CALIFORNIA RURAL INDIAN HEALTH BOARD

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I. PREFACE

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

II. The purpose of the Tribal MAA program is to:

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

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

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

I. INTRODUCTION TO TRIBAL MAA

A. What is Medi-Cal?

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

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

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

B. Medi-Cal Administrative Activities (MAA)

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

The goals of the MAA program are to:

1. Facilitate outreach to potential Medi-Cal enrollees;
2. Assist children and families in accessing needed Medi-Cal services;
3. Assist and support Tribes and Tribal Organizations to prepare

appropriate claims for administrative costs under the Medi-Cal program; and

4. Administer an effective, efficient statewide MAA program.

Other examples of MAA activities include:

1. Discussing access to health care with Tribal members, families, and others;

2. Assisting in early identification of children who could benefit from health services provided by Medi-Cal;

3. Contacting pregnant and parenting teens about the availability of Medi-Cal prenatal and well baby care programs and services such as maternity support services; and

4. Providing referral assistance to Tribal members, families, and others where Medi-Cal services can be provided.

C. MAA Program Principles

1. Activities must be found necessary for the proper and efficient administration of the Medi-Cal State Plan;

2. Time tracking logs methodology must capture 100% of time for participating staff for the period being measured;

3. Parallel coding for Medi-Cal and non-Medi-Cal activities is required to clearly identify those activities directly related to Medi-Cal;

4. There is monitoring for potential of “duplicative” payments;

5. Coordination of activities is expected and encouraged between Tribes and /or Tribal Organizations, other governmental entities, DHCS, Providers, community non-profits and other agencies related to activities performed;

6. There must be clear delineation between direct services and administrative activities;

7. There must be allocable share of costs (proportional share of costs based on the Medi-Cal Percentage (MCP) and non-discounted activities). Outreach and facilitating Medi-Cal application are not discounted; they are reimbursed as 100% Medi-Cal share at 50% FFP.

8. The federal government and the states share the costs of providing MAA-allowable administrative activities;

9. Provider participation – referrals must be to a Medi-Cal provider;

10. CMS reviews and approves programs and codes as meeting regulatory requirements as set forth in this Plan;

11. Free care principle precludes Medi-Cal from paying for the costs of Medi-Cal coverable services and activities that are available to all in the general population without charge.

D. Tribal MAA

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

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

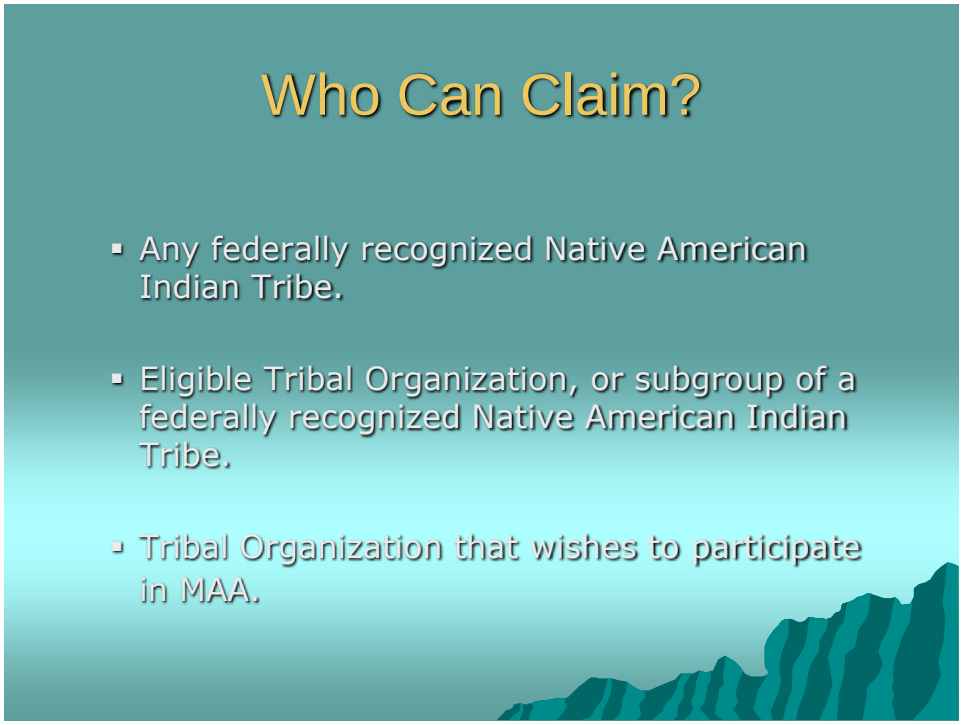
position to participate in this program. Due to federal IHS policy, Tribes must provide information about the Medi-Cal program, and assist those enrolled in Medi-Cal in gaining access to services and benefits. Through MAA, the related administrative costs can be reimbursed at a 50% match rate.

