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Medicaid Administrative Claiming Manual

Local Health Jurisdictions



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Revision highlights

1. National or State Public Health Emergencies (page 10):

In the event of a national or state public health emergency, natural disaster, or act of terrorism, HCA may allow certain modifications to LHJ MAC program requirements. These modifications may include changes to:

- RMTS response times
- RMTS activity codes
- Invoice due dates
- Training deadlines
- RMTS validity requirements
- Additional reimbursable activities related to infection control, surveillance, and prevention.

These modifications are effective in 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 emergency declaration ends.

2. Summary of MAC activity codes (page 18 and 19):

Code 6c Arranging Transportation for Medicaid Services (State or National Public Health Emergency Only) (Proportional MER)

Code 7a Interpretation for Non-Medicaid Services for 19 years and over

Code 7b Interpretation for Medicaid Services for 19 years and over (Proportional MER)

Code 7c Interpretation for Non-Medicaid Services for under 19 years

Code 7d Interpretation for Medicaid Services for under 19 years (Proportional MER)

Code 7e Interpretation for Medicaid Services for 19 years and over (State or National Public Health Emergency Only) (Proportional MER)

Code 7f Interpretation for Medicaid Services for under 19 years (State or National Public Health Emergency Only) (Proportional MER)

Code 8c Program Planning, Policy Development and Interagency Coordination Related to Medicaid Services (State or National Public Health Emergency Only) (Proportional MER)

Code 9c Medical/Medicaid Related Training (State or National Public Health Emergency Only) (Proportional MER)

Code 10c Referral, Coordination and Monitoring of Medicaid Services (State or National Public Health Emergency Only) (Proportional MER)

Code 12c SPMP Activity Related to the Administration of the Medicaid State Plan (State or National Public Health Emergency Only) (Proportional MER)

3. LHJ Staff Interpreters (page 22):

- Code 7a and Code 7b are for interpreter activities directed to individuals 19 years and over:
 - Code 7a: Interpretation for Non-Medicaid Services for 19 years and over.
 - Code 7b: Interpretation for Medicaid Services for 19 years and over.
- Code 7c and Code 7d are directed to individuals under 19 years:
 - Code 7c: Interpretation for Non-Medicaid Services under 19 years.
 - Code 7d: Interpretation for Medicaid Services for under 19 years.

4. Interpreter codes (page 25):

Staff who are qualified interpreters may use the activity code 7 when providing interpretation services. All staff may use this code when arranging interpretation services.

Code 7a: Interpretation for non-Medicaid Services for individuals 19 years and over.

Code 7b: Interpretation for Medicaid Services for individuals 19 years and over.

Code 7c: Interpretation for Non-Medicaid Services for individuals under 19 years.

Code 7d: Interpretation for Medicaid Services for individuals under 19 years.

5. Page 10:

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- Additional reimbursable activities related to infection control, surveillance, and prevention.

Introduction

The purpose of this Manual is to provide an overview of the Medicaid Administrative Claiming (MAC) Program and the roles and responsibilities of the RMTS and Fiscal Coordinators. This Manual also provides step-by-step instructions for completing the Coordinator's duties.

Purpose of the MAC program

Federal funds are available through the Health Care Authority's (HCA) MAC program to reimburse Local Health Jurisdictions (LHJs) for the cost of activities that support the efficient administration of the Medicaid State Plan (State Plan). HCA contracts with multiple local governmental entities in addition to LHJs to carry out the goals of the MAC program, which include:

- 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 interpretation and transportation services as well as interpreting for clients.
- Evaluating and improving access to Medicaid-covered services through program planning, policy development, and interagency coordination.

- Performing Skilled Professional Medical Personnel activities that are in direct support of the Medicaid State Plan.
- Providing or receiving training related to Medicaid services or MAC.
- Referring individuals to Medicaid-covered medical, dental, vision, mental health, family planning, pharmacy, and/or substance abuse treatment services. This includes coordinating and monitoring their delivery.

The **Medicaid State Plan** is an agreement between the state and federal government describing the populations and services the Plan covers, eligible providers, and the way services will be paid.

The MAC program in local health jurisdictions

Many of the programs operated by LHJs include MAC activities. These fall into several broad groupings:

Programs for low-income pregnant and parenting women, their families, and their children include, but are not limited to:

- Home visiting and parent education programs;
- Nutrition programs;
- The Medicaid pediatric immunization program/ Childhood Vaccine Program (CVP); school health; and child care consultation.

Programs for adults include, but are 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 include, but are 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
- Programs to assist the homeless.

The Program Description (found on the **URMTS site**) contains detailed descriptions of the types of programs where MAC activities occur that may be good candidates for participating in the MAC program.

The relationship between Medicaid services and MAC

The goal of the federal Medicaid program is to ensure that eligible individuals are enrolled and have access to services covered under the State Plan. Medicaid reimburses the State for the cost of direct medical services provided under the State Plan. The rate Medicaid pays for these services includes activities that are “integral to or an extension of” these services.

Medicaid also reimburses the State for MAC activities that are “necessary for the efficient administration of the State Plan.” As described above, these activities revolve around outreach, linkage, and program planning related to the Medicaid program and the services it covers.

“Administrative” activities that are part of a Medicaid covered service cannot be reported as MAC activities when these costs are included in the rate paid for the service. Typically, the “administrative” activities that are viewed as part of a service include functions such as scheduling, charting, travel, patient education and consultation, and billing.

Separating the costs of services from the costs of MAC activities is a key principle in the MAC program; its goal is to ensure there is no duplication of service or payment; that is, the same activity is not paid for twice.

All allowable MAC activities must demonstrate a benefit to the Medicaid program.

Applicable laws, regulations, and published guidance

Any LHJ or subcontractor participating in the MAC program must comply with applicable federal and state laws, regulations, published guidance, or their successors. These include, but are not limited to:

- **Section 1903 (a) of the Social Security Act.**
- **42 Code of Federal Regulations** 432.2, 432.45 and 432.50 (SPMP); 433.15 (FFP); 433.34 (supported by CAP methodology); 435.1009 (inmates of public institutions); and 433.51 (Certified Public Expenditures).
- **45 Code of Federal Regulations** 92.20(b)(2) (financial management & accounting records).
- **2023 School-Based Guide to Medicaid Services and Administrative Claiming**
- **2009 Children’s Health Insurance Program Reauthorization Act** (enhanced rate for interpretation).

MAC participation requirements

Interlocal agreement with HCA

An LHJ must enter an interlocal agreement with HCA in order to participate in the MAC program. The contract must be fully executed (signed by both parties) prior to the first calendar quarter in which an LHJ first participates in the MAC Program.

To reduce the risk of duplicate claiming for MAC activities, the LHJ must submit copies of any other medical outreach and linkage contracts/grants it may have to HCA for review prior to implementation, or upon HCA’s request. HCA will review these contracts to ensure there is no duplication of effort, cost, or payment with the MAC program, as described by the Centers for Medicare and Medicaid Services (CMS) in the **2023 School-Based Guide to Medicaid Services and Administrative Claiming**.

The LHJ MAC program is a partnership between HCA and the LHJs. Each LHJ is represented on the MAC Steering Committee through the lead agency in its RMTS consortium.

HCA-WSALPHO agreement

The Washington State Association of Local Public Health Officials (WSALPHO) is a 501(c)3 private, non-profit organization operating on behalf of the LHJs through a statewide LHJ MAC Steering Committee. WSALPHO manages the Steering Committee and appoints its membership. WSALPHO has entered into a contract with a third-party vendor to operate the time study and claiming system for the LHJ MAC program.

HCA has entered into a Memorandum of Understanding (MOU) with WSALPHO to establish the requirements and expectations necessary to ensure the LHJ MAC program remains in compliance with the CMS approved CAP and applicable federal regulations. HCA and the WSALPHO appointed LHJ MAC Steering Committee meet on a regular basis and have worked closely to develop and implement the MAC program for LHJs.

WSALPHO-LHJ agreement

WSALPHO represents the interests of the LHJs in the management of the MAC program, advocates for the LHJs, and promotes the quality and integrity of the MAC time study and claiming process. The Lead Agency from each LHJ consortium (or an LHJ operating its own RMTS) is required to participate in the WSALPHO LHJ MAC Steering Committee. WSALPHO contracts with individual LHJs who participate in the HCA MAC program to provide access to the time study and claiming system and technical assistance. Through its contract with the LHJ, WSALPHO charges an administrative fee that is used to pay for the costs of the time study and claiming system vendor. The fee is proportionally allocated across all LHJs who are contracted with WSALPHO. LHJs may pass these costs to their subcontractors, however they are prohibited from charging or requiring subcontractors to pay an administrative fee to participate in MAC. Each LHJ is responsible for ensuring its contract with WSALPHO complies and meets all MAC requirements.

HCA administrative fees

HCA charges each LHJ an administrative fee to offset its costs to administer the MAC program. The rate is based on the costs associated with the staff effort spent on MAC related work for an entire State Fiscal Year (SFY) and is billed as a line item on the quarterly claim form A-19-1A.

The administrative fee is due to HCA quarterly and will be deducted from the LHJs quarterly A19.

HCA's administrative fee is an unallowable expense for the MAC program and cannot be reported on the invoice as an allowable cost. LHJs may pass these costs to their subcontractors, however they are prohibited from charging or requiring subcontractors to pay an administrative fee to participate in MAC.

Subcontractors

LHJs are permitted to include subcontractor costs on the MAC invoice, if the subcontractor is assisting the LHJ in furthering its MAC program goals. Typically, an LHJ will subcontract with a community-based partner to perform MAC activities when the LHJ does not have sufficient resources or staffing to perform the activities. Subcontractors must have a written agreement with the LHJ.

The LHJ is required to provide a summary of the subcontractor's costs with each invoice, and maintain source documentation on site necessary for meeting federal claiming requirements. HCA will review all costs included on the LHJ's MAC invoice and may ask for supporting documentation or for unallowable or unsupported costs to be removed from the invoice.

RMTS and fiscal coordinators

Each LHJ is required to establish an RMTS coordinator and a Fiscal Coordinator. These coordinators are responsible for monitoring their LHJ's MAC program to ensure compliance with all applicable laws, regulations, and guidelines specific to MAC, and are required to comply with all roles, responsibilities, limitations, restrictions, and documentation requirements described in the HCA MAC contract, manuals, training materials or other documentation provided.

The RMTS coordinator is responsible for ensuring all aspects of the time study are functioning and in compliance while the Fiscal coordinator is responsible for ensuring all aspects of the claiming/invoicing process are functioning and in compliance. If desired, an LHJ may assign both roles to a single individual. HCA expects the MAC program to be managed similarly to other federal awards and expects the RMTS and Fiscal coordinators to report to, or work closely, with an administrator assigned oversight authority of the LHJ.

The designated LHJ MAC Fiscal/RMTS Coordinator is required by the HCA-LHJ contract to attend the monthly MAC HCA Statewide Coordinator meetings. If the LHJ/Fiscal coordinator is not available, a designated agency employee may attend.

The LHJ MAC Fiscal/RMTS Coordinator or their agency employee designee attends the quarterly consortium calls hosted by the Steering Committee & WSALPHO.

LHJs who act as a Lead Agency may designate an agency employee to attend related Steering Committee and HCA meetings to perform the duties as described in the manual.

LHJs who contract with a fiscal vendor to prepare the preliminary MAC invoice are responsible for ensuring all data is complete and accurate prior to certifying the invoice. The LHJ’s fiscal coordinator is responsible for reviewing all data entered into web-based invoice and to certify its accuracy. The LHJ and its contractor are responsible for meeting all MAC invoicing deadlines set by HCA. LHJs who utilize a fiscal vendor should use the below table to determine appropriate roles when preparing and certifying the MAC invoice.

