Washington State Health Care Authority

Medicaid Administrative Claiming Cost Allocation Plan

for King County Superior Court Juvenile Probation Services (KCSCJPS)

August 2013

TABLE OF CONTENTS

**For related definitions, please visit: http://hrsa.dshs.wa.gov/MAC/

INTRODUCTION

Some of Washington's most vulnerable residents experience difficulty accessing needed health care. Government agencies provide many services to Washington residents on a daily basis ensuring their overall well-being. Federal funds are available through the Health Care Authority's (HCA) Medicaid Administrative Claiming (MAC) program to reimburse government agencies for some of the cost of their allowable Medicaid administrative activities, when those activities support provision of services as outlined in the Washington State Medicaid Plan.

Purpose of the Washington State MAC Program

- Outreach to residents with no or inadequate medical coverage
- Explaining benefits of the Medicaid program
- Assisting residents in applying for Medicaid

Reimbursable MAC Activities

- Informing Washington State residents about Medicaid and providing them with applications for the program
- Assisting them in completing and submitting the Medicaid application for eligibility determination and eligibility reviews

University of Massachusetts Medical School

HCA contracts with the University of Massachusetts Medical School (UMMS) for the operation of the statistically valid time study model, and for the day-to-day administration of the time study and claims calculation (see Appendix A).

Contact Information

University of Massachusetts Medical School
Center for Health Care Financing
RMTS & School-Based Medicaid Program
333 South Street
Shrewsbury, MA 01545
MedicaidAdmMatch@umassmed.edu
800-535-6741, Option 6

Health Care Authority
Alan Himsl, Section Supervisor
Medicaid Outreach Section
P.O. Box 45530
Olympia, WA 98504-5530
alan.himsl@hca.wa.gov
360-725-1647 **or** toll free 800-562-3022 ext. 55147

SECTION I: MAC PROGRAM ADMINISTRATION

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

HCA contracts with the following government agencies who participate in the MAC program:

- Local Health Jurisdictions
- School Districts
- Federally Recognized Tribes
- Other Government Contractors

HCA administers the MAC program and oversees the activities of its contractors and UMMS, including:

- Working with MAC contractors
    - Monitoring contractor training
    - Collecting time study and claims data
    - Reviewing and approving the contractor's process for identifying participants
    - Determining when corrective action plans are necessary
- Managing the sampling methodology based on reports generated by the HCA MAC claiming system (system)
- Administering the activity coding system, both auto-mapped and manually coded by HCA staff

UMMS provides:

- Reports that provide total time study participant numbers by claiming group and the sample size determined by HCA
- Reports that identify
    - Claiming group
    - Sampled participants
    - Job titles
    - Moments selected
- Reports that reflect
    - Participant responses
    - Number of incomplete or contradictory responses
    - Final outcome of time study results
    - Trends related to non-responders

MAC contractor:

- Train Random Moment Time Study (RMTS) coordinators and participants and maintain documentation to confirm staff has participated in required RMTS training
    - Ensure the RMTS coordinator understands how important the response rate per contractor is, and that they are aware of applicable sanctions for non-compliance
- Review RMTS compliance rate and ensure the MAC contractor meets the 85% compliance level requirement. There are applicable sanctions for non-compliance.

Non-responses are moments not completed by participant within five (5) work days. The return rate of valid responses for each Contractor must be a minimum of 85%. To ensure enough moments are completed for a statistically valid sample, HCA oversamples by 15%.

A moment will be considered a non-response when it has expired or if HCA has requested additional information from a participant and the information has not been received within 15 days.
The response rate is calculated by dividing the number of completed moments by the total of all moments generated. If the response rate falls below 85%, all moments not completed will be added to the denominator for the calculation of each activity code percentage. The numerator will be the number of moments coded to the given activity code. Oversampled moments are not tracked separately.

HCA and UMMS will monitor the response rate of the Contractor by reviewing the RMTS Compliance Status Report. Any non-response rate greater than 15% is unacceptable, and HCA will require remedial action.

