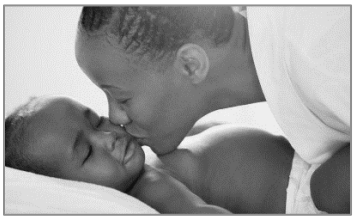
Fiscal Administration Policy & Procedure Manual



This Manual applies to Local Health Jurisdictions (LHJs) and Community Based Organizations (CBOs) operating our:

- Maternal, Child and Adolescent Health (MCAH) Program
- Black Infant Health (BIH) Program
- Adolescent Family Life Program (AFLP)
- California Home Visiting Program (CHVP)

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ADMINISTRATIVE FUNDING

OVERVIEW

Under the California Department of Public Health (CDPH), the State Maternal, Child and Adolescent Health Division (State MCAH) administers federal and state funds to local partners to promote the health of women of reproductive age, pregnant women, mothers, infants, children, and adolescents in California.

State MCAH will administer funds to Local Health Jurisdictions (LHJs) and Community Based Organizations (CBOs) annually through contracts and/or allocation agreements. All contracts and allocation agreements are subject to federal and state funding appropriations.

Funding sources that support MCAH activities include: Title V, Maternal, Infant and Early Childhood Home visiting Grant (MIECHV), State General Fund (SGF), Title XIX, and Federal Positive Youth Development (OAH) Funds.

HRSA GRANTS – TITLE V BLOCK GRANT AND MIECHV

The **Title V Block Grant** is federally administered by the Health Resources and Services Administration (HRSA). Title V Block Grant funds are used to reimburse MCAH, BIH, and AFLP program expenses incurred for activities consistent with the goals and purposes of the grant.

Title V funds seek to provide:

- Access to quality care, especially for those with low-income or limited availability of care
- Assistance in the reduction of infant mortality
- Access to comprehensive prenatal and postnatal care for women, especially low- income and at-risk pregnant women
- An increase in health assessments and follow-up diagnostic and treatment services
- Access to preventive and child care services as well as rehabilitative services for certain children
- Family-centered, community-based systems of coordinated care for children with special healthcare needs
- Toll-free hotlines and assistance in applying for services to pregnant women with infants and children who are eligible for Title XIX (Medicaid)

The **Maternal, Infant, and Early Childhood Home Visiting** (MIECHV) Funds the California Home Visiting Program and supports pregnant women and families and helps at-risk parents of children from birth to 3-5 years entry access the resources and hone the skills they need to raise children who are physically, socially and emotionally healthy and ready to learn.

California Home Visiting Program works in partnerships with LHJs to:

- Improve health and development

- Prevent child injuries, child abuse, neglect, or maltreatment, and reduce emergency department visits
- Improve school readiness and achievement
- Reduce crime, including domestic violence
- Improve family economic self-sufficiency
- Improve the coordination and referrals for other community resources and supports

Pursuant to 42 U.S.C., Section 704, the Agency cannot use Title V or MIECHV funds to:

- Provide inpatient services
- Make cash payments to intended recipients of health services
- The purchase or improvement of land; construction; or permanent improvement (other minor remodel) of any building or facility
- Satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds
- Providing financial assistance to any entity other than a public or non-profit private entity for research or training services
- Payment for any item or service (other than an emergency item or service) furnished by:
    - An individual or entity during the period such individual or entity is excluded from participation in any other federally funded program, and/or
    - At the medical direction or on the prescription of a physician during the period when the physician is excluded from participation in any other federally funded program.

STATE GENERAL FUNDS

State General Funds (SGFs) are used to enhance and promote MCAH programs. Pursuant to Section 123255 of the California Health and Safety Code, SGFs are used to maximize the reimbursement of available federal funds claimable under Title XIX of the Federal Social Security Act (42 U.S.C., Sec. 1396 et seq.).

AGENCY FUNDS

Agencies contribute funds toward the total cost of operating and promoting MCAH programs. Pursuant to Section 123255 of the California Health and Safety Code, non- federal agency funds can maximize the use of available matching federal funds claimable under Title XIX of the Federal Social Security Act (42 U.S.C., Sec. 1396 et seq.).

Agencies that receive Title V Block Grant funding and contribute Agency funds must report the Agency funds in the proposed program budget and the monthly/quarterly invoices.

CERTIFIED PUBLIC FUNDS

Title 42 of the Code of Federal Regulations (42 CFR), Section 433.51, which is based on the authority of Section 1903(a) of the Social Security Act, provides:

(a) Public funds may be considered as the State's share in claiming Federal Financial Participation (FFP) if they meet the conditions specified in paragraphs (b) and (c) of this section.
(b) The public funds are appropriated directly to the State or local Medicaid agency, or transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control or certified by the contributing public agency as representing expenditures eligible for FFP under this section.
(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

CBOs contracting with the Division or subcontracting with an LHJ under MCAH Programs may utilize public funds that -must be certified by a public agency as funds eligible for the drawdown of Federal Financial Participation.

Questions regarding use of funds not identified should be directed to your assigned contract manager.

TITLE XIX MEDI-CAL FUNDS - FEDERAL FINANCIAL PARTICIPATION

Federal Title XIX Medi-Cal (Medicaid) Funds may be used to reimburse a percentage of expenses incurred for personnel and associated operating costs for matchable activities allowable under Federal Financial Participation (FFP). These funds are applicable only to women and children who are Medi-Cal eligible or Medi-Cal beneficiaries. The Budget may include Title XIX federal funds matched at either an Enhanced rate (75% Federal Funds and with 25% Agency General Funds/SGF) or Non-Enhanced rate (50% Federal Funds and with 50% Agency General Funds/SGF). Agencies claiming Title XIX funding must conform to requirements contained in the FFP Section of this Policy and Procedure Manual.

FEDERAL FINANCIAL PARTICIPATION

OVERVIEW

Fiscal support for programs is available from federal Medicaid Title XIX Funds. This fiscal support is called Federal Financial Participation (FFP). The LHJs; i.e. city or county health departments, and CBOs responsible for the public health needs in the designated geographic area can claim partial reimbursement through FFP Title XIX funds. Programs can claim FFP funds when activities meet at least one (1) of the two (2) FFP objectives:

1. Assisting individuals eligible for Medi-Cal to enroll in the Medi-Cal program.
2. Assisting individuals on Medi-Cal to access Medi-Cal services.

The Centers for Medicaid and Medicare Services (CMS) regulations allow matching for administrative activities that are reimbursable at a Non-Enhanced rate (50/50) for the majority of expenses necessary for the proper and efficient administration of the Medi-Cal program. CMS also allows reimbursement at an Enhanced rate (75/25) for certain activities performed by Skilled Professional Medical Personnel (SPMP) with specified education and/or training, as well as their direct clerical support.

This reimbursement:

1. Reimbursement provided through matching Medi-Cal Title XIX funds with local agency general funds and/or State MCAH allocated SGF to maximize funding for the Program.
2. Applies to personnel employed directly by an FFP participating agency or subcontracted agency.

There are **two** factors that determine the amount of FFP funds an agency can claim:

1. Title XIX time studied activities
2. Agency's Medi-Cal Factor (MCF)

FFP TIME STUDIES

To claim Medi-Cal Title XIX funds, agency budgeted staff must document, through time studies, actual staff time worked in all programs during the time study period. Time studies are the primary documentation source of FFP and used to determine the percent of personnel time that is match able and non-match able. The time claimed to receive FFP match must be spent performing Medi-Cal administrative activities that meet at least one of the two FFP objectives.

Secondary Documentation

Secondary documentation to verify percentages of FFP matching must be provided during on-site audits and/or by written request by MCAH. Examples of secondary documentation include daily logs, appointment books, event flyers, meeting agendas with minutes, calendars, journals, and day planners. This documentation must identify the following:

- Staff name(s), Position(s), and Program(s)
- Date and time span of activities
- Activities conducted and intent of activities
- Number of clients seen or contacted (target audience)
- When using a variable MCF, verification and documentation of Medi-Cal enrollment is required (see the Medi-Cal Factor section of this manual for more information).

Requirements

Each person listed on a Program Budget claiming Title XIX activities (Full time, Part time, or Temporary staff), must complete daily time studies that document 100% of their paid work time for a minimum of one month each quarter and submit a State MCAH time study Data Summary Form or alternate approved format.

Note: Prior approval of an alternate time study format or data collection system must be approved by MCAH prior to implementation. Agencies must retain MCAH written approval for audit and administrative purposes while receiving MCAH Funding and provide such information to MCAH upon request.

Annually during the AFA process, all MCAH agencies must designate in writing their time study month as (1st, 2nd, or 3rd month) and must remain constant with the time study period throughout the fiscal year. Any deviation from the approved period must be pre-approved by the MCAH Program Consultant and Contract Manager via formal written approval. Time Study Data Summary Report Format

All MCAH funded agencies must use the MCAH developed time study template unless they have received formal written approval to use an alternate template. If an alternate time Summary Report Format is approved, it must be consistent with the MCAH Time Study Data Summary Report components identified below:

- Agency name
- Time study period
- Time study month
- First and last name of employee
- SPMP – yes or no
- Time base – full time/part time
- Employee classification or title
- Budget line number
- Percent of time studied to each program listed
- Percentage of time by activity classification
    - Enhanced – (75/25)
    - Non-Enhanced – (50/50)
    - Unmatched
- MCF for each program and/or staff listed

The immediate supervisor must review, approve, and sign in blue ink all time study documents. Time study documents, including secondary documentation, must be kept for a minimum of three years from the date of the last payment for the fiscal year, and may be presented to MCAH upon request at any time.

If staff does not conduct a time study within the required time study period, FFP is not claimable and your invoice will be rejected. Please consult your Contract Manager and Program Consultant with any time study questions.

FFP Time Studies & Function Codes:

The time study report is the mechanism used to document reimbursable activities performed by staff. There are 12-time study function codes used to identify these unique set of activities, including paid time-off.

When completing the time study, enter a function code (1-12) and a program code (A-L) into each half hour slot. Time worked in programs other than MCAH programs must be coded to Other Programs). See example below:

FFP Monthly Time Study Calculation

TIME STUDY PERIOD:			
TIME STUDY MONTH:			
AGENCY:		Program A: MCAH	Program G:
LAST NAME:		Program B: BIH	Program H:
FIRST NAME:		Program C: Other Programs	Program I:
JOB TITLE:		Program D:	Program J:
SPMP:		Program E:	Program K:
TIME BASE:		Program F:	Program L:

Directions: For each half hour of work, choose the appropriate Program code and Function Code (1, 2, etc.) combination from the drop-down list.

DATE		7:00	7:30	8:00	8:30	9:00	9:30	10:00	10:30	11:00	11:30	12:00	12:30	1:00	1:30	2:00	2:30	3:00	3:30	4:00
01/02/14	Monday		A2	A2	A2	A2	A2	A2	A2	A2	A2			B6	B6	B6	A1	A1	A1	A1
01/03/14	Tuesday		A3	A3	A3	A5	A5	A5	B7	B7	B7			C1	C1	C1	C1	C1	C1	C1
01/04/14	Wednesday		A3	A3	A3	A5	A5	A5	B7	B7	B7			A1	A1	A1	C5	C5	C5	C5
01/05/14	Thursday		A3	A3	A3	A5	A5	A5	B7	B7	B7			A1	A1	A1	A1	A1	A1	A1
01/06/14	Friday		12	12	12	12	12	12	12	12	12			12	12	12	12	12	12	12

Note: Time spent doing the following administrative activities associated with a function code is to be considered as time spent doing the function.

- The performance of necessary paperwork, travel, and supervision including the supervision of the SPMP staff by a SPMP supervisor.
- Employee break time is coded to the activity the employee is engaged in immediately before or after the break period. Lunchtime is **NOT** coded because it is unpaid time.

Once the function codes and program codes are entered for each week, the time study report calculates the percent of time, by program, that staff is allowed to claim within four rates of reimbursement. The rates are:

- **Enhanced (75/25)** – Reimbursement for Medi-Cal administrative activities performed by a Skilled Professional Medical Personnel (SPMP) or support staff directly supervised by a SPMP. The rate of reimbursement is $.75 for every dollar expended for activities that meet one of the two FFP objectives.
- **Non-Enhanced (50/50)** – Reimbursement for Medi-Cal administrative activities performed by any of the agency's staff. The rate of reimbursement is $.50 for every dollar expended for activities that meet one of the two FFP objectives.
- **Unmatched** – Reimbursement for activities performed by agency staff that meet the requirements of the Scope of Work but may or may not meet one of the two FFP objectives. This may be claimed under Title V or Agency funds.
- **Allocated** – Reimbursement for costs, which are prorated according to the ratio of time recorded under the above rates.

Reimbursement Rates & Function Codes

Each rate of reimbursement is unique in its reimbursement formula. Within the four rates, there are a total of 12-time study function codes. Each time study function code has a definable and unique set of activities that are performed by staff. Consequently, all activities and paid time-off are identified under the function codes in the appropriate reimbursement class.

Enhanced Rate

Enhanced rate function codes are reimbursed at the rate of 75/25 and may be used for salary, benefits, travel costs, training, and possibly subcontract costs. Subcontractor costs can be enhanced if the subcontractor is a governmental agency contracted by a governmental agency that time study (Refer to the Budget Documentation Section, for detailed information). The Enhanced rate covers activities performed by a SPMP /and support staff when directly supervised by a SPMP under the following function codes:

Function Code	Title/Description
2	SPMP Administrative Medical Case Management
3	SPMP Intra/Interagency Coordination, Collaboration & Administration
6	SPMP Training
8	SPMP Program Planning & Policy Development
9	Quality Management by SPMP

Non-Enhanced Rate

Non-Enhanced rate function codes are reimbursed at the rate of 50/50 for salary, benefits, training, travel costs, and associated operating expenses. Subcontractor costs may be reimbursed at a Non-Enhanced rate if Title XIX requirements are met. The Non-Enhanced rate covers activities under the following function codes:

Function Code	Title/Description
1	Outreach
4	Non-SPMP Intra/Interagency Collaboration & Coordination
5	Program Specific Administration
7	Non-SPMP Training

Unmatched Rate

The unmatched rate function code is for activities included in the Scope of Work (SOW) that may or may not meet one of the two FFP objectives.

Function Code	Title/Description
11	Other Scope of Work Activities

Allocated Rate

Allocated rate function codes are to be used by all staff to record usage of paid leave, holiday, vacation, sick leave or any paid leave other than Compensatory Time Off (CTO). The allocated activities are covered by the following function codes:

Function Code	Title/Description
10	Non-Program Specific General Administration: Non-program specific general administration is prorated between programs and matchable and unmatchable function codes. The portion allocated as matchable may only be matched at the Non-Enhanced rate (50/50).
12	Paid Time Off: Paid Time Off is prorated between programs and matchable and unmatchable function codes. CMS permits the matchable amount to be proportionately distributed between the Enhanced (75/25) rate and the Non-Enhanced (50/50) rate.

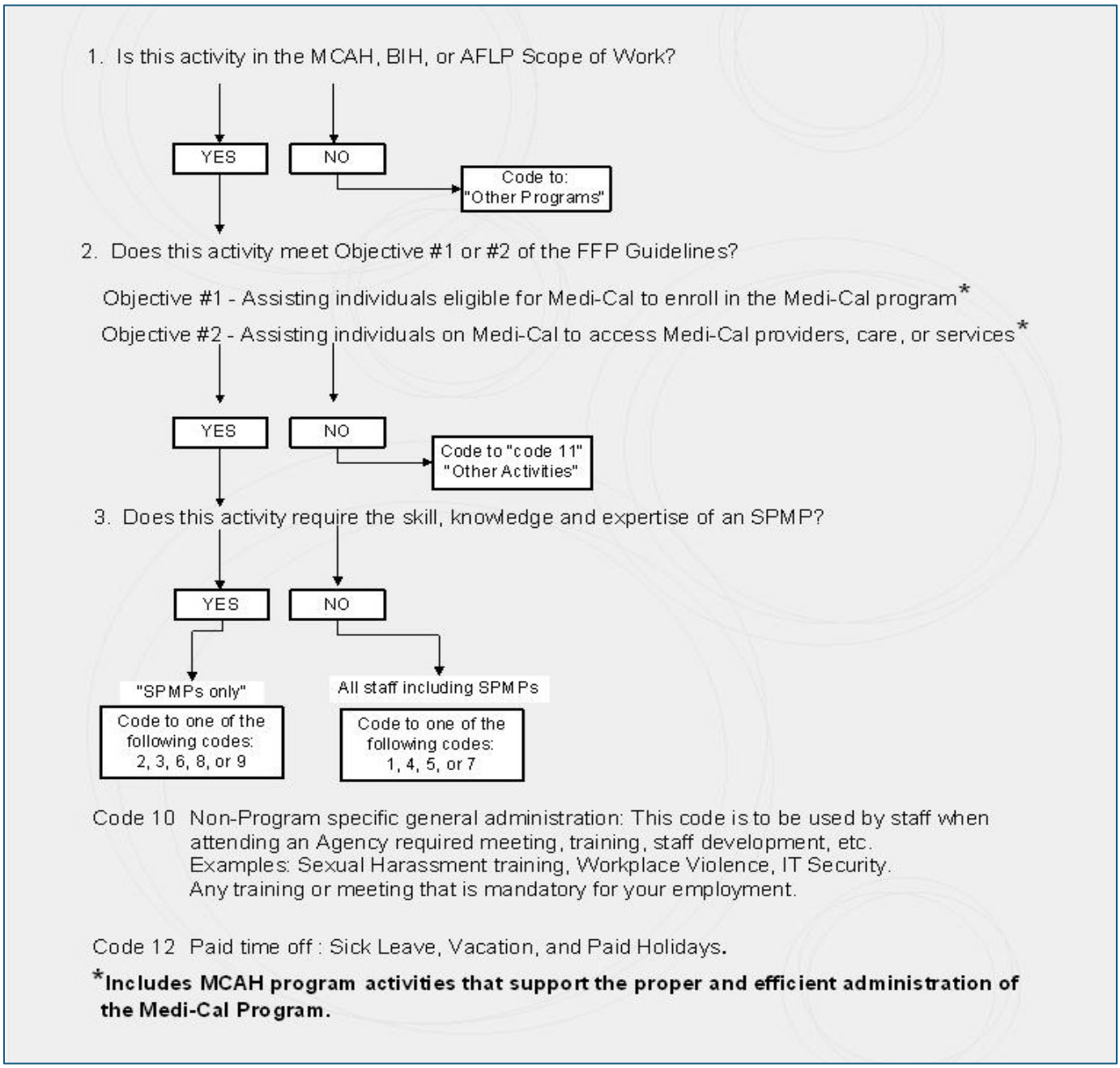
Additional Time Worked

Overtime and/or CTO being earned must be recorded to the function code appropriate for the activities being performed. CTO time is recorded when earned, and NOT to be recorded when used.

