New Mexico Children, Youth and Families Department

Behavioral Health Services, Juvenile Justice and Protective Services

Time Study and Medicaid Administrative Claiming Guide

January 1, 2023

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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 Children, Youth and Families Department (CYFD), Behavioral Health, Juvenile Justice, and Protective Services Programs as summarized herein. CYFD 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 CYFD 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 CYFD enter into multiple agreements for CYFD 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 CYFD 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 CYFD's functions under the agreements, CYFD 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 Children, Youth and Families Department became a Cabinet Department effective July 1, 1992. Substantial modifications to CYFD occurred on July 1, 1993, that increased CYFD's responsibilities and scope. These modifications involved the movement of various segments from other cabinet departments to consolidate the focus on children, youth and families into one department.

CYFD is dedicated to enhancing the safety, dignity and well-being of children, youth and families in New Mexico. CYFD protects children from abuse and neglect. CYFD operates the juvenile corrections' system; and CYFD seeks to prevent abuse, reduce juvenile crime, rehabilitate juvenile offenders and support healthy families. CYFD is the behavioral health authority for all children in New Mexico.

Behavioral Health Services Division

CYFD is the behavioral health authority for all children in New Mexico. BHS is the lead on children's behavioral health policy in collaboration with other State Agencies to include the Human Services Department (HSD), Department of Health (DOH), Public Education Department (PED), Early Childhood Education and Care Department (ECECD), and the Behavioral Health Collaborative (BHC). BHS staff provide technical assistance and consultation with providers and other CYFD colleagues serving children and youth who are:

- At-risk of CYFD custody
- Involved with CYFD
- Post-CYFD involvement
- Never involved with CYFD

Statewide, Behavioral Health Services efforts to improve the quality of life for children, youth and families include the following:

Community Behavioral Health Clinicians (CBHC):

- Provides additional clinical consultation to team members of CYFD involved children to decrease out-of-home placements
- Improves access to trauma responsive community behavioral health services and supports

Program & Finance:

- Program development and implementation of NM children's behavioral health service array
- Managers and staff work on programs and services that are funded in part through federal grants that support the startup of services that are then sustainable via Medicaid billing or other funding sources
- Provides support with administrative, quality management and financial oversight

Licensing & Certification Authority (LCA) Bureau:

- Supports children's behavioral health facilities to provide best practice trauma responsive care
- Monitors programming relating to health and safety of children

The LCA Bureau certifies compliance with state and federal regulations for an array of six children/youth Medicaid behavioral health services operated by in-state Medicaid providers. The LCA's certification reviews assess compliance with active treatment, quality of care, monitoring of trauma-responsive care, health and safety, personnel requirements, and other service delivery regulatory standards. The LCA licenses Medicaid facility-based providers as well as non-Medicaid Children's Crisis Shelters operating in New Mexico. The LCA also supports the development of additional services as identified by Behavioral

Health Services.

Types of Facilities the LCA Regulates:

- Accredited Residential Treatment Centers (ARTC)
- Non-accredited Residential Treatment Centers (RTC)
- Group Home Services (GHS)
- Treatment Foster Care Services (TFC)
- Day Treatment Services (DTS)
- Behavioral Management Services (BMS)
- Community Shelters
- Multi-Service Homes
- New or Innovative Programs

Juvenile Justice Services Division

The mission of Juvenile Justice Services (JJS) is to provide qualitative rehabilitative services and treatment for delinquent and at-risk juveniles in the least restrictive environment. JJS is committed to improving public safety and reducing juveniles' delinquent behavior in the State of New Mexico. To accomplish this mission, JJS must provide responsive, coordinated and cost-effective services to juveniles committed to CYFD custody. The services and activities are based on objective, measurable, well-defined criteria and are client and family focused and built on existing strengths.

JJS encompasses 7 specialized facilities and is responsible for monitoring and certification of all juvenile detention centers in the State of New Mexico. Staff that are located in the Secure Facilities will not participate in the MAC Program.

Probation and Aftercare integrates community-based probation and parole services with community-based transition, behavioral health, and other prevention and intervention services.

Probation and Aftercare plans, directs, coordinates and provides comprehensive and integrated services to children and youth by providing child abuse and neglect prevention services, opportunities to serve communities and by intervening with at-risk children to prevent further problems and maximizing the overall health and stability of children and their families. Services emphasize prevention and early intervention in probation services, aftercare and transition in parole services.

