct Charge

LGA employees whose position descriptions/duty statements include the administration of TCM and MAA on an LGA-wide basis may claim directly for the costs of these activities on the MAA invoice as a direct charge.

In addition, costs incurred in preparation and submission of MAA claims at any level, including staff time, supplies, and computer time, may be direct-charged. If the MAA/TCM Coordinator and/or claims administration staff are performing this function part-time, along with other duties, they must certify the percentage of total time spent performing the duties of MAA/TCM coordination and/or claims administration. (Do not assign a percentage of time spent on each allowable activity. Provide only the total percentage of time spent performing all the applicable activities listed in numbers 1 through 6 above.) The percentage certified for the MAA/TCM Coordinator/claims administration staff activities must be used as the basis for federal claiming.

NOTE: The costs of the MAA/TCM Coordinators' time and claims administration staff time must not be included in the TCM rate or in MAA claiming, since the costs associated with the time are to be direct-charged. Charges for supervisors, clericals, and support staff for these employees may be allocated based upon the percentage of certified time of the MAA/TCM Coordinator and claims administration staff. The cost of TCM claiming activity at the TCM provider level is to be included in the TCM rate.

INSTRUCTIONS FOR PREPARING THE MEDI-CAL ADMINISTRATIVE ACTIVITIES/TARGETED CASE MANAGEMENT COORDINATION AND LOCAL GOVERNMENTAL AGENCY CLAIMS ADMINISTRATION CLAIMING PLAN

1. Individually list each type of allowable MAA/TCM coordination and claims administration performed, and describe how staff perform this activity.
2. Indicate whether staff perform this activity part-time in addition to other duties.
3. Describe the method that will be used for claiming, i.e. direct-charge or time studies.
4. Indicate whether contractors or consultants are performing any claims-preparation activities.

Documents Required

- Attach copies of any contracts entered into for the performance of LGA claims administration.

TRAINING

(Attach additional pages if needed. See description and instructions on reverse.)

Claiming Unit: **Submittal Date:**

Local Governmental Agency:

DHS USE ONLY

CP Reference No. _____ **Original Approval Date:** **Amendment Approval Date:**

TRAINING

DESCRIPTION

Training, which may be given or received, includes training in general Medi-Cal program overview, such as: Services and changes in services: specific Medi-Cal Administrative Activities (MAA), e.g., Outreach, Eligibility Intake, etc.; general managed care program overview; completing MAA time studies and reporting requirements; and technical updates on Medi-Cal eligibility. Training must be related to the performance of MAA and must be claimed to the activity it relates to, e.g., Outreach, Eligibility Intake, etc. If the raining is related to the performance of MAA and overlaps several MAA categories, the training time may be divided among the individual MAA categories it relates to. Training unrelated to the performance of MAA must be charged to the related program, e.g., Targeted Case Management (TCM), Maternal and Child Health, Child Health and Disability Prevention, etc.

The only skilled professional medical personnel (SPMP) administrative activities that are allowable at the 75 percent federal financial participation (FFP) rate are those that directly relate to the SPMP's performance of his or her allowable SPMP administrative activities. Reimbursement cannot be claimed for medical or health-related training provided to or conducted by and SPMP. Training for SPMPs and non-SPMPs that is directly related to MAA that are non-enhanced is matched at the 50 percent FFP rate.

INSTRUCTIONS FOR PREPARING THE TRAINING CLAIMING PLAN

1. Individually list (by course title, if applicable) and clearly describe each allowable type of training activity and how it relates to the MAA.

2. The frequency of the training.

3. The approximate number of staff who, as a part of their job, perform the training. (Position descriptions/duty statements must list training as one of their duties.)

4. Indicate for each training course the approximate number of staff expected to attend the training course during the fiscal year.

5. Describe the method of determining time and costs for this activity when it is performed in-house or by subcontractors.

<u>Documents Required</u>

Attach to the claiming plan the following documents:

1. A list of subcontractors, if direct-charge invoices will be submitted.

2. Copies of those sections of the contracts that clearly describe the Training to be performed, how the time spent performing the Training will be documented, and that show the effective date of the contract. If direct-charging, the contract must clearly show the method used for determining the direct-charge claiming, i.e. the amount charged per training student or session.

DOCUMENTS REQUIRED FOR EACH
MEDI-CAL ADMINISTRATIVE ACTIVITY

A - Medi-Cal Outreach A (Not Discounted) B - Medi-Cal Outreach B1 and B2 (Discounted)	Flyers, announcements, or any materials that describe the outreach campaigns. If materials are unavailable when you submit the claiming plan, provide a statement that gives the location of where materials will be maintained for future DHS and CMS review. Position descriptions/duty statements for the staff performing the MAA A list of subcontractors. Copies of those sections of the contract that clearly describe the outreach to be performed, how the time spent performing the outreach will be documented, and that show the effective date of the contract. If direct-charging, the contract must clearly show the method used for determining direct-charge costs (including application of the Medi-Cal percentage discount) and the dollar amount to be paid to the contractor.
C - Facilitating Medi-Cal Application (Eligibility Intake)	Materials unique to or designed by the claiming unit for use in conjunction with this activity. Position descriptions/duty statements for the staff performing the MAA. A list of subcontractors, if direct-charge invoices will be submitted. Copies of those sections of contracts that clearly describe the Eligibility Intake to be performed, how the time spent performing the Eligibility Intake will be documented, and that show the effective date of the contract. If direct-charging, the contract must clearly show the method used for determining direct-charge costs (including application of the Medi-Cal percentage discount) and the dollar amount to be paid to the contractor.
D - Medi-Cal Non-Emergency, Non-Medical Transportation	Position descriptions/duty statements for the staff performing the MAA. Copies of those sections of contracts that clearly describe the transportation to be performed; how the time spent performing the transportation will be documented; how the transportation will be charged, e.g., per mile, per trip, etc.; how the rate is calculated; and that show the effective date of the contract. Documents that support the calculation of transportation costs. For example: sales receipts for vans, salary schedules for drivers, etc.
E - Contracting for Medi-Cal Services	Position descriptions/duty statements for the staff performing the MAA. Copies of a sample of the contracts being administered.

DOCUMENTS REQUIRED FOR EACH
MEDI-CAL ADMINISTRATIVE ACTIVITY
(CONTINUED)

F - Program Planning and Policy Development	Position descriptions/duty statements for the staff performing the MAA. *A listing of subcontractors* *Copies of any contracts entered into for the performance of PP&PD that: (a) clearly describe the PP&PD to be performed: (b) described how the time spent performing PP&PD will be documented: (c) the effective date of the contract: (d) if direct-charging, the method used for determining the direct-charge claiming (including application of the Medi-Cal percentage discount): and (e) the dollar amount to be paid to the contractor.* Resource directories, if available, and a list of service providers that are involved with developing strategies, interagency coordination, and developing resource directories.
G – MAA/TCM Coordination and Claims Administration	Position descriptions/duty statements for the staff performing the MAA. A certification statement from staff who perform this function in addition to other duties that indicates the percentage of total time spent performing this activity. Copies of any contracts entered into for the performance of LGA claims administration.
Training	Position descriptions/duty statements for the staff performing the MAA. Copies of those sections of the contracts that clearly describe the Training to be performed, how the time spent performing the Training will be documented, and that show the effective date of the contract. If direct-charging, the contract must clearly show the method used for determining the direct-charge claiming, i.e. the amount charged per student r session.

CLAIMING PLAN REVIEW RECORD

Name of LGA:	
Name of Reviewer:	Date of Review:

INFORMATION RECEIVED FROM LGA	**YES**	**NO**
"Certification Statement" form completed and signed.		
Table of contents, listing by section, each claiming unit included in the claiming plan.		
County/chartered city organization chart showing all departments, programs and sub contractors participating in MAA.		

CLAIMING PLAN APPROVAL	
Claiming Plan Approved: ( ) Yes ( ) No Date:	
IF NO: Date of letter to LGA:	
Date Claiming Plan Returned to DHS:	
Corrected Claiming Plan Approved: ( ) Yes ( ) No Date:	
IF YES- Date Forwarded to CMS:	
Date of CMS approval:	
Date LGA Notified of Approval:	
Effective Date of Claiming Plan:	

AMENDMENTS TO CLAIMING PLAN
Amendment No.: Date Received:
Approved: ( ) Yes ( ) No Date:
IF NO: Date of letter to LGA:
Date Amendment Returned to DHS:
Corrected Amendment Approved: ( ) Yes ( ) No
IF YES: Date Amendment Forwarded to CMS:
Date of CMS Approval:
Date LGA Notified of Approval:
Effective date of Amendment:

Name of Claiming Unit:		
INFORMATION RECEIVED FROM CLAIMING UNIT	**YES**	**NO**
"Claiming Unit Functions" form completed		

COMMENTS:

✓ MEDI-CAL ADMINISTRATIVE ACTIVITIES PERFORMED BY CLAIMING UNIT	
Medi-Cal Outreach A (Not Discounted)	
Medi-Cal Outreach B1 B2 (Discounted)	
Facilitating Medi-Cal Application (Eligibility Intake)	
Medi-Cal Non-Emergency, Non-Medical Transportation	
Contracting for Medi-Cal Services	
Program Planning and Policy Development	
MAA/TCM Coordination and Claims Administration	

MEDI-CAL OUTREACH A	YES	NO
1. Claiming plan identifies the type of Outreach A to be performed. (Selected from 1 and/or 2 of pg. 6 of "Preparing the Medi-Cal Administrative Activities Claiming Plan.")		
2. A clear description is provided of how each Outreach A activity will be performed to achieve the objective.		
3. The population targeted is identified.		
4. The length of time of the Outreach A is provided in days and/or hours		
5. The location of where the Outreach A will be conducted is provided.		
6. The number of times Outreach A programs/campaigns will be conducted during the fiscal year is provided. *Reviewer, if claiming plan indicates that Outreach B is an ongoing activity only, mark N/A.*		
7. Claiming plan indicates if Outreach A is an ongoing activity. *Reviewer, if not applicable, mark N/A.*		
8. Claiming plan indicates that time surveys will not be used and describes how the costs of Outreach A will be developed and documented. *Reviewer, if not applicable, mark N/A.*		
9. The names of subcontractors are provided when applicable. *Reviewer, if not applicable, mark N/A.*		

COMMENTS:

MEDI-CAL OUTREACH A DOCUMENTS RECEIVED	YES	NO
1. Position descriptions/duty statements for each of the staff performing MAA.		
2. Flyers, announcements, or any materials that describe the Outreach A campaigns.		
3. If claiming plan indicates that materials are not available, is a statement included that gives the location of where the materials will be maintained for future DHS and CMS review?		
4. A list of subcontractors. *Reviewer, if not applicable, mark N/A.*		
5. Copies of those sections of contracts that clearly describe the Outreach A to be performed, how the time spent performing Outreach A will be documented, and that show the effective date of the contract.		
6. If direct-charging, does the contract clearly show the method to be used for determining direct-charge costs claiming (including application of the Medi-Cal percentage discount) and the dollar amount to be paid to the contractor.		

COMMENTS:

MEDI-CAL OUTREACH B1 or B2 or B3	YES	NO
1. Claiming plan identifies the type of Outreach B to be performed. (Selected from 1., 2., and/or 3. of pg. 8 of "Preparing the Medi-Cal Administrative Activities Claiming Plan.")		
2. A clear description is provided of how each Outreach B activity will be performed to achieve the objective.		
3. The population targeted is identified.		
4. The method for calculating the Medi-Cal discount is provided.		
5. The length of time of the Outreach B is provided in days and/or hours.		
6. The location of where the Outreach B will be conducted is provided.		
7. The number of times Outreach B programs and/or campaigns will be conducted during the fiscal year . *Reviewer, if claiming plan indicates that Outreach B is an ongoing activity only, mark N/A.*		
8. Claiming plan indicates that Outreach B is an ongoing activity. *Reviewer, if not applicable, mark N/A.*		
9. Claiming plan indicates that time surveys will not be used and describes how the costs of Outreach B will be developed and documented. *Reviewer, if not applicable, mark N/A.*		
10. The names of subcontractors are provided when applicable. *Reviewer, if not applicable, mark N/A.*		

COMMENTS:

MEDI-CAL OUTREACH B1 or B2 or B3 DOCUMENTS RECEIVED	YES	NO
1. Position descriptions/duty statements for each of the staff performing MAA.		
2. Flyers, announcements, or any materials that describe the Outreach B programs/campaigns.		
3. If claiming plan indicates that materials are not available, is a statement included that gives the location of where the materials will be maintained for future DHS and CMS review?		
4. A list of subcontractors. *Reviewer, if not applicable, mark N/A.*		
5. Copies of those sections of contracts that clearly describe the Outreach B to be performed, how the time spent performing Outreach B will be documented, and that show the effective date of the contract. *Reviewer, if not applicable, mark N/A.*		
6. If direct-charging, does the contract clearly show the method to be used for determining direct-charge costs claiming (including application of the Medi-Cal percentage discount) and the dollar amount to be paid to the contractor. *Reviewer, if not applicable, mark N/A.*		

COMMENTS:

FACILITATING MEDI-CAL APPLICATION (ELIGIBILITY INTAKE)	YES	NO
1. Claiming plan identifies the Eligibility Intake objective. (Selected from 1., 2., 3., and/or 4. of pg. 10 of "Preparing the Medi-Cal Administrative Activities Claiming Plan.")		
2. A clear description is provided of how the Eligibility Intake will be performed to achieve the objective.		
3. Claiming plan indicates if the Eligibility Intake is performed by the LGA's subcontractors or by claiming unit staff.		
4. The names and addresses of the subcontractors are provided. *Reviewer, if not applicable, mark N/A.*		
5. Claiming plan indicates that time surveys will not be used and describes how the costs of Eligibility Intake will be developed and documented. *Reviewer, if not applicable, mark N/A.*		

COMMENTS:

FACILITATING MEDI-CAL APPLICATION (ELIGIBILITY INTAKE) DOCUMENTS RECEIVED	YES	NO
1. Position descriptions/duty statements for each of the staff performing MAA.		
2. Copies of any materials unique to or designed by the claiming unit for use in conjunction with this activity.		
3. A list of subcontractors if claiming plan indicates direct-charge invoices will be submitted. *Reviewer, if not applicable, mark N/A.*		
4. Copies of those sections of contracts that clearly describe the Eligibility Intake to be performed, how the time spent performing Eligibility Intake will be documented, and that show the effective date of the contract. *Reviewer, if not applicable, mark N/A.*		
5. If direct-charging, does the contract clearly show the method to be used for determining direct-charge costs (including application of the Medi-Cal percentage discount) and the dollar amount to be paid to the contractor? *Reviewer, if not applicable, mark N/A.*		

COMMENTS:

MEDI-CAL NON-EMERGENCY, NON-MEDICAL TRANSPORTATION	YES	NO
1. Claiming plan individually lists and clearly describes each allowable type of transportation activity.		
2. A clear description is provided of how the transportation activity is performed to achieve the objective.		
3. The names of subcontractors are provided. *Reviewer, if not applicable, mark N/A.*		
4. The method for calculating the Medi-Cal discount is provided.		
5. The claiming plan provides the method used to determine time and costs when the activity is performed by claiming unit staff or by subcontractors and how the cost is calculated.		

COMMENTS:

MEDI-CAL NON-EMERGENCY, NON-MEDICAL TRANSPORTATION DOCUMENTS RECEIVED	YES	NO
1. Position descriptions/duty statements for each of the staff performing MAA		
2. Copies of those sections of contracts that clearly describe the transportation to be performed; how the time spent performing the transportation will be documented; how the transportation will be charged, e.g., per mile, per trip, etc.; how the rate is calculated; and that show the effective date of the contract. *Reviewer, if not applicable, mark N/A.*		
3. Documents that support the calculation of transportation costs. For example: sales receipts or vans, salary schedules for drivers, etc.		

COMMENTS:

CONTRACTING FOR MEDI-CAL SERVICES AND MEDI-CAL ADMINISTRATIVE ACTIVITIES	YES	NO
1. Claiming plan individually lists each type of contract administered by the claiming unit and describes how staff perform contract administration for each contract listed.		
2. Each contract indicates whether the contract is for Medi-Cal populations only or whether the contract is for a combination of Medi-Cal and non-Medi-Cal populations.		
3. For those contracts that combine both Medi-Cal and non-Medi-Cal populations, the claiming plan indicates the Medi-Cal population served by each contract and the methodology used for determining the Medi-Cal percentage. *Reviewer, if not applicable, mark N/A.*		
4. An explanation is provided of the method for allocating time spent by employees between Medi-Cal and non-Medi-Cal contract functions. *Reviewer, if not applicable, mark N/A.*		

COMMENTS:

CONTRACTING FOR MEDI-CAL SERVICES AND MEDI-CAL ADMINISTRATIVE ACTIVITIES DOCUMENTS RECEIVED	YES	NO
1. Position descriptions/duty statements for each of the staff performing MAA.		
2. Copies of a sample of the contracts being administered.		

