New Mexico Aging and Long-Term Services Department

Time Study and Medicaid Administrative Claiming Guide

July 1, 2021

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INTRODUCTION

As the Medicaid authority for New Mexico, the Human Services Department (HSD) is committed to providing efficient and effective Direct Service (DS) and Medicaid Administrative Claiming (MAC) programs.

The Human Services Department (HSD) is the single state agency designated to administer or supervise the administration of the Medicaid Program under Title XIX of the Social Security Act for the State of New Mexico. HSD has the authority to delegate administrative functions set forth in Title XIX in order to employ methods of administration necessary for the proper and efficient operation of the State Plan. HSD has chosen to exercise this right by delegating certain functions to the New Mexico Aging and Long-Term Services Department (ALTSD) as summarized herein. ALTSD has the qualified personnel classified under the New Mexico State Personnel Department to perform the functions required of the delegated activities, per §1902(a)(33)(B) of the Social Security Act.

HSD delegates certain Medicaid administrative functions to ALTSD in accordance with Section 1903(a)(7) of the Social Security Act and the implementing regulations of 42 Code of Federal Regulation (CFR) 431.1 and 42 CFR 431.15, 45 CFR Part 74 and 95. HSD and ALTSD enter into multiple agreements for ALTSD to perform various administrative functions in support of the Medicaid administration.

HSD retains its sole responsibility for exercising administrative discretion in the administration and supervision of the Title XIX State Plan. Nothing in the Joint Powers agreements (JPAs) or the Governmental Services Agreements (GSAs) with ALTSD that are summarized herein delegates any of HSD's responsibility for exercising administrative discretion in the administration or supervision of the Title XIX State Plan, including program matters or the issuance of policies, rules, and regulations. In the performance of ALTSD's functions under the agreements, ALTSD does not have any responsibility to review, change or disapprove any administrative decision of HSD, or otherwise substitute its judgment for that of HSD as to the application of Title XIX policies, rules and regulations promulgated by HSD.

The New Mexico Aging and Long-Term Services Department (ALTSD) provides accessible, integrated services to older adults, adults with disabilities, and caregivers to assist them in maintaining their independence, dignity, autonomy, health, safety, and economic well-being, thereby empowering them to live on their own terms in their own communities as productively as possible.

Aging and Disability Resource Center (ADRC)

The ADRC exists to assist elders, persons with disabilities and caregivers find services and resources to help them live well and independently. The call center provides information and assistance regarding long-term care options counseling, benefits counseling through the State Health Insurance Assistance Program (SHIP), healthcare fraud prevention through the Senior Medicare Patrol (SMP), prescription drug assistance,

and healthcare options through the New Mexico Health Exchange. The call center also provides registration assistance for the state Medicaid Community Benefit 1115 waiver program.

All of these programs are to ensure that vulnerable people have access to information to help them continue to live in their communities safely.

Adult Protective Services (APS)

APS receives reports of abuse, neglect, or exploitation of incapacitated adults. APS conducts in-person investigations of allegations, alleged victims and perpetrators as well as all collateral contacts.

APS also has the authority to provide temporary adult services to help alleviate the risks to the incapacity person. This includes emergency caregiver or shelter care services, home care, attendant care and adult day care services. APS regulations require the utilization of institutional care Medicaid income criteria for the determination of financial eligibility for services. These services generally last 90 days (longer is some circumstances).

APS also providers short term case management of those adult services, documents at least quarterly face-to-face contact with clients, and works with them to develop and review plans for continuation of services and long-term solutions. Many of these individuals are eligible for waiver services or other Medicaid.

APS also conducts in-person and virtual outreach presentations at senior centers, banks, law enforcement, healthcare organizations, and any other community service providers that will participate in the trainings.

This MAC guide is specific for ALTSD Programs.

INTERAGENCY AGREEMENTS

The federal government permits state Medicaid agencies to claim reimbursement for activities performed that are necessary for the “proper and efficient administration” of the Medicaid State Plan as stated in Medicaid statute section 1903(a)(7) of the Social Security Act and the implementing regulations at Code of Federal Regulation (CRF) Title 42 (CFR, 431.1 and 42 CFR 431.15, and 45 CFR Part 74 and 95). In addition, Office of Management and Budget (OMB) A-87 was replaced by **OMB Uniform** Guidance at 2 CFR part 200, subpart E and appendices V and VII which contains the cost principals for state, local, and Indian tribal governments for the administration of federal awards states that “Governmental units are responsible for the efficient and effective administration of federal awards.”

The Centers for Medicare and Medicaid Services (CMS) has identified a series of activities, such as outreach, utilization review, and eligibility determination that are entitled to be claimed administratively through the Medicaid Administrative Claiming (MAC) program.

As mentioned above, HSD has coordinated with ALTSD to assist HSD in administering the New Mexico State Medicaid Plan in the most effective manner possible.

To receive federal matching funds for these programs, federal guidelines permit the use of statistical sampling as an option to monthly personnel activity reports to identify the proportion of administrative time reimbursable under the MAC program. HSD and the ALTSD will implement Random Moment Time Study (RMTS) methodology which is a permitted form of statistical sampling.

The common interest of HSD and the agencies is to ensure more effective and timely access of individuals to health care, to obtain the most appropriate utilization of Medicaid covered services, and to promote activities and behaviors that reduce the risk of poor health outcomes for the state's most vulnerable populations.

PARTICIPATION REQUIREMENTS

State agencies interested in participating in the MAC program must comply with requirements set forth by HSD. Agencies must review all requirements annually and make any necessary changes to ensure HSD of their compliance on a continual basis.

To participate in MAC, the New Mexico Aging and Long-Term Services Department of Health (ALTSD) must first enter into a contract with the New Mexico HSD. The agreement between the ALTSD and the HSD must be in effect the first day of the quarter in which the initial time study is initiated. A time study is a tool which is an accepted method of objectively allocating staff time to the various activities that are measured.

A copy of the GSA #17-630-8000-0001 is included in Appendix A as reference.

State Agency Responsibilities for Participation in MAC

Agencies are required to oversee their MAC program to ensure that procedures are implemented and performed consistently and appropriately. It is highly recommended that at least one individual serves as the Primary RMTS Coordinator/Contact and one individual serves as the MAC Financial Coordinator/Contact for each agency. When necessary, the same individual can fulfill both roles.

The following list of core responsibilities has been developed to assist agencies:

Information Flow – Receive correspondence and requests for information regarding MAC from HSD and ensure that the information is disseminated to all appropriate staff and contractors; encourages interdepartmental coordination and cooperation to improve program efficiency and effectiveness.

Policy – Ensure policy directives and instructions are consistent with statewide policy for MAC. Assign MAC program coordinators and assist them in defining their roles and responsibilities to include: development of an appropriate data used to determine the percentage of Medicaid clients, construction of the MAC claim (known hereafter as the claim), and establishment of a supporting documentation file. Clarify policy, program or fiscal questions raised by staff or contractors, and refer any requests for assistance or further clarification to HSD.