Protective Services Division

The Protective Services (PS) program area is responsible for the protection and well-being of children and is a federally designated state child welfare agency. PS provides child protective and child welfare services to children and families within the State. Child protective and child welfare services are provided through over 30 county offices with more than 800 employees. PS is responsible for administering the State's child abuse and neglect reporting hotline, and public foster care system, providing voluntary in-home

services to at risk children and their families to prevent children coming into foster care, licensing private child placement agencies, providing adoption and guardianship services, providing services to youth aging out of foster care, monitoring all public and private adoptions, administering interstate compact programs and reporting on an array of Federal grants related to child welfare.

The PS field offices respond to all allegations of child maltreatment and work to protect children from abuse and neglect. Services in the field offices include:

- Child Protective Services (CPS) Investigations
- Substitute care of children
- Voluntary In-home Services
- Adoption Services
- Youth Services
- Placement Services
- CPS Legal Services

PS maintains a 24-hour State Centralized Intake Unit, which is the first line for report and referral of possible cases of abuse and neglect. PS also develops policies and procedures for protective services workers as guidelines for protecting children. PS provides and tracks foster care and adoption services for children needing placement and supports those youth that are transitioning from foster care to adulthood and independent living. PS is responsible for administering the Federal and state funds used to provide services to and/or support maltreated children.

This MAC guide is specific for the CYFD Behavioral Health, Juvenile Justice and Protective Services.

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 CYFD 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 CYFD 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 Children, Youth and Families Department (CYFD) must first enter into a contract with the New Mexico HSD. The agreement between the CYFD 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 JPA #95-17 A1 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 January 1, 2023. 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 a minimum of 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 two separate staff pools 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. These pools 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

For the Juvenile Justice and Behavioral Health Divisions that will only be claiming for Medicaid Administrative Activities, the following sampling methodology will be applied:

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:

Correction for Finite Population

$$ss = \frac{Z2 \ * (p) * (1-p)}{c2} \qquad \text{new ss} = \frac{ss}{1+\frac{ss-1}{pop}}$$

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.).

The Protective Services Division of CYFD will be time studied separately from the Juvenile Justice and Behavioral Health populations due to the Title IV-E activities uniquely performed by their division. As a result, this population will utilize the same time study to allocate time spent for both Medicaid Administrative and Title IV-E activities which requires a higher level of precision at +/- 2% (two percent) with a 95% (ninety-five percent) confidence level for activities:

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

where:

Z = Z value (e.g. 1.96 for 95% confidence level)
p = percentage picking a choice, expressed as decimal (.5 used for sample size needed)
c = confidence interval, expressed as decimal (e.g., .02 = ±2)

Correction for Finite Population

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

The following table shows the sample sizes necessary to assure statistical validity at a 95% confidence level and tolerable error level of 2%. Additional moments will be selected to account for unusable moments, as previously defined. An oversample of a minimum of 15% will be used to account for unusable moments.

N=	Sample Size Required	Sample Size plus 15% Oversample
100,000	2345	2697
200,000	2373	2729
300,000	2382	2739
400,000	2387	2845
500,000	2390	2849
750,000	2393	2852
1,000,000	2395	2854
3,000,000	2399	2859
>3,839,197	2401	2860

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 respective 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.

   Skilled Professional Medical Personnel

   The Participant List will also delineate those positions that are Skilled Professional Medical Personnel (SPMP) versus non-SPMP staff. The SPMP designation allows for an enhanced Federal Financial Participation (FFP) rate of 75% for a state's Medicaid costs for the compensation, travel and training of skilled medical professionals. For example, SPMP personnel may include “physicians, dentists, nurses and other specialized personnel who have professional education and training in the field of medical care or appropriate medical practice and who are in an employer-personnel relationship with the Medicaid agency.” Contracted staff are not eligible to claim reimbursement at the enhanced rate of SPMP. Additional detail regarding SPMP is included in Appendix B.

   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 pools 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

Two staff pools will be used. Separate time studies will be conducted for each staff pool. The time studies will be mutually exclusive meaning that no staff will be included in more than one staff pool.

Staff Pool 1

- Comprised of staff that are qualified skilled professional medical personnel (SPMP) who 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:
  - Clinical Psychologist – SPMP
  - Licensed Counselor – SPMP
  - Licensed Medical Personnel – SPMP
  - Licensed Social Worker – SPMP
  - Physician – SPMP
  - Registered Nurse – SPMP

Staff Pool 2

- Comprised of staff that participate in administrative activities only as part of their regular duties and on a regular basis but do not meet the qualifications to be listed as SPMP.

