Medicaid Administrative Claiming Cost Allocation Plan

For
Washington State Federally Recognized Tribes

October 2014

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INTRODUCTION

Some of Washington's most vulnerable residents experience difficulty accessing needed health care. Washington State Federally Recognized Tribes provide many services to tribal 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 Washington State Federally Recognized Tribes for some of the cost of its allowable Medicaid administrative activities, when those activities support provision of services as outlined in the Washington State Medicaid Plan. HCA has complete authority and responsibility for the administration of the State Medicaid Program.

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
- Linking residents to appropriate Medicaid covered services.

Reimbursable MAC Activities

- Informing Washington State Tribal residents about Medicaid and providing them with applications for the program.
- Assisting Tribal residents in completing and submitting the Medicaid application for eligibility determination, or referring them to the local Community Service Office (CSO) or online resources to apply.
- Arranging Transportation in support of Medicaid covered services.
- Evaluating and improving access to Medicaid covered services.
- Providing or receiving tribal staff training related to Medicaid specific topics.
- Linkage activities such as referring individuals to Medicaid covered medical, dental, mental health, substance abuse treatment, and/or family planning services. This also includes coordinating and monitoring the delivery of those services.

University of Massachusetts Medical School

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

Contact Information

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SECTION I: MAC PROGRAM ADMINISTRATION

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

HCA contracts with the following government agencies for participation in the MAC program:
- Federally Recognized Tribes
- Public Hospitals/Public Hospital Districts
- Local Health Jurisdictions
- School Districts
- Other Government Contractors

HCA administers the MAC program and oversees the activities of Washington State Federally Recognized Tribes and UMMS, including:
- Working with Tribes to:
  - Train MAC Coordinators
  - Monitoring Tribal MAC training
  - Collecting and reviewing time study and claims data
  - 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 automapped and manually coded by HCA staff
- Accessing real time data to all time study results and reports
- Requiring full access to all Tribes supporting documentation

UMMS provides technical system support including developing:
- Reports that provide total time study participant numbers and sample size determined by HCA
- Reports that identify:
  - 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

Tribes ensure appropriate RMTS participation and oversight, including:
- MAC Coordinators, backups and participants have completed required training
  - Retain proof of required training
  - Ensure the MAC Coordinator understands the importance of completing moments, and are aware of applicable sanctions for low compliance rates
- Review RMTS compliance rate and ensure Tribes meets the 85% compliance level requirement.
- Evaluate and retain the *RMTS Compliance Status Report* as described in the Tribal Coordinator's Manual**.**

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.

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

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

1. What type of activity were you doing?
2. What were you doing?
3. Who were you with?
4. Why were you performing this activity?

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

The following data are used in claim calculations:

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

    Data needed for Client Based MER =

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

    Data needed for Social Services MER =

$$\frac{\text{Total number of unduplicated clients eligible for Medicaid served by the social service program}}{\text{Total number of unduplicated clients provided services by the program}}$$

MAC ACTIVITY CODES AND DESCRIPTIONS

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

CODE 1a   NON-MEDICAID OUTREACH

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

Example(s):

1. Informing 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 and/or distributing outreach materials such as brochures or handbooks for 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 paperwork, clerical activities, or staff travel required to perform these activities. *Outreach may only be conducted for the population served by the MAC Contractor, i.e. residents of the Tribes/County/District where the MAC Contractor provides services.*

Example(s):

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 and/or distributing information and compiling materials to inform individuals about the Medicaid program (including EPSDT, dental, vision), to help identify medical conditions that can be corrected and/or improved and indicate how and where to access services covered by the Medicaid program. (Note: ***Materials developed by the MAC Contractor must have HCA's prior approval*.)**
4. Assisting the Medicaid agency to fulfill the outreach objectives of the Medicaid program by informing individuals and families about health resources available through the Medicaid program.
5. Contacting pregnant women and parents about the availability of Medicaid prenatal and well-baby care programs and services.
6. Providing information regarding the Medicaid managed care program or managed care health plans to individuals and families and how to access them.
7. Encouraging individuals and families to access medical, dental, mental health, substance abuse treatment, and/or family planning services covered by the Medicaid program.

CODE 2a   FACILITATING APPLICATION FOR NON-MEDICAID PROGRAMS

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 make application. This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Example(s):

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

CODE 2b   FACILITATING MEDICAID ELIGIBILITY DETERMINATION

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

Example(s):

1. Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process.
2. Explaining Medicaid eligibility rules and 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.
5. Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
6. Providing necessary forms in preparation for the Medicaid eligibility determination.
7. Referring an individual and/or family to the local Community Service Office or online resources to apply for Medicaid benefits.
8. Assisting the individual and/or family in collecting and gathering required information and documents for the Medicaid application.