The MAC contractor must maintain an audit file and all documentation, in the file, must be readily available, readable, and be in a usable format for audit/review purposes by HCA, State Auditor's Office (SAO), and federal personnel upon request. The *RMTS Compliance Report* is one of several components of the audit file and provides the following detail:

- The moments the RMTS MAC contractor agency has during the quarter
- How many moments have occurred to date
- How many moments are completed, and the percentage of completed moments to total quarterly moments
- Number of moments not completed and expired
- Number of moments not completed and not expired
- Number of moments completed to date/total number of moments for the quarter

SECTION II: RANDOM MOMENT TIME STUDY METHODOLOGY

The RMTS methodology quantifies outreach and linkage activities of time study participants. It polls employees at random moments during their normal work day over a quarter, and calculates the results. This method provides a statistically valid means of determining what portion of a group's time is spent performing activities that are reimbursable by Medicaid, and is designed to be as quick and user friendly to participants as possible.

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

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

- What were you doing?
- Who were you working with?

- Why were you doing it?
- Where were you?

HCA uses data gathered through its statistically valid RMTS to track and quantify participant activities. Each contractor submits quarterly claims to HCA for reimbursable MAC activities. The reimbursements are calculated based on results of staff participation in the time study.

Data Used in Claim Calculations (see Appendix B)

- Participant personnel costs
- Revenue offsets
- Participant time spent on reimbursable activities
- Allowable direct or indirect costs
- Federal Financial Participation

SECTION III: MAC ACTIVITY CODES AND DESCRIPTIONS

RMTS participants and their coordinators do not code their activities. Their responses to RMTS questions will auto-map to the appropriate code or HCA staff will code them.

Activity Codes and Descriptions (provided for reference)

CODE 1a NON-MEDICAID OUTREACH

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

Examples

1. Informing families about wellness programs and how to access them.
2. Scheduling and promoting activities to educate individuals about benefits of healthy lifestyles and practices.
3. Conducting general health education programs or campaigns that address lifestyle changes in the general population (e.g., dental prevention, anti-smoking, alcohol reduction).
4. Conducting outreach campaigns to encourage people to access social, educational, legal, or other services not covered by Medicaid.
5. Conducting outreach activities in support of programs that are 100 percent funded by state general revenue.
6. Developing outreach materials such as brochures or handbooks for these programs.
7. Distributing outreach materials about these programs.

CODE 1b MEDICAID OUTREACH

Activities that inform eligible or potentially eligible individuals about Medicaid and how to access the program; such activities include bringing potential eligibles into the Medicaid system for the purpose of the eligibility process. Both written and oral methods may be used. This includes related paper, telephone, computer, clerical, and staff travel required to perform these activities. *Outreach may only be conducted for the population served by the contractor, i.e., residents of the county or district where the contractor provides services.*

Examples

1. Informing Medicaid eligible and potentially eligible children and families about the benefits and availability of services covered by Medicaid including preventive treatment, screening, and Early and Periodic Screening and Diagnosis Testing (EPSDT) services.
2. Providing information and compiling materials to inform individuals about the Medicaid program (including EPSDT, e.g., dental, vision), and how and where to obtain those benefits.
   Note: Materials developed by the contractor must have HCA's prior approval.
3. Distributing literature about the benefits, eligibility requirements, and availability of Medicaid programs, including EPSDT.
4. Assisting the Medicaid agency to fulfill the outreach objectives of the Medicaid program by informing individuals and their families about health resources available through Medicaid programs.
5. Contacting pregnant women and parents about the availability of Medicaid prenatal and well-baby care programs and services.
6. Providing information regarding Medicaid managed care programs and health plans to individuals and families and how to access that system.
7. Encouraging families to access medical, dental, mental health, substance abuse, or family planning services covered by the Medicaid program.