COMMENTS:

PROGRAM PLANNING AND POLICY DEVELOPMENT	YES	NO
1. Claiming plan individually lists each type of program planning and policy development (PP&PD) performed by full-time or part-time staff.		
2. Claiming plan provides the location where the activity is performed.		
3. Claiming plan indicates that the activity is performed in the LGA's health department and identifies the health programs involved. *Reviewer, if not applicable, mark N/A.*		
4. Claiming plan contains an explanation of the method for determining time and costs.		

COMMENTS:

PROGRAM PLANNING AND POLICY DEVELOPMENT DOCUMENTS RECEIVED	YES	NO
1. Position descriptions/duty statements for each of the staff performing MAA.		
2. Resource directories. NOTE TO REVIEWER: If claiming plan indicates that resource directories are not available, please note that in this space.		
3. A list of service providers that are involved with developing strategies, interagency coordination, and developing resource directories.		

COMMENTS:

MAA COORDINATION AND CLAIMS ADMINISTRATION	YES	NO
1. Claiming plan individually lists each type of coordination/claims administration performed and describes how staff perform this activity.		
2. Claiming plan indicates whether staff perform this activity part-time in addition to other duties.		
3. Claiming plan indicates the method that will be used for claiming this activity, i.e. direct-charge or time studies.		
4. Claiming plan indicates whether any claims-preparation activity is being performed by contractors or consultants. *Reviewer, if not applicable, mark N/A.*		

COMMENTS:

MAA COORDINATION AND CLAIMS ADMINISTRATION DOCUMENTS RECEIVED	YES	NO
1. Position descriptions/duty statements for each of the staff performing training.		
2. Copies of any contracts entered into for the performance of LGA claims administration.		

COMMENTS:

TRAINING	YES	NO
1. Claiming plan individually lists and clearly describes allowable type of training activity and how it relates to the MAA.		
2. Claiming plan indicates the frequency of the training.		
3. Claiming plan provides the approximate number of staff who, as a part of their job, perform the training. *Reviewer, position descriptions/duty statements must list Training as one of their duties.*		
4. Claiming plan provides, for each training listed, the approximate number of staff expected to attend during the fiscal year.		
5. Claiming plan contains a description of the method of determining time and costs when the activity is performed in-house or by subcontractors.		

COMMENTS:

TRAINING DOCUMENTS RECEIVED	YES	NO
1. Position descriptions/duty statements for each of the staff performing training.		
2. A list of subcontractors if the claiming plan indicates direct-charge invoices will be submitted.		
3. Copies of those sections of the contracts that clearly describe the Training to be performed, how the time spent performing the Training will be documented, and that show the effective date of the contract.		
4. If direct-charging, does contract clearly show the method used for determining the direct-charge claiming, i.e. the amount charged per student or session.		

COMMENTS:

CLAIMING PLAN *AMENDMENT* CHECKLIST

	CHANGES THAT MAY OR MAY NOT REQUIRE AN AMENDMENT TO EXISTING MAA CLAIMING PLANS COULD CONSIST OF THE FOLLOWING: **County:** **Name of Claiming Unit:** **Submittal Date:**	**Need To Submit Amendment To Your MAA Claiming Plan?**	✓
1	**C**hange in the originally submitted ***ORGANIZATION CHART.***	No	☐
2	**C**hange in ***ADDRESS, PHONE NUMBER, OR MAA/TCM COORDINATOR*** for a Claiming Unit.	No	☐
3	**A**ddition of new ***CLAIMING UNIT.***	No *	☐
4	**I**nactivity (i.e., non-claiming) of an approved ***CLAIMING UNIT***.	No *	☐
5	**D**eletion of previously approved ***CLAIMING UNIT***.	No *	☐
6	**C**hange in the ***DESCRIPTION*** of the specific ***CLAIMING UNIT*** functions performed by the Claiming Unit, as described in box #8, on page 3, of the *Claiming Plan Instructions*.	No	☐
7	**C**hange in the ***NAME*** of the ***CLAIMING UNIT*** (which affects the claims / invoicing).	**Yes**	☐
8	**D**esignation of activities as either ***OUTREACH B1 OR B2***. (Note: Amend GRID.)	**Yes**	☐
9	**A**ddition of new ***MAA CATEGORY*** to an existing Claiming Unit; e.g., adding PP&PD. (Note: Amend GRID.)	**Yes**	☐
10	**A**ddition of new, ***CAMPAIGN, PROGRAM, OR ACTIVITY*** that is substantially different from those approved for Outreach "A," "B1," and/or "B2" to an existing Claiming Unit.	**Yes**	☐
11	**I**nactivity (i.e., non-claiming) of an approved ***MAA CATEGORY*** for an existing Claiming Unit.	No *	☐
12	**D**eletion of previously approved ***MAA CATEGORY*** for a Claiming Unit, e.g., deleting PP&PD.	No *	☐
13	**C**hange in the "health programs" for which ***PP&PD*** is performed.	No *	☐
14	**A**ddition of new ***POSITION CLASSIFICATIONS*** performing MAA, as described in box #9, on page 3 of the *Claiming Plan Instructions*. (Note: Amend GRID and submit position descriptions/duty statements.)	No	☐
15	**D**eletion of a classification from the ***STAFF JOB CLASSIFICATION GRID***, as described in box #10, on page 3 of the *Claiming Plan Instructions*.	No	☐
16	**C**hange in the existing ***POSITION DESCRIPTION/DUTY STATEMENT.***	**Yes**	☐
17	**C**hange in the total ***NUMBER OF STAFF*** for which MAA will be claimed -- increase ***or*** decrease of 25 percent or more than the number in the approved Claiming Plan. (Note: Amend GRID).	**Yes**	☐
18	**C**hange in the number of staff who are ***SPMP*** or ***NON-SPMP***, as described in box #11, on page 3 of the *Claiming Plan Instructions*.	No	☐
19	**A**ddition of a new ***SUBCONTRACTOR*** to an existing Claiming Unit. (Note: Submit copies of those sections of contract that describe the activity to be performed.)	**Yes**	☐
20	**C**hange in the types of ***CONTRACTS*** for which "Contracting for Medi-Cal Services and MAA" is performed.	No	☐
21	**I**nactivity (i.e., non-claiming) of an approved ***SUBCONTRACTOR*** for an existing Claiming Unit.	No *	☐
22	**D**eletion of previously approved ***SUBCONTRACTOR*** from an existing Claiming Unit.	No *	☐

23	**C**hange in the ***METHODOLOGY*** used in calculating the Medi-Cal discount percentage for MAA.	**Yes**	☐
24	**C**hange in the ***METHODOLOGY*** used for determining how the time and costs for MAA will be developed and documented.	**Yes**	☐
25	**C**hange in how (methodology/basis) the rate is calculated for ***TRANSPORTATION*** costs.	**Yes**	☐
26	**I**ncrease/decrease in ***TRANSPORTATION*** costs (however, methodology is the same).	No	☐
27	**C**hange in the ***TARGETED POPULATION(S)***, e.g., addition of pregnant teens who need treatment.	No	☐
28	**C**hange in the ***LOCATION(S)*** where an approved MAA will be performed; e.g., changing the location from the "Main School Clinic" in Martinez, to the "Central School Clinic" in Pittsburgh.	No	☐
29	**C**hange in the ***NUMBER OF TIMES*** outreach campaigns, programs, or activities will be conducted; e.g., changing from weekly to biweekly.	No	☐
30	***OTHER:***		☐

*Even though amendments are **not** required for these **inactive and/or deletions**, if the local governmental agency (LGA) resumes claiming for these categories, please be sure the previously approved Claiming Plan is still applicable.

It is required that this *Checklist* accompany the MAA Claiming Plan amendment, along with a cover letter from the LEC and a new ***Certification Statement*** containing a new date and signature. This *Checklist* is not an all-inclusive listing of Claiming Plan amendment situations. If a circumstance arises that is not listed on this *Checklist*, please explain the situation under #30 above, or attach additional explanation. Also, be sure that the ***Table of Contents*** is resubmitted to reflect any changes. ***ONLY*** the pages of the existing MAA Claiming Plan, that are changing, need to be amended and submitted to the Department of Health Services (DHS). Please ***DO NOT*** resubmit the entire MAA Claiming Plan.

NOTE: If none of the items checked on the *MAA Claiming Plan Amendment Checklist* require an amendment, do not submit the *Checklist* to DHS.

SECTION 6

Determining the Medi-Cal Percentage

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Overview

The portion of costs that can be claimed as allowable for some Medi-Cal Administrative Activities (MAA) is based on the Medi-Cal percentage. Costs may be reduced or "discounted" by the Medi-Cal percentage when the activity benefits or involves both Medi-Cal and non-Medi-Cal populations. Methods for determining the applicable Medi-Cal percentage may vary for each MAA. The Medi-Cal percentage is multiplied against other factors to determine the amount of reimbursement. The Medi-Cal percentage must be determined each quarter and the method used to determine the percentage must be consistent with the methods identified in the MAA Claiming Plan.

MAA That May Require Discounting by the Medi-Cal Percentage

Outreach B1: This activity must always be discounted by the actual Medi-Cal client count or any other method approved by DHS and HFCA.

Outreach B2: This activity must always be discounted by the countywide Medi-Cal average as published by DHS.

Medi-Cal Non-Emergency, Non-Medical Transportation: If this activity is provided to both Medi-Cal and non-Medi-Cal populations, it must be discounted by the appropriate Medi-Cal percentage.

Contracting for Medi-Cal Services and Medi-Cal Administrative Activities: If the contracts administered under this activity provide services to both Medi-Cal and non-Medi-Cal populations, then it must be discounted by the appropriate Medi-Cal percentage.

Program Planning and Policy Development: If the Programs for which planning and policy development are performed serve both Medi-Cal and non-Medi-Cal populations; this activity must be discounted by the appropriate Medi-Cal percentage.

Definition of the Medi-Cal Percentage

The Medi-Cal percentage is the number of people served by the LGA who are actual recipients of the Medi-Cal program divided by the total number of people served by the LGA. The numerator is the number of the Medi-Cal recipients served by the claiming unit/LGA, and the denominator is the total number of persons served by the claiming unit/LGA.

A person who would be Medi-Cal eligible but has neither applied nor has been determined to be enrolled in Medi-Cal, or whose status is “pending,” is not to be counted in the numerator of the calculation to determine the Medi-Cal percentage. The term “enrolled” means that the individual has gone through a formal eligibility determination process and that the county social services agency has determined him/her to be eligible and currently able to receive Medi-Cal services. “Share of cost” clients are “spend down” clients and may or may not be Medi-Cal enrolled at any given point in time. Clients for whom the “share of cost” obligation has not been met are not considered Medi-Cal eligible for this purpose and are not to be included in the numerator of the calculation.

Approval of Methodologies For Determining Medi-Cal Percentage

State and federal guidelines require that the methodology used to determine the Medi-Cal percentage be “statistically valid." Currently, the two approved methodologies are based on “actual head count” and “countywide average Medi-Cal percentage.” These two methodologies are described below. A number of methods for determining the Medi-Cal percentage are possible. However, the acceptance of other proposed methodologies will ultimately be based on State and federal review and approval.

The procedure for securing approval is to include the proposed methodology in the MAA Claiming Plan. If the proposed methodology is not approved, any claims that used this methodology will be returned to the LGA unpaid so that the Medi-Cal percentage can be recalculated using an approved methodology.

LGAs should expect disapproval of a methodology if "staff judgement" or "management determinations" are the basis for calculating the Medi-Cal percentage. The Medi-Cal percentage must be current with the quarter being claimed and must be updated with each invoice submitted to the State Department of Health Services (DHS).

Each claiming unit within the LGA may use a different methodology. Decisions on which methodology to use in calculating the Medi-Cal percentage must be based on the nature of the claiming unit and by the kind of data that is collected on the client population. Following state and federal approval of the methodology, the claiming unit must use the approved methodology from quarter to quarter so

that the Medi-Cal percentage is current with the period of costs reflected on the MAA Invoice. Should a claiming unit elect to change methodologies, e.g., from actual count to countywide average, a MAA Claiming Plan Amendment must be filed no later than the end of the quarter in which the claiming unit wishes to use the new methodology.

Actual Head Count

A Medi-Cal percentage that is based upon the actual "head count" is determined from the total number of Medi-Cal recipients and the total number of all individuals served by the claiming unit. The total number of all individuals served by the claiming unit is defined in the claiming plan as the target population. The Medi-Cal percentage is the fraction of a claiming unit's target population who are actual recipients of the Medi-Cal program. To use this methodology, the claiming unit must define the population "served" and identify the Medi-Cal status of each person. Although a true actual head count would be done on an ongoing basis, a head count that is done for one full month during each quarter for which claims will be made is acceptable. A sampling taken once per year will not suffice to document the Medi-Cal percentage.

To document the Medi-Cal status of clients, staff must record the Medi-Cal number of each person served. This information can be documented on an information collection form or in the client's case record. Another strategy is to compare identifying information that the entity collects on the population with data on the Medi-Cal population kept by the local social services agency. This comparison must be done through electronic tape matches to ensure statistical validity and accuracy.

It should also be noted that county social services agencies may not include information on Supplemental Security Income (SSI) recipients who have Medi-Cal cards. Thus, this population, as well as children in foster care, may not be reflected in any tape match that is done by the LGA. It is also important to remember that the tape match is possible only when the LGA needing the data provides the social services agency with a list of its population and includes the agreed upon identifying information. The social services agency's response will be a single number, the percentage of the defined population who matched the Medi-Cal population.

Using Actual Head Count For Determining the Medi-Cal Percentage

For multiple “Outreach B1” campaigns, accurate data must be collected on the Medi-Cal status of each person reached for each outreach campaign. Two methods may be used to calculate the combined Medi-Cal percentage for all Outreach B campaigns. These methods are described in Section 8, MAA Summary and Detailed Invoice.

When contracting for Medi-Cal Services and Medi-Cal Administrative Activities and for Program Planning and Policy Development, two categories of MAA, more than one contract or program may be involved. The Medi-Cal percentage may vary by the contract being administered or by the program for which planning and policy development is being performed. See Section 8, MAA Summary and Detailed Invoice, for information on determining the Medi-Cal percentage for Program Planning and Policy Development. A similar procedure may be used for determining the Medi-Cal percentage for Contracting for Medi-Cal Services/Medi-Cal Administrative Activities.

Countywide Average Percentage

Claiming units may find that the collection of information about a population's Medi-Cal status may be intrusive or inefficient. In these cases, the claiming unit may use the percentage of the LGA’s total population that has Medi-Cal cards for its own Medi-Cal percentage. A list of these percentages, by county, is available from DHS.

SECTION 7

Medi-Cal Administrative Activities (MAA) Time Survey

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WHO SHOULD COMPETE THE TIME SURVEY

PROGRAM TIME SURVEY FOR PERSONS WHO PERFORM MAA (DHS Form 7094)—MAA

1. This form should be completed by all non-case managers who perform any allowable Medi-Cal Administrative Activities (MAA). These activities include Medi-Cal Outreach A and B, Facilitating Medi-Cal Application, Arranging for and/or Providing Medi-Cal Non-Emergency, Non-Medical Transportation, Contracting for Medi-Cal Services and MAA, and MAA/TCM Coordination and Claims Administration. Persons who do not perform any of these activities should not participate in the MAA time survey.

2. Community Based Organizations (CBOs): CBO staff who are non-case managers and who perform any allowable MAA must participate in the time survey if the CBO contract with the LGA does not clearly describe the MAA to be performed and specifically identify the amount to be paid for these activities ("non-specific" contract).

Completion of the time survey is not necessary if the CBO contract with the LGA clearly describes the MAA to be performed and specifically identifies the amount to be paid for these activities ("specific" contract).

NOTE: The current DHS regulations categorize CBOs as sub-contractors of the LGA and do not allow claims to be made for both TCM and MAA if performed by the same CBO staff person.

TIME SURVEY FORMS AND MAA/TCM COORDINATION AND CLAIMS ADMINISTRATION

MAA/TCM Coordination and Claims Administration is included on the time survey forms for MAA and TCM. A description of allowable MAA/TCM Coordination and Claims Administration activities is included in the MAA Claiming Plan Instructions. MAA/TCM Coordination and Claims Administration may be claimed through MAA for staff performing these functions at the LGA level and for staff

performing MAA Claims Administration at the claiming unit level.

For MAA/TCM Coordination and Claims Administration staff who do not perform other MAA or TCM, completion of the time survey is not required. However, it can be used as a tool to provide documentation for direct-charging the time spent on this activity. Completion of the survey is required for individuals for whom claiming will be done for this activity as well as for TCM and/or other MAA. This will ensure that time spent on all activities does not exceed 100 percent of one person's time.

TIME SURVEY FORMS AND LEAs

LEAs do not complete a time survey for TCM because the LEA TCM rate is based on a labor survey rather than on the TCM Time Survey and TCM Cost Report. LEAs choosing to claim for MAA must complete the MAA Time Survey. NOTE: The current DHS regulations categorize LEAs as subcontractors of the LGA for MAA and do not allow claims to be made for both TCM and MAA if performed by the same LEA staff person.