Staff Training – Identify required training among staff and contractors to ensure compliance established by HSD.

Quality Review – Ensure no duplicate billings occur and invoices for the claim are consistent with the criteria established before the claim is certified and submitted to HSD. Ensure the data used to calculate the Medicaid percentage, as applicable, is properly entered into the system and will provide any information requested by HSD regarding the claim.

HSD Required Participating Documents – Maintain the GSA or JPA with HSD

and ensure the processing of agreements or memoranda of understanding with any sub-contractors participating in MAC.

Audits/Reviews – Develop guidelines for establishing and maintaining supporting documentation files that are consistent with procedures outlined by HSD. Assist agency coordinators and/or their designees in maintaining supporting documentation files containing documents supporting the development of the claims. Conduct periodic reviews of the supporting documentation file to ensure that the files are current with all applicable HSD directives.

REGULATORY GUIDANCE

Title XIX of the Social Security Act (the Act) authorizes federal grants to states for a proportion of expenditures for medical assistance under the approved Medicaid State Plan, and for expenditures necessary for administration of the State Plan. This joint federal-state financing of expenditures is described in section 1903(a) of the Act, which sets forth the rates of federal financing for different types of expenditures.

Under §1903(a)(7) of the Act, federal payment is available at a rate of 50% for amounts expended by a state "as found necessary by the Secretary for the proper and efficient administration of the state plan," per 42 Code of Federal Regulations (CFR) 433.15(b)(7). The Secretary is the final arbiter of which administrative activities are eligible for funding. Certain administrative costs may be matched at higher federal financial participation (FFP) rates, for example:

- Family planning services – 90%
- Design, development, or installation of claims processing and information retrieval systems – 90%
- Operation of claims processing and information retrieval systems – 75%
- Compensation and training of skilled professional medical personnel and staff directly supporting those personnel if the criteria specified in § 432.50 (c) and (d) are met – 75%
- Funds expended for the performance of medical and utilization review by a Quality Improvement Organization (QIO) under a contract entered into under section 1902(d) of the Act – 75%

In addition, Office of Management and Budget (OMB) Circular A-87, was replaced by the **OMB Uniform** Guidance at 2 CFR part 200, subpart E and appendices V and VII which contains the revised cost principles for the administration of federal awards to state, local and Indian tribal governments, states that "Governmental units are responsible for the efficient and effective administration of Federal awards." Under either of these provisions, administrative expenditures must be reasonable and necessary for the performance of functions funded by the Federal award.

Claims for FFP must come directly from the single state Medicaid agency. In addition, the state must ensure that permissible, non-federal funding sources are used to match federal dollars. States sometimes contract with outside agencies to conduct certain Medicaid administrative activities on their behalf. In order for these costs to be claimable, the state Medicaid agency is required to have an interagency or other contractual agreement in place with any agency which performs Medicaid administrative activities on its behalf. These contractual agreements are designed to define and describe the relationship between the state Medicaid agency and the agencies with which it partners to perform

Medicaid administrative activities.

In order for Medicaid administrative expenditures to be claimed for federal matching funds, the following requirements must be met:

- Costs must be "proper and efficient" for the state's administration of its Medicaid state plan (§ 1903(a)(7) of the Act).
- Costs related to multiple programs must be allocated in accordance with the benefits received by each participating program consistent with The **OMB Uniform** Guidance at 2 CFR part 200, subpart E and appendices V and VII. This is accomplished by developing a methodology to assign costs based on the relative benefit to the Medicaid program and the other government or non-government programs.
- Costs must be supported by an allocation methodology that appears in the state's approved Public Assistance Cost Allocation Plan (42 CFR 433.34).
- Costs must not include funding for a portion of general public health initiatives that are made available to all persons, such as public health education campaigns.
- Costs must not include the overhead costs of operating a provider facility.
- Costs must not duplicate payment for activities that are already being paid through another source such as paid through a rate or paid through other programs.
- Costs may not supplant funding obligations from other federal sources.
- Costs must be supported by adequate source documentation.

RANDOM MOMENT TIME STUDY

Overview

A time study is a tool which is an accepted method of objectively allocating staff time to the various activities that are measured. It is based on objective, empirical data, and its results reflect how staff time is distributed across the range of activities. A time study should be a reasonable representation of staff activity during the specified time study period.

The State of New Mexico will utilize a Random Moment Time Study (RMTS) methodology effective July 1. 2021. RMTS is a federally approved, statistical sampling technique and is recognized as an accepted alternative to 100 percent time reporting. The RMTS method provides a verifiable, statistically valid sampling technique that produces accurate labor distribution results by determining what portion of the selected group of participant's workload is spent performing all work activities. The RMTS method polls participants on an individual basis at random time intervals over a given time period and totals the results to determine work effort for the entire population of participating staff over that same period.

RMTS eliminates the requirement for timesheets or daily time study logs and instead selects a "moment" in time for which three questions must be answered:
1) what were you doing; 2) who were you with; and 3) why were you performing this activity? An RMTS moment represents one minute at a particular time and moments are sampled and occur throughout each quarter. If sampled, the participant's only responsibility is to document what they were doing at that precise moment by answering the questions. Participants are not required to understand complicated Medicaid regulations or codes and the entire online process takes no more than a few minutes to complete.

Time Study

A fundamental step in the development of an appropriate RMTS is determining what staff should or should not participate in the time study process. To determine the time study sample New Mexico uses a pool which includes employed and contracted staff that provide services which are primarily medical in nature and/or the administrative activities that are in support of services covered by Medicaid. This pool would be made up of all provider agencies participating in a specific program.

Once the list of time study participants is compiled, randomly selected moments are then randomly matched to a staff participant. The sample moments are selected from applicable staff pools, along with the total number of eligible time study moments for each quarter. To ensure randomness in the selection process, the staff name and the selected moment are returned to the overall sample pool after each moment selection so as to be available for selection again.

Time Study Methodology

To determine the proportion of claims for administrative activities in support of this program and the proper allocation of costs, HSD utilizes a Random Moment Sampling (RMS) time study methodology that is monitored and administered at the state level by HSD staff and its selected contractor. Details concerning the RMS process and the individuals who may participate are described below.

The sampling period is defined as the three-month period comprising each quarter of the Federal Fiscal Year calendar. The following are the federal quarters followed for the Administrative Claiming program and a time study is performed for each of the quarters listed below:

- January 1 - March 31
- April 1 - June 30
- July 1 - September 30
- October 1 - December 31

Sampling Requirements

RMTS sampling methodology has been constructed to achieve a confidence level of 95 percent with precision level of +/- 5 percent.

+/- 5 Percent:

Statistical calculations show that a minimum sample of 384 completed moments each quarter, per time study staff pool, is adequate to obtain this precision when the total pool of moments is greater than 222,639. Additional moments are selected each quarter to account for any potential lost moments.