FFP Function Codes

See appendices 1-3 for examples regarding program specific SOW activities and the corresponding function code.

FFP Decision Tree



SPMP REQUIREMENTS PROFESSIONAL CLASSIFICATION

Policy

The Agency has the responsibility to substantiate claiming based on SPMP status. The Agency's job class specification must stipulate that the incumbent be from one of the following classifications and the Program duty statement must reflect enhanced and non- enhanced activities.

- SPMP per the Title 42, Code of Federal Regulations (CFR), Sections 432.2 and 432.50
- Physician;
- Registered Nurse;
- Physician Assistant;
- Dentist;
- Dental Hygienist;
- Nutritionist – with a Bachelor of Science (BS) degree in Nutrition or Dietetics and eligible to be registered with the Commission of Dietetics Registration (RD);
- Licensed Clinical Social Worker;
- Licensed Vocational Nurse
- Licensed Clinical Psychologist – with a PhD in psychology; or
- SPMP per State Department of Health Care Services policy:
    - Licensed Audiologist – certified by the American Speech and Hearing Association;
    - Licensed Physical Therapist;
    - Licensed Occupational Therapist – registered by the National Registry of American Occupational Therapy Association;
    - Licensed Speech Pathologist; and
    - Licensed Marriage, Family, and Child Counselors (includes Marriage and Family Therapist).

No longer considered SPMP per Title XIX new Guidance:

- *Master Social Work (MSW)*
- *Master Public Health (MPH)*
- *Health Education Consultant (HEC)*

SPMP REQUIREMENTS PROFESSIONAL EDUCATION AND TRAINING

Policy

SPMP are required to have education and training at a professional level in the field of medical care or appropriate medical practice before FFP can be claimed at an Enhanced Rate of 75%.

Per Title 42 CFR Section 432.50 (b)(6)(3)(ii) “Professional education and training” refers to the completion of a two-year or longer program leading to an academic degree or certificate in a medically related profession.

Completion of a program must be demonstrated by the possession a medical license, a certificate issued by a recognized national or state medical license or certifying organization, or a degree in a medical field issued by a college or university certified by a professional medical organization.

Experience in the administration, direction or implementation of the Medicaid program is not considered the equivalent of professional training in a field of medical care.

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

Procedure

As a resource tool you can refer or use the SPMP questionnaire as a resource. (See next page for example) You may reach out to your contract manager for the most recent version.

Complete the optional SPMP questionnaire to determine the SPMP/non-SPMP status of an employee. The questionnaire needs to be administered only once, although periodic repetition may help the Agency to identify changes in staff education and composition.

SPMP questionnaires should be kept as part of the Agency’s audit files while SPMP staff are employed with the Agency and through the documentation retention period.

Example of SPMP Questionnaire

Department of Health Care Services

Skilled Professional Medical Personnel & Directly Supporting Staff Questionnaire

PART I: INSTRUCTIONS

This Skilled Professional Medical Personnel (SPMP) and Directly Supporting Staff (DSS) questionnaire is intended to be a helpful tool for our state and county partners to utilize in making determinations as to whether a specific position or classification performing certain activities qualifies for enhanced SPMP/DSS Title XIX claiming.[1]

We encourage state and county partners to complete this SPMP/DSS questionnaire and maintain it as part of the supporting documentation for any enhanced SPMP/DSS Title XIX claiming.

For additional guidance regarding enhanced Title XIX claiming, please note the following:

- This SPMP/DSS questionnaire is not intended to be a replacement for applicable federal statutes, regulations, or audits that outline requirements for SPMP/DSS claiming but instead is adjunctive to those resources. Please review the applicable federal law (Social Security Act 1903(2)(A)) and regulations (Title 42, Code of Federal Regulations (CFR) Section 432.1 – 432.55), excerpted in relevant part below. For the full text, please visit one of the following links:
  - SSA Section 1903(2)(A), available at: https://www.ssa.gov/OP_Home/ssact/title19/1903.htm.
  - 42 CFR Sections 432.1 - 432.55, available at: https://www.gpo.gov/fdsys/pkg/CFR-1999-title42-vol3/pdf/CFR-1999-title42-vol3-part432.pdf.
- Each state and county partner claiming enhanced SPMP/DSS Title XIX expenditures must maintain supporting documentation evidencing compliance with applicable federal statutes, regulations, and audits.
- For more information about enhanced SPMP/DSS Title XIX claiming, please refer to the Department of Health Care Services (DHCS) document titled, "Title XIX Claiming, Expenditures and Invoicing Frequently Asked Questions," which was provided to state partners separately. DHCS will also post this document on the DHCS website.

PART II: SPMP CLASSIFICATIONS

Please use the following questions to help determine if you or
an employer or supervisor filling the form out on behalf of
requirements for enhanced Title XIX funding for SPM

The information contained in this document do
fessional advice. In addition, the

Title XIX Claiming Cover Letter

For invoices claiming enhanced SPMP Title XIX expenditures (including allocated rates for paid time off), LHJs are to submit their invoices using a standardized detailed description letter (see Attestation page 15 and accompanying documentation to substantiate expenditures billed under the applicable IA. Each state department or LHJ claiming expenditures under an IA must submit a Title XIX Claiming Cover Letter (as shown below) which includes the following information:

1

Department/County: Blue County

Title XIX Claiming Cover Letter

Program Name: Sample Screening Program

Invoice Number(s): L1234, L1235, L1236

Total amount of requested Title XIX funding: $13,221.92

FY and Quarter: 2017/2018, Q4

Period(s) of Service: April-June 2018

2

Direct Services (Types of services provided and to what Medi-Cal population; include information about procedural safeguards to assure expenditures billed are only for Medi-Cal services.):

Provided screening and case management services to Medi-Cal-eligible children under 6 years of age residing in Blue County. Function codes at the county level are used to indicate Medi-Cal eligibility; expenses billed under non-Medi-Cal-eligible function codes are not included in these invoices.

3 4

Staff Details				Hours: Non-Claimable (Incl. Primary Contract)		Hours: Non-Enhanced (50/50)		Hours: Enhanced (75/25)		Hours: Allocated (50/50 : 75/25 Ratio)	
				PCA Code(s):		PCA Code(s):		PCA Code(s):		Paid Time Off PCA:	
				Function Code(s):		Function Code(s):		Function Code(s):		Function Code(s):	
Name	Classification	SPMP Eligible (Y/N)	Monthly Salary with Fringe Benefits	Time %	Cost	Time %	Cost	Time %	Cost	Time %	Cost
Annabelle Griffiths	Public Health Nurse II	Y	$5,818.00	0.0%	$0.00	60.0%	$3,490.80	40.0%	$2,327.20	0.0%	$0.00
Bill Nye	Sr. Environmental Scientist	N	$6,182.00	20.0%	$1,236.40	60.0%	$3,709.20	0.0%	$0.00	20.0%	$463.65
Clarisse Matisse	Public Health Med. Officer II	Y	$10,004.00	20.0%	$2,000.80	20.0%	$2,000.80	55.0%	$5,502.20	5.0%	$269.84
David Johnson	Health Educ. Consultant III	N	$5,741.00	75.0%	$4,305.75	25.0%	$1,435.25	0.0%	$0.00	0.0%	$0.00
				100.0%	$0.00	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
				100.0%	$0.00	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
				100.0%	$0.00	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
				100.0%	$0.00	0.0%	$0.00	0.0%	$0.00	0.0%	$0.00
Direct service expenses			$1,202.00	15.0%	$180.30	85.0%	$1,021.70	0.0%	$0.00		
Indirect/operating expenses			$4,500.00	65.0%	$2,925.00	35.0%	$1,575.00	0.0%	$0.00		
Total Expenditures by PCA					$10,648.25		$13,232.75		$7,829.40		$733.49
					Title XIX federal funding:		$6,616.38		$5,872.05		$733.49

5

6

Summary of non-federal expenditures used for the Title XIX match, including source (e.g., County Realignment Funds, taxes, etc.) totaling: $20,225.08

$10,000.00 expended from Blue County 2016 Realignment Fund + $10,225.08 expended from Blue County general fund (including property tax revenue).

I certify under penalty of perjury that the information provided on this document is true and correct to the best of my knowledge, based on actual expenditures incurred for the period claim and that matching funds provided are in accordance with 42 CFR 433.51.

7

Approved by: Evelyn Ross Title: Health Program Manager III Phone: 123-456-7890 Email: Evelyn.Ross@Bluecounty.ca.gov

Health and Safety Code Sections 124050(322.2), 124060 (322.5), 124070 (323), 124075 (322.2) are the payment authority.

Attachment: invoice

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Page 1 of 19

Instructions for Filling Out the Title XIX Claiming Cover Letter by Section

1. **Header** – Enter names of state department or county/LHJ and program (e.g. Maternal, Child, and Adolescent Health), invoice number(s), state fiscal year and quarter, and period(s) of service covered by the invoice.

2. **Direct Services** – (Yellow cell) If the invoice includes direct services, provide information on the types of services provided and to what Medi-Cal population(s). Include information about procedural safeguards as to how the claiming state department or LHJ assures that the expenditures billed are for Medi-Cal beneficiaries or services only. *For example, some*

programs use a dedicated billing code at the county level to designate Medi-Cal eligibility of a service recipient.

3. **Staff Details** – For staff providing direct services or support, provide the following:

    a. Names of individual staff persons (no initials, full name is required).

    b. Use official state/LHJ classifications and titles (no acronyms; Must match duty statements and organizational charts provided). For SPMP staff with a Director/Coordinator/Supervisory classification, please add PHN, RN, etc. Example: RN-Perinatal Services Coordinator

    c. Names and classifications – Please ensure all name and classification columns are wide enough to accommodate all the words.

    d. SPMP eligibility status, to be consistent with the Code of Federal Regulations (CFR), Title 42, Part 432, State Personnel Administration:

        i. "Skilled professional medical personnel means physicians, dentists, nurses, and other specialized personnel who have professional education and training in the field of medical care or appropriate medical practice and who are in an employer-employee relationship with the Medicaid agency. It does not include other nonmedical health professionals such as public administrators, medical analysts, lobbyists, senior managers or administrators of public assistance programs or the Medicaid program." (Excerpted from 42 CFR Section 432.2, emphasis added.)

        Note: Consistent with federal guidance, DHCS interprets medical care and practice strictly in accordance with 42 CFR Section 432.50, Subsection (d).

        ii. "Directly supporting staff means secretarial, stenographic, and copying personnel and file and records clerks who provide clerical services that directly support the responsibilities of [SPMP], who are directly supervised by the [SPMP], and who are in an employer-employee relationship with the Medicaid agency." (Excerpted from 42 CFR Section 432.2.)

    e. Monthly salary, with fringe benefits.

4. **Hours** – Non-Claimable, Non-Enhanced, Enhanced, and Allocated Paid Time Off (PTO) -

    a. **PCA and function codes** should be those assigned to the services for each column. *Note: Please attach for DHCS' records standard detailed descriptions of the reimbursable activities that fall under each PCA/function code claimed as an expenditure. A brief list of function names is not sufficient.*

    b. **Percentage of time worked** per category of non-claimable or claimable function, from the period(s) of service for the invoice(s) summarized.

    Note: The calculation for Paid Time Off (PTO) is a weighted average that automatically calculates based upon the percentages of time the employee worked on Non-Claimable, Non-Enhanced, and Enhanced activities. For example, if an employee spent all of their work time performing Non-Enhanced activities, their paid time off will also be at the Non- Enhanced rate. However, if the employee spent only one-half of their time in

the office at the Non-Enhanced rate, only one-half of the paid time off will be reimbursed at the Non- Enhanced rate.

Please also note that the allocated cost of each employee's PTO is immediately visible at only its reimbursable portion, whereas the cost columns for Non- Enhanced and Enhanced activities show the total labor cost in each row and prorate to the reimbursable portion at the bottom, next to "Title XIX federal funding." Accordingly, the costs within each row may not add up to 100 percent of that employee's salary if any percent of their time is being reimbursed at the allocated rate for PTO. This does not indicate an error.

The percentage of time worked for each row must include at least one number above zero in order for the automatic calculations to be correct. The default is to have 100 percent in the Hours: Non-Claimable column. Please adjust this to the correct percentage when you complete the cover sheet.

c. **Direct service expenses**.

d. **Indirect / operating expenses** (if allowed under the appropriate IA) are ineligible for enhanced or allocated rates.

5. **Total amount of Title XIX federal funding being requested** – These cells will automatically calculate subtotals for enhanced, non-enhanced, and allocated rates. The overall total federal funding requested appears at the top right of the cover letter

6. **Summary of non-federal expenditures** (Yellow cell) used for matching the Title XIX reimbursement. Please describe the qualifying expenditures, including source (e.g., County Realignment Funds, taxes, etc.), in the box provided.

7. **Approval** – Sign printed copy. If signature is not clearly legible, please also type or print approver's full name. Please include official classification title (no acronyms), phone number, and email address.

8. **Page numbers** – Please add the current and total page numbers for the invoice submittal package. If the number of the employees for the invoice(s) summarized exceed the space on a single cover letter, include subsequent pages.

Additional guidance on Title XIX funding for your reference:

- CMS State Operations Manual available at cms.gov.
- Medicaid Administrative Claiming available at medicaid.gov.
- CMS Regulations & Guidance available at cms.gov.

Attestation Form

Certifies that SPMP criteria for all enhanced classifications have been met. This form must be signed by the signing authority listed on your Agency Information Form (AIF) which was submitted with your AFA package, dated, boxes checked, and returned MCAHFinAct@cdph.ca.gov with a CC to your Contract Manager. This form only needs to be submitted at the beginning of the fiscal year with your AFA package, however, if there are changes within staffing, a new form must be submitted to your Contract Manager.

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

KAREN L. SMITH, MD, MPH
Director and State Public Health Officer

EDMUND G. BROWN JR.
Governor

Attestation of Compliance with the Requirements for Enhanced Title XIX Federal Financial Participation (FFP) Rate Reimbursement for Skilled Professional Medical Personnel (SPMP) and their Direct Clerical Support Staff

In compliance with the Social Security Act (SSA) section 1903(a)(2), Title 42 Code of Federal Regulations (CFR) part 432.2 and 432.50, and the Federal and State guidelines provided, the _____ (Agency Name) has determined that the list of individuals in the attached Exhibit A are eligible for the enhanced SPMP reimbursement rate, for the State Fiscal Year _____, based on our review of all the criteria below:

☐ Professional Education and Training
☐ Job Classification
☐ Job Duties /Duty Statement
☐ Specific Tasks (if only a portion will be claimed as SPMP enhanced functions)
☐ Organizational Chart
☐ Accurate, complete, and signed SPMP Questionnaire
☐ Active California License/Certification

The undersigned hereby attests that he/she:

- Has personally reviewed the criteria above and its supporting documentation, and determined that the individuals meet the federal requirements for the enhanced SPMP reimbursement rate.
- Will maintain all the aforementioned records and supporting documentation for audit purposes for a minimum of 3 years.
- Certifies that SPMP expenditures are from eligible non-federal sources and are in accordance with 42 CFR Section 433.51
- Understands that if SPMP requirements are not met, the agency will be financially responsible for repaying the costs to the California Department of Public Health (CDPH).
- Understands that CDPH may request additional information to substantiate the SPMP claims and such information must be provided in a timely manner.

_____
Agency Name/ Local Health Jurisdiction

_____
Name and Title *Signature* *Date*

MEDI-CAL FACTOR (MCF)

POLICY

FFP funds are intended to reimburse agency costs for time spent doing certain administrative activities that benefit the Medi-Cal eligible population exclusively. However, Program activities are generally performed for both Medi-Cal and non Medi-Cal populations. Therefore, it is necessary to use a base Medi-Cal Factor (MCF) to identify what portion of the general population receiving services are Medi-Cal beneficiaries. A program's MCF is the percent of the primary target population served by the program that are current Medi-Cal beneficiaries.