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

E. Who qualifies to do Tribal MAA?

Any federally recognized Native American Indian Tribe, eligible Tribal Organization, or subgroup of a federally recognized Native American Indian Tribe and eligible Tribal Organization that wishes to participate in MAA is eligible. For interested Tribes and Tribal Organizations, DHCS will provide necessary training, consultation, and on-going technical assistance. DHCS will contract either directly with those Tribes and eligible Tribal Organizations that wish to participate in the MAA program, or Tribes and eligible Tribal Organizations may also subcontract with another Tribe or Tribal Organization with an existing contractual relationship with DHCS for Tribal MAA.

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



F. Where Does Tribal MAA Take Place?

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

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

A Tribal program participating in MAA does not have to be a Medi-Cal provider

in order to claim FFP, if the program is providing Medi-Cal-related outreach or facilitating application and/or refers clients to Medi-Cal-covered services.

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

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

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

G. Non-Claimable Activities

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

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

IV. PRINCIPLES OF ADMINISTRATIVE CLAIMING

A. General Information

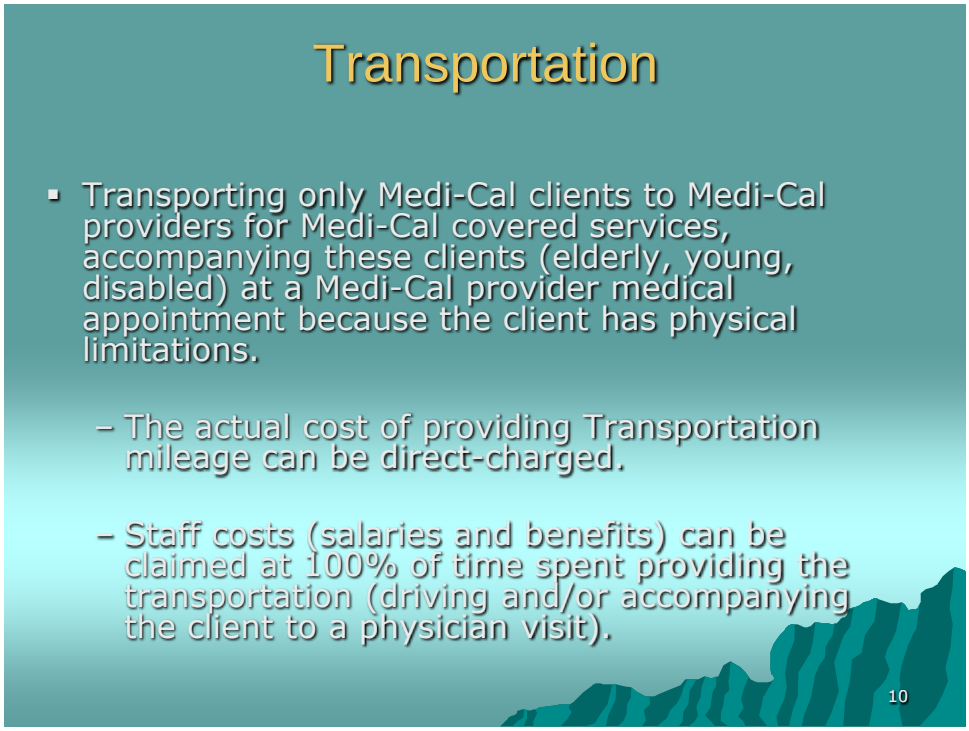
Tribal employees may perform administrative activities that support the Medi-Cal program. Some or all of the costs of these administrative activities may be reimbursable under Medi-Cal; however, an appropriate claiming mechanism must be used. The Time tracking log is the primary mechanism for identifying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