CODE 3   GENERAL WORK RELATED ACTIVITIES

This code should be used for general Tribal activities including, social services, educational services, teaching services, employment and job training and other activities that are not Medicaid related.   These activities include the development, coordination, and monitoring of these services. This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Example(s):

1. Perform general financial data entry or data tracking.
2. Adjudicate or resolve non-Medicaid billing complaints or issues.
3. Provide case management and develop individual patient plans.
4. Compile general patient statistics.
5. Develop or provide general health informational materials.

CODE 4 DIRECT MEDICAL SERVICES

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

Example(s):

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

CODE 5a TRANSPORTATION FOR NON-MEDICAID SERVICES

Assisting individuals and families in obtaining transportation for non-Medicaid covered services, or accompanying the client(s) to services not covered by Medicaid. This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Example(s):

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

CODE 5b ARRANGING TRANSPORTATION FOR MEDICAID SERVICES

Assisting individuals and families in obtaining transportation to services covered by Medicaid. This does not include the provision of the actual transportation service or the direct costs of the transportation (bus fare, taxi fare, etc.), but rather the administrative activities involved in arranging transportation. This includes related paperwork, clerical activities, or staff travel required to perform these activities. If the tribe has a contract with a Medicaid transportation broker to receive reimbursement for providing transportation services, the Tribal staff may not claim MAC when assisting clients in obtaining transportation under the MAC contract.

Example(s)

1. Working with a transportation provider to arrange transportation to Medicaid covered services.

CODE 6a ARRANGING INTERPRETER SERVICES FOR ACTIVITIES NOT COVERED BY MEDICAID

Providing interpreter or translation services as part of a non-Medicaid covered service. This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Example(s):

1. Arranging for, or providing interpreter services (spoken or signing) that assist individuals and families to access and understand social, educational, and vocational services.
2. Providing translated materials that assist individuals to access and understand social, educational, and vocational services.

CODE 6b   ARRANGING INTREPRETER SERVICES FOR ACTIVITIES COVERED BY MEDICAID

Providing interpreter or translation services (spoken or signing) that assists individuals and families to access and understand necessary care or treatment covered by Medicaid. This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Example(s):

1.   Arranging for or providing interpreter or translation services (spoken or signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid.
2.   Providing HCA approved translated materials that assist individuals to access and understand necessary care or treatment covered by Medicaid.

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

Activities associated with developing strategies to improve the coordination and delivery of non-medical services to individuals and families. Non-medical services may include social, educational, vocational, and legal services. This is only for employees whose position descriptions include program planning, policy development, and interagency coordination. This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Example(s):

1.   Identifying gaps or duplication of non-medical services (e.g., social, vocational, educational, and state mandated general health care programs) to individuals and families and developing strategies to improve the delivery and coordination of these services.
2.   Developing strategies to assess or increase the capacity of non-medical programs.
3.   Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration non-medical problems.
4.   Defining the relationship of each agency's non-medical services to one another.
5.   Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services to the tribal population.

CODE 7b   PROGRAM PLANNING, POLICY DEVELOPMENT IN CONJUNCTION WITH HCA, AND INTERAGENCY COORDINATION RELATED TO MEDICAL SERVICES

Activities associated with developing strategies to improve the coordination and delivery of Medicaid covered services when those activities are in direct support of the Medicaid agency and the Medicaid state plan. This includes activities associated with medical, dental, mental health, substance abuse treatment, and/or family planning services to individuals and families, and when performing collaborative activities with other agencies and/or providers in direct collaboration with the state Medicaid agency.

Example(s):

1.   Identifying gaps or duplication of medical/dental/mental health/chemical dependency services provided to Tribal members, and developing strategies to improve the delivery and coordination of these services.
2.   Evaluating the need for medical/dental/mental health/chemical dependency counseling services in relation to specific populations or geographic areas.
3.   At American Indian Health Commission (AIHC) meetings- discussing Medical/mental health/dental/chemical dependency service issues pertaining to specified populations

4. Developing strategies to assess or increase the capacity of medical, dental, mental health, substance abuse treatment, and/or family planning programs.
5. Monitoring medical, dental, mental health, substance abuse treatment, and/or family planning delivery Systems.
6. Working with other agencies and/or providers of medical, dental, mental health, substance abuse treatment, and/or family planning services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligibles, and to increase provider participation and improve provider relations.
7. Developing advisory or work groups of health professionals in conjunction with HCA to provide consultation and advice regarding the delivery of health care services to tribal populations.