MAA OUTREACH A AND MAA OUTREACH B1 AND B2

This section provides guidance on how to differentiate between Outreach A (Not Discounted by the Medi-Cal percentage) and Outreach B1 or B2 (Discounted by the Medi-Cal percentage). Both Outreach A and Outreach B1 or B2 may consist of discrete campaigns or may be an ongoing activity. Outreach may be conducted with groups or individuals, or through media campaigns. Outreach A and Outreach B1 or B2 may also be directed to services providers, agencies, or community groups to facilitate the referral of potentially eligible individuals to Medi-Cal eligibility offices and the referral of Medi-Cal eligibles to Medi-Cal-covered services. It is important that the language used in the MAA Claiming Plan follow the language used in the DHS MAA Claiming Plan Instructions for distinguishing between Outreach A and Outreach B1 or B2.

OUTREACH A (Not Discounted)

There are two purposes for this type of Outreach:

1. Bringing potential Medi-Cal eligibles into the Medi-Cal system for the purpose of determining Medi-Cal eligibility. This involves 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. The general public may consist of various population groups, some of which could be categorized as high risk, such as low-income pregnant women.

2. Bringing currently enrolled Medi-Cal beneficiaries into Medi-Cal services. This involves informing, encouraging, and referring Medi-Cal beneficiaries to access Medi-Cal-covered services, such as Child Health and Disability Prevention (CHDP) programs and Medi-Cal services providers. This type of outreach is directed only to persons known to be eligible for Medi-Cal, such as CalWORKs clients and persons who are current Medi-Cal beneficiaries, and not to the general public. The language used in these campaigns should clearly indicate that the message is directed to Medi-Cal beneficiaries and that referrals are only to Medi-Cal services.

NOTE:

- If a public health campaign contains a discrete segment targeted only to bringing Medi-Cal eligibles into Medi-Cal-covered services, only that segment would be time-surveyed to Outreach A. An example would be a two-hour presentation to Medi-Cal and non-Medi-Cal persons on the importance of Prenatal Care, with one hour devoted to informing the Medi-Cal eligibles how to access Medi-Cal prenatal care services providers.

- Outreach A includes information and referral activity that involves referring Medi-Cal eligibles to Medi-Cal services or referring potential Medi-Cal eligibles exclusively to Medi-Cal eligibility workers.

- Outreach A may include telephone, walk-in, or drop-in services only under the following circumstances:

    1. The service is exclusively for the purpose of referring potential beneficiaries to Medi-Cal eligibility offices and/or for referring Medi-Cal beneficiaries to Medi-Cal-covered services (e.g., a Medi-Cal referral hotline).

    2. The person time-surveying can clearly identify the time spent referring potential beneficiaries to Medi-Cal eligibility offices and/or referring Medi-Cal beneficiaries to Medi-Cal-covered services.

MAA OUTREACH A AND MAA OUTREACH B1 AND B2

OUTREACH A (Not Discounted)

*** The key to supporting a claim for Outreach A is to make sure that the intention of doing outreach to the general public and the various groups is not only to inform them of services but also to encourage them to apply for Medi-Cal benefits and to refer them to eligibility offices. If you just inform the general public about services covered under the Medi-Cal State Plan, with no encouragement to apply for benefits, this activity would be Outreach B1 or B2 (Discounted). It is important that staff understand the intent of Outreach A (Not Discounted) and incorporate these required elements into their outreach efforts.

OUTREACH B1 AND B2 (Discounted by an acceptable Medi-Cal percentage methodology)

Outreach B1 and B2 include outreach campaigns, programs, or ongoing activities directed toward bringing both Medi-Cal and non-Medi-Cal persons into health care services. This activity is performed with no specific intention of getting these groups or individuals to apply for Medi-Cal. Outreach B1 and B2 are discounted by the Medi-Cal percentage because the costs are only claimable to the extent that the activity brings Medi-Cal eligibles into Medi-Cal services.

Outreach B1 is outreach that will be discounted by an actual client count or other DHS-approved methodology for determining the Medi-Cal percentage.

Outreach B2 is outreach that will be discounted by using the DHS-issued Countywide Average Medi-Cal percentage.

Staff must be aware of which Medi-Cal discount methodology will be used for a particular outreach activity in order to code appropriately to Outreach B1 or Outreach B2.

Make sure that staff understand that their outreach efforts may be classified as Outreach A if their outreach activities include referring clients to apply for Medi-Cal and to Medi-Cal-covered services. This means that groups and individuals should be informed of services and encouraged and referred to apply for Medi-Cal.

NOTE:

- General telephone, walk-in, or drop-in services for the purpose of informing or referring persons, including Medi-Cal eligibles, to services covered by Medi-Cal is considered Outreach B1 or B2 because this type of service is not exclusively directed toward bringing potential Medi-Cal eligibles into the Medi-Cal system.

- The portions of broad campaigns for general health education that focus on Medi-Cal services, program benefits, and enrollment are allowable under Outreach B1 or B2. However, that portion of time not focused on Medi-Cal services must be coded to Other Programs/Activities. An example would be a Well Child campaign that includes education on how to care for a sick child, as well as information on accessing Medi-Cal-covered Well Baby Clinics.

FACILITATING MEDI-CAL APPLICATION (ELIGIBILITY INTAKE)

OVERVIEW

Facilitating Medi-Cal Application (Eligibility Intake) includes the following activities separately or in combination:

- Explaining Medi-Cal eligibility rules and the Medi-Cal eligibility process to prospective applicants.
- Helping an applicant fill out a Medi-Cal eligibility application.
- Gathering information from a client related to the application and to the client's eligibility determination/redetermination, including resource information and third-party liability (TPL) information as a prelude to submitting a formal Medi-Cal application to the county welfare 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.

HOW TO TIME SURVEY

This activity may appear similar to Outreach A (bringing potential Medi-Cal eligibles into the Medi-Cal system by encouraging and referring individuals who may be eligible for Medi-Cal to apply for Medi-Cal). However, Facilitating Medi-Cal Application is more pro-active and involves providing specific assistance rather than general information and referral to Medi-Cal eligibility offices. The person(s) completing the time survey will need to make the determination between these two activities.

Examples of Facilitating Medi-Cal Application activities include:

- Conducting a presentation for prospective applicants on the Medi-Cal application process.

- Providing Medi-Cal Application packets, including the actual application and instructions for completing the forms, to community centers serving prospective applicants.

- Providing translation services to assist non-English speaking applicants fill out the Medi-Cal eligibility application.

- Outposting a community worker at a Medi-Cal eligibility office to help applicants with Medi-Cal eligibility forms and to answer questions.

- Helping teens at a school clinic complete the Medi-Cal eligibility application and packaging the application forms for delivery to the Medi-Cal eligibility office.

- Working with a student's guardian to obtain copies of documents needed in order to apply for Medi-Cal.

MAA TRANSPORTATION

OVERVIEW

This activity includes arranging and/or providing non-emergency, non-medical transportation of Medi-Cal eligibles to Medi-Cal services, and when medically necessary, accompaniment by an attendant. "Non-medical" transportation means transportation by taxi, bus, van, car, etc. ("Medical transportation," which is not allowable under MAA, means vehicles such as ambulances, wheelchair vans, or litter vans.)

HOW TO TIME-SURVEY

There are two ways for persons who arrange for and/or provide MAA Transportation to time-survey. How you choose to time-survey will affect how you complete the MAA Invoice for this activity.

1. Code time to MAA Transportation only when arranging for and/or providing transportation of Medi-Cal beneficiaries to Medi-Cal services. In this case, the Medi-Cal percentage on the MAA Invoice would be 100 percent.

2. Code time to MAA Transportation when arranging for and/or providing transportation of Medi-Cal beneficiaries and non-Medi-Cal persons to Medi-Cal-covered services. In this case, the activity would be discounted by the Medi-Cal percentage on the MAA Invoice. The Medi-Cal percentage used must be either an actual count of Medi-Cal beneficiaries for whom transportation is provided or the Medi-Cal countywide average.

SEPARATE TRANSPORTATION UNIT OR SERVICE

In situations where an LGA operates a separate transportation unit or contracts for the provision of transportation services, the costs to the unit or the contractor of actually providing the Medi-Cal non-emergency, non-medical transportation services for Medi-Cal eligibles to

Medi-Cal services is an allowable MAA cost. Cost may be calculated on a per-mile basis, on a per-trip basis, or by any other reasonable method (to be reviewed for approval by DHS) and direct-charged on the MAA Invoice for each Medi-Cal client transported. If direct charge is used, time-surveying is not necessary.

DIRECT-CHARGING ACTUAL COSTS OF TRANSPORTATION

In addition to the time spent arranging for and/or providing MAA (non-emergency, non-medical) transportation, the actual costs of transportation may be direct-charged. Examples of these costs include taxi vouchers, bus tokens, mileage, costs of vans, drivers, etc. These costs are only allowable to the extent that the LGA incurs actual costs.

TRANSPORTATION COSTS AND TCM

Arranging for and/or providing MAA Transportation cannot be claimed by TCM Case Managers. Time spent arranging for transportation for a TCM client to any TCM related service is coded to TCM. Time spent by the case manager transporting and/or accompanying the TCM client is coded to TCM only if the case manager is performing case management functions while transporting or accompanying the client. In both of these cases, the cost of this time will be included in the TCM encounter rate and cannot be claimed separately through MAA.

MAA CONTRACT ADMINISTRATION (CONTRACTING FOR MEDI-CAL SERVICES AND MEDI-CAL ADMINISTRATIVE ACTIVITIES)

OVERVIEW

This activity involves entering into contracts with community-based organizations or other provider agencies for the provision of Medi-Cal services and/or Medi-Cal Administrative Activities (MAA). MAA Contract Administration does not include administration of contracts for Targeted Case Management (TCM).

Contract Administration may only be claimed when performed by an identifiable unit of one or more employees, whose tasks officially involve contract administration according to their job position descriptions. If an employee performs Contract Administration 100 percent of their paid time, the employee does not need to time-survey.

TCM case managers and LGA subcontractors, except for LEA staff, cannot claim Contract Administration. LEAs may contract for Medi-Cal services in connection with the LEA billing option.

The administrative costs of contracting by LGAs as service providers under managed care arrangements cannot be claimed as MAA and are considered to be in the capitation payment to the LGA.

Contract Administration includes:

- Identifying, recruiting, and contracting with community agencies as Medi-Cal services and/or MAA contract providers.
- 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.

HOW TO TIME-SURVEY

The MAA Time Survey form has two categories of Contract Administration.

Contract Administration "A" (Not Discounted): Employees are to time-survey to Contract Administration A when the contract(s) they are administering only involve Medi-Cal populations and/or MAA.

Contract Administration "B" (Discounted): Employees are to time-survey to Contract Administration B when the contract(s) they are administering involve both Medi-Cal and non-Medi-Cal populations. On the MAA Invoice, the costs of Contract Administration B must be discounted by the Medi-Cal percentage. The basis for determining this Medi-Cal percentage must be described in the MAA Claiming Plan

MAA CONTRACT ADMINISTRATION

NOTE: LGAs have two options for claiming the administration of contracts for allowable MAA:

1. Time spent administering contracts that only pertain to MAA may be coded to the activity, such as Outreach, for which the contract is being administered. If the contract is for more than one activity, such as Outreach and Facilitating Medi-Cal application, the time could be split proportionally between the activities.

2. Time spent administering contracts for the provision of MAA may be coded to Contract Administration “A” (Not Discounted) if the contract is solely for MAA, or if the contract is for MAA and for services to Medi-Cal populations. Code to Contract Administration “B” (Discounted) if the contract is for MAA and for services to both Medi-Cal and non-Medi-Cal populations.

MEDI-CAL ADMINISTRATIVE ACTIVITIES/TARGETED CASE MANAGEMENT (MAA/TCM) COORDINATION AND CLAIMS ADMINISTRATION

OVERVIEW

MAA/TCM Coordination and Claims Administration includes the following activities:

- Drafting, revising, and submitting MAA Claiming Plans and TCM performance monitoring plans.
- Serving as liaison with claiming programs within the LGA and with the state and federal governments on MAA/TCM. Monitoring the performance of claiming programs.
- Administering LGA claiming, including overseeing, preparing, compiling, revising, and submitting MAA claims on an LGA-wide basis to the state.
- Attending training sessions, meetings, and conferences involving TCM and/or MAA.
- Training LGA program and subcontractor staff on state, federal, and local requirements for MAA/TCM claiming.
- Ensuring that MAA and TCM claims do not duplicate Medi-Cal claims for the same activities from other providers. This includes ensuring that services are not duplicated when a Medi-Cal beneficiary receives TCM services from more than one case manager.
- Payment of the portion of the MAA/TCM Participation Fee that does not support the contract with the State Department of Health Services.

LGA employees whose position descriptions/duty statements include performance of the MAA/TCM Coordination and Claims Administration activities stated above on an LGA-wide basis may claim directly for the costs of these activities on the MAA Invoice as a direct charge. MAA Claims Administration may be direct-claimed at the claiming unit level. If the MAA/TCM Coordinator and/or Claims Administration staff are performing these functions part-time,

along with other duties, the staff must certify the percentage of time spent performing the duties of MAA/TCM Coordination and/or Claims Administration. Charges for supervisors, clericals, and support staff for these employees may be allocated based upon the percentage of certified time of the MAA/TCM Coordinator and Claims Administration staff.

IMPLICATIONS FOR THE MAA TIME SURVEY

Staff who only perform MAA/TCM Coordination and Claims Administration are not required to time-survey. However, the time survey can be used as a tool to support the percentage of time that is certified as being spent on these activities.

Staff who perform MAA/TCM Coordination and Claims Administration and also perform other MAA and/or TCM must time-survey.

See the section “Who Should Time Survey” and “Direct-Charging for MAA/TCM Coordination and Claims Administration.”

MAA/TCM COORDINATION AND CLAIMS ADMINISTRATION

EXAMPLES OF MAA COORDINATION ACTIVITIES

- Disseminating MAA-related policy, procedure, and training documents to MAA claiming units.
- Ensuring that MAA Contracts and TCM Provider Agreements are properly executed.
- Preparing MAA Claiming Plans and Claiming Plan Amendments.
- Developing protocols for implementation of MAA and/or TCM at the local level.
- Providing MAA- and TCM-related training.
- Responding to requests for information regarding the MAA and TCM programs.
- Reviewing and compiling the results of the MAA/TCM time surveys.
- Ensuring compliance with TCM case manager documentation.
- Ensuring compliance with TCM “free care” and TPL policies.
- Maintaining MAA and TCM audit files.
- Monitoring Medi-Cal TCM provider-agency capability and availability.

EXAMPLES OF MAA CLAIMS ADMINISTRATION ACTIVITIES

- Preparing TCM Cost Reports.
- Inputting Medi-Cal data from the TCM encounter logs into the data collection system.

- Reconciling TCM Medi-Cal encounter claims reported as rejected by the State.
- Maintaining and analyzing Medi-Cal TCM management information systems.
- Developing and maintaining a record keeping system for documenting MAA direct-charge expenses.
- Ensuring that MAA and TCM claims are submitted by the required due dates.
- Correcting MAA invoices rejected by the State.

DIRECT-CHARGING FOR "MAA/TCM COORDINATION AND CLAIMS ADMINISTRATION"

OVERVIEW

Direct-charging is permitted for the costs of staff performing MAA/TCM Coordination and Claims Administration at the LGA level or MAA Claims Administration at the claiming unit level. These staff are not required to participate in the MAA/TCM Time Survey process. However, they must certify the percentage of time spent and be able to provide documentation supporting this percentage. Their duty statements must show that these activities are part of their job. Charges for supervisors, clericals, and support staff for these employees may be allocated based upon the percentage of certified time of the MAA/TCM Coordination and Claims Administration staff. The costs of TCM claiming activity at the TCM provider level are to be included in the TCM rate.

MAA CLAIMING PLAN FOR "MAA/TCM COORDINATION AND CLAIMS ADMINISTRATION"

The MAA Claiming Plan for this activity must identify all LGA staff performing the activity and whether they perform the activity full-time or part-time. If supervisors, clericals, and support staff for these persons are also to be direct-charged, this must be stated in the MAA Claiming Plan. The MAA Claiming Plan must describe the methodology and documentation used to calculate and support the percentage time certified for these activities. Documentation should include the method of keeping time records. The claiming unit may want to assign a payroll account number for this activity. Ongoing time records or logs would provide a good audit trail and would allow the claiming unit to claim for actual costs, which might vary each quarter. An overhead or indirect rate, established according to A-87 principles, may be applied to personnel expenses.

The Claiming Plan requires the attachment of position descriptions showing that administration and coordination of MAA/TCM and/or claims administration are part of the job of persons to be direct-charged. Jurisdictions that have "generic" position descriptions for job classifications are

required to include duty statements describing the specific MAA/TCM-related responsibilities.

