Washington State Health Care Authority

Medicaid Administrative Claiming Cost Allocation Plan *For*

Local Health Jurisdictions

effective April 1, 2020

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Contents

INTRODUCTION

The Medicaid program is a national health care program established under Title XIX of the Social Security Act and administered by the federal Centers for Medicare and Medicaid Services (CMS). The Medicaid program furnishes medical assistance to families or individuals who are aged, blind, or disabled; as well as to individuals who are eligible for Medicaid because they lack the income and resources to meet the cost of necessary medical services.

Medicaid is a state and federal partnership under which CMS establishes basic program rules. Each State administers the program and develops its own policies and guidelines for program administration within federal regulations. The Health Care Authority (HCA) administers the program in Washington State, and contracts with Local Health Jurisdictions (LHJ) for assistance in administering the program.

Some of Washington's most vulnerable individuals experience difficulty accessing needed health care. LHJs provide many services to Washington residents on a daily basis, and are critical partners of HCA in ensuring the continued successful implementation of the Affordable Care Act.

Federal funds are available through the HCA Medicaid Administrative Claiming (MAC) program to reimburse Local Health Jurisdictions for some of the cost of their allowable Medicaid administrative activities, when those activities support the provision of services as outlined in the Washington Medicaid State Plan. HCA enters into agreements with LHJs to participate in the MAC program. HCA has complete authority and responsibility for the administration of the State Medicaid Program.

Purpose of the Washington State MAC Program

- Outreach to individuals with no or inadequate medical coverage.
- Explaining benefits of the Medicaid program.
- Assisting individuals in applying for Medicaid.
- Linking individuals to appropriate Medicaid covered services.
- Assisting the Medicaid program in carrying out program goals and objectives.

Examples of Reimbursable MAC Activities

- Informing individuals about Medicaid and the benefits or services offered through Medicaid.
- Providing applications or assisting individuals in gathering documentation to complete an application for Medicaid eligibility determination.
- Facilitating access to Medicaid covered services by arranging transportation and providing interpretation for clients.
- Evaluating and improving access to Medicaid covered services through program planning and policy development.
- Performing Skilled Professional Medical Personnel activities that are in direct support of the Medicaid State Plan.
- Providing or receiving training related to Medicaid or MAC.
- Referring individuals to Medicaid covered medical, dental, mental health, substance abuse treatment, and/or family planning services. This includes coordinating and monitoring the delivery of those services.

Infection control, surveillance, and prevention activities deemed in support of the Medicaid state plan during a national or state public health emergency, natural disaster or act of terrorism from the calendar quarter in which the date the "state of emergency" is declared through the first day of the month following the calendar quarter in which the PHE ends.

LHJ Programs Participating in MAC

LHJs operate many programs, some of which perform MAC activities. The LHJ programs that participate in the MAC program fall into several broad groupings:

Programs for low incomes women, children, and families:
Includes, but is not limited to, programs for low income pregnant and parenting women, their families and their children; home visiting and parent education programs; nutrition programs; and pediatric immunization program; school health; and child care consultation.

Programs for adults:
Includes, but is not limited to, programs targeting the identification and treatment of individuals with TB, HIV/AIDs, sexually transmitted diseases, and other communicable diseases; programs targeting substance abusers; tobacco cessation programs; and adult immunizations.

Programs for children, adults, and families:
Includes, but is not limited to oral health; family planning; Medicaid outreach and enrollment; neurodevelopmental services for infants and toddlers aged 0-3; programs that focus on early identification and treatment of medical conditions; and homeless programs.

SECTION I: MAC PROGRAM ADMINISTRATION

HCA is responsible for effectively and efficiently administering the MAC program, including appropriate oversight of participating LHJs and the vendor administering the time study and claiming system (System). HCA is required to complete comprehensive monitoring of all LHJs participating in the LHJ MAC program to ensure program integrity and the appropriate use of federal funds.

Administrative Fee

HCA charges MAC contractors an administrative fee to offset HCA's costs incurred in administering the program.

HCA will submit an invoice to each LHJ twice each fiscal year for an administrative fee that will not exceed HCA's actual costs to administer the program. Each LHJ must pay the administrative fees within 45 days of the date on the administrative fee invoice using non-federal dollars. All future A19-1As for LHJ MAC claims will be held for processing if the administrative fee is not paid within 45 days.

Roles and Responsibilities

Specific roles and responsibilities of each party are outlined below.

Health Care Authority

HCA is responsible for proper oversight and effective administration of the MAC program including but not limited to:

- Contracting with LHJs to perform MAC activities in support of the Medicaid State Plan.
- Directing and monitoring the Skilled Professional Medical Personnel (SPMP) MAC activities performed by the LHJs.
- Approving or denying an LHJ request to enter into a subcontract for MAC activities.
- Collaborate with WSALPHO to develop training materials for RMTS and fiscal coordinators and RMTS participants.
- Issuing reimbursement for HCA approved quarterly A19-1A invoices.
- Monitoring LHJ compliance with all federal, state and HCA MAC program requirements, and determining when corrective action plans are necessary.
- Evaluating RMTS and claiming data to identify trends, best practices for the MAC program, quality assurance, training needs or other areas in need of improvement.
- Implementing and managing all RMTS and claiming system components through a contracted vendor.
- Monitoring vendor compliance with all federal and state MAC program requirements as described in the vendor's contract.

Washington State Association of Local Public Health Officials (WSALPHO)

WSALPHO is responsible for leading a steering committee that represents statewide LHJs interests and concerns by:

- Maintaining a steering committee representing LHJs statewide, to address interests and express concerns to HCA and the vendor, and as occasionally to CMS as warranted.
- Collaborating with HCA and the vendor to ensure the efficient and effective operation of the MAC program, and to assist in the resolution of any program-wide or individual LHJs issues or concerns.
- Working with HCA to develop training materials for RMTS and fiscal coordinators and RMTS participants.
- Conducting regular conference calls or meetings with LHJs to determine program needs.

Local Health Jurisdictions

The LHJ is responsible for ensuring their MAC program is in full compliance with all federal, state or HCA requirements by performing internal oversight and monitoring activities, including but not limited to:

LHJ MAC Program Manager or designee:

- Designate employee(s) to serve as RMTS Coordinator and Fiscal Coordinator.
- Ensure Coordinators are trained by HCA on the MAC program, purpose of the RMTS, and the importance of accurately reporting time and claimed costs in the System prior to participation.
- Verify all Coordinators and RMTS participants have completed the required training.

- Monitoring HCA approved subcontractors to ensure RMTS and claiming is in compliance with all federal, state and HCA MAC program requirements, if applicable.
- Develop and monitor a process for collecting client data for use in calculating the MER.
- Develop and comply with corrective action plans required by HCA/SAO/CMS/OIG or another entity.
- Communicate with HCA and WSALPHO about program concerns.

RMTS/Fiscal Coordinator:

RMTS Topics

- Identify staff that will participate in the RMTS or be direct charged.
- Provide the vendor with all required RMTS data such as participants and calendars.
- Ensure all RMTS participants complete training prior to participation.
- Monitor RMTS participation to ensure quality assurance and accuracy.
- Monitor the RMTS compliance rate and take action to ensure the 85% compliance level requirement is met.
- Review the coding for all time survey moments for accuracy.
- Requesting technical assistance or training from HCA, as needed.

Claim Topics

- Prepare all required claiming data such as salary and benefits, direct charge costs, CPE local match forms, indirect cost rate forms, client data used to calculate the MER or other required information for entry into the system.
- Submit signed quarterly A19-1A invoice.
- Monitor invoicing/claiming activity for quality assurance in the claiming process.

Participant

- Complete RMTS training prior to participation.
- Accurately complete moments prior to expiration, and certify they are true and accurate.
- Actively seek out assistance with the MAC program if needed.

Vendor

The vendor is responsible for operating a web-based RMTS and claiming system, processing and calculating the MER, and providing ongoing technical System support such as developing or updating reports as needed that provide on demand, real-time, historical, or ad-hoc time study and claiming data including, but not limited to:

- Calendaring, participant uploads, compliance rate, RMTS calculations.
- Salary and benefit, other allowable costs, funding sources, offset funds, CPE, indirect cost rate or other financial data uploads used to calculate the claim.
- Total time study percentages including percentages by consortia, LHJ, subunit, subcontractor, participant, job title, activity code, or other data elements.
- Total claimed amounts including but not limited to amounts claimed by LHJ, subunit, subcontractor, participant, or other data elements.
- Processing client file uploads and generating the MER report.

- Working with HCA and the WSALPHO to develop training materials for RMTS and fiscal coordinators and RMTS participants.

SECTION II: RANDOM MOMENT TIME STUDY METHODOLOGY

All LHJs use a Random Moment Time Study (RMTS) methodology as the primary basis of allocating their allowable costs to the MAC program. HCA uses data gathered through the statistically valid RMTS to track and quantify time study participants' activities.

The RMTS methodology quantifies the daily activities of time study participants. It polls employees at random moments during their normal work days over a calendar quarter. Participants describe what they were doing at the time of a random moment and assign an activity code that matches the description. This method provides a statistically valid means of determining what portion of the participants' time is spent performing allowable activities that can be claimed under the MAC program, and is designed to be quick and user friendly to participants.

RMTS procedures are the same for all time study participants. For each random moment, the participant writes a narrative that provides details about their activity including who they were working with, what they were doing, and why they were doing it.

RMTS Consortia

In order to achieve statistical validity, some LHJs will organize into consortia for the purposes of the RMTS only. LHJs that are able to sustain their own statistically valid time studies will not participate in a consortium. Using a consortium structure for the RMTS is an effective management strategy to achieve administrative simplification, ensures the statistical validity of each RMTS, and facilitates the State's oversight and monitoring responsibilities.

Consortia are organized based on the similar duties their staff perform, organizational structure, type of programs, scope of work, or regional working relationships. The membership of a consortium will be evaluated and reconfigured annually based on changes in any of the above factors or in the number of participants. HCA will review and approve the consortia annually, prior to implementation.

Each consortium will have a lead LHJ agency whose role is to represent the consortium on the LHJ Steering Committee regarding issues related to the RMTS.

Each consortium and its member LHJs participate in a single RMTS. An LHJ cannot participate in multiple consortia, and a participant cannot participate in multiple RMTS.

The Universe of Moments in an RMTS

The sample universe is based on all possible schedules for all possible participants. Moments are assigned to participants based on their individual work schedules. No participant will be assigned moments outside of their work schedule. Each universe must consist of 2,401 moments in order to achieve statistical validity. The RMTS includes a 15% oversample, resulting in 2,761 total moments.