CODE 2a FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS

Activities that assist individuals and families to apply for non-Medicaid programs such as Temporary Assistance for Needy Families (TANF); food stamps; Women, Infants, and Children (WIC); day care; legal aid; and other social or educational programs and referring them to the appropriate agency to apply. This includes related paper, telephone, computer, clerical, and staff travel required to perform these activities.

Examples

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

CODE 2b FACILITATING MEDICAID ELIGIBILITY DETERMINATION

Activities that assist individuals and families in the Medicaid eligibility process; this includes related paper, telephone, computer, clerical, and staff travel required to perform these activities. *This activity does not include the actual determination of Medicaid eligibility.*

Examples

1. Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process.
2. Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
3. Assisting individuals and families in completing a Medicaid eligibility application.
4. Gathering information related to the application and eligibility determination for an individual, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
5. Providing necessary forms in preparation for the Medicaid eligibility determination.
6. Referring an individual or family to the local Community Service Office to apply for Medicaid benefits.
7. Assisting the individual or family in collecting and gathering required information and documents for the Medicaid application.

CODE 3 NON-MEDICAID OTHER PROGRAM ACTIVITIES

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

Examples

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

Code 10 GENERAL ADMINISTRATION

Performing activities that are not directly assignable to other program activities. This includes related paper, telephone, computer, clerical, and staff travel required to perform these activities.

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

Examples (typical activities but not all inclusive)

1. Taking paid time off, such as paid breaks, vacation, sick leave, bereavement, or other paid time off.
2. Establishing goals and objectives of programs as part of the agency's annual or multi-year plan.
3. Reviewing agency or program procedures and rules.
4. Attending or facilitating agency or unit staff meetings, training, or board meetings.
5. Performing administrative or clerical activities related to general agency functions or operations.
6. Providing general supervision of staff, including supervision of interns or volunteers, and evaluation of employee performance.
7. Reviewing technical literature and research articles.
8. Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

SECTION IV: PARTICIPATING IN THE RMTS

Staff Notification

Staff are notified by email of their RMTS moment five (5) minutes before the moment.

Drop Downs – Required Activity Descriptions

As RMTS participants move to each question, a drop down (see Appendix C) appears with selections that correspond with most activities they perform. If no choices on the drop down apply to that given moment, a free typed response must be recorded in the space provided. It is important that time is tracked according *to the activity being performed precisely at the random moment*. The drop downs relate to activities listed in the May 2003 CMS Administrative Guide, and will be auto-mapped to appropriate claiming codes. When free typed responses are provided, HCA staff review and determine which activity code applies.

Documentation to Support Moment Recorded

Centers for Medicare and Medicaid Services (CMS) specifies that documentation maintained in support of administrative claims must be sufficiently detailed in order to determine whether the activities are necessary for the proper and efficient administration of the state Medicaid plan.

Documentation can be saved in, but not limited to:

- Calendars
- Chart notes
- Activity log

In addition to calendars, chart notes, and activity logs the system provides a separate narrative box allowing the participant space to further document their activity (limited to 250 characters).
Please note that this documentation will not be used for the purpose of coding.

Note: It is the contractor's responsibility to ensure participants maintain adequate documentation.

Documentation to support moments recorded are required to be legible and usable, in the event of an audit.

All records including documentation to support moments recorded shall be retained for six (6) years after the expiration or termination of the agreement between HCA and the MAC contractor.

All support documentation is required to be made available, as requested, by HCA MAC program staff, CMS, and State Auditors.

Claims will be disallowed if the support documentation is not retained or is not provided in a timely manner.

Status of Responses

All responses for random moments must be completed within five (5) work days after the sampled moment. Participants select or provide only one response for each question. Before they can submit the answers online, participants must confirm that the answers are accurate and complete.

The MAC contractor's RMTS coordinator and HCA staff will monitor the status of responses. All participants with incomplete responses are contacted by the system four (4) times over the course of five (5) work days and reminded to complete the time study before the moment expires.

The MAC Contractor's RMTS coordinator is also required to contact and remind the staff to complete their moment.

