APPENDIX A

Abbreviations and Acronyms

Abbreviation/ Acronym	Term
ACC	Actual Client Count (a.k.a., DHCS Data Match)
Cal-SAFE	California School Age Families Education
CBO	Community Based Organizations
CFR	Code of Federal Regulations
CHDP	Child Health and Disability Prevention
CMS	Centers for Medicare & Medicaid Services
COE	County Office of Education
CPSP	Comprehensive Perinatal Services Program
DHCS	Department of Health Care Services
DHHS	Federal Department of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FFP	Federal Financial Participation
HCFA	Health Care Financing Administration
IDEA	Individuals with Disabilities Education Act of 1997
IEP	Individualized Education Program (or Plan)
IFSP	Individualized Family Service Plan
IHSP	Individualized Health Service Plan
ISP	Individualized Service Plan
LEA	Local Educational Agency
LEA BOP	LEA Medi-Cal Billing Option Program
LEC	Local Educational Consortium
LGA	Local Governmental Agency
LVN	Licensed Vocational Nurse
MAA	Medi-Cal Administrative Activities
MCO	Managed Care Organizations
MOU	Memorandum of Understanding
OMB A-87	Office of Management and Budget Circular A-87
OP	Operational Plan
PPL	Policy and Procedure Letter
PPPD&IC	Program Planning and Policy Development, and Interagency Coordination
RN	Registered Nurse
SMAA Manual	California School-Based Medi-Cal Administrative Activities Manual
SELPA	Special Education Local Plan Area
TPL	Third Party Liability

APPENDIX B

Sample SMAA Invoice

Tab 1: Total Moment Calculation

RMTS INVOICE INFORMATION

Version: 8.1.19

1	Claiming Unit Name:	
	CDS Code:	
2	DHCS Contractor (Region):	
3	Contract #:	
4	Prepared by:	
5	Title:	
6	Phone #:	
7	Invoice Date:	
8	Contract year/quarter:	
9	Period of Service:	
10	Invoice Number:	*Enter #s into tab 1-row 11, or copy/paste from Invoice Numbers template.*
11	Use this row as a *guide only* for the row above.	

	Region #	FY	Quarter	Inv. Version	Inv. Version	County Code	LEA Code	LEA Type

Total Number of Moments Selected Randomly Prior to the Start of the Quarter for Pool 1 in the Universe:	
Total Number of Invalid Moments:	
Total Valid Moments:	-
Compliance Percentage:	

Pool 1: Direct Svc. & Admin. Providers	Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10	Code 11	Code 12	Code 13	Code 14	Code 15	Code 16	Code 17	Code 18	Total Moments	Total Moments 1-16
Moments:																			0	0

SUMMARY FOR INVOICING ONLY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Total
	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Total Number of Moments Selected Randomly Prior to the Start of the Quarter for Pool 2 in the Universe:	
Total Number of Invalid Moments:	
Total Valid Moments:	-
Compliance Percentage:	

Pool 2: Admin. Svc. Providers ONLY	Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10	Code 11	Code 12	Code 13	Code 14	Code 15	Code 16	Code 17	Code 18	Total Moments	Total Moments 1-16
Moments:																			0	0

SUMMARY FOR INVOICING ONLY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Total
	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Tab 2: Activities and Medi-Cal Percentages Worksheet

	A	B	C	D	E	F	G	H	I	J	K
				RANDOM MOMENT TIME SURVEY RESULTS				FOR NON-ENHANCED CALCULATIONS		FOR ENHANCED CALCULATIONS	
	Type of Activity	Code	Medi-Cal Discount Percentage (Medi-Cal Eligibility Rate)	Participant Pool 1: Direct Svc & Admin Providers (RMTS Results) (a)	Participant Pool 2: Admin Providers Only (RMTS Results) (a)	Pool 1: Allocate Gen. Admin/Paid Time Off (Code 16)	Pool 2: Allocate Gen. Admin/Paid Time Off (Code 16)	Pool 1 RMTS Results: Apply Medi-Cal Discount % (Col. C X Col. F)	Pool 2 RMTS Results: Apply Medi-Cal Discount % (Col. C X Col. G)	Pool 1 RMTS Results: Apply Medi-Cal Discount % (Col. C X Col. F)	Pool 2 RMTS Results: Apply Medi-Cal Discount % (Col. C X Col. G)
	Non-Discounted:										
10	Medi-Cal Outreach	4	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
11	Facilitating Medi-Cal Application	6	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
12	Medi-Cal Claims Administration, Coordination & Training	15	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
	Discounted:										
13	Referral, Coordination, and Monitoring of Medi-Cal Services	8		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
14	Arranging Transportation in Support of Medi-Cal Services	10	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
15	Translation to Access Medi-Cal Services	12	0.00%	0.00%	0.00%	0.00%	0.00%			0.0000%	0.0000%
16	Program Planning, Policy Development & Interagency Coordination Related to Medi-Cal Services	14	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		
	Non-claimable:										
17	School-Related, Education, and Other Activities	1		0.00%	0.00%	0.00%	0.00%				
18	Direct Medical Services	2		0.00%	0.00%	0.00%	0.00%				
19	Non-Medi-Cal Outreach	3		0.00%	0.00%	0.00%	0.00%				
20	Facilitating Application for *Non* –Medi-Cal Programs	5		0.00%	0.00%	0.00%	0.00%				
21	Referral, Coordination, and Monitoring of *Non* –Medi-Cal Services	7		0.00%	0.00%	0.00%	0.00%				
22	Transportation for *Non* –Medi-Cal Programs	9		0.00%	0.00%	0.00%	0.00%				
23	Non-Medi-Cal Translation	11		0.00%	0.00%	0.00%	0.00%				
24	Program Planning, Policy Development & Interagency Coordination Related to Non-Medi-Cal Services	13		0.00%	0.00%	0.00%	0.00%				
	Allocated:										
25	General Administration/Paid Time Off	16		0.00%	0.00%	Allocated	Allocated				
						Allocated					
26	**TOTAL TIME:**			**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.0000%**	**0.0000%**
27	Number of Claiming Unit Staff Included in each Participant Pool										
28	**State Approved Indirect Cost Rate for the Current Billing Period**										