Invoicing responsibilities checklist

LHJ fiscal coordinator responsibilities	LHJ vendor responsibilities
Prepares the client-based MER file (if applicable) and uploads per instructions in the Coordinator Manual.	N/A
Provides fiscal vendor with any files or documentation necessary to complete the MAC invoice.	Prepares back-up documentation and ensures the documents are accurate and saved in a readable format for the LHJ fiscal coordinator to upload to the URMTS back-up documentation. Assists with preparing data necessary for preparation of the MAC invoice.
Reviews MAC invoice back-up documentation before entering data and uploading required back-up documentation into the URMTS invoice.	N/A
Certifies MAC invoice for HCA review.	N/A
Communicates with HCA and the WSALPHO contractor regarding HCA questions about the MAC invoice.	Assists LHJ fiscal coordinator in answering follow-up questions from HCA.
Generates A19 and signs and submits electronic copy, when notified by HCA that the invoice is approved.	N/A

National or state public health emergencies

In the event of a national or state public health emergency, natural disaster, or act of terrorism, HCA may allow certain modifications to LHJ MAC program requirements.

These modifications may include changes to:

- RMTS response times
- RMTS activity codes
- Invoice due dates
- Training deadlines
- RMTS validity requirements
- Additional reimbursable activities related to infection control, surveillance, and prevention.

These modifications are effective in 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 emergency declaration ends.

The role of the RMTS Coordinator

The RMTS Coordinator is responsible for the participation of its LHJ in the MAC program. This portion of the manual provides step-by-step instructions for managing the time study components of the LHJ's MAC program. The specific documents referenced in this manual can be found on the HCA and URMTS websites.

- **HCA's Medicaid Administrative Claiming web page**
- **URMTS Portal**

The RMTS Coordinator responsibilities are best understood as a set of distinct tasks which are generally time-limited to before, during, and after the quarter, as well as annual and ongoing tasks. There are many resources available to help you understand your responsibilities and ensure you meet program requirements and deadlines.

Useful RMTS Coordinator tools

- **MAC Participation Tasks:** A step-by-step list of tasks that must be completed before, during and after the quarter as well as annually and ongoing. The list is available below.
- **Coordinator's Quarterly Checklist of MAC Tasks:** This checklist will help you keep track of your responsibilities and is available on the **URMTS site**.
- **The Annual MAC Calendar:** The calendar is maintained on the **URMTS site** and displays the deadlines for each task.

MAC participation tasks

This list of tasks offers a step-by-step process for the successful management of your MAC program. As laid out below, the list includes explanations of why the tasks must be completed and refers to more detailed sections of the Manual and supporting documents.

Basic requirements for Time Study participation:

MAC activities must be part of the individual's day-to-day job.

Participants cannot be 100% federally funded nor have 100% of their costs in the indirect rate.

Before the quarter starts

- 1. Execute a signed MAC agreement between the LHJ and HCA.**
- 2. Identify staff who will participate in the time study.**

The time study participant list is locked for the quarter once it is entered into the URMTS system, and cannot be modified until the next quarter, with a few exceptions, such as a new email address. Creating an accurate list of participants is critical to time study success.

- a.** Review current Time Study participants.
 - Update participant information and/or status in the URMTS system.
 - Verify that no participants are 100% federally funded.
 - Verify or update the participant's work schedule.
- b.** Identify new Time Study participants.
 - Verify the participant has an "Eligible Job Classification." If the classification is not listed but the participant regularly performs MAC activities, it must be submitted to HCA for review and approval.
 - Remove any participants that are 100% federally funded or have 100% of their costs in your agency's indirect rate or an FQHC rate.
 - Verify whether a participant is an agency employee or contracted employee.
 - Verify whether a participant qualifies as Skilled Professional Medical Personnel (SPMP) and have them complete the appropriate SPMP questionnaire. The qualifications are described in the Time Study Management section of this Manual.

- Verify whether a participant who is an interpreter meets the **DSHS Language Testing and Certification Requirements**.
- Assign participants to an RMTS or direct charge cost pool.
- Participants who perform more than one allowable MAC activity as part of their regular job should be in the RMTS and assigned to:
 - CP1 for staff who qualify as Skilled Professional Medical Personnel (SPMP).
 - CP2 for staff who are not SPMP. Participants who only perform one MAC activity (a single cost objective) as part of their regular job should be direct charged and assigned to:
 - CP4 for staff who qualify as Skilled Professional Medical Personnel (SPMP).
 - CP5 for staff who are not SPMP.
- Enter participant demographics, work schedule and other data into the URMTS system.

3. Update the agency calendar in the URMTS.

Update the annual agency level calendar in the URMTS system. This calendar sets the standard business days, agency holidays, and closures.

4. Certify the participant list.

You must certify the participant data entered is in compliance and accurate by checking the certification box in the URMTS. You cannot change the participant list once it has been certified. You must be sure all participant data (work schedules and demographics) is entered for new participants or updated for current participants, and that the agency calendar has been updated. The URMTS system will then auto generate a master list of RMTS participants for the quarter and store it. This list cannot be changed once it is certified.

5. Verify all staff participating in the MAC program have completed the required training within the required deadlines.

New participants who have not completed online training prior to the beginning of a quarter will not be allowed to complete random moments in the RMTS until they certify their training.

Training deadlines are posted on the MAC program calendar found on the URMTS site. New participants are notified of the deadlines via their RMTS “welcome” emails. The coordinator is responsible for ensuring all participants have completed the required trainings on time.

- a. Verify all participants have completed the annual online training.
 - Staff cannot participate in the MAC program until they have completed the online training.
- b. Provide in-person training to all new participants, ensure training rosters are maintained onsite, and certify training completion in URMTS. Staff cannot answer moments unless they have completed the in-person training.
 - Provide in-person training to all new participants.
 - Train all staff whose costs will be direct charged.

Note: You must identify any new participants that have not received in- person training and deactivate them prior to certifying the participant list. All moments for participants who have incomplete training will be suspended and coded as invalid (Code 99) until they have completed in-person training.

Staff who have completed the online training, but have not completed the in-person training will be prevented from answering any RMTS moments.

6. Determine whether to Include MAC administrators, fiscal coordinators, RMTS supervisors, and code reviewers in a time study.

Determine whether the costs of any of the staff administering the MAC program are 100% covered by an indirect or FQHC rate. If not, these staff can be included in a time study.

- If they perform multiple MAC activities, assign them to the RMTS.
- If they only perform one MAC activity (such as RMTS administration, code reviews, or managing the claiming system, collecting client/clinic data for the MER etc.) assign them as a single cost object and direct charge.

Participant list certification

1. 28 business days prior to the start of the new quarter the WSALPHO vendor opens the new quarter RMTS.

The RMTS coordinator updates the participant list and adds new participants. New participants should be added as soon as possible to allow them adequate time to complete the required online training.

New participants receive their “Welcome” email, complete online required training, and required in-person training.

2. 10 business days prior the start of the new quarter Participant Training is due.

Participants certify their online New Participant and/or annual training. RMTS coordinators certify the in-person training of new participants is complete.

Any participant that has not met the online or in-person training requirements cannot complete their random moments until training is complete. Once training requirements are met, the participant is reinstated so that moments may be completed.

All moments that occur during the time a participant has not completed training are coded to 99 at the end of the quarter by the subcontractor coordinator/Code Reviewer.

3. 7 business days prior to the start of the new quarter, the Coordinator certifies the final participant list.

The participant list for the LHJ is generated and stored in URMTS on the consortium’s “RMTS” page for the applicable quarter. The certified list shows the certifier and the timestamp.

LHJs without certified participant lists cannot be included in the RMTS for the quarter.

- After the list is certified, certain updates will not be effective until the following quarter. This includes adding new participants, changing participant schedules, deactivating participants, changing participant cost pools, or job titles. Email addresses, supervisors and/or code reviewers may be updated throughout the quarter and will be effective immediately.

4. 6 business days prior to the start of the new quarter, moments are generated.

The consortium participant list (“participants.csv”) and the master moment list (the master moment list is only available to HCA) are generated and stored on the consortium’s “RMTS” page for the applicable quarter.

During the quarter

1. Monitor the RMTS to ensure moments are answered within 5 business days. You may view moments and use the “nudge” feature in the URMTS to ask participants to complete their random moments.

Follow up with any participant who is not completing their moments in a timely manner; stress the importance of completion for the statistical validity of the Random Moment Time Study.

For an RMTS to be statistically valid, 2,401 of the 2,761 moments assigned randomly each quarter must be completed within 5-business days.

Otherwise, HCA may require a Corrective Action Plan, and claiming could be jeopardized.

2. Review completed RMTS moments.

- Completed random moments should be reviewed regularly, preferably at least weekly.
- Responses should be reviewed to ensure they are consistent with the assigned code.
- If responses are not complete, or are unclear, a clarifying question may be asked.
 - You must not ask clarifying questions that are leading. Give participants a choice of code or suggest a code.
 - If the participant’s response is still unclear, or it does not support the activity code the participant selected, you must use your best judgment and select an appropriate activity code and document your reasoning in the comment box.

A simple test for checking the assignment of participant activities to allowable MAC codes is to ask whether the activity benefits the Medicaid program. If it does not, a non- allowable code should be used.

- Activities coded to the SPMP MAC code should be reviewed to ensure they support the administration of the Medicaid State Plan and the participant’s medical education and training is needed for the activity.
- If your LHJ is using a client-based MER, the MAC linkage codes should be reviewed to ensure the client ID is accurate.
- When RMTS participants complete their random moment and select one of the linkage codes (6b, 7b, 7d, 10b or 12b), the system will prompt them to enter a client ID. The system accepts any alpha-numeric format to accommodate different types of IDs that LHJs use. Client IDs must be HIPAA-compliant.
- The client ID field should only contain valid identifying information from the database listed in your LHJ’s annual MER proposal. The client ID field should not contain extra text such as “NA” or “not sure” or “no client ID”.
- Any moments reported to Code 7b or 7d should be reviewed to ensure the participant performing the interpretation meets the **DSHS Language Testing and Certification Requirements**.
- You must monitor them to ensure they are reviewing their assigned random moments regularly.

3. Update participant data as needed.

Limited participant data can be updated during the quarter. This includes updating email addresses, the supervisor or code reviewer, and the participant’s work/employment status (termination, retirement, extended leave). “Extended leave” means the participant will be absent from work for the majority of the quarter (two or more months). These changes will not affect moments already drawn for the current quarter.

After the quarter ends

1. Complete 100% Code Review and certify the accuracy of the RMTS.

- Verify that 100% of moments have been reviewed by you or a code reviewer.
- Review clarifying questions to verify they are not leading.
- Review a random sample of client IDs reported on RMTS moments to ensure they are accurate and from a client database/record keeping system documented on your annual MER proposal.
- Certify the initial 100% code review has been completed.
 - This must be completed 45 calendar days after the end of the quarter. Note: if the 45th day is a weekend, the due date is the following Monday. See the Annual MAC Calendar.
 - Once certified, the vendor is automatically notified. They have 10 calendar days to complete the 10% quality assurance review.
- Review the results of the 10% quality assurance sample.
 - Make corrections and follow up with participant training as needed.
 - Finalize and certify the accuracy of your LHJ's review of the 10% quality assurance sample and RMTS. This must be done no later than 10 calendar days after the 10% review is received. Note: if the 10th day is a weekend, the due date is the following Monday. See the Annual MAC Calendar.
- Finalize and certify the accuracy of your LHJ's code review and RMTS.
 - This must be done no later than 45 business days after the end of the quarter.

2. Review Single Cost Objective documentation for Direct Charge Staff.

- Review documentation to ensure it supports the single cost objective activity.
- Verify 100% of the staff's time is reported.
- Finalize and certify the accuracy of the direct charge documentation.
 - This must be done no later than 45 business days after the end of the quarter.

3. Prepare and submit the MER Client or Clinic file.

The clinic MER refers to the MER used for claiming units operating primary care or specialty clinics.