Related operating expenses can also be direct-charged. Examples might include travel to MAA/TCM-related training, computer equipment or programming expenses, or training materials. Programs using service bureaus or consultants to prepare claims may direct-charge these expenses. These items must be included in the Claiming Plan with a description of how the costs will be documented. In the case of items like computer equipment, the method for prorating the MAA/TCM share of cost must be stated if the item will also be used for other purposes. Assigning a MAA/TCM account number may be useful in isolating these expenses. Direct-charging some smaller expenses, such as printing time-survey forms, may not be worth the effort because all direct-charge expenses must be subtracted from overhead costs.

AVOIDING DUPLICATION OF COSTS

All costs that will be direct-charged under “MAA/TCM Coordination and Claims Administration” on the MAA Invoice cannot also be included in other sections of a MAA claim or in the TCM encounter rate.

INSTRUCTIONS FOR THE HOW TO CODE EXERCISE

OVERVIEW

The purpose of the "How To Code Exercise" is to generate discussion of the types of activities performed and to ensure consistency in how these activities are coded. Since each local program is unique, jurisdictions are advised to conduct a similar exercise as part of local time-survey training. Training participants should create a list of activities applicable to their specific claiming unit and/or program.

The underlying principle in determining how to code should be the primary purpose of the activity.

Example

MAA Outreach: Outreach A (Not Discounted) can be coded as long as effort is always made to either encourage/refer potential eligibles to Medi-Cal eligibility offices and to Medi-Cal services, or to encourage/refer Medi-Cal beneficiaries to Medi-Cal service providers. General promotion of and referrals to "health services," without specific reference to Medi-Cal, must be coded to Outreach B (Discounted). This differentiation should also be considered in the development of outreach materials.

TCM: If a Public Health Nurse (PHN) makes a home visit to conduct a TCM Assessment, the time spent may be coded to TCM even if during that visit the PHN spends a small amount of time, for example, responding to a client's question about a child's rash. If the purpose of the visit is to conduct a TCM Assessment and to provide education about nutrition, the PHN must code her time proportionally between TCM and Other Programs/Activities.

EXERCISE INSTRUCTIONS

There are two columns in which codes may be entered on the How to Code Exercise Form. Persons who will be using the MAA Time Survey Form are to use the MAA column. Persons who will be using the TCM Time Survey Form are to use the TCM column. Use the letters below to code the exercise form.

In several cases, the sample activities, as described, should be coded to more than one time-survey activity. There are two reasons for this. The first is that the time spent on some activities must be prorated because there is more than one purpose for the activity. The second reason is that some activities may be coded to TCM by a case manager if the client is considered a TCM client or to another code if the activity is not part of a TCM service. Note that if the primary purpose of the contact is TCM related, DHS allows coding of the contact to TCM, even if a brief amount of time is spent on other "incidental" activities.

CODING LETTERS

A = Medi-Cal Outreach A Training
B = Medi-Cal Outreach B1 or B2
C = Facilitating Medi-Cal Application
D = MAA Transportation
E = Contract Administration
F = MAA/TCM Coordination/Claims Administration
G = MAA Implementation
H = Targeted Case Management
I = Other Programs/Activities
J = Direct Patient Care
K = General Administration
L = Paid Time Off

MAA AND TCM TIME SURVEYS – HOW TO CODE EXERCISE

For each sample activity, fill in the Activity Code Letter(s) in the appropriate MAA or TCM column, and state the reason for your choice.

SAMPLE ACTIVITY	CODE(S)	REASON
1. A PHN does daily DOT visits to a high-risk family with multiple problems. On Tuesday and Thursday, the visit includes follow-up on the TCM service plan and further assessments.		
2. Charting and reading in preparation for home visits with Medi-Cal and non-Medi-Cal clients who are considered TCM-enrolled.		
3. Developing a presentation for a group of women enrolled in a WIC program who want to limit the number of children they have and who need help with resources, such as food stamps, budgeting, nutrition, and registering to vote.		
4. A PHN does DOT visit to a high-risk family with multiple problems. The visit includes checking an infant for diaper rash and teaching mom to use covers on electrical outlets.		
5. A social worker redetermines that a client remains eligible for Medi-Cal and helps process the paperwork.		
6. A health educator answer phones for a call-in period and makes referrals to obtain services for Medi-Cal, health clinics, food stamps, or outpatient mental health.		
7. A health educator and PHN collaborate for six hours on writing outreach campaign materials on lead poisoning; the materials are targeted to zip codes with high Medi-Cal rates and single-parent families.		
8. Health educators and a translator spend four hours in a laundromat talking with Latino women about HIV, birth control, well-baby clinics, and how to get on Medi-Cal.		
9. An outreach worker goes door to door for eight hours in a low-income neighborhood that has a high rate of Medi-Cal residents; the worker is delivering pamphlets about school drop-in centers, Medi-Cal application centers, and the risks of teenage sex.		

10. A PHN Case Manager visits a home on referral and assesses that the individual is in need of medical care for prevention (immunization, pap smear) and/or treatment of an illness. The PHN teaches the client about the need for medical care, screens and determines that the individual will probably be eligible for Medi-Cal, gives information on how to apply for Medi-Cal and gives the client a list of Medi-Cal providers.		
11. An individual comes to the Public Health Center, and an interview indicates that this person has symptoms of a medical condition in need of diagnosis and treatment. The individual is determined to be eligible for Medi-Cal and is given information on the need for care, how to apply for Medi-Cal, and a list of providers.		
12. The Social Service Aide is doing TB source-case finding and educates the family about the need for immunization, well-child care, and other preventive services. The Social Service Aide also refers the family to Medi-Cal and gives a list of providers.		
13. The PHN gives a group presentation to women of childbearing age. She discusses the need for medical care and provides some general information on communicable diseases and Medi-Cal.		
14. The PHN gives a group presentation to substance-abusing mothers, including the need for medical care, pap smears, family planning, well-child care, and immunizations. She also tells the group about available Medi-Cal providers and how to seek care.		
15. Staff are trained to TCM time-survey forms.		
16. Staff are trained to complete the MAA time-survey forms.		
17. Supervisors review and sign the MAA or TCM time-survey forms.		
18. Analyze time survey forms and summarize the data at the program level before preparing claims. Supervisors and their clerical staff complete this task.		
19. Take a 15-minute break.		
20. A TCM Case Manager attends a TCM Task Force meeting about policy and procedures.		
21. A TCM Case Manager helps a client develop a monthly budget and assess the client's need for further budget management and spending oversight.		
22. Staff attend a training on earthquake preparedness.		
23. Give blood for a county blood drive.		
24. Coordinate with a Medi-Cal provider to ensure that services are available in Spanish.		
25. Work eight hours on a holiday and get paid double time.		

26. A TCM Case Manager discusses with the conservatee's family members whether to maintain life support.		
27. As part of an outreach campaign to promote immunizations, individuals are given referrals to Medi-Cal eligibility offices and Medi-Cal services.		
28. An advice nurse, as part of her job, makes referrals to Medi-Cal eligibility workers and Medi-Cal services providers.		
29. An outreach campaign targets pregnant women and refers those without medical care to a CPSP provider.		
30. An outreach van travels to various locations and refers clients to Medi-Cal eligibility offices and Medi-Cal services.		
31. Staff attend a workshop on changes in MAA codes.		
32. A health educator conducts a class at a community center on how to complete Medi-Cal forms.		
33. A translator accompanies a case manager on a home visit.		
34. A community worker develops a list of Spanish-speaking providers for the case manager.		
35. A TCM Case Manager discusses eligibility requirements with a job-training program.		
36. A Medi-Cal Outreach Worker is outposted to family planning and immunization clinics.		
37. A community health aide makes a home visit on referral from the maternity clinic to "see what the Health Department can do" since the client does not currently have Medi-Cal or insurance.		
38. A community health worker participates in a Health Fair to discuss Medi-Cal eligibility.		
39. A PHN contacts potential CCS clients to talk about the CCS program and eligibility for it.		
40. The intake nurse at an immunization clinic screens clients for Medi-Cal eligibility.		
41. An outreach worker distributes Health Department pamphlets in a low-income neighborhood. The pamphlet includes information on Medi-Cal application and services.		
42 A Case Manager's assistant gathers and mails "support group" information to a TCM client.		

MAA/TCM TIME SURVEY HOW TO CODE EXERCISE – ANSWER KEY

For each sample activity on the How to Code Exercise Form there may be codes in the MAA column (for persons completing the MAA Time Survey Form) and/or in the TCM column (for persons completing the TCM Time Survey Form).

There may be more than one code in the MAA column and/or TCM column for two reasons:

1. The time spent on the sample activity must be prorated between two time-survey activity codes because the activity description includes both claimable and non-claimable components.

2. The coding depends on the primary purpose of the activity or on the context in which the activity is performed.

A = Medi-Cal Outreach A
B = Medi-Cal Outreach B1 or B2
C = Facilitating Medi-Cal Applications
D = MAA Transportation
E = Contract Administration
F = MAA Coordination/Claims Administration
G = MAA Implementation Training
H = Targeted Case Management
I = Other Programs/Activities
J = Direct Patient Care
K = General Administration
L = Paid Time Off

NOTE: The term "Medi-Cal-covered services" means those health services that can be reimbursed through Medi-Cal in California. For Outreach A, this means referring a Medi-Cal-eligible person to a Medi-Cal provider for one or more of these services. For Outreach B, this means referring any person for one or more of these services, even if the person is not a Medi-Cal eligible and the provider is not a Medi-Cal provider. A list of Medi-Cal-covered services is included in Section 1 of the DHS Training Manual, dated August 1995.

Activity #	MAA	TCM	REASON
1	J	H,J	On the days that TCM services are provided, time spent on those services may be coded to TCM. DOT is Direct Patient Care.
2	I	H	

3	I,A or B	I, A or B	This is primarily an education activity. However, if a portion of the presentation involves encouraging/referring the participants to apply for Medi-Cal or to use Medi-Cal services, that portion may be coded to Outreach A. If a portion of the presentation involves encouraging/referring participants to use Medi-Cal-covered health services, without encouraging the participants to apply for Medi-Cal, that portion may be coded to Outreach B.
4	I or J	I or J	
5	C	C	This does not involve the actual eligibility determination.
6	I, A or B, I		If the time spent specifically referring for Medi-Cal eligibility or referring Medi-Cal clients to Medi-Cal-covered services can be isolated, that portion can be coded to Outreach A. If the caller is not identified as Medi-Cal eligible, referral to Medi-Cal-covered services can be coded to Outreach B. Time spent referring to services, such as Food Stamps, that are not covered by Medi-Cal, is to be coded to Other Programs/Activities.
7	B	B	The campaign materials are assumed to include information on accessing health services related to CPSP.
8	A, I	A, I	The portion of this activity devoted to bringing persons into Medi-Cal services may be coded to Outreach A. The portion that is strictly educational must be coded to Other Programs/Activities.
9	A, I	A, I	The portion of this activity related to bringing persons into Medi-Cal services may be coded to Outreach A. The remainder appears to be education and must be coded to Other Programs/Activities.
10	A, I	A	If the individual is not part of a TCM target population, the portion of the visit related to bringing persons into Medi-Cal services may be coded to Outreach A. If the individual is a member of a TCM target population, and the PHN meets the definition of a case manager for the same target population, the visit may be coded to TCM.
11	A, J	A, J	The intent of this interview must be to bring the person into Medi-Cal services. If this interview is in a clinic setting, the portion related to assessing the need for medical treatment must be coded to Direct Patient Care.
12	A, I	A, I	The portion related to referring the family to Medi-Cal may be coded to Outreach A. The remainder related to TB source case finding must be coded to Other Programs/Activities.
13	B, I	B, I	If the intent of the presentation is outreach to bring persons into Medi-Cal-covered health services, the entire time may be coded to Outreach B. If a significant portion is education, the time must be prorated between Other Programs/Activities and Outreach B.
14	B, I	B, I	If the intent of the presentation is outreach to bring persons into Medi-Cal-covered health services, the entire time may be coded to Outreach B. If a significant portion is education, the time must be prorated between Other Programs/Activities and Outreach B.

15	F	H, F	TCM staff would code to TCM. If the person conducting the training is a MAA/TCM Coordinator, her/his time would be coded to MAA/TCM Coordination.
16	G	G	
17	F	H	
18	F	F	
19	K	K	
20		H	
21		H, I	The portion of the time spent teaching the client to develop a budget is to be coded to Other Programs/Activities. The portion of time assessing the client's need for and providing referrals to budget management resources can be coded to TCM. NOTE: For Public Guardian clients, TCM specifically excludes activities related to money management.
22	K	K	
23		I or L	If the employee is given time during the paid workday to do this, code to Other Programs/Activities. If the employee is required to take time off to do this, code to Paid Time Off.
24	A	A, H	If this activity involves updating referral resources for outreach purposes this activity may be coded to Outreach A. If this activity is performed relative to developing referrals for TCM clients, this activity is coded to TCM.
25	K*	K*	* If these hours are treated as earned "comp time", code to General Administration. If these hours are paid hours, code to the activity performed.
26		J or I	TCM is defined as "Services which assist a Medi-Cal eligible individual in a defined target population to gain access to needed medical, social, educational, and other services". Discussions with an individual's family about whether or not to maintain life support is not TCM. The fact that the individual is already on life support would indicate that access to needed medical services has already been provided. Therefore, such discussion would be coded as Direct Patient Care or Other Programs/Activities.
27	A	a	
28	A, I	A, I	The portion of this activity that solely involves referrals to Medi-Cal eligibility and Medi-Cal services can be coded to Outreach A. Referrals to services not covered by Medi-Cal and general medical advice is to be coded to Other Program/Activities.
29	B	B	
30	A	A	The intent of this outreach must be to bring persons into Medi-Cal services.
31	G	G	
32	C	C	
33		H	Assumes that this is a TCM visit.

34		H	
35		H	Must relate to meeting the case management needs of TCM clients.
36	A	A	It is assumed that the role of the Medi-Cal Outreach Worker is to bring persons into the Medi-Cal services.
37	A or B	A or B	The coding will depend on the focus of the visit. If emphasis is placed on applying for Medi-Cal, the time may be coded to Outreach A.
38	A	A	
39	B	B	CCS covers both Medi-Cal and non-Medi-Cal clients.
40	I, C	I or C	If this activity is a brief and routine part of clinic intake it is coded to Other Programs/Activities. If this activity goes beyond clinic intake and involves assisting the client to apply for Medi-Cal it may be coded to Facilitating Medi-Cal Application.
41	A	A	
42		H	

SECTION 8

MAA Summary and Detail Invoice

Table of Contents

MEDI-CAL ADMINISTRATIVE ACTIVITIES INVOICE

INSTRUCTIONS FOR THE MEDI-CAL ADMINISTRATIVE ACTIVITIES DETAIL INVOICE PREPARATION

A. INTRODUCTION

These instructions are for the Medi-Cal Administrative Activities (MAA) Detail Invoice with supporting worksheets and MAA Summary Invoice to be used for the MAA claiming process for the period beginning July 1, 1997. The claiming documents are:

- Medi-Cal Administrative Activities (MAA) Detail Invoice
- MAA Funding (Revenue) Sources Worksheet 1
- MAA Direct Charges Worksheet 2
- Program Planning and Policy Development Worksheet 3
- MAA Summary Invoice

The MAA Detail Invoice automatically integrates the costs and the funding source elements to be offset. The net costs are factored by the appropriate Medi-Cal discount percentage (MC%) and the activity percentages to arrive at the amount to be reimbursed.

Prior to preparing the invoice, review the following documents to ensure you are using the most current information.

- Program Policy Letters (PPL)
- Approved Claiming Plan and applicable amendments
- Applicable MAA contracts
- Provider Manual (MAA section)

Prior to submitting a MAA Detail Invoice, the Claiming Plan **must** be approved by the Administrative Claiming Operations Unit. The information entered on the MAA Detail Invoice **must** be consistent with that found in the approved Claiming Plan or subsequent Claiming Plan amendments. Invoices not consistent with the Claiming Plan or its amendments will be returned to the Local Governmental Agency (LGA).

Note: The name of the claiming unit on the MAA Detail Invoice and attachments *MUST* match the name on the approved claiming plan.

The major features of the MAA Claiming Documents are:

- There are seven cost pools on the Detail Invoice. All costs for the claiming unit must be included in one of the Cost Pools or on the Direct Charges Worksheet. Cost Pools 1 and 2 are for staff who participated in the annual time survey. Cost Pool 3a is for staff who perform no MAA and are not administrative. Cost Pool 3b represents the difference between total cost and claimable cost from the Direct Charges Worksheet 2. Cost Pool 4 is for enhanced activities that will be direct-charged, and Cost Pool 5 is for non-enhanced activities that will be direct-charged. Cost Pool 6 is for administrative costs that will be allocated to the other Cost Pools.

- The Detail Invoice is formatted to fit on **legal paper only**. The Summary Invoice is formatted to fit on **letter paper**.

- The form allows for the input of a specific Medi-Cal discount percentage for each claimable activity, where appropriate, and asks the methodology for determining each.

- CP6 costs are distributed based on personnel costs; however, CP6 funding sources are distributed on total cost.

- The direct-charge section of the claim allows for direct charges in accordance with the Agreement between the Centers for Medi-Care and Medicaid Services (CMS) and the State Department of Health Services (DHS).