The purpose of this section is to clarify Division policy and requirements regarding calculation, documentation, approval, and use of Medi-Cal Factors (MCFs) for the BIH, AFLP and MCAH Program.

BASE MCF

The Base MCF is the number of Medi-Cal births divided by the total number of live births for a region. It is re-calculated when new birth data is available.

AFLP Base MCF

AFLP's base MCF is calculated by the Division for each AFLP agency using their client data entered in the software information system provided by the Program Consultant.

BIH Program Base MCF

The BIH Base MCF is calculated by the Division for each BIH Agency using data from the BIH MIS Current Pregnancy Report (statewide aggregate data) and the BIH pregnant women enrollees from the prior calendar year. Each BIH Agency must use the MCF posted on the BIH Base MCF table.

MCAH Program Base MCF

The MCAH Base MCF is calculated by the Division for each MCAH Agency using data compiled from the Birth Statistical Master File to derive the percent of Medi-Cal paid births to total County live births. Each MCAH Agency can use the MCF posted on the MCAH Base MCF table.

Besides using the MCAH Base MCF posted by the Division, the MCAH MCF can also be any of the following:

1. **A Local MCF** determined by the Agency, approved by the Division, and used for some or all staff.
2. Factoring two or more MCFs for one staff (**multiple or weighted MCFs**).
3. **Variable MCFs** for staff dependent on their actual client contacts.

Note: When performing client counts for any of the above alternate methods, Medi- Cal beneficiaries with a Share of Cost (SOC) can be included in the Medi-Cal enrolled client counts.

When a MCAH Agency uses a MCF other than the MCAH Base MCF, supporting documentation is required to substantiate the invoiced MCF. If an audit reveals that the documentation does not support the invoiced MCF, the Agency will be responsible for repayment of the difference between the invoiced amounts and the amounts the documentation supports. If there is no supporting documentation, the repayment amount will be calculated based on the MCAH Base MCF.

LOCAL MCF

An Agency may have access to more current or region-specific final birth data and can use an alternate Local MCF for some or all of their staff. Local MCFs must be reviewed and approved by the Division each fiscal year they are used.

To use a Local MCF an Agency must:

1. Submit with the Agreement Funding Application (AFA), via the Budget Template (I) Justification worksheet, the data source(s) and methodology used for the calculation(s).
2. Calculations need to be based on population-wide, publicly available (posted on the city or county website) and statistically valid data.
3. Maintain the data sources, methodology, Division approval, client counts and any other supporting documentation for audit purposes.

When proposing a Local MCF, the data source(s) and methodology must be submitted to the Division for approval each fiscal year.

MULTIPLE MCFS FOR SINGLE STAFF

In some instances, Agency staff duties can be divided into two or more specific areas of responsibility. Each area is based on a different function, activity, or client contact, and stated on two or more budget and invoice lines. For example, a MCAH Director performs 60% general administrative MCAH Director duties and 40% Perinatal Services Coordinator (PSC) duties. The Director could be listed on two budget and invoice lines with one line stating 60% FTE as the MCAH Director performing administrative functions using the CDPH Base or Local MCF; and on the second line 40% FTE performing PSC duties claiming up to 95% MCF.

The Comprehensive Perinatal Services Program (CPSP) is a Medi-Cal program; therefore a MCF of up to 95% may be claimed for a PSC. Specific activities of the PSC will determine the percent of FFP match with each time study period.

The duty statement of the PSC must describe the activities assigned to that position including activities that qualify for FFP.

To use Multiple MCFs for the same staff an Agency must:

1. Submit with the AFA, via the Budget Template (I) Justification worksheet, the data source(s) and methodology used for the calculation(s).
2. Verify each fiscal year that there were no data changes or shifts in workload. If there are changes an updated methodology needs to be submitted for Division review and approval each fiscal year.
3. Maintain the methodology, Division approval, client counts, secondary documentation, and any other substantiating documentation for audit purposes.

WEIGHTED MCFS

Only MCAH Directors and Coordinators can use a "Weighted" MCF. A Weighted MCF must be approved by the Division. The weighted MCF is a projection factoring the expected FTEs and MCFs. You will invoice using the actual FTE based on the time studies and MCFs based on actual client counts for that quarter. The Weighted MCF is based on time (% FTE) spent in managing varying programs or entities that have a higher MCF than the MCAH Base or Local MCF.

The Weighted MCF is calculated by adding the sums of the MCF multiplied by the percentage of time performing activities in a program. For example:

Activity/Program	%Total FTE x MCF	Weighted MCF
CPSP	.1 FTE x 95%	9.5%
High Risk Visiting Program	.2 FTE x 80%	16.0%
General MCAH Work	.7 FTE x 52% (Base MCF)	36.4%
(MCF on Budget)	**1.0 FTE**	**61.9%**

To use a Weighted MCF an Agency must:

1. Complete the Weighted MCF table located at the bottom of the (I) Justification worksheet within the MCAH Budget Template.
2. Submit with the AFA via the MCAH Budget Template (I) Justification worksheet, the data source(s) and methodology used for the calculation(s).
3. Verify each year that there were no data changes or shifts in workload. If there are changes an updated methodology needs to be submitted for Division review and approval each fiscal year.
4. Maintain the data sources, methodology, Division approval, client counts, and any other supporting documentation for audit purposes.

VARIABLE MCFS

MCAH Agency staff whose job duties and duty statement specify that they work with a unique population are permitted to use Variable MCFs. A Variable MCF is one that varies each quarter and is based on 100% client counts during the time study month for that quarter.

The Variable MCF is determined each quarter using one of the following methods:

1. The total number of clients seen with documented Medi-Cal beneficiary identification numbers, divided by the total number of clients served by a specific staff member.
2. An Agency with a specialized program may determine a Variable MCF based on data for the entire program. If Division approved, all staff working in that program can use the same Variable MCF.

During an Agency's time study month each staff claiming a Variable MCF must document 100% of their client contact as either "non Medi-Cal" or "Medi-Cal" in their secondary documentation. "Medi-Cal" does not mean assumed eligibility. A client must be a current Medi-Cal beneficiary. Your secondary documentation must be able to substantiate a client's Medi-Cal enrollment status in the event of an audit.

When budgeting Variable MCFs for individual staff an Agency is ***projecting*** what the FYs ratio of Medi-Cal enrolled to total client contact will be for that specific staff. Budget projections should be based on prior year actual client counts and staff duty statements.

Invoicing with Variable MCFs must reflect ***actual client counts*** for that claiming period and client count documentation must be maintained for a minimum of three years for audit purposes. This documentation will be reviewed during an on-site audit, and copies can be requested at any time by Division staff to substantiate an Agency's Variable MCFs. If a client's Medi-Cal enrollment cannot be verified, they cannot be counted as Medi-Cal enrolled.

Documentation of client counts to support Variable MCFs must identify the following:

1. Staff name and position/title
2. Date and time span of activity
3. Activity and nature/intent of activity (e.g., outreach at health fair)
4. Total number of "clients" seen or contacted
5. Documented Medi-Cal verifications (e.g., beneficiary's Medi-Cal identification numbers)

To use a Variable MCF for one or more staff an Agency must:

1. Submit with the AFA via the MCAH Budget Template (I) Justification worksheet the data source(s) and methodology used for the calculation(s).
2. Staff or Program need to document 100% of their client contact as either Medi-Cal enrolled or not in their secondary documentation during the time study month. Verification of client enrollment status needs to be maintained for audit purposes.
3. Calculate MCF as a percent using the number of Medi-Cal enrolled clients to the total clients seen by a staff member for the quarter being invoiced. Use that MCF for the corresponding quarterly invoice for that staff member.
4. The actual client counts must be re-calculated each quarter for each quarterly invoice.
5. Maintain the data sources, methodology, quarterly calculation summaries, client counts, the Division approval, and any other supporting documentation for audit purposes.

MCAH DIRECTOR - MEDI-CAL FACTOR (MCF)

Policy

The Division's intent is to assure that all pregnant women and their children can obtain quality maternal and child health services in the State of California. The MCAH Director is responsible for overseeing local MCAH staff and activities that carry out this mission. It is important that the MCAH Director's MCF be representative of the target population being served.

LHJs can augment their Programs' funds using FFP, which provides federal funding (Title XIX) for certain activities that:

- Assist individuals eligible for Medi-Cal to enroll in the Medi-Cal program
- Assist individuals on Medi-Cal to access Medi-Cal services

Reimbursement of costs for matchable activities and related expenses is based on time spent by qualified staff performing matchable activities on behalf of Title XIX, Medi-Cal beneficiaries only. A Program's MCF is the percent of the primary target population served by the program that are current Medi-Cal beneficiaries.

Procedure

The local jurisdiction's MCAH Director Medi-Cal percentage, the MCF may be determined by one of three different methods:

- **Using the Division Base MCF Table** – The Division calculates the percent of Medi- Cal beneficiaries in the population of each local health jurisdiction based on the Medi- Cal paid delivery and birth data from the previous calendar year. The MCAH Director is allowed to time study all activities performed in the MCAH program time using the Division's Base MCF for reimbursement.
- **Using a locally determined MCF** – This is a locally determined MCF based upon population wide, publicly available or documented data (Local Base MCF), or direct documentation of Medi-Cal beneficiary's identification numbers (Variable MCF).
- **Using more than one MCF** – The MCAH Director may be responsible for overseeing local MCAH staff and activities in more than one MCAH program. The MCAH Director is allowed to time study to each specific MCAH program (such as MCAH, CPSP, FIMR, Education/Outreach and Dental) and use the MCF for each of these programs for claiming purposes. Each program can be budgeted and invoiced on separate lines in the J-Pers Worksheet of the MCAH Budget and Invoice template.

Requirements

Prior written approvals from the MCAH Program Consultant and Contract Manager is required to claim an MCF different from the one listed in the Division's MCAH Base MCF Table. Role and responsibilities for participation or oversight of local jurisdiction MCAH or MCAH-related programs must be addressed in the MCAH Director's duty statement.

Local jurisdictions must determine the percent of time spent per program based on actual time documented for activities/programs on the Division approved Time Study. The MCAH

Director must include 100% of their work time on the time study including time worked outside of MCAH related programs.

All data sources and methodology used to determine the MCAH Director MCF must be maintained for three years for audit purposes. The audit file must be maintained until the records retention schedule for the same audit period expires.

Note: If a State or Federal audit is performed in which there are findings resulting from the data or methodology used to determine the MCAH Director's MCF, the local jurisdiction is solely liable for any financial recovery and/or penalties as a consequence of the findings.

MCAH DIRECTOR - ENHANCED FFP FUNDING REQUIREMENTS

Policy

FFP rules have specific requirements concerning qualifications for SPMP that allow Title XIX matching of SPMP staff at the Enhanced rate (75/25). FFP requires that these special requirements be listed in the job specification or classification for SPMP staff claiming Title XIX funds.

LHJs may not be able to meet these federal requirements for some SPMP staff (most often the MCAH Director positions) when local jurisdictions place them in general management job specifications/classifications. This results in the local jurisdictions only being able to match the MCAH Director costs at a Non-Enhanced rate (50/50) for their time and activities.

Requirements

The MCAH Director position must be filled by a qualified physician or by a public health nurse, depending upon the population of the local jurisdiction. In order to claim at the enhanced rate (75/25), duty statements for a SPMP must reflect roles and responsibilities appropriate for the SPMP classification and level of expertise.

ENHANCED FFP CLAIMING

Policy

The ability to utilize Enhanced FFP claiming depends on the following considerations:

- **The employer-employee relationship with the primary contracting agency** - Only available for SPMP staff of a governmental entity that contracts directly with the Division or a Subcontractor of a government agency that is also a government entity
- **The health-related professional qualifications of individual staff** – Applied only when the activity must be performed by a SPMP and/or their direct clerical support staff

- **The specific activities that each staff perform** - Claimed for salaries, benefits, travel, training of the SPMP, and the SPMP direct clerical support staff who are in an employee-employer relationship with the government agency and who are involved in activities that are necessary for proper and efficient Medi-Cal administration
- **The proportion of the target population who are Medi-Cal beneficiaries**.

Reimbursement Requirements

For reimbursement at the Enhanced rate (75/25), SPMP staff must meet all of the following conditions:

- Time spent performing duties that require specific SPMP knowledge and skills
- The job specifications must require a SPMP
- Activities performed must fall within the function codes; 2, 3, 6, 8, or 9
- An SPMP Questionnaire must be completed and submitted for approval to the agency MCAH Director and retained by the agency for audit review purposes.

Expenditures for provision of medical services by a SPMP do not qualify for reimbursement via FFP because medical services are already paid for in either the Medi-Cal fee-for-service or managed care systems.

Support Staff

For reimbursement at the Enhanced rate (75/25), support staff must meet all of the following conditions:

- Be directly supervised by a SPMP, as shown on an organization chart; or under the substantive direction of a SPMP
- Be in a secretarial, stenographic, copy, file, or record clerk position providing direct support to the SPMP in support of enhanced functions
- Conducting activities that directly support SPMP functions to the extent that the non-professional can be responsible for performing functions directly necessary for carrying out of the professional medical responsibilities of a SPMP
- Provide clerical services directly necessary for carrying out the professional medical responsibilities and function codes of a SPMP
- Documentation must exist, such as a job description/duty statement, which states that the services provided for the SPMP are directly related and necessary in the execution of the SPMP responsibilities

Procedures

The following procedures must be followed to claim Enhanced FFP:

- Update staff documentation materials when changes occur.
- Maintain all claiming documentation as required through the document retention period.
- At a minimum, complete daily time studies during the designated time study month for **ALL** personnel with activities funded with Federal Title XIX funds.
- Complete a time study worksheet in 30-minute increments capturing time for a full- time employee; i.e., a 40-hour week (A part-time employee still needs to account for a 40-hour week). Identify all time and activities worked in the Program. Time worked in other programs, as well as any non-paid time must be put in another category such as “Other Program."
- Summarize daily activities and time for each employee being matched with Title XIX funds. Enter the totals into the FFP Calculation File, or a Division approved alternate FFP Calculation File, to calculate actual percentages of time.
- During the time study month any staff who is using paid leave, holiday, vacation, sick leave, or any other paid leave, or who performed activities unrelated to their Program- approved duty statement and did not time study for claimable activities may not claim FFP for that quarter. Please contact your Contract Manager for further details.

Special Circumstances

CBOs receiving MCH Block Grant funds to provide AFLP services are non-government agencies and are prohibited by Federal regulations from claiming and receiving Enhanced rate matching of 75/25.

NON–ENHANCED FFP CLAIMING

The Non-Enhanced rate (50/50) can be claimed for any of the agency's staff involved in activities that are necessary for proper and efficient Medi-Cal administration. This policy also applies to CBOs.

DOCUMENTATION FOR FFP CLAIMING

Policy

The following types of documentation must be part of the agency’s time study/FFP audit file:

- Organization chart(s)
- Job specification for each SPMP position
- Position duty statement for each employee
- Training log, agenda/brochure of training, and registration receipt
- Correspondence related to Division FFP policies
- Secondary documentation
- Working papers used to calculate/develop invoices

- SPMP questionnaire for claiming status
- Signed time studies

Requirements

Staff claiming FFP match are required to document by program the time spent performing all activities during their time study month. Any variance must be discussed with the agency's Program Consultant and Contract Manager.

All FFP supportive claiming materials must be kept for a minimum of three years from the date of the last payment of the fiscal year or final resolution on any audit findings, whichever is later.

UNMATCHED ACTIVITIES

Policy

Unmatched activities are those activities included in the SOW that do not meet either of the two FFP objectives. These activities are coded under Function Code 11 – Other Activities. These are not Title XIX activities and are invoiced using unmatched Title V, SGF, and/or Agency funds.

Ineligible Activities

Activities that are not eligible for FFP funding (but may be claimable under unmatched funding) but are required to meet the objectives of the SOW may include, but are not limited to the following:

**Note: These activities may qualify for FFP funding only when one of the two FFP objectives is met. If you have questions regarding matchable activities, please consult with your Program Consultant.*

- Anticipatory Guidance/Activities (e.g. parenting, safety, breastfeeding)
- Social Activities
- Childhood Safety
- Immunization clinics
- Work Force/Job Development
- School related activities
- Housing need activities
- Fetal Infant Mortality Review
- Parenting
- Day Care
- Routine Developmental Testing (i.e. Denver, NCAST etc.)
- Nutrition
- Domestic Violence Educational Prevention*
- Transportation*

Other expenses ineligible for FFP reimbursement include payment of activities and/or visits claimed under Targeted Case Management (TCM).

TITLE V 30/30 EARMARKING

OVERVIEW

Pursuant to Title V of the Social Security Act, Section 505, CDPH is mandated to provide oversight in the expenditure of Federal MCH Title V Block Grant funding. Federal MCH Title V Block Grant funding is the key source of support for promoting and improving the health of all mothers and children, including children with special health care needs.

Requirements

As required by Federal regulation, CDPH is required to track and utilize all Federal MCH Title V Block Grant funding as follows:

- At least 30% of Federal MCH Title V Block Grant funds received are to be expended for Preventive and Primary Care Services for Children (PPCSC)
- At least 30% of Federal MCH Title V Block Grant funds received is to be expended for Children & Youth with Special Health Care Needs (CSHCN)

TITLE V TIME STUDIES

Currently, only the MCAH Program is required to report Title V expenditures to be in compliance with Federal regulations. SIDS activities can be coded to Category I and FIMR should be coded to Category III.