CODE 8a   NON-MEDICAID RELATED TRAINING

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

Example(s):

1. Participating in or coordinating training that improves the delivery of services for programs other than Medicaid.
2. Training that result in continuing education credits.
3. Participating in or coordinating training that enhances self-help sobriety groups, WIC, exercise workouts, healthy cooking and parenting classes.

CODE 8b   MEDICAID TRAINING

Coordinating, conducting, or participating in training events regarding Medicaid related services, and how to assist individuals and families in accessing such services and how to effectively refer them for services. This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Example(s):

1. Participating in or coordinating training that improves the delivery of Medicaid covered services.
2. Participating in or coordinating training that enhances early screening, identification, intervention, and referral of individuals and families with special health needs to Medicaid covered services.

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

Referring, coordinating, and monitoring the delivery of non-Medicaid covered services. This includes related paperwork, clerical activities, or staff travel required to perform these activities.

Example(s):

1. Making referrals for and coordinating access to social and educational services such as child care, employment, job training, or housing.
2. Providing follow-up contact to ensure that an individual has received non-Medicaid covered services such as food and housing.
3. Making referrals for coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.
4. Participating in a meeting/discussion to coordinate or review a patient/Tribal member's need for non-health related services not covered by Medicaid
5. Gathering any information that may be required in advance of referrals to services not covered by Medicaid.

CODE 9b   REFERRAL, COORDINATION, AND MONITORING OF MEDICAID COVERED SERVICES

Referring, coordinating, and monitoring the delivery of Medicaid covered services such as medical, dental, mental health, substance abuse treatment, and/or family planning. This includes related paperwork, clerical activities, or staff travel required to perform these activities…

Note: Activities that are an integral part of or an extension of a direct medical service or targeted case management (e.g., patient follow-up, assessment, counseling, education, and/or consultation, and billing activities) will be reported as Direct Medical Services, Code 4. In these cases, **the activities are not claimable for MAC.** For example a client is in a follow-up appointment with a doctor or nurse, following a medical procedure or treatment. The client is being assessed to make certain the procedure or treatment worked.

Example(s):

1. Identifying and referring individuals who may be in need of Medicaid family planning services.
2. Referring, arranging for, or coordinating medical, dental health, mental health, substance abuse treatment, and/or family planning evaluations; this includes gathering of any information that may be required in advance of the Medicaid covered service.
3. Participating in a meeting or discussion to coordinate or review an individual's needs for Medicaid covered services.
4. Providing follow-up contact to ensure that an individual has received the prescribed medical, dental, mental health, substance abuse treatment, and/or family planning Medicaid covered services.
5. Coordinating the delivery of community based medical, dental, mental health, substance abuse treatment, and/or family planning Medicaid covered services for an individual with special health care needs.
6. Coordinating the completion of the prescribed services, termination of services, and the referral of an individual to other Medicaid service providers as may be required to provide continuity of care.

Code 10   GENERAL ADMINISTRATION

General functions that are not directly related to other specific program activities. This includes related paperwork, clerical activities, or staff travel required to perform these activities.

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

Example(s):

1. Taking paid time off, such as paid breaks, vacation, sick leave, bereavement, jury duty, or other paid time off.
2. Tribal Council meetings
3. Tribal Celebrations
4. Establishing goals and objectives of health related programs as part of the agency's annual or multi-year plan.
5. Reviewing general tribal/agency or program procedures and rules.
6. Attending or facilitating general agency staff and/or board meetings.
7. Performing administrative or clerical activities related to general agency functions or operation.
8. Providing general supervision of staff, including supervision of interns or volunteers, and evaluation of employee performance.
9. Reviewing technical literature and research articles.
10. MAC or RMTS System related training.
11. RMTS System monitoring, maintenance, and/or support.
12. Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

SECTION III: PARTICIPATING IN THE RMTS

Predefined Dropdown Responses

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

Documentation to Support Moment Recorded

HCA requires documentation be maintained in support of administrative claims. This documentation must be sufficiently detailed in order to determine whether the activities are necessary for the proper and efficient administration of the state Medicaid plan. It is Tribe's responsibility to ensure participants maintain adequate documentation for a minimum of 6 years, and that it be accessible for review.

Examples of supporting documentation include, but are not limited to:
- Calendars
- Chart notes
- Activity logs
- Tribal specific documenting tools

Narrative Description

In addition to the above required documentation, participants must provide a narrative description of the activity they recorded through the predefined dropdown responses. Once the participant selects a response for each question, a free type box appears, and the participant may enter up to 250 characters in the space provided. This narrative is not considered adequate supporting documentation.   HCA validates 15% of all moments.

Status of Responses

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

The MAC Coordinator and HCA staff will monitor the status of responses using RMTS reports. All participants with incomplete responses are notified 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.