- Review your agency's annual MER proposal to verify which databases/record-keeping systems should be used.
- Extract all data from these databases/record-keeping systems and compile into one single list using the template on the **URMTS site**.
- Upload the final MER client or clinic files to the **URMTS site**.

Note: All client or clinic data from all the programs and/or budget units that have staff participating in the MAC program must be included in the client or clinic MER file.

Annually

1. Enter the Agency Calendar for the year including agency holidays and other dates of closure.

Note: The calendar may also be updated before each quarter.

2. Ensure all MAC participants complete the annual online training.

- Remind current RMTS participants of the annual online refresher training requirement.
- Verify participants received the URMTS notifications for accessing the training and the deadline. **Prepare and submit the agency's annual MER proposal.**

Each year, you must prepare and submit your agency's MER proposal to HCA for review and approval. The proposal is **due no later than December first.**

- It must document the data sources (client or clinic database/record keeping system) and data collection process that will be used to prepare the quarterly client or clinic lists used to calculate the MER.
- If the data sources, data collection, calculation, and/or formulas change during the year, the proposal must be updated and resubmitted to HCA 30 business days prior to the change.

3. Review a randomly selected sample of client IDs.

Each quarter, you must review a random sample of the client IDs used to calculate the client MER to verify the client meets the requirements for inclusion in the MER calculation.

- The client must come from a database listed on the annual MER proposal.

4. Prepare and submit the agency's annual certificate of indirect costs.

Each year with your first quarter invoice, you must submit a certificate of indirect costs, documenting the indirect rate submitted to your cognizant agency.

Ongoing

- Participate in the **monthly LHJ coordinator calls.**
- Participate in scheduled **consortium calls** and consult with your Lead Agency.
- Provide **training and technical assistance** to staff participating in the MAC program as needed.
 - Monitor participant coding and consult with your Lead Agency regarding refresher topics, problem areas, etc.
 - Provide individual technical assistance and training to RMTS participants having difficulty writing good narrative descriptions, linking their activities to the appropriate time study code.
 - Provide individual technical assistance and training to staff documenting their single cost objective activity if they are having difficulties with their written descriptions.

Time Study management

Time studies are used to determine the amount of time and corresponding cost that can be claimed to the MAC program. There are two-time studies—a Random Moment Time Study and a Single Cost Objective (Direct Charge) Time Study. Both use a common set of activity codes; the same set of eligible job categories may participate in either time study. Skilled Professional Medical Personnel and interpreters may participate in either time study. There are some differences in the requirements for participating.

The MAC Time Study activity codes

To determine the amount of time spent performing MAC activities and their related costs, staff participate in a Random Moment Time Study (RMTS) or track 100% of the time spent on a single MAC activity. Both methods identify the amount of time staff spent performing one or more federally approved MAC activity codes. The activity codes represent all the work performed by LHJ staff participating in the MAC program. Some of these activities are allowable for MAC reimbursement; others are not. The activity codes are summarized in the following chart. The Activity Code Descriptions and the Quick Reference Guides provide detailed information on each code, as well as activity examples. These are available on the [URMTS site](#).

Summary of MAC activity 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 6c	Arranging Transportation for Medicaid Services (State or National Public Health Emergency Only) (Proportional MER)
Code 7a	Interpretation for Non-Medicaid Services for 19 years and over
Code 7b	Interpretation for Medicaid Services for 19 years and over (Proportional MER)
Code 7c	Interpretation for Non-Medicaid Services for under 19 years
Code 7d	Interpretation for Medicaid Services for under 19 years (Proportional MER)
Code 7e	Interpretation for Medicaid Services for 19 years and over (State or National Public Health Emergency Only) (Proportional MER)
Code 7f	Interpretation for Medicaid Services for under 19 years (State or National Public Health Emergency Only) (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 8c	Program Planning, Policy Development and Interagency Coordination Related to Medicaid Services (State or National Public Health Emergency Only) (Proportional MER)
Code 9a	Non-Medical/Non-Medicaid Related Training
Code 9b	Medical/Medicaid Related Training (Proportional MER)
Code 9c	Medical/Medicaid Related Training (State or National Public Health Emergency Only) (Proportional MER)
Code 10a	Referral, Coordination and Monitoring of Non-Medicaid Services
Code 10b	Referral, Coordination and Monitoring of Medicaid Services (Proportional MER)

Code 10c Referral, Coordination and Monitoring of Medicaid Services (State or National Public Health Emergency Only) (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 12c SPMP Activity Related to the Administration of the Medicaid State Plan (State or National Public Health Emergency Only) (Proportional MER)

Code 13a Coordination, Claims Administration and Oversight of Non-MAC Programs

Code 13b Coordination, Claims Administration and Oversight of MAC Program (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.

Direct Medical Services

Any activity that is integral to or an extension of a direct medical service (a service that can be billed to Medicaid or other third parties) cannot be reimbursed through the MAC program. These activities must be reported to Code 5: Direct Medical Services.

Skilled Professional Medical Personnel (SPMP)

Only individuals who qualify as SPMP may use activity code 12. These staff must complete SPMP questionnaires to verify and certify they meet the requirements for SPMP designation. These staff can only use the SPMP codes if their medical education and training was required for the activity and a non-SPMP would be unable to perform it.

Interpretation

Only individuals who meet Washington State **DSHS Language Testing and Certification Requirements** may use activity code 7 when providing interpretation.

The activity codes are arrayed as **parallel codes**, where an activity category (outreach, for example) is separated into a Medicaid/Medical and a non-Medicaid/non-Medical activity code. This assists participants in choosing the activity code for their random moment more accurately and ensures only Medicaid activities are reimbursed through the MAC program.

Eligible job classifications

The following job classifications have been approved to participate in the MAC program. They are grouped into broad job categories. Staff in these job classifications who perform allowable MAC activities as part of their regular work may be included in the MAC program. If they perform multiple MAC activities, they must participate in the RMTS. If they perform one single MAC activity, they must document their time and may be direct charged. These examples are not all-inclusive. If you have a job classification that is not listed below, please consult with your Lead Agency. The Lead Agency will work with HCA and the WSALPHO LHJ Steering Committee to evaluate the job classification to determine if it is allowable in the MAC program. As part of this evaluation, you may be required to complete HCA's Job Classification Assessment form.

Job categories and examples of job titles/classifications

Nurses: 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, dietitians, 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: 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: 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 Classification:

Positions that 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, MAC and/or Coordinators.

Administrative Support Classifications: Positions that 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.

Skilled professional medical personnel

Staff who have clinical education and training may be designated as a Skilled Professional Medical Personnel (SPMP) for purposes of the RMTS. These staff are permitted to perform additional MAC activities and reported to code 12.

- 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

Activities performed by staff designated as SPMP may be reimbursed at an enhanced rate of 75%. As a result, extra precautions must be taken to ensure activities are reported correctly and the potential of overclaiming is minimized. All activities reported by an SPMP to Code 12b are reimbursed at the enhanced rate. All other allowable activities reported by an SPMP, with the exception of interpretation for children, are reimbursed at 50%. An SPMP may only use activity code 12 when the following requirements are met:

- They must be LHJ employees (not contracted staff or

employees of a MAC subcontractor).

- They must be in a job classification where the minimum requirement is the completion of a two-year or longer program that leads to medical/nursing/clinical licensure or certification.
- Activities reported to 12b must be directed by HCA and in support of the administration of the Medicaid State Plan.
- The activity cannot be integral to or an extension of a direct medical service.
 - For example, a nurse practitioner providing family planning services to a client must use Code 5 (Direct Medical Services) when a random moment describes a referral linked to the purpose of the client's visit.
- The activity must require medical/nursing/clinical education and training to perform.
 - If a non-SPMP employee could perform the same activity, then it cannot be reported to code 12. It must be reported to another activity code.
- The staff must have a completed and current SPMP Questionnaire for Physicians and Nurses and/or SPMP Questionnaire for Allied Health Professionals.

SPMP Questionnaires: Documenting licensing and training

Staff designated as an SPMP must complete an SPMP questionnaire and provide proof of their medical license and education prior participating in the RMTS. Completed questionnaires are stored on the **URMTS site**. These staff must also complete additional online training specifically for SPMPs. There are two questionnaires which can be found on the **URMTS site**:

- SPMP Questionnaire for Physicians and Nurses.
- SPMP Questionnaire for Allied Health Professionals.

Dietitians, social workers, or counselors may meet the requirements for SPMP under certain conditions. The key element is their education and training. Their educational program must have been two years or longer and led to licensure or certification in a medical field.

For social workers (and counselors, by extension) CMS guidelines require that the SPMP candidate have the necessary graduate degree, with a specialization in clinical practice, health care practice, other medical application, or its equivalent. If the graduate program did not offer this type of specialization, or the SPMP candidate did not complete it, CMS recommended that equivalency standards for SPMP status be established on a case-by-case basis, using the following criteria:

- The SPMP candidate completed a graduate degree at a school that offered health care or medical

specializations but formally concentrated in another area and would qualify as an SPMP if they completed as many health courses as would be required for a concentration in health care.

- The SPMP candidate completed a graduate degree that offered concentrations, but none distinctly in health care or medical specializations. The transcript must show at least as many credits in health care as would be required for any concentration, with a minimum of four completed courses in health or medical applications.
- The SPMP candidate completed a graduate degree that did not offer concentration at all. The transcript must show more credits received in health care or medical applications than in any other specialized area of study. **No amount of on-the-job experience in any employment situation can be substituted for professional education and training.**

SPMP responses to an RMTS Moment: Activity Code 12b.

Staff designated as an SPMP have access to SPMP activity codes. If an SPMP receives a random moment while they are performing an activity that required their medical/clinical license or education/training, they may select activity Code 12a or 12b.

- 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.

Activity code 12b has additional requirements. This code may only be selected when the participant is completing HCA-directed activities that meet SPMP criteria and that are in direct support of the administration of the Medicaid State Plan.

When selecting Code 12b, SPMP participants must identify which HCA directed activity they were performing during their random moment:

HCA-directed SMP activities

Clinical Consultation: Clinical consultation with medical providers regarding best practices and adequacy of medical care includes but is not limited to consultation related to pediatric immunization issues, Access to Baby and Child Dentistry (ABCD), emerging treatment/therapies for high-risk populations, individuals with communicable diseases requiring extraordinary/non-standard medical care, and overdose prevention.

Coordination of Medicaid Covered Services:

Coordination of Medicaid covered services for medically at-risk populations includes but is not limited to coordination on behalf of medically fragile children, high-risk pregnant and parenting women, homeless individuals, and individuals with acute medical conditions.

Medically-Related Case Staffing: Case staffing, or case management on the medical aspects of cases requiring Medicaid-covered services includes but is not limited to the following high-risk populations: medically-involved children, including those in foster care; high-risk pregnant and parenting women; homeless individuals; and Individuals with communicable diseases requiring extraordinary/non-standard medical care.

Planning and Coordination with Local Medical Providers to Facilitate Earlier Referrals and Treatment:

Planning and coordination with local medical providers to facilitate earlier referrals and treatment includes but is not limited to the following high-risk populations: medically fragile children, including those in foster care; children in foster care; homeless individuals; children with special health care needs, developmental delays, or behavioral challenges; individuals with less complex, but escalating mental health conditions (PTSD, depression, anxiety, family stress, etc.).

Medical Consultation Regarding the Medicaid State Plan:

Providing medical consultation to the state regarding the Medicaid State Plan includes but is not limited to consultation with state and local medical providers to improve birth outcomes for Medicaid children; consultation with school personnel to improve health outcomes for children exhibiting developmental delays or behavioral challenges due to medical conditions, family stress, or other factors; and consultation with state and local primary care providers regarding Medicaid services.

Strategies to Improve Rates for Pediatric immunizations: Includes, but is not limited to clinical consultation with providers concerning strategies to improve rates for pediatric immunizations.