Note: This time study is required and separate from the Title XIX time study. Both Title XIX and Title V time studies are required with the quarterly invoice.

Time Studies must be performed for one full month during each fiscal quarter. Fiscal Quarters:

- July – September
- October – December
- January – March
- April – June

Each agency will designate in their AFA the month in each quarter that Title V 30/30 Earmarking Time Studies are to be completed. Agencies must communicate their selected month to the MCAH Program upon receipt of the first quarter time study.

BUDGETS DOCUMENTS

OVERVIEW

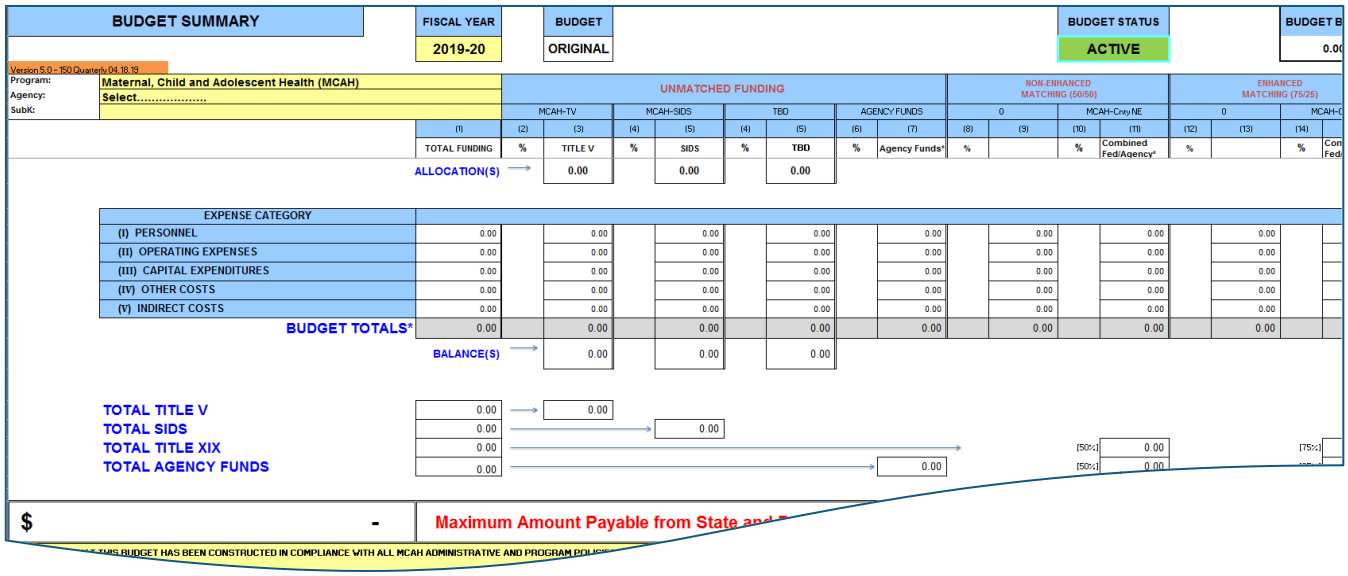
Budget documents form the basis for Agency payments and fiscal accountability for audit compliance. All expenses shown on the budget documents must directly relate to the accomplishment of the goals, objectives, activities, timelines and outcomes identified under the MCAH Program(s) Scope of Work (SOW).

The Program Budget/Invoice template contains all the necessary documents for submitting a proposed budget. The Budget/Invoice template will have only the Original Budget tab and Q1 tab open as working tabs. The rest of the tabs (Budget Revision -BRs, Invoice-Q2-Q4 or M2-M12, and Supplemental Sup) will be locked until your budget has gone through the approval process and is approved.

Justification worksheets are incorporated in the Budget/Invoice template file to allow agencies to document explanations of each expense listed under Personnel, Operating Expenses, Capital Expenditures and Other Costs. Justifications must include all particulars as specified by the Division for evaluating the necessity or desirability of each expenditure. This portion of the Program Budget Document is used for monitoring and auditing purposes.

The budget and corresponding justification worksheets are a required component of the final approved AFA.

BUDGET/INVOICE TEMPLATE

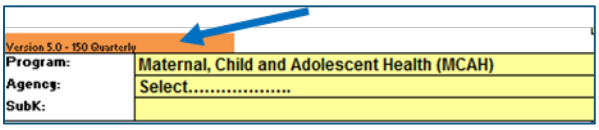


Note: Contact your Contract Manager if you are having any difficulty accessing the Budget/Invoice template.

- Within the Budget/Invoice template are cells shaded in yellow. These cells will accept data entry.

  Note: Some of the yellow shaded cells within the Federal/Agency Non-Enhanced column under the Operating Expenses and Other Charges line items contain automatic calculations that may be overridden to reduce percentages if necessary. All other cells are locked, and password protected to prevent accidental entries. Any unauthorized changes made to the original format will require a resubmission by the Agency.

Agencies must ensure that the most current approved version of the Program Budget/Invoice template file is used at all times. The template version is located at the top of the Budget Worksheet in the cell above the Program name.



- All other data (non-shaded cells) are calculated by formulas embedded in the worksheet cells.
- The allocation amount(s), the Indirect Cost Rate (ICR) percentage and application and the Base Medi-Cal Factor will automatically populate when the agency name is selected on the Budget Summary Page.
- Funding totals are automatically calculated and forwarded from each of the detail sections (Personnel, Operating Expenses, Capital Expenditures, Other Costs, Indirect Costs, and Operating Expenses) to the Budget Summary Page.
- Negative balances (or red) are not allowed on any budget or invoice summary page.
- The total balance shown on the Budget Summary Page cannot reflect a negative balance.
- There have been a few changes to the budget template this year. Please see the following (1 & 2) as we will address them throughout the next few pages.

BUDGET SUMMARY

The Budget Summary Page contains the following expense categories:

I. Personnel
II. Operating Expenses
III. Capital Expenditures (Major Equipment)
IV. Other Costs
V. Indirect Costs

EXPENSE CATEGORY
(I) PERSONNEL
(II) OPERATING EXPENSES
(III) CAPITAL EXPENDITURES
(IV) OTHER COSTS
(V) INDIRECT COSTS

Procedure

The following provides information on formatting, inputting & submission procedures:

- The Fetal Infant Mortality Review (FIMR) and Sudden Infant Death Syndrome (SIDS) programs are funded by Title V and cannot be reimbursed with Title XIX funds.
- Agencies cannot use federal funds derived from any other entity for the purpose of Title XIX reimbursement.
- The print command will automatically generate the Budget Summary Page and budget detail pages; however, you must select each justification worksheet individually to print.
- Each Program Budget/Invoice template file is used for both budgeting and invoicing purposes. Submit budget documents via email for each MCAH funded Program.
- Once the budget documents are approved by the Division, the budget needs to be signed by the Agency's Program Director and Fiscal Agent (Not applicable to clarify CBOs or CHVP).
- The Excel version of the Budget/Invoice template file must be sent via email to the Contract Manager.
- Submit a scanned signed copy of the budget via email to your Contract Manager. Signatures should be in blue ink.

(I) Personnel

Personnel Costs are listed as the first line item on the Budget and Invoice Summary Page. The Personnel Detail Section is titled "I." and is located after the "V. Indirect Costs Detail Section." The Personnel Detail Section needs to be completed prior to all other sections within the budget worksheet in order for the template to auto calculate for matching purposes.

(I) PERSONNEL DETAIL					
				TOTAL PERSONNEL COSTS	0.00
			FRINGE BENEFIT RATE		0.00
				TOTAL WAGES	0.00
	FULL NAME (First Name Last Name)	TITLE OR CLASSIFICATION (No Acronyms)	% FTE	ANNUAL SALARY	TOTAL WAGES
1					0.00
2					0.00
3					0.00
4					0.00
5					0.00

Staff initials, job title or classification, FTE, the average fringe benefit rate and annual salary entered in the Personnel Detail Section of the budget will populate the (I) Justification worksheet.

Total costs from the Personnel Detail Section will populate the Personnel line item on the Budget Summary Page.

Requirements

The requirements of the Personnel Detail Section are:

- All Program staff, regardless of time worked in the program, or funding source (unless included in indirect expense line items), must be included in the Personnel Detail Section.

- Personnel listed in the Personnel Detail Section must meet all applicable program policies and requirements as detailed in the Program Policy and Procedure Manual.
- Anticipated salary increases must be included in the initial preparation of the Personnel Detail Section.
- Vacancies must be budgeted at middle salary range.
- The Division allows reimbursement for fringe benefits that meet each of the following criteria:
    - Necessary and reasonable for the performance of the Program Agreement and budget
    - Determined in accordance with Generally Accepted Accounting Principles
    - Consistent with policies that apply uniformly to all activities of the Agency
- Fringe benefits may include, but are not limited to:
    - Health plans (i.e., health, dental and vision)
    - Unemployment insurance
    - Worker's compensation insurance
- Fringe benefits **do not** include:
    - Compensation for personal services paid currently or accrued by the Agency for services of employees rendered during the term of this agreement which is identified as regular or normal salaries and wages, vacation, sick leave, holidays, jury duty and/or military leave
    - Incentive or bonus pay
    - Relocation allowances
    - Hardship pay
    - Cost-of-living differentials
- Travel
    - Travel column has been added to the Personnel Detail section in the budget template. For budgeting purposes, the staff members who will be traveling will have to select the "X" from the drop down. This will also help average the Match % allowed in the Operating Expenses section for Travel.

Procedure

List each staff's first and last name and their job title or classification in the appropriate column (*Note: job titles and classifications should be consistent with all duty statements and organization charts*). Enter "VACANT" in the name column if the position is vacant.

- Enter percent of Full Time Equivalent (FTE) for each employee.
- Enter the total annual salary for employees as if they were employed full time.
- Once the FTE and annual salary are entered for an employee, the total wages will populate.
- Insert an average fringe benefit rate that will be applied to the total wages listed in each column. A fringe benefit rate is the cost of an employee's benefits divided by their total wages.
- Enter the non-enhanced and enhanced percentages based on historical time study data. The combined total of non-enhanced and enhanced percentages should not exceed the allowable MCF for each staff person. If the percentages do exceed the MCF, the cell containing the MCF will turn red. Adjustments to the non-enhanced and enhanced percentages will need to be made until they are at or below the MCF.
- Travel costs are automatically matched at the Non-Enhanced rate, based on the "Percent of Personnel Matched". Agencies electing to enhance travel costs must determine the allowable percentage or amount in accordance with FFP requirements.

Personnel (I) Justification Worksheet

- Chose Program name from the dropdown selection in column "I." (e.g., MCAH, FIMR, SIDS, AFLP, BIH).
- The Base MCF percentage will auto populate under the MCF% column for all staff. If the MCF type is variable, weighted, multiple, or local, enter the appropriate MCF percentage and select the corresponding MCF type from the dropdown menu.
- For the current Fiscal Year MCF rates please refer to the Agreement Funding Application instructions.

  Note: When selecting a Multiple MCF type (two or more lines for one staff), you must complete the "MCF % Justification" column.

- When selecting a Weighted MCF you must complete the Weighted MCF Calculation Table (located below the MCF Requirements on the (I) Justification Worksheet), in addition to providing written justification in the "MCF % Justification" column.
- Enter the MCF justification for each staff when using (or projecting for Variable MCFs) an MCF higher than the base. Include source data if applicable, i.e. Penelope software for AFLP. Justification cannot exceed 1024 characters.
- The MCF percentage entered under the justification worksheet will populate in column 16 of the Personnel Detail Section.

(II) Operating Expenses

The Operating Expenses Detail Section is comprised of three expense areas listed under the main expense category:

- Travel
- Training
- Operating Expenses (Other than Travel and Training, lines 1-15)

The total dollar amounts from the Operating Expenses Detail Section will populate the Budget Summary Page.

Operating expenses (other than travel and training) are automatically distributed to the Title V and Non-Enhanced Combined Federal/Agency columns according to how personnel costs are distributed (Percent of Personnel Matched). Lines 1 through 15 of the Operating Expense Detail Section cannot exceed the Percent of Personnel Matched. Some travel and training costs may be manually distributed to the Enhanced combined Federal/Agency columns if it is in accordance with FFP requirements.

The distribution of these costs can be changed as needed by manually entering new percentages into the percent columns. The allowable Percent of Personnel Matched for operating costs that are Title XIX reimbursable can be found in the Percent of Personnel Matched box located in column 16.

Travel

Travel costs are listed on the budget for all staff who travel to conduct Program business and to attend conferences and training that is directly related to the objectives described in the SOW.

The cost of travel cannot exceed the established State rates noted in the State Travel Reimbursement Information on the CalHR website.

Out-of-State travel is allowed for agency leadership to travel to the following national conferences:

- Annual meetings of the National Association of Maternal, Child and Adolescent Health Programs
- Center for Disease Control and Prevention's MCAH Epidemiology Conference
- Annual City Match Conference

Travel to other national conferences may be approved on a case-by-case basis and requires prior written MCAH approval. All requests must be submitted in writing via email to your CM and PC with a brief description that includes the items listed below:

- Name and date(s) of the conference, training, meeting, etc.
- Name and title of the individual(s) traveling

- Necessity of the trip, how it relates to the goals and objectives of the SOW and how it improves the skills of the attendee
- Travel location and dates
- Breakdown of the proposed costs of the trip

Out-of-State travel must be identified in the training area of the (II-V) Justifications worksheet of the budget and under the appropriate goal and objective in the SOW.

Travel costs are automatically matched at the Non-Enhanced rate, based on the Percent of Personnel Matched.

Travel can be reimbursed at an Enhanced rate if it is in accordance with FFP requirements. Travel cannot be matched at a higher percentage than the percent listed on the Personnel Detail Section for those staff traveling.

There is a Travel column on the Personnel Detail section in the budget template. To accurately calculate the average Match %, an "X" must be selected from the drop down for each staff member who will be traveling.

Requirements

Prior MCAH written approval is required for travel and training costs for staff not listed on the Program Budget, but who contribute a portion of their time to the MCAH program. Any written approval from the Division as well as any receipts or information required for Travel Reimbursement must be retained by the Agency for audit purposes.

Training

Training costs are listed on the budget for staff who conduct or attend conferences and training that are directly related to the objectives described in the SOW.

- Agencies may host or sponsor Program-related trainings, seminars, workshops or conferences.
- Training **cannot** be matched at a higher percentage than what is listed on the Personnel Detail Page for those staff for whom training is being budgeted. Training can be reimbursed at an Enhanced rate if a SPMP is providing training to another SPMP and it meets one of the FFP objectives.

Requirements

Prior written MCAH approval is required for the following:

- Training and associated travel and per diem costs for staff not listed on the budget, but who contribute a portion of their time to the Program.
- To host trainings, seminars, workshops, or conferences.

Procedure

Agencies requesting approval to host trainings or seminars must submit the following items:

- A description of the proposed training or seminar in the Program Budget Justification Narrative
- A written request at least 60 days prior to the proposed training or seminar date(s) to the Contract Manager and Program Consultant which includes:
    - The date and location of proposed training or seminar
    - Subject matter of the training or seminar
    - Draft of agenda and list of instructors
    - Draft of instructional/educational materials
    - Targeted audience and projected number of attendees
    - Draft of publicity materials
    - Total cost

Note: Federal regulations disallow the use of any federal funds for advocacy at the local, state, or federal level. Therefore, the $1,100 allocated for the semi-annual MCAH Action training conference may only be used for training and travel related expenses to assist in meeting the educational needs of the MCAH Director. This should be shown in your budget under the travel and/or training line items, as appropriate. Any expenses related in any way to advocacy must be paid from local agency funds and are not eligible for Title XIX matching funds.

Operating Expenses Other Than Travel and Training

Operating expenses other than travel and training include, but are not limited to, items or costs used to support staff such as:

- Rent (methodology required)
- Office Supplies
- Communications
- Duplication
- Utilities
- Postage
- Minor Equipment - Audio/Visual equipment or Telecommunication items (including phone systems, teleconferencing equipment computers, printers, and furniture) having a base unit cost of less than $5,000.

For lines 1 through 15, enter in each operating expense type and the corresponding dollar amount. A justification for each expense must be entered on the (II-V) Justifications Worksheet. The justification must be detailed enough to substantiate the costs.

Operating Expenses, other than travel and training, can only be reimbursed at the Non-Enhanced rate. The total percentage of the Non-Enhanced Combined Federal/State and Combined Federal/Agency columns in each line item cannot exceed the Percent of Personnel Match as indicated on the right side of column 15 in the Operating Expenses Detail.

Operating Expenses that do not meet the FFP requirements must be claimed as unmatched (see page 25). The formula in the cell under the non-enhanced column will have to be deleted in order to claim the expense as unmatched.

(III) Capital Expenditures

These expenditures are defined as major equipment items with a base cost of $5,000 or more and useful life expectancy of one or more years. MCAH must approve all capital expenditures in writing prior to purchase. Capital Expenditure items purchased using any amount of Division funds become the property of the State of California.

Expenses entered will automatically be spread based on the Percent of Personnel Matched, but may be adjusted as necessary by shifting costs between funding sources.

