Medicaid Administrative Claiming Cost Allocation Plan

For

Washington State Courts Juvenile Service Divisions

December 2021

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INTRODUCTION

Some of Washington's most vulnerable individuals have trouble accessing needed health care. Government agencies including Washington State Courts Juvenile Service Divisions (WSCJSD) provide services to Washington individuals daily ensuring their overall well-being. Federal funds are available through the Health Care Authority's (HCA) Medicaid Administrative Claiming (MAC) program to reimburse government agencies for some of the cost of their allowable Medicaid administrative activities, when those activities support provision of services as outlined in the Washington State Medicaid Plan. HCA has complete authority and responsibility for the administration of both the State Medicaid Program and the MAC program.

WSCJSD oversees many aspects of the life of a juvenile who has been accused of committing an offense. When a juvenile is placed on probation as an alternative to incarceration, they are typically assigned a probation officer who, among other probation court staff, designs a plan that will help the youth to become a successful member of the community. The primary goals of Juvenile Courts are to promote public safety, help youth build skills, address treatment needs, support families, and successfully restore youth to the community.

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

REIMBURSABLE MAC ACTIVITIES

- Informing individuals about Medicaid and providing them with applications for the program
- Assisting individuals in completing and submitting the Medicaid application for eligibility determination, or referring them to online resources to apply
- Arranging transportation in support of Medicaid covered services
- Evaluating and improving access to Medicaid covered services
- Arranging or coordinating translation/interpretation services that facilitate access to Medicaid covered services
- Providing or receiving training related to Medicaid specific topics (Include training provided by HCA)
- Linkage activities such as referring individuals to Medicaid covered medical, dental, mental health, substance use disorder, and/or family planning services. This also includes coordinating and monitoring the delivery of those services

UNIVERSITY OF MASSACHUSETTS CHAN MEDICAL SCHOOL

HCA contracts with the University of Massachusetts Chan Medical School (UMass) for the operation of the statistically valid Random Moment Time Study (RMTS) model, and for the day-to-day administration of the time study and claims calculation.

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SECTION I: MAC PROGRAM ADMINISTRATION

HCA is responsible for the administration and oversight of all MAC programs in the state of Washington. Only government agencies are eligible to contract with HCA to participate in the MAC program.

HCA contracts with the following government agencies for participation in the MAC program:

- Washington State Courts Juvenile Service Divisions (WSCJSD)
- Federally Recognized Tribes
- Local Health Jurisdictions
- Public School Districts
- Other Government Entities

HCA administers the MAC program and oversees the WSCJSD MAC activities in Washington state and UMass, including:

- Managing the sampling methodology based on reports generated by the online UMass RMTS and MAC Claiming System (System)
- Administering the activity coding in the System, both auto mapped and manually coded by HCA staff
- Accessing real-time data to all time study results and reports
- Requiring full access to all the courts and juvenile probation MAC supporting documentation
- Working with the WSCJSD to:
    - Train MAC Coordinators, RMTS, and/or MAC program in general
    - Monitor the WSCJSD MAC training
    - Collect and review time study and claims data
    - Determine when corrective action plans are necessary

UMass is responsible for providing a single web-based system that operates the RMTS, reimbursement calculations, as well as providing technical System support such as developing or updating reports that provide on demand, real-time, historical, or ad-hoc time study and claiming data including but not limited to:

- Calendaring, compliance rates, RMTS calculations
- Salary and benefit, offset funds, Certified Public Expenditures (CPE), indirect cost rate or other financial data used to calculate claims
- Total time study percentages including participant information, job title, moments selected, activity codes, sample size or other data elements
- Comparisons of multiple time study data elements, claim data elements, or both
- Working with HCA to develop training materials for RMTS/fiscal coordinators and RMTS participants

Ensure appropriate RMTS participation and oversight, including:

- MAC Coordinators, backups and participants have completed required training
    - Retain proof of required training
    - Ensure the MAC Coordinator understands the importance of completing moments, and is aware of applicable sanctions for low compliance rates
- Review RMTS compliance rates and ensure WSCJSD meet the 85% compliance level requirement
- Evaluate and retain the *RMTS Compliance Status Report* as described in the WSCJSD Coordinators Manual.

SECTION II: RANDOM MOMENT TIME STUDY METHODOLOGY

The RMTS methodology quantifies activities of time study participants. It polls participants at random moments during their normal workday over a quarter, and calculates the results. These random moments represent a one (1) minute interval. This method provides a statistically valid means of determining what portion of a group's time is spent performing activities that are reimbursable by Medicaid, and is designed to be quick and user friendly to participants.

Participants only complete the time study for randomly selected moments. Staff should **not** change their normal work activities, but should maintain their normal routines as they would any other day. This is important to the accuracy and validity of the time study.

RMTS procedures are the same for all participants. For each randomly selected moment, the participant will select or provide a response to each of the following questions:

1. What type of activity were you doing?
2. What were you doing more specifically?
3. Who were you primarily working or interacting with?
4. Why were you performing this activity?

HCA will implement a single statistically valid time study state wide. HCA will use data gathered through the RMTS to track and quantify participant activities. The WSCJSD will submit quarterly claims to HCA for reimbursable MAC activities. The reimbursements are calculated based on results of staff participation in the time study. The detailed claiming process is described in the MAC Coordinators Manual.

The following data are used in claim calculations:

- Revenue Offset
- Participant personnel costs
- Participant time spent on reimbursable activities
- Allowable direct or indirect costs
- Federal Financial Participation (FFP)
- Medicaid Eligibility Rate (MER)

