

New Mexico Human Services Department

Medical Assistance Division

Medicaid Administrative Claiming (MAC) Guide

For Functions Delegated to University of New

Mexico School of Medicine

Center for Development and Disability

September 30, 2013

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I. INTRODUCTION

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 Center for Development and Disability (CDD) of University of New Mexico at the School of Medicine. CDD has the qualified personnel classified and expertise to perform the functions required of the delegated activities, per §1902(a)(33)(B) of the Social Security Act.

HSD retains its sole responsibility for exercising administrative discretion in the administration and supervision of the Title XIX State Plan. Nothing in the Governmental Services Agreement (GSA) with CDD 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 CDD's functions under the agreements, CDD 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 federal government permits state Medicaid agencies to claim reimbursement for activities necessary for the "proper and efficient administration" of the Medicaid State Plan, in accordance with Medicaid statute §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.

The Center for Medicaid/Medicare Services (CMS) has identified a series of activities that must be claimed administratively through Medicaid Administrative Claiming (MAC). Among these are outreach, utilization review, eligibility determination and activities that determine a consumer's need for care.

CDD Background & Mission

The Center for Development and Disability (CDD), established in 1990, is New Mexico's University Center for Excellence in Developmental Disabilities Education, Research and Service (previously known as a UAP). These centers are authorized by the Developmental Disabilities Assistance and Bill of Rights Act to build the capacities of states and communities to respond to the needs of individuals with developmental disabilities and their families. The Center for Development and Disability (CDD) is one organization in the Association of University Centers on Disabilities Research, Education and Service (AUCD). The network is coordinated by and

receives core funding from the Administration on Intellectual and Developmental Disabilities (AIDD). Funding for other programs and projects is obtained through state contracts, federal grants and private funding. There are 67 centers nationwide, including at least one in every US state and territory, which function as a national network of programs.

The mission of the CDD is the full inclusion of people with disabilities and their families in their community by engaging individuals in making life choices, partnering with communities to build resources, and improving systems of care.

The CDD accomplishes this mission through innovative:

Interdisciplinary training

Dissemination of information

Provision of exemplary direct service and technical assistance

Applied research

II. 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, which contains the 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 entities 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 entity 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 entities 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 (OMB A-87). This is accomplished by developing a method 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 offered or should be provided by other entities, or paid through other programs.
- Costs may not supplant funding obligations from other federal sources.
- Costs must be supported by adequate source documentation.

III. Participation Requirements

To participate in this MAC, the CDD must first enter into a contract with the New Mexico HSD. The agreement between the CDD 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.

The agreement summarized in Section IV below, between the HSD and the CDD, include a description of the functions delegated to CDD.

IV. Interagency Agreements subject to this MAC

The purpose of this Governmental Services Agreement (GSA) is to set forth the terms and conditions of the transfer of certain program functions for individuals with disabilities from HSD-MAD to CDD. It is also the purpose of this GSA to designate specific administrative and programmatic responsibilities for services following the transfer between the two agencies in accordance with the State Plan.

CDD is to perform the following administration functions necessary for the proper and efficient operations of the State Plan:

A. Achieve goals to improve the health care of Medicaid-enrolled individuals statewide through:

- (1) Engage in activities that increase Medicaid system capacity, close Medicaid service gaps, and improve Medicaid services.
- (2) Expand access to participating Medicaid providers for individuals with developmental disabilities, including Autism Spectrum Disorder.
- (3) Increase the use of quality, evidence-based improvement methods among participating Medicaid providers resulting in positive changes to systems of care.
- (4) Utilize best practices as a means to not only achieve better developmental outcomes, but also more efficient use of resources.
- (5) Improve a number of health care issues through systems change and increasing provider utilization of best practices in a variety of community settings that serve Medicaid patients.
- (6) Serve as a multi-year Quality Improvement Initiative process to enhance knowledge of specific best practices and to build capacity for improved care for Medicaid-eligible patients throughout the state.
- (7) Provide the HSD Medical Assistance Division (HSD/MAD) with detailed information and supporting data on jointly developed objectives as directed to demonstrate the effectiveness of Center for Development and Disability programs.
- (8) Provide case management or care coordination services for specific populations of children with and at risk for developmental disabilities and their families.