Interpreters

LHJs may have staff or contractors who provide interpreter services for Medicaid services, such as First Steps or family planning, or for MAC activities, such as Medicaid outreach, assistance with applications, or linkage to Medicaid services. The interpreters act as a third party in these transactions and interpret to support the work of LHJ staff.

LHJ Staff Interpreters

Some LHJ staff provide interpreter services on behalf of other LHJ staff if they meet the DSHS requirements. These activities may be reported to the activity code 7. The LHJ interpreter staff may only use activity code 7 when the following requirements are met:

- The individual is a direct employee of the LHJ.
- The individual meets the **DSHS Language Testing and Certification Requirements**.
- The interpretation is on behalf of an LHJ staff who is providing a direct medical service or other MAC outreach or linkage-related activities.
- The individual participates in the RMTS.

If the interpretation activity does not meet these requirements, then it cannot be reported to code 7. It must be reported to another activity code. It is the responsibility of the RMTS Coordinator to ensure LHJ interpreter staff understand when to use Code 7.

A participant does not need to meet the DSHS requirements to arrange for interpreter services. This is an allowable activity for Code 7. There are two sets of parallel codes for Code 7:

- Code 7a and Code 7b are for interpreter activities directed to individuals 19 years and over:
 - Code 7a: Interpretation for Non-Medicaid Services for 19 years and over.
 - Code 7b: Interpretation for Medicaid Services for 19 years and over.
- Code 7c and Code 7d are directed to individuals under 19 years:
 - Code 7c: Interpretation for Non-Medicaid Services for under 19 years.
 - Code 7d: Interpretation for Medicaid Services for under 19 years.

Interpretation activities may be reimbursed at an enhanced rate of 75% for Medicaid-related interpreter services performed by interpreters on behalf of children under 21. As a result, extra precautions must be taken to ensure activities are reported correctly and the potential of overclaiming is minimized. It is critical that any interpretation reported to Code 7d meets the above criteria. All activities reported to code 7d are reimbursed at the enhanced rate. All other allowable activities reported by an LHJ interpreter staff are reimbursed at 50%.

Interpreter Contracts

If your LHJ contracts with individuals or agencies to exclusively provide interpreter services, then a portion of the contract costs can be included in the MAC invoice as a direct charge if the following requirements are met:

- The contractor must meet the **DSHS Language Testing and Certification Requirements**.
- Only the portion of the contract related to MAC interpretation activities is direct charged.
- Each interpretation event/encounter is documented and tracks the interpreter activity. Each event/encounter must document, at minimum:
 - Appointment time/duration.
 - Client Name/ID/transaction information.
 - Interpreter Agency.
 - Interpreter Name or Employee ID.
 - Language/communication type.
 - Requestor or nurse name.

Note: Because this documentation contains Protected Health Information (PHI) as defined in the federal HIPAA regulation, it is retained by the LHJ and not uploaded to the URMTS. PHI including client names and ProviderOne numbers must be stripped from this file if the other information in the file is requested by representatives of Washington Federation of State Employees (WFSE).

Random Moment Time Study (RMTS)

The Random Moment Time Study (RMTS) is the primary basis of allocating allowable costs to the MAC program. The RMTS quantifies the daily activities of the RMTS participants. It polls staff at random moments during their normal workdays over a calendar quarter. Participants describe what they were doing at the time of a random moment and assign an activity code that matches their written description.

RMTS Consortia

Some LHJs are large enough to sustain their own RMTS, while others may choose to group together and share an RMTS. LHJs that group together become members of an RMTS consortium. For administrative efficiency, it is recommended that an LHJ have at least 50-time study participants to consider sustaining its own RMTS.

Consortia are organized according to a number of criteria, including the similar duties their staff perform, organizational structure, type of programs, scope of work, or regional working relationships. The WSALPHO Steering Committee reviews the composition of each RMTS consortium annually, with input from its members.

If needed, changes to the consortium membership may be recommended and submitted to HCA for review and approval. Reconfiguration of an RMTS consortium will be based on changes in any of the above factors or in the number of participants. The RMTS Consortia list is available on the [HCA site](#) and [URMTS site](#) and provides information related to consortium membership and which LHJs sustain their own RMTS.

Each consortium participates in a single RMTS. A participant cannot be in more than one RMTS. Each RMTS consortium has a Lead Agency whose role is to participate in the LHJ Steering Committee and represent the consortium's interests and concerns related to the RMTS.

Lead Agencies

The Lead Agencies must commit to the role for a minimum of one calendar year and must notify WSALPHO and HCA at least 90 days before the beginning of a quarter if they intend to opt out of this role. This advance notice will give the consortium members and WSALPHO adequate time to identify a new Lead Agency and to notify HCA of the change.

If your LHJ is a Lead Agency, you are expected to ensure all functions and activities of a Lead Agency are completed. The Lead Agencies are expected to:

- Participate on the LHJ Steering Committee, which meets regularly (weekly during peak periods, and

quarterly/periodically during non-peak periods).

- Periodically monitor each LHJ member's progress on completing the 100% code review throughout each quarter and send reminders to coordinators as appropriate.
- Provide technical assistance to LHJ members if requested, or as needed if problems such as delays in coding review are noticed, or questions arise about coding or eligible participants.
- Collaborate with WSALPHO and the LHJ Steering Committee to facilitate periodic consortium calls (typically quarterly but as often as monthly if needed), which are used to provide training, program updates, and discuss concerns or issues.
- Collaborate with WSALPHO and the LHJ Steering Committee to review RMTS results for any significant changes between quarters.

RMTS response rate and statistical validity

It is a federal requirement that any RMTS used for the MAC program must be statistically valid and it must achieve 2401 valid moments each quarter. To ensure there are enough valid moments to reach statistical validity, the RMTS includes a 15% oversample, for a total of 2761 moments. The moments in each quarterly RMTS consist of all scheduled time within the individual work schedules of all participating staff.

Dates that are excluded from the sample include agency holidays, agency closures, and weekends. The RMTS generates a random sample of 2,761 moments prior to the start of the quarter. No participants will be assigned moments outside their work schedule as listed in their agency's certified RMTS participant list. If an RMTS has less than 2,401 completed moments, HCA will require a Corrective Action Plan.

All moments must be completed within 5 business days (Monday-Friday, excluding holidays), and be certified as true and accurate by the participant. Any moment completed after the 5-business day deadline or not returned at all will be counted as invalid unless there is supporting documentation that the participant was on paid or unpaid leave.

If the 85% compliance rate (a minimum of 2401 completed moments) is not met, the invalid moments are reported to a non-Medicaid time study code and included in the calculation of time study results. Expired moments can only be coded to 15 (paid time off), 16 (unpaid time off), or Code 99 (invalid). The RMTS coordinator must ensure all RMTS moments are reviewed.

Documenting Single Cost Objective (SCO) MAC activities (direct charges)

The time staff spend on MAC activities is generally captured through the Random Moment Time Survey. However, some LHJs have staff that regularly perform a single MAC activity (known as a single cost objective or SCO) as part of their job responsibilities. These costs can be direct charged.

An example would be an accountant who prepares the MAC invoice each quarter, or an LHJ staff interpreter hired as a personal service contractor to interpret for First Steps clients. As the RMTS coordinator, you must decide whether the staff should be included in the RMTS or direct charged instead.

Include in the RMTS:

- The MAC activity happens throughout the quarter
- The participant performs more than one MAC activity.

Include as a direct charge:

- The activity happens in discrete blocks of time
- The participant only performs one MAC activity.

Note: If 100% of the participant's costs are included in the indirect cost rate, they cannot be in the RMTS or direct charged.

If you opt to direct charge staff, you must ensure they understand how to document their time in the URMTS. They must document the single MAC activity over the whole quarter. It must have sufficient detail that a third party would understand what they were doing and how it related to the MAC activity code. They must also certify their documentation of the single MAC activity. 100% of the staff time must be documented. The participant documents the MAC activity, and the Fiscal coordinator must document the remaining hours worked in the quarter.

After the end of the quarter, the direct charge form must be approved before it is considered final. SCO participants are not permitted to approve their own form. The direct charge form must be approved by a supervisor or another staff person with knowledge of MAC and the SCO participant's work.

Reminder: The invoice preparer must verify that the "total hours paid" field that the employee reported on their direct charge form is correct.

RMTS overview

This section of the Manual contains an overview of the components of the RMTS. Detailed instructions for using the URMTS site are available in the URMTS Guide (available on the **URMTS site**).

Entering participant data, generating random moments

Prior to the start of a quarter, the LHJ RMTS Coordinator uploads or updates information about each RMTS participant into the RMTS system. The information includes the participant's name, job title, claiming unit, supervisor, work schedule, employment status, and SPMP status.

RMTS email notification

RMTS participants are notified for each random moment via email at the time the moment occurs. There is no advance notification.

Interpreter codes

Staff who are qualified interpreters may use the activity code 7 when **providing** interpretation services. All staff may use this code when **arranging** interpretation services.

- Code 7a: Interpretation for non-Medicaid Services for individuals 19 years and over.
- Code 7b: Interpretation for Medicaid Services for individuals 19 years and over.
- Code 7c: Interpretation for Non-Medicaid Services for individuals under 19 years.
- Code 7d: Interpretation for Medicaid Services for individuals under 19 years.

5-day deadline for completing moments

All moments must be completed within 5-business days of the moment occurring. If a participant has not responded to the moment by the third day (72 hours after the moment occurred), they receive a reminder email notifying them of their outstanding moment. The participant's supervisor is also notified. Since all moments require a response, the email reminders will continue until the moment is answered.

Moments not completed within 5 business days when a participant is working and not on paid or unpaid leave are considered "expired" and locked. If a participant is on paid or unpaid leave, these moments can be assigned to activity code 15 or 16.

Expired moments

If the moment is not completed within 5-business days, access to the moment for the purpose of writing a description and selecting a code is locked. Participants must still complete the moment after the 5- business day deadline, but they can only choose one of three options: paid time off, unpaid time off, or working and did not respond.

Quality assurance

Reviewing random moments

The RMTS coordinator is responsible for ensuring that 100% of all coded moments are reviewed for accuracy. This is accomplished by looking at each RMTS moment and reviewing whether:

- The narrative description matches the activity code.
- The client IDs recorded on RMTS moments coded to 6b, 7b, 7d, 10b, or 12b are appropriate (real client, real ID from database/record keeping system reported on the annual MER proposal).
- The participant's job classification includes program planning activities for RMTS moments code to 8a-b (Program Planning, Policy Development, and Interagency Coordination).
- The participant providing interpretation services recorded to 7a-d meets the **DSHS Language Testing and Certification Requirements**.
- The narrative description indicates that the activity requires medical education and training, is in support of the administration of the Medicaid State Plan, and could only be performed by an SPMP staff for RMTS moments coded to 12a-b.

As the RMTS coordinator, you may assign other LHJ staff to be code reviewers. You are responsible for overseeing code reviewers and spot checking their work.

Once an RMTS moment has been certified and submitted, and the 5-day window has closed, it becomes available for the code review process. The 100% review must be completed no later than 45 business days from the end of the quarter and it is recommended that code reviewers review moments regularly throughout the quarter.

The code review process is more effective when completed throughout the quarter for two reasons:

- Issues with writing accurate narratives or selecting appropriate codes can be identified quickly and corrected by providing additional training.
- Clarifying questions are more effective if they are asked promptly after the moment occurs because the participant will have a more accurate memory of the activity.

Asking a clarifying question

If a participant's moment is unclear, a code reviewer may ask a participant a clarifying question. The clarifying question **must not** be used to ask a leading question and should **only** be used if additional information is needed to assign an activity code to the activity described by the participant for the random moment. Most typically, the question would be asked to clarify what was occurring at the time of the moment when a whole meeting or client encounter is described in the narrative. A clarifying question might also be asked to understand the meaning of an acronym or to ask for more detail.

A clarifying question should be open-ended. Do not ask a question where the participant can simply answer "yes" or "no."