Tabs 3 & 4: Direct Charges Worksheet – Participant Pools 1 & 2

	A		B	C	D	E	F		G	H	I	J	K		L	M	N	O		P	Q	R	S
	PARTICIPANT POOL 1: COST CATEGORY	**MAA ACTIVITY CODE**	**SALARIES (Object 1000–2999)**						**BENEFITS (Object 3000–3999)**						**PERSONAL SERVICE CONTRACTS (Object 5800)**					**OTHER COSTS (Object 4000–5999)**			
			GROSS STAFF SALARIES	Medi-Cal Certified Time Factor	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE		GROSS STAFF BENEFITS	Medi-Cal Certified Time Factor	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE		Contract Costs	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE		Total Other Costs	Medi-Cal Discount Percentage	CLAIMABLE	NON-CLAIMABLE
29	**Medi-Cal Outreach**	4																					
a			$ -	0.00%		$ -	$ -		$ -	0.00%		$ -	$ -		$ -		$ -			$ -		$ -	
b			$ -	0.00%		$ -	$ -		$ -	0.00%		$ -	$ -		$ -		$ -			$ -		$ -	
c			$ -	0.00%		$ -	$ -		$ -	0.00%		$ -	$ -		$ -		$ -			$ -		$ -	
d			$ -	0.00%		$ -	$ -		$ -	0.00%		$ -	$ -		$ -		$ -			$ -		$ -	
	TOTAL		$ -	0.00%		$ -	$ -		$ -	0.00%		$ -	$ -		$ -		$ -			$ -		$ -	
30	**Facilitating Medi-Cal Applic**	6																					
a			$ -	0.00%		$ -	$ -		$ -	0.00%		$ -	$ -		$ -		$ -			$ -		$ -	
b			$ -	0.00%		$ -	$ -		$ -	0.00%		$ -	$ -		$ -		$ -			$ -		$ -	
c			$ -	0.00%		$ -	$ -		$ -	0.00%		$ -	$ -		$ -		$ -			$ -		$ -	
d			$ -	0.00%		$ -	$ -		$ -	0.00%		$ -	$ -		$ -		$ -			$ -		$ -	
	TOTAL		$ -	0.00%		$ -	$ -		$ -	0.00%		$ -	$ -		$ -		$ -			$ -		$ -	
31	**Medi-Cal Claims Admin., Coordination, & Training**	15																					
a			$ -	100.00%		$ -	$ -		$ -	100.00%		$ -	$ -		$ -		$ -			$ -		$ -	
b			$ -	100.00%		$ -	$ -		$ -	100.00%		$ -	$ -		$ -		$ -			$ -		$ -	
c			$ -	0.00%		$ -	$ -		$ -	0.00%		$ -	$ -		$ -		$ -			$ -		$ -	
d			$ -	0.00%		$ -	$ -		$ -	0.00%		$ -	$ -		$ -		$ -			$ -		$ -	
	TOTAL		$ -	0.00%		$ -	$ -		$ -	0.00%		$ -	$ -		$ -		$ -			$ -		$ -	
	NON-DISCOUNTED SUB-TOTAL		$ -			$ -	$ -		$ -			$ -	$ -		$ -		$ -			$ -		$ -	
32	**Referral, Coordination, and Monitoring of Medi-Cal Services**	8																					
a			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
b			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
c			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
d			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
	TOTAL		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
33	**Arranging Transportation in Support of Medi-Cal Services**	10																					
a			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
b			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
c			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
d			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
	TOTAL		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
34	**Translation to Access Medi-Cal Services**	12																					
a			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
b			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
c			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
d			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
	TOTAL		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
35	**Program Planning, Policy Dev. & Interagency Coordination Related to Medi-Cal Services**	14																					
a			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
b			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
c			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
d			$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
	TOTAL		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -		$ -	0.00%	$ -	$ -
	NON-ENHANCED DISCOUNTED SUB-TOTAL		$ -			$ -	$ -		$ -			$ -	$ -		$ -		$ -	$ -		$ -		$ -	$ -
36	**NON-ENHANCED TOTAL COSTS**		$ -			$ -	$ -		$ -			$ -	$ -		$ -		$ -	$ -		$ -		$ -	$ -
	ENHANCED TOTAL COSTS		$ -			$ -	$ -		$ -			$ -	$ -		$ -		$ -	$ -		$ -		$ -	$ -

Tab 5: Payroll Data Collection Worksheet

		A	B		C	D	E	F
	Non-Administrative SALARIES (Objects 1000-2999)	**Participant Pool 1:** Functions 1000-2699, 2800-6999, & 7200-9999	**Participant Pool 2:** Functions 1000-2699, 2800-6999, & 7200-9999	**Non-Administrative BENEFITS** (Objects 3000-3999)	**Participant Pool 1:** Functions 1000-2699, 2800-6999, & 7200-9999	**Participant Pool 2:** Functions 1000-2699, 2800-6999, & 7200-9999	**Participant Pool 1 Totals:** Total Claiming Unit Salaries & Benefits	**Participant Pool 2 Totals:** Total Claiming Unit Salaries & Benefits
43	Total Non-Federally Funded Claiming Unit Salaries **(b)**	$ -	$ -	Total Non-Federally Funded Claiming Unit Benefits **(b)**	$ -	$ -	$ -	$ -
44	**Less:** Time Survey Participants in Pool 1 (Employee) Salary Costs **(c)**	$ -		**Less:** Time Survey Participant in Pool 1 (Employee) Benefit Costs **(c)**	$ -			
45	**Less:** Time Survey Participants in Pool 2 (Employee) Salary Costs **(c)**		$ -	**Less:** Time Survey Participant in Pool 2 (Employee) Benefit Costs **(c)**		$ -		
46	**Less:** Direct Charge Salary Costs in Participant Pools 1 and/or 2	$ -	$ -	**Less:** Direct Charge Benefit Costs in Participant Pools 1 and 2	$ -	$ -		
47	**TO NON-MAA COST POOL:** Tab 6 (Pool 1): Row 53, Col. K Tab 7 (Pool 2): Row 75, Col. K	$ -	$ -	**TO NON-MAA COST POOL:** Tab 6 (Pool 1): Row 54, Col. K Tab 7 (Pool 2): Row 76, Col. K	$ -	$ -		
	School Administration and General Administration SALARIES	Functions 2700-2799, 7000-7119, & 7130-7189	Functions 2700-2799, 7000-7119, & 7130-7189	**School Administration and General Administration BENEFITS**	Functions 2700-2799, 7000-7119, & 7130-7189	Functions 2700-2799, 7000-7119, & 7130-7189		
48	Total Non-Federally Funded Claiming Unit Salaries **(b)**	$ -	$ -	Total Non-Federally Funded Claiming Unit Benefits **(b)**	$ -	$ -	$ -	$ -
49	**Less:** Time Survey Participants in Pool 1 (Employee) Salary Costs **(c)**	$ -		**Less:** Time Survey Participants in Pool 1 (Employee) Benefit Costs **(c)**	$ -			
50	**Less:** Time Survey Participants in Pool 2 (Employee) Salary Costs **(c)**		$ -	**Less:** Time Survey Participants in Pool 2 (Employee) Benefit Costs **(c)**		$ -		
51	**Less:** Direct Charge Salary Costs in Participant Pools 1 and/or 2	$ -	$ -	**Less:** Direct Charge Benefit Costs in Participant Pools 1 and/or 2	$ -	$ -		
52	**TO ALLOCATED COST POOL:** Tab 6 (Pool 1): Row 53, Col. L Tab 7 (Pool 2): Row 75, Col. L	$ -	$ -	**TO ALLOCATED COST POOL:** Tab 6 (Pool 1): Row 54, Col. L Tab 7 (Pool 2): Row 76, Col. L	$ -	$ -	$ -	$ -
							Total from Column E	Total from Column F

(b) A summary general ledger report for Salary and Benefits Costs entered in these cells (Rows 43 and 48, Columns A, B, C, and D) is required to be submitted with the invoice. Invoices submitted without this documentation will not be processed or paid by CMS.

(c) Supporting payroll documentation for Salary and Benefit Costs entered in these cells (Rows 44, 45, 49, and 50, Columns A, B, C, and D) is required to be submitted with the invoice. Invoices submitted without this documentation will not be processed or paid by CMS.