The MAC Contractor's RMTS coordinator will report annual leave, sick leave, and leave without pay to HCA staff to code.

Random Sampling Precision and Required Confidence Level

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

The only days that are excluded from potential moments are holidays and days the agency is not open for business.

A combination of every participant in the pool or claiming group and each minute they work during a quarter is created. All combinations are pooled and 2762 moments are randomly selected. Each combination represents a specific one-minute interval within the participants' standard business/work hours. Each quarter, all participants' names and moments are returned to the pool, guaranteeing the randomness of the selection process.

Oversampled responses do not substitute for completed responses where there are no Medicaid activities.

All completed/incomplete/expired moments are counted in the sampling methodology.

In 2012, KCSCJPS served: 7,708 children/youth.

- Juvenile Court Services: 5,403
- Family Court Services (Social Workers): 2,305 children

KCSCJPS Positions Eligible to Participate

The time study is a method of measuring staff time and the percentage of time spent on MAC activities. It serves as a basis to allocate staff costs that should be attributed to Medicaid reimbursable activities, reflecting actual duties and responsibilities of participating staff. To determine if a staff member is eligible to participate, first consider whether the employee's assigned duties reasonably include Medicaid activities. That staff's funding source must be non-federal.

King County Superior Court Juvenile Probation Services (KCSCJPS) Staff List

- At-Risk Youth Case Manager/Juvenile Court Specialist
- Education and Employment Specialist
- Juvenile Probation Counselor
- Juvenile Probation Counselor/Lead
- Juvenile Probation Supervisor
- Social Worker

Positions excluded are the following:

- Family Law Facilitator
- Supervisor, Juvenile Drug Court
- Supervisor, Medicaid Administrative Claiming

Summary of RMTS Process Components

1. Annually: Contractor updates a claiming year calendar in the system by May 1 before the start of each claiming year. (Claiming year mirrors the state fiscal year (SFY) which runs from July through June.)
2. Quarterly:

- Contractor enters and confirms a list of eligible participants, staff hours, and any updates to the calendar in the system 30 days prior to the start of each quarter.

  Note: HCA will confirm the eligible participant list on a quarterly basis.

3. Contractor enters and confirms staff salary and benefits in the system to be used for claim calculation after the close of the quarter.
4. Participants and moment times are randomly selected from the RMTS pool.
5. New participants receive User IDs and Passwords via email, and are reminded to complete online training before they receive their initial randomly selected moment.
6. Participants receive email notification of a moment 5 minutes prior to the moment.
7. Participants receive follow-up notification if they do not respond within:

   a) 24 hours
   b) 48 hours
   c) 72 hours with a copy to the RMTS coordinator and/or supervisor

8. The RMTS coordinator can access the following reports:
   a) *RMTS Participant Moment Not Completed Report*: This report shows each moment that was not completed for the date range selected. This allows them to contact and remind the staff to complete the moment.

9. The RMTS coordinator reports annual leave, sick leave, and leave without pay, to HCA staff to code.
10. Participants complete the time study.
11. After five (5) work days, the moment expires and the participant will not be able to complete or edit the response.

HCA staff and RMTS participants will see different screens allowing them to review the answers and select the appropriate code. Neither participants nor HCA coders will have access to screens that indicate the impact on a claim calculation.

If a RMTS participant submits a written response or illogical combination of responses for any moment, HCA staff will code the response. HCA staff will follow up with participants when a response does not provide enough information to code; if additional information is not submitted within the required time frame (two weeks before the end of the quarter), the moment will be lost. All completed responses are included in tabulating RMTS survey results.

Hand-Coding of Responses

1) HCA staff logon to the Administrative Claiming section of the UMMS System and check "Moments Awaiting Approval".
2) The next screen shows Participants (Name, Employee ID, and Email ID) Activity Code Status, and date and time of the moment where the participant manually free typed a response or checked an illogical combination of answers.
3) The initial HCA coder reviews the responses and assigns an activity code.
4) If more information is needed, the coder sends an email to the participant with a copy to the RMTS coordinator. The participant has fifteen (15) days to respond.

    a) With the participant response, the coder assigns a code. This e-mail is retained for audit purposes.
    b) If there is no response, the moment is coded to Code 3

5) The second coder reviews the moment and either approves or disapproves.
6) If coders do not agree, a third coder will be consulted and a code will be agreed on.