It is important that clarifying questions are not asked in a way that "leads" or "coaches" the participant to give a certain answer. All clarifying questions are recorded in the coding history of each RMTS moment. As the RMTS coordinator, you are responsible for monitoring code reviewers to ensure the clarifying questions are used appropriately.

Some examples of an appropriate clarifying question are:

- (Participant's name), you described a whole meeting. Will you please clarify what was being discussed at the time of your random moment?
- (Participant's name), you describe driving to training. Will you clarify why you were attending this training?
- (Participant's name), your description indicates you referred a client for services. Will you clarify what service you referred her to at the time of your random moment?

Code corrections

During the code review process there may be moments where the reviewer determines the code assigned by the participant does not align with the written description. The reviewer may also need to correct the code based on the response to a clarifying question or on a comment received as part of the 10% quality assurance sample reviewed by the vendor.

The code reviewer must write a note in the comment box to explain why the code was corrected. Reasons to correct a code:

- The narrative description of the moment does not support the code selected by the participant.
- The response to the clarifying question indicates a different activity code is needed.

The clarifying question and answer will appear in the coding history of each random moment, as well as comments from the 10% quality assurance review. Corrections to the original code, and any explanations for correcting the original code entered in the “Comment” box, will also appear in coding history of each random moment.

Instructions for correcting a code in the URMTS system are explained in the URMTS Guide.

10% quality assurance sample

Each LHJ must participate in a third-party quality assurance review completed by WSALPHO’s RMTS vendor. The review consists of drawing a 10% random sample of all moments completed by the LHJ, reviewing the moments for accuracy, and identifying concerns or trends, and providing feedback to the LHJ. The 10% random sample quality assurance review process is automatically generated after the LHJ completes its 100% code review and certifies the RMTS moments.

As the coordinator, you will be notified when the quality assurance review is complete and are responsible for reviewing the comments and making any necessary corrections. Once you have done this, you must certify the RMTS moments as final. These moments can no longer be changed, and they will be used in the RMTS calculations.

RMTS deadlines and certification of RMTS

It is crucial that all LHJs complete their RMTS reviews by the required contract deadlines. Failure to do so impacts all other LHJs in the consortium and can negatively impact the RMTS results and reimbursements.

All LHJs are required to comply with contract deadlines for certifying their random moments within the RMTS. Lead Agencies, on behalf of the Steering Committee, are encouraged to check with all members of their consortium during the quarter, to ensure an LHJ does not miss any deadlines associated with the RMTS.

In the event an LHJ misses any deadline, HCA will take corrective action which may include the following actions:

- Contact the LHJ to identify any needed assistance; provide technical support as needed and notify the Steering Committee of the missed deadline.
- Follow up in 10 calendar days, if the LHJ has not completed the necessary tasks, HCA will issue a corrective action plan and notify the Steering Committee.

WSALPHO reserves the right to reorganize consortium membership as needed, which may include non-compliance.

HCA monitoring

HCA is responsible for performing oversight of the LHJ’s MAC program to ensure the program is effectively administered and the LHJ is complying with all roles, responsibilities, limitations, restrictions, and documentation requirements. HCA reviews all components of the time study, claiming, training, or other MAC related topics.

HCA reviews all claimed costs prior to issuing reimbursement to ensure the costs are allowable, reasonable, and are supported by source documentation that is sufficiently detailed to permit HCA, CMS, or others to determine whether the costs are necessary for the proper and efficient administration of the state plan. This includes but is not limited to, staff costs, operating expenses, and subcontracted vendor costs.

HCA monitors each LHJ individually and collaborates with WSALPHO and the LHJ Steering Committee on statewide or consortia-wide issues or concerns. HCA will issue corrective action plans as necessary and may apply sanctions if the LHJ does not implement or comply with the corrective action.

Claiming

Introduction

- The MAC invoice is the method used to calculate the amount of federal reimbursement for each quarter. It is based on the allowable expenses of the LHJ's subunit(s), the RMTS results of its consortium, the applicable MER applied to each time study activity code, and the availability of allowable funding, or Certified Public Expenditures (CPE).
- A subunit is one or more budget units or programs within an LHJ (claiming unit) where staff perform MAC activities and participate in the RMTS. A subunit may be the entire LHJ or distinct program or budget unit(s) within the LHJ.
- All costs of the subunit (the budget/program unit(s) where LHJ staff participate in the RMTS) must be included in the invoice unless these costs are already included in the indirect rate.
- Any expenses that are 100% related to an LHJ's FQHC must be excluded from the budget unit to avoid duplication of cost or payment.

General principles for claiming

The following principles are key to understanding how the invoice works and the way it is organized. Each of these principles will be discussed in more detail in this Manual, but they are summarized here.

- **The use of cost pools.** Cost pools are used to separate reimbursable MAC costs from those that are non-reimbursable. Additionally, the cost pools in the funding section of the invoice ensure that funds are properly accounted for in the invoice.
- **Certified Public Expenditures (local match).** To receive federal reimbursement, allowable MAC expenses must be supported with "eligible" funds. Eligible funds are state or local tax dollars whose scope of work is either unrestricted or can be used to support MAC activities. A shortage of these funds reduces the amount of the claim for reimbursement. An LHJ can only request reimbursement for expenses the LHJ actually incurred and that are supported with eligible funds.
- **Revenue offset.** All federal funds that pay for MAC activities must be "offset" against the expenditures reported on the MAC invoice. The offset ensures the federal government is not paying twice for the same activities – once through a federal grant that includes MAC activities in its scope of work, and a second time through MAC reimbursement.

- **Duplication of cost/payment.** An expense may only be claimed once on the invoice. If a cost is included in the indirect rate, it cannot be reported as an allowable personnel or non-personnel expenditure on the MAC invoice. Costs for direct medical services (that can be billed to Medicaid or commercial insurance) cannot be claimed as a MAC expense because this results in a duplication of payment.

Basic formula of the MAC invoice

1. Actual quarterly expenditures of the budget unit/program(s) and all adjustments posted during the claiming quarter where MAC activities are performed.

Are reduced by any federal revenue that must be offset

2. Adjusted actual quarterly expenditures of the budget unit/program(s) where MAC activities are performed.

Are multiplied by

3. The percentage of time spent on allowable MAC activities (from the Random Moment Time Study).

And are multiplied again by

4. The Medicaid Eligibility Rate (the share of cost Medicaid will contribute to each activity code).

And are multiplied finally by

5. The federal financial participation rate of 50% or 75% (75% for eligible SPMP activity and for interpretation for individuals under 19 years), and 50% for all other allowable MAC activities.

Federal requirements for the MAC invoice

- The invoice must calculate the total cost of allowable MAC activities within the budget unit/program(s).
- It must demonstrate there is no duplication of payment or cost – that the federal government is not paying twice for the same MAC activity. (This is done through revenue offset).
- It must document that there are adequate non-federal funds to support the costs of allowable MAC activities and be used as CPE

HCA requirements for the MAC invoice

- Data needed for the invoice calculation must be entered into the URMTS.
 - Supporting documentation required by HCA must be uploaded into the web based URMTS.
 - All local matching funds used as CPE certified each quarter in the URMS.
 - A signed copy of the A19-1A must be submitted to HCA.
 - There is a 120-calendar day filing deadline.
- Note:** HCA will not seek reimbursement for any invoice received after the 23rd month of the two-year federal filing deadline.

Reporting expenditures

Cost pools

All expenditures of the budget/program unit(s) must be included in the invoice, unless these costs are already included in the entity's indirect rate. Actual expenditures from the quarter and all adjustments posted during the quarter being invoiced are assigned to one of six cost pools, which are described in more detail below.

Cost pools

MAC cost pools

- Cost pool 1: SPMP
- Cost pool 2: Non-SPMP Non-MAC cost pool
- Cost pool 3

Direct charge cost pools

- Cost pool 4: SPMP
- Cost pool 5: Non-SPMP

Allocable cost pool

- Cost pool 6

MAC cost pool 1 (CP1) is for employees that have been designated as Skilled Professional Medical Personnel (SPMP) in the RMTS. An SPMP is an employee of the LHJ who has completed a two-year or longer program leading to an academic degree or certification in a medically related profession (physicians, nurses, registered dietitians, clinical social workers, etc.) and who is in a job classification requiring this medical training and education.

- SPMP staff must be direct employees of the LHJ and not personal service contractors or employees of a subcontractor.
- 100% of the costs of the SPMPs' salaries and benefits are reported to CP1.
- Travel and training costs directly associated with specific SPMP staff may also be included in CP1 (Federal regulations permit these activities to be reimbursed at the enhanced rate of 75%).
- Clerical staff who only support SPMP staff in the RMTS may also be included in CP1. (They do not have to be in the time study if the organizational chart clearly demonstrates they only support SPMP staff).
- Other costs that can be associated to specific SPMP staff may also be reported to CP1. (If these costs cannot be associated with an individual staff, they must be assigned to CP6 and allocated instead).

A claiming rule

Report 100% of actual expenditures. This includes federal and non-federal funds.

The one exception is to exclude employees that are 100% federally funded (from salaries and benefits to the proportional share of other costs and the indirect rate).

MAC cost pool 2 (CP2) is for all other RMTS participants.

- 100% of their salaries and benefits are reported to this cost pool.
- The costs of clerical staff that only support staff who are CP1 and CP2 may also be included in CP2 (they do not have to be in the time study if the organizational chart demonstrates they **only** support staff in the RMTS.) If these staff support both RMTS participants and staff not in the RMTS, then their costs must be assigned to CP6.
- The costs of any personal service contractors participating in the RMTS should be included in CP2.
- Any other expenditure that can be assigned to individual RMTS participants in this cost pool may be reported to CP2. (If these costs cannot be associated with an individual staff, they must be assigned to CP 6, and allocated instead).

Non-MAC cost pool 3 (CP3) is for all non-allowable expenditures. It includes the salaries and benefits of employees in the budget unit/program(s) who:

- Do not perform MAC activities and are not in the RMTS.
- Are not clerical or supervisory staff whose costs can be allocated.
- Are not entirely included in the indirect cost rate.
- Are 100% federally funded.

The non-MAC cost pool is also for unallowable other costs such as medical or education supplies. (The assignment of "other costs" to the appropriate cost pool is discussed in the Other Costs section of this manual.)

Direct charge cost pool (CP4) is for reporting allowable SPMP costs that are identified and documented outside the RMTS Process.

- Captures direct charges for SPMP activities performed by SPMP.
- Includes “Direct Charging Personnel Costs” and “Direct Charging Contract and Other Costs” as described below.

Typical direct charges

Staff who prepare the MAC invoice, prepare the MER, or update the RMTS participant lists are good candidates for direct charging. They do no other MAC Activity, and their costs are not 100% included in the indirect cost rate.

Direct charge cost pool (CP5) is for reporting allowable non-SPMP costs that are identified and documented outside the RMTS Process.

- Captures direct charges for all other (non SPMP) allowable personnel and other costs.
- Includes “direct charging personnel costs” and “direct charging contract and other costs” as described below.

Direct charging personnel costs. Personnel and other costs may be direct charged for employees who perform a single MAC activity (a “single cost objective”) as part of their day-to-day job responsibilities.

- Only the time and costs associated with the single MAC activity may be direct charged.
- If staff perform more than one MAC activity as part of their job responsibilities, they should be included in the RMTS.
- The employee who is direct charging a MAC activity must document the time spent performing the activity continuously over the quarter.
- The time must be documented in the single cost objective section within the URMTS.
- At the end of the quarter, the cost of the direct charged MAC activity is calculated one of two ways:
 - The percentage of time spent on the single cost objective is applied to the salaries and benefits of the direct charged employee(s).
 - The second option is to first allocate non-productive hours (general administration and paid time off) between the MAC activity reported in the single cost objective section of the URMTS and all other activity documented by the employee, then applying the adjusted percentage of time spent on the single cost objective to the employee’s costs.