The following formula is used to calculate the number of moments sampled for the time study pool:

$$ss = \frac{Z2 * (p) * (1-p)}{c2}$$

Correction for Finite Population

$$new\ ss = \frac{ss}{1 + \frac{ss-1}{pop}}$$

Where:

ss = sample size
Z = Z value (e.g. 1.96 for 95 percent confidence level)
p = percentage picking a choice, expressed as decimal (.5 used for sample size needed)
c = confidence interval, expressed as decimal (e.g., .05 = ±5)
pop = population

The following table shows the sample sizes necessary to ensure statistical validity at a 95 percent confidence level and tolerable error level of 5 percent. Additional moments will be selected to account for lost moments, as previously defined.

N=	Sample Size Required
10,000	370
20,000	377
30,000	379
40,000	381
50,000	381
75,000	382
100,000	383
>222,639	384

Additional moments of at least 15% oversample should be selected each quarter to account for any lost moments (observations that cannot be used for analysis, i.e., incomplete moments or moments selected for staff no longer at the agency, etc.).

In the event there is a "state of emergency" or other disaster declared in the State of New Mexico that results in closures that impact the agency's ability to participate in the RMTS as defined in the "Random Moment Time Study" section of this document, HSD will apply an "averaging" methodology to quarters occurring during the "state of emergency," including the quarter in which the state of emergency is declared and through the quarter in which the state of emergency period ends. The RMTS will use an average of the three previously completed quarters prior to agency closures for claiming for any individual quarter impacted by the emergency. HSD will notify the Center for Medicaid & Chip Services (CMCS) within 15 days of determining that a quarter is statistically invalid, including the reason for the determination along with details and dates of the declaration of emergency. Upon HSD's determination that a quarter is statically invalid, the RMTS will not be conducted if the time study has not yet been initiated for the quarter or will be cancelled immediately upon determination within the quarter.

HSD and the agency will evaluate staff calendars to determine standard operational hours each federal quarter for which staff is compensated for providing services. Based on federal fiscal year quarters, HSD and the agency will determine the most common begin and end dates for sampling purposes. All days and times of operation will be included in the potential days to be chosen for the quarterly time study.

RMTS Process

The RMTS process consists of the following steps:

1. Identify total pool of time study participants;
   a) Develop the RMTS Participant List
   b) Certify the Participant List
2. Identify total pool of time study moments;

3. Randomly select moments;
4. Randomly match each moment to a participant;
5. Notify selected participants of their moment;
6. Time study participants respond to their assigned moment; and
7. Central coders code the moment.

1. Identifying the pool of time study participants.

   At the beginning of each quarter, participating agencies must submit a comprehensive list of all staff (employed and contracted) eligible to participate in the RMTS. This list is referred to as the Participant List (PL). From the PL, all participants are assigned into the staff pool. The staff perform various functions in support of the Medicaid program as well as other non-Medicaid activities in carrying out their job responsibilities.

   A job title will be included for each person listed on the PL. The agency (contracted provider) must maintain a description on file for each job title listed on the PL.

   Direct Support

   Staff must participate in either direct service or administrative activities to be included in the time study. Associated clerical or administrative support staff that report to individuals included on the Participant List are not to be included in the time study. These administrative staff are eligible be included in the claiming process by allocating their time and appropriate costs based on the total time study effort.

   This Participant List may include vacant positions that are planned to be filled during the reporting quarter. If a vacant position is filled during the quarter, the individual will complete the time study (if sampled), and actual costs incurred for the position during the quarter are eligible to be reported. If a vacant position is not filled during the quarter, then any sampled time study moments are coded to Not Working/Not Paid and no costs are eligible to be reported. If a position becomes vacated during the quarter and is later filled with a direct replacement, the direct replacement will complete the time study (if sampled), and the proportional costs incurred for both the original participant and direct replacement are eligible to be reported. If the vacated position is not filled during the quarter, then any sampled time study moments are coded to Not Working/Not Paid and only those proportional costs eligible during the period staff received compensation can be reported.

   Each agency must certify that the PL of staff they are submitting to be included in the eligible staff pool are appropriate for inclusion in the time study and eventual claim. Any staff deemed inappropriate during the coding and state oversight processes will be removed from the financial reporting and excluded from the

eventual claim.

Staff Pools

A single staff pool will be used.

Staff Pool

- Comprised of staff that participate in administrative activities only and staff that participate in direct service activities and also in administrative activities as part of their regular duties and on a regular basis.

  Participants in this pool may include:
  - Case Manager/Case Worker
  - Home Health Aide
  - Option Counselor
  - Outreach Worker
  - Program Administrator
  - Pre-Enrollment Staff
  - Public Outreach
  - Service Coordinator

- Certain staff should not participate in the time study. In general, these include:

  - 100% Federally funded staff
  - Any staff who do not typically or potentially perform allowable Medicaid administration functions

Failure by an agency to certify its RMTS PL will result in non-compliance with RMTS requirements and will cause the agency to become ineligible to participate in administrative claiming for the specified period.

2. Identify total pool of time study moments.

   The total pool of "moments" within the time study is represented by calculating the number of working days in the sample period, times the number of work hours of each day, times the number of minutes per hour, and times the number of participants within the time study. The total pool of moments for the quarter is reduced by the exclusion of weekends, holidays and hours during which employees are not scheduled to work.

3. Randomly select moments.

   Using a statistically valid random sampling technique, the desired number of random moments is selected from the total pool of moments (see *Sampling Requirements* above). To ensure randomness, each time the selection of a minute occurs, the minute is returned to the overall sample pool to be available for

selection again. In other words, the random selection process is done with replacement so that each minute is available to be selected each time a selection occurs.

4. Randomly match each moment to a time study participant.

   Each randomly selected moment is matched up, using a statistically valid random sampling technique, with an individual from the total pool of participants. Each selected moment is defined as a specific one-minute unit of a specific day from the total pool of time study moments and is assigned to a specific time study participant. To ensure randomness, each time the selection of a staff participant's name occurs, the participant's name is returned to the overall sample pool to be available for selection again. In other words, the random selection process is done with replacement so that each person is available to be selected each time a selection occurs.

5. Notify selected participants about their moment.

   Time study participants are notified via email, or other method, of their requirement to participate in the time study and of their sampled moment.

   - Sampled participants are notified of their sampled moment three weekdays prior to the moment.

6. Time study participants respond to their assigned moment.

   For the selected moment, each sampled participant is required to record and submit their activity by answering the following questions:

   - Were you working at the time of your moment?
     - Yes or No
     - If the sampled participant indicates they were not working, they will be required to confirm if they were on paid or unpaid time off at the time of the moment.
     - If the sampled participated indicates they were working, they will be asked the following free form questions:
   - Who were you with?
   - What were you doing?
   - Why were you performing this activity?

