Washington State Health Care Authority

Medicaid Administrative Claiming
LHJ MAC Coordinator Training
MAC Program Changes

MAC Program Overview

- HCA partners with LHJs to administer the Medicaid State Plan.
- MAC activities are claimable when they are necessary for the efficient administration of the State Plan.
- CMS (the Centers for Medicare and Medicaid Services) relies on HCA, as the single state Medicaid agency, to ensure program compliance.

Roles and Responsibilities of the MAC Coordinator

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- Responsible for the participation of your LHJ in the MAC program.
- Primary tasks:
  - Work with program managers to identify appropriate participants, oversee their training.
  - Manage the day-to-day RMTS operations.
  - Monitor participant response rates; ensure a minimum 85% compliance rate.
  - Review 100% of all completed moments; ensure accuracy.

Useful Tools

- Step-by-step instructions for completing the tasks required of a MAC coordinator begin on page 9 of the Coordinator Manual. *(See MAC Coordinator Manual)*

- A checklist of coordinator tasks and time frames is another resource. (*See implementation & ongoing task checklist)*

- A month-by-month calendar organizes major tasks along a yearly continuum. (*See task calendar*.)

An RMTS Overview

Consortiums

Statistical Validity

Corrective Action

Participants

RMTS Consortia

- LHJs have the option of joining together in an RMTS consortium to ensure the statistical validity of the time study and for administrative efficiency.
- Each consortium has a lead agency.
- Composition of the consortium is evaluated annually by WSALPHO. *(See Consortia List)*

Statistical Validity

- Statistical validity is critical.
- 85% of all moments in an RMTS must be completed within 5 working days.
- If the 85% completion rate is not reached there may be corrective action.
- Each LHJ's moments affect the overall statistical validity of all LHJs in a consortium, because they share one set of time study results.

Corrective Action

- The LHJ MAC contract describes the corrective actions that can be implemented if consortiums fail to meet the 85% completion rate in a quarter. Refer to schedule A, number 5 of your contract.

Eligible Participants

- Cannot be 100% in the indirect rate
- Cannot be 100% federally funded; costs must be properly offset
- Must be in approved job category. (*See page 16 of the Manual.)*
- Duty statement needed for each job classification.

  (See duty statement template.)

- NEW! Staff documenting a single cost objective (direct charge) must be included in participant update; duty statement is required.
- New participants must be trained on the RMTS prior to beginning the time study.

The Transition between MAC Claiming Plans/CAPS

Transitioning: Moving from "Old" Plan to New

Current ("Old") Plan:

Quarters: Through March 31, 2015

Code Review: Use AdMatch through September 30, 2014.

MER Report: Use ACES-based MER through September 30, 2013.

Invoice: Use Excel document for quarters through March 31, 2015

New Plan:

Quarters: Beginning April 1, 2015

Code Review: Use URMTS beginning October 1, 2014.

MER Report: Use RAC-based MER beginning October 1, 2013.

Invoice: Use web-based application for quarters beginning April 1, 2015.

Changes in the MAC Program and RMTS System as of April 1, 2015

Changes in the RMTS System

Changes in the RMTS Response Form

- Narrative (what, with whom, why) is written first.
- Then activity code is selected.

Moment Certification

- Participants certify the accuracy of their moments at the time they are submitted.
- This eliminates the need for RMTS quarterly sign off reports (effective October-December 2014 quarter).

New Training Requirements

- Mandatory online training for all participants before they can be in the April 2015 RMTS – certification required.
- Annual mandatory online training for all participants required before the January 2016 RMTS – certification required.
- In-person participant training required for April 2015 RMTS.

The Time Study Activity Codes

Reminders

- 17 codes in new system, most with parallel codes (this includes code 99).
- No longer a “c” sub code for child-related activities.
- No longer a requirement to select a location for outreach activities.

Activity Code Resources

- The complete set of CMS approved **MAC Activity Code Descriptions for LHJs, October 2014.**
- The **Code Crosswalk** is designed to assist with the transition between old and new activity codes.
- The one-page **RMTS Code Quick Reference** guides for each of activity code.

Code 5: Defining Direct Medical Services

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

- Use Code 5 when providing direct medical services and treatment to an individual.

- These services may be billed to Medicaid or other third party insurers.

More on Direct Medical Services

- Direct medical services also include activities that are considered to be integral to or an extension of the healthcare service.

- These include but are not limited to:
  - patient follow up
  - assessment
  - counseling
  - education and/or consultation
  - charting
  - billing activities
  - patient registration, scheduling, and follow up
  - quality assurance and monitoring
  - or other physician extender activities

Transportation

- Code 6b is not limited to arranging transportation to Medicaid services through the Medicaid transportation broker.
- This code does not include providing transportation, or accompanying someone to a medical service.
- This code does not include arranging transportation for Targeted Case Management (TCM) services.

The Interpretation Codes

All interpretation activity is reported to one of four codes (7a-7d). This includes interpretation related to direct medical services, outreach, and linkage activities.