- The resulting percentage of MAC activity is then applied to the employee’s salaries and benefits and to any other allowable expenditure attributed to that employee. These expenditures are then entered on the direct charge section of the URMTS invoice.
- The expenditures remaining after an employee’s MAC-related costs have been direct charged should be assigned as follows:
 - Use CP3 if the employee is not in an administrative job classification. For example, an employee assigned to a non-MAC program who is responsible for compiling the data needed for the LHJ’s client MER. The costs associated with their MAC-related work would be direct charged. The remaining costs (supporting non-MAC activities only) are assigned to CP3 if the LHJ reports all costs.
 - Do not report the costs if the non-reimbursable remaining expenditures are in a budget unit whose staff perform no MAC activities, and no one is eligible to participate in the RMTS.
 - **Do not report the costs at all if the remaining costs are included in the agency’s indirect rate.**

A claiming rule: Do not duplicate costs

An example of duplication of cost is when an employee’s costs are in the agency’s indirect rate and also included in the MAC invoice.

Direct charging contract and other costs. Other allowable expenditures may be direct charged with proper documentation. Documentation should include a brief description of what the contract is for, proof of payment, and must clearly demonstrate the charged amount is a MAC related expense. Examples of contracts that might be direct charged include:

- The MAC related portion of contracts for interpretation services.
- The travel and per diem expenses of an LHJ MAC coordinator who participates in the RMTS, but who travels to a MAC invoice training session in another city.
- The cost of the LHJ’s contract with WSALPHO for the services of the MAC contractor.
- The MAC-related costs of subcontractors.
- The MAC related portion of contracts for claims management.

Allocated cost pool (CP 6) is for expenditures that can be allocated across all other costs pools in proportion to the personnel costs reported in each.

- The costs of supervisory and support staff that support staff in CP1—CP5 can be assigned to CP6 if:
 - They are not 100% in the indirect rate
 - They are not 100% federally funded
 - They are not reported in another CP
- Other costs may also be assigned to this cost pool if they are allocable expenses and not reported in another CP (see next section on "Other costs").
- If benefits are not tracked by individual employee, they can be assigned to CP6, where they will be allocated proportionately across all cost pools

Direct charged Interpreter contracts

Interpreter contracts that provide both Medicaid and non-Medicaid services must be reported to CP6. Refer to page 15 for the required supporting documentation.

Examples: interpretation for vital statistics, or environmental health planning.

Other costs

Other costs can be included in the MAC invoice. The allowability of these costs is based on 2 Code of Federal Regulations (CFR) Section 200, 420-475.

Allowable and unallowable costs

An **allowable cost** is one that benefits the MAC program, and which Medicaid will pay its fair share (see MER section).

An **unallowable cost** is one that has no benefit to the MAC program, and one which Medicaid will not pay for.

There are two rules for assigning other expenditures that are not in the indirect rate to a cost pool:

- Unallowable costs must be assigned to CP3.
- Allowable costs may be assigned to the same cost pool of the specific employee they are associated with, or they can be assigned to CP6 for allocation.
 - Some other costs will always be assigned to CP3, because they are, or should be, part of the payment from another Medicaid program, or because there is no benefit to the MAC program.
- Other allowable costs can always be assigned to CP6, based on the federal guidelines in 2 CFR 200, 420-75: *Considerations for Selected Items of Cost*.
- Other costs should be organized by object code. Other costs can be totaled by cost pool, including the direct charge cost pools, on the invoice. Backup documentation in the General Ledger should display detail for each item of cost by date, object code, amount, and payee.

Excerpt: Examples of costs commonly assigned to a CP3 or CP6

The benefit of a cost to the Medicaid program should always be considered in assigning an expense to CP3 or CP6. If there is no benefit, the expense should be assigned to CP3. If the benefit is partial, or allocable, use CP6. Review the *Considerations of Other Costs* section of the Omni-Circular for the allowability of specific costs.

CP3

- Medical supplies or equipment; pharmaceutical supplies
- Education materials (for parent education, health education, etc.
- Environmental health or vital records materials or supplies
- Professional liability insurance
- Client and volunteer incentives
- Client transportation; client support
- Hazardous waste disposal
- Environmental health equipment & supplies
- Contracts for medical/clinical services
- The costs of any trainers, materials, or supplies related to providing initial or advanced training for an employee's essential job requirements.
- The cost of registration for any continuing education not specifically related to maintaining professional licensure or registration.

CP6

- Office supplies and materials, including the cost of computing devices
- Contracts for administrative services
- Office supplies and office equipment; equipment repairs and maintenance
- Communications
- Food for all staff events
- Janitorial/maintenance services
- Portion of county's indirect rate charged to claiming unit, when not in the indirect rate
- Postage
- Printing
- The costs of any trainers, materials, or supplies for training to improve the delivery of Medicaid services or on the scope or benefits of Medicaid services.
- The cost of registration for any continuing education specifically related to maintaining professional licensure or registration.

Pass through contracts

Some LHJs are part of county multi-service agencies and may act as agents for federal or state pass-through contracts. If the funds for these contracts are included in the expenses of the MAC budget unit(s)/programs(s), they should be reported to CP 3 in the Expenses section of the URMTS Web-based invoice. The indirect rate is not applied to these contract costs

The indirect cost rate

MAC claims for reimbursement may include indirect costs, which must be developed in accordance with all applicable regulations and guidelines including the Office of Management and Budget **2 CFR Chapter I, Chapter II, part 200**, et al (OMNI Circular). The LHJ must prepare an annual Certificate of Indirect Costs that certifies the accuracy of the indirect cost rate proposal submitted to their Cognizant Agency. The certification is maintained with the invoice back-up documents. Invoices will not be processed by HCA if the rate in the back-up documentation does not match the rate on the invoice.

A careful review of the costs included in the indirect rate is required to ensure they are not included on the MAC invoice. This prevents duplication of cost.

If an indirect rate is applied to the MAC invoice, the LHJ must retain a copy of the indirect rate cost proposal submitted to their cognizant agency and signed a copy of HCA's indirect cost rate form must be submitted with the Q1 invoice each year.

The URMTS web-based invoice supports indirect cost rates based on:

- Salaries only.
- Salaries and benefits.
- Modified total direct costs.

Reporting funding

Why funding is reported on the invoice

To participate in the MAC program, the LHJ must have sufficient allowable state or local funds to pay for allowable MAC expenditures. There are three purposes to this section:

- **To display all funding sources that support the actual expenditures of each budget unit/ program** included in the invoice. (The total funding reported on the invoice should match the total expenditures.)
- **To display the eligible funding sources that support allowable MAC activities.** This funding is the LHJ's Certified Public Expenditures (CPE) (local match).
Note: If the LHJ does not have enough eligible funding sources to support the MAC activities, the amount to be claimed is reduced so that only eligible expenditures are reimbursed.
- **To display any federal or other unallowable funds that paid for MAC activities that must be "offset" or applied against the costs that form the basis of the invoice** to ensure that the federal government does not pay twice for the same activity.

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).

CMS requires that funds being offset against expenses in the MAC cost pools; include:

- Funds that support 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 allowable 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 – for example, the state matching funds for ABCD Receipts recorded in the LHJ's general ledger as reduction of expenditure type transactions offsetting or reducing expense items allocable to federal awards. An example might be a rebate received for a bulk purchase of copier paper – these costs would be assigned to CP6.
- Funds that support non-MAC activities (such as payments for Medicaid services, fees, insurance, and federal grants supporting non-MAC activities) to ensure they are not reported as CPE (local match).
- Costs from non-MAC cost objectives are removed from the non-MAC cost pool.

Note: There are a few federal grants where the authorizing legislation requires them to be a payer of last resort. This means that Medicaid is the first payer for services covered by Medicaid and Medicaid administrative activities. Four grant sources where Medicaid must be the first payer are:

- Title V Maternal and Child Health Block Grant.
- Ryan White HIV/AIDS grants.
- Part B funds under the Individuals with Disabilities Education Act (IDEA).
- Part C funds under the Individuals with Disabilities Education Act (IDEA).

Assigning funding to the funding page on the invoice - step by step

You must identify the funds that paid for the actual expenditures included in the invoice and assign them to the appropriate funding cost pools. A cash basis or accrual method may be used. There are seven funding (cost) pools which are used to separate sources of funding that paid for MAC and non-MAC activities, and to separate the allowable and unallowable sources of funding that paid for MAC activities. CP3 is used to report non-MAC funding and CPA is used to report local matching funds. All other CPs are used to offset unallowable sources of funding that paid for MAC activities.

Reminder

Do **not** report all revenue received in the quarter. Only enter the funding that paid for expenses reported on the invoice. Remember to include the funding that paid for indirect costs.

Funding reported in the invoice must not exceed the expenditures reported in the invoice. In addition, local matching funds (reporting to CPA) must be actual expenditures and must not exceed the total computable MAC expenditures. Assign each funding source to one of the seven cost pools based on the scope of work associated with the funding source:

CP A (local match/CPE): Allowable funding that paid for MAC activities

CP1 (revenue offset): Unallowable funding that paid for SPMP MAC activities

CP2 (revenue offset): Unallowable funding that paid for non-SPMP MAC activities

CP3 (non-MAC revenue): All funding that pays for non-MAC activities

CP4 (revenue offset): Unallowable funding that paid for direct charged SPMP MAC activities

CP5 (revenue offset): Unallowable funding that paid for direct charged non-SPMP MAC activities

CP6 (revenue offset): Unallowable funding that paid for MAC activities, but cannot practically be assigned to CP1 or CP2

Note: Since funding is reported to a cost pool based on its scope of work, the totals in each of the funding cost pools generally will not equal the totals reported to each expense cost pool. **This is to be expected.**

Assigning funding

1. Funds paying for non-MAC activity. Identify funds whose scope of work has no MAC activity and assign these funds to CP3. Examples of funds that would always be assigned to CP3 are payments for direct medical services (Medicaid payments for First Steps; fees for services the LHJ provides; and federal grants that do not pay for MAC activity such as WIC and SNAP-Ed.

2. Allowable funds paying for MAC activity. Allowable funds are most often state and local tax dollars. They may be general purpose funds, where the LHJ determines how they will be used, or grant funds with a scope of work that includes MAC activities. Identify the allowable funds that actually paid for the MAC activities and assign these funds to CPA. Examples of allowable funds include State Local Public Health Assistance funds, liquor and forestry tax revenues, local levies for health and mental health services, and/or local general funds.

3. Unallowable funds paying for MAC activity.

Revenue offset is part of the process of assigning funds to the funding worksheet. Revenue offset means that federal grants that are paying for MAC, based on their scope of work, cannot be used for local match and cannot be assigned to CPA.

Revenue offset ensures that the cost basis of the MAC invoice excludes any unallowable funds that pay for MAC activities. The purpose of revenue offset is to make sure that the federal government is not paying twice for a MAC activity.

To offset revenue, identify unallowable funds and assign them to CP1, CP2, CP4, CP5, or CP6 (based on where the expenses were reported). Once the “offset” funds are assigned to the appropriate CPs, the cost reduction occurs automatically.

For example, the federal immunization funds in the Department of Health’s consolidated contract support activities related to the Medicaid Pediatric Immunization program cannot be used as local match because they already pay for MAC expenses. These funds must be offset. If the amount of funding assigned to individual staff can be identified, then assign the appropriate amount to the CP where the staff’s salary is reported. If the LHJ’s financial system does not assign funding at the individual staff level, then the funding can be assigned to CP6, where it will be automatically allocated, and offset based on the percentage of personnel costs reported to CP1—CP6.

Note: Certain types of private funds (such as grants from foundations or local United Way program) may be used as local match for the MAC program under certain conditions.

- The scope of work must include allowable MAC activities and support staffing the RMTS or whose costs are being direct charged.
- The funds must be approved for use by the National Institutional Reimbursement Team (NIRT) in advance of their use.