On the (II–V) Justifications Worksheet, briefly describe the necessity and cost for each expenditure.

(IV) Other Costs

The Other Costs Detail Section is comprised of two expense areas as listed under the main expense category below:

- Subcontracts
- Other Charges (i.e., Client Support Materials, Educational materials, etc.)

The total dollar amounts entered in the Other Costs Detail Section will populate the Budget Summary Page.

Subcontracts

A subcontract is a written agreement between the Agency and a subcontractor. Subcontracts or consultant services can be used only for activities directly related to meeting the goals and objectives of the primary SOW. Subcontractors of LHJs may match at the Enhanced rate only if the subcontractor is performing Enhanced activities **and is a governmental agency**. If a subcontractor is matching at either the Enhanced or Non- Enhanced rate, they are subject to all guidelines as stated in the FFP Section of this Policy and Procedure Manual.

The use of a subcontractor or consultant must be explained and justified on the (II-V) Justifications Worksheet. Line item titles and amounts entered in the Other Costs Detail section will populate in the

(II-V) Justification Worksheet. Briefly describe the necessity, types of services and cost for each subcontract.

Note: For any subcontract $5,000 or more, the agency must provide a subcontract package for review and approval as described in the Subcontract

Requirements section of Exhibit D (F) included in this manual.

Other Charges

Other Charges include, but are not limited to, costs to support the program such as:

- **Client support materials** items used in support of desired behaviors/goals or items that have been determined as necessary for risk reduction after an assessment has been completed. Items such as cabinet locks, plug covers, pak 'n plays, cribs, car seats, breast pumps, diapers, baby clothes, school readiness materials (e.g., picture books, manipulative toys), bus passes or other transportation tokens and flash drives can be included in the invoiced amount.
- **Educational Materials**
- **Outreach Materials**
- **Services** such as development costs of media campaign advertising

Line item titles and amounts entered in the Other Costs Detail Section will populate in the (II-V) Justification Worksheet. On the worksheet provide a brief explanation of the necessity and cost of each expenditure.

(V) Indirect Cost

Beginning January 1, 2014 and each year thereafter, CDPH requires each Local Health Department to submit their proposed ICR percentage and application using either total personnel costs (wages and fringe benefits) or total allowable direct costs (personnel wages, fringe benefits, operating costs, capital expenditures and *other costs). Agencies are required to use the department approved ICR percentage and application method as published on the CDPH website. Agencies may have the option of selecting less than the approved ICR by completing the MCAH ICR Certification form located on the current Fiscal Year AFA website.

- Total Indirect Costs: From the funding allocated, Agencies are allowed to claim up to 25% of total personnel costs (wages and fringe benefits) or 15% of total allowable direct costs (personnel wages, fringe benefits, operating costs, capital expenditures and *other costs) to cover the Program's indirect costs.

  ***When using direct costs method agencies may only claim overhead charges on the first $25,000 for each subcontract.**

- AFLP CBO's grant agreements are limited to claiming up to 15 percent of personnel costs (wages and fringe benefits). Unless an alternate Federal approved ICR has been submitted to MCAH and approved for use.

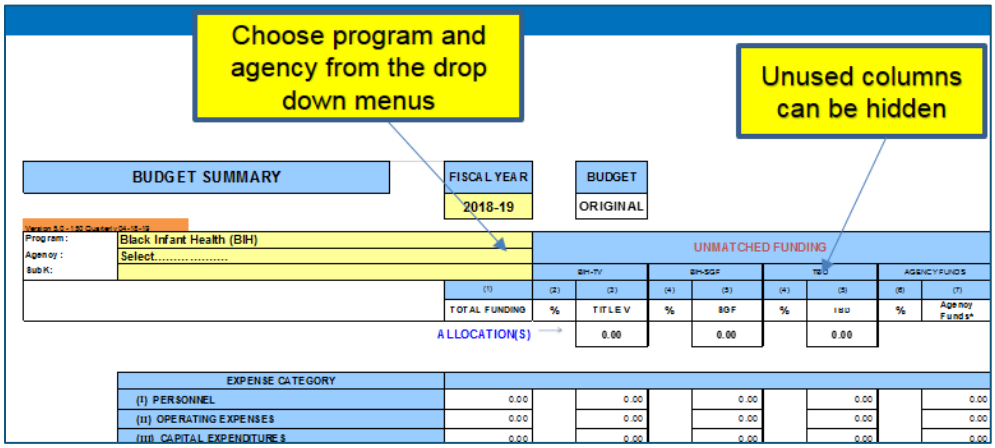
- Total Indirect Costs are distributed among the Agency's Unmatched and Non-Enhanced budget columns based upon the Percent of Personnel Matched.

- Total Indirect Costs are not matched at an Enhanced rate.

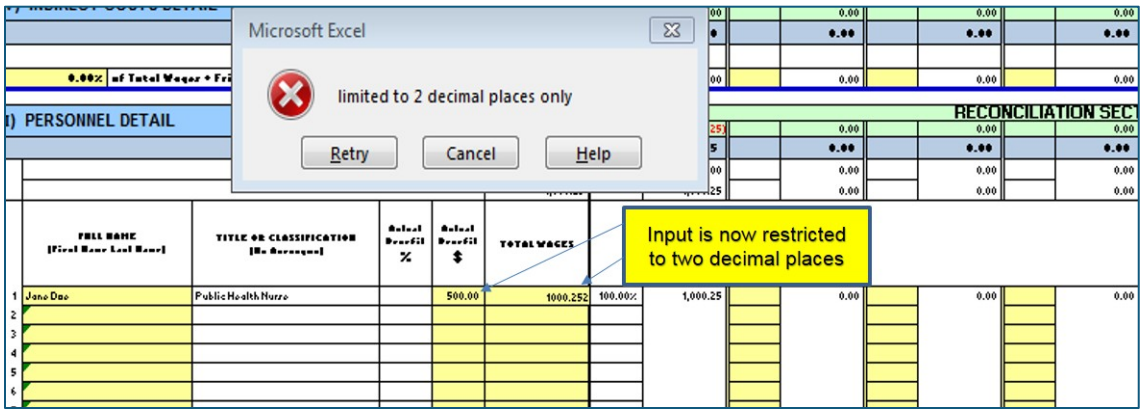
UPDATES TO BUDGET/INVOICE TEMPLATE

There have been a few changes to the budget template this year. Please see the following (1 & 2) as we will address them throughout the next few pages.

1. MCAH / BIH / AFLP Templates Combined
    - Use drop downs to select your program
    - Hide unused columns that you don't need



2. Invoices & Title XIX Cover Sheet
    - Limitation to 2 decimals ($.01)
    - $XX,XXX Alignment to the penny



BUDGET REVISIONS

OVERVIEW

The Division allows changes to previously approved Program Budget Documents to update and accurately reflect program need once per fiscal year. Budget revision proposals will be accepted only during the third quarter of the current fiscal year. Agencies must first contact their assigned Contract Manager, complete the BR tab on the budget template, and submit for review and approval. MCAH contract managers and program consultants will review the request and if the revision is approved, the contract manager will inform the agency of the approval. All budget revisions will require CDPH/MCAH written approval prior to implementation.

REQUIREMENTS FOR BR'S

Agencies allowed to proceed with a budget revision must submit their proposed revision as follows:

- Request the revision template via email from your MCAH Contract Manager.
- Submit the proposed budget revision via email to your Contract Manager.
- Obtain formal written approval from CDPH/MCAH.
- Sign approved budget template and submit to your CDPH/MCAH Contract Manager.
- Any invoice affected by the pending budget revision cannot be submitted to the Division until the revised budget is approved.

The following documents are required for submission via email:

- Cover Letter stating reason the budget revision is necessary and where changes are requested
- Revised Budget Template (including completed Justification tabs)
- Revised or additional duty statements, if applicable
- Revised organization charts, if applicable
- Any other documents/forms that are applicable

Once the revised budget documents are approved by CDPH/MCAH, the agency will submit a signed copy of the budget documents to their MCAH Contract Manager

INVOICES AND PAYMENTS

INVOICES

The Division reimburses agencies for actual costs incurred in meeting the objectives as specified in the SOW, not to exceed the approved Program budget.

Quarterly and monthly invoices are due 45 days after the end of the invoiced period and 45 days after for final invoices. A preliminary review is not required, but can be helpful in identifying potential errors. Prior to submitting a formal invoice, agencies may submit their invoice package directly to their Contract Manager for preliminary review. A preliminary review must be submitted no less than two (2) week prior to the invoice deadline. Contact your Contract Manager to arrange the review.

Agencies ready to submit their invoices must utilize their approved and State MCAH certified budget and invoice workbook. As communicated on CDPH/MCAH Alert Letter 20160710 on October 7, 2016, ALL signed invoices and supporting documentation must be submitted via email in PDF and Excel format to the dedicated MCAH invoice inbox: MCAHInvoices@cdph.ca.gov. *To avoid any delays, please send all the required documents in one email.*

Invoice Submission

Your contract manager and Program Consultant will review the invoice for correct format, accuracy and availability of funds. Failure to use the appropriate naming convention can result in delays in reimbursement. To ensure appropriate processing, please use the following invoice naming protocol and in the subject line of the email:

Agreement Number, Agency Name, Fiscal Year and Invoice Month and Number (starting with Month 1 or Quarter 1 as applicable)

CBO Example:

AGREEMENT #17-10004, SAN DIEGO COUNTY, FY 2018-19, MONTHLY/QUARTERLY, INVOICE

LHJ Example:

AGREEMENT #201801, SACRAMENTO COUNTY, FY 2018-19, Q1 INVOICE

Invoice package includes the following:

- **Signed Cover letter on official agency letterhead (PDF)** – the date the cover letter was prepared, Program being invoiced, Inclusive dates for invoicing period, Agreement number, invoice number, total amount of the invoice, Explanation on the cover letter regarding any variance from the approved budget such as:
    - Personnel changes or vacancies

- Substitutions of items budgeted under Other Costs
- Adjustments or corrections from a prior quarter

Contact name, Original Signature and contact number, Remittance Address

- **Signed Invoice (PDF)** – signed and dated in blue ink by the Agency's Fiscal agent and Program Director
- **Excel Version of the invoice** (invoicing of the approved CDPH/MCAH invoice excel workbook)
- **Signed & completed TXIX Cover Sheet** (if applicable)
- **Signed and checked Attestation form** (only applicable if there are new staffing)
- **Title V and/or Title XIX Time Studies** (if applicable)- Time Study Data Report for Summary of FFP (for all staff invoicing Title XIX Funds) and/or Title V Time Study Report for the time study month of the invoice period (for all staff in the MCAH budget invoicing Title V Funds)

For updated invoicing process, including a list of invoice deadlines please visit the CDPH/MCAH website.

Your Contract Manager and Program Consultant will review the invoice package for the correct format, accuracy and available funds. It may be returned due to incompleteness or other discrepancies that cannot be processed by Program staff.

FFP Requirements

Invoicing requirements for FFP are as follows:

1. Expenses requiring prior written approval will be reimbursed only if approval has been granted.
2. Personnel costs invoiced must be based on either a time card or a time study (for all personnel claiming FFP), rather than approved budget documents. Budget documents are only an estimate of expenditures and invoices are based on actual costs.
3. Invoices claiming FFP must be accompanied by an approved time study report for each person claiming FFP. The time study report must reflect 100% of employee's paid work time for a minimum of one full month per quarter, and at a minimum contain the following information:
   - Agency Name
   - Time study period
   - Time study month
   - First and last name of employee

- Employee classification or title
- SPMP – yes or no
- Time base – full time/part time
- Budget line number
- Percent of time studied to each program listed
- Percentage of time by activity classification
    - Enhanced – (75/25)
    - Non-Enhanced – (50/50)
    - Unmatched
- MCF for each program and/or staff listed

4. The time study summary report is contained in the Division FFP Calculation File which is available in the Forms Section of the AFA page on the MCAH website. Agencies must use the most current version of the FFP Calculation File or a Division approved alternate.
5. Negative balances (red) are not allowed on any total line.
6. When the budget is overspent in one column and underspent in another, agencies have the option to move expenses from an Enhanced rate to a Non-Enhanced rate (from 75/25 to 50/50), or from matched funds (Title XIX) to unmatched funds (Title V, SGF, agency funds).
7. Information entered on the invoice will automatically update the Fund Reconciliation Worksheet. This worksheet is used to monitor remaining fund balances and should be reviewed before submitting invoices to avoid payment reductions due to insufficient funds.

Special Considerations

MCAH provides two methods to **recoup costs from previous quarters or months** when the fiscal year has not been closed.

1. Recoup on subsequent invoices for the same fiscal year when the year is not closed out. Agencies should contact their MCAH CM for assistance with this option.
2. The Supplemental Invoice.

Costs entered as changes or adjustments from a previous quarter must be listed and described on a separate line item in the appropriate expense category. Please describe the following:

- The type of cost or line item.
- Invoice period in which the cost was incurred.

- Percentages used to distribute the costs should be the same as those used on the invoice originally submitted for the period in which the expenditures occurred.
- Any changes or adjustments must be explained on the invoice cover letter.

CBOs that submit monthly invoices have the choice to invoice using the most current information data system downloaded MCF for each month, or to use the same MCF for all three months of the quarter. At the beginning of each fiscal year CBO's that invoice monthly must decide which method to use.

Note: Federal regulations disallow the use of any federal funds for advocacy at the local, state, or federal level. Therefore, the $1,100 allocated for the semi-annual MCAH Action training conference may only be used for training and travel related expenses to assist in meeting the educational needs of the MCAH Director. This should be shown in your budget under the travel and/or training line items, as appropriate.Any expenses related in any way to advocacy must be paid from local agency funds and are not eligible for Title XIX matching funds.

Agencies are responsible for federal audit exceptions and must indemnify the State in the event any exceptions are found, such as services that were:

- Invoiced for FFP but were not eligible for FFP
- Invoiced for FFP but for which there was no proper FFP match
- Invoiced for FFP but for which Agency dollars were not expended, as invoiced, when claiming FFP
- Invoiced for FFP but were not adequately documented

MCAH approval and payment of invoices is not evidence of allowable costs. Allowable costs are determined by means of a State and/or Federal fiscal and program audit.

Supplemental Invoices

A Supplemental Invoice is to be used only when the Agency determines additional charges are necessary after all invoices have been submitted and processed by MCAH. Supplemental invoices must be pre-approved by the CM prior to submission.

If a Supplemental Invoice is being submitted, it must meet all the requirements for a standard invoice as noted above and must additionally:

- Be titled "Supplemental Invoice"
- Reflect only the amount of the supplemental billing
- Reflect the same percentage distribution as the invoice period in which the actual cost was incurred

Invoice Detail Worksheet

Invoice Detail Worksheets are nearly identical to the Budget Worksheet in format and operation, and share many of the same policies and requirements. Therefore, this Section will only note the unique differences of the Invoice Worksheets. Please refer to the Budget Documents Section for more information regarding Budget/Invoice policies, requirements and procedures.

Personnel Detail Section:

- For each staff member enter the actual fringe benefit amount for the month or quarter in which you are invoicing.
- For each staff member enter the total wages for the time period being claimed
- If matching, enter the non-enhanced and enhanced percentages.
- Enter the percent time in program for each staff member that is claiming FFP. This percentage can be found on the Time Study Data Report for Summary of FFP.

Invoice Deadlines

Invoice Deadlines for the following programs: MCAH, AFLP, BIH, CHVP SGF/MIECHV

Quarter	Inclusive Dates	Date Due to MCAH
Quarter 1	July-September	November 15th
Quarter 2	October-December	February 15th
Quarter 3	January-March	May 15th
Quarter 4	April-June	August 15th

*Approved Supplemental Invoices due September 30th

PAYMENTS

The Division is liable only for actual costs expended against the approved Program Budget and SOW.

Maximum Amount Payable

The maximum amount payable for any fiscal year cannot exceed the Division approved Agreement and Budget amounts for that fiscal year. The Agency must meet all the objectives as specified in the SOW and have incurred the actual costs to receive the maximum amount payable under an approved Agreement and Budget. Agencies are responsible for ensuring that all costs included in this proposal are allowable in accordance with the requirements of Federal award(s) to which they apply, including 45 CFR Part 75, Uniform Administrative Requirements, Cost Principles and Audit Requirements for Health and Human Services Awards.

Reimbursement Limitations

The Division will not reimburse the Agency for:

- Overtime at a rate greater than the employee's regular hourly salary
- Earned CTO
- Any services that the Agency may claim for reimbursement under any other State, Federal, Agency, or other governmental entity contract or grant, any private contract or agreement, or from the Medi-Cal program
- Any services provided under this Agreement and Budget, which are otherwise reimbursable by any third-party payer(s). The Agency must fully exhaust its ability to receive third-party reimbursement
- Any subcontract funds expended prior to Division approval may not be reimbursable in the event the Division should subsequently disapprove the proposed subcontract

If the Agency receives any third-party reimbursement for services already reimbursed by the Division, the Agency must immediately remit that amount to the Division or offset the amount against future invoices.