   Required response times and follow-up for moments must be completed as follows:

   - Sampled participants are notified of their sampled moment three weekdays prior to the moment.
   - Sampled participants have three weekdays from the sampled moment to complete and submit their response.

- Daily reminders (excluding weekends) are sent via e-mail to sampled participants who have not completed their sampled moment until the moment has either been certified or is no longer in the response period.
- Daily reminders (excluding weekends), are sent via e-mail to the designated RMTS Contact containing a list of all moments for which their sampled staff participants have not completed.
- The RMTS Contact is responsible for contacting sampled staff participants that have not completed their sampled moment to prompt the required response.
- For any moment not completed within three weekdays of the sampled moment date:
    - The participant's login will not work and they will no longer be able to respond to the time study. However, in the event that a participant is not working during their sampled moment, and unable to complete the moment, the RMTS Contact can report that participant was either on "Paid Time Off" or "Not Working/Not Paid". The Program Contact can report participants as "Paid Time Off" or "Not Working/Not Paid" at any time prior to the last business day of the quarter.
- For those participants who do not have online capability, the RMTS Contact at the represented agency will be able to print out the notification and distribute it to the participant. The participant can complete the sample by directly contacting the administrative claiming contractor's call center. The call center staff is trained to walk the participant through the appropriate questions, and then document the response in the system. The contractor's system then tracks and makes it visible to all system users that the response was taken over the phone.

7. Central coders code the moment.

   Time study activity codes assist in the determination of time and associated costs that are related to and reimbursable under the Medicaid program. The time study activity codes have been designed to reflect all of the activities performed by time study participants.

   Sampled moments must be coded within three weeks after the sampled moment date. Each moment selected from the pool is included in the time study and coded according to the responses submitted by the sampled participant.

   Central coders employed by the State or its contractor review the time study participant responses and, with adequate information, assign the appropriate activity code. All moments will be coded independently by at least two central coders as part of a quality assurance process.

   Every effort will be made to assign the appropriate time study activity code. If sufficient information is not provided, the central coder will contact the time study participant and the designated RMTS Contact and request additional information.

If sufficient information is not received within three weeks after the sampled moment date, the moment will be coded as a non-Medicaid activity.

Time Study Return Compliance

HSD will require a compliance rate for the time study survey of at least 85 percent. The compliance rate is defined as the percent of valid, certified moments. If the return rate of valid moments is less than 85%, non-returned moments shall be included and coded as non-allowable until an 85% compliance rate is obtained. To ensure that enough moments are received to have a statistically valid sample, a minimum of 15% over-sampling should be used. If the 85% percent valid response rate is met without having to code to non-Medicaid time, the not returned moments will be ignored since they are compensated by over sampling.

HSD will monitor each agency to ensure they are properly returning sample moments. If the agency has not reached 85% compliance, HSD may take appropriate action using sanctions, which may include but not be limited to conducting more frequent monitoring reviews, eliminating the agency's claimed portion of federal funds, or ultimately, termination of the agency's GSA or JPA. HSD will send out non-compliance warning letters to all agencies that did not achieve a 85% percent compliance rate, but only if they also have not returned moments of greater than five moments.

Additionally, the agency must participate in all of the four time study quarters conducted during the federal fiscal year in order to claim MAC costs for all four of those quarters. Failure to participate in a time study quarter will make the agency ineligible to claim MAC costs for that quarter.

Quality Assurance

Coding results will be reviewed by HSD on a quarterly basis. HSD will review a sample of the completed coding results and original staff participant responses to ensure the codes selected for sampled moments are valid and accurate.

HSD will discuss and resolve any discrepancies identified in the quarterly review. In addition to the quarterly review, at its discretion, HSD may review the completed coding and original staff participant responses at any time throughout the claim process or as needed for further review or audit purposes.

At the end of each quarter, once all RMTS data has been received and time study results have been calculated, statistical compliance reports will be generated to serve as documentation that the sample results have met the necessary statistical requirements.

The time study will identify the portion of the RMTS participant's time:

- Related to providing MAC administrative activities;
- Directly or indirectly related to providing direct service (DS) activities, and
- Related to other activities.

The results of the time study for this program will be used to claim for MAC administrative services only.

RMTS Training

1. Training materials.

   HSD will make accessible, via the HSD and contractor websites, RMTS training materials used for training. Agencies are encouraged to use and distribute to designated RMTS Contacts and time study participants materials provided by HSD regarding the time study.

2. Training types.

   - RMTS Contact (designated by the agency).

     Annual training is mandatory for all contacts designated by the agency as a RMTS (or Program) Contact. The RMTS Contacts are responsible for ensuring the agency complies with all RMTS requirements. Training sessions are conducted by the HSD, authorized individuals from the agency or the contractor.

     HSD or the contractor will also offer training sessions to RMTS Contacts quarterly. Training will include an overview of the RMTS process, software system and information on how to access and input information into the RMTS system. It is essential for the RMTS Contacts to understand the purpose of the RMTS, the appropriate documentation and completion of the RMTS, the timeframes and deadlines for participation, and the consequences of non-compliance.

   - Sampled staff training.

     Prior to each sampled moment, participants are required to complete online training.

   - Central coder training.

     HSD will provide training to the central coding staff for the implementation of RMTS, and on an as needed basis. Training will include discussing issues regarding the coding of moments. Training will also include an overview of activity codes, samples of activities, appropriate processes for making coding determinations, program updates, process modifications, and compliance issues unique to HSD.

TIME STUDY ACTIVITY CODES AND DESCRIPTIONS

Code	Activity
1.a	Outreach – Non-Medicaid
1.b	Outreach – Medicaid
2.a	Eligibility – Non-Medicaid
2.b	Eligibility - Medicaid
3	Educational and Social Activities – Non-Medicaid
4	Direct Medical Services
5.a	Transportation – Non-Medicaid
5.b	Transportation – Medicaid
6.a	Translation – Non-Medicaid
6.b	Translation – Medicaid
7.a	Program Planning, Development and Interagency Coordination – Non-Medical
7.b	Program Planning, Development and Interagency Coordination – Medical
8.a	Training – Non-Medical / Non-Medicaid Related
8.b	Training – Medical / Medicaid Related
9.a	Referral, Coordination, and Monitoring – Non-Medicaid Services
9.b	Referral, Coordination, and Monitoring – Medicaid Services
10	General Administration
11	Not Paid / Not Worked

RMTS ACTIVITY CODE DESCRIPTIONS

CODE 1.a. OUTREACH – NON-MEDICAID

Use this code when performing activities that inform individuals about their eligibility for non-Medicaid social, vocational and educational programs (including special education) and how to access them; describing the range of benefits covered under these programs and how to obtain them. Both written and oral methods may be used. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples:

- Informing individual or family about wellness programs and how to access them.
- Scheduling and promoting activities that educate individuals about the benefits of healthy lifestyles and practices.
- Conducting general health education programs or campaigns that address life-style changes in the general population (e.g., dental hygiene, anti-smoking, alcohol reduction, etc.).
- Conducting outreach campaigns that encourage persons to access social, educational, legal or other services not covered by Medicaid.
- Distributing outreach materials regarding the benefits and availability of these programs.