Tabs 6 & 7: Costs and Revenues Worksheet – Participant Pools 1 & 2

	A	B	C	D	E	F	G	H	I	J	K	L	M
				TIME SURVEY			DIRECT CHARGE				NON-MAA	ALLOCATED	
PARTICIPANT POOL 1: CATEGORY (OBJECTS)	Participant	Non-Enhanced MAA Time Survey Percentage	Enhanced MAA Time Survey Percentage	Equals Non-Enhanced MAA Funded Costs (A X B)	Equals Enhanced MAA Funded Costs (A X C)	Non-Claimable Time Survey Costs (A - D - E)	Claimable Non-Enhanced	NON-CLAIMABLE Non-Enhanced	Claimable Enhanced	NON-CLAIMABLE Enhanced	NON-CLAIMABLE (Functions: 1000-2699, 2800-6999, 7200-9999)	GENERAL & ADMIN. (Functions: 2700-2799, 7000-7119, 7130-7189)	CONTROL TOTAL
PERSONNEL COSTS	$	%	%	$	$	$	$	$	$	$	$	$	$
53 Salaries (1000-2999)	$ -	0.00%	0.00%	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
54 Benefits (3000-3999)	$ -	0.00%	0.00%	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
55 **SUBTOTAL: PERSONNEL COSTS**	$ -	0.00%	0.00%	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
REVENUE OFFSETS												Non-Offset	
56 Federal Revenues (8100-8299)							$ -	$ -	$ -	$ -		$ -	$ -
57 LCFF Sources Revenues (8010-8099)												$ -	$ -
58 Other State Revenues (8300-8599)							$ -	$ -	$ -	$ -		$ -	$ -
59 Other Local Revenues (8600-8799)												$ -	$ -
60 Other Financing Sources (8910-8979)												$ -	$ -
61 Contributions to Restricted Programs (8980-8999)												$ -	$ -
62 **Total Revenues**							$ -	$ -	$ -	$ -		$ -	$ -
63 Personnel Costs less Revenue Offsets				$ -	$ -	$ -	$ -	$ -	$ -	$ -			
64 Allocation Percentages				0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%		0.00%

N — CLAIMING UNIT OTHER COSTS - NET OF FEDERALLY FUNDED EXPENDITURES (d) (Objects 4000-5999; Resource 0000-2999, 5640-5649 & 6000-9999; Functions 2700-2799, 7000-7119 & 7130-7189)

Enter Amount: Other Costs from Columns D – J included in Column L

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
OTHER COSTS AND ALLOCATIONS														
65 Personal Service Contracts	$ -	0.00%	0.00%	$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	
66 Direct Charge Other Costs							$ -	$ -	$ -	$ -		$ -	$ -	
67 **ALLOCATION OF OTHER COSTS:**				$ -	$ -	$ -	$ -	$ -	$ -	$ -			$ -	
68 **ALLOCATION OF GENERAL & ADMIN.**				$ -	$ -	$ -	$ -	$ -	$ -	$ -				
69 **Subtotal Costs**				$ -	$ -	$ -	$ -	$ -	$ -	$ -			$ -	
70 Indirect Rate Applied				$ -	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	
71 **TOTAL COSTS**				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
FFP CALCULATIONS														
72 **MAA CLAIMABLE COSTS**				$ -	$ -		$ -		$ -					
73 **Apply FFP Percentages (50% & 75%)**				$ -	$ -		$ -		$ -					
74 **TOTAL FEDERAL SHARE**				$ -										

California School-Based Medi-Cal Administrative Activities Manual

B-5

Sample SMAA Invoice
REVISION 2019

Tabs 8 & 9: LEC and LGA Summary Invoice Pages

RANDOM MOMENT SUMMARY INVOICE

Participant Pools 1 & 2

Claiming Unit Name:	Info fills from Tab 1
CDS Code:	Info fills from Tab 1
S Contractor (Region):	Info fills from Tab 1
Contract #:	Info fills from Tab 1

Invoice Date:	Info fills from Tab 1
Contract year/quarter	Info fills from Tab 1
Period of Service:	Info fills from Tab 1
Invoice Number:	Enter #s into tab 1-row 11, or copy/paste from Invoice Numbers template.

Type of Invoice (Select "X" in one):

Original Invoice [X]

Corrected Invoice [-]

Revised Invoice [-]

Participant Pool 1 $	-
Participant Pool 2 $	-
MER:	0.00%
ICR:	0.00%

Total Amount to be Reimbursed at Non-Enhanced 50% Rate	$ -
Total Amount to be Reimbursed at Enhanced 75% Rate	$ -
TOTAL to be Reimbursed by Federal Government	$ -

I certify under penalty of perjury that the information provided on this invoice is true and correct, based on actual expenditures of the claiming unit incurred for the period claimed, and that the funds/contributions expended, as necessary for federal matching funds pursuant to the requirement of 42 CFR 433.51, are allowable administrative activities, and that these claimed expenditures have not previously been, nor shall not subsequently be, used for federal match in this or any other program. I have notice that this information is to be used for filing of a claim with the Federal government for Federal funds and that knowing misrepresentation constitutes violation of the Federal False Claims Act. The LEA will maintain documentation supporting the expenditures claimed on the accompanying form. I acknowledge that all records of funds expended are subject to review and audit by the California Department of Health Care Services (DHCS). I understand that DHCS must deny payment of any claim if it is determined that the certification and/or claim form is not adequately supported for purposes of Federal Financial Participation.

_____
Typed Name of Signer

_____
Title

Department of Health Care Service
Safety Net Financing Divi:
School-Based Medi-Cal Administrative Acti
1501 Capitol Ave., MS 460:
PO Box 997413
Sacramento, CA 95899-741

_____
LEC Coordinator Signature

_____
Date

LEC / LGA REMIT ADDRESS

Attention to:	
Address Line 1:	
Address Line 2:	
Address Line 3:	
City, State, Zip Code:	

Tabs 10 & 11: Averaging Quarter Worksheets – Participant Pools 1 & 2

Quarter 2

Total Number of Moments Selected Randomly Prior to the Start of the Quarter:	
Total Number of Invalid Moments:	
Total Valid Moments:	-
Compliance Percentage:	

	Claiming Unit Name:	Info fills from Tab 1
	HCS Contractor (Region):	Info fills from Tab 1
	Contract #:	Info fills from Tab 1

	Invoice Date:	Info fills from Tab 1
	tract year/quarter:	Info fills from Tab 1
	Period of Service:	Info fills from Tab 1
	Invoice Number:	Enter #s into tab 1-row 11, or copy/paste from Invoice

Pool 1:	Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10	Code 11	Code 12	Code 13	Code 14	Code 15	Code 16	Code 17	Code 18	Total Moments	Total Moments 1–16
Moments:	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

SUMMARY FOR INVOICING	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Total
	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Quarter 3

Total Number of Moments Selected Randomly Prior to the Start of the Quarter:	
Total Number of Invalid Moments:	
Total Valid Moments:	-
Compliance Percentage:	

Pool 1:	Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10	Code 11	Code 12	Code 13	Code 14	Code 15	Code 16	Code 17	Code 18	Total Moments	Total Moments 1–16
Moments:	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

SUMMARY FOR INVOICING	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Total
	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Quarter 4

Total Number of Moments Selected Randomly Prior to the Start of the Quarter:	
Total Number of Invalid Moments:	
Total Valid Moments:	-
Compliance Percentage:	

Pool 1:	Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10	Code 11	Code 12	Code 13	Code 14	Code 15	Code 16	Code 17	Code 18	Total Moments	Total Moments 1–16
Moments:	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

SUMMARY FOR INVOICING	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Total
	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

Quarter Average *(Averaging by %)*

Codes	Code 1	Code 2	Code 3	Code 4	Code 5	Code 6	Code 7	Code 8	Code 9	Code 10	Code 11	Code 12	Code 13	Code 14	Code 15	Code 16
QUARTER 2	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
QUARTER 3	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
QUARTER 4	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Average	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
s into Tab 2, Line Number:	17D	18D	19D	10D	20D	11D	21D	13D	22D	14D	23D	15D	24D	16D	12D	25D

APPENDIX C

Data Match Procedures

DATA MATCH INSTRUCTIONS

1) In order to request Data Match data for the SMAA Program, users must first create a MOVEit user account. Please complete the "Attachment A: MOVEit User Identification" form. You will need to provide the first and last name, e-mail address, phone number, job titles, and level of access for all staff authorized to submit school district enrollment data (limit 5 user accounts).