Activity Coding

Each moment has a status that indicates where it is in the process. Moment status is displayed on multiple system reports. The RMTS Coordinator of each agency must closely monitor any participants with a moment status of "Incomplete" and follow up with them prior to the end of the grace period.

Following is a tool for identifying the status of moments:

ACTIVITY CODING PROCESS
Status of Moments

Moment Status	Definition	Moment Status Complete	Comments
Auto-Mapped	If the participant uses predetermined responses available for each question, the moment will auto-map to that code.	Yes	If the responses do not make sense or if a free typed response is submitted, the moment cannot be auto-mapped. Auto-mapped responses do not require HCA review.
Incomplete	Moments remain active until completed by participant.	No	Moments are active from the time they are generated through the end of their grace period. Participants may only respond to or change responses on active moments.
Incomplete Expired	Moments not completed by the participant and are past the grace period.	No	Once a moment is expired, the participant can no longer open the moment and respond to it.
Manual Incomplete	Participant manually free typed a response or illogical combination.	Yes for participant No for HCA staff	HCA staff will select the activity code or obtain more information from the participant before selecting the activity code.
Pending	If HCA staff needs additional information, they send an email to the participant with a cc to the RMTS coordinator and change the moment status to Pending.	No	HCA staff is responsible to check and uncheck the Pending box. While it is checked, the moment status remains Pending.
Approval Required	HCA staff needs to review free typed responses or illogical combinations and assign activity codes.	Yes for participant No for HCA staff	
First Approval	First HCA staff coder has assigned an activity code to the response and a second coder has not yet reviewed the assigned code.	Yes for participant No for HCA staff	
Approval Pending	HCA coders do not agree on an activity code. A third coder will be consulted and the three will agree on a code. The third coder will approve the agreed upon code.	Yes for participant No for HCA staff	
Approved	HCA coders have reviewed the participant's responses and approved the activity code.	Yes	Time and activity code recorded for use in claim calculation.
Not Paid Time	Participants indicate that they were not scheduled to work at the time of their moment. Automapped to non-claimable code.	Yes	HCA coders may manually code for participants who are on extended leave or have left the agency.

The contractor's MAC RMTS Coordinator and HCA staff have a number of reports to assist them in monitoring the status of participant responses:

- *Training Documents Viewed Report*: This report shows the names of those participants who have completed the RMTS training. This report will be available to MAC contractors and HCA staff. If the participant has not completed the on-line training as evidenced by receiving a certificate upon completion, he/she will not be able to participate in the time study.

- *Training Documents NOT Viewed Report*: This report shows the names of those participants who have NOT completed the RMTS training. This report will be available to MAC contractors and HCA staff. If the participant has not completed the training, he/she will not be able to participate in the time study.

- *RMTS Participant Moment Not Completed Report*: This report shows each moment that was not completed for the date range selected. This report will be available to MAC contractors.

SECTION V: TRAINING

All contractor staff entered into the system as eligible participants must have completed HCA's online RMTS training. HCA reviews and approves all training curriculum and materials prior to its use.

Coordinator Training

Initial training will be provided by HCA to RMTS coordinators, including:

- Overview of the RMTS system
- Complete review of the Coordinator's role
- Importance of completing moments
- Importance of contractor's response rate
- Accessing and entering staff information into the system
- Timeframes and deadlines
- Accessing system reports
- Claiming process
- Development of an audit file
- Non-compliance consequences

RMTS Participant Training (required prior to participating)

Participants are required to complete annual online training in the System prior to participating in the time study. It is the responsibility of the MAC Contractor's RMTS Coordinator to monitor the RMTS reports in the System to ensure all participants have completed the required training prior to participating to the time study. Participants will receive a certificate when they successfully complete the training.The MAC Contractor's RMTS Coordinator must retain proof of training in the Contractor's audit file. The System will prevent any participant from answering moments if they have not completed the online training.