Recovery of Overpayments

The Division will recover overpayments to the Agency including, but not limited to, payments determined to be:

- In excess of allowable costs
- In excess of expenditures that can be supported by required time study documentation (i.e., required FFP, Title XIX matching)
- In excess of the amounts usually charged by the Agency or any of its subcontractors
- For services not documented in records of the Agency or any of its subcontractors
- For any services where the documentation of the Agency or any of its subcontractors only justifies a lower level of payment;
- Based upon false or incorrect invoices
- For services deemed to have been excessive, medically unnecessary or inappropriate
- For services arranged for or rendered by persons who did not meet the standards for participation in the program at the time the services were arranged for or provided
- For services not covered in the program SOW
- For services that should have been billed to other programs, the Medi-Cal program or any other entitlement program for which the client was eligible to receive payment for such services

Procedures

The Division has three available options for the recovery of overpayments:

1. Agency may pay the full amount in one payment
2. Agency may arrange with CDPH Accounting Section to make payments (12 months maximum)
3. Agency may request that the Division deduct the amount of over payment from a subsequent invoice(s). Repayment is to be made as soon as possible but final payment shall not exceed 12 months from the date of the discovery

Upon receipt of an audit 'Action Notice,' CDPH Accounting will send an invoice to the Agency, establish accounts receivables, and work with the Agency in determining a recovery method. All recovery activities are coordinated directly through CDPH Accounting.

Payment Withholds

The Division, at its discretion, may withhold up to 100% of any amount billed for services until the Agency complies with the provisions of the Agreement. The Division will notify the Agency in writing regarding non-compliance determinations.

This notification includes:

- The reason for each payment withhold determination
- The percentage withheld (if applicable), or the intent to withhold
- The effective date, conditions, and duration of the withhold

The Agency will be afforded reasonable opportunity to discuss with the Division and respond to the notification. Upon Agency compliance, the Division will release the amount withheld for payment to the Agency.

AUDITS

OVERVIEW

All Agencies that receive funding from the Division are expected to comply with all State and Federal funding, reporting and audit requirements per Exhibit F. State and Federal representatives have the right to monitor, audit and/or conduct on-site reviews of Agency's and/or subcontractors within reasonable times of business operation for compliance with the provisions of the Program Agreement.

The Division can conduct on-site technical assistance. On-site technical assistance is an informal review of processes initiated by either the Division or a MCAH-related program Agency.

ON-SITE TECHNICAL ASSISTANCE REVIEWS

The Division can conduct on-site technical assistance. On-site technical assistance is an informal review of processes initiated by either the Division or a MCAH-related program Agency.

The intent of these reviews is ensure program fidelity and to address agency specific challenges. Administrative and Fiscal reviews will look for potential audit problems before they are discovered in a comprehensive audit. The reviews help ensure the agency is properly prepared for an Annual Financial & Compliance and/or Comprehensive audit. An Agency can also request in writing technical assistance with program or fiscal areas of concern.

The on-site technical assistance review will consist of:

1. Entrance Meeting
2. On-site Review
3. Exit Meeting
4. Summary report of on-site review
5. Corrective Action Plan, if applicable
6. Monitoring corrective action plan, if applicable
7. Fiscal recovery plan, if applicable

Entrance Meeting

The purpose of the technical assistance review is to allow the assigned program consultant and contract manager to meet with the Agency to discuss the scope and purpose of the program. As part of the entrance meeting the team will discuss the following specifics:

- How the review will be conducted
- The Agency records that need to be made available for review
- Space for the team to work during business hours

Exit Meeting

The purpose of the exit meeting is to discuss the on-site review and any findings, if applicable.

If there are findings, the Agency will be given 2-4 weeks to provide documentation to MCAH Division in order to rectify the findings before the summary report is written.

Corrective Action Plan (CAP)

If an audit reveals that an Agency is not following required procedures or maintenance of documents, the Division will notify the Agency in writing and require that they develop and submit a Corrective Action Plan (CAP). The CAP must identify the timelines and processes the Agency will implement in order to become compliant.

Additionally, the Division can select an agency to receive a comprehensive audit by an independent third party to evaluate program and fiscal performance. Investigative audits will be in accordance with the requirements of Federal award(s) to which they apply, including 45 CFR Part 75, Uniform Administrative

Requirements, Cost Principles and Audit Requirements for Health and Human Services Awards.

TERMS AND CONDITIONS

GENERAL TERMS AND CONDITIONS

All MCAH Agreements and Budgets are subject to restrictions, limitations, or conditions enacted by Congress and/or state Legislature or any statute enacted by Congress and/or state Legislature or any court action which may affect the provisions, terms, or funding of a Program Agreement and Budget in any manner.

The Division has the option of voiding or revising a Program Agreement and Budget to reflect any reduction of funds with 30-days written notice. If any Program Agreement and Budget is deemed to be invalid, the Division will have no liability to pay any funds whatsoever to the Agency or to furnish any other considerations under this Program Agreement and Budget. If/when this occurs, the Agency is no longer obligated to perform any provisions of this Program Agreement and Budget.

Agencies that enter into agreement with the Division to provide MCAH-related services, and accept the Division funding, are legally required to provide the full level of services outlined in the program SOW regardless of the proportion of funding provided by the Division.

To review the general terms and conditions please refer to General Terms and Conditions for non-IT services contracts except for Interagency Agreements (Effective 4/4/2017).

SPECIAL TERMS AND CONDITIONS

All federally funded service contracts or agreements are subject to the California Department of Public Health rules and regulations set forth in the following exhibits.

- **Exhibit D** – CDPH Special Terms and Conditions for Cooperative Agreement in accordance to HSC 38070 (version June 2016). Please print for further details.

- **Exhibit F** – Federal Terms and Conditions for Federally Funded Subvention/Local Assistance Agreement (version June 2016). Please print for further details.

ADDITIONAL MCAH PROVISIONS

Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services exceeding $5,000 for any articles, supplies, equipment, or services. The Contractor shall obtain at least three competitive quotes which should be submitted, or adequate justification provided for the absence of bidding.

b. CDPH reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.

   (1) Upon receipt of a written notice from CDPH requiring the substitution and/or termination of a subcontract, the Contractor shall take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by CDPH.

c. Actual subcontracts (i.e. written agreement between the Contractor and a subcontractor) exceeding $5,000 are subject to the prior review and written approval of CDPH.

d. Contractor shall maintain a copy of each subcontract entered into in support of this Agreement and shall, upon request by CDPH, make copies available for approval, inspection, or audit.

e. CDPH assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.

f. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.

g. The Contractor shall ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement and shall be the subcontractor's sole point of contact for all matters related to the performance and payment during the term of this Agreement.

h. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

i. "(Subcontractor Name) agrees to maintain and preserve, until three years after termination of (Agreement Number) and final payment from CDPH to the Contractor, to permit CDPH or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."

   - Funds expended by a subcontractor prior to the primary Agency obtaining the Division written approval for the subcontract may not be reimbursable in the event the Division should subsequently disapprove the proposed subcontract.

   - The Division is liable for reimbursement only for actual costs attributed to the numbered line items identified on the Budget Summary Page that are related to the SOW.

   - The maximum amount payable to the subcontractor must be specified in the subcontract and must be equal to or less than the amount of the approved Agency AFA.

Audit and Record Retention

The Agency and/or subcontractors audit files must be kept readily available for inspection by the Division staff and/or State and Federal auditors for a period of seven years. Audit file documents and information shall include, but are not limited to books, records, documents and other evidence, accounting procedures and practices, sufficient to reflect properly all direct and indirect costs by funding source of whatever nature claimed to have been incurred in the performance of this Program Agreement and Budgets, as well as matched funding costs and expenses.

All files must be kept in a central location. If this is not possible, records are to be stored in as few locations as possible. Program and Administrative Management must be aware of the location of the files. Audit trails must comply with Government Auditing Standards that includes full documentation of costs charged or allocated (via approved cost allocation methodology).

The following information must be kept in the audit files, including all agreement documents:

1. Policy and Procedures Manual and associated Policy and Information Letters.
2. Initial fiscal year budget and all subsequent revisions.
3. SOW, duty statements, organization charts, position classifications.
4. Copies of all changes that occur to any of the documents above during the year, including the Division approvals of those changes.
5. FFP time studies (Calculation file, summary report with secondary documentation).
6. Copies of FFP calculation reports.
7. Invoices and any back-up documentation to support invoiced costs.
8. Cost allocation documentation
9. Supplemental invoice (if applicable).

Additional audit compliance requirements can be found in Exhibit F.

Capital Expenditures and Inventory Controlled Items

The Division must grant approval for the purchase of Capital Expenditures and Inventory- Controlled Items. All Capital Expenditures and Inventory-Controlled Items purchased by the Agencies or by the CDPH MCAH Program on behalf of Agencies must be necessary and used toward fulfilling the terms of the MCAH Agreement and Budget. Agencies must maintain a written inventory (CDPH 1204) of all Capital Expenditures and Inventory- Controlled Items purchased with the Division funds.

The Division may require the submission of paid vendor receipts for any purchase, regardless of dollar amount. The Division also has the right to either deny claims for reimbursement or to request repayment for any purchase determined to be unnecessary, inappropriate or unused in carrying out performance under this MCAH Agreement and Budget.

APPENDICES

- Appendix 1 - Federal Financial Participation (FFP) guidance for MCAH agencies
- Appendix 2 - Federal Financial Participation (FFP) guidance for BIH agencies
- Appendix 3 - Federal Financial Participation (FFP) guidance for AFLP agencies

APPENDIX 1 - FEDERAL FINANCIAL PARTICIPATION (FFP) GUIDANCE FOR MCAH AGENCIES

Function Code 1 - Outreach

This function code is to be used by all staff (SPMP and Non-SPMP) when performing activities that inform Medi-Cal eligible or potentially eligible individuals, as well as other clients, about health services covered by Medi-Cal and how to access the health programs. Activities include a combination of oral and written informing methods that describe the range of services available through the Medi-Cal program and the benefits of preventive or remedial health care offered by the Medi-Cal program.

Scope Activity Examples:

1. Helping client review Medi-Cal related documents for enrolling in Medi-Cal.
2. Helping client review Medi-Cal related documents for medical and mental health providers that accept Medi-Cal.
3. Providing information and assistance on transportation related to accessing Medi-Cal services.
4. Assisting client to schedule appointments that are related to Medi-Cal health services.
5. Developing Annual Community Resource Guide including Medi-Cal services and providers to increase access to care.
6. Assisting client to access Medi-Cal services or care and helping them to understand the need for treatment and follow up.
7. Developing a brochure that provides information regarding available Medi-Cal services.
8. Home Visitor/Case Manager completed assessment form with client to determine appropriate referrals to Medi-Cal services.
9. Hosting a table at a health fair and encouraging participation in Medi-Cal or services funded by Medi- Cal.

Function Code 2 – SPMP Administrative Medical Case Management

This function code is to be used only by SPMPs when participating in medical reviews; assessing the necessity for and types of medical care associated with medical case management and case coordination activities for Medi-Cal eligible required by individual Medi-Cal beneficiaries.

Scope Activity Examples:

1. Case management of Medi-Cal clients regarding a medical problem such as hypertension, gestational diabetes, pre-term labor etc. (including home visits and related activities such as chart reviews, visit preparation, charting, travel time, appointment confirmation, data collection, etc.) - refer to specialists as needed.
2. Provide assistance to develop protocols that address clinical and health issues and medical, dental and mental health services.
3. Consult with clients to assist them in understanding and identifying health problems and recognizing the need for and value of preventive health care.
4. PHN or SPMP making an assessment on a Medi-Cal client whose condition indicates further screening and referral to Medi-Cal provider.
5. Assist Medi-Cal client in contacting her physician for clarification on a specific medical condition such as gestational diabetes and its effect on her pregnancy.
6. Provide clinical expertise to the case manager about client's infant that is not achieving height/weight goals for age and its potential causes.
7. PHN or SPMP completed assessment form during Life Planning meeting with participants to determine appropriate referrals to Medi-Cal services.
8. PHN/RN consults with Medi-Cal provider in regard to client or infant's health needs.
9. SPMP consult with Mental Health provider with regards to participant mental health needs.

Function Code 3 – SPMP Intra/Interagency Coordination, Collaboration and Administration

This function code is to be used only by SPMPs when performing collaborative activities that involve planning and resource development with other agencies which will improve the cost effectiveness of the (Medi-Cal) health care delivery system and improve availability of medical services.

Scope Activity Examples:

1. SPMP participation in conference calls with other agencies to better serve Medi-Cal and Medi-Cal eligible participants to improve access to Medi-Cal services for high-risk, pregnant and postpartum clients.
2. Monitor the health status of the MCAH population including disparities and social determinants of health and work with local leadership to address identified issues.
3. Provide assistance to Medi-Cal OB providers to become CPSP providers and implement CPSP.
4. Collaborate with other agencies in planning to address unmet needs to improve access to Medi-Cal health and dental services and decrease barriers to care.
5. Work with community collaboratives, Medi-Cal and Medi-Cal Managed Care plans/providers to decrease barriers to drug treatment services for Medi-Cal enrolled pregnant and parenting women and their partners.
6. Work with California Children's Services or other collaboratives to improve care coordination for children with special health care needs.
7. SPMP attends interagency meetings to discuss and develop ways to reduce barriers and increase participation in Medi-Cal funded services.
8. Using skilled professional medical expertise, identify & interact with local health care providers, key informants in the community, managed care plans, coalitions, etc. for the purpose of:
    - Identifying gaps and services to better assist underserved populations and needs in the community.
    - Sharing data & analysis based on findings.
    - Developing shared policies or protocols to address identified needs.
    - Assisting the collaborative to develop a QA or QI plan to ensure the effectiveness of the collaborative's activities.

Function Code 4 - Non-SPMP Intra/Interagency Collaboration and Coordination

This function code is to be used by non-SPMP staff (or SPMP staff in which their medical expertise is not necessary) when performing activities that are related to program planning functions, including collaborative and intra/interagency coordination activities.

Scope Activity Examples:

1. Meet with other Public Health programs to discuss collaborative activities to better serve the Medi-Cal population.
2. Participate in conference calls to encourage providers to increase the number of Medi-Cal clients they accept and educate them on Presumptive Eligibility.
3. Coordinate logistics for MCAH Collaborative groups whose purpose includes improving access to Medi-Cal Services.
4. Contact and coordinate with dental practices in the County to develop a resource directory of services provided to Medi-Cal/Denti-Cal clients.
5. Prepare for MCAH local Advisory Board meetings to improve coordination of healthcare services in a seamless delivery system.
6. Collaborate with mental health, substance use and other agencies to identify resources that will facilitate client access to mental health/substance use services.

Function Code 5 – Program Specific Administration

This function code is to be used by all staff when performing activities that are related to (Medi-Cal) program specific administration.

Scope Activity Examples:

1. Maintaining and monitoring program information - entering all client data into a program tracking database.
2. Attending Medi-Cal outreach eligibility and enrollment training.
3. Monthly supervision meetings to identify/address gaps in service delivery and provide support to case managers in Medi-Cal enrollment and access to care.
4. Plan outreach activities to Medi-Cal eligible individuals to facilitate access and linkage to Medi-Cal enrollment and services.
5. Consult and provide technical assistance to MCAH staff regarding Medi-Cal policy development and administration.
6. Inputting time study data, reviewing time study data for invoicing.
7. Develop MCAH budget and monitor Title XIX reimbursement expenditures.
8. Under the direction of the SPMP, to improve collaboration with California Children's Services (and other relevant Medi- Cal programs); coordinate and convene stakeholder meetings.
9. Assisting the SPMP to implement MCAH including policies and procedures that support the Medi-Cal population.
10. Training and orientation for use of FFP for non SPMP staff.

Function Code 6 – SPMP Training

This function code is to be used only when training is provided for or by SPMPs and only when the training activities directly relate to the SPMP's performance of specifically allowable SPMP administrative activities.

Scope Activity Examples:

1. Attending training on new treatment modalities for pregnant and postpartum women including hypertension, mental health issues, etc.
2. Using skilled medical expertise to present or conduct professional training to health care providers that will improve quality of care i.e. risk factors for prematurity, LBW, infant mortality.
3. Attend expert trainings and professional education in-services relevant to the role of the medical professional and to administration of MCAH Programs to facilitate access to Medi-Cal services.
4. Attend professional education for SPMP Medical Case Management to increase skills of SPMP to better facilitate access to care for Medi-Cal clients and Medi-Cal eligible.
5. SPMP specific activities of New Director's (must be SPMP) Training related to barriers and access to care of Medi-Cal and Denti-Cal services.
6. Orientation and training of new SPMP staff regarding FFP rules and regulations as they pertain to an SPMP.
7. Travel related to any of the above mentioned trainings.

Function Code 7 – Non-SPMP Training

This function code is to be used by all staff (SPMP and Non-SPMP) when training relates to Non-SPMP allowable (Medi-Cal) administrative activities and to the medical care of clients.

Scope Activity Examples:

1. C.M.s/Supervisors receive training on infant/maternal mortality, LBW, and prematurity to facilitate client enrollment and linkage to appropriate Medi-Cal services.
2. CM's/Supervisors receive instruction or provide staff training on how to complete the FFP Log and secondary documentation.
3. Training a new staff member to their responsibilities relative to Medi-Cal enrollment and referral services.
4. Training Community Health Workers in areas of health related topics and assisting clients to access medical care.
5. Staff attending a Health Disparities training including barriers to enrollment in Medi-Cal.
6. Travel related to any of the above trainings.

Function Code 8 – SPMP Program Planning and Policy Development

This function code is to be used only by SPMPs and only when performing (Medi-Cal) program planning and policy development activities. The SPMP's tasks must officially involve program planning and policy development, and those tasks must be identified in the employee's position description/duty statement.