Figure 1: Attachment A: MOVEit User Identification

2) Please submit the request to the SMAA mailbox at smaa@dhcs.ca.gov.

3) Upon receiving the information, DHCS will send a notification e-mail to the users that contains a confidential user ID and temporary password that must not be shared with anyone. See Attachments B and C.

4) The notification e-mail directs users to the DHCS Extranet Password Manager System at https://ext2.dhcs.ca.gov/WebPassMgr/default.aspx, where users can manage their account and create their permanent password.
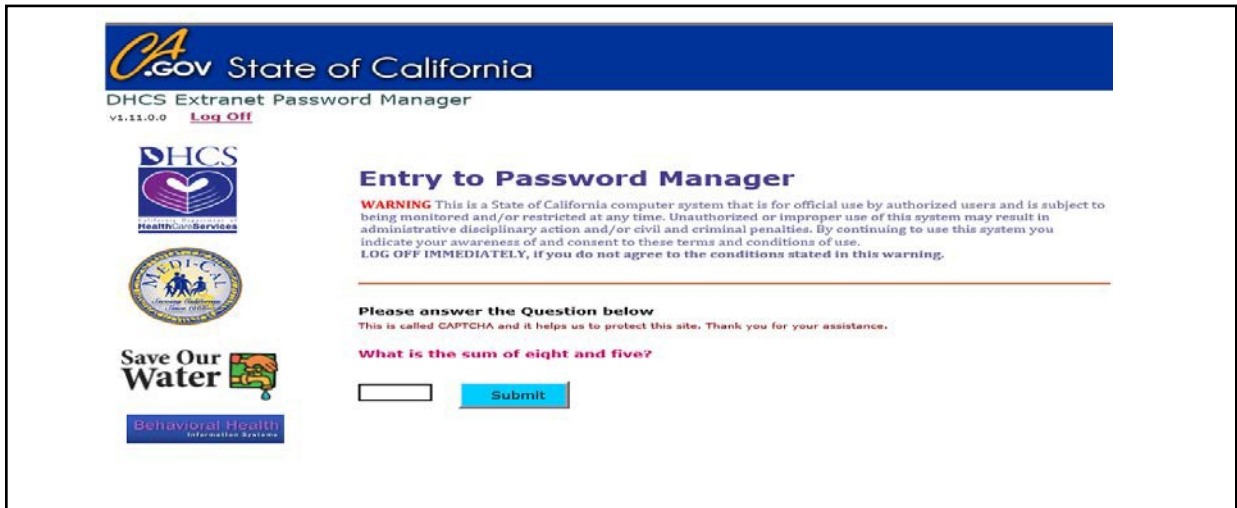
Figure 2: DHCS Extranet Password Manager

5) Users will be required to log in to the Extranet Password Manager and create their own password within <u>four</u> calendar days from the date the e-mail is sent. Passwords will need to be changed/updated every <u>60 days</u> or they will expire. Users will receive an e-mail update that will prompt them to change their password.

6) The e-mail notification also directs users to the MOVEit e-Transfer server at https://etransfer.dhcs.ca.gov, where users can send and receive Data Match Data.

7) Click on the DHCS e-Transfer server link at https://etransfer.dhcs.ca.gov/. Use your user ID and password to log in to your MOVEit e-Transfer account.
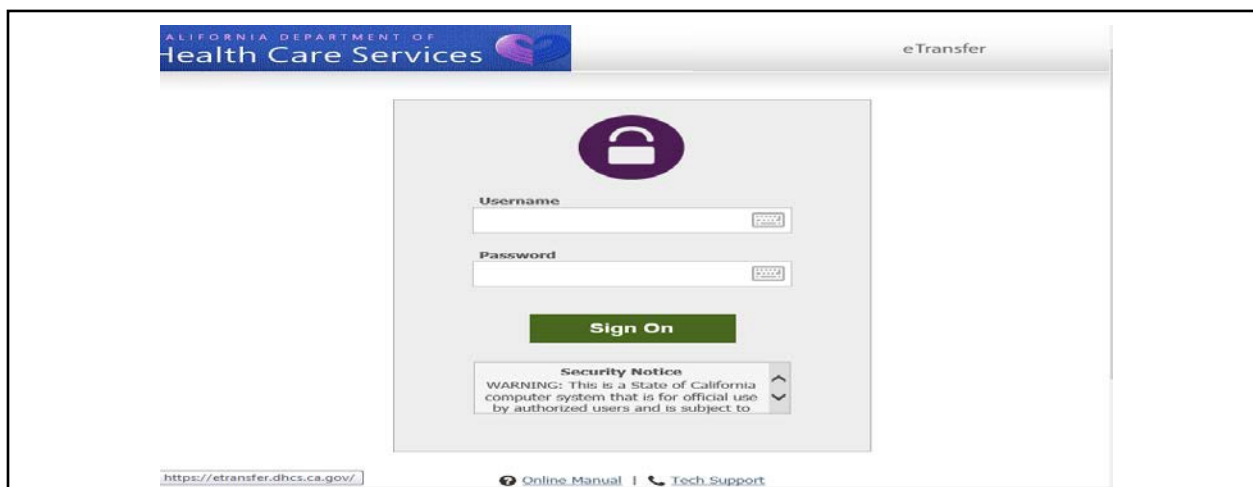

Figure 3: MOVEit e-Transfer log-in page.

8) "Install Wizard"

When you first log in to MOVEit, the program will send you to a page from which you can choose to install the "Install Wizard," or choose to disable it. If you choose "**Install wizard the Upload/Download Wizard (ActiveX),**" you will be sent to a page which will download the ActiveX control. This may take several seconds. (You may need to alter your browser's security settings to permit signed ActiveX controls to be installed in order to successfully complete the process - see screenshots below).

NOTE: In order to upload/download a large file size, you must install the Upload/Download Wizard. However, if you don't see the **"Install the Upload/Download Wizard (ActiveX)"** as described, and you are able to upload /download file(s) through eTransfer, this means it is already installed on your machine and you may disregard this section**.**

Figure 4: Install the Upload/Download Wizard

9) To submit Data Match Data to DHCS through the MOVEit software, please create a **Microsoft Office Excel worksheet** using the following required fields as column headers:

    a) Last Name
    b) First Name
    c) Middle Initial
    d) Date of Birth
    e) Gender

	A	B	C	D	E
	TAPE MATCH DATA INFORMATION FOR (LEA NAME)				
	LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH	Gender
	AAAA	JOHN	T	MM/DD/YY	M
	BBBB	MARY	R	MM/DD/YY	F

Figure 5: Data Match Data Spreadsheet.