MAC ACTIVITY CODES

SUMMARY OF CODES

CODE 1a	Non-Medicaid Outreach	Unallowable Activity (U)
CODE 1b	Medicaid Outreach	Total MER (TM)/50 Percent FFP
CODE 2a	Facilitating Application for Non-Medicaid Programs	Unallowable Activity (U)
CODE 2b	Facilitating Medicaid Eligibility Determination	Total MER (TM)/50 Percent FFP
CODE 3	Non-Medicaid other Program Activities	Unallowable Activity (U)
CODE 4	Direct Medical Services	Unallowable Activity (U)
CODE 5a	Arranging Transportation for Non-Medicaid Services	Unallowable Activity (U)
CODE 5b	Arranging Transportation for Medicaid Services	Proportional MER (PM)/50 Percent FFP
CODE 6a	Arranging or Coordinating Non-Medicaid Translation or Interpretation	Unallowable Activity (U)
CODE 6b	Arranging or Coordinating Translation or Interpretation Related to Medicaid Services	Proportional MER PM/50 Percent FFP
CODE 7a	Program Planning, Policy Development, and Interagency Coordination Related to Non-Medical Services	Unallowable Activity (U)
CODE 7b	Program Planning, Policy Development, and Interagency Coordination Related to Medical/Medicaid Services	Proportional MER PM/50 Percent FFP
CODE 8a	Non-Medical/Non-Medicaid Related Training	Unallowable Activity (U)
CODE 8b	Medical/Medicaid Related Training	Proportional MER PM/50 Percent FFP
CODE 9a	Referral, Coordination, and Monitoring of Non-Medicaid Services	Unallowable Activity (U)
CODE 9b	Referral, Coordination, and Monitoring of Medical/Medicaid Services	Proportional MER PM/50 Percent FFP
CODE 10	General Administration	Reallocated Activities (R)

MAC ACTIVITY CODES AND DESCRIPTIONS

Responses to RMTS moments are auto mapped to the appropriate CMS approved activity code by the System. Any illogical or free typed responses are manually coded only by UMass. Neither participants nor MAC Coordinators can view or edit activity codes.

CODE 1a NON-MEDICAID OUTREACH-U

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 and obtain them. Both written and oral methods may be used. This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Example(s):

1. Informing individuals and families of the Juvenile Functional Family Parole family-focused reentry aftercare model.
2. Informing individuals and families about wellness programs and how to access them.
3. Scheduling and promoting activities to educate individuals about benefits of healthy lifestyles and practices.

4. Conducting general health education programs or campaigns that address lifestyle changes in the general population (e.g., dental prevention, anti-smoking, alcohol reduction).
5. Conducting outreach campaigns to encourage individuals to access social, educational, legal, or other services not covered by Medicaid.
6. Developing and/or distributing outreach materials such as brochures or handbooks for these programs.

CODE 1b MEDICAID OUTREACH-TM/50 Percent FFP

Activities that inform eligible or potentially eligible individuals about Medicaid and how to access the program; such activities include bringing potential eligible individuals into the Medicaid System for the eligibility process. Both written and oral methods may be used. This includes related paperwork, clerical activities, or staff travel required to perform these activities. *Outreach may only be conducted for the population served by the MAC Contractor, i.e. juveniles and their parents or guardians.*

Example(s):

1. Informing individuals and families of the Juvenile Rehabilitation Integrated Treatment Model programs and Mental Health Systems.
2. Informing individuals and families of Medicaid mental health treatment if it directly related to the client's care and medically necessary.
3. Informing individuals and families of Medicaid Apple Health mental health and substance use disorder treatment services, including crisis services, short-term mental health treatment, and inpatient psychiatric services.
4. Informing Medicaid eligible and potentially eligible youth and families about the benefits and availability of services covered by Medicaid including preventive treatment, screening, and Early and Periodic Screening and Diagnosis Testing (EPSDT) services.
5. Providing and/or distributing information and compiling materials to inform individuals about the Medicaid program (including EPSDT, dental, vision), to help identify medical conditions that can be corrected and/or improved and indicate how and where to access services covered by the Medicaid program. (Note: ***Materials developed by the MC Contractor must have HCA's prior approval.)***
6. Assisting the Medicaid agency to fulfill the outreach objectives of the Medicaid program by informing individuals and families about health resources available through the Medicaid program.
7. Contacting pregnant women and parents about the availability of Medicaid prenatal and well-baby care programs and services.
8. Providing information regarding the Medicaid managed care program or managed care health plans to individuals and families and how to access them.
9. Encouraging individuals and families to access medical, dental, mental health, substance abuse treatment, and/or family planning services covered by the Medicaid program.

CODE 2a FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS-U

Activities that assist individuals and families to apply for non-Medicaid programs such as Temporary Assistance for Needy Families (TANF); Supplemental Nutrition Assistance Program (SNAP); 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 paperwork, clerical activities, or staff travel required to perform these activities.

Example(s):

1. Explaining the eligibility process for non-Medicaid programs.
2. Assisting individuals and families in collecting and/or gathering information for non-Medicaid program applications.
3. Assisting individuals and families in completing the application, including necessary translation activities.
4. Developing and verifying initial and continuing eligibility for non-Medicaid programs.
5. Providing and packaging necessary forms in preparation for the non-Medicaid eligibility determination.
6. Assisting families in obtaining/applying for services provided through general health initiatives.
7. Explain eligibility requirements to obtain housing assistance.

CODE 2b FACILITATING MEDICAID ELIGIBILITY DETERMINATION- TM/50 Percent FFP

Assisting individuals and families with the Medicaid eligibility process; this includes related paperwork, clerical activities, or staff travel required to perform these activities. *This activity does not include the actual determination of Medicaid eligibility.*

Example(s):

1. Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process.
2. Assisting individuals and families in completing a Medicaid eligibility application.
3. Gathering information related to the application and eligibility determination for an individual, including resource information.
4. Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
5. Referring an individual and/or family to online resources to apply for Medicaid benefits.
6. Assisting the individual and/or family in collecting and gathering any required information and documents for the Medicaid application.

CODE 3 NON-MEDICAID OTHER PROGRAM ACTIVITIES-U

WSCJSD work closely with those who are on probation in lieu of jail time after being convicted of a crime. Responsibilities include **evaluating individuals on probation to determine the best course of rehabilitation and providing resources.**

This code should be used for performing non-medical or non-Medicaid related activities such as public health information, employment, job training, teaching, and social services. Includes working on projects or programs that are unrelated to the administration of the Medicaid program. This includes related paper, telephone, computer, clerical, and staff travel required to perform these activities.

Example(s):

1. Working and advising youth of their educational options for the future.
2. Providing the court system with written reports for the youth that staff is responsible for.
3. Referring to general health initiative services in the community.
4. Developing a safety plan with a youth and/or their family.
5. Making referrals for and coordinating access to social, such as child care, employment, job training, and housing.
6. Gathering any information that may be required in advance of referrals to services not covered by Medicaid.
7. Participating in a meeting or discussion to coordinate or review an individual's need for vocational and non-health related services.
8. Monitoring and evaluating the non-medical portion of an individual's plan of care as appropriate
9. Providing follow-up contact to ensure that an individual has received non-Medicaid covered services such as food and housing.