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

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

California provides reimbursement for medically necessary, medical (specialized), non-emergency transportation as a California service to Medi-Cal recipients. The provision of all other non-medical, non-emergency transportation has been delegated to the counties, and in this case to Tribes and Tribal Organizations, to provide administratively. The Medi-Cal State Plan provides the assurance that transportation to and from providers is reimbursable. 42 CFR parts 431.53(a) and 440.170(2) states, “If other arrangements are made to assure transportation under Section 431.53 of this subchapter, FFP is available as an administrative cost.” Since California does not provide separate reimbursement for non-emergency, non-medical transportation as a direct benefit, these costs are properly reimbursed as TMAA. For Tribes or Tribal Organizations operating Tribal health facilities with funding authorized by Title I or III of the Indian Self-Determination and Education Assistance Act (Public Law

93-638, as amended), informally referred to as “638” clinics, no other method of Medi-Cal reimbursements of these administrative costs is available in California. These costs will be claimed as described in Section VI. part B, 1.c),”Non-Emergency, Non-Medical (Non-Specialized) Transportation.”



B. Operational Principles of Activity Codes

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

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

2) Capture 100 Percent of Time

In order to ascertain the portion of time and activities that are related to administering the Medi-Cal program, a Time tracking log will be used. The Time tracking log reflects all of the time and activities (whether allowable or unallowable for Medi-Cal administrative claiming) performed by employees participating in the MAA program. The Time tracking log mechanism entails careful documentation of all TMAA work performed by certain Tribal staff and is used to identify the Tribal staff time that is attributable to Medi-Cal reimbursable activities. The unique responsibilities and functions performed by the Time tracking log participants, as well as the special factors and programs applicable to Tribes or Tribal Organizations, are accounted for and included in the Time tracking log codes.

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

The Time tracking log activity codes capture 100% of the activities performed by the Time tracking log participants. All staff will be trained on proper coding procedures, including reporting activities under the parallel codes.

4) Assure No Duplicate Payments

Federal, state and local governmental resources should be expended in the most cost-effective manner possible. In determining the administrative costs that are reimbursable under Medi-Cal, duplicate payments are not allowable. That is, Tribes or Tribal Organizations may

not claim FFP for the costs of allowable administrative activities that have been or should have been reimbursed through an alternative available funding source.

5) Coordination of Activities

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

6) Provider Participation in the Medi-Cal Program

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

a). The medical service must be furnished to a Medi-Cal eligible individual;

b). The medical service must be included in the Medi-Cal State Plan;

c). The medical service is not provided free-of-charge to non- Medi-Cal eligibles; and

d). The provider must furnish services as a participating provider in the Medi-Cal program, with a provider agreement and a Medi-Cal provider identification number; or must furnish such services as a provider for Medi-Cal enrollees of a Medi-Cal managed care plan.

Referral activities allowable for MAA claiming must be aimed at assisting the Medi-Cal-enrolled patient in making a referral to a willing Medi-Cal provider for a Medi-Cal-covered service. Allowable MAA referral activities provided by Tribal health programs include the time spent in searching for a willing provider and may include time spent in unsuccessful contacts with providers.

7) No Free Care

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

a). Establish a fee for each service that is available;

b). Collect third party insurance information from all those served (Medi-Cal and non-Medi-Cal); and

c). Bill other responsible third party insurers.