B. Implement the following Center for Development and Disability programs:

- (1) ***Fetal Alcohol Syndrome Disorder (FASD) Programs:*** improve access and quality of early identification and treatment of children with FASD by improving the ability of health care providers to recognize possible FASD, to refer early to appropriate services and to provide interventions that are evidence based.
- (2) ***Autism Spectrum Disorders (ASD) Programs*** - Improve access to and quality of care for Medicaid-eligible individuals with Autism Spectrum Disorders through improved coordination of services, addressing challenging behaviors early and through increased use of evidence-based interventions by Medicaid providers.

- (3) ***Medically Fragile Programs*** - Improve access to quality care for Medicaid-eligible children who are medically fragile by improving coordination of services and through increased use of evidence-based interventions by Medicaid providers.
- (4) ***Early Childhood Programs*** - Improve access to quality care for Medicaid-eligible infants and toddlers with developmental disabilities, delays, or who are at risk for developmental disabilities, by improving coordination of services and through increased use of evidence-based interventions by Medicaid providers.
- (5) ***Treatment Foster Care Program*** - Work with Medicaid Treatment Foster Care providers and their foster families to improve the identification and treatment of Medicaid-eligible children in the foster care system following severe neglect and/or abuse who are at risk for developmental delays Increase the use of best practice assessments and interventions addressing attachment, behavior and educational challenges.

C. Expand provider networks through the development of knowledge and skills in providing treatment to Medicaid-eligible individuals with disabilities. Implement changes that result in sustainable improvements in care. Coordinate with the Medicaid managed care organizations (MCOs) as necessary and appropriate to identify areas in need of access to skilled providers.

V. **Time Study**

A. Overview:

The Center for Development and Disability (CDD) is to use a daily worker log time study to capture personnel costs. Time and effort reports (timesheets) are required for all personnel costs charged to Medicaid grant dollars. CDD must use time and effort reporting to document the work of its employee and allocate their work to the various funding sources. The time and effort reports for employees working on multiple programs or activities must:

- (1) Be an after-the-fact determination of the employee's actual effort;
- (2) Account for total activity for which employees are compensated and which is required in fulfillment of their obligations to CDD (for example, if a professor spends 50% of his/her time on the CDD program and 50% on teaching, time and effort for both programs must be included on the report);
- (3) Be signed by the employee and a supervisor with first-hand knowledge of the activities performed by the employee (signatures on the timesheets is affirmation that the report is an accurate accounting of the actual time the employee spent on the project);

- (4) Be a randomized two week study each quarter.

CDD has 240 employees. This two week time study using the attached daily worker log will capture how staff spends 100% of their time and provide a 95% confidence level. The two weeks of the quarter used for the time study will be chosen at random by the CDD Time Study Coordinator. Time study dates will correlate to standard pay period dates, starting on a Monday at 7am and ending in 2 weeks on a Friday at 6pm. There are approximately six pay periods each quarter. Employees will be given a two day notice by email of the start date for the time study and the exact dates for the time study. The employee will track their time in 15 minute intervals for the two weeks and will submit their time study to the coordinator by 5pm three working days after completion of the time study period. A non-response on the time study will be coded as Non-Medicaid. The roster of employees selected to complete the time study will be updated each quarter to account for employee separations, new hire and changes in employee work responsibilities.

B. SPMP Codes:

Codes used by SPMP can be reimbursed at 75% only when skilled professional medical knowledge and education are required. If an SPMP is performing an activity that does not require the use of skilled professional medical knowledge or training, then he or she would use the appropriate activity code. Job descriptions are attached in Appendix A.

C. Codes for all staff:

Staff who do not qualify as SPMP may not use codes 2a, and 3a.

D. Time Study Training:

Participants will be trained prior to each time study period. The purpose of the training is to familiarize them with the codes and the use of the daily log. A mandatory training will be held just prior to the quarter beginning the implementation of this claiming guide and the last week of each of the following quarters for employees new to the process. Training will be conducted by the CDD employee assigned to be the time study coordinator. Employees who are unable to attend a scheduled training will schedule a time to be individually trained by the coordinator. The power point to be used for participant training is attached in Appendix D.