  Participants in this pool may include:
  - Adolescent Substance Abuse Reduction Effort (ASURE) Staff
  - Client Service Agent
  - Domestic Violence Staff
  - Eligibility Specialist
  - Family Engagement Lead
  - In-Home Services Worker
  - Investigator
  - Juvenile Probation Parole Officer
  - Permanency Planning Worker

    - Placement Specialist
    - Placement Worker
    - Program Administrator
    - Reintegration Staff
    - Statewide Youth Coordinator
    - Unlicensed Infant Mental Health Staff
    - Unlicensed Social Worker
    - Wraparound 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.

   At a minimum, 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?
     - If the sampled participant is a SPMP, they will be asked a follow-up question asking: "Could only someone with your skilled professional medical knowledge and training complete this activity?" (Yes or No)

   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 an 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 – Non SPMP
1.c	Outreach – Medicaid – SPMP Only
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 – Non SPMP
7.c	Program Planning, Development and Interagency Coordination – Medical – SPMP Only
8.a	Training – Non-Medical / Non-Medicaid Related
8.b	Training – Medical / Medicaid Related – Non SPMP
8.c	Training – Medical / Medicaid Related – SPMP Only
9.a	Referral, Coordination, and Monitoring – Non-Medicaid Services
9.b	Referral, Coordination, and Monitoring – Medicaid Services – Non SPMP
9.c	Referral, Coordination, and Monitoring – Medicaid Services – SPMP Only
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.
- Informing individual or family about CYFD services and supports.
- Informing individual or family about disability related supports and services.
- 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.
- Assisting in early identification of children with special medical/dental/mental health needs through various IDEA child-find activities (e.g. screening and evaluation designed to locate, identify, and refer as early as possible young children with disabilities and/or who are at risk for developmental delay that are in need of early intervention).
- Developing outreach materials such as brochures or handbooks for these programs.
- Distributing outreach materials regarding the benefits and availability of these programs.

CODE 1.b. OUTREACH – MEDICAID – **Non SPMP**

Use this code when non SPMP 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 1.c. OUTREACH – MEDICAID – **SPMP Only**

This code is used only by staff who are Skilled Professional Medical Personnel and only when skilled professional medical knowledge is required to identify medically at-risk individuals and persuade recipients or potential recipients to enter care through the Medicaid system. Include related paperwork or staff travel required to perform these activities. Outreach campaigns directed to the entire population to encourage potential Medicaid eligible individuals to apply for Medicaid are allowable, and the costs do not have to be discounted by the Medicaid percentage. Use this code when SPMP 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.

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, 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.
- A nurse speaking at a community function about early detection of health problems.
- A psychologist talking to a parenting group about mental illness and signs to look for in adolescents.

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 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.
- A mental health worker assisting an individual enroll in literacy classes.
- A family support or information specialist providing information/support for an

individual or family to access non-Medicaid services.

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, childcare, housing and other services. Include any paperwork, clerical activities or staff travel required to perform these activities.

General examples:

- Participating in or presenting training relating to job searches.
- Facilitating family support groups.
- Family education services.
- Parent support groups.
- Career counseling.
- Employment and job training.
- Nutrition services.
- Behavioral (discipline).
- IHFS reports and administrative activities.
- Appearing in court on behalf of consumer trying to maintain custody of her children.

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, EPSDT 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.
- Targeted case management activities
- Specialized rehabilitation services.
- Developmental assessments and diagnostic testing.
- Parental skills training and counseling.
- 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:

- Scheduling or arranging transportation for social, vocational, and/or educational programs and activities.

- Accompanying the client to services not covered by Medicaid.

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.

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:

- Accompanying an individual/family to the physician's office to translate from Spanish to English medically related information between the MD and the individual.
- 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.
- Developing translation materials that assist to access and understand necessary care or treatment covered by Medicaid.
- Developing and translating training or other materials/courses to for Medicaid providers who serve Medicaid clients in their native language.

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.
- Monitoring the non-medical delivery systems.
- 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.
- Analyzing non-medical data related to a specific program, population, or geographic area.
- 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 advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services and state-mandated health screenings.
- Developing non-medical referral sources.
- Coordinating with intra-agency/inter-agency committees to identify, promote and develop non-medical services.