Scope Activity Examples:

1. Meeting with Medi-Cal providers to develop referral protocols for women with risk factors for adverse birth outcomes.
2. Meeting with dental providers to increase access to dental services for pregnant or postpartum women.
3. Review of local perinatal statistics to identify gaps in services in order to develop strategies to address adequacy of services related to birth outcomes.
4. Develop professional health related educational materials for MCAH staff training to meet policy directives.
5. Reviewing and modifying Policies and Procedures including Medi-Cal enrollment eligibility, referral processes and barriers to access to care.
6. Participate in the planning, implementation, and evaluation of MCAH services that relate to the Medi-Cal programs.
7. MCAH Directors and PSC's work with Medi-Cal Managed Care plans to ensure access to appropriate care.
8. Provide technical assistance to ensure policies increase access to/ utilization of Medi-Cal services.

Function Code 9 – Quality Management by Skilled Professional Medical Personnel

This function code is to be used only by SPMPs and only when performing quality management activities (that benefit the Medi-Cal eligible population).

Scope Activity Examples:

1. Reviewing client charts for quality case management to ensure appropriate follow-up and access to Medi-Cal services.
2. Reviewing staff work, e.g. time study and secondary documentation for meeting the FFP requirements.
3. Assess and review the capacity of the agency and its providers to deliver medically appropriate health assessment, preventive health services and medical care, and respond to appeals on medical quality of care issues.
4. Assess and review population needs and capacity of the agency to provide services or the need to refer to appropriate Medi-Cal services.
5. Develop, implement and monitor MCAH program implementation and outcome data for quality assurance.

Function Code 10 – Non-Program Specific General Administration

This function code is to be used by all staff when performing non-program specific administrative activities that relate to multiple functions or to no specific, identifiable functions due to the general nature of the activities. This is an allocated function code. Time recorded under this function code will be prorated amongst all programs (BIH, MCAH, AFLP etc.) included in the time study and matched and unmatched function codes. The portion allocated as matchable may only be matched at the Non-Enhanced rate.

Scope Activity Examples:

1. Attend Public Health Safety Meeting.
2. Management Academy classes, annual mandatory Airborne/Blood Borne Pathogen Training.
3. Develop and provide health promotion activities for agency employees.
4. Staff attend agency meetings and non-MCAH related trainings such as HIPAA, Safety Training, Sexual Harassment.

Function Code 11 – Other Activities

This function code is to be used by all staff to record time performing activities which are in the AFLP SOW but not specific to the administration of the Medi-Cal program. These activities do not qualify for FFP match.

Scope Activity Examples:

1. Client events including workshops, graduation, parenting, health education, and domestic violence classes.
2. Meeting with a MCAH client to help them create an educational or career plan.
3. Home visits or portions thereof with clients that focus on non Medi-Cal covered services.
4. Outreach, program planning and policy development activities of non-Medi-Cal programs financed by other federal and state programs.
5. All SIDS risk reduction educational activities.
6. Assistance to obtain shelter, housing, transportation to non-Medi-Cal related services.

Function Code 12 – Paid Time Off

This function code is to be used by all staff to record usage of paid leave, holiday, vacation, sick leave or any paid leave other than CTO. This is an allocated function code. Time recorded under this function code will be prorated amongst all programs (BIH, MCAH, AFLP etc.) included in the time study and matched and unmatched function codes. CMS permits the matchable amount to be proportionately distributed between the Enhanced rate and the Non-Enhanced rate.

Scope Activity Examples:

1. Paid time off for a Holiday.
2. Paid time off for sick leave.
3. Paid time off for vacation.
4. Paid time off for jury duty.

APPENDIX 2 - FEDERAL FINANCIAL PARTICIPATION (FFP) GUIDANCE FOR BIH AGENCIES

Function Code 1 – Outreach

This function code is to be used by all staff (SPMP and Non-SPMP) when performing activities that inform Medi-Cal eligible or potentially eligible individuals, as well as other clients, about health services covered by Medi-Cal and how to access the health programs. Activities include a combination of oral and written informing methods that describe the range of services available through the Medi-Cal program and the benefits of preventive or remedial health care offered by the Medi-Cal program.

1. FHA completed assessment form during Life Planning meetings with participants to determine appropriate referrals to Medi-Cal services.
2. Helping client review Medi-Cal related documents for enrolling in Medi-Cal.
3. Helping client review Medi-Cal related documents for medical and mental health providers that accept Medi-Cal.
4. Providing information and assistance on transportation related to accessing Medi-Cal services.
5. Assisting client to schedule appointments that are related to Medi-Cal health services.
6. Developing Annual Community Resource Guide including Medi-Cal services and providers to increase access to care.
7. Assisting client to access Medi-Cal services or care and helping them to understand the need for treatment and follow up.
8. Developing a brochure that provides information regarding available Medi-Cal services.
9. Hosting a table at a health fair and encouraging participation in Medi-Cal or services funded by Medi- Cal.
10. Non-SPMPs may use this code when providing case management/care coordination that meets the FFP objectives.

Function Code 2 – SPMP Administrative Medical Case Management

This function code is to be used only by SPMPs when participating in medical reviews; assessing the necessity for and types of medical care associated with medical case management and case coordination activities required by individual Medi-Cal beneficiaries.

Scope Activity Examples:

1. Case management of Medi-Cal clients regarding a medical problem such as hypertension, gestational diabetes, pre-term labor etc. (including home visits and related activities such as chart reviews, visit preparation, charting, travel time, appointment confirmation, data collection, etc.) - refer to a Medi-Cal specialist as needed.

1. Provide assistance to develop protocols that address clinical issues, including medical, dental and mental health services.

2. Consult with clients to assist them in understanding and identifying health problems and recognizing the need for and value of preventive health care - refer to Medi-Cal provider as needed.

3. PHN or MHP making an assessment on a Medi-Cal client whose condition indicates further screening and referral to Medi-Cal provider.

4. Assist Medi-Cal client in contacting her physician for clarification on a specific medical condition such as gestational diabetes and its effect on her pregnancy.

5. Provide clinical expertise to the case manager about client's infant that is not achieving height/weight goals for age and its potential causes.

6. PHN or MHP completed assessment form during Life Planning meetings with participants to determine appropriate referrals to Medi-Cal services.

7. PHN/RN Consult with Medi-Cal provider in regard to client or infant's health needs.

8. MHP Consult with Mental Health provider in regard to participant mental health needs.

Function Code 3 – SPMP Intra/Interagency Coordination, Collaboration and Administration

This function code is to be used only by SPMPs when performing collaborative activities that involve planning and resource development with other agencies which will improve the cost effectiveness of the (Medi-Cal) health care delivery system and improve availability of medical services.

Scope Activity Examples:

1. SPMP participation in conference calls with other agencies to better serve Medi-Cal and Medi-Cal eligible participants to improve access to Medi-Cal services for high-risk, pregnant and postpartum clients.
2. Collaborate with other agencies in health care planning and resource development to improve the access and quality of the health care delivery system and decrease barriers in accessing Medi-Cal health and dental services.
3. Work with community collaborative, Medi-Cal and Medi-Cal Managed Care plans/providers to decrease barriers to drug treatment, mental health and prenatal care services for Medi-Cal enrolled pregnant and parenting women.
4. SPMP attending interagency meetings to discuss ways to reduce barriers and increase participation in Medi-Cal funded services.
5. Using skilled professional medical expertise, identify and interact with local health care providers, key informants in the community, managed care plans, coalitions, etc. for the purpose:
    - Identifying gaps and services to better assist underserved populations and needs in the community.
    - Sharing data and analysis based on findings.

Function Code 4 – Non-SPMP Intra/Interagency Collaboration and Coordination

This function code is to be used by non-SPMP staff (or SPMP staff in which their medical expertise is not necessary) when performing activities that are related to program planning functions, including collaborative and intra/interagency coordination activities.

Scope Activity Examples:

1. Meet with other Public Health programs to discuss collaborative activities to serve the Medi-Cal population.
2. Participate in discussions with perinatal providers to encourage them to increase the number of Medi- Cal clients they accept and educate them on Presumptive Eligibility.
3. Coordinate logistics for BIH Collaborative groups, BIH Advisory Board and others whose purpose includes improving access to Medi-Cal Services. This may include creating MOUs/interagency agreements for the coordination of services and/or referrals.
4. Contact and coordinate with dental practices in the County to develop a resource directory of services provided to Medi-Cal/Denti-Cal clients.
5. Collaborating with mental health, substance abuse and other agencies to link clients to services.

Function Code 5 – Program Specific Administration

This function code is to be used by all staff when performing activities that are related to (Medi-Cal) program specific administration.

Scope Activity Examples:

1. Maintaining and monitoring program information - entering all client data into the ETO.
2. Attending Medi-Cal outreach eligibility and enrollment training.
3. Monthly supervision meetings to identify/address areas of concern in service delivery and provide support to case managers in Medi-Cal enrollment and access to care.
4. Plan CM activities including outreach regarding Medi-Cal and Medi-Cal covered services.
5. Consults with BIH staff to review job performance activities, client caseloads, including enrolling in Medi-Cal and access to care, and provide supervision.
6. Inputting time study data, reviewing time study data for invoicing.
7. Develop BIH budget and monitor Title XIX reimbursement expenditures.
8. Assisting the SPMP to implement BIH including policies and procedures that support the Medi-Cal population. For example, how to do outreach / how to do referrals / how to connect with Medi-Cal.
9. Training and orientation for use of FFP for non SPMP staff.

Function Code 6 – SPMP Training

This function code is to be used only when training is provided for or by SPMPs and only when the training activities directly relate to the SPMP's performance of specifically allowable SPMP administrative activities.

Scope Activity Examples:

1. Attending training on new treatment modalities for pregnant and postpartum women including hypertension, Mental Health issues, etc.
2. Using skilled medical expertise to present or conduct professional training to health care providers that will improve quality of care i.e. risk factors for prematurity, LBW, infant mortality.
3. Attend expert trainings and professional education in-services relevant to the role of the medical professional and to administration of BIH Programs to facilitate access to Medi-Cal services.
4. Attend professional education for SPMP Medical Case Management to increase skills of SPMP to better facilitate access to care for Medi-Cal clients and Medi-Cal eligible.
5. SPMP specific activities. Training for new Director's on Medi-Cal related topics such as training related to barriers and access to care of Medi-Cal and Denti-Cal services.
6. Orientation and training of new SPMP staff regarding FFP rules and regulations as they pertain to an SPMP.

Function Code 7 – Non-SPMP Training

This function code is to be used by all staff (SPMP and Non-SPMP) when training relates to Non-SPMP allowable (Medi-Cal) administrative activities and to the medical care of clients.

Scope Activity Examples:

1. C.M.s/Supervisors receive training on infant/maternal mortality, LBW, preventative health care and prematurity to facilitate client enrollment and linkage to appropriate Medi-Cal services.
2. CM's/Supervisors receive instruction or provide staff training on how to complete the FFP time study and secondary documentation.
3. Training a new staff member to their responsibilities relative to Medi-Cal enrollment and referral services.
4. Provide training to external Community Health Workers in areas of health related topics and assisting clients to access medical care.
5. PHN or MHP assessing medical or mental health needs of participants in order to facilitate referrals.
6. The portion of trainings, orientations or meetings that are related to health disparities, FFP or Medi-Cal services.

Function Code 8 – SPMP Program Planning and Policy Development

This function code is to be used only by SPMPs and only when performing (Medi-Cal) program planning and policy development activities. The SPMP's tasks must officially involve program planning and policy development, and those tasks must be identified in the employee's position description/duty statement.

Scope Activity Examples:

1. MCAH director, PSC, BIH coordinator meeting with Medi-Cal providers to develop referral protocols for women with risk factors for adverse birth outcomes.
2. Meeting with dental providers to increase access to dental services for pregnant or postpartum women.
3. Review of local perinatal statistics to identify gaps in services in order to develop strategies to address adequacy of services related to birth outcomes.
4. Develop professional educational materials for BIH staff training to meet policy instructions.
5. Reviewing and modifying policies and procedures including Medi-Cal enrollment eligibility, referral processes and barriers to access care.
6. Participate in the planning, implementation, and evaluation of BIH services that relate to the Medi-Cal programs.
7. Staff attending a Health Disparities training including barriers to enrollment in Medi-Cal services and access to care.

Function Code 9 – Quality Management by Skilled Professional Medical Personnel

This function code is to be used only by SPMPs and only when performing quality management activities (that benefit the Medi-Cal eligible population).

Scope Activity Examples:

1. Reviewing client charts for quality case management to ensure appropriate follow-up and access to Medi-Cal services.
2. Reviewing staff work, e.g. time study and secondary documentation for meeting the FFP requirements.
3. Implement continuous quality improvement activities as stated in the BIH Policies and Procedures manual.
4. Assess and review population needs and capacity of the agency to provide services or the need to refer to appropriate Medi-Cal services.
5. Develop, implement and monitor BIH quality assurance for ETO data.

Function Code 10 – Non-Program Specific General Administration

This function code is to be used by all staff when performing non-program specific administrative activities that relate to multiple functions or to no specific, identifiable functions due to the general nature of the activities. This is an allocated function code. Time recorded under this function code will be prorated amongst all programs (BIH, MCAH, AFLP etc.) included in the time study and matched and unmatched function codes. The portion allocated as matchable may only be matched at the Non-Enhanced rate.

Scope Activity Examples:

1. Agency related activities, such as, fire drills.
2. Management Academy classes, annual mandatory Airborne/Bloodborne Pathogen Training.
3. Develop and provide health promotion activities for agency employees.
4. Staff attend agency meetings and non-BIH related trainings such as HIPAA, Safety Training, Sexual Harassment or County New Employee Orientation.

Function Code 11 – Other Activities

This function code is to be used by all staff to record time performing activities which are in the BIH SOW but not specific to the administration of the Medi-Cal program. These activities do not qualify for FFP match.

Scope Activity Examples:

1. Client events including workshops, graduation, parenting, health education, and domestic violence classes that do not result in a Medi-Cal referral.
2. Meeting with a BIH client to help them create an educational or career plan.
3. Home visits with clients that focus on non-medical issues such as relationships, child development and parenting concerns.
4. Program planning for "Social Support and Empowerment" activities.
5. All SIDS risk reduction educational activities.
6. Assistance to obtain shelter, housing, car seats, transportation (basic needs).

Function Code 12 – Paid Time Off

This function code is to be used by all staff to record usage of paid leave, holiday, vacation, sick leave or any paid leave other than CTO. This is an allocated function code. Time recorded under this function code will be prorated amongst all programs (BIH, MCAH, AFLP etc.) included in the time study and matched and unmatched function codes. CMS permits the matchable amount to be proportionately distributed between Enhanced and Non-Enhanced rates.

Scope Activity Examples:

1. Paid time off for a holiday.
2. Paid time off for sick leave.
3. Paid time off for vacation.
4. Paid time off for jury duty.

APPENDIX 3 - FEDERAL FINANCIAL PARTICIPATION (FFP) GUIDANCE FOR AFLP AGENCIES

Function Code 1 Outreach

This function code is to be used by all staff (SPMP and Non-SPMP) when performing activities that inform Medi-Cal eligible or potentially eligible individuals, as well as other clients, about health services covered by Medi-Cal and how to access the health programs. Activities include a combination of oral and written informing methods that describe the range of services available through the Medi-Cal program and the benefits of preventive or remedial health care offered by the Medi-Cal program.

Scope Activity Examples:

1. Case manager completed assessment form during visits with participants to determine appropriate referrals to Medi-Cal services.
2. Helping client review Medi-Cal related documents for enrolling in Medi-Cal.
3. Helping client review Medi-Cal related documents for medical and mental health providers that accept Medi-Cal.
4. Providing information and assistance on transportation related to accessing Medi-Cal services.
5. Assisting client to schedule appointments that are related to Medi-Cal health services.
6. Developing and/or distributing a resource guide including Medi-Cal services and providers to increase access to care.
7. Assisting client to access Medi-Cal services or care and helping them to understand the need for treatment and follow up.
8. Hosting a table at a health fair and encouraging participation in Medi-Cal or services funded by Medi- Cal.

Function Code 2 SPMP Administrative Medical Case Management

This function code is to be used only by SPMPs when participating in medical reviews; assessing the necessity for and types of medical care associated with medical case management and case coordination activities for Medi-Cal eligible required by individual Medi-Cal beneficiaries.

Scope Activity Examples:

1. Case management of Medi-Cal clients regarding a medical problem such as hypertension, gestational diabetes, pre-term labor etc. (including home visits and related activities such as chart reviews, visit preparation, charting, travel time, appointment confirmation, data collection, etc.) - refer to specialists as needed.
2. PHN or MHP assessing medical or mental health needs of participants in order to facilitate referrals.

Function Code 3 SPMP Intra/Interagency Coordination, Collaboration and Administration

This function code is to be used only by SPMPs when performing collaborative activities that involve planning and resource development with other agencies which will improve the cost effectiveness of the (Medi-Cal) health care delivery system and improve availability of medical services.

Scope Activity Examples:

1. SPMP participation in conference calls with other agencies to better serve Medi-Cal and Medi-Cal eligible participants to improve access to Medi-Cal services for high-risk, pregnant and postpartum clients.