Random Sampling Precision and Required Confidence Level

The RMTS sampling methodology achieves a 95% confidence level with a precision of +/- 2%. To ensure enough moments are completed to be statistically valid, the System oversamples by 15% for a total of 2,761 moments per RMTS. If an RMTS does not meet statistical validity requirements, HCA will require a Corrective Action Plan.

The System generates and assigns moments prior to the start of the quarter for each RMTS. Each random moment is drawn with replacement, so that after a participant and moment are selected, the participant and moment will be returned to the potential sampling universe. Every moment within the participants' individual work schedules has an equal chance of being selected as one of the 2,761 random moments. HCA has full access to all data for all moments. No LHJ has access to any data for moments prior to their occurrence.

All moments must be completed within 5 business days (Monday-Friday, excluding holidays), and are certified as true and accurate by the participant. Participants on paid or unpaid leave are exempt from this requirement. If less than 85% of all the moments in an RMTS are submitted within the five business days, all expired moments must be counted as invalid. All moments completed within the 5-business day deadline are counted as valid moments. Any moment completed after the 5-business day deadline will be counted as invalid unless there is supporting documentation that the participant was on paid leave or unpaid time off. Expired moments can only be coded to 15 (paid time off), 16 (unpaid time off), or Code 99 (invalid). All RMTS moments must be reviewed and validated by the RMTS coordinator, as described in the manual. During a national or state public health emergency, natural disaster or act of terrorism from the calendar quarter in which the date the “state of emergency” is declared through the first day of the month following the calendar quarter in which the PHE ends. only all moments must be completed within 15 business days (Monday—Friday, excluding holidays).

In the event of a national or state public health emergency, natural disaster or act of terrorism, the program may suspend penalties for individual LHJs that do not achieve an 85% RMTS participation rate. If a consortium’s RMTS is not statistically valid due to an overall compliance rate of less than 85% and the lack of compliance results in less than 2401 valid moments, the program may apply methodology that calculates RMTS results based on all completed moments for one quarter only. If the consortium has a compliance rate of less than 85% for a second consecutive quarter, a necessary number of invalid moments will be recoded as non-MAC activities to achieve 2,401 valid moments. This methodology may only be used during a national or state public health emergency, natural disaster or act of terrorism from the calendar quarter in which the date the “state of emergency” is declared through the first day of the month following the calendar quarter in which the PHE ends.

Summary of RMTS Process Components

Annually:

1. Evaluated and reconfigured consortium membership as needed.
2. Update the master LHJ calendar in the System.

Quarterly:

Prior to Quarter Start

1. Prior to the start of the quarter, update the participant list and work schedule. The RMTS coordinator must certify the participant list is accurate. The participant list is locked after it is certified.
2. Prior to the start of the quarter, "Welcome" emails are sent to new participants with usernames and instructions for establishing a password, and completing online training (participants cannot complete moments until they have completed the online training).
3. Five days prior to the start of the quarter, HCA cues the System to generate the random moments for the quarter.

During the Quarter

1. Participants receive notification of their random moments at the time the random moments occur.
2. Participants, RMTS coordinators, and supervisors are reminded daily to respond to moments not completed within 72 hours.
3. All moments are locked to the participant upon completion or after 5 business days, whichever comes first.
4. If a moment is completed after five business days, the participant may only select 14b (paid time off), 14c (unpaid time off), or Code 99 (Working and did not respond – moment expired).
5. The RMTS coordinator must verify and certify all expired moments as valid or invalid.

After the Quarter Ends

1. The RMTS coordinator must verify and certify all moments as valid or invalid as described in the manual.
2. HCA will review a random ten percent sample generated by the System to verify the accuracy of the coding.
3. The System verifies the results to ensure the 95%/2% threshold for statistical validity is met and that the threshold for compliance with 85% valid moments is met.

MAC Activity Codes

Summary of Codes

Code 1a	Non-Medicaid Outreach
Code 1b	Medicaid Outreach (Total MER)
Code 2a	Outreach to Non-Medicaid Providers to Accept Underserved Clients
Code 2b	Outreach to Medicaid Providers to Accept Medicaid Patients (Total MER)
Code 3a	Facilitating Applications for Non-Medicaid Programs
Code 3b	Facilitating Applications for Medicaid Programs (Total MER)
Code 4	Non-Medicaid Other Program Activities
Code 5	Direct Medical Services
Code 6a	Arranging Transportation for Non-Medicaid Services
Code 6b	Arranging Transportation for Medicaid Services (Proportional* MER)
Code 7a	Interpretation for Non-Medicaid Services for Adults
Code 7b	Interpretation for Medicaid Services for Adults (Proportional* MER)
Code 7c	Interpretation for Non-Medicaid Services for Children under 21
Code 7d	Interpretation for Medicaid Services for Children under 21 (Proportional* MER)
Code 8a	Program Planning, Policy Development and Interagency Coordination Related to Non-Medical Services
Code 8b	Program Planning, Policy Development and Interagency Coordination Related to for Medical Services (Proportional* MER)
Code 9a	Non-Medical/Non-Medicaid Related Training
Code 9b	Medical/Medicaid Related Training (Proportional* MER)
Code 10a	Referral, Coordination and Monitoring of Non-Medicaid Services
Code 10b	Referral, Coordination and Monitoring of Medicaid Services (Proportional* MER)
Code 11a	Non-Medicaid Pediatric Immunization Activities
Code 11b	Medicaid Pediatric Immunization Program Activities (Total MER)
Code 12a	SPMP Activity not in Support of the Medicaid State Plan
Code 12b	SPMP Activity Related to the Administration of the Medicaid State Plan (Proportional* MER)
Code 13a	Coordination, Claims Administration and Oversight of Non-MAC Programs
Code 13b	Coordination, Claims Administration and Oversight of MAC Programs (Total MER)
Code 14	General Administration
Code 15	Paid Time Off
Code 16	Unpaid Time Off
Code 99	Working and did not respond (Moment expired). These moments are considered invalid.

*Please see "Determining Proportional Medicaid Share". These activity codes are split into two subcodes in the invoice for claiming purposes. One subcode consists of moments where a client ID is used and the LHJ's client MER is applied. The second subcode is for moments where no client ID has been reported; the modified countywide MER is applied. A clinic MER is used exclusively for MAC linkage related activities in LHJ programs that operate primary care of specialty clinics.

Activity Code Descriptions

Code 1a NON-MEDICAID OUTREACH

Activities that inform individuals and families about social services, legal, education, or other services not covered by Medicaid; such activities may involve describing the range of benefits covered under these programs, how to access them, and how to obtain them. Both written and oral methods may be used. This includes related clerical work, correspondence, and travel.

Examples:

1. Conducting outreach campaigns that encourage people to access social, educational, legal, or other services not covered by Medicaid.
2. Providing outreach to potentially eligible individuals, families and communities regarding the availability of non-Medicaid programs.
3. Identifying and/or contacting medically at risk individuals about available non-Medicaid services and their benefits.
4. Informing individuals and families about the benefits and availability of non-Medicaid programs and services, such as; the Breast, Cervical and Colon Cancer Health program; TANF; SNAP (food stamps); Women, Infants, and Children (WIC); Medicare: Head Start; legal aid; housing jobs; child care; food or clothing assistance; and encouraging them to apply and access the services and resources covered by these programs.
5. Providing information regarding non-Medicaid health insurance programs. Includes troubleshooting around eligibility and benefits of non-Medicaid health insurance on behalf of high-risk clients.
6. Encouraging individuals and families to access non-Medicaid prevention-based health and wellness services.
7. Coordinating arrangements for interpreter services for non-Medicaid outreach activities. Coordinating arrangements for interpreter services for Medicaid outreach activities by an interpreter not qualified by the State.
8. Maintaining and distributing educational materials and information about non-Medicaid programs and services, including information about their benefits, eligibility, and availability for display and/or distribution in the LHJ or the community.
9. Receiving and disseminating updates on eligibility for non-Medicaid programs.

Code 1b MEDICAID OUTREACH

Activities that inform eligible or potentially eligible individuals about Medicaid and how to access the program; such activities include bringing potential eligibles into the Medicaid system for the purpose of the eligibility process. Both written and oral methods may be used. This includes related clerical work, correspondence, and travel.

Examples:

1. Conducting outreach campaigns that encourage people to access health services covered by Medicaid.
2. Providing outreach to potentially eligible individuals, families and communities regarding the availability of Medicaid coverage.
3. Identifying and/or contacting medically at risk individuals about available non-Medicaid services and their benefits.
4. Informing eligible and potentially eligible individuals about the benefits of Medicaid programs and covered services such as First Steps, EPSDT, ABCD and encouraging them to apply and access services covered by these programs.
5. Providing information regarding Medicaid managed care programs, and other health plans. Includes providing information about how to access Medicaid benefits not covered under these programs and troubleshooting around Medicaid eligibility and Medicaid benefits on behalf of high-risk clients.
6. Encouraging individuals and families to access Medicaid prevention-based health and wellness services.
7. Coordinating arrangements for interpreter services provided by an interpreter who complies with the DSHS Language Testing and Certification Program for Medicaid outreach activities.
8. Maintaining and distributing educational materials and information about Medicaid programs and services, including information about their benefits, eligibility, and availability for display and/or distribution in the LHJ or the community.
9. Receiving and disseminating updates on eligibility for Medicaid programs.

Code 2a OUTREACH TO NON-MEDICAID PROVIDERS TO ACCEPT UNDERSERVED CLIENTS

Targeted outreach activities that encourage non-Medicaid and/or non-medical providers to accept underserved clients into their services. This includes related clerical work, correspondence, and travel.

Use the non-Medicaid program planning code (Code 8a) when working with other agencies to increase provider participation in non-Medicaid programs.

Code 2b OUTREACH TO MEDICAID PROVIDERS TO ACCEPT MEDICAID PATIENTS

Targeted outreach activities that encourage Medicaid providers to accept Medicaid beneficiaries into their care (encouraging dentists to accept Medicaid children as their patients, for example). This includes related clerical work, correspondence, and travel.

Use the Medicaid program planning code (Code 8b) when working with other agencies to increase provider participation in the Medicaid program.

Code 3a FACILITATING APPLICATIONS FOR NON-MEDICAID PROGRAMS

Activities that assist individuals and families in applying for non-Medicaid programs such as Temporary Assistance for Needy Families (TANF); food stamps; Women, Infants, and Children (WIC); day care; legal aid; and other social or educational programs and referring them to the appropriate agency to make application. This includes related clerical work, correspondence, and travel.