Code 7a and 7b are used for interpretation activities for services provided to adults, *including* pregnant women 21 and over.

Code 7c and 7d are used for interpretation activities for services provided to children under age 21, *including* those who are pregnant.

NEW! Training Codes

- Training activities have been consolidated into two codes: 9a and 9b.
- There are three exceptions:
  - SPMP credentialing related training should be coded to the appropriate SPMP code (12a or 12b).
  - Training for program coordinators directly related to coordination, claims administration, and oversight of the MAC program should be coded to 13b (and 13a for non-MAC programs).
  - Required general administration training, such as worker safety training, diversity training, driver safety training, etc., should be coded to General Administration (Code 14).

Expanded Access to the Code for Claims Coordination, Administration, & Oversight

- These two codes (13a and 13b) are now available to all participants.

- Code 13a may be used by employees who have responsibilities for managing or coordinating components of programs other than MAC.

- Code 13b may be used by employees with responsibilities for managing or coordinating components of the MAC program.

Pediatric Immunization Program

- Use **Code 11b** for pediatric immunization activities for federally-vaccine eligible children.
  - This includes Vaccine for Children (VFC) program activities.

- Use **Code 11a** for activities related to State-vaccine eligible children or vaccines not covered by Medicaid.

- The Child Profile Immunization Registry is now called the Washington State Immunization Information System (WIIS).

*WIIS can be used for recording adult vaccination history. Entering this data for adults is **Code 4**.*

Outreach and Facilitating Applications

When writing activity descriptions for outreach (Code 1) and facilitating applications (Code 3), be sure to state what **program** you're informing about or application you're facilitating or assisting with.

Reminder: WA Apple Health (Medicaid) is the new name for the Medicaid program for children ***and*** adults in Washington state.

More on Outreach and Applications

The Washington Healthplanfinder website (wahealthplanfinder.org) can be used to apply for all healthcare coverage in Washington, including Medicaid and commercial/private health insurance plans.

- Use **Code 1a** when performing general outreach activities or **Code 3a** when assisting or facilitating applications through wahealthplanfinder.org for commercial/private health insurance plans.
- Use **Code 1b** when performing outreach activities to explain Medicaid (WA Apple Health) benefits or **Code 3b** when assisting or facilitating applications for Medicaid (WA Apple Health) coverage.

General Administration

See handout describing Code 14.

The 2003 School-Based Medicaid Administrative Claiming Guide notes that general administration should be used for activities that cannot be assigned to a specific program.

Additional Resources - Program Guides

- The HCA/LHJ steering committee is developing guides on coding activities in key LHJ program areas.

- A guide on WIC activities has been developed in coordination with the State WIC program. (*See handouts*.)

SPMP Activities

Key Changes

SPMP activities are HCA-directed.

- Participants must match their SPMP descriptions to an HCA-directed SPMP activity by checking a box on the RMTS response form. *(See handout.)*

Certification

- The SPMP now certifies that professional medical education and training that leads to licensure or certification was required to perform the SPMP MAC activity, rather than writing a separate narrative in the RMTS.

Quality Assurance:
The Code Review and Correction Process

The Code Review Process

- The RMTS review process must be finalized no later than 45 days after the quarter ends, beginning with the April-June 2015 quarter.

- Reviewing your LHJ's random moments on a regular, timely basis is strongly encouraged, especially because you can now ask a clarifying question (if the participant's narrative is unclear).

Reviewing Moments

- If the participant's narrative response does not reflect the code assigned, the code reviewer may correct the code, or ask a clarifying question.
- The code may only be changed without asking a clarifying question when a moment was clearly miscoded.
- The reason for the correction must be documented in the comment box for the audit trail.

NEW! The Clarifying Question

- A clarifying question can be asked on any completed moment.

- The purpose of the question is to get clarification on what the participant wrote, not to ask a leading question that would substantially change or compromise what the participant wrote.

- Examples of clarifying questions are provided in the *Things to Remember: Asking a CQ handout*.

Code Review Based on CQ Response

- If the CQ response indicates another code would be more appropriate, you may reassign the code.
- Any changes must be clearly documented in the comment box for audit purposes.
- If the CQ response does not indicate any change is needed, the moment is accepted.

Completing a Random Moment

Writing Good Activity Descriptions

- The description of a random moment should contain three parts - "*what was I doing*", "*whom was I with*", and "*why was I doing it*."

- A claimable MAC description should demonstrate how the activity benefits the Medicaid program.

- Refer to the quick reference guide for examples on writing activity descriptions.

NEW! Responding to a Clarifying Question

- When a clarifying question (CQ) is asked by a code reviewer (because a random moment description is unclear), participants will receive an e-mail letting them know that a clarifying question has been asked about a moment.
- Participants should respond as specifically as they can, as soon as they can.
- The email subject line will be: *[RMTS] Clarification Request for Survey from (date/time of random moment)*

Single Cost Objective Activities

NEW! Requirements

- Beginning with April-June 2015 quarter, only staff who perform a single MAC activity (a single cost objective) may use the direct charge method.