2. Collaborate with other agencies in planning to address unmet needs to provide access to Medi-Cal health and dental services and decrease barriers to care.

3. Work with community collaborative, Medi-Cal and Medi-Cal Managed Care plans/providers to decrease barriers to drug treatment services for Medi-Cal enrolled pregnant and parenting women.

4. SPMP attending interagency meetings to discuss ways to reduce barriers and increase participation in Medi-Cal funded services.

5. Using skilled professional medical expertise, identify & interact with local health care providers, key informants in the community, managed care plans, coalitions, etc. for the purpose: identifying gaps and services to better assist underserved populations and needs in the community sharing data& analysis based on findings

Function Code 4 Non-SPMP Intra/Interagency Collaboration and Coordination

This function code is to be used by non-SPMP staff (or SPMP staff in which their medical expertise is not necessary) when performing activities that are related to program planning functions, including collaborative and intra/interagency coordination activities.

Scope Activity Examples:

1. Meet with other public health, education, and other community programs to discuss collaborative activities to serve the Medi-Cal population.
2. Office Assistant staff coordinate logistics for AFLP Collaborative groups whose purpose includes improving access to Medi- Cal Services.
3. Contact and coordinate with dental practices in the County to develop a resource directory of services provided to Medi-Cal/Denti-Cal clients.
4. Collaborating with mental health, substance abuse and other agencies to link clients to services.

Function Code 5 Program Specific Administration

This function code is to be used by all staff when performing activities that are related to (Medi-Cal) program specific administration.

Scope Activity Examples:

1. Maintaining and monitoring program information - entering all client data into Lodestar.
2. Attending Medi-Cal outreach eligibility and enrollment training.
3. Monthly supervision meetings to identify/address areas of concern in service delivery and provide support to case managers in Medi-Cal enrollment and access to care.
4. Plan CM activities including outreach regarding Medi-Cal and Medi-Cal covered Services.
5. Consults with AFLP staff to review job performance activities, client caseloads, including enrolling in Medi-Cal and access to care, and provide supervision.
6. Inputting time study data, reviewing time study data for invoicing.
7. Develop AFLP budget and monitor Title XIX reimbursement expenditures.
8. Assisting the SPMP to implement AFLP including policies and procedures that support the Medi-Cal population. For example, how to do outreach / how to do referrals / to connect with Medi-Cal.
9. Develop training and orientation for use of FFP for non SPMP staff.

Function Code 6 SPMP Training

This function code is to be used only when training is provided for or by SPMPs and only when the training activities directly relate to the SPMP's performance of specifically allowable SPMP administrative activities.

Scope Activity Examples:

1. Attending training on new treatment modalities for pregnant and postpartum women including hypertension, mental health issues, etc.
2. Using skilled medical expertise to present or conduct professional training to health care providers that will improve quality of care i.e. trauma informed care, risk factors for prematurity, LBW, infant mortality.
3. Attend expert trainings and professional education in-services relevant to the role of the medical professional and to administration of AFLP programs to facilitate access to Medi-Cal services.
4. Attend professional education for SPMP Medical Case Management to increase skills of SPMP to better facilitate access to care for Medi-Cal clients and Medi-Cal eligible.
5. SPMP Specific activities. Training for new Director/Coordinator on Medi-Cal related topics such as training related to barriers and access to care of Medi-Cal and Denti-Cal services.
6. Orientation and training of new SPMP staff regarding FFP rules and regulations as they pertain to an SPMP.

Function Code 7 Non-SPMP Training

This function code is to be used by all staff (SPMP and Non-SPMP) when training relates to Non-SPMP allowable (Medi-Cal) administrative activities and to the medical care of clients.

Scope Activity Examples:

1. CMs/Supervisors receive training on prenatal heath, interconception health, infant/maternal mortality, LBW, and prematurity to facilitate client enrollment and linkage to appropriate Medi-Cal services.
2. CM's/Supervisors receive instruction or provide staff training on how to complete the FFP Log and secondary documentation.
3. Training a new staff member to their responsibilities relative to Medi-Cal enrollment and referral services.
4. Training CMs in areas of health related topics and assisting clients to access Medi-Cal services.
5. Staff attending a health disparities training that addresses barriers to enrolling or accessing Medi-Cal services.

Function Code 8 SPMP Program Planning and Policy Development

This function code is to be used only by SPMPs and only when performing (Medi-Cal) program planning and policy development activities. The SPMP's tasks must officially involve program planning and policy development, and those tasks must be identified in the employee's position description/duty statement.

Scope Activity Examples:

1. AFLP Director/Coordinator meeting with Medi-Cal providers to develop referral protocols.
2. Meeting with dental providers to increase access to dental services for program participants.
3. Review data and conduct community needs assessments related to improving program-related outcomes, including identifying service gaps and developing strategies to improve services, and access to services.
4. Develop educational materials for AFLP staff training to meet Medi-Cal policy directives.
5. Reviewing and modifying policies and procedures, including Medi-Cal enrollment eligibility, referral processes and barriers to access to care.
6. Participate in the planning, implementation, and evaluation of AFLP services that relate to the Medi-Cal programs.

Function Code 9 Quality Management by Skilled Professional Medical Personnel

This function code is to be used only by SPMPs and only when performing quality management activities (that benefit the Medi-Cal eligible population).

Scope Activity Examples:

1. Reviewing client charts or other quality improvement activity to ensure appropriate follow-up and access to Medi-Cal services.
2. Reviewing staff work, e.g. time study and secondary documentation for meeting the FFP requirements.
3. Assess and review population needs and capacity of the agency to provide services or the need to refer to appropriate Medi- Cal services.
4. Develop, implement and monitor Medi-Cal quality assurance for Lodestar data.

Function Code 10 Non-Program Specific General Administration

This function code is to be used by all staff when performing non-program specific administrative activities that relate to multiple functions or to no specific, identifiable functions due to the general nature of the activities. This is an allocated function code. Time recorded under this function code will be prorated amongst all programs (BIH, MCAH, AFLP etc.) included in the time study and matched and unmatched function codes. The portion allocated as matchable may only be matched at the Non-Enhanced rate.

Scope Activity Examples:

1. Agency related activities, such as, fire drills.
2. Attend Public Health Safety Meeting.
3. Management Academy classes, annual mandatory Airborne/Blood borne Pathogen Training.
4. Develop and provide health promotion activities for agency employees.
5. Staff attend agency meetings and non-AFLP related trainings such as HIPAA, Safety Training, Sexual Harassment.

Function Code 11 Other Activities

This function code is to be used by all staff to record time performing activities which are in the AFLP SOW but not specific to the administration of the Medi-Cal program. These activities do not qualify for FFP match.

Scope Activity Examples:

1. Client events including workshops, graduation, parenting, health education.
2. Meeting with an AFLP client to help develop goals and a life plan.
3. Home visits or portions thereof with clients that focus on non Medi-Cal covered services.
4. Outreach, program planning and policy development activities of non-Medi-Cal programs financed by other federal and state programs.
5. All SIDS risk reduction educational activities.
6. Assistance to obtain shelter, housing, transportation to non-Medi-Cal related services.

Function Code 12 Paid Time Off

This function code is to be used by all staff to record usage of paid leave, holiday, vacation, sick leave or any paid leave other than CTO. This is an allocated function code. Time recorded under this function code will be prorated amongst all programs (BIH, MCAH, AFLP etc.) included in the time study and matched and unmatched function codes. CMS permits the matchable amount to be proportionately distributed between the Enhanced rate and the Non-Enhanced rate.

Scope Activity Examples:

1. Paid time off for a holiday.
2. Paid time off for sick leave.
3. Paid time off for vacation.
4. Paid time off for jury duty.

GLOSSARY OF TERMS AND ACRONYMS

Term	Definition
A&I	Audits & Investigations Division, DHCS.
ACTUAL COST	The actual price paid for real bona fide purchase costs of goods and services pursuant to the conduct of the MCAH Agreement and Budget.
AFA	Agreement Funding Application (AFA). The agreement between the Division and the Agencies to administer the MCAH programs. This includes, but is not limited to, the SOWs, Budget Documents, and Policies and Procedures.
AFLP	Adolescent Family Life Program (AFLP).
AGENCY	A Local Health Jurisdiction (LHJ); i.e., city or county health department or Community Based Organization, responsible for the public health needs in that designated geographic area. In California there are 61 Local Health Jurisdictions, 58 county public health departments and 3 city public health departments (Berkeley, Long Beach & Pasadena).
AGENCY FUNDS	Agency contributions towards the budget to help fund the activities needed to fulfill the program SOW.
ALLOWABLE COST	Costs incurred which are necessary to meet the provisions of the SOW and are approved in the MCAH Agreement and Budget.
BASE COST PER UNIT	The purchase price of an item, excluding tax, delivery, installation charged, etc.
BUDGET REVISION	A revision in the previously approved budget to change line items and/or amounts.
CAPITAL EXPENDITURES	Major Equipment with a base cost per unit of $5,000 or more and a useful life expectancy of one or more years, including Telecommunications, and Electronic Data Processing/ Automated Data Processing software
CBO	A Community Based Organization (CBO), a non-profit organization which works to serve the disadvantaged in the community in which it is located.
CDHS	The California Department of Health Services (CDHS) was split into two departments; the California Department of Public Health (CDPH) & the Department of Health Care Services (DHCS), effective July 1, 2007.
CDPH	California Department of Public Health (formerly a component of the CDHS), formed July 1, 2007.
CDPH 1203	*Contractor's Equipment Purchased with CDPH Funds* is a form to track Contractor equipment and miscellaneous property which is purchased with CDPH funds and is used to conduct state business under the contract.

Term	Definition
CDPH 1204	Inventory/Disposition of CDPH Funded Equipment form for inventory and disposition of equipment purchased with CDPH funds.
CMS	Centers for Medicaid and Medicare Services (CMS).
CONFIDENTIAL INFORMATION	Any information containing patient identifier, including but not limited to: • Names • Address • Telephone number • Social Security number • Medical identification number • Driver license number
CONTRACT (CM)	A Division staff assigned to an agency, who provides MANAGER consultation concerning fiscal direction and issues such as Budget development and Invoicing.
CORRECTIVE ACTION PLAN (CAP)	If an audit reveals that an Agency is not following required procedures or maintenance of documents, the CDPH MCAH Division will instruct the Agency to develop a Corrective Action Plan (CAP). The CAP will define the corrective actions the Agency must implement to become compliant. The CAP must be reviewed and approved by Division staff.
CPSP	Comprehensive Perinatal Services Program (CPSP) is an obstetrical, psychosocial, nutritional, and health education services and related case coordination provided by or under the personal supervision of an approved CPSP provider during pregnancy and 60 calendar days following delivery.
CTO	Compensatory Time Off (CTO), time off in lieu of overtime pay.
DHCS	Department of Health Care Services (DHCS), formerly the California Department of Health Services (CDHS), renamed July 1, 2007.
DUTY STATEMENT	Defined activities specific to program and position requirements and are considered legal and contractual obligations which can be audited.
ENHANCED RATE	Federal Title XIX reimbursement of eligible approved costs at the ratio of 75% federal dollars to 25% State or Agency general fund dollars.
FFP	Federal Financial Participation (FFP) program is a funding mechanism used to generate additional revenue by reimbursing Agency or State funds with Title XIX dollars at an Enhanced and/or Non-enhanced rate for the proper and efficient administration of the Medi-Cal program's two objectives.
FRINGE BENEFITS	Employer contributions for employer portion of payroll taxes (i.e., FICA, SUI, SDI, Training), Employee health plans (i.e., health, dental, and vision),

Term	Definition
	Unemployment Insurance, Workers Compensation Insurance, and Employer's portion of pension. Retirement plans are included, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.
FTE	Full-Time-Equivalent (FTE) means a standard eight-hour workday; 40 hours per week; or 2,080 hours per year.
GOALS	Goals are overall statements of the mission and purpose of the program or an individual program component.
GOOD CAUSE	Circumstances which are beyond the control of the agency and includes, but is not limited to: • Damage to or destruction of the Agency's business office and/or records by a natural disaster, including fire, flood, or earthquake or when circumstances involving such disaster have substantially delayed Agency's operations. • Theft, sabotage, or other deliberate, willful acts by an employee that have been reported to the appropriate law enforcement or fire agency when applicable. • Other circumstances that are clearly beyond the control of the Agency that have been reported to the appropriate law enforcement or fire agency when applicable. • Failure by the Division to fully execute the MCAH Agreement and Budget later than six months after the MCAH Agreement and Budget start date. • Untimely illness or absence of any employee trained to prepare invoices, reports, or Budget Revisions. This does not include an Agency vacancy. All circumstances will be reviewed and approved/disapproved on a case-by-case basis by Division management. • Failure by the Division to fully execute revisions before the MCAH Agreement and Budget's termination, expiration date, or fiscal year end.
INDIRECT COSTS	Those costs which are within the Agency and cannot be clearly identified as expenses to direct program costs. The calculation is based on Total Wages (excluding benefits) from the Personnel Detail Worksheet.
JOB SPECIFICATION	County civil service classification describing standard educational and experience requirements for appointment to specific positions. Job Specification can be referred to as a classification specification

Term	Definition
LHJ	A Local Health Jurisdiction (LHJ), i.e., city or county health department, responsible for the public health needs in that designated geographic area
MAA	Medi-Cal Administrative Activities (MAA).
MAJOR EQUIPMENT	A tangible or intangible item having a base unit cost of $5,000 or more with a life expectancy of one (1) year or more and is either furnished by CDPH or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.
MCAH	Maternal, Child and Adolescent Health (MCAH).
MCAH DIRECTOR	The Maternal, Child and Adolescent Health (MCAH) Director is an individual appointed by the Agency who is responsible for carrying out the terms and conditions of the MCAH program Agreement and Budget.
MCAH-RELATED PROGRAMS	Programs operated under the CDPH MCAH Division and accountable to follow the policies set forth in this manual; MCAH, AFLP, FIMR, SIDS, BIH and CHVP.
MCF	The Medi-Cal Factor (MCF) is a percentage that identifies the portion of the region's general population receiving MCAH-related services that are Medi-Cal beneficiaries. The MCF is one of two components that determine Title XIX claiming amounts.
MEDI-CAL	California's Medicaid program that provides healthcare and service to those who meet Medi-Cal eligibility requirements.
MEDI-CAL ELIGIBLE	Individuals who have applied for and been granted Medi-Cal benefits, as well as the Medi-Cal potential eligible population (i.e., the population at the poverty rate qualified to receive Medi-Cal benefits).
MEDS	Medi-Cal Eligibility Data System (MEDS).
MINOR EQUIPMENT	A tangible item having a base unit cost of less than $5,000 with a life expectancy of one (1) year or more and is either furnished by CDPH or the cost is reimbursed through this Agreement.
NON-ENHANCED FUNDING	Federal Title XIX reimbursement of eligible approved costs at the ratio of 50% federal dollars to 50% State or Agency general fund dollars.
OMB Circular A-133	Federal Office of Management and Budget (OMB), in reference to Circular A-133, Audits of states, local governments and non-profit organizations.
ORGANIZATION CHART	A diagram illustrating the interrelationship of the local health jurisdiction staff associated with all MCAH-funded programs.
OUTREACH	Activities to inform and/or connect persons to available services or care.

Term	Definition
PROGRAM CONSULTANT (PC)	A Division staff person, assigned to an agency or program, that provides skilled expertise in the areas of program standards, SOW, personnel, program policy development, and quality improvement.
PSC	Perinatal Services Coordinator (PSC) is the person, in collaboration with the MCAH Director, responsible for the implementation of the CPSP in the LHJ.
QA	Quality Assurance (QA). A program for the systematic monitoring, evaluation, and improvement of the various aspects of a program, entity or group.
SALARY SAVINGS	Salary savings are a result of unfilled positions and reduced FTEs and are not allowable in AFLP without Contract Manager Approval. The criteria is that services provided should not be diminished to cover operational expenses. Please consult the MCAH Program Consultant or Contract Manager.
SECONDARY DOCUMENTATION	Secondary documentation gives support to the claiming of matchable FFP funding, can be requested by the Division to verify high percentages of FFP matching, and is reviewed during on-site audits to verify the percentage of FFP matching.
SGF	State General Fund (SGF).
SIDS	Sudden Infant Death Syndrome (SIDS).
SOW	A Scope of Work (SOW) is a component in the MCAH Agreement and Budget which contains the goals, objectives and methods of evaluation to be met under the terms and conditions of this MCAH Agreement and Budget.
SPMP	Skilled Professional Medical Personnel (SPMP) have the education and training at a professional level in the field of medical care or of an appropriate medical practice.
SUBCONTRACT	A written agreement between the Agency and a subcontractor specifically related to securing or fulfilling the Agency's obligation to the Division under the terms of the MCAH Agreement and Budget.
TCM	Targeted Case Management (TCM), a Medicaid program.
TIME STUDY	A method to record time spent on all activities for those staff claiming FFP.
TITLE V FUNDS	Unmatchable federal MCAH Block Grant funds authorized under Title V of the federal Social Security Act.
TITLE XIX FUNDS	Federal Medicaid money obtained under Title XIX of the federal code by means of State and/or local revenue match for costs of activities related to eligible and potentially eligible Medi-Cal women and children.
WIC	Women, Infants and Children (WIC) Supplemental Food Program, USDA, a Federal funded nutrition program.