B. SPREADSHEET APPLICATION

The MAA Claiming Documents have been formatted using Lotus 1,2,3, Release 5. **(Requests for an Excel version should be directed to the Administrative Claiming Unit.)** Before using the claiming disk for the first time, it is recommended that an extra copy of the disk be made.

The computerized MAA Detail Invoice and supporting worksheets allow the preparer to enter costs, funding sources, activity percentages, Medi-Cal discount percentages and heading information only once. The data entered on the worksheets will automatically carry forward to the MAA Detail Invoice. The lines and columns where data can be entered are marked with the word "Enter," and the cells are not shaded. All other sections of the MAA Detail Invoice are automatically calculated and are shaded. **FORMULAS** and **FORMATS MUST NOT BE ALTERED** in any way as this will distort the calculation of the federal financial participation (FFP).

C. GENERAL INSTRUCTIONS FOR ENTERING DATA

Data should only be entered where indicated. Data should **NEVER** be entered in the shaded areas or in sections marked "Formula." Doing so will alter the spreadsheet and, therefore, incorrectly calculate the components of the claim, resulting in an erroneous amount of reimbursement. Data to be input is obtained from external sources, such as accounting system reports, spreadsheets, journals, payroll records, etc. Only those data elements (cells) that appropriately reflect costs and funding sources applicable to the claiming entity should be included. Once all the items are entered, the spreadsheet will automatically calculate the remainder of the claim.

All data entered on the claim must have documented evidence linking it to the specified cost pool or funding source designation and must be maintained in the audit file. For example, salaries and benefits assigned to SPMP by entry into Cost Pool 1 should be evidenced by payroll documentation to show the expenditure of such salaries and benefits on individuals who qualify as SPMP.

How to Enter Percentages

The cells that require a percentage to be input already have been formatted to display as a percent. When entering percentage data in these cells, use the decimal form. For example:

35%	should be keyed as " .35"
5%	should be keyed as " .05"
100%	should be keyed as "1"

Rounding

All numbers should be rounded to two (2) decimal points. If the third decimal place is a "5" or higher, round up. Otherwise, round down. For example:

35.674%	should be entered as	"35.67"
12.075%	should be entered as	"12.08"
49.463%	should be entered as	"49.46"

D. CONSTRUCTING COST POOLS (CP)

For each period claimed, **all** costs and funding sources for the claiming entity must be assigned to one of the cost/funding source pools (CP) or be direct-charged. The Local Governmental Agency (LGA) has the option of including all costs/funding sources for a program or to include only those costs/funding sources for the unit that performs MAA and will be reimbursed through the MAA Claiming process. The second option is **only** permissible if the costs are in a separate budget unit and can be separately identified, as might be claimed for Public Field Health Nurses.

Cost Pool 1

Staff whose costs should be included in Cost Pool 1 are:

- Staff who have been designated as Skilled Professional Medical Personnel (SPMP) **and** have participated in the activity time survey.

- Clerical Staff who work for, are supervised by, and provide "direct clerical support" to the SPMP in Cost Pool 1.

- Supervisors of the SPMP in Cost Pool 1.

- Supervisors of clerical staff who work for and provide "direct clerical support" to the SPMPs in Cost Pool 1.

- Personal Services Contractors who participated in the activity time survey, who have been designated as SPMP, and for whom an employer/employee relationship with the agency can be demonstrated.

Note 1: If the clerical staff or supervisors split their time between cost pools, only a proportionate share of their costs should be entered in each cost pool according to the documented time spent in each.

Cost Pool 2

Staff whose costs should be included in Cost Pool 2 are the following:

- All other staff who participated in the time survey.

- Clerical staff who work for the staff in Cost Pool 2.

- Supervisors of the staff in Cost Pool 2.

- Supervisors of clerical staff who directly support Cost Pool 2.

- Personal Services Contractors who have not been designated as SPMP and/or for whom an employer/employee relationship with the agency cannot be demonstrated.

Cost Pool 3a

Includes the costs associated with staff who did not participate in the time survey and are NOT included in any of the other Cost Pools or on the Direct Charges Worksheet 2. This typically includes staff who provide treatment, counseling, clinical services, lab services, or other non-claimable activities of the claiming unit.

Cost Pool 3b (FORMULAS ONLY—DO NOT ENTER)

Represents the difference between the total cost and the claimable costs from the Direct Charges Worksheet 2. **Costs are not directly entered into this cost pool.** These costs will automatically be transferred from the Direct Charges Worksheet 2 to CP 3b. The cells for this cost pool contain formulas and should not be altered. The costs in CP 3b are automatically combined into CP 3a, on line L, on the first page of the MAA Detail Invoice.

Cost Pool 4 (FORMULAS ONLY—DO NOT ENTER)

Represents direct-charges from the Direct Charges Worksheet 2 that are reimbursed at the enhanced rate. **Costs are not directly entered into this cost pool.** Costs are entered on PPPD Worksheet 3. These costs will automatically be transferred from Direct Charges Worksheet 2 to CP 4. The cells for this Cost Pool contain formulas and should not be altered.

Cost Pool 5 (FORMULAS ONLY—DO NOT ENTER)

Represents the direct-charges from the Direct Charges Worksheet 2 that are reimbursed at the non-enhanced rate. **Costs are not directly entered into this cost pool.** These costs will automatically be transferred from the Direct Charges Worksheet 2 to CP 5. The cells for this Cost Pool contain formulas and should not be altered.

Cost Pool 6

Costs include general or administrative staff in the claiming unit who:

- did not time-survey **AND**
- whose costs are not included in any department/program (internal) or in the countywide (external) indirect rate **AND**
- whose costs are not direct-charged **AND**
- who, 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 cost pools. Their cost will be allocated to the other cost pools based on the ratio of personnel costs.

E. ENTERING THE COST DATA IN THE MAA DETAIL INVOICE

The federal government requires that actual expenditures be reported. The disposition of federal funds may not be reported on the basis of estimates. Therefore, costs must be claimed when they have actually been incurred; not accrued.

Line A: Enter the **salary** costs of the staff assigned to CP1, CP2, CP3a, and CP6.

Line B: Enter the **benefit** costs of the staff assigned to CP1, CP2, CP3a, and CP6.

Note: Benefits should be determined by the standard conventions of the accounting system. Exact amounts should be used if they are available. However, if these costs are normally computed as a percentage of salaries, use this method to determine the benefit's costs.

Line D: Enter the cost of Personal Services Contractors in CP1, CP2, and CP3a.

Line H: Enter the other costs directly attributable to CP1, CP2, and CP3a if they can be properly identified. Otherwise, enter the **"other costs"** on line H of CP6 for allocation to the other cost pools. Generally, the "other costs" include the normal day-to-day and monthly operating expenses necessary to run the claiming unit.

Other Costs also include departmental/agency (internal) and countywide/citywide (external) overhead or indirect costs. Internal indirect costs typically include the costs of a department's administrative and office staff, as well as staff from legal, fiscal accounting, personnel, etc. External indirect costs typically include the costs of the central control agencies of the LGA (Auditor-Controller, Treasurer, General Services, Personnel, etc.)

Indirect costs claiming principles for federally subsidized programs are promulgated under the federal Office of Management and Budgets (OMB) Circular A-87; therefore, indirect costs may be referenced as "A-87."

External indirect cost rate plans (ICRPs), usually prepared through the county/city Auditor-Controller's Office, must be submitted to and approved by the State Controller's Office. Internal ICRPs must be prepared and on file with the LGA for each claiming unit. Both these plans must be prepared in accordance with the provisions of OMB Circular A-87 to withstand an audit. **Under no circumstance will the costs of staff included in either of the indirect cost rates or Direct Charges Worksheet 2 also be included again as a specific cost in any of the cost pools.** Attachment A identifies costs that may be included in "Other Costs."

F. ENTERING MEDI-CAL DISCOUNT PERCENTAGES

Lines AB, AC, AE, AG, and AI:
Enter the claiming unit's Medi-Cal discount percentage for the period being claimed for the activities that must be discounted. Unlike the activity percentages, **the Medi-Cal discount percentage must be determined for each quarter being claimed.** These percentages must be determined by an actual count or must be the countywide average provided by DHS. Any other method must be approved by DHS prior to being used.

Indicate the methodology used to determine the Medi-Cal discount percentage for each activity with an "X" in the area designated on the MAA Detail Invoice. CWA means the countywide average. AC means the actual count.

Some activities do not have to be factored by the Medi-Cal discount percentage. Those activities, as listed below, are identified on lines AA, AD, AF, AH, AJ, and AK. A percentage of 100 percent has been input on the spreadsheet and **must not be altered**.

- Medi-Cal Outreach (A)
- Facilitating Medi-Cal Application
- Contract Administration (A)
- Program Planning and Policy Development (A)
- MAA/TCM Coordination/Claims Administration
- MAA Implementation Training

G. ENTERING ACTIVITY PERCENTAGES

When entering activity percentages, please refer to Section C, "General Instructions for Entering Data."

Lines AA-AP:
For CP1 and CP2, enter the activity percentages determined from a one-month time survey conducted during the month designated by DHS or from an DHS-approved subsequent time survey. (Refer to PPL No. 96-017)

The total for each Cost Pool must equal 100 percent.

Generally, time surveys are conducted only once for each fiscal year. The activity percentages determined by that annual time survey are to be used on each quarterly invoice.

Local governmental agencies have the option to time-survey during months other than that designated by DHS. To conduct additional time surveys, the LGA must submit a request to DHS at least thirty (30) days prior to the beginning of the quarter in which the time survey will be conducted. DHS will either approve or deny the request. Once approved, the time survey must be completed. See PPL #96-017 for further information.

H. FUNDING (REVENUE) SOURCE WORKSHEET 1

The purpose of offsetting funding (i.e., Revenue) against cost is to arrive at the net cost in which the federal government is willing to share. When determining when to report revenue, each claiming unit should consult their annual budget. Revenue should generally be recorded against the corresponding cost of the period. If it is anticipated that funds will be received at one time for the entire year, it is reasonable to divide these funds so as to report a portion of them on each quarterly claim. If the entire annual revenue is reported in one quarter, it may more than offset that quarter's cost, resulting in the LGA needing to refund money because costs were overstated in other quarters within a given fiscal year.

Unanticipated revenue for the current fiscal year, or for a prior fiscal year not previously offset, should be offset in the current fiscal year as explained above. Should the aforementioned revenue be received in the last quarter of the current fiscal year, it must be reported in that quarter.

For more information on Funding Sources (Revenue), please refer to the PPLs issued under separate cover.

The purpose of the Funding Source (Revenue) Worksheet 1 is to list **all** funding sources of the claiming unit. To arrive at the net cost, for which the federal government will match, it is necessary to offset all applicable funding sources.

In general, the only funds that need **not** be offset are LEC General Funds (including realignment funds), other local funds, and MAA reimbursements. The following rules govern which revenues received by a program must be offset, i.e., subtracted from costs before a federal match is determined.

1. All federal funds, along with maintenance of effort and other state/local matching funds required by the federal grant, must be offset.

2. All State General Fund monies that have been previously matched by the federal government must be offset. This includes Medi-Cal Fee for Services money.

3. State General Funds specifically targeted or earmarked to the delivery of services may not be used again to draw down a federal match for administrative activities. These targeted funds must be offset.

4. Insurance collected from non-governmental sources for the delivery of direct client services may not be used to draw down a federal match for administrative activities. These funds must be offset if the related expenses are included in the MAA invoice.

Note: The number of lines by funding source may be increased by adding rows; however, each row must be added on the row preceding the categorical total.

I. ASSIGNING FUNDING SOURCES TO COST POOLS (WORKSHEET 1)

The claim form provides for the application of the funding source to the appropriate cost pool. Therefore, before entering the amounts, the preparer must follow these steps:

- Classify funding sources by type, i.e., Insurance, Medi-Care, etc.

- Determine the purpose of the funding, i.e., Direct Patient Care, Counseling, Outreach, etc.

- Assign the funding source to the appropriate cost pool.

Whereas costs are assigned to a cost pool based on the workers assigned to that pool, the assignment of funding is determined by the **purpose** of the funding, not necessarily the associated workers. Because funding is normally for a service or product, it is often not identified with a worker or group of workers in the same way that salaries and benefits costs are identified. The rationale for assigning a funding source to a specific cost pool should be documented and retained as part of the audit file.

The Funding Source Worksheet has seven sections:

- Medi-Cal Fees and Match
- Federal Grants and Match
- State General Funds
- Medi-Care
- Insurance
- Fees
- Other Revenue (Funding Sources)

All funding sources must be assigned to one of these seven sections. If additional lines are required, they may be inserted just above the total line in each section. The formulas will not be affected by the additional line(s) if so inserted. Adding lines to the Funding (Revenue) Source Worksheet 1 may cause the worksheet to print out on multiple pages. All pages must be submitted.

The "Purpose" column is to identify the purpose of the funding/revenue. This should be brief but descriptive enough so the reviewer can determine if the funding has been assigned to the proper cost pool.

The "Not Offset" column is for identifying those funding sources that **are not** offset against costs. This would include county general funds, realignment funds, and all other funding sources used to cover cost. These funding sources are identified so the reviewer can relate the total costs to the total funding for that claiming unit.

The remaining columns are to assign funding sources that must offset costs to the appropriate cost pool. Each section has columns identifying which cost pool will be offset by the funding source. "XXX"s have been inserted where it is **not** appropriate to assign funding sources.

Funding sources that are NOT associated with any particular activity or NOT identified to a specific cost pool, but should be offset against the claiming unit, should be assigned to CP6. This allocates the funds to be offset to the other cost pools based on total cost.

Funding requiring offset, which is received for Program Planning and Policy Development being direct-charged, must be assigned to CP3, CP4, and CP5 in accordance with

the percentage of cost allocated to non-claimable, enhanced, and non-enhanced.

Other funding requiring offset for non-enhanced costs that are being direct-charged must be assigned to CP3 and CP5 in accordance with the percentage of costs allocated to non-claimable and non-enhanced.

Only funding sources for MAA where costs are in CP1 or CP2 should be assigned to CP1 or CP2 on the Funding Source Worksheet. Funding sources for non-claimable activities should be assigned to CP3.

For example, a Public Health Nurse who performs both MAA and non-MAA is required to time-survey. All costs for this nurse should be assigned to CP1. Funding received for payment of direct health care should be assigned to CP3. Funding for any other non-MAA should be likewise assigned to CP3. **ONLY funding for MAA should be assigned to CP1.**

Once all the funding sources have been assigned, Funding Source (Revenue) Worksheet 1 will automatically add the columns and transfer them to the MAA Detail Invoice form, line O. Funding Source Worksheet 1 must contain the certification statement and must be signed and returned with the MAA Detailed Invoice.

J. DIRECT CHARGES WORKSHEET 2

Allowable costs for time and resources related to MAA are determined through either a time survey or separately identified and direct-charged. The purpose of the Direct Charges Worksheet 2 is to capture costs determined through methodologies other than the time survey.

Costs may be direct-charged only if they are so identified in the MAA Claiming Plan. Unlike the costs captured through the time survey, costs to be direct-charged must be tracked on an on-going basis throughout the fiscal year. These costs are separately itemized on the Direct Charges Worksheet 2 and included in the audit file maintained by the LGA.

There are five categories of costs that may be direct-charged:

(1) MAA/TCM Coordination and Claims Administration

(2) Program Planning and Policy Development when performed 100 percent of staff paid time

(3) Medi-Cal Non-Emergency, Non-Medical Transportation

(4) MAA Contractors with MAA "specific" contracts

(5) Other costs that can be identified as specifically pertaining to the performance of MAA.

MAA/TCM Coordination and Claims Administration

Direct-charging is permitted for the costs of staff performing MAA/TCM Coordination and Claims Administration at the LGA level or MAA Claims Administration at the claiming unit level. The costs at the provider level for TCM claiming activities are included in the TCM rate. This activity is not factored by the Medi-Cal discount percentage. Each staff performing this activity must be separately listed with the corresponding percentage of time identified. By signing the Direct Charges Worksheet, you are certifying the percentage of time associated with MAA/TCM Coordination and Claims Administration. A separate certificate statement is not required.

Direct-charging is also permitted for the related "Other Costs" of staff performing MAA Coordination and Claims Administration. For example, Other Costs that may be direct-charged include equipment used exclusively for the execution of MAA.

Program Planning and Policy Development

Direct-charging should be used to report costs for staff who perform Program Planning and Policy Development 100 percent of their paid time. If performed less than 100 percent, the costs must be determined through the time

survey. See the Section, K. Program Planning and Policy Development for more information.

Medi-Cal Non-Emergency, Non-Medical Transportation

The actual cost of providing Medi-Cal Non-Emergency, Non-Medical Transportation may be direct-charged. These costs include bus tokens, taxi fares, mileage, etc. There are two ways to direct-charge these costs.

(1) Record all costs for transporting all clients to a Medi-Cal-covered service. The costs must then be factored by the appropriate Medi-Cal discount percentage,

(2) Record only the costs of transporting Medi-Cal clients to Medi-Cal-covered services. No discount factor would be applied if using this methodology.