Examples:

1. Explaining eligibility rules and the eligibility process for non-Medicaid programs to prospective applicants.
2. Assisting individuals and families collecting and/or gathering information for non-Medicaid program applications such as TANF, SNAP, WIC, SSI, and the EIP program for persons with HIV/AIDS.
3. Providing necessary forms and assisting individuals and families in completing an application for non- Medicaid services, including necessary translation activities.
4. Packaging all forms needed to submit an application for a non-Medicaid program, and assisting the individual to submit the application.
5. Assisting individuals in the application process for non-Medicaid services.
6. Following up or verifying initial and continuing eligibility for non-Medicaid programs.
7. Receiving and disseminating updates on eligibility for non-Medicaid programs.

Code 3b FACILITATING APPLICATIONS FOR MEDICAID PROGRAMS

Activities that assist individuals and families in the Medicaid eligibility process. This includes related clerical work, correspondence, and travel. *This activity does not include the actual determination of Medicaid eligibility.*

Examples:

1. Explaining Medicaid eligibility rules and the eligibility process for Medicaid programs to prospective applicants.
2. Assisting individuals and families collecting and/or gathering information needed to submit a Medicaid application, including resource information and third party liability (TPL) information.
3. Providing necessary forms and assisting individuals and families to complete a Medicaid application.
4. Packaging all forms needed to submit an application for a Medicaid program, and assisting the individual to submit the application.
5. Referring an individual and/or family to resources to apply for Medicaid benefits.
6. Following up or verifying initial and continuing eligibility for Medicaid programs.
7. Receiving and disseminating updates on eligibility for Medicaid programs.

Code 4 NON-MEDICAID OTHER PROGRAM ACTIVITIES

Performing non-medical or non-Medicaid related service activities such as public health Information, employment, job training, teaching, and social services that are not Medicaid related. Includes working on projects or programs that are unrelated to the administration of the Medicaid program. This includes related clerical work, correspondence, and travel.

Examples:

1. Conducting public health education activities.
2. Teaching parent education, first aid or CPR classes in the community.
3. Purchasing food, clothing or other supplies for a client.
4. Investigating or reporting communicable diseases and conducting infection control activities. Includes mandated surveillance reports required by the State or the Centers for Disease Control and Prevention.

5. Performing direct services related to the WIC program – issuing checks, certification appointments, weighing and measuring infants and children, conducting breastfeeding or nutrition education, etc.
6. Teaching individuals and their family members about ways to improve or maintain their health status (e.g., nutrition, physical activity weight reduction).
7. Implementing IDEA-related requirements for the Individualized Family Service Plan (IFSP), which includes ensuring annual and other necessary reviews of the IFSP are conducted, parental sign offs are obtained, and actual IFSP meetings with the child's family are scheduled and held.
8. Planning and implementing educational goals of an IFSP.
9. Preparing for or conducting oral hygiene education or dental screenings, such as the screenings that are part of the Smile Survey.
10. Responding to requests for or processing vital records.
11. Preparing for and attending court appearances and any court-related activity.
12. Preparing for and participating in car passenger safety programs.
13. Transporting clients to services.

Code 5 DIRECT MEDICAL SERVICES

Providing direct client care, treatment, education, and/or counseling services to an individual. This includes immunizations and administrative activities that are an integral part of or extension of a Medicaid service (e.g., patient follow-up, developmental assessments, and billing activities). This includes related clerical work, scheduling activities, charting, correspondence, and travel.

Examples:

1. Developing a plan of care if part of a Medicaid service.
2. Providing Medicaid covered direct clinical and treatment services, such as First Steps, Directly Observed Therapy, and other direct medical care.
3. Providing MSS or ICM services when the enrolled MSS or ICM client is out of billable units.
4. Administering first aid, injections, or medication to an individual.
5. Completing developmental assessments.
6. Providing Targeted Case Management (if covered as a medical service under Medicaid).
7. Assisting clients to complete a Take Charge application, when the LHJ is a Take Charge provider.
8. Testing for communicable disease.
9. Providing family planning services.
10. Administering immunizations, including travel-related vaccines.
11. Performing vaccine ordering and storage activities related to the administration of the LHJs' own immunization program – tracking vaccine inventory, monitoring refrigeration temperature logs, etc.

Code 6a ARRANGING TRANSPORTATION FOR NON-MEDICAID SERVICES

Assisting individuals and families in obtaining transportation to services not covered by Medicaid, or accompanying the client(s) to services not covered by Medicaid. This includes related clerical work, correspondence, and travel.

Example:

1. Scheduling or arranging transportation to social, vocational, and/or educational programs and activities.

Code 6b ARRANGING TRANSPORTATION FOR MEDICAID SERVICES

Assisting individuals and families in obtaining transportation to services covered by Medicaid. This does not include the provision of the actual transportation service or the direct costs of the transportation (bus fare, taxi fare, etc.), but rather the administrative activities involved in obtaining transportation. This includes related clerical work, correspondence, and travel.

Example:

1. Scheduling or arranging transportation to Medicaid covered services

Code 7a INTERPRETATION FOR NON-MEDICAID SERVICES FOR ADULTS

Arranging for or providing translation or interpreter services as part of non-Medicaid service. This includes related clerical work, correspondence, and travel.

Example:

1. Arranging for interpreter services (oral or signing) that assist adults to access and understand social, educational, and vocational services, or providing these services as part of the delivery of a non-Medicaid service.

Code 7b INTERPRETATION FOR MEDICAID SERVICES FOR ADULTS

Arranging for or providing translation or interpretation services (oral and signing) for adults as part of a Medicaid service. This includes related clerical work, correspondence, and travel. **NOTE***: Employees of or interpreters under contract to the LHJ may only use Codes 7a-7d if they meet HCA qualifications to be an "authorized interpreter".*

Example:

1. Arranging for interpreter services by a State-qualified interpreter that assist adults to access and understand necessary care or treatment covered by Medicaid, or providing these services as part of the delivery of a Medicaid-covered service.

Code 7c INTERPRETATION FOR NON-MEDICAID SERVICES FOR CHILDREN UNDER 21 YEARS

Arranging for or providing translation or interpreter services as part of non-Medicaid service or providing these services as part of the delivery of a non-Medicaid service. This includes related clerical work, correspondence, and travel.

Example:

1. Arranging for or providing translation or interpreter services (oral or signing) that assist children under 21 years to access and understand social, educational, and vocational services, or providing these services as part of the delivery of a non-Medicaid service.

Code 7d INTERPRETATION FOR MEDICAID SERVICES FOR CHILDREN UNDER 21 YEARS

Arranging for or providing translation or interpretation services (oral and signing) for children under 21 as part of a Medicaid service. This includes related clerical work, correspondence, and travel. **NOTE***: Employees of or interpreters under contract to the LHJ may only use Codes 7a-7 if they meet HCA qualifications to be an "authorized interpreter".*

Example:

1. Arranging for interpreter services by a State-qualified interpreter that assist children under 21 to access and understand necessary care or treatment covered by Medicaid, or providing these services as part of the delivery of a Medicaid-covered service.

Code 8a PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO NON-MEDICAL SERVICES

Activities associated with developing strategies to improve the coordination and delivery of non-medical services to individuals and families. Non-medical services may include social, educational, vocational, and legal services. **Only employees whose position descriptions include program planning, policy development and interagency coordination may use this code.** This includes related clerical work, correspondence, and travel.

Examples:

1. Identifying gaps or duplication of non-medical services such as social, vocational, educational, and state mandated general health care programs to individuals and families and developing strategies to improve the delivery and coordination of these services.
2. Developing strategies to assess or increase the capacity and cost-effectiveness of non-medical services.
3. Monitoring non-medical service delivery systems.
4. Developing procedures for tracking requests for assistance with non-medical services and the providers of such services.
5. Evaluating the need for non-medical services in relation to specific populations or geographic areas, including analyzing data related to a specific program, population, or geographic area.
6. Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems.
7. Defining the relationship of each agency's non-medical services to one another.
8. Developing advisory or work groups of professionals to provide consultation and advice around the delivery of non-medical services to targeted populations.
9. Developing non-Medicaid referral sources such as directories of providers of non-medical services. Includes the development of web-based referral sources.
10. Coordinating with interagency committees to identify, promote, and develop non-medical services for targeted populations.
11. Working with other agencies and/or providers that provide non-medical services to expand access to specific populations.

Code 8b PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO MEDICAL SERVICES

Activities associated with the development of strategies to improve the coordination and delivery of medical, dental, and mental health services, and when performing collaborative activities with other agencies and/or providers.

Employees whose position descriptions include program planning, policy development and interagency coordination may use this code. This code refers to activities such as planning and developing procedures to track requests for services; the actual tracking of requests for Medicaid services would be coded under Code 10b, Referral, Coordination and Monitoring of Medicaid Services. This includes related clerical work, correspondence, and travel.

Examples:

1. Identifying gaps or duplication of medical/dental mental health services such as outreach, medical, dental, mental health, substance abuse or family planning to individuals and families and developing strategies to improve the delivery and coordination of these services.
2. Developing strategies to assess or increase the capacity and cost-effectiveness of medical/dental mental health services.
3. Monitoring medical/dental/mental health service delivery systems.
4. Developing procedures for tracking individual and family requests for assistance with medical/dental/mental health services and the providers of such services, including Medicaid.
5. Evaluating the need for medical, dental, mental health, substance abuse or family planning services in relation to specific populations or geographic areas, including analyzing Medicaid data related to a specific program, population, or geographic area.
6. Working with other agencies or providers of medical/dental/mental health and family planning services to improve the coordination and delivery of services and to improve collaboration around the early identification of these issues.
7. Defining the relationship of each agency's Medicaid services to one another. Includes working with the Medicaid agency, Medicaid managed care plans, and other Medicaid providers to make good faith effort to locate, promote and develop EPSDT health services referral relationships.
8. Developing advisory or work groups of professionals to provide consultation and advice around the delivery of medical/dental/mental health services.
9. Developing medical referral sources, such as directories of Medicaid providers and managed care plans that provide services to targeted population groups; e.g. , EPSDT children. Includes the development of web-based referral sources.
10. Coordinating with interagency committees to identify, promote, and develop Medicaid services for targeted populations.
11. Working with other agencies and/or providers that provide Medicaid services to expand access to specific populations; to increase provider participation by identifying, recruiting and promoting the enrollment of potential Medicaid providers; and to improve provider relations.

Code 9a NON-MEDICAL/NON-MEDICAID RELATED TRAINING

Coordinating, conducting, or participating in training events regarding the benefit of programs other than Medicaid. This includes related clerical work, correspondence, and travel.