CODE 4 DIRECT MEDICAL SERVICES-U

Providing direct client care, treatment, education, and/or counseling services to an individual. This includes administrative activities that are an integral part of or extension of a medical service (e.g., developmental assessments and billing activities). This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Note: Direct Medical Service means the provision of a medical, dental, vision, mental health, family planning, pharmacy, substance abuse or a Medicaid-covered service and all related activities, administrative or otherwise, that are integral to, or an extension of, the healthcare service.

Example(s):

1. Developing a plan of care when part of a medical service.
2. Providing direct clinical and treatment services.
3. Administering first aid, or prescribing injections or medication to an individual.
4. Completing developmental assessments.
5. Providing Targeted Case Management (if covered as a medical service under Medicaid).

CODE 5a ARRANGING TRANSPORTATION FOR NON-MEDICAID SERVICES-U

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.

The individual's probation may include home visits by a probation officer as well as ***office visits to the probation department***. These are designed to monitor the individual's adherence to the probation plan.

Example(s):

1. Scheduling or arranging transportation to meet at probation department or offsite on regular basis.
2. Scheduling or arranging transportation that refers juvenile to additional social programs or assistance as needed or required.
3. Scheduling or arranging transportation to vocational, and/or educational programs and activities.

CODE 5b ARRANGING TRANSPORTATION FOR MEDICAID SERVICES -PM/50 Percent FFP

WSCJSD primary objective is to assist individuals to become active, healthy participants in society through a counseling, motivating, assisting with help from additional programs, rehabilitation, substance abuse, and monitoring of activities.

This activity includes 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 arranging transportation. This includes related paperwork and clerical activities, required to perform these activities.

Example(s):

1. Scheduling or arranging transportation to Medicaid covered services.
2. Scheduling or arranging transportation to Medicaid covered rehabilitation services.
3. Scheduling or arranging transportation to Medicaid covered behavioral health services for substance use disorder and mental health services.

CODE 6a ARRANGING OR COORDINATING NON-MEDICAID TRANSLATION OR INTERPRETATION-U

The Washington WSCJSD are committed to ensuring equal access to justice for all individuals regardless of their ability to communicate in the spoken English language. Language interpreters play an essential role in ensuring due process and helping juvenile services function efficiently and effectively.

Staff could contribute in arranging or coordinating translation/interpretation services for non-Medicaid activities. This includes related paperwork, clerical activities or staff travel required to perform these activities.

Example(s):

1. Arranging for translation/interpretation services (oral or signing services) for translating written documents, often of a legal nature, from English into the target language and from the target language into English.
2. Arranging for translation/interpretation services (oral or signing services) that assist the individual to access and understand social, educational, and vocational services.
3. Developing translation/interpretation materials that assist individuals to access and understand social, educational, and vocational services.

CODE 6b ARRANGING OR COORDINATING TRANSLATION OR INTERPRETATION RELATED TO MEDICAID SERVICES- PM/50 Percent FFP

Arranging or coordinating translation/interpretation services for Medicaid-related activities if it is not included and paid for as part of a medical assistance service. This includes related paperwork, clerical activities or staff travel required to perform these activities.

Note: Translation/interpretation must be provided either by separate units or separate employees performing solely translation/interpretation functions for the Juvenile probation officers and it must facilitate access to Medicaid covered services. WSCJSD does not need to have a separate administrative claiming unit for translation/interpretation. Juvenile probation employees who arrange or coordinate Medicaid translation/interpretation services should use this code.

Example(s):

1. Arranging for translation/interpretation services (oral and signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid.
2. Developing translation/interpretation materials that assist individuals to access and understand necessary care or treatment covered by Medicaid.

CODE 7a PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO NON-MEDICAL SERVICES-U

Education, medical concerns, and court mandates are addressed by the probation department, as are family issues. 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. This is only for employees whose position descriptions include program planning, policy development, and interagency coordination. This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Example(s):

1. Identifying gaps or duplication of non-medical services (e.g., 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 of non-medical programs.
3. 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.
4. Defining the relationship of each agency's non-medical services to one another.
5. Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services to juvenile probation populations.

CODE 7b PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO MEDICAL/MEDICAID SERVICES- PM/50 Percent FFP

Medical concerns, and court mandates are addressed by the probation department, as are family issues. Activities in direct support of the Medicaid agency and the Medicaid state plan associated with the development of strategies to improve the coordination and delivery of medical, dental, mental health, substance abuse treatment, and/or family planning services to individuals and families, 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 related services will be mapped to Code 9.b., Referral, Coordination and Monitoring of Medical Services.* This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Note: Only staff whose official job descriptions include program planning, policy development and interagency coordination may use Code 7b for collaborative development of strategies to improve the coordination and

delivery of Medicaid related services to juvenile probation population; e.g., planning and developing procedures to track requests for services.

Example(s):

1. Identifying gaps or duplication of medical, dental, mental health, substance abuse treatment and/or family planning services and developing strategies to improve the delivery and coordination of these services.
2. Evaluating the need for medical, dental, mental health, substance abuse treatment and/or family planning services and developing services in relation to specific populations or geographic areas.
3. Developing strategies to assess or increase the capacity of medical, dental, mental health, substance abuse treatment, and/or family planning programs.
4. Monitoring medical, dental, mental health, substance abuse treatment, and/or family planning delivery Systems.
5. Working with other agencies and/or providers of medical, dental, mental health, substance abuse treatment, and/or family planning services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligible individuals.
6. Developing advisory or work groups of health professionals in conjunction with HCA to provide consultation and advice regarding the delivery of health care services.

CODE 8a NON-MEDICAL /NON-MEDICAID RELATED TRAINING-U

Coordinating, conducting, or participating in training events regarding the benefit of programs other than Medical. This includes related paperwork, clerical activities, or staff travel required to perform these activities

Example(s):

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 8b MEDICAL/MEDICAID RELATED TRAINING- PM/50 Percent FFP

Collaborative workgroups of state and federal officials are addressing topics that are critical for ensuring a solid health insurance infrastructure. Coordinating, conducting, or participating in training events regarding Medicaid related services, and how to assist individuals and families in accessing such services and how to effectively refer them for services. This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Example(s):

1. Participating in or coordinating training that improves the delivery of Medicaid covered services.
2. Participate in or coordinate training in “Medicaid and Justice-Involved Populations.”
3. Learn information and tools to assist states in implementing strategies that implement Medicaid enrollment and care coordination strategies for eligible individuals.