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

8) Federal and State Financial Participation

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

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

conditions:

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

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

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

9) Time tracking log Staff Training

Staff will receive adequate training before participating in their first time TMAA Specific Activities. Training should be conducted with signed documentation as evidence of such training. Once trained, all staff will participate in an annual TMAA Specific Activities training. Attendance at the annual training session cannot be claimed on the Time tracking log by the Tribal MAA coordinator or by the TMAA Specific Activities participants**.** Staff will understand clearly how to complete the Time tracking log form; know how to report activities under the appropriate codes; understand the difference between Medi-Cal covered and other activities; and know where to obtain technical assistance if there are questions. Professional staff will understand the distinctions between

the performance of administrative activities and direct medical services and those administrative activities that are an inherent part of the direct medical service. The Tribal MAA contractor must have a mechanism in place to assess how often training is necessary and to revise the training schedule, if appropriate. To ensure consistent application, all training documentation will be maintained and available for site review and audit purposes. Documentation will show the content of the training provided to participating MAA staff and the frequency of training. The frequency of training should take into account staff turnover.

10) Monitoring Process

In order to ensure that the Time tracking log is statistically valid as specified in Section V. part C, "Tribal MAA Time tracking log", DHCS will monitor the compliance of Tribal claiming units. DHCS will monitor the claim each quarter by review and analysis of the invoice. Additionally, DHCS has dedicated resources for audit staff to regularly conduct financial and compliance audits to support meeting federal requirements. (See Sections V. part B, Claiming, "Documentation" and VII, "Performance Standards/Program Oversight and Monitoring", and Appendix E).

11) Offset of Revenues

A government program may not be reimbursed in excess of its actual costs, i.e., make a profit. Allocated costs must be offset by the amount of other funding sources in order to assure there is no duplication of payment for administrative activities. To the extent that other funding sources have paid or would pay for the costs of performing Tribal MAA, federal reimbursements are not available, and the costs must be removed from the total reported costs of performing Tribal MAA. See Office of Management and Budgets OMB Circular A-87 (OMB A-87), Attachment A, part C, item 4. The following are some of the funding categories that must be offset against unallowable costs:

- All "non-authorized" federal funds.
- All State expenditures that have previously been matched by the

Federal Government (i.e., most State grants).

• All State grants that are a pass-through of federal funds.

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

12) Timely Filing Requirements

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

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

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

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

13) No Contingency Fees

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

"Cost of professional and consultant services rendered by persons or organizations that are members of a particular profession or possess a special skill, whether or not officers or employees of the governmental unit, are allowable, subject to section 14 when reasonable in relation to the services rendered and when not contingent upon recovery of the costs from the Federal Government."

V. CALIFORNIA TRIBAL MAA CLAIMING METHODOLOGY

A. Comprehensive Activity Codes

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

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

CODE 4. Initial Medi-Cal Outreach activities which include informing eligible or potentially eligible clients about the Medi-Cal program and services available to the client and how to access them. Medi-Cal only Outreach campaigns directed toward bringing Medi-Cal eligibles into the Medi-Cal system for the purpose of determining eligibility or to

encourage potential Medi-Cal eligibles to apply for Medi-Cal. Activities may include, but are not limited to:

a. Providing initial information about services that will help identify medical conditions that can be corrected or improved by services through Medi-Cal.
b. Informing individuals initially on how to effectively access, use, and maintain participation in all health resources under the federal Medi-Cal program.
c. Providing initial referral assistance to families where Medi-Cal services can be provided.
d. Providing information regarding Medi-Cal managed care programs and health plans to individuals and families and how to access that system.
e. Conducting a family planning health education outreach program or campaign that is targeted specifically to family planning Medi-Cal services that are offered to Medi-Cal eligible individuals.
f. Participating in or coordinating trainings that improve the delivery of Medi-Cal services.