It is the responsibility of the MAC Coordinator to monitor the RMTS reports to ensure moments are answered timely. The MAC Coordinator must follow up with all participants who have outstanding moments prior to their expiration. HCA will periodically review the RMTS reports during the quarter to ensure the MAC Coordinator is following up with this requirement. If HCA identifies any issues or concerns from this review, HCA will contact the MAC Coordinator to provide technical assistance.

Random Sampling Precision and Required Confidence Level

In collaboration with the Department of Social and Health Services (DSHS) Research and Data Analysis Division (RDA), HCA has developed a stratified RMTS sampling approach for the Tribal MAC program.

The stratified random sampling approach will produce a single statewide RMTS-based tribal MAC claim that achieves two objectives: (1) meet CMS precision requirements, and (2) produce sufficient information to allow allocation of the single statewide claim to individual Tribes based on the RMTS responses for each Tribe's staff. This approach both respects tribal sovereignty and ensures that the statewide tribal MAC claim meets CMS requirements.

At the heart of this approach is the use of stratified RMTS sampling. CMS precision standards for RMTS reporting, based on simple random sampling, requires 2,400 sample moments, with a 15 percent oversample, for a total of 2,760 sample moments. These requirements are designed to guarantee a 95 percent confidence interval of +/- 2 percent under simple random sampling.

It is a well-established result from basic statistical theory that, for any given sample size, a stratified approach to sampling will achieve estimates that are unbiased and at least as precise as estimates developed from simple random sampling. A common approach to achieving increased precision for a given sample size is to create multiple sampling strata and draw samples from each strata in proportion to the size of the subpopulation in the strata For tribal MAC reporting, each Tribe will be an independent sampling strata. However, some Tribes have few staff engaged in MAC activities, and without modification the proportional stratified random sampling approach would leave some Tribes with small sample sizes that would produce unstable Tribe-specific claiming amounts from reporting period to reporting period. Therefore, rather than using strictly proportional stratified random sampling, HCA will oversample small Tribes to ensure that each Tribe has a sufficient number of RMTS responses to allow for reasonably stable estimates over time. HCA requires a minimum of 200-300 sampled RMTS moments per reporting period, depending on tribal preferences.

This minimum sample size for small Tribes will require a larger sample size than 2,760 sample moments per reporting period, due to the oversampling of small Tribes above what would be required under proportional stratified random sampling. Tribes that are large enough not to require oversampling will be sampled at the rate that would be required under proportional stratified random sampling. The oversampling of small Tribes requires that in producing the statewide tribal claim, the responses from the oversampled Tribes need to be "down weighted" appropriately to account for the oversampling. The UMMS RMTS application is designed to support a variable weighting approach. With appropriate re-weighting of RMTS responses from oversampled Tribes, the state will produce a single statewide claim that will meet – and in fact exceed – CMS precision requirements.

Once the statistically valid single statewide MAC claim is processed, each Tribe will be allocated a portion of the statewide claim in proportion to the relative share they would have received had they submitted a claim based on their own staff's RMTS responses. Operationally, this could be done by running the UMMS RMTS application to produce a claiming amount for each Tribe, to be used only for purposes of allocating the single statewide tribal MAC claim. To reiterate, the state would submit a single statewide claim for all Tribes, but would "simulate" separate tribal claims to determine how to allocate the statewide claim amount across the participating Tribes.

Positions Eligible to Participate

Positions eligible to participate in the RMTS must be for staff who are not already participating in another HCA MAC time study and:

- Who are not Navigators/In Person Assistors providing outreach, application assistance, enrollment activities or contracted through the Washington State Benefits Exchange/ Healthplanfinder;
- Who are directly employed or contracted by the Tribe, or an HCA approved MAC subcontractor;
- Who are reasonably expected to perform MAC related activities;
- Whose positions are not funded with federal dollars, or have been appropriately off-set according to CMS guidelines;
- Whose positions are not included in an approved indirect rate.