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

Non-SPMP 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 Non-SPMP 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.
- Monitoring the medical/dental/mental health delivery systems.
- Developing procedures for tracking families' requests for assistance with medical/dental/mental services and providers, including Medicaid.
- Evaluating the need for medical/dental/mental services in relation to specific populations or geographic areas.
- Analyzing Medicaid data related to a specific program, population, or geographic area.
- Working with other agencies and/or providers that provide medical/dental/mental health 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 health problems.
- Developing strategies to assess or increase the cost effectiveness of medical/dental/mental health programs.
- 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.
- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services.
- 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 intra-agency/inter-agency 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.
- Developing training materials to improve the quality of care provided to Medicaid clients.
- Intra-agency/inter-agency coordination to improve delivery of Medicaid services.
- A group of local physicians working together to develop a triage and referral instrument that will be used throughout the service area to reduce inappropriate referrals and intake redundancy for Medicaid funded services (e.g., physical health, mental health).
- 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.
- Evaluate the need for new modalities of medical treatment and care.

CODE 7.c. PROGRAM PLANNING, DEVELOPMENT, AND INTERAGENCY COORDINATION – MEDICAL – **SPMP Only**

SPMP 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/students, and when performing collaborative activities with other agencies and/or providers. This code refers to quality management activities performed by SPMP 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.
- Monitoring the medical/dental/mental health delivery systems.
- Developing procedures for tracking families' requests for assistance with medical/dental/mental services and providers, including Medicaid.

- Evaluating the need for medical/dental/mental services in relation to specific populations or geographic areas.
- Analyzing Medicaid data related to a specific program, population, or geographic area.
- 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 individuals, 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.
- Developing strategies to assess or increase the cost effectiveness of medical/dental/mental health programs.
- 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.
- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services.
- 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 intra-agency/inter-agency 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.
- Intra-agency/Inter-agency coordination to improve delivery of Medicaid services.
- A group of local physicians working together to develop a triage and referral instrument that will be used throughout the service area to reduce inappropriate referrals and intake redundancy for Medicaid funded services (e.g., physical health, mental health).
- Developing training materials to improve the quality of care provided to Medicaid clients.

- 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.
- Evaluate the need for new modalities of medical treatment and care.

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.
- Participation in training to improve computer skills for data collection
- Training regarding non-medical social service issues.
- Training regarding educational issues.

CODE 8.b. TRAINING – MEDICAL/MEDICAID RELATED – **Non SPMP**

Use this code when non SPMP 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.
- Participating in or coordinating training that enhances early identification, intervention, screening, and referral of students with special health needs to such services (e.g., Medicaid EPSDT 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 coordinating training that improves the medical knowledge and skills of medical personnel.
- Conducting seminars and presentations to parents, community members, teachers on:
  - Identification of physical disabilities and other medical conditions that can be corrected or ameliorated by services covered through Medicaid.
  - Providing training on where and how to seek assistance through the Medicaid system.

CODE 8.c. TRAINING – MEDICAL/MEDICAID RELATED – **SPMP Only**

Use this code when SPMP is 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.
- Participating in or coordinating training that enhances early identification, intervention, screening and referral of students with special health needs to such services (e.g., Medicaid EPSDT 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 coordinating training that improves the medical knowledge and skills of medical personnel.
- Conducting seminars and presentations to parents, community members, teachers on:
  - Identification of physical disabilities and other medical conditions that can be corrected or ameliorated by services covered through Medicaid.
  - Providing training on where and how to seek assistance through the Medicaid system.

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/or monitoring the delivery of mandated health screens (e.g., vision, hearing, scoliosis).
- 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.
- Participating in a meeting/discussion to coordinate or review a need for scholastic, vocational, and non-health related services not covered by Medicaid.
- Monitoring and evaluating the non-medical components of the individualized plan as appropriate.
- Follow up monitoring with a client referred to a homeless shelter.
- A non-mental retardation service coordinator transitioning an individual from a state hospital to the community.
- Screening or making referrals for childcare, housing, or employment/job training services.

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

Use this code when making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. This code is used when Non-SPMP 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 referrals for and/or scheduling EPSDT screens, inter-periodic screens, and appropriate immunizations.
- Making or arranging for any Medicaid covered long-term care, 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 developmental, long-term care, 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.
- Following-up to ensure the prescribed medical/dental/mental health 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.
- Monitoring and evaluating the Medicaid service components of the IEP as appropriate.
- Coordinating medical/dental/mental health service provision with managed care plans as appropriate.
- Making referrals for and/or coordinating medical evaluations that are not delegated by a physician.
- Making referrals for and/or coordinating dental evaluations that are not the result of an appointment with a dentist.
- Providing information about, making referrals for, and/or scheduling health screens, exception to periodicity screens and appropriate immunizations for individuals who are not on schedule and/or who have special needs or health problems.
- 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.
- Writing the Determination of Mental Retardation (DMR) report.
- Initial treatment planning for an individual prior to the determination of eligibility for mental retardation service coordination.