Examples:

1. Participating in or coordinating training that improves the delivery of services for programs other than Medicaid.
2. Participating in or coordinating training that enhances early screening, identification, intervention, and referral of individuals and families to non-Medicaid services.
3. Participating in training on administrative requirements related to non-medical/non-Medicaid services.

Code 9b MEDICAL/MEDICAID RELATED TRAINING

Coordinating, conducting, or participating in training events regarding the benefits of Medicaid related services, and how to assist individuals and families to access such services and how to more effectively refer them for services. This includes related clerical work, correspondence, and travel.

Examples:

1. Participating in or coordinating training that improves the delivery of Medicaid covered services.
2. Participating in or coordinating training that enhances early screening, identification, intervention, and referral of individuals and families with special health needs to Medicaid covered services.
3. Participating in training on administrative requirements related to medical/Medicaid services including giving or receiving training on the MAC program.

Code 10a REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES

Making referrals for, coordinating, and monitoring the delivery of non-Medicaid services. This includes related clerical work, correspondence, and travel.

Examples:

1. Making referrals for and coordinating access to social and educational services such as childcare, employment, job training, and housing.
2. Gathering any information that may be required in advance of these referrals to services not covered by Medicaid.
3. Participating in a meeting or discussion to coordinate or review an individual's need for scholastic, vocational, and non-health related services not covered by Medicaid, including monitoring the non-medical components of an Individual Family Service Plan (IFSP), as appropriate.
4. Monitoring and evaluating the non-Medicaid components of an individual's ISFP as appropriate.
5. Providing follow-up contact to ensure that an individual has received needed non-Medicaid services.
6. Coordinating the delivery of community-based, non-Medicaid services for a child with special health care needs or with developmental delays.
7. Coordinating the completion of the prescribed services, termination of services, and the referral of an individual to other non-Medicaid service providers as may be required to provide continuity of care.
8. Providing information to other staff on the individual's related non-Medicaid services and plans.
9. Coordinating the provision of non-Medicaid services with other providers, as appropriate.

Code 10b REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES

Making referrals for, coordinating, and monitoring the delivery of Medicaid covered services such as medical, dental, mental health, substance abuse, or family planning. This includes related clerical work, correspondence, and travel. **Activities that are an integral part of or an extension of a medical service or targeted case management (e.g., patient follow-up, assessment, counseling, education and/or consultation, and billing activities) must be reported under Code 5, Direct Medical Services.**

Examples:

1. Making referrals for and coordinating medical, dental, mental health, substance abuse, or family planning services covered by Medicaid, including medical or physical examinations or necessary evaluations; and arranging for any Medicaid covered diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/behavioral health condition.
2. Gathering any information that may be required in advance of these referrals to services covered by Medicaid.

3. Participating in a meeting or discussion to coordinate or review an individual's needs for health related services covered by Medicaid, including monitoring the medical components of an Individual Family Service Plan (IFSP), as appropriate.
4. Monitoring and evaluating the Medicaid components of an individual's ISFP as appropriate.
5. Providing follow-up contact to ensure that an individual has received prescribed Medicaid covered services.
6. Coordinating the delivery of community based medical/dental/behavioral health Medicaid services for a child with special health care needs.
7. Coordinating the completion of the prescribed services, termination of services, and the referral of an individual to other Medicaid service providers as may be required to provide continuity of care.
8. Providing information to other staff on the individual's related medical, dental, or mental health Medicaid services and plans.
9. Coordinating the provision of Medicaid services with other providers, including managed care plans, as appropriate.

Code 11a NON-MEDICAID PEDIATRIC IMMUNIZATION PROGRAM ACTIVITIES

Activities related to non-Medicaid Pediatric Immunization Programs. This includes related clerical work, correspondence, and travel.

Examples:

1. Retrieving information on the history of an individual's non-Medicaid covered vaccinations when requested by outside providers or parents.
2. Reviewing non-Medicaid covered vaccination records to identify individuals who are due for scheduled immunizations, and sending out reminder notices.
3. Responding to other requests for information about non-Medicaid covered vaccinations.
4. Training outside medical providers on using the Washington Immunization Information System (WIIS) for vaccinations not covered by Medicaid.
5. Encouraging community medical providers to participate in non-Medicaid immunization programs.
6. Monitoring local supply of free non-Medicaid vaccines provided by federal government in response to a mass outbreak (H1N1, for example) to ensure vaccines are appropriately targeted.

Code 11b MEDICAID PEDIATRIC IMMUNIZATION PROGRAM ACTIVITIES

Activities related to the Medicaid Pediatric Immunization Program. This includes related clerical work, correspondence, and travel.

Examples:

1. Adding and editing information in the Washington Immunization Information System (WIIS) about a child's immunizations, including updating missing information on immunization history.
2. Retrieving information from WIIS on a child's vaccination history when requested by outside providers or parents.
3. Responding to other requests for information about Medicaid covered pediatric immunizations.
4. Training Medicaid pediatric immunization providers on using WIIS.
5. Encouraging community-based medical providers to participate in the Medicaid Pediatric Immunization (Vaccine for Children) Program, and assisting them with initial and annual

enrollment.

6. As directed by the Department of Health, monitoring local supply of Medicaid covered pediatric vaccines provided through the Vaccine for Children program to ensure medically appropriate vaccines are provided to all eligible children, monitor accountability of Medicaid pediatric immunization providers via site visits and review of reporting procedures; track vaccine distribution, and ongoing assessment of vaccine management practices.

Code 12a SPMP ACTIVITY NOT IN SUPPORT OF THE MEDICAID STATE PLAN

Only staff that meet the criteria for Skilled Professional Medical Personnel may use this code when their skilled professional medical education and training are required to perform the activity, and the activity is not related to the administration of the Medicaid State Plan.

Examples:

1. Clinical consultation with providers regarding best practices and adequacy of non- medical care.
2. Coordination of non- medical services for medically at-risk populations.
3. Case staffing on complex cases not requiring medical services.
4. Planning and coordination with local medical providers to facilitate earlier referrals and treatment for non-medical services for high-risk populations.
5. Providing medical consultation to the state on non-Medicaid topics.

Code 12b SPMP ACTIVITY RELATED TO THE ADMINISTRATION OF THE MEDICAID STATE PLAN

Only staff that meet the criteria for Skilled Professional Medical Personnel may use this code when their skilled professional medical education and training are required to perform the activity, and the activity is in support of the Medicaid State Plan.

Medicaid provides must use Code 5 (Direct Medical Services) when performing any SPMP activity that is integral to or an extension of direct patient care, and reimbursed through the Medicaid program.

Use when skilled professional medical education and training is required to perform medically related activities in support of the Medicaid State Plan and directed by Health Care Authority. Includes assessing the need for or consulting with Medicaid providers about the need for and/or adequacy of an individual's medical care and treatment. Includes related clerical work, correspondence, and travel.

Examples include but are not limited to:

1. Clinical consultation with providers regarding best practices and adequacy of medical care.
2. Coordination of medical services for medically at-risk populations.
3. Case staffing on complex cases requiring medical services.
4. Planning and coordination with local medical providers to facilitate earlier referrals and treatment for high-risk populations
5. Providing medical consultation to the State on the Medicaid State Plan.
6. Clinical strategies to improve rates for pediatric immunizations

Code 13a COORDINATION, CLAIMS ADMINISTRATION, AND OVERSIGHT OF NON-MAC PROGRAMS

Reserved for use by the individuals designated by the LHJ to manage or coordinate components of non-MAC programs – the time surveys, invoicing, or overall program administration. This includes related clerical work, correspondence, and travel.

Examples:

1. Identifying staff to participate in time surveys for non-MAC programs.
2. Gathering data for preparing claims for grant funded programs.
3. Ensuring that claims are submitted in a timely manner.
4. Monitoring compliance with grant requirements.

Code 13b COORDINATION, CLAIMS ADMINISTRATION, AND OVERSIGHT OF MAC PROGRAM

Reserved for use by the individuals designated by the LHJ to manage or coordinate components of the claiming unit's MAC program – the time surveys, invoicing, or overall program administration. This includes related clerical work, correspondence, and travel.

Examples:

1. Identifying RMTS participants; gathering information needed for their inclusion in the RMTS.
2. Reviewing participant coding for RMTS moments.
3. Gathering data for and preparing the MAC quarterly invoice and supporting documentation.
4. Ensuring that MAC invoices are submitted in a timely manner.
5. Monitoring compliance with MAC time survey participation and RMTS response rate, annual participant training, and invoicing requirements.

Code 14 GENERAL ADMINISTRATION

This code should be used by time study participants when performing activities that are not directly assignable to program activities. This includes related clerical work, correspondence, and travel. **Administrative functions that are included in the agency's indirect rate must not be reported to this code (the costs related to these functions should not be included in the MAC invoice).**

Examples (these are typical activities but are not all inclusive):

1. Attending or facilitating agency or unit staff meetings, trainings, or board meetings.
2. Performing administrative or clerical activities related to general agency functions or operations.
3. Providing general supervision of staff, including supervision of interns or volunteers, and evaluation of employee performance.
4. Establishing goals and objectives of health-related programs as part of agency's annual or multi-year plan.
5. Reviewing agency procedures and rules.
6. Reviewing technical literature and research articles.
7. Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.
8. Taking paid breaks.
9. Developing and monitoring agency or program budgets.
10. Flex time when not recorded in the payroll system as either paid or unpaid of, but rather as paid work time (usually used by an exempt employee).
11. Completing a random moment**.**

Code 15 Paid Time Off

Taking time off such as vacation, bereavement, paid sick leave, paid holiday time, or paid jury duty.

Code 16 Unpaid Time Off

Used when at unpaid lunch, not scheduled to work in the claiming unit, when working on a function or activity that is included in the agency's indirect rate, or when working in a federally funded program or other activity whose costs are not included in the MAC invoice. Also used for paid leave when the agency does NOT record paid leave as a discrete expense when taken. Flex time when recorded in the payroll as unpaid time off (usually used by non-exempt employees).

Code 99: Working and Did Not Respond. (Moment expired.) These moments are considered invalid.

SECTION III: PARTICIPATING IN THE RMTS

RMTS procedures are the same for all participants. Participants receive moments randomly throughout the quarter.

Participant Notification

Participants are notified by email of a random moment at the time the random moment occurs. There is no advance notification. The email notification includes the date and time of the random moment as well as a unique URL that links the participant to the System. The participant must then log into the System and complete the moment. There is no advance notification of RMTS moments.