CODE 9a REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES-U

Juvenile probation officers typically work with **at-risk youth** referring, coordinating, and monitoring the delivery of non-Medicaid covered services. This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Example(s):

1. Making referrals for and coordinating access to social and educational services such as child care, employment, job training, or housing.

2. Gathering any information that may be required in advance of referrals to services not covered by Medicaid.
3. Participating in a meeting or discussion to coordinate or review an individual's need for vocational and non-health related services not covered by Medicaid.
4. Monitoring and evaluating the non-medical segments of an individual's plan as appropriate.

CODE 9b REFERRAL, COORDINATION, AND MONITORING OF MEDICAL/MEDICAID SERVICES- PM/50 Percent FFP

The goal of WSCJSD is usually the rehabilitation of the offender, in the belief that juveniles have an opportunity to turn their lives around with intervention.

Referring, coordinating, and monitoring the delivery of Medicaid covered services such as medical, dental, mental health, substance abuse treatment, and/or family planning. This includes related paperwork, clerical activities, or staff travel required to perform these activities. Note any targeted case management, if provided or covered as a medical service under Medicaid should be reported under Code 4, Direct Medical Services.

Example(s):

1. Referring individuals and families to Medicaid behavioral health treatment if it is directly related to the client's care and medically necessary.
2. Making referrals for and/or ccoordinating the delivery of community based medical, dental, mental health, substance abuse treatment, and/or family planning Medicaid covered services for an individual with special health care needs.
3. Referring, arranging for, or coordinating medical, dental health, mental health, substance abuse treatment, and/or family planning evaluations; this includes gathering of any information that may be required in advance of the Medicaid covered service.
4. With permission from individuals and families exchange Medicaid information to support physical and behavioral health providers working with individuals with substance use disorders. Individuals have a right to decide who may share and receive their information.
5. Gathering any information that may be required in advance of medical/dental/mental health referrals.
6. Identifying and referring individuals who may need Medicaid family planning services.
7. Participating in a meeting or discussion to coordinate or review an individual's needs for Medicaid covered services.
8. Providing follow-up contact to ensure that an individual has received the prescribed medical, dental, mental health, substance abuse treatment, and/or family planning Medicaid covered services.
9. 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.

CODE 10 GENERAL ADMINISTRATION-R

This code should be used when performing activities that are not directly related to other specific program activities. This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Note: Certain functions, such as payroll, maintaining inventories, developing budgets, executive direction, etc., are considered overhead and are only allowable through the application of an approved indirect cost rate.

Example(s):

1. Taking paid time off, such as paid breaks, vacation, sick leave, bereavement, jury duty, or other paid time off.
2. Establishing goals and objectives of health-related programs as part of the agency's annual or multi-year plan.
3. Reviewing agency's procedures and rules.
4. Developing and monitoring agency or program budgets.
5. Attending or facilitating unit staff meetings, training, or board meetings (this includes MAC training).
6. Performing administrative or clerical activities related to MAC coordinator activities.
7. Attending or facilitating general agency staff and/or board meetings.

8. MAC or RMTS System related training.
9. RMTS System monitoring, maintenance, and/or support, and completing a random moment.
10. Supervisor related activities including but not limited to performance evaluation for example.
11. Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

SECTION III: PARTICIPATING IN THE RMTS

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

PREDEFINED DROPDOWN RESPONSES

To complete RMTS moments, participants may use a set of predefined dropdown responses which correspond with common activities they perform. If none of the predefined responses apply to that given moment, participants must free type a response in the space provided. It is important that time is tracked according to the activity being performed precisely at the random moment. The dropdown responses related to activities listed in the Coordinator Manual and will be auto mapped to appropriate claiming codes. UMass staff will review and determine which activity code applies for all free typed responses.

DOCUMENTATION TO SUPPORT MOMENT RECORDED

Documentation in support of administrative claims must be sufficiently detailed 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 WSCJSD 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.

Examples of supporting documentation include, but are not limited to:

- Calendars
- Chart notes
- Activity logs
- RMTS Reports

NARRATIVE DESCRIPTION

Narrative descriptions must describe in detail, what activity was being performed, and how it relates to Medicaid. Narratives must clearly describe why the activity was being performed and who was involved. Referral activities should specifically state to whom or where a referral was made, and coordination activities should clearly explain what services were being coordinated and specifically state who was involved. In addition to the above required documentation, participants must provide a narrative description of the activity they recorded through the predefined dropdown responses. Once the participant selects a response for each question, a free type box appears, and the participant must enter up to 250 characters in the space provided to record their narrative.

STATUS OF RESPONSES

All responses for random moments must be completed within five (5) work days after the sampled moment. Moments expire after the five (5) work day grace period and are no longer available. Participants select or free type only one response for each question. Before they can submit the responses, participants must certify that the responses are accurate and complete.

The MAC Coordinator and HCA staff will monitor the status of responses using live RMTS reports. The System will notify all participants with incomplete responses 4 hours, 12 hours and 24 hours before the moment expires to complete the time study. It is the responsibility of the MAC Coordinator to monitor the RMTS reports to ensure moments are answered timely. The MAC Coordinator must follow up with all participants who have outstanding moments prior to their expiration. HCA will periodically review the RMTS reports during the quarter to ensure the MAC Coordinator is following up with this requirement. If HCA identifies any issues or concerns from this review, HCA will contact the MAC Coordinator to provide technical assistance.

RANDOM SAMPLING PRECISION AND REQUIRED CONFIDENCE LEVEL

HCA will conduct the RMTS methodology on a quarterly basis for those contractors which are participating in this program. The purpose of the study is to identify the proportion of administrative time allowable and reimbursable under the MAC program. A time study reflects how staff time is distributed across a range of activities. A time study is not designed to show how much of a certain activity staff perform; but how time is allocated among different activities.