CODE 9.c. REFERRAL, COORDINATION, AND MONITORING – MEDICAID SERVICES – **SPMP Only**

Use this code when making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. This code is used when SPMP 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 referrals for and/or scheduling EPSDT screens, inter-periodic screens, and appropriate immunizations.
- Making or arranging for any Medicaid covered developmental, long-term care, 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 developmental, long-term care, medical/dental/mental health referrals.
- Participating in a meeting/discussion to coordinate or review needs for health-related services covered by Medicaid.
- Following-up to ensure the prescribed developmental, long-term care, medical/dental/mental health 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.
- Monitoring and evaluating the Medicaid service components of the IEP as appropriate.
- Coordinating medical/dental/mental health service provision with managed care plans as appropriate.
- Making referrals for and/or coordinating medical evaluations that are not delegated by a physician.
- Making referrals for and/or coordinating dental evaluations that are not the result of an appointment with a dentist.

- Providing information about, making referrals for, and/or scheduling health screens, exception to periodicity screens and appropriate immunizations for individuals who are not on schedule and/or who have special needs or health problems.
- 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.
- Writing the Determination of Mental Retardation (DMR) report.
- Initial treatment planning for an individual prior to the determination of eligibility for mental retardation service coordination.

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.
- Reviewing technical literature and research articles.
- 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.
- Activities related to conducting a Death/Mortality Review.

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:

- Part-time/contracted staff whose sampled moment occurs during non- scheduled work hours
- 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.

CYFD 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, 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 applicable 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 applicable 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 (Non SPMP)	TM (50%)
1.c	Outreach - Medicaid (SPMP Only)	TM (75%)
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 (Non SPMP)	PM (50%)
7.c.	Program Planning, Development and Interagency Coordination Medical (SPMP Only)	PM (75%)
8.a	Non-Medical/Non-Medicaid related Training	U
8.b	Medical/Medicaid related Training (Non SPMP)	PM (50%)
8.c.	Medical/Medicaid related Training (SPMP Only)	PM (75%)
9.a.	Referral, Coordination, and Monitoring Non-Medicaid Services (All Staff)	U
9.b.	Referral, Coordination, and Monitoring Medicaid Services (Non SPMP)	PM (50%)
9.c.	Referral, Coordination, and Monitoring Medicaid Services (SPMP Only)	PM (75%)
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, 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 based on SPMP;
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.

<u>Claim Calculation Example</u>

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)	equals
Subtotal	multiplied by
Percent of FFP (50% for some costs and 75% for other costs)	equals

<u>Claim Submission</u>

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 CYFD 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 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, CYFD 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 JPA

APPENDIX B – FEDERAL REIMBURSEMENT FOR SPMP

The first requirement is that an employer-employee relationship must exist between the SPMP and the agency participating in MAC. Enhanced FFP does not apply to contracts with private organizations or independent contractors. Medical professionals on contract do not qualify as SPMP.

The second requirement for SPMP status is based on two conditions: professional education (including training as part of academic work) and job function. In 1986, CMS implemented regulations in 42 CFR §432.50 that defined professional education as "the completion of a 2-year or longer program leading to an academic degree or certification in a medically related profession. This is demonstrated by possession of a medical license, certificate, or other document issued by a recognized national and state medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the administration, direction or implementation of the Medicaid program is not considered the equivalent of professional training in a field of medical care."

Agencies must provide documentation related to the qualification of time study personnel as SPMP and retain this documentation.

Copy of qualifying license or certification.

- Must possess licensure or certification from a recognized national or state licensing or certifying organization as evidence of successful completion of a qualifying professional education. Transcripts or degrees of completed academic work are insufficient.
- The license or certification must be current as of the time study quarter.
- In instances where photocopies of the license are prohibited by the licensing board, the personnel must obtain a letter from the licensing board indicating current licensure.
- In instances of the nursing Interstate Compact, the documentation from the licensing board indicating current licensure and approved use of the interstate reciprocity option must be obtained.

Copy of valid job description.