CODE 6. Facilitating Medi-Cal Application: includes explaining Medi-Cal rules and application process to prospective applicants, assisting applicant to complete the application, forms gathering information related to the application and eligibility determination from a client as a prelude to submitting the application to the county social services department, and/or providing necessary forms; Activities may include, but are not limited to:

a. Verifying an individual's current Medi-Cal eligibility status.
b. Explaining Medi-Cal eligibility rules and the Medi-Cal eligibility process to prospective applicants.
c. Assisting individuals or families to complete a Medi-Cal eligibility application, including the joint Medi-Cal/Healthy Families application unless the applicant has indicated on the application that he/she does not want Medi-Cal.
d. Gathering information related to the application and eligibility determination for an individual, including resource information and third party liability information, as a prelude to submitting a formal Medi-Cal application, including the Medi-Cal portion of the joint Medi-Cal/Healthy Families application.
e. Providing necessary forms and packaging all forms in preparation for the Medi-Cal eligibility determination.

f. Referring an individual or family to the local Medi-Cal or joint Medi-Cal/ Healthy Families application.

CODE 8. Ongoing Referral, Coordination and Monitoring of Medi-Cal Services activities which includes searching for referral purposes Medi-Cal providers in the area); Activities may include, but are not limited to:

a. Making referrals for and/or coordinating medical or physical examinations and necessary medical/mental health evaluations.
b. Making referrals for and/or scheduling certain Child Health and Disability Prevention screens, inter-periodic screens, and appropriate immunization.
c. Referring individuals for necessary medical health, mental health, or substance abuse services covered by Medi-Cal.
d. Arranging for any medical/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/mental health condition.
e. Gathering any information that may be required in advance of referrals.
f. Providing information to other staff on an individual's medical/dental/mental health/chemical dependency services and plans, provided that such participation is not an extension of a direct service.
g. Participating in a meeting/discussion to coordinate or review and individual's needs for health related services covered by Medi-Cal in a non-clinical setting not reimbursable through an all-inclusive rate or other billable fee-for-service mechanism.
h. Providing follow-up contact to ensure that an individual has received the prescribed medical/mental health services.
i. Coordinating the completion of the prescribed services, termination of services, and the referral of the individual to other Medi-Cal service providers as may be required to provide continuity of care.
j. Coordinating the delivery of medical/mental health services for an individual with special/severe health care needs.

CODE 10. Arranging Transportation for Medi-Cal Services – This activity includes assistance in securing/arranging transportation for an individual or family to a medical appointment for the delivery of Medi-Cal services; Activities may include, but are not limited to:

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

CODE 14. Providing interpreter services to a Medi-Cal client such as sign language during a medical appointment;

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

CODE 16. Program Planning and Policy Development; Activities may include, but are not limited to:

a. Identifying gaps or duplication of medical/dental/mental health/chemical dependency counseling services provided to patients/Tribal members and developing strategies to improve the delivery and coordination of these services.

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

c. Monitoring the medical/dental/mental health/chemical dependency counseling service delivery systems.

d. Developing procedures for tracking families' requests for assistance with accessing medical/dental/mental health/chemical dependency counseling services and providers, including Medi-Cal. (This does not include the actual tracking of referral to Medi-Cal services, which would be coded under Code 8a and 8b.)

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

f. Analyzing Medi-Cal data related to a specific program, population, or geographic area.

g. Working with other agencies and/or providers that provide

medical/dental/mental health/chemical dependency counseling services, to improve the coordination and delivery of services, to expand access to specific populations of Medi-Cal eligible individuals, and to increase provider participation and improve provider relations.

h. Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental health/chemical dependency problems.

i. Developing strategies to assess or increase the cost effectiveness of medical/dental/mental health/chemical dependency counseling programs.

j. Defining the relationship of each agency's Medi-Cal services to one another.

k. Working with Medicaid resources, such as the Medicaid agency and Medicaid managed care plans, to make good faith efforts to locate and develop health services referral relationships.

l. Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services.

m. Working with the Medi-Cal agency to identify, recruit and promote the enrollment of potential Medi-Cal providers.

n. Developing medical referral sources such as directories of Medi-Cal providers and managed care plans, which will provide services to targeted population groups.

o. Program planning and interagency coordination concerned with implementation of the Medi-Cal program, such as meetings with DHCS to develop strategies for extending coverage of mental health services to family members of the Medi-Cal enrollee.