Examples of Eligible Position/Job Titles

Application Coordinator	Family Services Director	Nurse/Clinic Nurse/Community Health Nurse
	Family Support Specialist	
Billing & Benefits Specialist	Family Practice Physician	Office Manager
Billing Manager		
Business Coordinator/Manager	Health Administrative Specialist	Patient Benefits Tribal Assistor
	Health Administrator	Physician Assistant
Care Coordinator	Health and Human Services Director	Program Coordinator
Case Manager/Clinic Coordinator/Clinical Case Manager	Health Benefits Coordinator	Program Manager
Caseworker	Health Services Manager	Public Health Research and Program Manager
Chemical Dependency Counselor		
Chemical Dependency Professional	Indian Child Welfare Case Worker	Receptionist
Chemical Dependency Supervisor/Manager/Administrator	Indian Child Welfare Coordinator	Recovery Specialist
Clinical Supervisor		Referral Scheduler Medical Records
Community Health Administrator	Medical Assistant	
Community Health Representative (CHR)	Medical Receptionist	Substance Abuse Prevention Specialist
Contract Health Services Clerk/Specialist/Manager	Medical Records/Referrals	
	Medical Registration Clerk	Tribal Health Director
Data Entry Coder	Mental Health Supervisor	
Dental Assistant	Mental Health Therapist	Wellness Center Administrator
Dental Office Manager		Wellness Intake Administrator
Diabetes Case Manager		
Diabetes Community Health Representative		
Domestic Violence Counselor/Victim Resource		

Summary of RMTS Process Components

1. **Annually**: Tribe updates a claiming year calendar in the System by May 1 before the start of each claiming year as described in the Manual. (Claiming year mirrors the state fiscal year (SFY) which runs from July 1 through June 30.)

2. **Quarterly**:
   a. Tribes enters/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.
   b. Tribes enters/confirms actual staff salary and benefits in the System to be used for claim calculation within 60 days after the close of the quarter.
3. Participant and moment times are randomly selected from the RMTS pool.
4. New participants receive User IDs and Passwords via email, and are reminded to complete online training before they receive their initial randomly selected moment.
   - All participants will receive System generated email notifications from MedicaidAdmMatch@UMMSmed.edu. These emails include a link to the System prompts to complete the online training modules (see the [Manual).](#)
5. Participants receive an email notification approximately 5 minutes prior to the designated time. The email will include the scheduled date and time.
6. Participants receive follow-up notification if they have not responded within 24, 48, 72 hours after the moment.
   a) 72 hours with a copy to the MAC coordinator and/or supervisor
7. Participants complete the time study.
8. After five (5) work days; the moment expires and cannot be altered.
9. Free typed or illogical combinations of responses are reviewed and coded by HCA staff throughout the quarter. This process will be completed no later than 15 work days from the end of the quarter. *If needed, participants are contacted via email for clarification.*

SECTION IV: TRAINING

All Tribal staff entered into the System as eligible participants must have completed the annual online training. HCA has reviewed and approved the online training.

Note: Any training material developed by the Tribe, Tribal Sub Contractor or Tribal Contractor consultant <u>must be reviewed and approved by HCA prior to its use</u>.

Coordinator Training

HCA will train all MAC Coordinators on the following:

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

RMTS Participant Training

Participants are required to complete annual online training in the System prior to participating in the time study. Participants are required to complete the training prior to answering their first moment, and then every 365 days after that. The online training will help participants to:

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

It is the responsibility of the MAC 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 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 Manual).

SECTION V: CLAIMING

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

General

Tribes must:
- Submit claims in accordance with the contract and the Manual.
- Only use the State of Washington A19-1A Invoice Voucher produced by the System;
- Ensure only individuals with HCA approved signatory power signs the A19
    - By signing the A19 the Tribe certifies the accuracy of the data entered into the System.
- Submit signed A19s on a quarterly basis;
- Submit a completed and approved Certificate of Indirect Costs annually;
- Submit annual Local Match Certification and CPE forms with the 4th fiscal quarter (April-June) A19;
    - HCA will not process any A19s, until the Local Match Certification and CPE Worksheet forms are submitted and approved by HCA
- All original A19s must be submitted no later than 365 days from the end of the quarter being billed.
- All A19s must be signed, dated and mailed to HCA at:

> Tribal Program Specialist
> Health Care Authority
> HCS / Medicaid Outreach Section
> PO BOX 45530
> Olympia, WA 98504-5530

Medicaid Eligibility Rate (MER)

Each Tribe will calculate the MER based on how they deliver services. This will respect tribal sovereignty, and account for each Tribe's unique health delivery system.

Tribes have the possibility of two MERS, resulting in one claim:

a) "Client" based MER calculation is based on native and nonnative populations who receive services provided by the clinic staff.

The "Client" based MER is calculated according to the following formula:

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

b) "Social Services" based MER. This MER calculation is program specific and based on caseload.

Tribes may offer a variety of programs other than those located in a clinic where staff may
perform activities eligible for MAC claiming, including but not limited to:

- Elder/Senior services programs
- WIC
- Childcare programs
- Food assistance programs
- Diabetes programs
- Indian Child Welfare
- Indian health programs (non-clinic based)

For the "Social Services" based MER the Tribal program collects client identifying information on folks assigned to a caseload or assigned to a staff as they walk through the door.