MAA Contractors

If the contract specifically describes the MAA to be performed and the contract specifies the amount for each MAA performed, it is not necessary for the contractor to time-survey. The scope of the contract must include the MAA to be performed, such as Outreach A, the staff performing the activity, and the deliverables. The contract must also identify how the Medi-Cal discount percentage will be determined, if appropriate.

Other Costs

Non-personnel costs associated with the performance of MAA may also be direct-charged. The activity associated with these costs must be identified. Additionally, it must be determined if the cost must be factored by a Medi-Cal percentage. The discount factors for non-personnel costs may be different from the activity of the staff performing MAA.

The Direct Charges Worksheet 2 is divided into four sections:

- Section 1: Enhanced - Cost Pool 4 (Program Planning and Policy Development)
- Section 2: Non-enhanced - Cost Pool 5 (Program Planning and Policy Development)
- Section 3: Non-Enhanced - Cost Pool 5 (Non-PPPD)
- Section 4: Total to Cost Pool 3b

When determining which costs are to be direct-charged, remember that those costs cannot appear anywhere else on the MAA Detail Invoice because this would result in duplicate claiming.

Sections 1 and 2:
The first two sections are for costs related to the performance of Program Planning and Policy Development (PPPD) when performed 100 percent of staffs' paid time. Costs are not entered directly into these two sections, but are entered on the PPPD Worksheet 3 and are automatically transferred from this worksheet to Sections 1 and/or 2 of the Direct Charges Worksheet 2. Detailed steps for this process are in Section K (PPPD Worksheet 3).

Section 3:
This section is to be used to enter all costs, other than PPPD, to be direct-charged. Data from this section of the worksheet will automatically be transferred to the MAA Detailed Invoice.

- Costs should be entered in unshaded cells of Section 3 of the Direct Charges Worksheet 2 in the appropriate cost column. Separate columns have been provided to record the costs for salaries and benefits of claiming unit staff, Personal Services Contracts, MAA Transportation, and Other costs. **Do not enter PPPD costs in this section.**
- In the Description section, list the categories of costs to be direct-charged as defined in the approved claiming plan.

- For each category of costs to be direct-charged, a Medi-Cal discount percentage **OR** a Time Factor must be entered in the Medi-Cal/Certified Time Factor column.

- For MAA/TCM Coordination and Claims Administration costs, enter the time percentage in the Medi-Cal/Certified Time Factor column. As this activity does not require discounting by a Medi-Cal percentage, the time percentage is the only factor that will be applied. If this activity is performed 100 percent of the staffs' paid time, enter "1" in the column. If more than one person is to be direct-charged for this activity and the certified time percentages are different, enter each position and the certified time percentage separately. If actual costs associated with the performance of this activity, such as travel, are to be direct-charged, list these costs on a separate line and enter the cost in the column labeled "Other Costs." Refer to PPL No. 97-014.

Note: When assigning a factor to costs for such items as equipment or travel associated with MAA/TCM Coordination and Claims Administration, it is critical to evaluate how much of those costs are claimable as MAA. This factor may frequently be different from the factor used to certify the time spent on that activity.

- For activities requiring a Medi-Cal discount percentage, enter the percentage discount in the Medi-Cal/Certified Time Factor column. The appropriate Medi-Cal discount percentage is determined by the methodology identified in the approved claiming plan.

Examples for Section 3

Example 1: The cost of transportation may be direct-charged in one of two ways. The first is to record the cost for transporting only Medi-Cal eligibles to a Medi-Cal service. In this case, the activity would not be discounted by a MC% (enter "1" in the cell to show 100-percent Medi-Cal discount percentage). The second alternative is to record the cost of transporting everyone to a Medi-Cal-covered service. An appropriate MC% is determined by actual head count or countywide average according to the claiming plan, and this percentage is entered in the Medi-Cal/Certified Time Factor column cell.

Example 2: A MAA/TCM Coordinator spends 85 percent time on MAA/TCM Coordination and Claims Administration. Additionally, an accountant spends 45 percent of his/her time preparing claims. The MAA/TCM Coordinator would be listed and "85" entered in the Medi-Cal/Certified Time Factor column. If the Coordinator had costs associated with MAA, the costs should be listed on a separate line in the "Other Costs" column and the factor should be 100 percent. The accountant would be listed separately, and a "45" would be entered in the Medi-Cal/Certified Time Factor column.

The percentages of time must be determined and documented in accordance with the approved MAA claiming plan. These percentages may differ each quarter because they are determined on an on-going basis.

Section 4:
This section is a summary of the non-claimable costs determined from Section 3 and the PPPD Worksheet 3. Data is not to be entered in this section. These totals are automatically transferred to the MAA Detail Invoice.

The Direct Charges Worksheet 2 must contain the certification statement and be signed by the person with the requisite authority. It must be submitted with the MAA Detail Invoice.

K. PROGRAM PLANNING and POLICY DEVELOPMENT WORKSHEET 3

The PPPD Worksheet 3 has been developed to determine the reimbursable amount for PPPD activities that are being direct-charged. According to the Agreement between the CMS and DHS (Addendum No. 3), this activity may be direct-charged **only** if performed by a unit of one or more employees who spend 100 percent of their paid time performing program planning and policy development. The claimable portion of this activity is then automatically transferred to the Direct Charges Worksheet 2.

If PPPD is performed less than 100 percent of paid time, it cannot be direct-charged. Instead, employees must time-survey and record their time spent performing this activity under either PPPD (A) or PPPD (B). Costs for these employees should be included in Cost Pool 1 or Cost Pool 2, NOT on the PPPD Worksheet.

PPPD is the only activity that currently qualifies for enhanced funding when performed by an SPMP. SPMP employees who perform only this activity are not required to participate in the annual time survey but must track their time to account for the various programs they are planning/developing, the time performing general administrative activities, and paid time off because general administration is NOT reimbursable at the enhanced rate (75%). Non-SPMPs need only track time spent on the various programs, not on general administration, because all time is reimbursable at the non-enhanced rate (50%). The methodology used to track the time spent on the different programs must be described in the Claiming Plan.

The worksheet is divided into two sections, one for SPMPS and one for non-SPMPs. The section for SPMP takes into account salary and benefits to be reimbursed at the enhanced rate (75%) while calculating all other costs at the non-enhanced rate (50%). Costs for the SPMP must be entered in the appropriate section. Costs for the non-SPMPs must likewise be entered in the appropriate section. For each program type, the amount of time spent and the Medi-Cal discount percentage, where appropriate, must be entered. When entering this information, it is critical to segregate the information for the SPMPs and the non-SPMPs in the area identified.

The worksheet has been designed to accommodate the following program types:

(1) Medi-Cal Services for Medi-Cal clients only: this is for programs that are developed for a Medi-Cal-covered service for Medi-Cal eligibles only. The Medi-Cal discount percentage is always 100 percent.

(2) Medi-Cal Services (general population): this is for programs developed for a Medi-Cal-covered service but may be available to the entire county/city population. The MC% should be the countywide average.

(3) Non-Medi-Cal Program: this is for programs for services not covered under the Medi-Cal program; therefore, it is not claimable. The Medi-Cal discount percentage is zero, and the cell is preformatted.

(4) Medi-Cal Programs with identified Medi-Cal beneficiaries: this is for programs that are for a Medi-Cal-covered service and the Medi-Cal population to benefit from the program can be specifically identified. The worksheet is designed to accommodate seven of these program types. Others may be added by inserting rows on the spreadsheet, formulas must be copied.

All other areas of the worksheet contain formulas. Data **must not** be entered in these areas. The areas are shaded for easy identification. The claimable portion of costs are automatically transferred to the Direct Charges Worksheet 2, Section 1 or 2. The non-claimable portion of costs are transferred to Section 4.

L. SUPPORTING DOCUMENTATION

The following document must be submitted for each MAA Detail Invoice submitted for payment:

- Funding Source (Revenue) Worksheet 1 (**must** have a certification statement and an original signature)

Additionally, the following documents must be submitted with each initial quarterly claim of each fiscal year:

- A list of all classifications of staff whose costs have been assigned to CP6 and the number of staff in each of the classifications

- Description of "Other Costs" categories for each cost pool except CP3a

Note: DHS reserves the right to request this information be submitted for additional quarterly claims.

The following documents must be submitted with each MAA Detail Invoice if costs are being direct-charged:

- Direct Charges Worksheet 2 (**must** have a certification statement and an original signature)

- Program Planning and Policy Development Worksheet 3

M. CLAIMING FOR CONTRACTORS

A separate MAA Detail Invoice is required for each contractor, except a Personal Services Contractor. Personal Services Contractors may be included on the claim from the claiming unit. The requirement to provide cost and funding data for cost pools depends on the provision and purpose of the contract between the LGA program and the contractor and on the funding source used to reimburse the contractor.

If the contract is "non-specific," meaning that the contract does not clearly describe the MAA to be performed and specifically identify the amount to be paid for each allowable activity, contractor staff must time-survey. To have those costs factored by the time-survey results, the contractor must enter costs into CP2 for both SPMP and non-SPMP individuals. If operating expenses and overhead costs are an integral part of the contract amount, these costs may be entered on the first page of the MAA Detail Invoice on line H, "Other Costs."

If the contract is "specific," meaning that the contract describes the MAA to be performed and the specific amount to be paid for each activity, it is not necessary for contractor staff to time-survey. In this case, costs are to be entered in Section 3, Non-Enhanced CP5, of the Direct Charges Worksheet 2. In the "description" section, list each MAA included in the contract separately, such as Outreach A, Outreach B, etc., with the associated contract amount (costs) entered in the "Other Costs" column. The Medi-Cal discount percentage is required for the following activities:

- Medi-Cal Outreach (B1 and B2)
- Arranging for Transportation
- Program Planning and Policy Development (B)

When the LGA program contracts out to provide specific MAA using only their unmatched General Funds, a listing of all funding sources is not required from the contractor. It is required that the LGA program certify the source of the LGA funding for the contract and that no offset is required because these funds are unmatched LGA General Funds only. This certification should be made on **county/city letterhead** and signed using the same certification statement found on the Funding Source (Revenue) Worksheet. Worksheet 1 may also be used for this purpose.

N. COMPLETING THE HEADER ON THE DETAIL INVOICE

Each MAA Detail Invoice must contain the following items:

- County or City name.
- Contract Number: use the number specific to the period of service (FY) claimed.
- Period of Service: identifies the period of time covered on the invoice.
- Program/Department: identifies the major program such as Public Health, Public Guardian, Schools, etc.
- Claiming Unit: identifies the unit within the program as identified in the Claiming Plan. For example, the claiming unit may be a Field Nursing for the Public Health. The program name and the claiming unit name will be the same if the claim is for the entire program. For example, the Public Guardian program may not have any subunits. That claim would have "Public Guardian" for both the Program and the Claiming Unit.

If the claim is for a **contractor** of the Claiming Unit, the name of the contractor must also be identified. This should be added to the name of the Claiming Unit. For example, if Public Health has a Perinatal claiming unit that contracts with ABC contractor for Outreach, the Claiming Unit would be designated as "Perinatal-contractor ABC."

- Invoice Number: the standard invoice numbering system is designed to identify the fiscal year and the quarter claimed. For example, invoice number 99/00-1 is the claim for the first quarter (July 1, 1999–September 30, 1999) of fiscal year 1999/2000.

Invoice Number	Period of Service
99/00 - 1	July 1, 1999–September 30, 1999
99/00 - 2	October 1, 1999–December 31, 1999
99/00 - 3	January 1, 2000–March 31, 2000
99/00 - 4	April 1, 2000–June 30, 2000

Once the header information has been entered on the MAA Detail Invoice, it will automatically be carried to each of the worksheets.

MAA SUMMARY INVOICE

The MAA Summary Invoice is used to aggregate information from the MAA Detail Invoice onto a single page that identifies the cost categories for reimbursable costs associated with Cost Pools 1 & 2 and the Direct Charges. Each Detail Invoice should have a separate accompanying MAA Summary Invoice.

To complete the MAA Summary Invoice, enter data as follows:

County:	Enter the name of the county or city
Period of Service:	Enter the period of services (FY) for the MAA Detail Invoice
Contract Number:	Enter the contract number that corresponds to the period of service.
Invoice Number:	Enter the invoice number that corresponds to the MAA Detail Invoice number.
Line 1:	Enter the amount identified on line CG of the MAA Detail Invoice
Line 2:	Enter the amount identified on line CH of the MAA Detail Invoice.
Line 3:	Enter the amount identified on line CI of the MAA Detail Invoice.

If the MAA Detail Invoice must be adjusted down, the Administrative Claiming Operations Unit (ACOU) in the Department of Health Services can make these adjustments after consulting with the submitting LGA. The ACOU will adjust the MAA Summary Invoice accordingly and fax the revised MAA Detail and MAA Summary invoice to the LGA MAA/TCM Coordinator.

SUBMITTING THE MAA DETAIL and MAA SUMMARY INVOICE

It is the responsibility of the MAA/TCM Coordinator to review all invoices for completeness and accuracy prior to submitting them to the State Department of Health Services. Invoices submitted using an incorrect format will be returned without being reviewed. To expedite the review and payment process, it is necessary to follow all the instructions.

The following items must be included:

- MAA Summary Invoice
- MAA Detail Invoice
- Funding (Revenue) Sources Worksheet 1
- Direct Charges Worksheet 2 (if claiming)
- Program Planning and Policy Development Worksheet 3 (if direct-charging)
- Review Checklist
  - **>** for MAA Detail Invoice
  - **>** for MAA Summary Invoice
- Supporting Documentation, when requested

The original and two copies of the MAA Detail Invoice and MAA Summary Invoice are required. Only the original from each of the other documents is necessary.

Invoices should be sent to:

Department of Health Services
Administrative Claiming Operations Unit
Attn: Ms. Georgia Rivers
714 P Street, Room 1640
P.O. Box 942732
Sacramento, CA 94234-7320

PAYMENT PROCESS

MAA claims are submitted to DHS, Administrative Claiming Operations Unit (ACOU). The invoices are reviewed for fiscal integrity and compared to the Claiming Plan. Once approved by ACOU, the invoice is forwarded to the Accounting Section for payment processing. The Accounting Section will prepare the invoices for payment and forward them to the State Controller's Office (SCO) for payment. Warrants are made payable to the LGA Treasurer. Once an invoice is sent to the SCO, a warrant may be expected within two weeks.

All paid invoices are reported to the federal government on a quarterly basis on the Report of Expenditures, Form 64 (HCFA 64). All invoices must be reported within two years of the end of the quarter claimed. Invoices submitted for the first time beyond the two-year time frame will be returned without being processed for payment. To comply with this requirement, all LGA invoices must be submitted to the Department of Health Services within eighteen (18) months of the end of the quarter claimed.

DETERMINING MEDI-CAL DISCOUNT PERCENTAGE FOR OUTREACH B

How is a Medi-Cal discount percentage derived for Outreach when there is more than one Outreach campaign for the periods of service?

For example, assume that there were five Outreach campaigns for a period of service. In each campaign, accurate data was collected for (1) count of people in the campaign who are Medi-Cal recipients and (2) total head count of the campaign.

A Medi-Cal discount percentage was calculated for each campaign by dividing Medi-Cal population counts by the total population count. The following method may be used to calculate the combined Medi-Cal Discount Percentage for the five Outreach campaigns.

Sum the total population counts of the five outreach campaigns. Sum the Medi-Cal population counts of five outreach campaigns. Divide the summation of the total population counts of all five outreach campaigns. The result is your Medi-Cal Discount Percentage for all five Outreach Campaigns.

	Outreach 1	Outreach 2	Outreach3	Outreach 4	Outreach 5	Total
1) Medi-Cal population count	6,500	200	200	4,000	2,000	12,900
2) Total population count	10,000	1,000	2,000	5,000	2,000	20,000
3) Medi-Cal Discount Percentage	65%	20%	10%	80%	100%	64.5%

SUBMITTING CORRECTIONS and REVISIONS

Corrections

All invoices submitted to DHS for payment are reviewed by staff in the Administrative Claiming Operations Unit (ACOU). If errors are found or additional documentation is required, state staff will contact the MAA/TCM Coordinator. It may be possible to resolve the error by phone or by the LGA submitting (FAX and/or mail) additional documentation. If this can be accomplished in a few days, the invoice will be held in the ACOU pending resolution. Otherwise, the invoice(s) will be returned to the LGA with a written explanation of the reasons it is being returned for correction.

When the LGA corrects and returns the rejected invoice, it must identify the resubmitted invoice as a Corrected Invoice. The corrected invoice must be identified as a "Correct Invoice" in the transmittal letter and also in the invoice number. The invoice number should reflect the correction by adding a C-1 to the invoice number. If subsequent corrections are required, the invoice number will reflect the number of corrections (C-2), etc.

Revisions

Sometimes, after an invoice has been processed and paid, an LGA may discover the need to make revisions to the invoice. In these situations, the LGA should recompute the invoice and submit it along with the invoice as it was originally paid. The revised invoice must be identified as a "Revised Invoice" in the transmittal letter and also in the invoice number (R-1).