This activity is not reimbursable if staff performing this function is employed full-time in a service provider setting, such as a clinical

environment. The full costs of the employee's salary are assumed to be included in the billable fee-for-service or all-inclusive rate and separate MAA claiming is not allowed.

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

CODE 17. Coordination and Claims Administration. This code is used by Tribal MAA coordinators and claims administration staff when performing activities that are directly related to MAA coordination and claims administration. Activities under this code must be detailed in the Claiming Plan. Activities may include, but are not limited to:

a. Drafting, revising and submitting MAA Claiming Plans.

b. Serving as liaison for regional and local MAA claiming programs and with the State and Federal Governments on Medicaid administrative claiming (i.e., Tribal MAA Coordinators or their designees).

c. Monitoring the performance of claiming programs.

d. Administering MAA, including overseeing, preparing, compiling, revising and
submitting claims.

a. Ensuring that MAA claims do not duplicate Medi-Cal claims for the same activities from other programs and managed care plans.

b. Entering into contracts with organizations performing MAA with preference given to Native American Indian Tribes and/or Tribal Organizations.

c. Recruiting and contracting with organizations performing MAA with preference given to Native American Indian Tribes and/or Tribal Organizations as Medi-Cal contract providers.

d. Monitoring subcontractor capacity and availability.

e. Ensuring compliance with the terms of the contract.

B. Claiming

Documentation

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

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

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

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

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

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

- Original Time tracking log forms and secondary documentation;
- Copies of the original invoice worksheets and templates;
- Documentation related to salaries and wages, including personnel activity reports;
- Documentation demonstrating Direct Charges that are allocable to Medi-Cal;
- Documentation of the calculation of the Indirect Rate;
- Accounting records supported by source documentation such as canceled checks, paid bills, payrolls, contract, and sub-grant award documents;
- Documentation detailing and supporting Indirect Costs; and
- Adequate documentation for personnel costs.

C. Tribal MAA Time tracking logs

Method

Tribal MAA participants will use a Time tracking log to summarize time spent on approved Tribal MAA activities.

VII. PERFORMANCE STANDARDS/PROGRAM OVERSIGHT AND MONITORING

A. Roles and Responsibilities

The responsibility for proper administration of the MAA program is shared between DHCS, the Tribal MAA contractor, Tribal MAA Coordinators and Site Coordinators. The responsibility for administering the Time tracking logs is

shared by the individual participant, the participant's supervisor, the Tribal MAA Coordinator, the Site Coordinator, and DHCS. DHCS designates the Time tracking log periods, issues the Time tracking log forms and training materials, trains Tribal MAA coordinators and participants, and reviews the audit file in its entirety during site visits.

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

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

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

The supervisor of the Time tracking log participant verifies that the number of paid hours recorded is the actual hours paid and that the activities are approved in the claiming plan, in accordance with the job classification and duty statement. Each Time tracking log participant attends Time tracking log training on the MAA program, to learn which MAA activities are within their scope of work, and how to properly document their paid time. Each individual is responsible for completing the form as instructed.

It is the responsibility of the Tribal MAA Coordinators who sign the invoice to assure the accuracy of the Time tracking logs, and compliance with the Tribal MAA Implementation Plan, contract, provider manual, and claiming plan. Each Tribal MAA Coordinator will conduct reviews of Tribal claiming units every three years. These reviews should consist of desk and field reviews of the audit file which includes, but is not limited to, completed Time tracking

logs, training materials, and invoices (including back up documentation) associated with the claiming unit. This review function shall be performed by the Tribal MAA contractor, and cannot be subcontracted. A Summary of Findings report will be furnished to the claiming unit and a copy will be submitted to DHCS to ensure compliance.