E. Time Study log:

A copy of the CDD time study log is attached in Appendix C

VI. Time Study Codes

Codes marked “Enhanced” will be reimbursed at 25:75 for SPMP activities when skilled professional medical knowledge and education are required. Codes marked “Not Enhanced” will be reimbursed at 50:50. Codes marked “Not covered” are Non-Medicaid.

Code 1a. Medicaid Outreach (Not Enhanced)

This code is used by individuals who are not SPMP or for SPMP when skilled professional medical knowledge is not required. This code is used when performing activities that inform eligible or potentially eligible individuals about Medicaid, how to access Medicaid and the range of services offered through Medicaid. Includes the following:

- Related paperwork, clerical activities and/or staff travel
- Outreach activities directed toward bringing Medicaid eligible individuals into Medicaid covered services
- Health education program or activities targeted specifically to Medicaid services
- Identification of children with special needs
- Contacting pregnant women and parenting teens about prenatal and well-child care
- Designing and implementing strategies to identify pregnant women at risk for poor outcomes because of drug use, alcohol, poor nutrition, teens, lack of PNC
- Designing and implementing strategies to identify children with special needs
- Encouraging families to access medical/dental/mental health services provided by Medicaid

Code 1b. Non-Medicaid Outreach (Not covered)

This code is used when performing activities that inform individuals about NON-Medicaid programs, how to access them and their range of benefits. Non-Medicaid programs include social, educational, legal and other services not covered by Medicaid. Includes the following:

- Related paperwork, clerical activities and/or staff travel
- General health campaigns

Code 2a. Referral, Coordination, and Monitoring of Medicaid Services-SPMP only (Enhanced)

SPMP use this code when making referrals for, coordination and/or monitoring the delivery of Medicaid covered services that require skilled professional medical knowledge and training. Includes the following:

- Related paperwork and/or staff travel to perform these activities
- Making referrals for and/or coordinating medical and/or dental evaluations for clients
- Gathering of information that may be required in advance of these referrals or evaluations

- Participating in inter/intra-agency meetings to coordinate need for Medicaid covered services.
- Coordinating the completion of the prescribed services, termination of services, and the referral and transition of the client to other Medicaid service as may be required to provide continuity of care.
- Providing information to other staff on medical/dental/mental health plans and services
- Targeted case management that is not a covered Medicaid service.

Code 2b. Referral, Coordination, and Monitoring of Medicaid Services- not SPMP (Not Enhanced)

Staff should use this code when making referrals for, coordination and/or monitoring the delivery of Medicaid covered services and skilled professional medical knowledge and training is not required. Includes the following:

- Related paperwork and/or staff travel to perform these activities
- Making referrals for and/or coordinating medical and/or dental evaluations for clients
- Gathering of information that may be required in advance of these referrals or evaluations
- Participating in inter/intra-agency meetings to coordinate need for Medicaid covered services
- Coordinating the completion of the prescribed services, termination of services, and the referral and transition of the client to other Medicaid service as may be required to provide continuity of care.
- Providing information to other staff on medical plans and services

Code 2c. Referral, Coordination, and Monitoring of Non-Medicaid Services (Not covered)

This code should be used when making referrals, coordinating and/or monitoring the delivery of NON-Medicaid services, such as social, educational, legal and other services not covered by Medicaid. Includes the following:

- Related paperwork, clerical activities and/or staff travel.

Code 3a. Program Planning, Development, and Interagency Coordination –SPMP (Enhanced)

SPMP use this code when program planning, policy development and interagency coordination are performed by SPMP whose tasks involve program planning, policy development and interagency coordination according to their position description. These activities must require the use of skilled professional medical knowledge and training. Includes the following:

- Related paperwork and/or staff travel required to perform these activities.
- Working with agencies providing Medicaid services to improve coordination and delivery of services, to expand access to specific populations of Medicaid eligible and to improve collaboration around the early identification of medical problems.
- Reducing overlap, duplication and gaps in available Medicaid services
- Focusing Medicaid services on specific populations or geographic areas.
- Defining the scope of each agency's Medicaid service in relation to the other.
- Developing strategies to increase Medicaid system capacity.
- Interagency coordination to improve delivery of Medicaid services.