Participants may also have the option to receive RMTS notifications via text (SMS) message. The text notifications are in addition to email notifications. Text messages are sent to enrolled participants at the time of the random moment and include a unique link to the System. The participant must then log into the System to complete the moment.

Completing a Moment

Participants respond to their random moments, by following instructions on the screen directing them to write a detailed narrative statement that documents the activity they were performing during the one minute interval of their random moment. The narrative statement must include information about the "who", the "what", and the "why" of the activity. The participant then selects the activity code that best reflects the activity they described in their narrative.

For the two SPMP activity codes (Code 12a: SPMP Activity Not in Support of the Medicaid State Plan and Code 12b: SPMP Activity Related to the Administration of the Medicaid State Plan), the participant must describe the SPMP education and training required in order to perform the activity. The System allows only SPMP staff to select an SPMP code and requires the SPMP to certify that medical education and training was needed to perform the activity. The System requires the SPMP to identify an HCA-directed activity in support of the Medicaid State Plan from drop-down menu within the System in addition to writing the narrative response.

For all linkage codes (Code 6a - Arranging Transportation for Non-Medicaid Services; Code 6b – Arranging Transportation for Medicaid Services; Code 10a - Referral, Coordination, and Monitoring of Non-Medicaid Services; and Code 10b - Referral, Coordination, and Monitoring of Medicaid Services), the participant must respond to following statement: "If you have a client ID for the individual you assisted and the activity is not associated with direct patient care, please enter it in the box. If no number is available, leave the box empty."

Once the participant completes all fields, s/he will check a box to certify that the moment is accurate. The participant then submits the moment and it is saved in the System. The participant cannot make any changes to a moment after they certify the moment.

Documentation

Documentation in support of administrative claims must be sufficiently detailed in order to determine whether the activities are necessary for the proper and efficient administration of the Medicaid State Plan and support the appropriateness of the administrative claim. It is the LHJ's responsibility to maintain adequate source documentation that is accessible for review in an auditable, useful, and readable format for all data used to determine the MAC claim.

Job Classifications Eligible to Participate

Job classifications eligible to participate in the RMTS include employees:

- Who are directly employed or contracted by the LHJ, or an HCA approved subcontractor;
- SPMP staff must be direct employees of the LHJ and may not be contractors;
- Who are reasonably expected to perform MAC related activities;
- Whose positions are not 100% funded with federal dollars;
- Whose positions are not entirely included in the certified indirect rate; and
- Who perform infection control, surveillance, and prevention activities for public health crisis deemed in support of the Medicaid state plan during a national or state public health emergency, natural disaster or act of terrorism from the calendar quarter in which the date the "state of emergency" is declared through the first day of the month following the calendar quarter in which the PHE ends.

The following groups of job categories are eligible to participate in the LHJ MAC program. They may participate in the RMTS, or their costs may be direct charged. Each participating LHJ and their subcontractors uses a unique process specific to its county, health district, or agency to determine job titles; there is not a common statewide process to identify job classifications.

The list below includes the job categories that are eligible to participate in the RMTS. Other titles may be added if their job responsibilities include performing MAC activities and reviewed and approved by HCA.

To prevent duplicative claiming, activities of staff supported by costs assigned to a claiming unit's certified indirect rate may not be claimed as a MAC activity.

Job Category	Examples of Job Titles/Classifications
Nurses	Includes, but is not limited to: public health nurses, community health nurses, registered nurses, nurse practitioners, nurse epidemiologists, and licensed practical nurses.
Other Medical Professionals	Includes, but is not limited to: behavioral health specialists, psychologists, dental hygienists, dieticians, drug and alcohol treatment counselors, family therapists, mental health practitioners, nutritionists, occupational therapists, physicians, physical therapists, clinical social workers, and speech language pathologists.
Other Professional Classifications	Includes, but is not limited to: health educators, autism specialists, case managers/care coordinators, childcare consultants, early intervention staff such as educators and family resource coordinators. It also includes specialists in other programs where MAC activities occur, such as vaccine coordination, asthma management, and communicable disease.
Community Outreach and Linkage Classifications	Includes, but is not limited to: positions whose main focus is outreach and enrollment into Medicaid and other programs (such as outreach workers, eligibility specialists, and patient services representatives). It also includes positions that perform outreach and linkage activities such as advocates, case managers, family support workers, home visitors, patient care coordinators, mental health liaisons, and WIC staff whose job functions include activities outside their federal scope of work. Medical interpreters and translators are also included.
Manager/Supervisor/Administrator Classifications	The staff in these positions perform MAC activities in addition to their administrative functions. The costs associated with these activities are not in any indirect rate. The classifications include, but are not limited to: department or program directors, supervisors, managers, and/or administrators of specific programs, accountants with responsibility for preparing the MAC claim, and/or MAC Coordinators.
Administrative Support Classifications	The staff in these positions also perform MAC activities in addition to their administrative functions. The costs associated with these activities are not in any indirect rate. The classifications include, but are not limited to: clerical positions, administrative and office assistants to other program staff (such as office manager, account clerk, communicable disease technician, department assistant, program assistant, health program aide, medical office assistant, nursing coordinator assistant, nutrition aide, WIC clerk). This classification grouping may also include staff that provide more generalized administrative support such as operations supervisors, and software support specialists.
Other job classifications associated with a public health crisis (during a	The staff in these positions perform MAC activities in addition to their administrative functions. The costs associated with these activities are not in any indirect rate. The classifications include, but are not limited to: call center staff,

national or state public health emergency, natural disaster or act of terrorism from the calendar quarter in which the date the "state of emergency" is declared through the first day of the month following the calendar quarter in which the PHE ends.	logistics staff, community engagement staff, health and medical liaisons, emergency management staff, lab coordinators and investigators.

Skilled Professional Medical Personnel Qualifications

HCA has a critical local resource in the Skilled Professional Medical Personnel (SPMP) staff within the LHJs. Their clinical expertise, education and training will be used to advance the goals of the Medicaid State Plan and assist HCA in effectively implementing the Affordable Care Act (ACA). HCA will direct LHJ SPMP staff through an Interagency Agreement to perform certain SPMP activities on behalf of HCA that support the goals and initiatives of the Medicaid State Plan. These SPMP activities will facilitate ongoing process improvement and access to care, identify and train providers in clinical best practices and improve the cost effectiveness of medical care. These activities require the SPMP's professional and/or medical education and training and are not duplicative of, nor included in, the provision of a direct medical service. Only LHJ staff who meet the qualifications for SPMP are eligible for the enhanced FFP rate. The Interagency agreement verifies all federal requirements regarding SPMP claiming as described in 42 CFR 432.50 are met.

On a quarterly basis, the LHJs will produce and provide the HCA Medical Director with a written report documenting progress, accomplishments, barriers, and suggested recommendations identified while performing HCA directed SPMP activities. As part of HCA's ongoing program planning and policy development activities, appropriate LHJ SPMP and program staff may also meet quarterly with HCA to review the report, and if needed, update HCA directed SPMP activities.

SPMP activities allowed for enhanced reimbursement are explicitly defined in the Interlocal agreement. Examples include, but are not limited to:

- Clinical consultation with providers regarding best practices and adequacy of medical care.
- Coordination of medical services for medically at-risk populations.
- Case staffing on complex cases requiring medical services.
- Planning and coordination with local medical providers to facilitate earlier referrals and treatment for high-risk populations
- Providing medical consultation to the State regarding the Medicaid State Plan.
- Clinical strategies to improve the rates for pediatric immunizations.

Interpreter Services Qualifications

LHJs that have interpreters performing MAC activities as part of their assigned job duties may include these staff in the RMTS. Enhanced reimbursement (75% FFP) is available for the cost of Medicaid-related interpreter services performed by interpreters on behalf of children under 21. All interpreters participating in the MAC program must meet HCA qualifications to be an "authorized interpreter".

SECTION IV: TRAINING

All training materials will be developed by HCA in collaboration with the LHJs. Training will be a mix of on-line and in-person training. Responsibility for training will be shared jointly by HCA and the LHJs.

RMTS/Fiscal Coordinator

HCA will provide in person and online training for the coordinators. Coordinators must certify they have completed online training prior to participation, and annually thereafter. Completion and certification of training is tracked within the system.

Online Training

All RMTS/fiscal coordinators must complete online training which includes but is not limited to:

- Logging into the System.
- The purpose of the RMTS.
- How to use the RMTS.
- Entering expenditure data into the System.
- Entering funding supporting the expenditures and offsetting funds that pay for MAC activities.
- Entering the indirect rate and supporting documentation.
- Entering data needed for the MER and maintaining supporting documentation.

In Person Training

RMTS/fiscal coordinators will be trained prior to performing their duties, and as needed thereafter. The training includes, but is not limited to:

RMTS Topics

- Overview of the MAC program.
- Roles and responsibilities.
- Subcontractor monitoring (if applicable).
- MAC program compliance requirements and corrective actions.
- Overview of the RMTS:
    - Using the web-based RMTS system.
    - RMTS methodology and processes.
    - Statistical validity and compliance rates.
    - Identifying RMTS participants and assigning appropriate cost pools.
    - Entering participant information into the system.
    - Understanding how the System notifies participants of moments.
    - Understanding how to complete a moment—how to write a “who”, “what”, “why”.
    - Understanding SPMP requirements including qualifications and allowable activities.
    - Understanding the importance of completing moments within the 5 working day deadline.
    - Navigating the system to enter information or complete monitoring activities.
- Overview of the MER:
    - Understanding the different MERs and their application.

- Understanding the process for collecting client data required to calculate the client- or clinic-based MER.

Fiscal/Accounting Topics

- Overview of the MAC program.
- Roles and responsibilities.
- MAC program compliance requirements and corrective actions.
- Overview of claiming:
  - Using the web-based claiming system, including the quarterly CPE local match certification and the A19-1A.
  - Claiming methodology and processes.
  - Claiming requirements and deadlines.
  - Entering financial data into the system.
  - Understanding how the system calculates the claim.
  - Navigating the system to enter information or complete monitoring activities.
- Overview of the MER:
  - Understanding the different MERs and their application.
  - Process for collecting client data required to calculate the client- or clinic-based MER.
- Identifying allowable personnel and other costs.
- Assigning costs to the appropriate cost pools.
- Assigning funding to the appropriate cost pools.
- Offsetting revenue that pays for MAC activities.
- Understanding the application of the RMTS results, indirect rate, and MER to allowable expenditures.
- Certifying public expenditures including NIRT requirements.

RMTS Participants

HCA provides online training for RMTS participants. RMTS participants must certify they have completed online training prior to participation, and annually thereafter. Completion and certification of training is tracked within the system. In person training is provided by the LHJ RMTS coordinator.