B. Training

DHCS will provide technical assistance and training to the CRIHB TMAA Coordinator and the Coordinator will be responsible for providing annual training to the Tribal MAA staff and as additionally requested or on an as needed basis.

1) Risk Factors

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

2) Monitoring Activities and Schedule

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

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

• On-site monitoring by DHCS Program staff will be provided to each claiming unit at a minimum of once every three years or more frequently if deemed necessary by DHCS.
• Technical assistance will be provided on an as needed or requested basis by DHCS.
• During the site visit, and as Tribes or Tribal Organizations submit invoices for MAA reimbursement, contract performance standards and MAA policies will be reviewed, and claims will be checked for accuracy, compliance and non-duplication of claimed time.
• Regularly conduct financial and compliance audits by DHCS audit staff to support meeting federal requirements as deemed necessary by DHCS Financial Audits Branch.
• A random selection of 10% of the Time tracking logs will be validated by DHCS staff within 90 days of the end of the Time tracking log period. The validation will consist of reviewing the participant responses and the corresponding code assigned by the participant to determine if the code was accurate.

• DHCS will provide to the CMS Regional Office a quarterly report of time reported from Time tracking logs. This will be required in such a manner as to allow for claiming time frames up to 18 months after the end of the applicable quarter. This report will designate the location of where codes 4a, 4b, 6a, 6b, 8a, and 8b are performed.

3) Site Visits and Corrective Action

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

4) Documentation and Reporting

DHCS will maintain copies of the monitoring tool and Summary of Findings in the contractor file, including all corrective action plan

responses. Documentation of technical assistance visits, training, and billing reviews will be maintained by DHCS.

D. Tribal MAA Claiming Plan

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

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

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

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

1. A summary of all staff and position classifications for which MAA will be claimed and the MAA activities each classification will perform on a Claiming Unit Functions Grid (referred to as the Grid) as specified and provided by DHCS. This will include what staff will Time tracking log and what activities staff will be approved to perform.

2. Position Descriptions/Duty Statements that match the position classifications for which MAA will be claimed.

3. Organization Charts that show the relationships of Time tracking logging staff, as entered in the invoice.

4. The location and scope-of-work of the Tribal claiming unit(s) for

which claims will be submitted, the nature of their work, and their location.

5. Contracts/Memorandum of Understanding for MAA services provided by personnel for which MAA will be claimed and/or whose costs will be included in the invoice.

6. Documentation as to the status of the claiming unit as either a federally-recognized Tribe or Tribal Organization approved by CMS for claiming MAA.

7. Designation of a Tribal MAA Coordinator for the Tribal MAA contractor. This Coordinator will serve as liaison for the Tribal MAA contractor with the State and Federal governments for MAA.

8. Any other documentation or information deemed necessary by DHCS.

VIII. APPENDICES

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

California Rural Indian Health Board Inc. was founded in 1969 by Tribal Governments in California to serve as the central coordinating point for the planning and development of an Indian-controlled health care delivery system. The first notable success in this mission was the acquisition of earmarked funding in the Indian Health Service (IHS) appropriation for 1973. This award provided funds directly to CRIHB for the purpose of establishing tribally operated health programs in California. In 1983 CRIHB was awarded its first PL 93-638 Indian Self Determination and Education Assistance Act (ISDEAA) contract to

provide IHS funded comprehensive health care services through a unique subcontracting process. CRIHB thereby attained the status of a tribal organization, a status that has been continually maintained into the present. Today, CRIHB also operates a number of non-IHS funded programs from federal, state and philanthropic sources to provide services on a statewide basis. These programs variously fund direct care services through an internet based voucher process, a sub-grant process, or directly provide support and technical assistance services to Tribes, Tribal Organizations, or the Indian community more generally.

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

health services, the wide disparity in the size and, the administrative capacity of both Tribes and Tribal Organizations, CRIHB continues to provide a useful means of achieving critical mass and economies of scale for health service programming in California.