Code 3b. Program Planning, Development, and Interagency Coordination (Not Enhanced)

This code is used when program planning, policy development and interagency coordination are performed by staff whose tasks officially involve program planning, policy development and interagency coordination according to their position description. Includes the following:

- Related paperwork and/or staff travel required to perform these activities.
- Working with agencies providing Medicaid services to improve coordination and delivery of services, to expand access to specific populations of Medicaid eligible and to improve collaboration around the early identification of medical problems.
- Reducing overlap, duplication and gaps in available Medicaid services.
- Focusing Medicaid services on specific populations or geographic areas.
- Defining the scope of each agency's Medicaid service in relation to the other.
- Developing strategies to increase Medicaid system capacity.
- Interagency coordination to improve delivery of Medicaid services.

Code 3c. Program Planning, Development, and Interagency Coordination- NON-Medicaid related (Not covered)

This code is used when program planning, policy development and interagency coordination not

related to Medicaid services are performed by staff whose tasks officially involve program planning, policy development and interagency coordination according to their position description. Includes the following:

- Related paperwork and/or staff travel required to perform these activities.

Code 4. Direct Medical Services (not covered)

Staff use this code when providing direct client diagnostic testing, assessment, counseling and/or treatment covered under the state's Medicaid plan. Includes the following:

- Related paperwork, clerical activities and/or travel to perform these activities
- Medicaid and Non-Medicaid direct client services
- Reviewing medical histories and/or test results
- Physical exam and/or psychological testing
- Counseling, parent skill training, patient education
- Follow up with the client
- Billing activities

Code 5. Research and Teaching Activities (Not covered)

This code is used for research activities and teaching activities.

- Teaching university classes and mentoring university students.
- Any activities related to research.

Code 6. General Administrative (Not Enhanced)

This code is used when engaging in general administrative activities related to Medicaid services performed by the CDD. This code is also used for all staff breaks, lunch and/or any form of paid leave. Includes the following:

- General supervision of staff
- Evaluation of employee performance
- Establishing goals and objective for health-related programs
- Reviewing program procedures and rules.

- Developing budgets and maintaining records
- Performing general administrative and/or clerical activities
- Processing employee payroll and other employee-related forms
- Technology support

Code 7. Non-Response (Not Covered)

This code will be used when the employee does not document their time in the daily worker log; Coded as Non-Medicaid.

VII. Federal Reimbursement for Non- Skilled Professional Medical Personnel (Non-SPMP)

For non-SPMP personnel, the time and effort report for employees performing solely on the CDD program in support of the Medicaid administration must:

- Must be an after-the-fact certification that the employee worked 100 percent of their time on that program;
- Be prepared quarterly.
- Be signed by the employee and supervisory official having first-hand knowledge of the work performed;
- Applies to full-time and part-time employee.

VIII. Federal Reimbursement for Skilled Professional Medical Personnel (SPMP)

Section 1903 specifies various federal financial participation rates for expenses necessary for the proper and efficient operation of the Medicaid program. Normally, general administration gets 50% FFP (42 CFR § 433.15(b)(7)) and is usually referred to as a non-enhanced FFP. In Section 1903(2)(A), the FFP rate of 75% is available for expenses of skilled professional medical personnel (SPMP) and their direct clerical supporting staff. This section of the Act is further codified in the Code of Federal Regulation (42 CFR 432.2 and 432.50(b)(1)).

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):

- A. The SPMP must meet the SPMP qualifications for professional education and training, for example:
 - (1) Physicians
 - (2) Registered Nurses
 - (3) Licensed Clinical Psychologists with a Ph.D./PsyD in psychology
 - (4) Licensed Speech Language Pathologists certified by the American Speech and Hearing Association
 - (5) Licensed physical and occupational therapists
 - (6) Licensed Medical Social Workers with a Master's degree in Social Work (MSW)

- B. A list of SPMP licensure and certification, job classification and brief job descriptions is attached in Appendix A.