- All direct charge MAC activities must be documented on HCA's standardized form. *(See Single Cost Objective handout.)*

- The Single Cost Objective form must be submitted with each invoice.

Tips for Training Participants

Open Discussion

Best Practices/Resources:

- Discussion on best practices for training participants.

- Training resources that you can use to train participants.
  (See ADMATCH: Training Resources website)

Changes to the MER

Major Changes

- No separate child and adult-based MER; a combined MER will be used.
- As of October-December 2013 quarter, new criteria for determining Medicaid eligibility for MAC is used.
  - RAC instead of ACES
- Three different MERs may be used with linkage related activity codes which require a proportional or discounted MER.

Three Proportional MERs

- Negotiations with CMS allows LHJs to potentially use three different options when applying a proportional MER to linkage-related codes (6b, 7b, 7d, 10b, and 12b), which are:

  - Modified countywide MER
  - Client-based MER
  - Clinic-based MER (limited to PHSKC)

The Modified Countywide MER

- The Modified Countywide MER is the average of two percentages based on the number of Medicaid enrollees in high poverty census tracts and medium-low poverty census tracts. *(See RDA Table handout)*

- This MER must be applied to linkage-related activities when the individual(s) served is not a known client (no record is maintained in the agency).

The Client-Based MER

- The client-based MER may be used for linkage-related MAC activities when the individual(s) is a known client of the agency, and personal data is collected and retained in an auditable database.

- A client de-identifier is used to verify which linkage-related activities were provided to a known client.

- The de-identifier must be real and capable of identifying a specific individual/client.

De-Identified Client ID - What is it?

A client identification number that does not include any part of a client's name; SSN; dates (including DOB, admit, discharge, etc); address; zip code; license number.

Examples: Patient registration number, WIC or CSHCN number, Nightingale Notes number etc.

- If a de-identified ID system is not used in your agency, one will need to be created if the Client-Based MER will be used.

Client De-Identifier

- When recording a linkage-related activity (6b, 7b/d, 10b, or 12b) in the RMTS, the following message is displayed:

  If you have a de-identified client ID for the individual you assisted and the activity is <u>not</u> associated with direct medical services, please enter it in the box. If no number is available, leave the box empty.

- The client-based MER will be applied to this activity if a client de-identifier must be entered.
- The modified countywide MER will be applied if no client de-identifier is entered.

The Clinic-Based MER
For PHSKC only

- This MER is used for linkage-related MAC activities for PHSKC programs that operate primary care or specialty clinics.
- The PHSKC clinic's patient data is the basis of the clinic-based MER.
- No de-identifier required.

Selecting a MER

- LHJs may choose to use both the modified countywide MER and client-based MER for their linkage-related MAC activities.

- A client-based MER will be applied to moments reported to Codes 6b, 7b, 7d, 10b, or 12b where the client is known, and a de-identified client number is listed on the RMTS response form.

Selecting a MER (continued)

- LHJs may also choose to use the modified countywide MER for all linkage-related MAC activities.

- The LHJ must inform HCA which proportional MER or MERs will be used in the invoice, using the MER proposal form. *(See MER Proposal Handout)*

Subcontractors

HCA Requirements

- Draft MAC agreement with subcontractor must be submitted to HCA for approval prior to beginning of quarter, along with the Subcontractor Review Form.
- Subcontractors cannot participate in RMTS until subcontracts are approved.
- 100% of subcontractors' allowable MAC expense must be paid using LHJ state, local or NIRT-approved funds before the LHJ claims these costs to HCA.

Subcontractor Monitoring

- Subcontractors must be monitored as sub recipients.
- Monitoring must occur annually, with monitoring reports maintained at the LHJ.

Claiming Overview

NEW! Submittal Deadlines

- The RMTS code review process must be completed within 45 days after the quarter ends.
- Vendor has 10 working days to complete the 10% sampling of completed random moments.
- Beginning with the April-June 2015 quarter, invoices must be submitted no later than 120 days after the end of the quarter.

NEW! Web-Based Claiming System

- Beginning with the April-June 2015, claiming information currently reported on the Excel-based invoices will be entered into a web-based claiming system.

- RMTS results and MER reports will be accessed from this new system.

In-Depth Fiscal Training in June

- Confirmed Training Locations
  - Snohomish, June 3rd
  - Thurston, June 10th
  - Yakima, June 16th
  - Spokane, June 17th

Fiscal Training Topics

- Assigning expenses to the correct cost pool
- Offsetting revenue
- Certified public expenditures
- Indirect rate based on salaries, personnel costs, or total direct costs
- Subcontractor CPE requirements
- Documenting in the invoice for direct charge
- Maintaining audit file
- Using the web-based invoice application

Oversight and Monitoring

- HCA role
- Lead Agency/Consortium role
- Individual LHJ role

Need More Information?
Contact Jennifer Inman (HCA) at
jennifer.inman@hca.wa.gov or
360-725-1738.

End of Training

Thank you for your attention and your ongoing efforts in implementing a successful MAC program.