Online Training

All participants must complete online training which includes but is not limited to:

- Overview of the MAC program.
- Logging into the System.
- The purpose of the RMTS.
- How to use the RMTS.
- Responding to a moment.
- Understanding the time study activity codes.

In Person Training

Participants will be trained by the LHJ RMTS coordinator prior to participating in the RMTS for the first time, and as needed thereafter. The training includes, but is not limited to:

- Overview of the Medicaid program and Medicaid services.
- Overview of the MAC program.
- MAC participation requirements.
- SPMP requirements.
- Understanding the time study activity codes.
- Timelines for completion.
- Roles and responsibilities.

SECTION V: CLAIMING

HCA uses the data gathered through the RMTS to determine the percentage of time LHJ staff spend performing allowable MAC activities. HCA reimburses the LHJ for the federal share of the cost the LHJ spent on staff performing allowable MAC activities.

Calculating the MAC Claim

The MAC Program claim calculation has five components:

1. Cost pool construction.
2. Calculating allowable Medicaid administrative time via the Random Moment Time Study or direct charge documentation.
3. Calculation and application of the pertinent MER.
4. Calculation and application of the indirect cost rate.
5. Application of the appropriate FFP rate.

The preparation of the MAC claim will adhere to the principles laid out in 2 CFR Chapter I, Chapter II, part 200, et al (OMNI Circular). Detailed instructions on MAC claiming are in the manual.

Claiming Requirements

HCA will review all A19-1A invoices submitted before reimbursement.
Please refer to the manual for detailed instructions on MAC claiming.

The LHJ must:

- Submit claims that have been reviewed to ensure compliance with all state and federal regulations, the Interlocal agreement, and the manual.
- Verify the accuracy of the RMTS results.
- Verify the accuracy of the clinic-based and client-based MER.
- Verify the accuracy of invoice data and back up source documentation, including:
    - Staff salaries and benefits.

- Other costs.
- Funding sources and revenue offset.
- CPE worksheet on invoice (for subcontractors).

- Document that subcontractors are paid 100% of their total computable MAC costs.
- Use the state of Washington A19-1A Invoice Voucher produced by the System.
- Ensure only individuals with HCA approved signatory authority signs the A19-1A to certify the accuracy of the claimed costs and data entered into the system.
- Submit the CPE Local Match Certification Form with each A19-1A.
- Submit a completed and approved Certificate of Indirect Costs annually.
- Sign, date, and mail original A19-1A quarterly, but no later than 365 days from the end of the quarter being billed to HCA.

Constructing Cost Pools

Cost pools use federal cost accounting principles to allocate a "fair share" of a budget units expenses to the Medicaid Administrative Claim. For each quarterly claim, all expenses that are not part of a certified indirect rate are assigned to one of six cost pools. Cost pool assignment ensures that the expenses of the budget unit are not being claimed twice to federal programs. The six cost pools are as follows:

- Cost Pool 1: MAC SPMP.
- Cost Pool 2: MAC Non-SPMP.
- Cost Pool 3a and 3b: Non-MAC.
- Cost Pool 4: MAC Direct Charge – enhanced.
- Cost Pool 5: MAC Direct Charge – non-enhanced.
- Cost Pool 6: Allocated.

MAC Cost Pools

Cost Pool 1 SPMP: The salaries and benefits of RMTS participants designated as SPMP are assigned to this cost pool. As per the federal requirements in 42 CFR 432.50, they must be employees of the LHJ, have completed a two-year or longer program leading to an academic degree or certification in a medically related profession, and be in a job classification that requires SPMP education and training. Travel and training costs that can be directly linked to SPMP should be included in Cost Pool 1.

Cost Pool 2 Non-SPMP: The salaries and benefits of all other staff participating in the RMTS, including any personal services contractors, are assigned to Cost Pool 2. Travel, training and other non-personnel costs that can be directly linked to the non-SPMP time study participants should be included in Cost Pool 2.

Non-MAC Cost Pool

Cost Pool 3a: The costs associated with staff in the budget unit who do not perform MAC, are not in the indirect rate, and who do not provide administrative or clerical support to the unit are assigned to Cost Pool 3a. Any staff whose total costs are 100% federally funded are also assigned to this cost pool. Travel, training and other non-personnel costs that can be directly linked to these staff should be included in Cost Pool 3. This cost pool also includes other non-allowable non-personnel costs (e.g. medical supplies, malpractice insurance, audit compliance.)

Cost Pool 3b: Any direct charged costs that are not claimable are assigned to Cost Pool 3b.

Direct Charge Cost Pools

The costs of staff that can be 100% attributable to a single MAC activity can be direct charged, particularly if the staff work a limited schedule and it is not feasible to participate in the RMTS or if the staff are part of emergency response/management efforts during a national or state public health emergency, natural disaster or act of terrorism from the calendar quarter in which the date the "state of emergency" is declared through the first day of the month following the calendar quarter in which the PHE ends. Any costs that are direct charged must have supporting time documentation, and the staff must certify quarterly that the time being direct charged is true, accurate, and correct.

Cost Pool 4: This cost pool is associated with SPMP staff.

Cost Pool 5: This cost pool includes non-SPMP staff as well as vendor costs that are 100% attributable to MAC. Subcontractors who are federal subrecipients are not direct charged.

Allocated Cost Pool

Cost Pool 6: Costs of administrative staff who did not participate in the RMTS and who support staff in other cost pools are in Cost Pool 6. Other allowable and allocable non-personnel costs, including travel and training that cannot be linked to specific staff or that are linked to staff in Cost Pool 6, are assigned to Cost Pool 6. Allocation of Cost Pool 6 expenses is based on the distribution of personnel costs in the other cost pools.

Allocable Share of Time

Time documentation (RMTS and direct charge) and the Medicaid Eligibility Rate (MER) combined form the basis for allocating time between MAC and non-MAC activities. For each RMTS, time survey results of all participants are aggregated to determine the percentage of time in each activity code. The activity codes in the RMTS capture four categories of costs as described below. The MER determines the proportional share of the cost of the activities to be allocated to the Medicaid program.

1. **Unallowable** – The activity is unallowable as a Medicaid administrative cost.
2. **100% Medicaid Share or Total Medicaid** – The activity is solely attributable to the Medicaid program, and as such is not subject to the application of a proportional Medicaid percentage.
3. **Proportional Medicaid Share** – The activity is allowable as administration under the Medicaid program, but the allocable share of costs is determined by applying a proportional Medicaid percentage.
4. **Allocated Activities**—The activity is allocated across other codes based on the percentage of time spent on allowable and unallowable Medicaid administrative activities.

Determining Proportional Medicaid Share

Omni Circular §200.405 states that " . . . a cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received." All MER calculations will be calculated quarterly, and based on the quarter claimed.

Within the category "Proportional Medicaid Share" described above, there are two groups of MAC activities that staff may perform, each with a different type of MER applied: a) activities that benefit LHJ clients directly and b) activities that particularly benefit a larger population in the geographical region the LHJ serves. The following three MERs will be used:

Client Based MER The client based MER is used for linkage-related MAC activities performed with programs where clients are identified, and personal data is collected and retained in an auditable data base. Calculation:

$$\frac{\text{Number of clients served by the budget unit that are Medicaid enrollees}}{\text{Total number of clients served by the budget unit}}$$

Clinic-Based MER **A** clinic-based MER will be used for linkage-related MAC activities for LHJ programs that operate primary care or specialty clinics. Activities that are integral to or an extension of a billable services are reported as a direct medical service, not linkage. Calculation:

$$\frac{\text{Number of patients served by the primary care or specialty clinic that are Medicaid enrollees}}{\text{Total number of patients served by the primary care or specialty clinic}}$$

Modified Countywide MER **This** MER is used for linkage-related MAC activities within programs where clients are not identified, or when demographic data is unable to be collected, reported, or retained. This MER is also used for program planning around medical services for Medicaid and non-Medicaid populations. Calculation:

> As described in the "*Methods and Technical Tables Calculating an Alternate Method to the Medicaid Eligibility Rate for Washington Local Health Jurisdictions"*, developed by the Research and Data Analysis Division of as the Washington Department of Social and Health Services.

Obtaining and Processing Data for the Medicaid Eligibility Rate

Individuals may be determined Medicaid enrolled or eligible for a variety of Medicaid programs. For the MAC program, only certain Medicaid programs are allowable for determining Medicaid eligibility for the purpose of calculating the MER. Recipient Aid Categories (RAC) are used to identify the Medicaid program that an individual is eligible for. Only RAC codes approved by HCA as allowable for determining eligibly for the purpose of calculating the MER for the MAC program are allowed. Individuals who are Medicaid enrolled or eligible for programs that do not have an HCA MAC approved RAC code must be excluded from the "total Medicaid Eligible" count used in numerator the MER calculation. However, they must still be counted in the "total population" count used as the denominator of the MER calculation. Please see the manual for the HCA MAC approved RAC codes and instructions on determining Medicaid eligibility for the purpose of the MER.

Program operations run concurrent with a clinic owned and operated by an LHJ present a special challenge to computing a proportional MER given the disproportionately high Medicaid client base typically served by public health centers, yet also offer a rich dataset from which a more precise MER may be computed. LHJs that directly operate primary or specialty care clinics and host Medicaid Administrative program operations from these programs must isolate those Medicaid Administrative activities in a discrete sub-unit (the "clinic sub-unit") and shall use a clinic-based MER specific to the population in this sub-unit.

Many LHJs do not have the volume, the resources, or mandate to offer specialty or primary care clinics in their communities. However, many LHJs do offer client-based programs supported with datasets from which a more precise client-based MER may be computed. The LHJ must submit a MER proposal including a narrative that specifies the source of data the calculation used (including definitions of the numerator and denominator). HCA will review and approve this proposal before the LHJ may participate in the MAC program. Any changes to this plan must be submitted to HCA for review and approval prior to the start of the quarter. HCA has established procedures for monitoring the accuracy of data that will support a client-based MER using client ID numbers which can be used for audit purposes by HCA. However, an LHJ may elect to use the Modified Countywide MER for all activities requiring the proportional MER.

The procedures for collecting client information for the MER are as follows:

1. During the quarter, staff in the budget units whose costs will be included in the MAC claim enter information about all their clients into their client information systems or data bases.
2. At the end of the quarter, each LHJ claiming unit (i.e., subunit or subcontractor) rolls up the identifying information on every individual that has received services during the quarter, not just persons that are the focus of MAC activities, to the extent it is available:
    a. Name (last, first, middle initial).
    b. Date of birth.
    c. ProviderOne Client ID.