HCA uses a sampling methodology that achieves a 95% confidence level with a precision of +/- 2%. Results from statistical analysis indicate that 2401 sampled moments are required for each quarter. To ensure enough moments are completed to be statistically valid, the system oversamples by 15% for a total of 2762 moments per pool.

A combination of every participant in the pool and each minute they work during a quarter is created. All combinations are pooled, and 2762 moments are randomly selected. Each combination represents a specific one-minute interval within the participants' standard business/work hours.
The only days that are excluded from potential moments are holidays, and non-work days identified in the RMTS calendar.

NON-RESPONSES AND MINIMUM RESPONSE RATE

Non-responses are moments not completed by the participant within five (5) work days. The return rate of valid responses for each contractor must be a minimum of 85%. To ensure that enough moments are completed for a statistically valid sample, HCA oversamples by 15%. The response rate is calculated by dividing the number of completed moments by the total of all moments generated. If the state-wide response rate falls below 85%, all of the moments that are not completed will be added to the denominator for the calculation of each activity code percentage. The numerator will be the number of moments coded to the given activity code. Oversampled moments are not tracked separately.

A moment will be considered a non-response when it has expired. HCA and UMass will monitor the response rate of contractor by reviewing the RMTS Compliance Status Report. Any contractor non-response rate greater than 15% is unacceptable, and HCA will require remedial action.

JOB CLASSIFICATIONS ELIGIBLE TO PARTICIPATE

Job classifications eligible to participate in the RMTS include employees:

- Who are directly employed or contracted by the WSCJSD;
- WSCJSD staff must be direct employees of the WSCJSD 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 from the date of the Washington State "state of emergency" through the national state of emergency period for the COVID related activities only.

EXAMPLES OF ELIGIBLE POSITION/JOB TITLES

The following groups of job categories are eligible to participate in the MAC program. Each participating WSCJSD uses a unique process specific to its county 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.

Administrative Services	**Social and Health Related Services**	**Educational/Training**
At-Risk Youth Case Manager/Juvenile Court Specialist	Juvenile Probation Counselor/Lead	Education and Employment Specialist
MAC Coordinators	Assistant Probation Counselors	Aggression Replacement Training (ART) Trainers
Back-up MAC Coordinators	Juvenile Probation Supervisors	Regional Core Training (RCT) Trainers
Juvenile Services Associates	Juvenile Probation Officers	Diversion Trainers
Juvenile Services Secretary	Assistant Probation Officers	Health and Education Advocacy
Office/Clerical	Nurse Practitioners/Licensed Practical Nurse (LPN) - Probation Services only (Urine Test, etc.)	
	Treatment Counselors/Chemical Dependency Professionals	
	Alternative Program Supervisors	
	Social Workers	

SUMMARY OF RMTS PROCESS COMPONENTS

ANNUALLY:

MAC Coordinators update a claiming year calendar in the System by June 1st; before the start of each claiming year as described in the MAC RMTS Coordinator Manual. (Claiming year mirrors the state fiscal year (FY) which runs from July 1st through June 30th.)

QUARTERLY:

Prior to Quarter Start

- MAC Coordinators enter/confirm a list of eligible participants, staff work schedules, and complete any updates to individuals staff work schedules in the System by the 10th of the months prior to the start of each quarter.
- New participants receive "welcome" emails with usernames and instructions for establishing a password, and completing online training (participants cannot complete moments until they have completed the online training).
- Five days prior to the start of the quarter, HCA and UMass confirm that all set-up is complete and cues the System to generate the random moments for the quarter.

During the Quarter

- Participants receive an email notification at the exact time of each randomly assigned moment. The email will include the assigned date and time.
- If assigned moments are not answered, participants receive follow-up notification via email 72 hours, 48 hours and 24 hours prior the moment's expiration date and time with a copy to the MAC coordinator and /or supervisor(s) on the last two notices.
- Participants complete the time study.
- After five (5) business days; the moment expires and cannot be altered.
- Free typed responses are reviewed and coded by UMass central coders throughout the quarter. This process will be completed no later than 2 weeks from the end of the quarter. If needed, participants are contacted via email for clarification. Clarification questions from central coders and clarifying responses from participants are saved in the system to support moment activity documentation.

After the Quarter Ends

- MAC Coordinators enter/confirm the actual staff salary and benefits expenditures for participating staff in the System to be used for claim calculation within 120 days after the close of the quarter.
- HCA reviews a random 5% sample of moments generated by the System to verify the accuracy of the coding.
- The System verifies the results to ensure the 95%/2% threshold for statistical validity is met and that the threshold for compliance with 85% participation (answered moments) is met.

SECTION IV: TRAINING

Staff participating in the program must complete training prior to participation and annually thereafter. UMass provides online training for participants, while the RMTS coordinators are required to provide live training to new participants, and as needed. Staff **must** certify they have completed the online training prior to answering their first moment, and/or performing any activity within the System. The System tracks the online training and certification.

Note: Any training material developed by the courts and probation services must be reviewed and approved by HCA prior to its use**.**

RMTS COORDINATOR TRAINING

HCA will train all MAC Coordinators on the following:

- Overview of the RMTS System
- The Coordinator's role
- Importance of completing moments and adequate narrative for documenting activities
- Importance of the RMTS response rate
- Accessing and entering staff calendar and data into the System
- Timeframes and deadlines
- Accessing System reports
- Claiming process
- Development of an audit file
- Non-compliance and other consequences

RMTS PARTICIPANT TRAINING

The online training will help participants:

- Log into the RMTS System
- Understand the RMTS
- Answer a moment

It is the MAC Coordinator's and/or supervisors' responsibility to monitor the RMTS reports in the System to ensure all participants have completed the required training prior to participating to the time study. Participants will receive a certificate when they successfully complete the training. The System will prevent any participant from answering moments if they have not completed the online training.

Information on participant training completion can be accessed in the system using On-line Management Reports.

SECTION V: CLAIMING

Please refer to the Coordinators Manual for a detailed description of MAC claiming.