Information on participant training completion can be accessed in the system using On-line Management Reports (see Coordinator Manual in Appendix C).

SECTION VI: CLAIMING

Refer to the Claiming Guide (see Appendix B) for detailed information on the RMTS claiming process.

Contractor Administrative Fee

HCA will submit an invoice to the MAC Contractor twice each fiscal year for an administrative fee that will not exceed HCA's actual costs to administer the program. Administrative fees paid by the MAC Contractor are used only to offset HCA's costs incurred in administering the program.

The MAC Contractor must pay HCA administrative fees within 45 days of the date on the administrative fee invoice using non-federal dollars. The administrative fee is not eligible for claiming of Medicaid FFP. All future A19s will be held for processing if the administrative fee is not paid in a timely manner.

SECTION VII: OVERSIGHT AND MONITORING

HCA performs appropriate oversight and monitoring of the MAC program to ensure compliance with state and federal guidelines. This oversight and monitoring must be conducted at the MAC contractor, and state level.

Non-Responses and Minimum Response Rate

Non-responses are moments not completed by participants within five (5) work days. CMS expects the return rate of valid responses for each claiming group to be at least 85**%**. To ensure enough moments are completed for a statistically valid sample, HCA oversamples by 15%. This process is tracked within the system.

HCA and UMMS will monitor the response rate of the Contractor by reviewing the *RMTS Compliance Status Report*. Any non-response rate greater than 15% is unacceptable, and HCA will require remedial action:

- **Non-response rates greater than 15%:**
  - HCA will send written notification to the Contractor requesting a corrective action plan.
  - The Contractor must develop and submit the corrective action plan to HCA for approval within 30 days of HCA's notification.
  - Failure to provide a timely corrective action plan may result in contract termination.
  - 85% compliance rate must be met in the following quarter.
- N**on-response rates greater than 15% for two (2) consecutive quarters:**
  - HCA will reduce reimbursement by 35% for the second consecutive quarter.
  - The Contractor will be notified via certified mail of the reduced reimbursement.
  - 85% compliance rate must be met in the following quarter.
- N**on-response rates greater than 15% for three (3) consecutive quarters:**
  - HCA will deny all reimbursement for the third consecutive quarter.
  - The Contractor will be prohibited from participating in MAC for the following quarter (4th consecutive quarter).

- The MAC Contractor will be notified via certified mail of the withheld reimbursement and prohibited participation in MAC.

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

Verifying Results of Moments

At the end of each quarter, HCA generates a sub-sample of 15% of the moments coded, both by auto mapping and manual assignment, for validation in each claiming group. When a participant's moment for validation has been assigned the correct code, it will be validated as accurate, complete, or referred to a different HCA coder. If two HCA staff are unable to agree, a third person (Medicaid Outreach unit supervisor) will be consulted to break the tie. The validation cannot be conducted by the same HCA staff coding the responses.

MAC Codes to be used by KCSCJPS:

CODE 1a	**NON-MEDICAID OUTREACH**
CODE 1b	**MEDICAID OUTREACH**
CODE 2a	**FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS**
CODE 2b	**FACILITATING MEDICAID ELIGIBILITY DETERMINATION**
CODE 3	**NON-MEDICAID OTHER PROGRAM ACTIVITIES**
Code 10	**GENERAL ADMINISTRATION**

Verifying Narrative Description

HCA MAC Program Staff will review the narrative description for all moments included in the 15% samples of manually coded and automapped moments, to ensure the narrative corresponds with the activity provided. HCA will follow up with participants if needed. If HCA requests documentation and it is not received by fifteen (15) work days of the request, the moment will be coded as a non-response. These moments will go into the MAC Contractor's non-response rate calculation.
HCA will track trends, identify automapping errors and identify discrepancies between the narrative description and activity responses provided. HCA will make necessary changes to the System, or provide additional training as needed to correct any issues identified.