- The job description must indicate use of SPMP education and training in the performance of their job duties.
- The job description must indicate the specific qualifying SPMP license or certification that is required to fill the position. If non-SPMP personnel are capable of filling the position, the position cannot be considered as qualifying as an SPMP even if filled by an individual holding a qualifying license or certification.
- To be considered a valid job description, the job description must include the signatures of personnel filling the position, the signature of their immediate supervisor, signature dates, and be accurate as of the time study quarter.

Section 1903(2)(A) and 42 CFR 432.2 and 432.5 specified that 75% FFP is available for

the salaries, benefits, training, and travel expenses for SPMP; the SPMP must meet the federal education and training requirements and perform activities requiring specialized medical knowledge and skills. Expenses of supporting (clerical) staff that provide direct support to the SPMP and are directly supervised by the SPMP also get 75% FFP.

Administrative expenses claimed at the enhanced FFP require a well-documented process. For SPMP claiming, the following basic documentation is required (not in order of importance):

1. The SPMP must meet the SPMP qualifications for professional education and training, for example:
    a. Physicians,
    b. Registered Nurses,
    c. Dentists,
    d. Other specialized medical professionals, like
        i. Licensed Clinical Psychologists with a Ph.D. in psychology,
        ii. Licensed Audiologists certified by the American Speech and Hearing Association,
        iii. Physician Assistants,
        iv. Dental Hygienists,
        v. Licensed Dietitians
        vi. Physical Therapists
        vii. Occupational Therapists
        viii. Speech-language Pathologists
        ix. Licensed Ph.D. Psychologists
        x. Licensed Psychological Associates (LPA)
        xi. Medical Social Workers with a Master's degree in Social Work (MSW) with a specialty in a medical setting, etc.
2. The SPMP must be in a position that requires professional medical knowledge and skills, like
    a. Job classification,

    b. Job description,

    c. Medical licensure and certification, etc.

3. The SPMP must perform functions that require professional medical knowledge and skills, for example:

    a. Liaison on medical aspects of the program with providers of services and other agencies that provide medical care,

    b. Furnishing expert medical opinions,

    c. Reviewing complex physicians' billings,

    d. Participating in medical review, or independent professional review team activities,

    e. Assessing, through case management activities, the necessity for, and adequacy, of medical care and services, etc.

4. The administrative support activities must be collected based on an approved time study method. The time study is designed to support FFP claiming in a uniform system that allows staff to enter time working on multiple programs.

5. The SPMP must meet the employer-employee relationship requirements.

6. There must be an agreement between the Medicaid agency and other public agencies if the SPMP is not working at the Medicaid agency.

7. Activities provided by skilled professional medical personnel must be directly related to the administration of the Medicaid program and cannot include direct medical assistance.

8. SPMP claiming for directly supporting staff must meet the following criteria:

    a. Directly supporting staff are:

    b. Secretarial,

    c. Stenographic,

    d. Copying personnel,

    e. File and records clerks.

    f. Provide clerical functions directly necessary for carrying out the professional medical responsibilities and functions of the SPMP as follow:

    g. The SPMP is the direct supervisor of the supporting staff and responsible

for the work and performance of the supporting staff.

h. The SPMP is responsible for preparing, conducting, and signing the directly supporting staff's performance appraisal as the immediate first-level supervisor.

i. The SPMP and directly supporting staff relationship is reflected on the organization chart.

j. Civil service job specifications require clerical skills such as typing, filing, or photocopying.

k. Program duty statements reflect clerical functions in direct support of SPMP.

9. Additional considerations when claiming SPMP are:

   a. Activities provided by the SPMP cannot include direct services or extension thereof.

   b. Expenses cannot be claimed as administration if they are an integral part or extension of a direct medical or remedial service, such as patient follow-up, patient assessment, patient education, counseling, development of the medical portion of an Individualized Service Plan (ISP), or other physician extender activities." The Guide further states that: "Payments for allowable administrative activities must not duplicate payments that have been or should have been included and paid as part of a rate for services, part of a capitation rate, or through some other state or Federal program.

   c. SPMP performed functions that any non-SPMP staff could also perform as part of their job duties would not get the enhanced FFP rate. Examples of these functions are: (1) reviewed and helped complete medical assessment forms, (2) attended care conferences, and/or (3) provided information about services available in the community.

   d. Unless specified in Section 1903, 42 CFR or approved by CMS, professional services contract will be reimbursed at the 50% FFP.

   e. The Children, Youth and Families Department includes SPMP staff, however, these staff do not spend 100% of their time in this role and function to perform SPMP activities that require their furnishing their medical expertise and opinions.