CODE 1.b. OUTREACH – MEDICAID

Use this code when staff are performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access the program. Such activities include bringing potential eligible individuals into the Medicaid system for the purpose of the eligibility process. Both written and oral methods may be used. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples:

- Informing Medicaid eligible and potential Medicaid eligible individual or family about the benefits and availability of services provided by Medicaid (including preventive treatment, and screening).
- Assisting the Medicaid agency to fulfill the outreach objectives of the Medicaid program by informing individuals, students and their families about health resources available through the Medicaid program.
- Providing information regarding Medicaid managed care programs and health plans to individuals and families and how to access that system.
- Encouraging families to access medical/dental/mental health services provided by the Medicaid program.
- Providing information about Medicaid screening that will help identify medical conditions that can be diagnosed and treated early (e.g., dental, vision), before they become more serious and the treatment more costly.

- Helping individual or family use health resources, including their own talents and knowledge, effectively and efficiently.
- Developing and/or compiling materials to inform individual or family the Medicaid program and how and where to obtain those benefits. This activity should not be used when Medicaid-related materials are already available (such as through the Medicaid agency). As appropriate, developed outreach materials should have prior approval of the Medicaid agency.
- Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program.
- Informing individuals with disabilities about the availability of Medicaid services.
- Present information on medical services at health fairs.

CODE 2.a. ELIGIBILITY – NON-MEDICAID

Use this code when helping an individual to become eligible for non-Medicaid programs. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples:

- Explaining eligibility processes to prospective applicants for non-Medicaid programs such as DDSD State General Fund, In-Home and Family Support, Temporary Assistance for Needy Families (TANF), food stamps, Children's Health Insurance Program (CHIP), Women, Infants, and Children (WIC), Children with Special Health Care Needs (CSHCN), Chronically Ill and Disabled Children (CIDC), Free and Reduced Lunch Program, Head Start, and Low Energy Assistance Program (LEAP) for non-Medicaid eligibility.
- Developing and verifying initial and continuing eligibility for non-Medicaid programs.
- Assisting an applicant in completing the application for non-Medicaid programs.
- Assisting the individual or family collect/gather information and documents for the non-Medicaid program application.
- Assisting individuals to provide third party resource information at non- Medicaid eligibility intake.
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

CODE 2.b. ELIGIBILITY – MEDICAID

Use this code when assisting an individual in the Medicaid eligibility process. Include related paperwork, clerical activities, or staff travel required to perform these activities. This activity does not include the actual determination of Medicaid eligibility.

General examples:

- Verifying current Medicaid eligibility status.

- Explaining Medicaid eligibility rules and the Medicaid eligibility process.
- Referring individual or family to the local Assistance Office to make application for Medicaid benefits.
- Tracking referred clients/students to substantiate completion of the Medicaid application process and offering assistance.
- Assisting to complete a Medicaid eligibility application.
- Assisting in collecting/gathering required information and documents for the Medicaid application.
- Assisting to provide third party resource information at Medicaid eligibility intake.
- Participating as a Medicaid eligibility outreach outstation, but does not include determining eligibility.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.

CODE 3. EDUCATIONAL AND SOCIAL ACTIVITIES – NON-MEDICAID

Use this code when performing activity related to social services, educational services, employment services, job training, child care, housing and other services. Include any paperwork, clerical activities or staff travel required to perform these activities.

General examples:

- Providing referrals for services including:
    - Facilitating family support groups.
    - Family education services.
    - Parent support groups.
    - Career counseling.
    - Employment and job training.
    - Nutrition services.
    - Counseling.
    - Behavioral (discipline).
    - IHFS reports and administrative activities.

CODE 4. DIRECT MEDICAL SERVICES

Use this code when staff (employees or contracted staff) is providing direct medical services. This code includes pre and post activities associated with the actual delivery of the direct client medical services, e.g., paperwork or staff travel required to perform these services.

General examples:

- Medical screenings (including scoliosis), vision screenings, hearing screenings, dental screenings, and nurse consults.
- Administering first aid.
- Administering medication or providing immunizations.

- Individual and group psychotherapy.
- Individual and group counseling about issues of physical and mental health or substance abuse.
- Specialized rehabilitation services.
- Developmental assessments and diagnostic testing.
- Technical assistance which contribute to client advocacy and family empowerment.
- Direct clinical and treatment services:
    - Obtaining or reviewing medical history information.
    - Performing physical examinations.
    - Determining diagnosis.
    - Reviewing test results.
    - Referring for specialized medical services.
    - Dispensing medications or supplies.
    - Educating and counseling about management of medication routine.
- Time spent providing Rehabilitation Services other than crisis intervention services without authorization.

CODE 5.a. TRANSPORTATION – NON-MEDICAID

Use this code when assisting an individual to obtain transportation to services not 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 providing transportation.
Include related paperwork, clerical activities or staff travel required to perform these activities.

General examples:

- Making referrals for transportation for social, vocational, and/or educational programs and activities.

CODE 5.b. TRANSPORTATION – MEDICAID

Use this code when assisting an individual to obtain 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 providing transportation. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples:

- Scheduling or arranging transportation to Medicaid covered services.
    - Arranging for a taxi to the doctor.
    - Scheduling Medicaid transportation to the doctor.
    - Referrals to AAAs for transportation.

- Referrals to other transportation services.

CODE 6.a. TRANSLATION – NON-MEDICAID

Use this code when providing translation services for non-Medicaid activities. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples:

- Arranging for or providing translation services for the purpose to access and understand social, educational and vocational services.
- Arranging for or providing translation services including oral and signing services.
- Developing translation materials to assist in accessing and/or understanding social, educational and vocational services.

CODE 6.b. TRANSLATION – MEDICAID

Use this code when assisting to obtain translation services for the purpose of accessing Medicaid services. Include related paperwork, clerical activities, or staff travel required to perform these activities. Translation may be allowable as an administrative activity, but only if it not included and paid for as part of a direct medical service (which would be assigned Code 4 – Direct Medical Service).

General examples:

- Serving as a translator on how to access Medicaid services. This includes alternative languages, Braille, sign languages, and translation due to illiteracy.
- Arranging for or providing translation services (oral or signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid.

CODE 7.a. PROGRAM PLANNING, DEVELOPMENT, AND INTERAGENCY COORDINATION – NON-MEDICAL

Use this code when performing activities associated with developing strategies to improve the coordination and delivery of non-medical services. Non-medical services may include social services, educational services, vocational services, and state mandated health screenings. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples:

- Identifying gaps or duplication of non-medical services (e.g., social, vocational, educational and mandated general health care programs) to individuals and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of non-medical programs.

- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services. Note: the actual tracking of requests would be coded under code 9.
- Evaluating the need for non-medical services in relation to specific populations or geographic areas.
- Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical or social problems.
- Defining the scope of each agency's non-medical services in relation to other services.
- Developing non-medical referral sources.
- Coordinating with interagency committees to identify, promote and develop non-medical services.

CODE 7.b. PROGRAM PLANNING, DEVELOPMENT, AND INTERAGENCY COORDINATION – MEDICAL

Staff should use this code when performing activities associated with the development of strategies to improve the coordination and delivery of medical/dental/mental health services to clients and when performing collaborative activities with other agencies and/or providers. This code refers to quality management activities performed by staff such as monitoring the authorization for medical services (utilization review) process, ongoing program assessment and evaluation, and the development of standards and protocols. Include related paperwork, clerical activities or staff travel required to perform these activities.

General examples:

- Identifying gaps or duplication of medical/dental/mental services to individuals and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of medical/dental/mental health programs.
- Evaluating the need for medical/dental/mental services in relation to specific populations or geographic areas.
- Working with other agencies and/or providers that provide medical/dental/mental services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligible individual's, and to increase provider participation and improve provider relations.
- Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental problems.
- Defining the scope of each agency's Medicaid service in relation to other services.
- Working with Medicaid resources, such as the Medicaid agency and Medicaid managed care plans, to make good faith efforts to locate and develop health services referral relationships.
- Working with the Medicaid agency to identify, recruit and promote the enrollment of potential Medicaid providers.

- Developing medical referral sources such as directories of Medicaid providers and managed care plans that will provide services to targeted population groups.
- Coordinating with interagency committees to identify, promote and develop medical services to individuals with I/DD.
- Containing Medicaid costs and improving services to individuals with I/DD as part of program goals.
- Developing resource directories of Medicaid services.
- Working with other agencies providing Medicaid services to improve coordination and delivery of services, to expand access to specific populations of Medicaid eligible clients, and to improve collaboration around the early identification of medical problems.
- Focusing Medicaid services on specific populations based upon recent epidemiological data with the intent of reducing the need for long-term or more costly Medicaid services.
- Defining the scope of each agency's Medicaid service in relation to other services.
- Developing strategies to increase Medicaid system capacity and close Medicaid service gaps by in-depth analysis of Medical data related to a specific program or specific group.
- Interagency coordination to improve delivery of Medicaid services.
- Conduct periodic review of protocols.
- Perform peer reviews, medication management and monitoring, and monitoring of the service authorization and re-authorization process,
- Schedule, coordinate, and conduct medical chart or case reviews for adequacy of assessment, documentation, and appropriate intervention.
- Assess and review the capacity of the agency and its providers to deliver medically appropriate health assessments, preventive health services and medical care, and respond to appeals on medical quality of care issues.

CODE 8.a. TRAINING – NON-MEDICAL/NON-MEDICAID RELATED

Use this code when coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefit of the programs other than the Medicaid program. For example, training may include how to assist families to access the services of education programs, WIC, housing, and how to more effectively refer clients/students for those services. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples:

- Participating in or coordinating training that improves the delivery of services for programs other than Medicaid.
- Participating in or coordinating training that improves relationships between and among local agencies.
- Training regarding non-medical social service issues.
- Training regarding educational issues.

CODE 8.b. TRAINING – MEDICAL/MEDICAID RELATED

Use this code when staff are coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefits of medical/Medicaid related services, how to assist families to access such services, and how to more effectively refer clients/students for services. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples:

- Participating in or coordinating training that improves the delivery of medical/Medicaid related services.
- Coordinating training to assist families to access Medicaid services.
- Participating in training for outreach and eligibility assistance.
- Outreach workers being trained on the provision of direct services so that they can inform potential service recipients.
- Participating in or presenting training that improves the quality of identification, referral, treatment and care of individuals with I/DD, e.g., talking to new staff about the DDSD referral process or available DDSD and health- related services.

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

Use this code when making referrals for coordinating and/or monitoring the delivery of non-medical services. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples:

- Screening and making referrals for, and coordinating access to, social and educational services such as employment, job training, and housing.
-
- Making referrals for, coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.
- Gathering any information that may be required in advance of these non- Medicaid related referrals.
- Follow up monitoring with a client referred to a homeless shelter.

CODE 9.b. REFERRAL, COORDINATION, AND MONITORING – MEDICAID SERVICES

Use this code when making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. This code is used when staff are participating in medical reviews, and assessing the necessity for and types of, medical care associated with medical case management and case coordination activities required by Medicaid individuals. The activity is not conducted as part of a standard medical examination or

consultation and is not a direct service. Include related paperwork, clerical activities, or staff travel necessary to perform these activities.

General examples:

- Making referrals for and/or coordinating medical or physical examinations and necessary medical/mental health evaluations.
- Making referrals for and/or coordinating dental examinations
- Making or arranging for any Medicaid covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition.
- Referring clients/students for necessary medical health, mental health, or substance abuse services covered by Medicaid.
- Gathering any information that may be required in advance of medical/dental/mental health referrals.
- Participating in a meeting/discussion to coordinate or review needs for health-related services covered by Medicaid.
- Providing follow-up contact to provide feedback whether further treatment or modification of existing treatment are required.
- Coordinating the delivery of community based medical/dental/mental health services for an individual with special/severe health care needs.
- Coordinating the completion of the prescribed services, termination of services, and referral to other Medicaid service providers as may be required to provide continuity of care.
- Providing information to other staff on the related medical/dental/mental health services and plans.
- Coordinating medical/dental/mental health service provision with managed care plans as appropriate.
- Making referrals for and/or coordinating dental evaluations that are not the result of an appointment with a dentist.
- Using medical expertise in providing information to other personnel or health care providers on the individual's medical services and plans.
- Gathering and/or reviewing medical-based information in advance of referrals to or evaluations with other medically trained professionals.
- Participating in inter/intra-agency meetings to coordinate or review a need for Medicaid covered services.
- Providing follow-up contact to ensure the prescribed services were received.
- Coordinating the completion of medical services to ensure the services are provided according to standard medical protocol and evidence-based practices.
- Using medical expertise in ensuring continuity of care between providers of medical services.
- Linking individuals with mental illness to crisis intervention.

CODE 10. GENERAL ADMINISTRATION

Use this code when engaged in general administration activities or performing activities that are not directly assignable to program activities. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples:

- Taking paid lunch, breaks, leave, or other paid time not at work.
- Providing general supervision of staff and evaluation of employee performance, including licensure supervision.
- Processing employee payroll and other employee-related forms.
- Developing budgets and maintaining records.
- Maintaining inventories and ordering supplies.
- Establishing goals and objectives of programs as part of the agencies annual or multi-year plan.
- Reviewing procedures and rules.
- Attending or facilitating staff meetings, staff training, or board meetings.
- Performing administrative or clerical activities related to general functions or operations.
- Providing general supervision of staff, including supervision of student teachers or classroom volunteers, interns and evaluation of employee performance.
- Performing general administrative and/or clerical activities related to central or regional office functions or operations.
- Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

CODE 11. NOT PAID / NOT WORKED

Non-worked/non-paid time is time for which a participant in the time study is not working AND is not being compensated.