Activity Coding

Participants, RMTS coordinators, and HCA staff access and see different screens. This allows HCA staff to review participant answers and manually select appropriate codes. Participants, RMTS coordinators, and HCA staff do not have access to screens indicating the impact on a claim calculation.

If a participant submits a free typed response or illogical combination of responses for any moment, HCA staff will code the response. HCA staff follows up with participants when a response does not provide enough information to code; if additional information is not submitted within the required time frame (two weeks before the end of the quarter), the moment will be lost. All completed responses are included in tabulating time study results.

Each moment has a *status* indicating where it is in the time study process and that status is reflected on multiple system reports. The RMTS coordinator must closely monitor any moments with an "Incomplete" status and follow up with the participant to complete their time study prior to the end of the grace period (see Appendix C).

Trends

Additional monitoring that HCA staff conducts includes an ongoing review and examination of trends that may include total claims and reimbursement levels. Any significant variations from historical trending are communicated to the MAC Contractor for explanation. HCA staff also schedule and participate in regular meetings and/or conference calls with MAC Contractor to discuss time study trends, the required 85% compliance level, and other Medicaid or time study issues.

Required Documentation – Audit File

The MAC Contractor maintains the following documentation at all times based on each contracted SFY. It is advisable to maintain copies of the documentation in an Audit File to be available for review by HCA, State Auditor's Office (SAO), and federal personnel upon request.

- Current Interlocal Agreement with HCA
- Any MAC contract(s) with other agencies, such as:
  - outreach organizations
  - school districts
- Any subcontracts
- Any contracts with consultants/billing agents
- Financial claiming documentation
  - All A-19 Invoice Vouchers
  - Detailed expenditure worksheets and financial files for reporting, verifying, and reconciling eligible claim expenditures. Ensure the financial files show the complete funding source(s).
    - Direct Costs—salary, benefits
    - Indirect Rate Certificate
    - Current Local Match Certificate

- HCA MAC Monitoring Report(s)
  - All quarterly *RMTS Compliance Status Reports* (see Coordinator's Manual in Appendix C)
  - Local level monitoring reports, including subcontractor
  - State and/or federal audit reports, and any related documents and corrective action plans that include the MAC program
  - Training documents (rosters and training curriculum, materials)

Frequency of Monitoring

HCA conducts contractor monitoring at least once every three (3) years. This monitoring will consist of either an on-site, desk, and/or combination review.

HCA will identify one fiscal quarter of claims as the focus for an in-depth review. Based on the results of this review, HCA may select additional quarters for further claims review. The contractor is required to provide information and access to necessary staff in a timely manner to facilitate these reviews. A contractor that does not fully cooperate may be subject to sanctions.

HCA monitors and reviews components of the MAC program documentation including, but not limited to:

- Participant list – ensure only eligible staff are included on the participant list
- RMTS time study results
- Training – RMTS coordinator and participant compliance
- Financial file detail (verification of salary and benefits)
- Documented responses and coded activities received from selected participants that are not auto-mapped. Any necessary follow-up will be conducted to determine the appropriate activity code.
- Training and curriculum materials

NOTE: Monitoring may occur more frequently if HCA deems necessary.

Scheduled Three (3) Year Monitoring

HCA conducts Contractor monitoring at least once every three (3) years for the MAC Contractor. Monitoring may occur more frequently if the MAC Contractor has a questionable history, or if significant issues are identified through quarterly reviews. Monitoring will consist of either an on-site, desk, and/or combination review.