GENERAL

WSCJSD must:

- Submit claims in accordance with the contract and the Coordinators Manual
- Only use the state of Washington A19-1A Invoice Voucher (A19) produced by the System
- Ensure only authorized individuals sign the A19
    - By signing the A19 the WSCJSD certifies the accuracy of the data entered into the System.
- Submit signed A19s on a quarterly basis
- Submit a completed and approved Certificate of Indirect Costs annually
- Submit quarterly Local Match Certification and CPE forms with the signed A19
    - HCA will not process any A19s, until the CPE Local Match Certification form is submitted and approved by HCA
- HCA must receive the signed/dated A19 Invoice Voucher from the WSCJSD to the HCA Program Manager through email no more than thirty (30) calendar days after HCA has approved the claim submission in the RMTS/claiming system.

RMTS MEDICAID ELIGIBILITY RATE (MER)

HCA will implement a single statistically valid time study across all participating WSCJSD's, and will use data gathered through the RMTS to track and quantify participant activities. WSCJSD's will submit quarterly claims to HCA for reimbursable MAC activities. The reimbursements are calculated based on results of staff participation in the time study. The detailed claiming process is described in the WSCJSD Coordinator's Manual.

The following data are used in claim calculations:

- Revenue Offset
- Participant personnel costs
- Participant time spent on reimbursable activities
- Allowable direct or indirect costs
- Federal Financial Participation (FFP)
- Medicaid Eligibility Rate (MER)

Medicaid Eligibility Rate (MER)

Each WSCJSD will calculate the MER based on how they deliver services. This will account for each WSCJSD unique health delivery system.
The MER calculation is based on populations who receive services provided by the court staff.

The MER is calculated according to the following formula:

$$\frac{\text{Total number of unduplicated clients eligible for Medicaid served by the court}}{\text{Total number of unduplicated clients provided with services by the court}}$$

The participating WSCJSD will track both the total unduplicated number of clients eligible for Medicaid during the quarter, and the total number of unduplicated clients provided with services during the

quarter. The MER will be calculated for each individual WSCJSD via a data match by comparing the WSCJSD client list with HCA's Medicaid eligibility list. Eligibility is only based on approved Recipient Aid Category (RAC) codes.

ANNUAL INDIRECT RATE

The WSCJSD is prohibited from claiming any expenses as direct costs on any A19, if those expenses are included in an approved indirect rate. All staff included in an approved indirect rate are prohibited from participating in the time study.

Indirect rates must be reviewed and approved by the Contractor's cognizant agency. HCA requires:

- An indirect rate covering the 12-month calendar year
- A copy of the cognizant agency's approval letter
- Copies of all documentation used by the cognizant agency to calculate the indirect rate
- Documentation from the cognizant agency if the rate changes
- The WSCJSD to provide any additional documentation related to indirect rates if requested

SOURCE OF FUNDS & CERTIFIED PUBLIC EXPENDITURES

WSCJSD must use Certified Public Expenditures (CPE) to obtain Federal Financing Participation (FFP). WSCJSD must document the local matching funds quarterly. HCA will review the source of funds to ensure that they are allowable.

Federal statute and regulation permit state, local, or Tribal government to provide the non-federal share of Medicaid expenditures. Funding for the non-federal share may be directly appropriated to a government unit by their legislature or other authority, transferred between government units, or actual expenditures incurred by the government units may be certified as public expenditures eligible for Medicaid FFP. Regardless of the method used to fund the non-federal share, the funding must be provided by a unit of government.

CMS policy is authorized by Section 1903 (W) (6) of the Social Security Act which specifically identifies states, and units of governments 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

WSCJSD are prohibited from requiring or allowing private non-profits to participate in the financing of the non-federal share of expenditures unless they get approved by the National Institute Reimbursement Team (NIRT). Non-governmental units may not voluntarily provide, or be contractually required to provide, any portion of the non-federal share of the Medicaid expenditure.

REVENUE OFFSET

Revenue offset is a key principle in understanding the purpose of the funding worksheet. Federal regulations in 2 CFR 225(C)(4) state that for a cost and its funding to be reimbursable, it cannot be used to meet cost sharing or matching requirements of any federal award in either current or prior period, except as specifically provided by federal law of regulations.

To ensure that costs from other federal funding sources that overlap with MAC are not paid twice, the invoice removes them from (offset against) the MAC cost pools prior to the application of the RMTS results and the Medicaid Eligibility Rate (MER).

Sample categories of revenue offset which must be applied in developing the net costs (not all inclusive):

- All federal funds
- All state expenditures which have been previously matched by the federal government
- Insurance and other fees collected from non-governmental sources
- All applicable credits such as receipts or reduction of expenditure type transactions offsetting or reducing expense items allocable to federal awards as direct or indirect costs.

Certain revenues must be offset to reduce costs to determine the total amount of costs in which the federal government will participate. To the extent the funding sources have paid or would pay to participate in the costs, federal Medicaid funding is not available and the costs must be removed from total costs Per OMB Circular A-87.

REVENUE OFFSET PROCESS

- To determine the amount of total allowable staff salary and benefits, WSCJSD must first perform revenue offset by subtracting any federal or state grant dollars included in the salary and benefits.
- Time study statistics must be applied to the remaining salary and benefits (total allowable staff salary).
- To comply with this requirement, the WSCJSD must subtract from the staff salary and benefits, any federal or state grants received, including but not limited to, any funds received on behalf of a program for the work they do.
- In some cases, the revenue offset amount could include donations if those donations were specifically given to a program.

Example - Revenue Offset Process

Quarterly Gross Staff Salary/ Benefits	$100,000
Other Federal/State funds received (Offset Amount)	($ 20,000)
Quarterly Net Salary/Benefits	$ 80,000
RMTS results (MAM 50% / Non-MAM 50%)	($ 40,000)
Adjusted Salary/Benefits after applying RMTS	$ 40,000

Applying a MER% of 30% to the Adjusted S/B:

Net Total Computable (TC) $12,000

Applying the 50% Federal Financial Participation to the TC:

$6,000 local funds & $6,000 Medicaid funds = $12,000 TC

ADMINISTRATIVE FEE

The administrative fee for the MAC program is intended to cover the cost of staff at the HCA to administer the program. Participating contractors will only pay an administrative fee to the extent that they participate in the program

The method of collecting the administrative fee is a line item withholding on each quarterly claim. The calculation of the rate to be used on the quarterly claims will be based on the costs associated with the staff effort specifically spent on MAC related work for an entire State Fiscal Year, (SFY). This cost will be divided by the dollar amount of administrative claims submitted by the participating contractors in the MAC program for the same SFY. The calculated rate will be used on the claims for the subsequent SFY. At the end of the period, during the process of developing the rate for the new period, the rate used for the period ending will be validated using the actual claimed expenditure information for that period and any variances will be settled with the contractor during the second quarter of the new SFY.