The "Social Services" based MER is calculated according to the following formula:

$$\frac{\text{Total number of unduplicated clients eligible for Medicaid served by the social service program}}{\text{Total number of unduplicated clients provided services by the program}}$$

For each MER possibility, the participating Tribe will track both the total unduplicated number of clients eligible for Medicaid during the quarter, and the total number of unduplicated clients provided with services during the quarter. The MER will be calculated for each individual Tribe via a data match by comparing the Tribe's client list with HCA's Medicaid eligibility list. Eligibility is only based on approved Recipient Aid Category (RAC) codes.

Primary Care Case Management Program (PCCM)

Tribes have the option of participating in PCCM or MAC. To ensure that duplication of services and payment does not occur across programs, Tribes must participate in only one of the two programs, not both.

Indirect Rate

The Tribe 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 Tribe's cognizant agency. HCA requires:

- A completed Certificate of Indirect Costs annually
- An indirect rate covering a 12 month time period
- A copy of the cognizant agency's approval letter
- Tribe's to provide any additional documentation related to indirect rates if requested

Source of Funds

Tribes must document the source of all funds and ensure the local matching funds:
- Are within the Tribe'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

Revenue Offset

Certain revenues must be offset to reduce costs to determine the total amount of costs in which the federal government will participate. To the extent the funding sources have paid or would pay to participate in the costs, federal Medicaid funding is not available and the costs must be removed from total costs (see OMB Circular A-87, Attachment A, Part C., Item 4.a.).

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

- All federal funds
- All state expenditures which have been previously matched by the federal government (includes Medicaid funds for medical assistance, such as payments for services under fee-for-service and SCHIP funds)
- Insurance and other fees collected from non-governmental sources
- All applicable credits such as receipts or reduction of expenditure type transactions offsetting or reducing expense items allocable to federal awards as direct or indirect costs.

Revenue Offset Process

- To determine the amount of total allowable staff salary and benefits, the contractor must first perform revenue offset by subtracting any federal or state grant dollars included in the salary and benefits.
- In some cases, the revenue offset amount could include donations if those donations were specifically given to a program.
- Time study statistics must be applied to the remaining salary and benefits (total allowable staff salary).

Certified Public Expenditures

Tribe's must comply with the following requirements for Certified Public Expenditures:

- A Designated Authorizing Representative of the Tribe 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 Tribe 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 Tribe must certify applied donated matching funds have been preapproved for use by Centers for Medicare and Medicaid (CMS)/National Institutional Reimbursement Team.
- The Tribe 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.
- The Tribe must reimburse the total computable expended amounts to Tribal subcontractors for performance of allowable Medicaid administrative activities. The Tribal subcontractor must not be required to provide the non-federal share of the payment, or return any portion of the total computable cost to the Tribe.
  Once the Tribe has incurred the total computable expended amounts, they must submit an invoice to the state agency requesting reimbursement of the eligible Federal Financial Participation.

Administrative Fee

There is no administrative fee for Tribal participation in MAC.

SECTION VI: OVERSIGHT AND MONITORING

HCA has established proper internal controls for program monitoring and oversight to ensure the integrity of the MAC program. As part of HCA's oversight, in depth monitoring activities will be performed on an on-going basis. These activities include, *at a minimum*, the following actions:

Non Responses and Minimum Response Rate

Non-responses are moments not completed by the participant within five (5) work days. The return rate of valid responses for the Tribe 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. All non-response or incomplete responses will be assigned to Code 3.

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 Tribe 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 Tribe requesting a corrective action plan.
    - The Tribe must develop and submit the corrective action plan to HCA for approval within 30 working 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 Tribe 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 Tribe will be prohibited from participating in MAC for the following quarter (4th consecutive quarter).
    - The Tribe will be notified via certified mail of the withheld reimbursement and prohibited participation in MAC.

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

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

Trends

Trends to be identified and monitored may include total claims and reimbursement levels. Any significant variations from historical trending will be followed up with the Tribe as a component of the ongoing review process.

HCA staff will also schedule and participate in regular meetings, webinars, and/or conference calls with the Tribe to discuss time study trends, compliance levels, and other Medicaid or time study issues.

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

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

Time study components
- Participant list
- Non response rates
- Free type responses
- Narrative Description
- Illogical responses
- Automapping
- Correlation between narrative description and responses
- Percent of time allocated to each code, with a focus on code 10

Activity Code 10

HCA will review the percentage of time allocated to code 10 for individual participants on an annual basis. Any amount over 10% will be fully investigated for accuracy. HCA will require the Tribe to remove any participants with the majority of their work *accurately* recorded as code 10, from the RMTS. These salary and benefits should be reimbursed through the application of an indirect rate.