Corrections and Revisions require a new MAA Summary Invoice and Checklist.

EXAMPLES OF OTHER COSTS

"Other Costs" are those costs, other than salary and benefits, that are necessary for the proper and efficient administration of the Medicaid program. While many operating (other) costs are claimable, some are not. Below is a list of typical costs that may be claimed for reimbursement and a list of costs that are not claimable and must be listed as "Other Costs" in Cost Pool 3a. Both lists are only examples and are not considered comprehensive.

Claimable Operating (Other) 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
- 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

All of the above are claimable costs only if they do not relate to non-claimable categories of cost. For example, repair and maintenance of office equipment used to support activities of SPMPs in Cost Pool 1 are claimable costs. The repair and maintenance of an X-ray machine or lab equipment are not claimable costs and must be entered as "Other Costs" of Cost Pool 3a.

Non-Claimable Operating Costs

- Malpractice insurance
- Equipment used for providing medical treatment
- Medical supplies
- Drugs and medications
- Take back
- Costs of elected officials and their related costs

- Costs for lobbying activities
- Fund Raising

CHECKLIST FOR PREPARING THE MAA DETAIL INVOICE FOR MEDI-CAL ADMINISTRATIVE ACTIVITIES

Each Medi-Cal Administrative Activities (MAA) Detail Invoice must have a completed checklist verifying the following items before it will be processed for payment. In addition, the claims will be reviewed for reasonableness and consistency.

_____ You have an approved claiming plan on file.

_____ The proper format is used.

_____ The LGA name is on the invoice.

_____ The correct contract number is used.

_____ The period of service is correct.

_____ The Claiming Unit name is the same as identified in the Claiming Plan.

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

_____ The methodology used to determine the Medi-Cal discount percentage is consistent with the claiming plan.

_____ The required certification statements are on the required documents and signed.
MAA Detail Invoice.
MAA Funding (Revenue) Source Worksheet 1.
MAA Direct Charges Worksheet 2.

_____ The invoice is dated and has an original signature (preferably in BLUE ink.)

_____ The Direct Charges Worksheet 2 is dated and has an original signature.

_____ The Funding Source Worksheet is dated and has an original signature.

_____ The total amount to be reimbursed is greater than zero and there are no “Error” comments on the claim.

_____ The required supporting documentation is attached.
(Cost Pool 6 and a description of “Other Costs” for each Cost Pool, except 3a, for the initial quarterly claim of each fiscal year.)

_____ The original of the claim and two copies are included.

SIGN AND DATE INDICATING ALL ABOVE ITEMS HAVE BEEN REVIEWED PRIOR TO SUBMISSION.

_____ _____
SIGNATURE DATE

CHECKLIST FOR PREPARING THE MAA SUMMARY INVOICE FOR MEDI-CAL ADMINISTRATIVE ACTIVITIES

Each MAA Summary Invoice sent to the Department of Health Services, Administrative Claiming Operations Unit (ACOU) by the Local Governmental Agency (LGA) must be accurate and complete. To assist the staff in reviewing and processing your Medi-Cal Administrative Activities (MAA) Claims expeditiously, please complete this checklist and verify the following items before sending your MAA Summary Invoice to be processed by ACOU.

_____ Prepare a cover letter, identifying any irregularities or variations in the MAA Detail Invoice, and attach it to the MAA Summary Invoice.

_____ Confirm that the MAA Summary Invoice is prepared on the letterhead of the agency that is under contract with the Department of Health Services.

_____ Confirm the County/City Name is correct.

_____ Confirm the contract number is correct.

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

_____ Confirm the Program/Department name is the same as the MAA Detail Invoice.

_____ Verify that the invoice number is the same as the MAA Detail Invoice.

_____ Confirm the 50 percent amount (line 1) is the same as line CG on the MAA Detail Invoice.

_____ Confirm the 75 percent amount (line 2) is the same as line CH on the MAA Detail Invoice.

_____ Confirm the total (line 3) is the same as line CI on the MAA Detail Invoice.

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

_____ _____

SIGNATURE DATE

AUDIT FILE CHECKLIST

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

_____ Contract with the State Department of Health Services

_____ Contract with Host County

_____ All Memorandums of Understanding or contracts with community-based organizations and all personal services contracts.

_____ Organization charts for the agency

_____ Duty statements for staff performing administrative activities

_____ A copy of the survey used to determine if staff qualify as Skilled Professional Medical Personnel

_____ Time Study sheets with supervisor's signature

_____ Approved claiming plans

_____ Supporting material, i.e., flyers, brochures, attendance forms

_____ Documentation to support the Medi-Cal Discount Percentage claimed

_____ Worksheets and spreadsheets used in developing the claim

_____ Copy of the methodology used to establish the agency's indirect cost rate

Acronyms Used in the MAA Detail Invoice and the Instructions for the Invoice

AC	Actual Count
ACOU	Administrative Claiming Operations Unit
CMS	Centers for Medi-Care and Medicaid Services
CP	Cost Pool
CWA	Countywide Average
DHS	California Department of Health Services
FFP	Federal Financial Participation
GA	General Administration
HCFA	Health Care Financing Association
HCFA-64	HCFA Report of Expenditures, Form 64
ICRP	Indirect Cost Rate Plan
LEC	Local Educational Consortium
MAA	Medi-Cal Administrative Activities
MC%	Medi-Cal Discount Percentage
OMB	Office of Management and Budgets
OMB Circular A-87	Federal Office of Management and Budgets Circular A-87—Guide for Indirect Cost for State and Local Government
PPPD	Program Planning and Policy Development
PTO	Paid Time Off
SCO	State Controller's Office
SPMP	Skilled Professional Medical Personnel
TM	Tape Match
ADFC (u)	Unadjusted AFDC Count
ADFC (a)	Adjusted AFDC Count

SECTION 9

Medi-Cal Administrative Activities (MAA) Documentation

Table of Contents

RECORD KEEPING AND RETENTION

Overview

The heart of Medi-Cal Administrative Activities (MAA) claiming is the time survey. Federal regulations require that records be kept for three years after the end of the quarter in which the expenditures were incurred. If an audit is in progress, all records relevant to the audit must be retained until the completion of the audit or the final resolution of all audit exceptions, deferral's and/or disallowances. All records retained must be in readily reviewable form, in an audit file by program and be available to the state and federal government upon request in accordance with record retention requirements set forth under the 42 Code of Federal Regulations (CFR) Section 433.32. This documentation includes all **original** time-survey documentation. The time-survey documentation must be kept in a central location and easily accessible.

Similarly, the documents that support the construction of a MAA claim need to be kept three years after the last claim revision. These documents include the documentation that supports the Medi-Cal percentage, the basis of the cost pools, documentation of Skilled Professional Medical Personnel (SPMP) status, and position descriptions and/or duty statements for all staff performing MAA.

Building and Maintaining an Audit File

Each Local Governmental Agency (LGA) must develop an audit file beginning the first quarter in which a time survey is conducted. A checklist has been developed to assist the LGA in this task. Documentation is necessary to respond to audit inquiries and is also essential when staff who were responsible for the time survey or the MAA claim leave the organization, and when new staff must take on this responsibility.

MEDI-CAL ADMINISTRATIVE ACTIVITIES (MAA) AUDIT GUIDELINES

The following guidelines are provided to assist in development of an audit documentation file. Adherence to these guidelines will minimize the risk of audit disallowances. Documentation unique to each quarterly claim should be kept in a separate file. In some cases, required documentation for each quarterly claim will be identical, i.e., organization charts, position descriptions, duty statements etc. In other cases, materials will be too voluminous to keep in the file, e.g., time cards. In both of these cases documentation should be kept in the audit file detailing where the materials can be found. It may also be helpful if you maintain, and refer to, a general MAA file for documentation used from quarter to quarter. All materials referenced **must** be available for review throughout the record retention period.

Records to be retained by the Local Governmental Agency (LGA) for each MAA claiming unit include but are not limited to:

Time Survey Materials

A listing of employees participating in each time survey must be maintained in the audit file. Include name, position classification, and SPMP status, if applicable.

The original time survey used during the month of the time survey must be included in the file to support the MAA claim, signed by the worker and supervisor. The time survey must be completed throughout the course of the day—not at the end of the day or end of the week—to assure accuracy. Time survey documents should be clean and legible, and are to be competed by the staff person for whom time is being recorded using his or her best judgment based on the description of activities relative to MAA. Supervisors are **not** to make any corrections or alterations to the time surveys. When making corrections to time surveys, staff should not use white out; instead, use a single strikeout and initial. Time surveys are legal documents that serve as the basis for MAA claiming.

Copies of time cards for the time-survey period, **or** documentation where they can be found, must be available during the record retention period.

MAA Claiming Plan

The MAA Claiming Plan approved by DHS and CMS specific to the claiming unit and any amendments denoting any changes to the claiming plan and/or activities performed by

	the unit must be retained by the LGA. Refer to MAA Claiming Plan requirements under Section 5 of this manual.
Position Descriptions/ Duty Statements	Position description and/or duty statement for each classification of individuals performing MAA activities must be retained. The position descriptions and/or duty statement must contain language showing that the position descriptions and duties match the activities in the MAA Claiming Plan.
Organization Chart	An organization chart for each quarter claimed, depicting all department programs, or subcontractors participating in MAA. If the claiming unit is a subunit of a much larger department or umbrella agency, it is not necessary to have pages of the various subcharts; however, an overall organizational chart, depicting how the claiming unit fits into the total structure, is necessary.
Medi-Cal Percentages	Documentation of the methodology, calculations, and supporting data used to determine the percentage of Medi-Cal recipients—a statistic to be used in the quarterly MAA claim—that must be retained in the audit file by the LGA. The Medi-Cal percentage calculation and documentation must be updated each quarter. Please reference Section 6, Determining the Medi-Cal Percentage, in this manual.
Contracts/ Memorandums of Understanding	Copies of all signed contracts, MOUs or lateral agreements including exhibits with the LGA et al., for the MAA period of the claim must be retained. These contracts must include the MAA contract with DHS.
Claim Documents	A copy of each claim, by quarter, including worksheets and calculations used in the development of the MAA claim, must be retained in the audit file for each fiscal year. Supporting documentation for all costs and revenue included in the MAA claim must also be included. Narrative descriptions of the calculations and supporting documentation for any costs included in the MAA claim must be retained in the audit file.
SPMP Questionnaire	Copies of the SPMP questionnaire indicating allowable qualifications must be retained for staff for whom reimbursement at the enhanced rate will be claimed. Refer to Guides and Examples under Section M-12, of this manual.

AUDIT FILE CHECKLIST

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

Time Survey Materials

Original time-survey logs to be signed by the employee and the employee's supervisor.

Copies of time cards for the time study period of all staff participating in the time survey.

Copies of the computations that calculated the allowable administrative time.

MAA Claiming Plan and Amendments

The approved Claiming Plan specific to claiming units and any approved amendments denoting any changes to the claiming plan and/or activities performed by the claiming unit.

All supporting documentation for the Claiming Plan including flyers, brochures, agendas, attendance logs or training logs of individual staff, contracts, resource directories. Refer to Section 5 of this manual for Documents required for each MAA.

Position Descriptions/ Duty Statements

Duty statements and/or position descriptions for staff performing MAA.

Copies of the survey used to determine if staff qualify as Skilled Professional Medical Personnel (SPMP).

Organization chart showing the relationship of SPMP clerical staff to SPMPs.

Claim Documents

Worksheets, spreadsheets and methodology used in developing the claim.

Copies of methodology for calculating agency indirect cost rate.

Documentation to support the Medi-Cal percentage claimed.

Contracts

The contract between the Department of Health Services and the Local Governmental Agency (LGA).

All lateral agreements between the LGA and other public entities.

Contracts or sub-contracts between any public entities participating in MAA/TCM and their contract agencies.

Time surveys (as above) if contractors are time-surveying; written description of methodology used to calculate costs if time surveys are not used.

The contract with the Host County.

SECTION 10

Medi-Cal Administrative Activities (MAA) Claiming for Subcontract Agencies

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SUBCONTRACT AGENCIES AND COMMUNITY-BASED ORGANIZATIONS

Overview

Local Governmental Agencies (LGA) may use subcontractors (including independent subcontractors and Community Based Organizations) to perform some or all of their functions. Under certain conditions, these subcontractors may participate in MAA.

All activities performed by subcontract agencies are reimbursable only at 50 percent. Federal regulations do not permit reimbursement at the enhanced rate for any activities performed by subcontract agencies.

LGA subcontractors are not permitted to claim for Contracting for Medi-Cal Services and MAA. LGA subcontractors can only claim for "support activities" under Program Planning and Policy Development.

A subcontract agency that has "mixed" functions is one that performs some MAA and some "non-claimable administrative activities. In this case, there are two options that may be pursued. If the subcontract with the LGA is "non-specific," meaning that the subcontract does not clearly describe the MAA to be performed and specifically identify the amount to be paid for each allowable activity, subcontractor staff must time-survey. If the subcontract with the LGA is "specific," meaning that the subcontract describes the MAA to be performed and the specific amount to be paid for each activity, it is not necessary for subcontractor staff to time-survey. In this case, the allowable activities can be direct-charged as MAA.

Conditions for Participating in MAA

Federal and state policies place some limitations on the terms by which subcontractors may participate in MAA. These policies are summarized as follows:

1. Subcontracts

A subcontract must be in place between the LGA and the subcontractor. This subcontract must be effective the first day of the quarter in which a MAA claim is submitted to DHS.

The subcontract must contain language that the subcontractor will perform a designated set of functions

claimable as allowable MAA and that funds eligible to be used as match for FFP are available for these activities.

The subcontract must contain language that the subcontractor will comply with the time survey and claiming methodology described in the MAA Contract.

2. Time Survey

Except as noted below, annual time surveys must be completed by subcontractor's staff whose costs are the basis of the MAA claim. If the subcontract with the LGA describes the MAA to be performed and the specific amount to be paid for each activity, it is not necessary for the subcontractor staff to time-survey.

3. The MAA Invoice

Quarterly invoices for subcontractors are submitted through the LGA to DHS. A separate MAA Detail Invoice is required for each subcontractor. Each Detail Invoice must be accompanied by a separate MAA Summary Invoice that aggregates the information on the Detail Invoice.

The subcontractor's invoice should include not only the name of the subcontractor, but also the name of the LGA with whom it has contracted.

4. Federal Financial Participation (FFP)

All subcontractor costs are reimbursed at 50 percent.

5. The Match for FFP

The subcontractor is required to provide match funds for FFP. These are funds received from the LGA for the performance of MAA or other funds eligible to be used as match for MAA.

SECTION 11

MAA Contracts

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MAA Contract

In order for a Local Governmental Agency (LGA) to claim reimbursement for Medi-Cal Administrative Activities (MAA), Welfare and Institutions Code 14132.47(b) requires that a contract be in place between the Department of Health Services (DHS), the single state agency responsible for administering the Medicaid program, and the LGA. This document is called the MAA Contract.

Lateral Agreement/ Memorandum of Understanding

The MAA contract is designed so the LGA may act on behalf of other governmental agencies claiming reimbursement for MAA. However, if these other agencies intend to seek reimbursement through MAA, then a similar agreement or contract needs to be developed with the LGA that holds the DHS contract. Its language mirrors the DHS contract so that other participating agencies may be held to the same terms and conditions set forth in the contract between DHS and the LGA.

Contract Agencies

LGAs and governmental agencies within local LGAs may deliver their services through contract providers. These contract agencies or community-based organizations may also participate in MAA. The contract language needs to reflect the intent of the contract so that other participating agencies may be held to the same terms and conditions set forth in the contract between DHS and the LGA.

Host County/ DHS Contract

The LGA designated to be the administrative and fiscal intermediary for all LGAs is considered to be the “Host County” and contracts with DHS to perform administrative activities. DHS determines each year the staffing requirements upon which the DHS-projected costs are based. The projected costs include the anticipated salaries, benefits, overhead, operating expenses, and equipment necessary to administer the MAA program.

The contract requires the host county to submit invoices to and collect from each LGA, their portion of the payment for the DHS-projected administrative costs, for which each participating LGA is liable. Funds are disbursed to DHS on a quarterly basis to reimburse the costs incurred by DHS for the performance of administrative activities. The host county must pay DHS within 60 days of receipt of the invoice.

Host County/ LGA Contract

The Host County contracts with participating LGAs and invoices the LGA for the annual participating fee. The contract specifies the responsibility of the Host County and the LGA and includes the scope of work for the Host County contractors.

SECTION 12

Medi-Cal Administrative Activities Guides and Examples

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SKILLED PROFESSIONAL MEDICAL PERSONNEL

In 1986, HCFA implemented regulations at section 432.50 of 42 Code of Federal Regulations (CFR) with defined professional education and training as:

> …the completion of a 2-year or longer program leading to an academic degree or certification in a medically related profession. This is demonstrated by possession of a medical licensee, certificate, or other document issued by a recognized National and State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the administration, direction, or implementation of the Medicaid program is not considered the equivalent of professional training in the field of medical care.