At the beginning of the fiscal year (prior to calculation of the first quarterly claim for the year), HCA will use the MAC Claiming System screen to enter the two (Admin Fee % and UMass Fee %) preliminary annual fee percentages to be used for the fiscal year. The same fee percentages are applied to all contractors within the contractor type (i.e. WSCJSD claims will be calculated with their own fee percentages.)

CORRECTIVE ACTION PLANS

HCA will pursue a corrective action plan if a Contractor fails to meet any MAC program requirements described in the CAP, Manual, this Agreement, or as determined by HCA. HCA will pursue a corrective action plan if the contractor fails to address or correct any problems timely and sufficiently as determined by HCA.

The Contractor must develop and submit a corrective action plan response to HCA for approval within thirty (30) days of HCA's notification. If a Contractor fails to meet the requirements outlined in the corrective action plan, HCA will impose sanctions that may include, but are not limited to; conducting more frequent reviews, delayed or denied payment of MAC claims, recoupment of funds, or termination of this Agreement.

Examples of Contractor actions that may result in corrective action and/or sanctions include, but are not limited to:

a) Repeated and/or uncorrected errors in financial reporting;
b) Failure to maintain adequate documentation;
c) Failure to cooperate with state or federal staff;
d) Failure to provide accurate and timely information to state or federal staff as required;
e) Failure to meet time study minimum response rates;
f) Failure to meet statistical validity requirements; and
g) Failure to comply with the terms and conditions of this agreement.

If the Contractor fails to meet the requirements outlined in the corrective action HCA will impose sanctions including but not limited to:

a) Conducting more frequent reviews,
b) Delaying or denying payment of MAC claims,
c) Recouping of funds, or
d) Terminating the Contract.

Corrective Action Termination

In the event HCA determines that Contractor has failed to comply with the terms and conditions of this Contract, HCA has the right to suspend or terminate this Contract. HCA will notify Contractor in writing of the need to take corrective action.

If corrective action is not taken within five (5) Business Days, or other time agreed to in writing by both parties, the Contract may be terminated.

HCA reserves the right to suspend all or part of the Contract, withhold further payments, or prohibit Contractor from incurring additional obligations of funds during investigation of the alleged compliance breach and pending corrective action by Contractor or a decision by HCA to terminate the Contract.

SECTION VI: OVERSIGHT AND MONITORING

HCA has established proper internal controls for program monitoring and oversight to ensure the integrity of the MAC program. As part of HCA's oversight, in depth monitoring activities will be performed on an on-going basis.

HCA performs monitoring activities to ensure that Contractors follow the federal and state regulation for the MAC program. These activities include, *at a minimum*, the following actions:

NON-RESPONSES AND MINIMUM RESPONSE RATE

Non-responses are moments not completed by Participant within five (5) business days, except for expired moments where the Participant was on paid or unpaid leave. The return rate of valid responses for the RMTS must be a minimum of eighty five percent (85%).

The following remedial action is required of the Contractor if the RMTS response rate drops below eighty-five percent (85%):

a) Non-response rates greater than fifteen percent (15%):
   - **i.** HCA may send written notification to the Contractor requesting Corrective Action Plan to ensure a minimum eighty five percent (85%) compliance rate for the RMTS is achieved in subsequent quarters.
   - **ii.** The Contractor must develop and submit the plan to HCA for approval within thirty (30) business days of HCA's notification.
   - **iii.** Failure to provide a timely corrective action plan within thirty (30) business days may result in the Contractor being prohibited from participation in MAC for the following quarter or contract termination.
   - **iv.** An eighty five percent (85%) compliance rate for the RMTS must be met in the following quarter.

b) Non-response rates greater than fifteen percent (15%) for two (2) consecutive quarters:
   - **i.** HCA may reduce reimbursement by thirty five percent (35%) for the second consecutive quarter.
   - **ii.** The Contractor will be notified via Certified Mail of the reduced reimbursement.
   - **iii.** Eighty five percent (85%) compliance rate for the RMTS must be met in the following quarter.

c) Non-response rates greater than fifteen percent (15%) for three (3) consecutive quarters:
   - **i.** HCA may deny all reimbursement for the third consecutive quarter.
   - **ii.** The Contractor may be prohibited from participating in MAC for the following quarter, which is the 4th consecutive quarter

iii. HCA will notify the affected Contractor via certified mail of the denied reimbursement for the third consecutive quarter and prohibited participation in MAC.

iv. None of the affected Contractors may claim for any denied or reduced reimbursement from the three consecutive quarters of non-compliance.

WSCJSD must not claim for any denied or withheld reimbursement. WSCJSD must begin participating in MAC following the prohibited quarter (5th consecutive quarter). If the WSCJSD resumes claiming during the 5th consecutive quarter, and still fails to meet the minimum response rate of 85%, the contract may be terminated.

WSCJSD must abide by all rules and limitations as outlined in the contract and the Manual.

EXAMPLE OF RE-CALCULATION DUE TO FAILURE TO MEET 85% PARTICIPATION

The following is an example of how HCA will handle situations where RMTS participation falls below the required 85%. Please note, that moments not answered are assigned to Code 3; therefore, the result in this example is a reduction in the percentage of claimable time from 10.41% to 8.75%.