All monitorings will consist of a programmatic and fiscal review. The MAC Contractor is required to provide access to necessary staff and records in a timely manner to facilitate these reviews. If the MAC Contractor that does not fully cooperate, the MAC Contractor will be subject to corrective action plan. HCA monitors and reviews components of the MAC program documentation including, but not limited to:

Components Monitored for the MAC Contractor

- HCA programmatic review will consist of an in depth analysis of time study responses and back up documentation that may consist of multiple quarters. Based on the results of this review, HCA may select additional quarters for further review. HCA program staff will:
    - Participant list – ensure only eligible staff are included on the participant list
    - RMTS time study results
    - RMTS Coordinator and participant training compliance
    - MAC related training documents (rosters and materials)
    - Review documentation of randomly selected moments
    - MAC Audit File

- HCA fiscal review will consist of an in depth analysis of one quarter of claims. Based on the results of this review, HCA may select additional quarters for further claims review. HCA Fiscal staff will:
    - Compare a 15% sampling of Contractor payroll records to the information in the System.
    - An HCA public information data analyst will generate the sample of 15% or a minimum of ten (10) participants (whichever is greater)
    - Review source of funding to ensure CPE complies with section 1903(w) (6) (A) of the Social Security Act and 42 CFR 433.51.

Subcontractors

This MAC contractor is not allowed to subcontract.

HCA Fiscal Review

Quarterly A-19 Review Process

- MAC contractor sends original A-19 to HCA
- Program staff reconciles A-19 totals to the system
- Program sends the approved and signed A-19 to fiscal
- Fiscal verifies the indirect rate
- Fiscal reconciles the A-19 to the system
- Fiscal approves the A-19 and prints appropriate backup reports from the system
- Fiscal locks the A-19 when paid

NOTE: The MAC contractor is required to certify its quarterly claims as actual incurred public expenditures. The A19-1A has the following statement: As the Designated Authorizing Representative: I certify the expended amount shown on this A19 invoice is accurate, valid, and represents expenditures eligible for federal financial participation (FFP) in accordance of Certification of Public Expenditure (CPE) CFR 42.Sec 433.51; that applied matching funds are not already used as matching funds in other federal programs and being reimbursed by other federal grants; and any applied donated matching funds have been preapproved for use by Centers for Medicare and Medicaid (CMS)/National Institutional Reimbursement Team.

Subcontractors

This MAC contractor is not allowed to subcontract.

Annual Indirect Rate

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

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

- An indirect rate covering the 12 month calendar year
- A copy of the cognizant agency's approval letter
- Copies of all documentation used by the cognizant agency to calculate the indirect rate
- Documentation from the cognizant agency if the rate changes
- The MAC Contractor to provide any additional documentation related to indirect rates if requested
    - Fiscal receives the Certificate of Indirect Rate (see Appendix B) from contractor
    - Fiscal maintains documentation showing contractor Indirect Costs
    - Fiscal sends indirect rates to MAC program staff to upload into the UMSS system

Sources of Funding and Certified Public Expenditures

The MAC contractor must document the source of all funds and ensure the local matching funds:

- Are within the MAC contractor's control and budget
- Have complete backup documentation
- Are only provided by a unit(s) of government
- Are reasonable, allocable and allowable for FFP
- Meet all Certified Public Expenditure (CPE) regulations

Certified Public Expenditures

The MAC contractor must comply with the following requirements for Certified Public Expenditures:

- A Designated Authorizing Representative of the MAC contractor must certify the expended amount shown on their quarterly invoice is accurate, valid, and represents expenditures eligible for federal financial participation (FFP) in accordance of Certification of Public Expenditure (CPE) CFR 42.Sec 433.51
- A Designated Authorizing Representative of the MAC contractor must certify applied matching funds are not already used as matching funds in other federal programs and being reimbursed by other federal grants
- A Designated Authorizing Representative of the MAC contractor must certify applied donated matching funds have been preapproved for use by Centers for Medicare and Medicaid (CMS)/National Institutional Reimbursement Team.
- The MAC contractor is prohibited from requiring or allowing private non-profits to participate in the financing of the non-federal share of expenditures. Non-governmental units may not voluntarily provide, or be contractually required to provide, any portion of the non-federal share of the Medicaid expenditures.

Corrective Actions

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

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