10) Please complete the worksheet and save the file using the following naming scheme: TMR [Full School Name][FY/QTR].
    (TMR = Data Match Release)

11) The worksheet is ready for uploading and submission to the MOVEit account directory for your LEC, LGA, or LEA. To submit the Data Match Data Information worksheet please log in to your MOVEit account and follow the instructions below:

12) In the Home page, use the drop down menu to select your LEC/LGA/LEA subfolder.
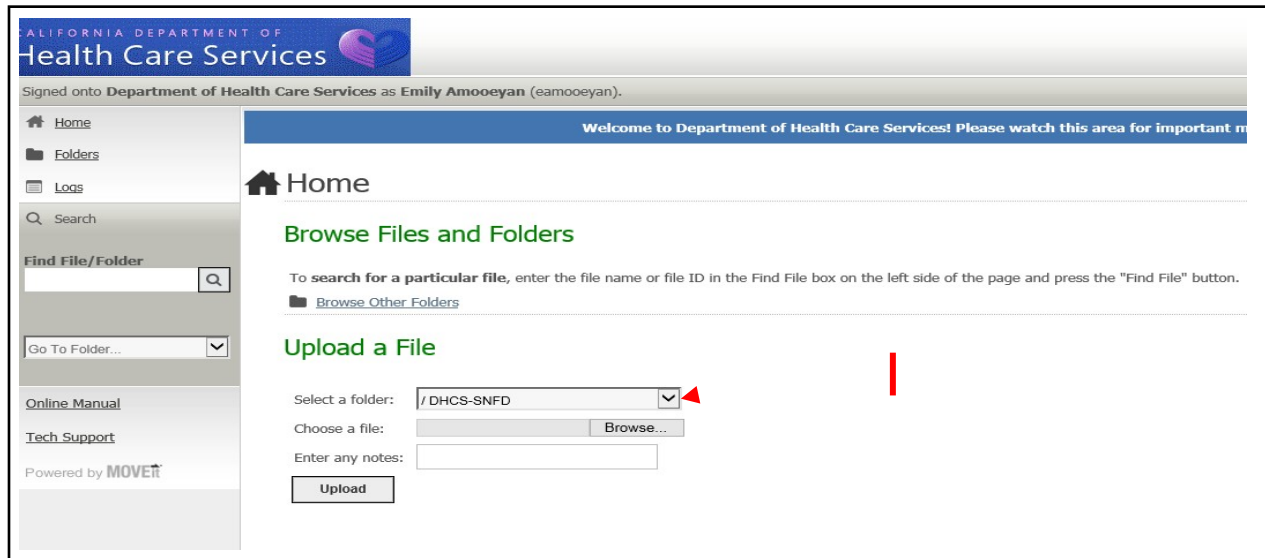
13) Click on the "Browse" button and upload the Data Match Data worksheet for the fiscal year and quarter for each LEA.
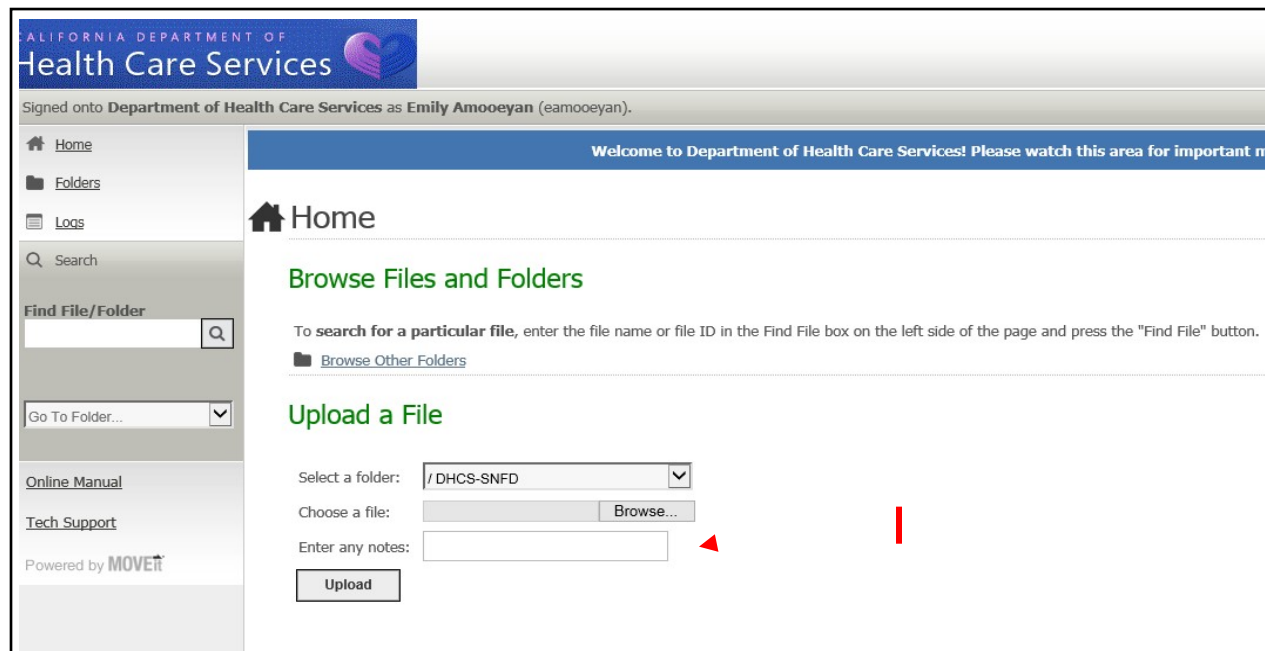
14) Enter any notes you have about the file you are uploading. (optional)

15) Click "Upload".
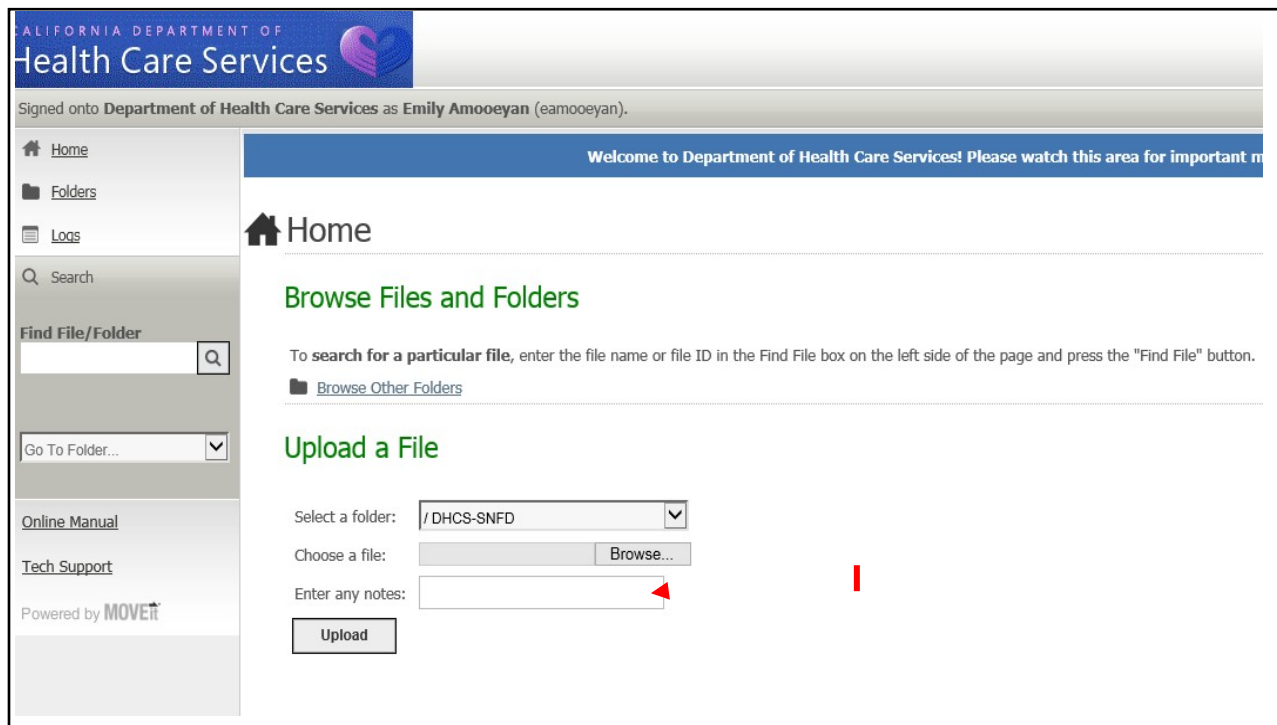
16) The LEC/LGA/LEA representative must send an e-mail to SMAA at smaa@dhcs.ca.gov and notify DHCS of the submission of the new Data Match Data worksheet.