The CFR goes on to say that to receive 75 percent FFP for the allowable costs of these staff:

> …The skilled professional medical personnel are in positions that have duties and responsibilities that require those professional medical knowledge and skills.

In regard to the 75 percent FFP for clerical staff who provide direct support to Skilled Professional Medical Personnel (SPMP), the CFR states:

> …The directly supporting staffs are secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that are directly necessary for the completion of the skilled 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.

GUIDELINES FOR SECURING ENHANCED FEDERAL FINANCIAL PARTICIPATION

Stipulations for Enhanced Funding:

Seventy-five percent (Enhanced) federal matching rate can be claimed for salaries, benefits, travel and training of SPMP and their directly supporting clerical staff who are in an employee-employer relationship with the Contractor and are involved in activities that are necessary for proper and efficient Medi-Cal administration. Fifty percent (non-enhanced) federal matching can be claimed for SPMP and directly supporting clerical staff performing related activities that are non-enhanced. Expenditures for the actual furnishing of medical services by SPMP do not qualify for federal matching at 75 percent nor 50 percent and should not be claimed as FFP is available only for Medi-Cal administration.

SPMP costs may be matched at the 75 percent rate in proportion to the time worked by SPMP in performing those duties that require professional medical knowledge and skills, as evidenced by position descriptions, job announcements or job classifications and when qualified functions are performed such as:

- Liaison on medical aspects of the program with providers of services and other agencies that provide medical care,
- Furnishing expert medical opinions,
- Reviewing complex billings from physicians,
- Participating in medical review, or
- Assessing, through case management activities, the necessity for and adequacy of medical care and services.

Directly supporting staff costs may be matched at the 75 percent rate in proportion to the time worked by clerical staff in performing those clerical job responsibilities that directly support skilled professional medical personnel (Part 423.2, 42 CFR). The directly supporting staff must provide clerical services that are directly necessary for carrying out the professional medical responsibilities and functions of the

SPMP. The SPMP must be immediately responsible for the work performed by the clerical staff and must directly supervise (immediately first-level supervision) the supporting staff and the performance of the supporting staff's work.

Classifications Eligible for Enhanced Funding:

It is the Contractor's responsibility to substantiate claiming based on SPMP status. The Contractor's job specification must stipulate that the incumbent be from one of the below classifications and the program duty statement must reflect enhanced and non-enhanced activities.

A. Skilled professional medical personnel (SPMP) per the Title 42, Code of Federal Regulations (CFR), Charger IV, and the Federal Register.

1. Physician,
2. Registered Nurse,
3. Physician Assistant,
4. Dentist,
5. Dental Hygienist,
6. Nutritionist—with a Bachelor of Science (B.S.) degree in Nutrition or Dietetics and eligible to be registered with the Commission of Dietetics Registration (R.D.),
7. Medical Social Worker—with a Master's degree in Social Work (M.S.W.) with a specialty in a medical setting,
8. Health Educator—with a Master's degree in Public or community Health Education and graduated from a institution accredited by the American Public Association or the Council on Education for Public Health,
9. Licensed Vocational Nurse—who have graduated from a two-year program, and

B. SPMP per the U.S. Department of Health and Human Services Departmental Appeal Board decisions:

1. Licensed Clinical Psychologist—with a Ph.D. in psychology.

C. SPMP per State Department of Health Services policy:

1. Licensed Audiologist- -certified by the American Speech and Hearing Association,

2. Licensed Physical Therapist

3. Licensed Occupational Therapist- -registered by the National Registry of American' Occupational Therapy Association,

4. Licensed Speech Pathologist, and

5. Licensed Marriage, Family and Child Counselors.

D. Directly supporting staff:

1. Clerical Staff—in direct support of and supervised by skilled professional medical personnel,

2. The employer's job specification must require clerical skills, and

3. The program duty statement must reflect clerical functions in support of skilled professional medical personnel.

SPMP includes only professionals in the field of medical care. SPMP does not include non-health professionals, such as public administrators, medical budget directors or analysis, lobbyists, or senior managers of public assistance or Medicaid programs.

Direct support staff means clerical staff who:

- Is a secretarial, stenographic, copy file, or record clerk that provides direct support to the skilled professional medical personnel.

- Provides **clerical services** directly necessary for carrying out the professional medical responsibilities and functions of the skilled professional medical personnel, and

- Has **documentation** such as a job description, that the services provided for the skilled professional medical personnel are directly related and necessary to the election of the SPMP responsibilities.

Professional Education and Training

Skilled professional medical personnel are required to have education and training at a professional level in the field of medical care or appropriate medical practice before FFP can be claimed at 75 percent. "Education and training at professional level" means the completion of two-year or longer program leading to an academic degree or certificate in a medically related profession. Completion of a program may be demonstrated by possession of a medical license or certificate issued by a recognized national or staff medical licenser or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the administration, direction, or implementation of the Medicaid program will not be considered the equivalent of professional training in a field of medical care.

TO: _____

FROM: _____

RE: Skilled Professional Medical Personnel—Targeted Case Manager Questionnaire

To determine whether you qualify as Skilled Professional Medical Personnel and/or TCM Case Manager for claims being made for federal funding, please complete the following form and return it to the person indicated above no later than _____. Thank you.

Name: _____

Division _____

Position Classification: _____

1. Are you a physician licensed to practice medicine in the State of California? ___

   If **YES,** provide license number (_____), signed this form and turn it in.
   Please attach a copy of the license you received and a C.V. If available.
   If **NO,** proceed to Question 2.

2. Have you completed an educational program in a health-related field? _____Other Field?_____

   If YES, list the highest academic degree you received in a health-related or other field, the subject in which it was received, and the name of the college/university where it was earned, and proceed to Question 3. Please attach a copy of the diploma you received, and a C.V. If available.

   Academic Degree Field

   College/University

   If NO, proceed to Questions 3.

3. Did your educational program last at least two years? _____

4. Did our educational program lead to a licensure in a medically-related profession? _____

   If **YES,** provide license type and number and issuing Sate, and sign this form and turn it in. Please attach a copy of the license you received, and a C.V., if available.

   License Type License Number

   If **NO,** proceed to Question 5.

5. Did your educational program lead to a certification or registration by a health or health-related national or California certifying organization? _____

If **YES,** please provide certification/registration type and number (if appropriate), the name of the certifying organization, and sign this form and turn it in. Please attach a copy of the certification or registration you received, and a C.V. if available.

_____
Certification/Registration Type Cert./Reg. Number

_____
Certifying/Registry Organization

If **NO,** proceed to Question 6.

6. Did part of your educational program involve medical or heal-related training including fieldwork (e.g., in health, mental health, or substance abuse)? _____

If YES, describe the training/fieldwork, sign the form and turn it in.

_____
_____
_____

–

Please attach a copy of any certificates or documentation describing your training, and a C.V. if available.

If NO, proceed to Question 7.

7. As part of your educational program, did you take any courses that had a medical or heal-related focus (e.g., About health, mental health, or substance abuse)? _____

If YES, list these courses below, sign this form and turn it in.

_____ _____
_____ _____
_____ _____

Please attach a copy of any certificates or course completion notices you received, and a C.V. if available

If NO, proceed to Question 8.

_____

8. How any years of experience do you have performing case management duties in a health or human services field? Please attach documentation of your experience.

   3 or more years
   2 years
   1 year
   Less than 1 year

9. Does your direct supervisor have designation as an SPMP?

Please sign below and turn this form in.

Signature of Claimant/Employees:

_____

Signature Date

Supervisor's statement of additional qualifying requirements for either SPMP status, or TCM Case Manager status:

_____

_____

_____

_____

Supervisor's Recommendations:

_____

_____

_____

_____

Signature-Supervisor Date

I have reviewed the form and the attached documentation and have determined the following:

SPMP Case Manager status	Meets Essential Requirements	Does Not Meet Essential Requirements

_____

Signature-Medi-Cal Administrative Program Manager Date

MAA REVENUE OFFSET/MATCH MATRIX

REVENUE SOURCE	QUALIFYING CONDITIONS	Must Be Offset (Yes/No)	Permissible as Match (Yes/No)
A. MEDI-CAL SERVICE REVENUE			
Patient Care Revenue	The related expenses are included in the MAA invoice.	*Yes*	No
TCM Revenue	The related expenses are included in the MAA invoice.	*Yes*	No
B. FUNDS RECEIVED FROM FEDERAL GRANTS			
1. Federal Funds Received From Federal Grant Programs Which May Not be Used To Match Other Federal Funds	The related expenses are included in the MAA invoice.	*Yes*	*No*
2. Federal Funds Received From Federal Grant Programs Which May Be Used For Match Under 42 CFR, 433.51	a. The funds are used at the local level for provision of MAA b. The related expenses are included in the MAA invoice.	No	*Yes*
C. STATE GRANTS			
1. State Funds	) (1a) The funds are used as required match for Federal funds at the State level, and) (1b) The related expenses are included in the MAA invoice.	*Yes*	No
2. State Funds	) (2a) The funds are targeted specifically for the delivery of direct client medical services, and) (2b) The related expenses are included in the MAA invoice.	*Yes*	No
3. State Funds	) (3a) The funds are not already being used as a match for Federal) (3b) The funds are not specifically targeted for the delivery of direct client medical client medical services,) (3c) The funds are used at the local level for the provision of MAA services, and) (3d) The related expenses are included in the MAA invoice.	No	*Yes*

D. PRIVATE MEDICAL INSURANCE PAYMENTS, CLIENT PAYMENTS, & ANY OTHER THIRD PARTY REVENUES FOR DIRECT CLIENT MEDICAL SERVICES			
	The related expenses are included in the MAA invoice.	***Yes***	No
E. LOCAL MAINTENANCE OF EFFORT (MOE)			
1. Local MOE	) (1a) The MOE funds are used as required match for Federal funds, and) (1b) The related expenses are included in the MAA invoice.	***Yes***	No
2. Local MOE	) (2a) The MOE funds are <u>not</u> already used as required match for Federal) (2b) The funds are used at the local level for the provision of MAA services, and) (2c) The related expenses are included in the MAA invoice.	No	***Yes***
F. DONATIONS AND TAXES (Received by LGA or LGA Subcontractor)			
1. Donations	) (1a) The funds are eligible according to Federal regulations at 42 CFR, t 433, Subpart B,) (1b) The funds are used at the local level for the provision of MAA services and) (1c) The related expenses are included in the MAA invoice.	No	***Yes***
2. Taxes	) (2a) The funds are eligible according to Federal regulations at 42 CFR, t 433 Subpart B,) (2b) The funds are used at the local level for the provision of MAA services, and) (2c) The related expenses are included in the MAA invoice.	No	***Yes***
G. OTHER REVENUE (Such as Fees and Fines)			
1. Other Revenue	) The funds are <u>restricted</u> to a specific purpose unrelated to MAA, and) The related expenses are included in the MAA invoice.	***Yes***	No
2. Other Revenue	) The funds are <u>unrestricted</u> and may be used at the discretion of the LGA,) The funds are used at the local level for the provision of MAA services,) The related expenses are included in the MAA invoice.	No	***Yes***
H. LOCAL GENERAL FUNDS			
	a. Local funds are as defined by Federal regulation at 42 CFR, 433.51, **b.** The funds are used at the local level for the provision of MAA services, and **c.** The related expenses are included in the MAA invoice.	No	***Yes***

MEDI-CAL ADMINISTRATIVE ACTIVITIES (MAA) HIGHLIGHTS

Medi-Cal Administrative Activities (MAA) are activities necessary for the proper and efficient administration of the Medi-Cal program. The federal Centers for Medi-Care and Medicaid Services (CMS) will match the local costs of performing allowable activities. These activities include the following:

- Outreach: Bringing potential eligibles into the Medi-Cal system and assisting all eligible individuals to obtain Medi-Cal services.
- Facilitating Medi-Cal Application.
- Non-Emergency, Non-Medical Transportation of Medi-Cal recipients to Medi-Cal services.
- Contracting for Medi-Cal Services.
- Program Planning and Policy Development Related to Medi-Cal Services.
- MAA Related Training
- MAA/TCM Coordination and Claims Administration.

What Do You Need to Know to Decide Whether to Participate Administration.

1. Which, if any, of your program personnel perform MAA claimable activities?
2. What percentage of your service population is certified eligible for Medi-Cal?
3. How much of your MAA costs are already paid for by other sources of funding?
4. Can you certify the actual expenditure of 100 percent of allowable local matching funds?

<u>Steps in the MAA Claiming Process</u>

- Obtain a copy of the MAA/TCM Manual from the Local Governmental Agency (LGA) MAA/TCM Coordinator. Determine from the manual whether you are currently performing MAA and/or TCM.

- Identify units and personnel in your organization that perform MAA/

- Identify funding which meets the federal requirements for local matching funds.

- Notify the MAA/TCM Coordinator that you intend to claim for MAA. The LGA must notify the state Department of Health Services (DHS) 30 days prior to the quarter in which you conduct your first MAA time survey and begin claiming. The LGA contracts with DHS for their performance of MAA. Your organization must enter into an agreement with the LGA to perform MAA.

- Arrange to receive MAA Training and instructions from the MAA/TCM Coordinator.

- Conduct a month-long survey to determine the percentage of staff time spent performing allowable MAA.

- For activities requiring discounting by the Medi-Cal percentage, determine the methodology you will use to conduct an actual count of persons served or ask the LGA for the countywide average percentage of Medi-Cal recipients.

- Prepare a MAA Claiming Plan describing in detail the MAA for which you intend to claim. The MAA Claiming Plan must be submitted to DHS by the LGA in the quarter in which you intend to begin claiming. DHS and CMS must approve the plan before claims can be submitted. The LGA will inform you when your plan has been approved.

- Obtain a copy of the MAA Invoice disk and prepare the MAA Invoice. MAA invoices are based on the actual costs of performing MAA and are submitted by the LGA to DHS on a quarterly basis.

- Maintain required program and fiscal audit file documentation.

EXAMPLES OF *ALLOWABLE* AND *NOT ALLOWABLE* PROGRAM PLANNING & POLICY DEVELOPMENT (PP&PD) ACTIVITIES

Allowable PP&PD Activities:

1. Developing a plan to initiate *Mobile Clinic* services to provide CHDP exams and immunizations

2. Developing an interagency *referral* and *tracking* system to expedite access to Medi-Cal services

3. Participating on an *Interagency Perinatal* Task Force to develop strategies to improve access to pediatric services.

4. Participating on an *OB-GYN Advisory Committee*, comprised of physicians, managed care representatives, county employees, and community agency representatives. The purpose of the committee is to develop strategies to improve access to and increase OB-GYN services for Medi-Cal beneficiaries.

5. Participate on the *St Vincent de Paul* Medical Advisory Committee. The purpose of the Committee is to identify health needs of the homeless, particularly families with children, and to develop strategies to address those needs. The majority of the clients are potentially Medi-Cal eligible.

6. Working in collaboration with *school nurses* and community providers on a community needs assessment, development and implementation of services, and evaluation; the planned services include the full range of Medi-Cal services used by children.

7. Developing and reviewing policies and procedures for coordinating medical services for *geriatric* patients.

8. Developing and maintaining *Medi-Cal resource* information and *directories* of services.

9. Developing and overseeing the *Medi-Cal Infant to Age Three* project to increase utilization of Medi-Cal services and Targeted Case Management.

10. Consulting with medical providers on Medi-Cal policies and procedures to ensure that clients receive the *Medi-Cal services* for which they are eligible.

11. Coordinating, planning, and developing policies related to children's services, which includes obtaining resources for Medi-Cal-covered *school-linked health services*.

12. Serving on the *Infant Mortality Review Committee*, which reviews causes of death to identify medical issues in children under age one; the purpose is to develop objectives of prevention and medical intervention for high-risk families.

13. Developing and implementing a telephone line for *Spanish language* Medi-Cal referral.

14. Collecting, analyzing, and reporting Medi-Cal student *statistical data* to evaluate service needs and program utilization.

15. Attending the *Infant Immunization Initiative* planning meetings to plan, implement, and evaluate increased Medi-Cal-covered immunization services.

16. Recruiting for and accompanying Medi-Cal beneficiaries to a meeting to address barriers to Medi-Cal *enrollment and to utilization* of Medi-Cal services.

17. Conducting surveys or focus groups with clients regarding access to and the effectiveness/appropriateness of current Medi-Cal services.

Not Allowable PP&PD Activities:

1. Participating in a *Youth Services Networking Breakfast* to discuss the causes of teen pregnancy.

2. Developing *interagency policies* and procedures to identify battered women.

3. Attending monthly Community Forum meetings, the purpose of which is *networking* and information sharing.

4. Proposal writing in a collaborative setting with other agencies for services *not related* to Medi-Cal.

5. Planning meetings with other agencies for services *not related* to the Medi-Cal program.

6. Conducting *referral to providers* regarding services not related to Medi-Cal.

7. Conducting surveys or focus groups with school site councils regarding *Non-Medi-Cal* services.

8. Attending *general training* on promoting community collaboration.