Activity Coding

Neither participants nor MAC Coordinators have access to data which may impact claim calculation, nor do they have access to view or edit activity codes.

HCA staff will review and manually code all moments not automapped throughout the quarter. This process will be completed no later than 15 work days from the end of the quarter. HCA may request follow up documentation from participants for manually coded moments. If follow up documentation is not received by HCA within 15 work days of the request, the moment will be coded as a non-response. These moments will go into the Tribe's non-response rate calculation.

All free typed responses will be maintained in the System to provide necessary audit trails.

Examples of non-automapped moments include:
- Free typed responses
- An illogical combination of responses.

Status of Moments

Each moment has a *status* indicating where it is in the time study process and that status is reflected on multiple System reports. The MAC Coordinator must closely monitor any moments with an "Incomplete" status and follow up with the participant to complete their time study prior to the end of the five (5) work day grace period.

Description of Moment Coding

Moment Status	Definition	Moment Status Complete	Comments
Auto-Mapped	If the participant uses predefined responses available for each question, the moment will auto-map to that code.	Yes	If the responses do not make sense or if a free typed response is submitted, the moment cannot be automapped. HCA validates 15% of all moments.
Incomplete	Moments remain active until completed by participant.	No	Moments are active from the time they are generated through the end of their grace period. Participants may only respond to or change responses on active moments.
Incomplete Expired	Moments not completed by the participant and are past the grace period.	No	Once a moment is expired, the participant cannot open the moment and respond to it.
Manual Incomplete	Participants manually free typed a response or illogical combination.	Participant: Yes HCA staff: No	HCA staff will select the activity code or obtain more information from the participant before selecting the activity code.
Pending	If HCA staff need additional information, they send an email to the participant 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.	Participant: Yes HCA staff: No	
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.	Participant: Yes HCA staff: No	
Approved	HCA first and second coders have reviewed the participant's responses and approved the activity code.	Yes	Time and activity code is recorded for use in claim calculation.
Pending Approval	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.	Participant: Yes HCA staff: No	
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.

Verifying Results of Moments

At the end of each quarter, HCA validates 15% of all moments.

HCA performs two levels of review for all sampled moments to ensure the correct code has been assigned.

- The first level coder reviews, assigns a code to the moment, and refers it to the second level coder.
- The second level coder reviews, confirms the accuracy of the code, and completes the moment.
    - If the second level coder is unable to confirm the accuracy of the code, the moment is referred to a third coder for final review.

All sampled moments must be validated for accuracy. The validation is completed at the end of each quarter and cannot be conducted by the same staff who coded the moments.

Verifying Narrative Description

HCA 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 Tribe'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.

Required Documentation – MAC Audit File

Tribe's must maintain and have available the following documentation in a readable, and usable format for audit/review purposes by HCA, State Auditor's Office (SAO), and federal personnel upon request.

Copies of all:
- Current Interagency/Interlocal Agreement with HCA
- Dun and Bradstreet Data Universal Numbering System (DUNS) number
- Statewide Vendor (SWV) number
- MAC Contractor MAC Organization Chart
    - Administrator
    - CFO and/or Business Manager
    - MAC Program Administrator
    - Consultant and/or billing agent
    - MAC Coordinator
    - Participating staff by claiming group(s) with names and job titles
- All MAC related contracts with consultants/billing agents
- All MAC Contracts/Grants related to outreach and linkage such as:
    - School districts
    - Outreach organizations
    - Community based organizations
    - Washington HealthPlanFinder
- MAC Subcontractor Documentation:
    - List of all Tribal subcontracts
    - Copy of contract
    - Subcontractor information form (as submitted to HCA)

- o HCA approval notification from HCA
- MAC Financial claiming documentation
  - o Copies of signed quarterly A-19 invoice vouchers and all detailed documents in support of that quarterly claim
  - o Tribal Subcontractor invoices for services provided under the Tribe's Contract
  - o Signed copy of annual Local Match Certification form
  - o Signed Certified Public Expenditure worksheet listing funding sources, description and back-up documentation
  - o Copy of Indirect Cost Rate Certification, methodology description and back-up documentation
- All HCA Tribal MAC Monitoring Report(s)
- All quarterly *Compliance Status Reports* as described in the [Manual](#).
- All State and/or federal audit reports, including the most recent OMB Circular A-133 Audit and any related documents and corrective action plans that relate to the Tribal MAC program
- All Tribal MAC related training documents (rosters and materials)
- All quarterly participant lists
- All Participant job titles and duty/job descriptions

Scheduled Three (3) Year Monitoring

HCA conducts MAC Contractor monitoring at least once every three (3) years for each 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.