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

B. The State of California and Indian Nations

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

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

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

In 2000, a total of 2.5 million persons (0.9 percent of the U.S. population) classified themselves as AI/AN alone and 4.1 million (1.5 percent) classified themselves as AI/AN alone or in combination with another race. Approximately 26 percent of AI/AN lived in poverty, which is twice the national rate and the highest poverty rate of all racial/ethnic populations. AI/AN experience persistent socioeconomic burdens and significant health disparities in their rates of diabetes, cancer, injuries, and pulmonary diseases. Statistics that reflect the overall low health status of AI/AN in California include:

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

• 16 percent of American Indian births in 2002 were to teen moms compared to 10 percent for Whites.

• There were 8.1 deaths per 1000 American Indian live births in 2001 compared to 4.7 for Whites. This rate discrepancy was probably even higher though as it does not include the finding of an Indian Health Program (IHP) study that showed misclassification on death certificates for American Indian children under age 15 was three to four times greater than reported in State mortality data.

• 74 percent of American Indian mothers in 2001 received first trimester prenatal care as compared to 90 percent for Whites.

• Diabetes prevalence for ages 50-64 is consistently higher among AI/AN (19.6 percent) as compared to Whites (8 percent).

• AI/AN with diabetes have a high incidence of diabetes complications such as eye, kidney, lower extremity amputations, and cardiovascular disease. Cardiovascular disease was the leading cause of death in AI/AN and diabetes is a high contributing risk factor for cardiovascular disease.

• Diabetes mellitus is one of the most serious health challenges facing AI/AN in the United States today. Diabetes contributes to several of the leading causes of death in American Indians - heart disease, cerebrovascular disease, pneumonia, and influenza. On average, AI/AN are 2.6 times as likely to have diabetes as non-Hispanic whites of a similar

age.

• From 1999 through 2001, AI/AN had significantly higher average death rates due to chronic liver disease and cirrhosis.

• From 1999 through 2001, AI/AN females in California had the highest average death rate from accidents. Injuries cause 75 percent of all deaths among Native Americans age 19 and younger. The overall death rate from preventable injuries remains nearly twice as high for native people as for the general population.

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

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

• Studies of the health and health services available to American Indians and their families throughout the state. The IHP assisted with the completion of a congressionally mandated statewide report regarding the health status of nonfederal recognized Indians. The IHP participated in a study of racial misclassification on death certificates. The misclassification study, published in the American Journal of Public Health in 1997, demonstrates a 200-300-percent error rate in classification of deaths to American Indian children. These findings are significant in terms of planning and evaluation of the impact/success of public health children's services to American Indians. The IHP also serves as the lead California agency for a national study regarding the impact of managed care on Indian health service delivery systems.

• Coordination with similar programs of the Federal Government, other states, and voluntary agencies.

• American Indian Health Policy Panel (AIHPP). The AIHPP provides advice to the Director/Department and the program on issues regarding Indian health. It is composed of four members representing rural areas,

four members representing urban areas, and two community members at-large. Panel members are selected by the Director and serve a two-year term.

• Traditional Indian Health Education. IHP administers two contracts that provide forums for clinic medical, dental, and public health nursing providers, and community members to learn about traditional Indian health beliefs and practices. Forums are held in spring, and there is a gathering in Northern and Southern California.

IMPLEMENTATION TIMELINE:

January 9, 2009	Tribal Medicaid Administrative Activities (MAA) Implementation Plan approved by Centers for Medicare & Medicaid Services (CMS).
December 18, 2009	TMAA Transportation Invoice, Invoice Instructions, and Transportation Time tracking log approved by CMS.
March 5, 2010	Direct Contract between California Department of Health Care Services (DHCS) & Federally recognized California Tribal Organizations as the basis to claim Federal financial participation (FFP) for Tribal Medi-Cal Administrative Activities (TMAA). *(Direct legal contract for non-transportation TMAA activities)= no time study!*
August 16, 2010	CMS approved the Tribal MAA non-transportation invoice. *(The terms and conditions that apply to the direct contract are applicable to the invoice as well).*