17) DHCS will send a notification to LECs/LGAs and non-contracted LEAs within 15 business days that the Data Match request is complete.

18) The processed files will be uploaded back to the LEC/LGA/LEA MOVEit subfolder and users will receive a notification e-mail from DHCS that the process is complete.

19) The processed files will be labeled as "RETURNED.txt" and can be downloaded from the MOVEit subfolders.

o   Example of a file name uploaded by users in the MOVEit subfolder:
   ➢   TMR [Full School Name] [FY/QTR].txt
o   Example of a file name uploaded by DHCS after the process is complete:
   ➢   TMR [Full School Name] [FY/QTR] **RETURNED**.txt

Files Returned from DHCS:

1.) Log in to your MOVEit account to download the **RETURNED** files from DHCS. Click on the "Folders" icon on the left top corner on the Home page.
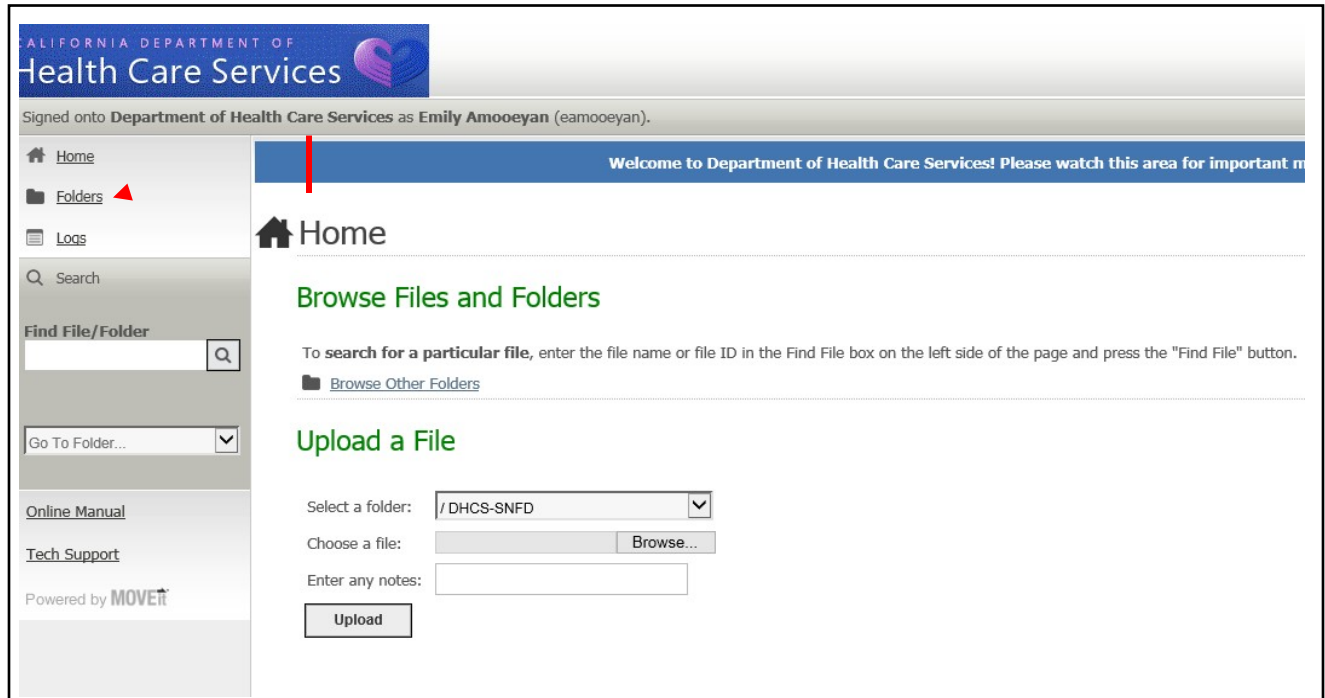
2.) Click on DHCS-SNFD folder.
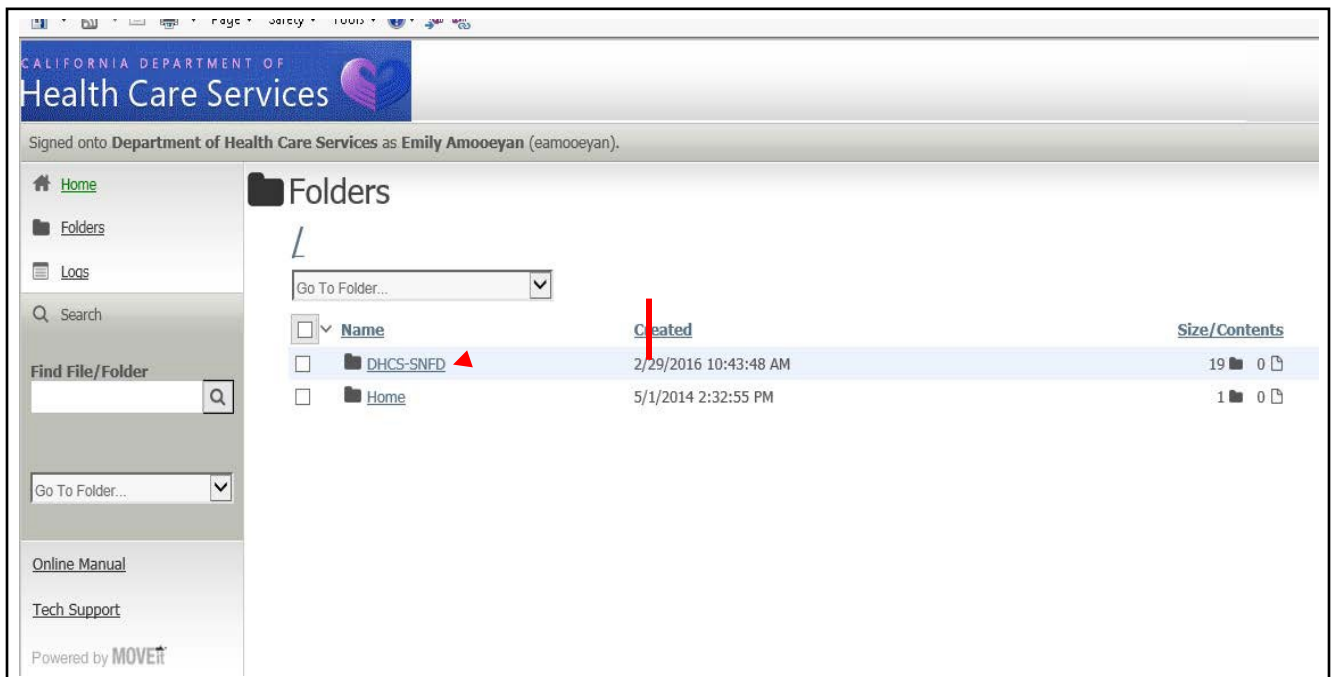
3.) Click on your LEC/ LGA/LEA subfolder.
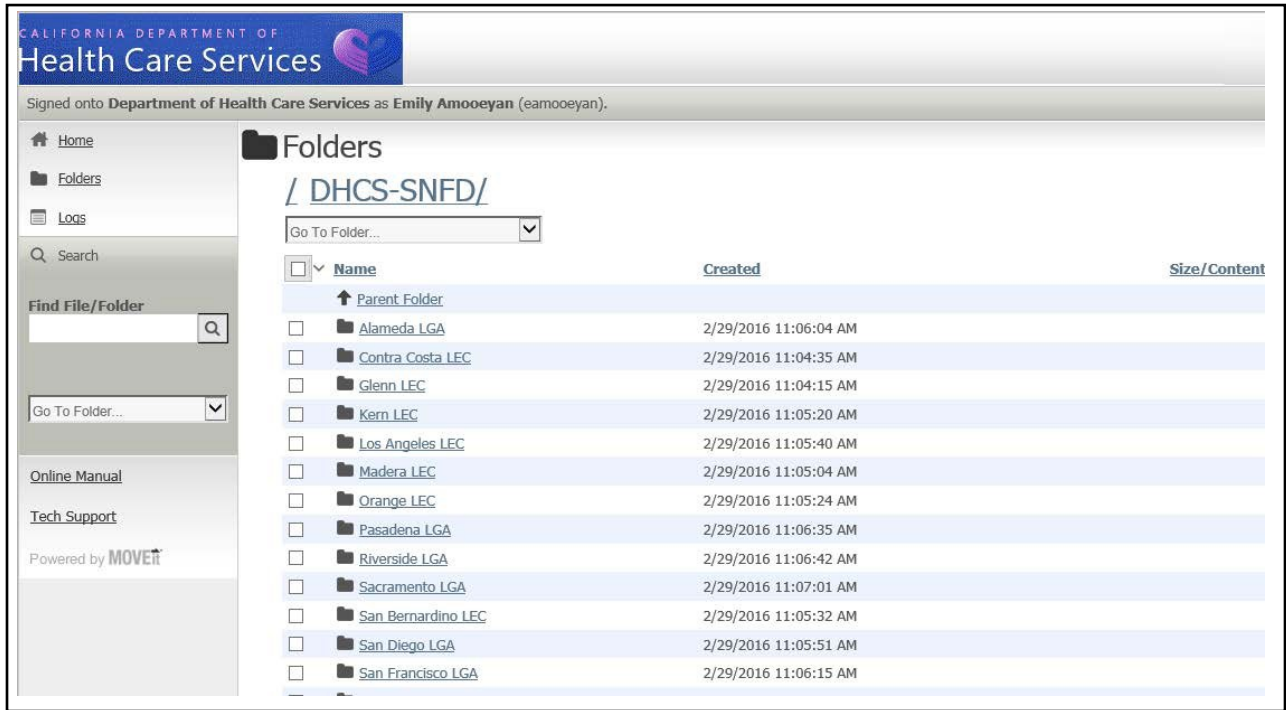
4.) Click on the download icon on the right hand corner of the page and download the files.
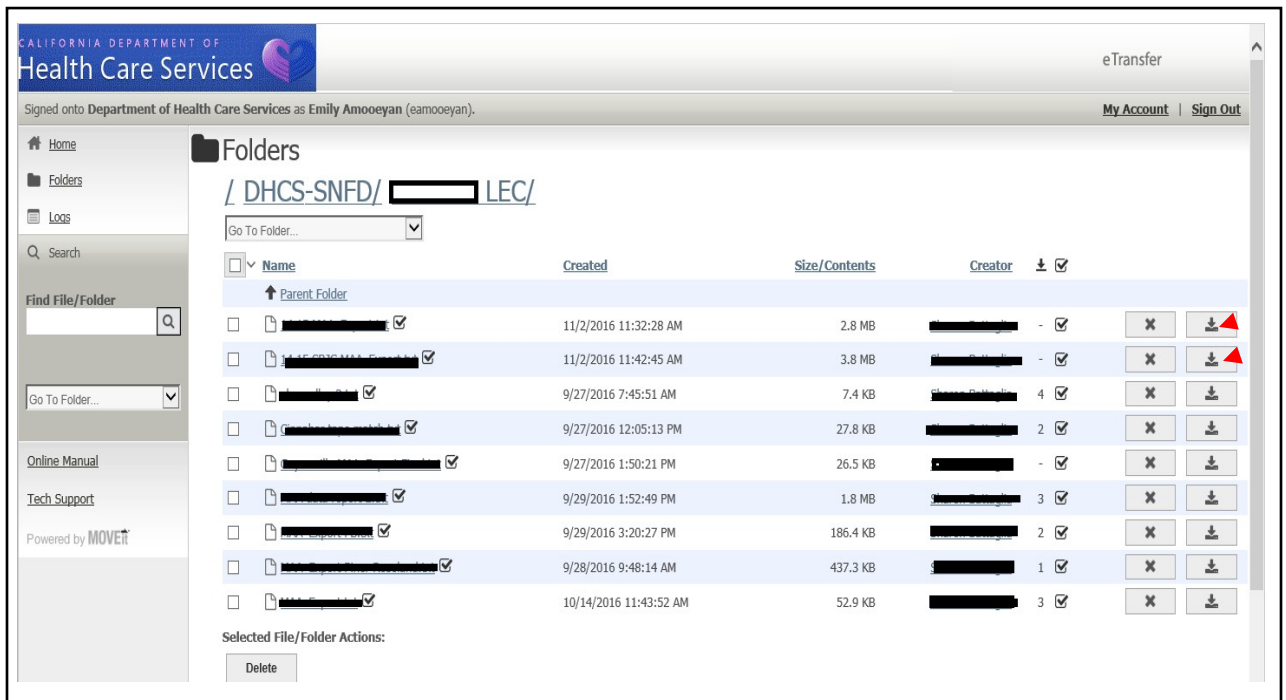
School Based Medi-Cal Administrative Activities
Attachment A: MOVEit User Identification

LEC/ LGA Name: _____

(Access is limited to <u>5 users</u>)

NUMBER	LAST/FIRST NAME	PHONE NUMBER	EMAIL	TITLE	FILE LEVEL ACCESS: (READ, WRITE)	CHANGE ACCESS: REMOVE/ADD (CHANGE DATE)
1						
2						
3						
4						
5						

School Based Medi-Cal Administrative Activities
Attachment B: New Users

Subject: DHCS *MOVEit e-Transfer* [Secure]

Here is your user ID and temporary password for the MOVEit e-Transfer Account.
Your User ID is: **xxxxx**
Your Temporary password is: **Password1**
Please click on the link below to access your account.
https://etransfer.dhcs.ca.gov/
Note: You must change your temporary password and create a permanent password through the DHCS Extranet system by following the instruction below.

****

Here is your user ID and temporary password for the WebAdmin_CatchALL Extranet Account.
Your User ID is: **dhsextra\xxxxxx**
Your Temporary password is: **Password1**
Please click on the link below to update your account information and create your permanent password.
https://ext2.dhcs.ca.gov/WebPassMgr/default.aspx

****

If the links above is not clickable, then copy and paste it into your web browsers address bar.