For Scheduled Monitoring:

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. A MAC Contractor that does not fully cooperate will be subject to corrective action plan. HCA monitors and reviews components of the MAC program documentation including, but not limited to:

Components Monitored:

- 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:

  - o Participant list – ensure only eligible staff are included on the participant list
  - o RMTS time study results
  - o MAC Coordinator and participant training compliance
  - o MAC related training documents (rosters and materials)
  - o Review documentation of randomly selected moments
  - o 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 Financial Services, Accounting staff will:
  - o Compare a 15% sampling of Tribe's payroll records to the information in the System.
  - o An HCA public information data analyst will generate the sample of
    - ▪ 15% or a minimum of ten (10) participants (whichever is greater)
  - o Review source of funding to ensure CPE complies with section [1903(w)(6)(A) of the Social Security Act](#) and [42 CFR 433.51](#).

Corrective Action Plans

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

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

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

Other Outreach and Linkage Contracts

To ensure the effective and efficient administration of the MAC program, HCA will review all contracts/grants related to outreach and linkage activities. The Tribe must submit copies of any contracts/grants related to outreach and linkage to HCA for review *prior to implementation*. HCA will review these contracts for, including but not limited to:

- Duplication of effort as described by CMS in the Guide; Section IV: PRINCIPLES OF ADMINISTRATIVE CLAIMING, B, 4 and 5
- Duplication of payment as described by CMS in the Guide Section IV: PRINCIPLES OF ADMINISTRATIVE CLAIMING, B, 4 and 5

MAC Subcontractors

Tribes must submit any proposed Tribal MAC subcontract(s) to HCA for review and approval prior to implementation. Tribes *must not enter into any MAC subcontract prior to receiving written approval from HCA*. Tribal MAC Subcontractor monitoring is the Tribe's *responsibility*. The required HCA Subcontractor Review form can be found in the Manual.

Tribes **must:**
- Ensure that any subcontract for Tribal MAC activities meets, *at a minimum*, all the terms and conditions required in the HCA MAC contract.
- Assume all responsibility for MAC activities performed by any Tribal MAC subcontractor(s).
- Monitor all Tribal MAC subcontractors to ensure program integrity, and maintain an annual monitoring report for each Tribal MAC subcontractor in the Audit File.
- Maintain a current list of all sources of funding that Tribal MAC subcontractors are receiving.
- Not charge Tribal MAC subcontractors an administrative fee for participation in MAC claiming. The Tribe assumes all administrative costs.
- Ensure all federal funds are properly off-set and retain ample documentation demonstrating the off-set complies with CMS requirements.
- Ensure handling of Certified Public Expenditures (CPEs) complies with section 1903(w)(6)(A) of the Social Security Act and 42 CFR 433.51.
- Maintain documentation demonstrating that each Tribal MAC subcontract has been paid 100% of its total MAC related costs before Tribe submits an A19 Invoice to HCA for MAC reimbursement.

Section VII: HCA Financial Services Review of Tribal Claiming

The HCA Financial Services, Accounting department will perform fiscal reviews on a regular basis. This includes but is not limited to:

Quarterly A19 Review Process

- Tribes sends original A19 to HCA
- Program staff check the indirect rate is not greater than allowed
- Program staff verify A19 totals match the UMMS System
- Program staff send the approved and signed A19 to Financial Services, Accounting
- Accounting staff verify the indirect rate
- Accounting staff verify A19 totals match the UMMS System and prints appropriate backup reports
- Accounting staff approve the A19 for payment

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.

Annual Indirect Cost Rate

- Accounting staff receive a copy of the approved indirect cost rate from Tribe's cognizant agency with backup supporting documentation
- Accounting staff maintain a spreadsheet of all Tribal MAC contractor indirect cost rates
- Accounting staff send indirect cost rates to program staff to upload into the UMMS System

Sources of Funding and Certified Public Expenditures

Tribe's must comply with the following requirements for Certified Public Expenditures (CPE):

- A Designated Authorizing Representative of the Tribe 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 Tribe 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 Tribe must certify applied donated matching funds have been preapproved for use by Centers for Medicare and Medicaid (CMS)/National Institutional Reimbursement Team.
- Participating Tribes are prohibited from requiring or allowing private non-profits to participate in the financing of the non-federal share of expenditures. Non-governmental units may not voluntarily provide, or be contractually required to provide, any portion of the non-federal share of the Medicaid expenditures.
- The Participating Tribe must reimburse the total computable expended amounts to Tribal MAC subcontractors for performance of allowable Medicaid administrative activities. The Tribal MAC subcontractor must not be required to provide the non-federal share of the payment, or return any portion of the total computable cost to the Tribes.