ORIGINAL RMTS RESULTS

Activity Code	Count of Moments	RMTS % (results for Claim Calc)	Reimbursable Time
1a	24	1.05%	
1b	9	0.39%	0.39%
2a	30	1.31%	
2b	56	2.45%	2.45%
3	272	11.89%	
4	715	31.26%	
5a	24	1.05%	
5b	9	0.39%	0.39%
6a	2	0.09%	
7a	19	0.83%	
7b	27	1.18%	1.18%
8a	85	3.72%	
8b	2	0.09%	0.09%
9a	52	2.27%	
9b	135	5.90%	5.90%
10	826	36.12%	re-allocated
Subtotal	**2287**	**100.00%**	**10.41%**
Not Paid Time	24		
Left/LOA	18		
Total Answered	2329		
Not Answered	433		
Grand Total	2762		
Participation %	**84.32%**		

REVISED RMTS RESULTS

Activity Code	Count of Moments	RMTS % (results for Claim Calc)	Reimbursable Time
1a	24	0.88%	
1b	9	0.33%	0.33%
2a	30	1.10%	
2b	56	2.06%	2.06%
3	705	25.92%	
4	715	26.29%	
5a	24	0.88%	
5b	9	0.33%	0.33%
6a	2	0.07%	
7a	19	0.70%	
7b	27	0.99%	0.99%
8a	85	3.13%	
8b	2	0.07%	0.07%
9a	52	1.91%	
9b	135	4.96%	4.96%
10	826	30.37%	re-allocated
Subtotal	**2720**	**100.00%**	**8.75%**
Not Paid Time	24		
Left/LOA	18		
Total Answered	2762		
Not Answered	0		
Grand Total	2762		
Participation %	**100.00%**		

TRENDS

Trends to be identified and monitored may include total claims and reimbursement levels. Any significant variations from historical trending will be followed up with the Contractor as a component of the ongoing review process.
HCA staff will also schedule and participate in regular meetings, webinars, and/or conference calls with the Contractors to discuss time study trends, compliance levels, and other Medicaid or time study issues.

HCA will monitor all components of the time study and claiming for trends. Examples include:

Claiming components

- A19 review
- Direct costs claimed
- Local Match Certification
- Indirect rate
- CPE

Time study components

- Participant list
- Non-response rates
- Free type responses
- Narrative Description
- Illogical responses
- Auto mapping
- Correlation between narrative description and responses
- Percent of time allocated to each code

ACTIVITY CODING

During each quarter, when a moment is answered, this moment/response could fall into two different categories: auto-mapped or non-auto-mapped.

- Auto-mapping occurs when a participant selects all dropdown responses, which the system can automatically auto-map to the appropriate code according to the coding cross walk.
- Non-auto-mapping occurs when the system does not automatically auto-maps the code according to the coding cross walk. HCA reviews 100% of all non-auto mapped moments/responses and assigns the appropriate code. Examples of this category include:
    - ✓ Free typed responses
    - ✓ An illogical combination of response

The procedure for non-auto-mapping is completed by UMass staff (coders). The coders review and the moments/responses as assign and activity code. If two coders are unable to agree, a different staff member (third coder) will be consulted to assign the final code.

UMass may request follow up documentation from participants for non-auto-mapped moments. If follow up documentation is not received by UMass within 2 weeks of the request the moment will be coded as pending expired.

Note: RMTS participants and RMTS Coordinators do not have access to view or edit participant's responses and assigned activity codes.

DESCRIPTION OF MOMENT CODING

Moment Status	Definition	Moment Status Complete	Comments
Auto-Mapped	If the participant uses predefined responses available for each question, the moment will auto-map to that code.	Yes	If the responses do not make sense or if a free typed response is submitted, the moment cannot be auto mapped. HCA validates 15% of all WSCJSD moments.
Incomplete	Moments remain active until completed by participant.	No	Moments are active from the time they are generated through the end of their grace period. Participants may only respond to or change responses on active moments.
Incomplete Expired	Moments not completed by the participant and are past the grace period.	No	Once a moment is expired, the participant cannot open the moment and respond to it.
Manual Incomplete	Participants manually free typed a response or illogical combination.	Participant: Yes UMass staff: No	UMass staff will select the activity code or obtain more information from the participant before selecting the activity code.
Pending	If UMass staff needs additional information, they send an email to the participant and change the moment status to Pending.	No	UMass staff is responsible to check and uncheck the Pending box. While it is checked, the moment status remains Pending.
Approval Required	UMass staff needs to review free typed responses or illogical combinations and assign activity codes.	Participant: Yes UMass staff: No	
First Approval	First UMass staff coder has assigned an activity code to the response and a second coder has not yet reviewed the assigned code.	Participant: Yes UMass staff: No	
Approved	UMass first and second coders have reviewed the participant's responses and approved the activity code.	Yes	Time and activity code are recorded for use in claim calculation. When UMass coders do not agree on an activity code, HCA will be consulted to assign the final code.
Pending Expired	UMass staff change the moment to pending expired when requested information from the participant have not been received within 2 weeks after the request.	No	
Not Paid Time	Participants indicate that they were not scheduled to work at the time of their moment. Auto mapped to non-claimable code.	Yes	UMass coders may manually code for participants who are on extended leave or have left the agency.

STATUS OF MOMENTS

Each moment has a *status* indicating where it is in the time study process and that status is reflected on multiple System reports. The MAC Coordinator must closely monitor any moments with an "Incomplete" status and follow up with the participant to complete their time study prior to the end of the quarter.

VALIDATING RESULTS OF MANUALLY CODED MOMENTS

At the end of each quarter, HCA generates a 15% sample of the non-auto mapped coded responses/moments that have been manually coded by UMass to verify accuracy.

VERIFYING NARRATIVE DESCRIPTION

UMass will review the narrative description for all moments included in the manually coded and auto mapped moments, to ensure the narrative corresponds with the activity provided. UMass will follow up with participants if needed. If UMass requests documentation and it is not received by 2 weeks of the request, the moment will be coded as a non-response. These moments will go into the Contractors non-response rate calculation.
HCA and UMass will track trends, identify auto mapping errors and identify discrepancies between the narrative description and activity responses provided. HCA and UMass will make necessary changes to the System, or provide additional training as needed to correct any issues identified.

RECOMMENDED DOCUMENTATION

Documentation in support of administrative claims must be sufficiently detailed 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 WSCJSD'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.

SCHEDULED THREE (3) YEAR FISCAL MONITORING

HCA conducts MAC Contractor fiscal monitoring at least once every three (3) years for each Contractor. HCA fiscal review will consist of an in-depth analysis of one quarter of claims. Based on the results of this review, HCA may select additional quarters for further claims review.

HCA Financial Services, Accounting staff will:

- Compare a 15% sampling of Contractors payroll records to the information in the System.
- An HCA public information data analyst will generate the sample of 15% or a minimum of ten (10) participants (whichever is greater)
- Review source of funding to ensure CPE complies with all federal, state, HCA and MAC regulations.

MAC SUBCONTRACTORS

Contracted WSCJSD's are not authorized to add subcontractors on their MAC participation staff roster.