The MERs are calculated quarterly and all data used to determine the MER must be based on the quarter being claimed. The manual provides instructions on providing data to calculate the clinic or client based MER.

Applying the Indirect Rate

MAC claims for reimbursement can include indirect costs. The costs included in the indirect rate vary from LHJ to LHJ. Indirect costs included in an LHJ's MAC claim must be developed in accordance with guidelines published in the Office of Management and Budget 2 CFR Chapter I, Chapter II, part 200, et al (OMNI Circular). The LHJ must certify the accuracy of the indirect cost rate proposal submitted to their Cognizant Agency annually by completing a Certification of Indirect Costs and submitting it to HCA. Costs claimed as direct costs cannot not duplicate costs reimbursed through application of the indirect cost rate.

Revenue Offset

In accordance with federal cost principles applicable to states and local governments (2 CFR 225.55.Appendix A, B.11), MAC is a cost objective.[i] 2 CFR 225 (C)(4) states that for a cost and its funding to be allowable, it cannot be used to meet cost sharing or matching requirements of any other federal award in either the current or a prior period, except as specifically provided by federal law or regulation. Allowable costs and their related funding should also be the "net of applicable credits."

Funding from federal or other sources that does not pay for MAC activities is aligned with a different (non-MAC) cost objective under 2 CFR 225. For full compliance with the "net of all applicable credits" cost principle, non-MAC credits must be offset against the non-MAC costs. Establishing whether a cost objective contains funding for activities that potentially overlap with MAC activities or has no potential for overlap with MAC (non-MAC funding) requires understanding the scope of work and terms of each funding source[ii]. LHJs will assess whether each cost objective contained within the MAC budget unit(s) has potential to overlap with MAC. This assessment will occur as frequently as necessary to ensure proper allocation of cost, but at least annually. If any portion of the scope of work overlaps with MAC activities, the entire cost objective is deemed to overlap.

To ensure that costs from those objectives that overlap with MAC are not paid twice, they are removed from (offset against) the MAC cost pools prior to application of the time study results and Medicaid Eligibility Rate. The following funding must be offset against expenses in the MAC cost pools to develop the net costs in which Medicaid will participate:

- Funds that reimburse the cost of MAC activities, including but not limited to any federal pass through funds from the Washington State Department of Health (DOH) that support claimable MAC activities and any SNAP revenue supporting a combined application process.
- Any otherwise eligible local matching funds that serve as mandatory match and pay for MAC activities.
- Receipts recorded in the LHJ's general ledger as reduction of expenditure type transactions offsetting or reducing expense items allocable to federal awards.
- Funds that pay for non-MAC activities such as payments for Medicaid services, fees, insurance, and federal grants supporting non-MAC activities are assigned to the non-MAC cost pool to ensure they are not used as local match. Costs from non-MAC cost objectives are removed from the non-MAC cost pool.

The net remaining eligible costs after offset are then allocated to Medicaid based on time study statistics and the application of a proportional MER to certain activity codes. The time study provides the basis for allocating the costs of multiple cost objective employee participants between MAC and non-MAC cost objectives. LHJs should review the funding of time study participants regularly and remove those employees that are no longer supported by funds eligible for treatment as local match.

Calculating the MAC Claim

The LHJ's quarterly claim is determined by calculating the total adjusted costs, multiplying these costs by the adjusted RMTS results, and the applicable Medicaid Eligibility Rate (MER), adding any direct charges, and then applying the appropriate FFP rate.

Total Adjusted Costs:

All of the actual salaries, benefits, personal service contracts, and non-personnel expenditures of the budget unit are assigned to one of six cost pools.

Based on the MER, a portion of the costs assigned to the direct charges cost pools (Cost Pool 4 - SPMP and Cost Pool 5 – non-SPMP) is separated into the non-MAC cost pool 3b. For example, if the appropriate MER for the direct charge activity is 40%, then 60% of the direct charge cost would be assigned to Cost Pool 3b.

The total of all costs for Cost Pool 6 are distributed to Cost Pool 1, Cost Pool 2, Cost Pool 3, Cost Pool 4, and Cost Pool 5 based on the percentage of personnel costs in each of these cost pools. For each of the MAC Cost Pools (1, 2, 4, and 5), total costs are then reduced by any revenue that must be offset against the MAC cost pools to arrive at the total adjusted costs for each cost pool.

A = Subtotal Personnel (salaries, benefits, personal service contracts, travel, and training)

B = Non-Personnel Costs

C = Direct Charges

D = Distributed Cost Pool 6

E = Revenue Offsets

(A + B + C +D) – E = Total Adjusted Costs

RMTS Results:

The RMTS percentages for each time study activity code are calculated from the RMTS results. In calculating the distribution of time by activity code, General Administration and Paid Time Off are allocated to all other time survey activity codes, as these two activities benefit both MAC and non-MAC programs proportionately.

Medicaid Eligibility Rate (MER)

The appropriate MER is applied to each activity code.

Federal Financial Participation Rate (50%/75%)

The allowable Federal Financial Participation (FFP) rate for the LHJ invoice is either 50% or 75%. The 75% FFP rate is applied to the total claimable costs for SPMP activity (Code 12b) and for interpretation for pregnant women and children under 21 (Code 7d). The 50% FFP rate is applied to the costs of all other claimable MAC activity. The costs associated with the two FFP rates determine the total amount of the invoice. This is the last step of the claim calculation.

Federally Qualified Health Centers

Among the Washington LHJs, only Public Health – Seattle & King County (PHSKC) have staff who participate in the two federal programs: the Health Center Program-CFDA 93.224 [also known as

Federally Qualified Health Center (FQHC) program] and Medical Assistance Program-CFDA 93.778 (referenced in this document and the Medicaid Administrative Claiming program). By having staff engaged in both programs, PHSKC is able to provide a holistic healthcare experience to their clients by performing MAC activities such as Medicaid outreach, enrollment, and linkage in addition to direct medical services covered through the FQHC program.

To receive proper reimbursement for these services and activities, PHSKC claims through both the FQHC and MAC program. The FQHC rate does not reimburse the full cost of these staff; therefore allowable MAC activities that are not otherwise reimbursed by Medicaid are claimed through the MAC program. No FQHC costs may be claimed through the MAC program, making it critical for all FQHC and MAC costs to be separated to ensure no duplication exists.

PHSKC separates the FQHC and MAC costs by using the RMTS to separate linkage activities that occur with FQHC clients and offsetting any FQHC revenue. Activities that are integral to or an extension of a billable service are reported as a direct medical service, not linkage.

Funding the non-Federal Share of MAC Expenses: Certified Public Expenditures

The LHJ must comply with the following requirements for Certified Public Expenditures (CPE):

Federal Guidelines

Federal statue and regulation permits State, Local or Tribal governments to provide the non-federal share of Medicaid expenditures. The funding of the non-federal share may be directly appropriated to the government units by their legislature or other authority, transferred between the government units, or actual expenditures incurred by the government units may be certified as expenditures eligible for Medicaid FFP.

CMS policy is authorized by Section 1903(w) (6) (A) of the Social Security Act which specifically identifies States, and units of government within a State, as the appropriate agencies to fund the non-federal share of Medicaid costs. The non-federal share may be funded with proceeds derived from:

- State and local taxes.
- Funds appropriated to State University teaching hospitals.
- Funds transferred from or certified by units of government within a State.
- Funds of the unit of government not considered to be provider-related donations.
- Funds of the unit of government not derived from an impermissible health care related-tax.

Funds of the unit of government that are not considered to be provider-related donations, or are not derived from an impermissible health care related-tax, may be used as the non-federal share of MAC expenditures when these funds have been approved by CMS' Center for Medicaid and State Operations' National Institutional Reimbursement Team (NIRT).

Any LHJ wishing to obtain NIRT approval should submit a NIRT questionnaire to the Health Care Authority approximately 6-9 months in advance of the date the funds will be identified as CPE on the LHJ's claim. Funds that have previously received NIRT approval in Washington State include the United Way and hospital contributions to LHJs.

Subcontractors' CPE

LHJs must reimburse the total computable cost to subcontractors for performance of allowable Medicaid administrative activities. The total computable cost is the sum of the federal and non-federal share of these costs. Once the LHJ has incurred the total computable cost, they may submit an invoice to the state for reimbursement of the eligible Federal Financial Participation. The subcontractor must not be required to provide the non-federal share of the payment, or return any portion of the total computable cost to the LHJ. In signing the A-19, the LHJ attests to the accuracy of the subcontractor's claim.

Non-Governmental Subcontractors

LHJs are prohibited from requiring or allowing non-governmental units (e.g. private non-profit agencies) participating in the MAC program as subcontractors of the LHJ to contribute to the financing of the non-federal share of their MAC expenditures.

Non-governmental units may not voluntarily provide, or be contractually required to provide, any portion of the non-federal share of expenditures they incur related to the performance of MAC activities.

LHJs are prohibited from requiring or allowing private non-profits to participate in the financing of the non-federal share of expenditures. Non-governmental units may not voluntarily provide, or be contractually required to provide, any portion of the non-federal share of the Medicaid expenditures.

Governmental Subcontractors

The agreement between the LHJ and the governmental subcontractor states that the subcontractor must certify in writing to the LHJ that the expenditures incurred in the performance of MAC activities are eligible for FFP. They must provide documentation that the funding supporting the certified expenditures is derived from an allowable source, as noted above. If the governmental subcontractor will use any non-public funds as CPE, they must first be approved by NIRT, as described above.

Reporting Certified Public Expenditures

Each quarter, the LHJ is required to certify all sources of funds used for CPE are accurate, allowable, and in compliance with applicable regulations by completing a Certified Public Expenditure Local Match certification and by signing the A19-1A. The State Auditor's Office Budgeting, Accounting and Reporting System (BARS manual) is used to identify and document the revenue account codes for all local matching funds reported as CPE. Only an authorized LHJ staff may certify the public expenditures.

SECTION VI: OVERSIGHT AND MONITORING

HCA performs monitoring activities to ensure the LHJs are in compliance with the federal and state regulations for the MAC program. The LHJ is required to provide access to necessary staff and records in a timely manner to facilitate these reviews. An LHJ that does not fully cooperate will be subject to corrective action plan. HCA may request additional ad-hoc reports through the vendor to facilitate monitoring activities.