General examples:

- Staff member takes an unpaid day off during the sampled moment
- Non-paid sick time
- Non-paid leaves of absence
- No longer employed by the program

ADMINISTRATIVE CLAIMING COST ALLOCATION AND METHODOLOGY

Overview

The federal government permits state Medicaid agencies to claim reimbursement for activities performed that are necessary for the "proper and efficient administration" of the State Medicaid Plan. Historically, CMS has provided some latitude to states in determining the kinds of activities for which they may seek reimbursement. CMS has identified a series of activities, such as outreach, utilization review, eligibility determination, and activities which determine an individual's need for care, that are entitled to be claimed through the MAC program.

The cost allocation methodology and financial data used for the Medicaid administrative claiming program are consistent with the requirements of **OMB Uniform** Guidance at 2 CFR part 200, subpart E and appendices V and VII and generally accepted accounting standards.

ALTSD will submit quarterly claims to HSD. These claims will be based on the quarterly costs, the time study, the Medicaid eligibility rate, and the FFP.

The Elements of the Claim

The claim submitted to the state for reimbursement has several elements: eligible costs, revenue offset, Medicaid percentage, allowable Medicaid administrative time, and federal financial participation (FFP). The following describes each:

1. Total Costs

Total costs are determined based on a calculation of direct personnel costs, direct support costs, allocated costs, indirect costs, and revenue offsets as described below.

A. Direct Personnel Costs

Direct personnel costs include salaries, wages, fringe benefits, contracted personnel payments for those staff included on the Participant List. Restricted federal funding must be deducted from the actual expenses; only state and local funding is included in calculating the claim. Employees whose positions are 100 percent federally funded must be excluded from time studies and cannot participate in the MAC program. Employees whose salaries are supported with partial federal funding are allowed to participate in the time study and MAC program, but the federally funded portion of their salary should be excluded when calculating the claim.

B. Direct Support Costs

General administrative personnel costs for staff that support the agency as a whole

will be included in the MAC Claim. These costs will be allocated across the staff pool based on HSD's approved allocation methodology. The allocation method used will ensure non duplication of costs at the agency.

C. Allocated Costs

Agency-wide costs that cannot be easily identified at the participant level such as audit, bonding, legal, maintenance, materials and supplies, professional services, rental, taxes, and travel and training costs. These costs will be allocated across the staff pool based on HSD's approved allocation methodology.

2. Offset of Federal Revenues

The cost pool to be allocated is prohibited from containing federal funds, and from including any non-federal fund base that is already matched for federal funds through another claiming channel.

Funding Sources
Claims for approved Title XIX administrative functions may not include expenditures of:

- Federal funds received by the agency directly.
- Federal funds that have been passed through a State or local agency (e.g., outreach funding).
- Non-federal funds that have been committed as local match for other federal or State funds or programs.

Payments to Third Party Contractors
Expenditures that are paid to third-party contractors by the participating agencies for the help and administration of the MAC program are not allowable as costs for administrative claiming reimbursement.

3. Medicaid Eligibility Rate (MER)

Another factor required to determine the amount of the claim is the Medicaid percentage, sometimes referred to as the Medicaid Eligibility Rate (MER). The Medicaid percentage is determined based on the total unduplicated Medicaid client/student count for the quarter divided by the total unduplicated client/student count for the quarter. Some programs support a one hundred percent population of Medicaid recipients where a MER calculation is not required. Included below is the methodology utilized for the MER calculation for programs that do not support a one hundred percent population of Medicaid recipients.

This methodology is most commonly used in agencies or programs that collect fairly specific data on the client population. The Medicaid percentage is a fraction, the numerator of which consists of all persons in the agency's or program's caseload or

service population who are actual Medicaid recipients. The denominator of the fraction is the total number of persons served by the agency or program during the claim period minus the Medicaid pending clients. The resulting fraction, or percentage of Medicaid recipients in the caseload, should be as current to the quarter of the claim as possible. Where this is not feasible, the nearest possible determination should be made.

The calculation is based on individuals (an unduplicated count), where the formula would be as follows:

Unduplicated list of Medicaid clients divided by the unduplicated total list of clients in the program:

$$\frac{\text{Total unduplicated Medicaid client count for the quarter}}{\text{Total unduplicated client count for the quarter}}$$

= Medicaid Percentage for the quarter

4. Allowable Medicaid Administrative Time

The time study activity codes assist in the determination of time and associated costs that are related to and reimbursable through Medicaid. The time study activity codes have been designed to reflect all of the activities performed by time study participants per agency. Time study activity codes can be found in the Time Study Activity Codes and Descriptions section of this guide.

The time study activity codes are assigned indicators that determine its allowability, federal financial participation (FFP) rate, and Medicaid share. An activity code may have one or more indicators associated with it.

The time study activity code indicators are:

Application of FFP rate	50 or 75 percent	Refers to an activity that is allowable as administration through Medicaid and claimable at the 50 or 75 percent FFP rate.
Allowability & Application of Medicaid Share	U	Unallowable – refers to an activity that is unallowable as administration through Medicaid. This is regardless of whether or not the population served includes Medicaid eligible individuals.
	TM	Total Medicaid – refers to an activity that is allowable under Medicaid as administration but for which the costs are not limited to the proportion of Medicaid eligible population served.
	PM	Proportional Medicaid – refers to an activity, which is allowable as Medicaid administration under Medicaid, but for which the costs are limited to the proportion if Medicaid eligible population served.
	R	Reallocated – refers to those general administrative activities which must be reallocated across the other activity codes on

		a pro rata basis. These reallocated activities are reported under Code 10, General Administration.

Included below is a chart displaying the reimbursement rate for each activity code and whether the application of Total or Proportional Medicaid reimbursement.