The process for requesting approval for private funds to be used as local match (CPE) is managed on a case-by-case basis by the HCA. It is recommended that requests for NIRT approval be made at least six – nine months before they will be included in the invoice, to allow for adequate processing and review time by HCA and NIRT.

More on revenue offset

This is the term used to ensure that the cost basis of the MAC invoice excludes any unallowable funds that pay for MAC activities. The purpose of revenue offset is to make sure that the federal government is not paying twice for a MAC activity.

Once the “offset” funds are assigned to the appropriate CPs, the cost reduction occurs automatically.

Revenue offset: An example

An LHJ may have SPMP eligible public health nurses in the RMTS. Part of their job may be to provide First Steps services. The rest of their work is in the Nurse Family Partnership (NFP) program, which is supported with state and local tax dollars. The payments received for First Steps services must be assigned to CP3 because they are for a direct medical service, which is a non-MAC activity. State and local tax dollars that pay for their MAC-related NFP work can be assigned to CPA. Funds that pay for their non-MAC NFP activity would go to CP3, even if they are state or local tax dollars.

The following example is based on the nurse being the only person in the RMTS in either CP1 or CP2.

- The nurse’s total expense for the quarter is \$25,000.
- The nurse is supported with \$8,000 in First Steps revenue and \$17,000 in state general funds.
- The total computable cost of this nurse’s MAC activity is \$10,000 (displayed on the URMTS funding page). This represents the amount of local match required to be reported to CPA.
- The funding for the nurse is assigned as follows:
 - The \$8,000 in First Steps revenue is assigned to CP3 because it supports non-MAC activity.
 - \$10,000 of the state general funds is assigned to CPA to cover the cost of the nurse’s MAC activities.
 - The remaining \$7,000 is assigned to CP3 because it is paying for the remaining non-MAC NFP activity of the nurse.

How to offset funding

1. Identify any federal or private funds supporting staff in the RMTS where the scope of work includes claimable MAC activities. These funds must be offset.
2. If the funding is assigned to specific individuals, total the amount expended on staff in CP1 and/or CP2 and enter the total(s) in CP1 and/or CP2 next to the name of the funding source on the Funding page.
3. If the funding is not assigned to individuals, enter it in CP6 next to the name of the funding source on the Funding page.

Certification of public expenditures

Federal guidelines

The federal government (Medicaid) provides partial reimbursement for allowable MAC activities through the Certified Public Expenditure (CPE) process. Federal regulations permit state, local, and tribal governments to provide the non-federal share of Medicaid expenditures. The funding of the non-federal share may be directly appropriated to government units by their legislature or other authority, transferred between the government units or actual expenditures incurred by the government unit may be certified as expenditures eligible for Medicaid reimbursement.

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 only 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).

Certifying Public Expenditures process

Quarterly, each LHJ must identify the allowable local matching funds that pay for MAC activities by certifying them as public expenditures. This certification is completed within the web-based claiming system. BARS codes are required for all funds used as local match.

CPE and non-governmental subcontractors

LHJs must pay their subcontractors 100% of the total computable of their allowable MAC costs before the LHJ may invoice HCA for these expenditures. LHJs may not require or allow their non-governmental MAC subcontractors to contribute to the financing of the non-federal share of their MAC expenditures.

CPE and governmental contractors

The MAC agreement between the LHJ and the governmental subcontractor must state that the subcontractor must certify in writing to the LHJ that the expenditures incurred in the performance of MAC activities are eligible for federal reimbursement. The subcontractor must provide documentation that the funding supporting 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.

Medicaid Eligibility Rate (MER)

Allocable share of costs

All expenses must be sorted, or allocated, into four categories to determine whether they are allowable as Medicaid administrative expenses. The MER is used to determine what share, or proportion, of the allowable expenses are reimbursable by the federal government for each quarterly MAC invoice. There four categories are:

- **Unallowable** – The activity is unallowable as a Medicaid administrative cost. No MER is applied, and these costs are not part of the calculation used to determine the MAC reimbursement.
- **100% Medicaid Share or Total Medicaid** – The activity is solely attributable to the Medicaid program, and Medicaid will pay 100% of the cost for these activities.
- **Proportional Medicaid Share** – The activity is allowable as administration under the Medicaid program, but only the portion that is attributable to Medicaid enrollees. This MER reduces the total amount of the activity so that only the percent related to Medicaid enrollees is part of the calculation used to determine the MAC reimbursement.
 - Without a proportional MER, a time study participant would need to note the Medicaid status of each person that was the target of a MAC linkage-related activity. The application of a proportional MER simplifies the time study process for staff by removing this administrative burden.
- **Allocated Activities**—The activity is allocated across other codes based on the percentage of time spent on allowable and unallowable Medicaid administrative activities.

Proportional MER

There are three proportional MERs, which are described below. The modified countywide MER is used for all activity codes that require a proportional MER unless the LHJ opts to apply a client or clinic-based MER to its MAC-linkage related activities, in addition to the modified countywide MER. (This option must be included in the LHJ's annual MER proposal.)

To use the client or clinic-based MER, the LHJ must track and maintain a record-keeping system or electronic database of all individuals they serve in the budget units/programs included in the MAC invoice for each quarter.

Modified Countywide MER

- The Modified Countywide MER was developed to recognize the uneven distribution of poverty within the jurisdiction of an LHJ. It uses poverty and census data to identify the percentage of Medicaid enrollees within high poverty census tracts and in medium-low poverty census tracts. The two percentages are then averaged together, to create a modified countywide MER.
- This MER is applied to all MAC activity codes that require a proportional MER and where the population targeted by the LHJ is more representative of the countywide population than the LHJ's client base – program planning is the primary example.
- This MER is also applied to the linkage-related MAC activity codes when the LHJ opts to use the client-based MER. A client ID must be entered into the RMTS moment for linkage-related activities in order for the client-based MER to replace the modified countywide MER.
- The LHJ does not need to provide any data for this MER. It is generated by the WSALPHO vendor and is automatically applied to the appropriate codes in the invoice.

Preparing the Modified Countywide MER

1. HCA extracts a file that includes all Medicaid-eligible clients during the specific quarter. The file will follow the specified file format below, including header rows.
2. When prepared, the file is posted to **sft.wa.gov** under the account HCA-WSALPHO.
3. The WSALPHO vendor is notified when the file has been posted and downloads the file from HCA-WSALPHO_2.
4. The WSALPHO vendor processes the file with the census data tract information and populates the web-based claiming system with the results.

Modified Countywide MER timeline

- 21 days after calendar quarter ends, HCA provides the file to the WSALPHO vendor for processing to begin.
- 30 days after calendar quarter ends, the WSALPHO vendor completes processing and posts data to the web-based claiming system.

See the MAC Annual Calendar for specific dates.

Client-based MER

- The client-based MER is based on the percentage of clients who are Medicaid enrollees served divided by the total number of clients served during a quarter.
- This client population is based on the program/budget units that are included in the invoice.
- The LHJ must have a record-keeping system or database that tracks all clients served within these program/budget units.
- This MER is only applied to the moments where an RMTS participant enters a client ID into the RMTS moment for MAC activity codes 6b, 7b, 7d, 10b, 12b. The invoice separates the moments reported to 6b, 7b, 7d, 10b, 12b into two sub-categories:
 - One that includes all moments with a client ID. The client-based MER is applied to these moments.
 - The other includes all moments without a client ID. The modified countywide MER is applied to these moments.

Quality assurance for the Client-based MER

LHJs must do periodic checks to verify that the client IDs reported in the RMTS are linked to actual clients included in databases used to generate the list of clients for the client-based MER.

Clinic-based MER

- The clinic-based MER may only be used by LHJs that operate primary care or specialty clinics.
- This MER is based on the percentage of patients who are Medicaid enrollees served by the clinic programs divided by the total number of patients served by the clinic programs over a quarter.
- The clinic population is based on all of the LHJ's clinics included in the invoice.
- This MER is only applied to activity codes 6b, 7b, 7d, 10b, and 12b.

MER proposal

Each year, the LHJ must determine what MER, or combination of MERs they will use. The LHJ must submit a MER proposal to HCA no later than December 1st of each year. The purpose of the proposal is to inform HCA which proportional MERs will be used for the upcoming year and describe the databases that will be used if a client or clinic MER will be applied. An LHJ may also elect to use the modified countywide MER for all activity codes. The MER proposal form is located on the HCA website.

Instructions for creating the client/clinic MER file

Reminders

The client/clinic files must include all clients/patients served during the quarter (not just the Medicaid enrollees).

The client/clinic files must only be drawn from the databases documented on the HCA approved MER proposal.

A quarterly client/clinic MER file must be submitted if the LHJ will use a client/clinic-based MER for its linkage-related MAC activities, and the LHJ must have the client/clinic MER documented in its annual MER proposal approved by HCA.

The file is not required if the LHJ will only use the modified countywide MER. At the end of each quarter, the LHJ must create a single list of all individuals served by the budget units or programs included in the MAC invoice.

This list must use the record keeping systems or databases indicated on the annual MER proposal, and must include 100% of individuals served within the budget units or programs.

The clinic/client MER file must be prepared in a .csv format as described below, and submitted to the WSALPHO contractor, who prepares the client/clinic MER file for submission to HCA or its designated contractor (Provider One) to verify the Medicaid status of all clients/patients served during the quarter. The specific format requirements for the clinic/client MER file are as follows.

The .csv file must contain a “header” row with the field names. These field names must appear exactly as they are listed and are case sensitive. There are four required fields:

- **FIRST_NAME:** The client’s first name is entered here. If a nickname or other name is used, it can also be entered in one of the following formats:
 - James “Jimmy”
 - James (Jimmy)
- **LAST_NAME:** The client’s last name is entered here. Hyphenated names or multiple names are accepted.
- **DOB:** The client’s date of birth is entered here. The format MM/DD/YYYY should be used.
- **POCID:** This is the client’s ProviderOne client ID. If an ID is known, it may be entered here. If it is unknown, leaving the field blank will serve as an entry. Please note that the field must be included in your file even if you leave all entries blank.

Other optional fields may also be included in your file.

- **MIDDLE:** If a client has a middle name or initial it may be entered here. The full middle name or the initial may be used. Do not use special characters such as “.”
- **GENDER:** The client’s gender may be included by designating M or F (Male or Female) in the field.
- **SUBUNIT:** Enter the subunit ID for each client, if the LHJ is submitting a file with more than one subunit’s data (this is just for reference).

When the file is complete, submit it via the web-based claiming system on the MER Request page.

When the file has been processed through ProviderOne, an electronic 271 file is created and uploaded to HCA’s SFT website. The file includes each client record and is used to generate the client/clinic MER percentage, which will be automatically uploaded to the LHJ’s web-based invoice.

Contractor costs

An LHJ may enter contracts with companies or individuals for a wide range of goods and/or services. LHJs must adhere to federal and state requirements in their agreements with contractors. An LHJ may request reimbursement for the MAC-related costs of its eligible contracts. To do so, the expenses cannot be included in the indirect cost rate, and LHJ must pay 100% of the MAC expense (both the federal and non-federal share). Only allowable sources of funds, documented by the LHJ on its CPE local match certification form, are eligible for reimbursement.

There are several types of contracts, and several ways to report the expenses on the MAC invoice.

Personal service contracts

A personal service contract establishes an employer/employee agreement between an LHJ and an individual contractor to provide a specific professional function within the LHJ. These contractors can either participate in the RMTS or direct charge their MAC activity. Examples include:

- Outreach staff
- Nurses
- Medical directors
- Billing/accounting staff

Note: Personal services contracts do not include general, continuing LHJ functions like delivery services, equipment rental, or janitorial services.

Good and services/vendor contracts

These contracts are typically for services and goods that are needed for the LHJ to perform its work. Examples include:

- Records management systems
- Office supplies
- Janitorial services

Other vendor contracts

These contracts are typically for other organizations to do work on behalf, or in partnership with the LHJ. Examples include:

- Services provided to target populations on behalf of the LHJ (such as homeless outreach or neurodevelopmental centers).