Note: please change your password within four (4) days from today's date or your account may become inactive and your password will need to reset.
Passwords will need to be changed/updated every 60 days or they will expire.

School Based Medi-Cal Administrative Activities
Attachment C: Existing Users

Subject: DHCS *MOVEit e-Transfer* [Secure]

Your Moveit e-transfer account is now active.

Here is your user ID and temporary password for the MOVEit e-Transfer Account.
Your User ID is: **xxxxx**
Please use the same password as for your DHCS Extranet Account.
Please click on the link below to access the MOVEit account.
https://etransfer.dhcs.ca.gov/

Forgot your password?

If you cannot remember your password, you must send an e-mail to the SMAA mailbox at SMAA@dhcs.ca.gov. You will receive an email notification from the DoNotReply@dhcs.ca.gov that provides you a temporary password. Click on https://ext2.dhcs.ca.gov/WebPassMgr/default.aspx, to update your account information and create your permanent password.

****

If the links above is not clickable, then copy and paste it into your web browsers address bar.

Note: please change your password within four (4) days from today's date or your account may become inactive and your password will need to reset.
Passwords will need to be changed/updated every 60 days or they will expire.

APPENDIX D

Participant Exception Form

DHCS

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Random Moment Time Study (RMTS) Participant Exception
(Attachment A)

LEC/LGA/Consortia:

Claiming Unit	Participant Name	Participant Job Classification	Fiscal Year	Quarter

Print Coordinator Name

I, the undersigned, state the following: As a public administrator, a public officer, or other public employee of the above named LEC/LGA/Consortia, I am duly authorized or designated to sign this Certification for the Random Moment Time Survey (RMTS) for the fiscal years and quarters noted above. I understand that making false statements for the purpose of filing a false or fraudulent claim is punishable under Welfare and Institutions Code sections 14107, 14107.11, and other applicable provisions of law. This Certification is made under penalty of perjury.

Coordinator Signature   Date

Submit forms to: SMAA@DHCS.CA.GOV

DHCS 6136 (7/24)

APPENDIX E

LATE INVOICE SUBMISSION REQUEST

DHCS

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Date:

To: DHCS School-Based MAA Chief
From: LEC Coordinator (include Region)
or
             LGA Coordinator (include
County) Subject: Late Invoice Submission
Request

Claiming Unit:_____Invoice Number: _____

We are requesting delayed submission of our invoice for:

Fiscal Year:_____   Quarter: _____

The reason the invoice will not be submitted in a timely manner is: _____
_____

The following steps will be taken to ensure that future invoices are submitted timely:
_____

The invoice will be sent to DHS on: _____
                                         Date

Please contact me if you have any questions or require further information at
___-___-___

_____LEC/LGA Coordinator

Submit forms to: SMAA@DHCS.CA.GOV

DHCS 4024 (9/15)

APPENDIX F

Time Survey Participant Equivalency Form

DHCS

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Time Survey Participant Equivalency Request

LGA/LEC:_____   Submittal Date: _____

Claiming Unit:_____   Fiscal Year and Quarter: _____

Proposed Equivalent Job Classification Title:

_____

Number of Positions that will Participate:_____

Pursuant to the California School-Based Medi-Cal Administrative Activities (SMAA) Manual, each LEC/LGA must ensure claiming unit staff performing school-based Medi-Cal activities are included on the authorized Time Study Participant (TSP) list. Please answer to the following questions for the Equivalent Job Classification listed above in order to describe how that job classification complies with the authorized list and performs an equivalent job function. Please attach additional pages as necessary.
(Include a job description and copies of credential, certification or license, if applicable)

1. In which participant pool is this job classification being placed?
   ____Participant Pool #1   ____Participant Pool #2

2. To what authorized job classification is this equivalent? (list pool and position number)

3. What are the job functions of this position that makes it equivalent to the authorized job classification?

4. Provide a clear description of the type of activities performed.

5. Provide a clear description of how the activity will be performed to achieve the objective.

6. Identify the target population.

I certify that the information provided herein is true and correct and accurately reflects the performance of Medi-Cal Administrative Activities (MAA) or LEA Medi-Cal Billing Option Program (LEA BOP) services. I also certify the information provided complies with 42 Code of Federal Regulations (CFR) 433.15(b)(7) and 2 CFR Part 200 et seq.

Print Name: _____

Signature: _____ Date: _____

Title: _____

DHCS 4023 (9/2)

APPENDIX G

Funding Source Change Form

DHCS

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

Random Moment Time Study Participant Funding Source Change (Attachment A)

LEC/LGA/Consortia:			Funding Change Occurred	
Claiming Unit	Participant Job Classification	Participant Name	Fiscal Year	Quarter

Print Coordinator Name

I, the undersigned, state the following: As a public administrator, a public officer, or other public employee of the above named LEC/LGA/Consortia, I am duly authorized or designated to sign this Certification for the Random Moment Time Survey (RMTS) for the fiscal years and quarters noted above. I understand that making false statements for the purpose of filing a false or fraudulent claim is punishable under Welfare and Institutions Code sections 14107, 14107.11, and other applicable provisions of law. This Certification is made under penalty of perjury.

Coordinator Signature   Date

Submit forms to: SMAA@DHCS.CA.GOV

DHCS 3107 (6/15)

APPENDIX H

SMAA Policy and Procedure Letters

Time Survey Subject	*Pages*
PPL 15-01: MAA Activities Related to IEPs	H-1

State of California—Health and Human Services Agency
Department of Health Care Services

DHCS

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: May 5, 2015   **PPL No. 15-011**

TO: Local Educational Consortia (LEC) and
            Local Governmental Agency Coordinators (LGA)

Subject: Medi-Cal Administrative Activities Related to Individualized Educational
            Programs (IEPs)

The purpose of this Policy and Procedure Letter (PPL) is to provide guidance to LECs
and LGAs participating in the School-Based Medi-Cal Administrative Activities (SMAA)
program regarding individual code assignments for Random Moment Time Study
(RMTS) moment responses that are related to the development and/or implementation
of an IEP.

According to Centers for Medicaid and Medicare Services (CMS) 2003 Medicaid
School-Based Administrative Claiming Guide, Section B 4(b):

> The development of an IEP is a requirement of the Individuals with Disabilities
> Education Act (IDEA), the primary purpose of which is to facilitate the child's
> education. Because it is an education requirement, <u>Medicaid does not pay</u> for the
> administrative activities associated with the development of the IEP. Once the
> IEP is established and implemented, however, <u>Medicaid does pay</u> for
> administrative activities that are directly related to the provision of those Medicaid
> covered services that are identified in the IEP, and which are furnished to
> Medicaid eligible children.

In compliance with CMS guidelines, administrative activities provided in the
development of the IEP, including initial assessments, and activities that take place
within the IEP meeting itself are not eligible for Medicaid/Medi-Cal reimbursement.

Safety Net Financing Division
1501 Capitol Avenue, MS 4603, P.O. Box 997436
Sacramento, CA, 95899-7436
Phone: (916) 552-9113 Fax: (916) 324-0738
www.dhcs.ca.gov

California School-Based Medi-Cal
Administrative Activities Manual

H-1

SMAA Policy and Procedure Letters
REVISION 2019

If you have any questions or require further assistance regarding this PPL, please contact Tony Teresi, Chief, School-Based MAA Unit at (916) 552-9049, or Tony.Teresi@dhcs.ca.gov

Sincerely,

ORIGINAL SIGNED BY MICHELLE KRISTOFF

Michelle Kristoff, Chief
Medi-Cal Administrative Activities Section