Code	Activity	Medicaid Share Indicators
1.a	Outreach - Non-Medicaid (All Staff)	U
1.b	Outreach - Medicaid	TM (50%)
2.a	Eligibility - Facilitating Non-Medicaid (All Staff)	U
2.b	Eligibility - Facilitating Medicaid (All Staff)	TM (50%)
3	Other Non-Medicaid/Educational & Social Services	U
4	Direct Medical Services	U
5.a	Transportation Non-Medicaid (All Staff)	U
5.b	Transportation Medicaid (All Staff)	PM (50%)
6.a	Translation Non-Medicaid	U
6.b	Translation Medicaid	PM (75%)
7.a.	Program Planning, Development and Interagency Coordination Non-Medical (All Staff)	U
7.b.	Program Planning, Development and Interagency Coordination Medical	PM (50%)
8.a	Non-Medical/Non-Medicaid related Training	U
8.b	Medical/Medicaid related Training	PM (50%)
9.a.	Referral, Coordination, and Monitoring Non-Medicaid Services (All Staff)	U
9.b.	Referral, Coordination, and Monitoring Medicaid Services	PM (50%)
10	General Administration	R
11	Not Paid/Not Worked	U

5. Federal Financial Participation (FFP) Rate

Costs incurred for the quarter being claimed are multiplied by the results of the time study to arrive at the allowable claimable costs. These costs are then multiplied at either 50 percent or 75 percent FFP to determine the amount of the federal allowable portion to be reimbursed.

To calculate the claim, the agency must:

1. Assemble the total costs based on the eligible costs (direct, direct support, indirect, and allocated) from which exclusions have been subtracted, as defined in the sections above;
2. Allocate the costs based on the quarterly time study results described in the Time Study Activity Codes and Descriptions section. Only time assigned to allowable time study codes can be allocated to Medicaid administration. Time assigned to the Total Medicaid (TM) codes are reimbursed at the FFP rate of 50 percent or 75 percent;
3. Calculate the claim by applying the time study results; Medicaid eligibility percentage, as described above; and total costs for final claim amounts; and
4. Maintain a separate documentation file for each quarter billed, as discussed in the Recordkeeping, Documentation and Audit/Reviews section.

Claim Calculation Example

Participant staff costs (Direct & Allocated)	multiplied by
Percent of time claimable to Medicaid administration	multiplied by
Medicaid percentage (the percentage of Medicaid eligible individuals in the service population)	plus
Subtotal	multiplied by
Percent of FFP (50% for some costs and 75% for other costs)	equals

Claim Submission

Participating agencies are responsible for submitting administrative claims in accordance with these guidelines:

1. All staff involved in the preparation and certification of administrative claims must attend HSD sponsored training sessions concerning regulations, policies and procedures, the provision of Medicaid-reimbursable services and the preparation and submission of claims.

2. All administrative claims must be prepared and submitted following HSD requirements, in accordance with federal and state Medicaid regulations, policies and guidelines, and any federal and state revisions thereto. Agencies are required to maintain documentation that appropriately identifies the certified funds used for MAC claiming. The documentation must also clearly illustrate that the funds used for certification have not been used to match other federal funds. Failure to appropriately document the certified funds could result in non-payment of claims.

3. Claims must be accurate and complete when submitted for payment, prior to submission of the claim to HSD. Agencies will only be reimbursed the federal share of any MAC claims billed. An authorized individual designated as the financial contact will be required to certify the accuracy of the submitted claim. The certification statement will be included as part of the invoice and will meet the requirements of 45 CFR parts 74 and 95.

RECORD KEEPING, DOCUMENTATION AND AUDITS/REVIEWS

Agencies that submit administrative claims must maintain separate files of all documentation used to construct claims for each quarter billed. Required documents include:

1. The accounting information upon which the cost share is based, plus the basis for any inclusion or exclusion where costs were added or subtracted from the accounting system's totals to compile the cost pool;
2. A list of all revenues that were offset, according to source, when calculating the claim;
3. Rationale and calculations used to determine the percentage of the population that represents Medicaid recipients if applicable;
4. Original time study documentation, including sample pool participants, by function, title, name, location, and coding;
5. The completed quarterly claim; and
6. A copy of the warrant and remittance advice.

These documents, along with any other supporting information used to substantiate the claim, must be maintained for a minimum period of six years. Program coordinators at participating agencies must ensure that files are current, complete, accessible and secure.

To ensure that participating agencies understand the program and have in place the requisite guidelines and procedures for program administration, HSD staff will institute three key methods of monitoring and oversight, to include:

1. State level desk audits will be conducted of the quarterly administrative claims that are submitted. These audits will be conducted on a 2-year cycle with one (1) claim per agency reviewed every two (2) years. This will be comprised of a review of the agency's calculation and supporting documentation, and a determination of the appropriateness of the claim and whether the formula was applied correctly.

2. Trends will be identified by HSD staff based on day-to-day telephone calls and e-mail inquiries from participating agencies. Follow-up trainings will be tailored to correspond with these trends, and technical assistance will be provided as needed. HSD staff will also use trends apparent from official grievances and appeals to coordinate trainings and direct the focus of on-site visits.

3. HSD staff will maintain open lines of communication and a willingness to resolve problems, address issues and concerns and provide technical assistance, as indicated.

In addition, HSD staff will provide monitoring and oversight to the statewide contractor to include:

1. HSD will review and approve all training material and program documentation completed by the contractor.

2. HSD will review and approve all categories of staff used in the program, prior to implementation by the contractor.

3. HSD will review and approve the time study methodology prior to implementation by the contractor. This review will include approval of time study questions, time study response format, and related process requirements.

4. HSD will provide training to the contractor's central coding staff upon implementation, and on an as needed basis. Training will discuss issues regarding the coding of moments. Training will include an overview of activity codes, samples of activities, appropriate processes for making coding determinations, program updates, process modifications, and compliance issues.

5. HSD and ALTSD will review a sample of coded moments each quarter to ensure that coding is consistent and accurate across the sample. HSD will provide feedback to the contractor if any modifications are necessary as a result of this review.

6. HSD will review and approve the financial reporting process and template prior to the implementation by the contractor.

7. HSD will review and approve the appropriate claim template with the contractor prior to implementation. HSD will review claims prior to payment, to include the appropriate inclusion of unrestricted indirect cost rates, Medicaid eligibility rates and expenditures.

The measures for monitoring and oversight listed above are designed to ensure that participating agencies comply with program guidelines, policies and regulations. However, in the instance when a participating agency is found through a desk or onsite audit or other means of oversight to be out of compliance, the following principles and guidelines shall apply:

1. The claim for the quarter may be recalculated by HSD or its contractor, based on the audit, and approved for payment;

2. The claim for the quarter may be denied;

3. The agency may be required to submit a Corrective Action Plan to HSD within 30 working days to remedy the noncompliance issue;

4. If indicated, funds owed may be recouped from the agency.

5. In all cases, the agency has the option to appeal through the HSD administrative hearing process pursuant to the Medicaid provider hearing regulations.

6. If indicated, the agency may be terminated from participation in the MAC program.

CONCLUSION

This plan is reflective of extensive collaboration between HSD, ALTSD and many of New Mexico's sister agencies, and is the product of numerous discussions that have taken place since 2019. This collaborative approach has proven essential; not only as a means of strengthening both interagency and state relationships, but also for informing and guiding decision-making about the Medicaid Administrative Claiming program's optimal organizational structure, needed policy revisions, areas in need of clarity and overall operations.

APPENDIX A – COPY OF GSA