Assigning contract expenses

Contract expenses are assigned to a cost pool based on their purpose.

- Contracts expenses that support general agency functions or that cannot be assigned to a specific program must be assigned to CP6. This allocates the expenses proportionally across all cost pools. Examples include, but are not limited to IT or computer support, janitorial services, accounting services or health officer/ medical directors.
- Contracts expenses that do not support any MAC-related activities must be assigned to CP3. Examples include, but are not limited to laboratory services, hazardous waste disposal, program related educational materials such as parenting workbooks, client incentives, medical supplies, uniforms, or staff or personal service contractors who are assigned to CP3.
- Contracts expenses that are 100% MAC-related may be assigned to CP5. An example would be the MAC-related administrative fees charged to the LHJ by WSALPHO.
- Personal service contract employees that perform MAC and non-MAC activity and participate in the RMTS should be assigned to CP2.
- Personal service contract employees that perform a single cost objective MAC activity and do not participate in the RMTS can have the MAC-related portion of their expenses assigned to CP5.
Note: Personal service contractor expenses cannot be assigned to SPMP cost pools (CP1 or CP4).
- Contracts that perform both MAC and non-MAC activities must separate the MAC expenses from the non- MAC expenses. Documentation of the separation is required. The MAC expenses may be direct charged with 100% MER. Examples include but are not limited to contract interpreters or contracts with NDCs or similar organizations.
Note: A MER may be applied to contractor expenses.

Administrative fees

HCA administrative fees

The fees HCA charges the LHJs for administering the MAC program may not be claimed as a MAC expense by the LHJs. HCA claims federal reimbursement for these costs, these fees are not allowable MAC costs. The administrative fees should be reported to Cost Pool 3 on the invoice.

WSALPHO administrative fees

The fees WSALPHO charges the LHJs for managing the MAC program (such as operating the RMTS through

its contractor and providing training and technical support to the MAC program) may be direct charged to cost pool 5 as a MAC expense, as these fees are based on actual costs.

LHJ administrative fees

The LHJ may also charge its subcontractors a proportionate share of the cost of the WSALPHO contract, and the subcontractors may direct charge to cost pool 5 these costs on the MAC invoice.

Submitting and correcting invoices

Note: Please see the URMTS Guide for technical descriptions of this process.

1. LHJ completes and certifies the invoice.
2. HCA reviews the invoice. If corrections are needed, HCA can request that the online invoice be unlocked for editing.
3. HCA approves the invoice and authorizes the LHJ to generate the A19. The LHJ generates the A19 form and then signs, scans and emails the A19 to HCA.
4. HCA signs the A19 and forwards to HCA Accounting for review.
5. HCA Accounting will review the A19. If corrections are needed, a revised invoice will need to be submitted. (Repeat steps 1-4).
6. HCA Accounting approves the A19 and processes the A19 for payment.

Glossary

A19-1A Invoice Voucher (A19): The State of Washington Invoice Voucher used by the LHJ to submit claims for reimbursement of allowable MAC costs. It certifies that all costs, including CPE and the indirect cost rate are certified as accurate, allowable and in accordance with applicable federal regulations.

Actual Expenditures: The MAC invoice must be based on actual expenditures of the budget unit/program(s) and all adjustments posted during the claiming quarter where MAC activities are performed.

Allocated Expenditures: Allowable expenditures that are assigned to Cost Pool 6 in the MAC invoice, and which are allocated across all other cost pools because they cannot be assigned to a single cost objective or a single employee.

Allowable or Claimable Expenditures: Expenditures that are necessary and reasonable for the performance of the MAC program. An allowable expense may be greater than the amount allocated to the MAC program.

Budget Unit/Cost Center: An organizational subunit within an LHJ where both direct and indirect costs may be segregated and charged for accounting purposes.

Certified Public Expenditures (CPE): The non-federal (local) share of the total computable MAC expenditure. The payments must meet the criteria in 42 CFR 433.51. The LHJ's non-federal tax dollars or other eligible funds that are not otherwise obligated, and which pay for the total computable MAC expenditures. The non-federal share of the local match is designated as Certified Public Expenditures (CPE). This revenue must be in the LHJ's budget and under its control. These funds cannot be contributed by healthcare providers as local matching funds and subcontractors cannot certify local match funding. All local match funds must meet CPE requirements.

Claiming Unit or Entity: The local health jurisdiction (LHJ) is the claiming unit/claiming entity. Only governmental entities can contract with HCA for Medicaid Administrative Claiming activities and is the only entity that can submit invoices for reimbursement.

Cognizant Agency: The single agency representing all others in dealing with grantees in common areas and who reviews and approves grantees' indirect cost rates. OMB published a list of Cognizant Agency assignments for some State agencies, cities, and counties on January 6, 1986 (51 FR 552). The Cognizant Agency for governmental units not on that list is the one that provides the most grant funds to the entity.

Cost Objective: A function, organizational subdivision, contract, grant, or other activity for which cost data are needed and for which costs are incurred.

Cost Pools: Groupings of a claiming unit's individual expenses that are the basis for allocating costs between MAC and Non-MAC activity.

Centers for Medicare and Medicaid Services (CMS): The agency within the federal Department of Health and Human Services (DHHS) with national oversight responsibility for the Medicare and Medicaid programs.

CMS Guide (Guide): The 2023 School-Based Guide to Medicaid Services and Administrative Claiming produced by CMS, including any supplements, amendments, or successor guides.

Code of Federal Regulations (CFR): The codification of the general and permanent rules published in the Federal Register by the departments and agencies of the Federal Government.

Code Reviewer: An individual designated by the LHJ RMTS coordinator to review the completed random moments of a select group of RMTS participants, to ask clarifying questions, and to correct any codes that the participant assigned incorrectly.

Consortium or RMTS Consortium: A grouping of several LHJs that organize for the purpose of participating in a common Random Moment Time Study, and where the results of this RMTS are used by all the consortium members. Each consortium must have a lead agency.

Direct Charge: Direct invoicing of certain costs identified as 100 percent allowable. These costs are entered in the Direct Charge worksheet of the MAC invoice. Some direct charge costs must be discounted by the Medicaid Eligibility Rate. Direct charges must be itemized and explained in back-up documentation to be submitted with the invoice.

Direct Medical Service: Medical care or treatment billable to Medicaid or another third party or provided on a sliding scale or without charge to those who cannot afford to pay. A direct medical service includes activity that is integral or an extension of this billable service, such as scheduling patient follow up, charting, assessments, billing, linkage, or any other activity that is included in the rate established for the medical service.

Document Vault: A component of the URMTS Document Management System that stores files uploaded by the LHJ to document/ensure program compliance.

Federal Financial Participation (FFP): The proportion of allowable expenditures to be reimbursed by the federal government for allowable (or claimable) Medicaid administrative activities.

Fiscal Coordinator: The LHJ employee responsible for preparing the quarterly MAC invoice.

Health Care Authority (HCA): The single state Medicaid agency that has authority and responsibility for administration of the State Medicaid Plan and Medicaid Administrative Claiming programs.

Indirect Cost (Indirect Cost Rate): Costs that benefit more than one cost objective and cannot be readily identified with a particular cost objective can be categorized as indirect costs and included in an indirect cost rate proposal submitted to the Contractor's Cognizant Agency. The indirect cost rate must be certified by the Contractor annually using the HCA Certificate of Indirect Costs form. See 2 CFR 200, Appendix VII for additional guidance on the development of an indirect cost rate.

Interpreter: An individual providing Interpreter services through the LHJs' MAC program who meets DSHS Language Testing and Certification requirements.

Lead Agency: The LHJ designated by members of an RMTS consortium to act as its representative on the WSALPHO MAC Steering Committee, and whose responsibility is to represent the consortium on issues related to the time study.

Local Health Jurisdiction (LHJ): A local health jurisdiction is a local government agency that carries out a wide variety of programs to promote health, help prevent disease, and build healthy communities in Washington State. It is the claiming entity that contracts with the Health Care Authority to perform Medicaid Administrative Claiming on behalf of its subunits and subcontractors.

Local Matching Funds (Local Match): Non-federal tax dollars or other eligible funds that are not otherwise obligated that are used to pay for the total computable cost of MAC activities.

Medicaid Administrative Claiming (MAC): A program administered by HCA that reimburses contracted governmental entities for a proportion of expenditures for medical assistance under an approved Medicaid state plan, and for expenditures necessary for administration of the state plan.

Medicaid Eligibility Rate (MER): The calculation that determines the proportional cost of an allowable (or claimable) MAC activity that will be reimbursed by the federal government – a Total MER (100%) and three proportional MERs (a modified countywide MER, a clinic-based MER, and a client-based MER).

MER Proposal: A document describing which MERs an LHJ subunit will use for the year covered by the proposal, and the sources of data that will be used to establish the client or clinic MER.

Response Rate: The percentage of moments in the RMTS considered valid for purposes of determining statistical validity. A valid moment is a moment that was completed within the 5 business day deadline, or where the employee was on paid or unpaid leave at the time of the moment.

RMTS Coordinator: The LHJ employee with designated responsibility for managing the Random Moment Time Survey.

Random Moment Time Study (RMTS): A time documentation methodology where a statistically valid number of moments is randomly selected from all moments worked by time study participants in the quarter and their activity at each of those moments is coded to an approved time survey activity code.

Revenue Offset: Revenue that has a restricted purpose and therefore is not available for certification as a public expenditure and used as local match. The Funding Worksheet of the invoice isolates these dollars, reducing the amount of revenue that can be used for local match.

RMTS Participants: Individuals who participate in the RMTS.

Single Cost Objective: Single cost objective refers to costs that can be assigned to a single federal award/program. In terms of the MAC program, single cost objective also refers direct charging the related costs of to an employee performing only one MAC activity code on a consistent basis. The time spent on this single MAC activity must be documented in the URMTS on an ongoing basis, and the associated costs claimed as a direct charge in the URMTS invoice.

Skilled Professional Medical Personnel (SPMP):

An employee of a public agency who has completed a two year or longer program leading to an academic degree or certification program in a medically related profession, demonstrated by possession of a medical license, certificate or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization and who is in a position that has duties and responsibilities requiring that professional medical knowledge and skills.

Statistical Validity: The percentage of random moments that must be completed, and considered valid, to meet federal requirements for a statistically valid time study. Each RMTS consists of 2761 moments; the required minimum response rate of valid moments must be 85% for the time study to be statistically valid.

Subunit: One or more budget units or cost centers within the LHJ that are individually reported on the LHJ's MAC invoice.

Subcontractor: A subcontractor is an agency with which the LHJ has an agreement to perform MAC activities on its behalf.

Total Computable (TC): The total cost of claimable MAC activities. This includes both the federal and non-federal share.

Unallowable Expenditures: Costs that are not necessary and reasonable for the performance of the MAC program. Unallowable expenditures must be assigned to CP3.

Uniform Administrative Requirements, Cost Principles, and Audit Requirement for Federal Awards (Omni-Circular):

A federal guide on cost allocation principles codified in 2 CFR 225 Sections 200 and 225.

URMTS: The electronic, web-based application that manages the RMTS, MER, invoicing, and document management system used by LHJs participating in HCA's MAC program. The URMTS is operated by Hansine Fisher and Associates on behalf of the Washington State Association of Local Public Health Officials (WSALPHO).

URMTS Document Management System: A storage system within the URMTS for uploading LHJ documents needed for program compliance and for downloading forms, manuals, training resources and other documents for RMTS coordinators, fiscal coordinators, and participants.

WSALPHO: The Washington State Association of Local Public Health Officials (WSALPHO).

WSALPHO MAC Steering Committee: The WSALPHO MAC Steering Committee (Steering Committee) functions as an advisory board working under the direction of WSALPHO leadership. The Steering Committee provides broad oversight of the LHJ MAC program in Washington State and acts as a point of contact for LHJ staff.