HCA reviews RMTS results and claimed costs quarterly, and personnel costs triennially. Monitoring will consist of either an on-site, desk, and/or combination review. Monitoring activities may occur more frequently for a high risk grantee as defined by 45 CFR 92.12. Monitoring includes an in-depth review of the components of the MAC program. HCA will provide feedback to the LHJ related to trends, areas of concern, technical assistance and training opportunities.

Corrective Action Plans

HCA will pursue a corrective action plan if the LHJ fails to meet MAC program requirements or to correct problems identified. The LHJ must develop and submit a corrective action plan to HCA for approval within thirty (30) days of HCA's notification. If the LHJ fails to meet the requirements outlined in the corrective action plan, HCA will impose sanctions including but not limited to; conducting more frequent reviews, delayed or denied payment of MAC claims, recoupment of funds, or termination of contract.

Examples of other actions that may result in sanctions include, *but are not limited to*:

- Repeated and/or uncorrected errors in financial reporting.
- Failure to maintain adequate documentation.
- Failure to cooperate with state or federal staff.
- Failure to provide accurate and timely information to state or federal staff as required.
- Failure to meet time study minimum response rates.

HCA Responsibilities

HCA has established proper internal controls for program monitoring and oversight to ensure the financial integrity of the MAC program. Any work performed by a third party vendor is subject to HCA review, including but not limited to, the calculation of the RMTS results, MER, and invoice, as well as general operating elements. As part of HCA's oversight, in depth monitoring activities will be performed regularly, and include, *at a minimum*, the following actions:

Random Moment Time Study (RMTS)

Prior to the beginning of each quarter:

Verify the LHJs have certified that:

- All calendar information entered is accurate.
- All staff entered into the system are eligible to participate.
- All time study participants included in the RMTS work in approved job classifications that are eligible to participate in the RMTS.

During the quarter:
Monitor the compliance rate for each RMTS. If the non-response rate is over 15%, remedial action will be required.

After the end of the quarter:
HCA will review data for each RMTS including:

- Trends related to non-response rates, correlation between narrative and code, illogical responses, percent of time allocated to each code and significant fluctuations.
- Amount of time allocated to SPMP and non-SPMP activities for staff designated as SPMP
- HCA will require the vendor to review a random sample of 10% of moments for each RMTS to verify the accuracy of the activity code based on the narrative.
- HCA will review the backup documentation for a 10% random sample of the vendor's review to ensure they are sufficiently detailed enough to support the activity recorded in the time study.
- Non-Response rates and the need for related corrective action if over 15%.

Non-responses are moments not completed by participant within five (5) work days, with the exception of expired moments where the participant was on paid or unpaid leave. The return rate of valid responses for each RMTS must be a minimum of 85**%**. To ensure enough moments are completed for a statistically valid sample, each RMTS includes a 15% oversample. HCA monitors each RMTS by reviewing System reports. Any non-response rate greater than 15% is unacceptable, and HCA will require remedial action:

<u>Non-response rates greater than 15%:</u>

- HCA will send written notification to the LHJ(s) requesting a Corrective Action Plan to ensure a minimum 85% compliance rate for the RMTS is achieved in subsequent quarters.
- The LHJ(s) must develop and submit the plan to HCA for approval within thirty (30) days of HCA's notification.
- Failure to provide a timely corrective action plan within 30 days may result in the LHJ(s) being prohibited from participation in MAC for the following quarter.
- An 85% compliance rate for the RMTS must be met in the following quarter.

<u>Non-response rates greater than 15% for two (2) consecutive quarters:</u>

- HCA will reduce reimbursement by 35% for the second consecutive quarter for all affected LHJ(s) in the RMTS.
- The LHJ(s) will be notified via Certified Mail of the reduced reimbursement.
- 85% compliance rate for the RMTS must be met in the following quarter.

<u>Non-response rates greater than 15% for three (3) consecutive quarters:</u>

- HCA will notify the affected LHJ(s) via certified mail of the denied reimbursement for the third consecutive quarter and prohibited participation in MAC.
- None of the affected LHJ(s) may claim for any denied or reduced reimbursement from the three consecutive quarters of non-compliance. The LHJ(s) may be prohibited from participating in MAC for the following quarter (4th consecutive quarter).

Annually HCA will:

- Approve or deny proposed changes to the composition of the RMTS consortia:
    - All proposed changes must be submitted to HCA no later than September 30th.
    - HCA will approve or deny proposed changes no later than November 30th.
- Review all monitoring results for trends, areas of concern, technical assistance and training opportunities related to the RMTS.
- Verify all coordinators and participants completed annual training prior to participating in MAC
- Review MAC-related training schedules, curriculum, documents, materials, and rosters to ensure accuracy of materials.
- Review annual LHJ monitoring reports and/or corrective action plans for all subcontractors (if applicable).

Claiming

HCA will complete the following monitoring activities for each LHJ:

Quarterly HCA will:

- Verify the following data has been certified as accurate and backup documentation has been entered into the system:
    - Staff salary and benefits and other costs funding and revenue offset.
    - Quarterly CPE local match form.
    - Subcontracts are paid 100% total computable of MAC costs.
    - MER data.
    - Indirect Rate.
    - RMTS Activity Results.
- Verify the signed A19-1A matches the claiming data.
- Review quarterly monitoring results for trends, areas of concern, technical assistance, and training opportunities related to claiming. HCA may request specific ad-hoc reports from the vendor to facilitate this review.

Annually HCA will:

- Review monitoring results for trends, areas of concern, technical assistance, and training opportunities related to claiming. HCA may request specific ad-hoc reports from the vendor to facilitate this review.
- Verify each LHJ has an HCA approved MER proposal.

On a triennial schedule, HCA will:

Complete a fiscal review of each LHJ to ensure, at a minimum, payroll records correspond to the data entered into the system and source documentation of expenditures claimed as CPE to ensure they are fully supported and allowable.

Skilled Professional Medical Personnel

HCA will schedule quarterly program planning and policy development meetings with appropriate HCA and LHJ staff. HCA will review the quarterly SPMP report produced by the LHJs to ensure the activities

performed were effective in supporting HCA's goals, and the Medicaid State Plan. As needed, HCA will make changes to the directed SPMP activities based on the ACA, HCA initiatives or the progress, accomplishments, barriers, and suggested recommendations provided in the LHJs quarterly report.

Subcontractor

To ensure the effective and efficient administration of the MAC program, HCA will review all LHJ contracts/grants related to outreach and linkage activities that may result in duplication with the MAC program prior to implementation. HCA will review these contracts for, including but not limited to duplication of effort as described by CMS in the Guide; Section IV: PRINCIPLES OF ADMINISTRATIVE CLAIMING, B, 4 and 5 and duplication of payment as described by CMS in the Guide Section IV: PRINCIPLES OF ADMINISTRATIVE CLAIMING, B, 4 and 5.

LHJ Responsibilities

Random Moment Time Study (RMTS)

The LHJs are responsible for monitoring the time study compliance rate and providing additional training to staff as needed. Minimum compliance rates will apply to each LHJ.

Prior to the beginning of each quarter:

- Enter and certify the accuracy of all calendar information in the system.
- Enter and certify that all RMTS participants in the system have HCA-approved job positions.
- Ensure all coordinators and participants have completed training before entering them into the system as an eligible RMTS participant.

During the quarter:

- Monitor the compliance rate for their RMTS. If the non-response rate is over 15%, remedial action must be taken and HCA may require a corrective action.

After the end of the quarter:

- Conduct a 100% coding review of all moments for accuracy.

Annually:

- The lead agency for an RMTS consortium will submit any proposed changes to its membership to HCA for approval.
- Verify that participants have completed annual training.

Claiming

The LHJs are responsible for ensuring the accuracy of claiming data.

Before the beginning of the quarter, the LHJ will:

- Submit any requests to obtain NIRT certification for any donations.
- Review the status of all NIRT-approved funds to determine if they need to resubmitted for recertification.

Before submitting a quarterly claim:

- Enter and certify the accuracy of all salary and benefit or direct cost information in the system.
- Enter and certify the accuracy of the following information entered into the system is accurate:
    - Other Costs, eligible for reimbursement to the extent that they support MAC activities.
    - Funding sources and Revenue offset.
    - Quarterly CPE Local Match certification to ensure CPE complies with section 1903(w)(6)(A) of the Social Security Act and 42 CFR 433.51.
    - Any funds that require NIRT approvals or updates are in place prior to use.
    - Backup source documentation for MER calculation.
    - Indirect Cost Rate Certification
    - Review and certify the claim for accuracy and supporting documentation prior to submitting to HCA for review and approval.

Annually the LHJ will:

- Pull a sample randomly from the System of client IDs to verify their client status for purposes of the MER.
- Notify HCA which proportional MERs will be used for linkage-related activities.
- Notify or confirm to HCA which proportional MERs will be used for linkage-related activities.
- Prepare MER proposal at least annually or as needed when data sources change.

Skilled Professional Medical Personnel

The LHJs will produce a report describing the outcome of HCA directed SPMP activities, including but not limited to the progress, accomplishments, barriers, and suggested recommendations. Appropriate LHJ staff will participate in scheduled quarterly program planning and policy development meetings with HCA to review the report and discuss the effectiveness of the activities performed in supporting HCA's goals, and the Medicaid State Plan. The LHJs will ensure SPMP staff are trained on changes made to the HCA directed SPMP activities, and will closely monitor the RMTS to ensure all activities coded to the enhanced rate comply with the Interlocal agreement, and verifying all SPMP requirements are met.

Subcontractors

To ensure that LHJs are complying with federal and state requirements in handling subcontractors that are considered subrecipients, they must do the following.

- Submit proposed MAC outreach and linkage subcontract(s) to HCA for review and approval prior to implementation. LHJs must not enter into any subcontract prior to receiving written approval from HCA.
- Ensure that any subcontract for MAC activities meets, *at a minimum*, all the terms and conditions required in the HCA MAC contract.
- Maintain documentation demonstrating that each subcontract has been paid 100% of its total MAC related costs before the LHJ submits an A19-1A Invoice to HCA for MAC reimbursement.

- Ensure handling of CPE complies with section 1903(w)(6)(A) of the Social Security Act and 42 CFR 433.51.
- Assume all responsibility for MAC activities and claiming performed by its subcontractor(s).
- Monitor subcontractors as federal subrecipients to ensure program integrity and compliance. The required HCA Subcontractor Review form can be found in the manual.
- Maintain an annual monitoring report for each subcontractor.

[i] 2 CFR 225.55 B (11) 'Cost objective'' means a function, organizational subdivision, contract, grant, or other activity for which cost data are needed and for which costs are incurred.

[ii] As described on page 44 of the 2003 CMS Medicaid School-Based Administrative Claiming Guide