- C. The SPMP must perform functions that require professional medical knowledge and skills, for example:
 - (1) Liaison on medical aspects of the program with providers of services and other agencies that provide medical care
 - (2) Furnishing expert medical opinions
 - (3) Reviewing complex physicians' billings
 - (4) Participating in medical review, or independent professional review team activities
 - (5) Assessing, through case management activities, the necessity for, and adequacy, of medical care and services, etc.

- D. The administrative support activities must be collected based on either an actual time allocation or 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.

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

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

- G. SPMP claiming for directly supporting staff must meet the following criteria:
 - (1) Secretarial
 - (2) Stenographic
 - (3) Copying personnel
 - (4) File and records clerks
 - (5) Provide clerical functions directly necessary for carrying out the professional medical responsibilities and functions of the SPMP as follow:
 - a. The SPMP is the direct supervisor of the supporting staff and responsible for the work and performance of the supporting staff.
 - b. The SPMP is responsible for preparing, conducting, and signing the directly supporting staff's performance appraisal as the immediate first-level supervisor. The SPMP and directly supporting staff relationship is reflected on the organization chart.

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

H. Additional considerations when claiming SPMP are:

- (1) Activities provided by the SPMP cannot include direct services or extension thereof.
- (2) 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 Education Plan] or [Individualized Family Service Plan], 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.
- (3) SPMP performed functions that any non-SPMP 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.
- (4) Unless specified in Section 1903, 42 CFR or approved by CMS, professional services contract gets 50% FFP.

IX. Other Cost

In addition to salaries and benefits of CDD staff along with a 5.5% indirect cost (see rates in Appendix B), rent is charged separately. The CDD is an off-campus center and rent is paid to an external landlord. The normal indirect cost rate, including rent, for the University of New Mexico is 51%. Since this GSA between HSD and CDD uses a smaller indirect cost rate, rent is identified and charged separately.

X. Review and Attestation

Review Procedures of CDD

The CDD billing unit, consisting of a CDD accountant and a time study coordinator, is the MAC unit. This MAC unit conducts reviews of all MAC program claims to assure their accuracy and to determine that appropriate documentation exists to support the claims. This oversight includes, but is not limited to, reviews of documentation to assure that the accuracy, sampling, and completeness of time studies, as well as the documentation necessary to justify that the claimed expenditures comply with state and federal requirements of the program.

The MAC unit will review all claims submitted by CDD. There are three levels of review and monitoring of claims. The MAC unit will review all claims for levels 1 and 2. For level 3 a CDD designee, usually a program manager, will review a sampling of claims.

Level 1 is a technical review in which the mechanics of the claim, such as mathematical computations and presence of all required information are checked. This level of review is conducted on all claims prior to submission to HSD. The mathematical accuracy of 100% of each quarter's claims will be performed before submission to HSD for reimbursement.

Level 2 is a desk review of all claims. The data for any particular claim are compared to past claim data to look for patterns that seem out of the normal range. There are also internal comparisons of activities reported and cost data to identify any combinations of time spent on a given activity and the costs of that activity that seem out of an acceptable range.

Level 2 reviews will include a review of the following potential risk factors:

- Time study results with outliers of percentage of code usage weighted by the following order: 1) Non-Discounted; 2) Discounted; 3) Reallocated;
- History of errors or problems;
- Claims with individuals included in the claiming plan that use code 7 (Non-response-Time Not Documented);
- Number of claiming units

Level 3 is a full field review. At least 10% of the claims will be reviewed. Until CDD can establish a protocol of review based on historical claims data, CDD will perform a full field review of enough claims to cover 50% of the claimed amounts submitted each quarter. The CDD's initial review will be a minimum of 10 claims and a maximum of 15 claims. If the initial review uncovers significant and/or systemic problems, additional review may be performed.

The number selected for a full field review will also be influenced by the risk factors associated with the:

- Inaccuracies detected during the mathematical accuracy check performed on all claims as identified in Level 1 review.
- Risk factors outlined in Level 2 review.

The MAC unit of CDD will perform an initial limited review of the remaining claims based on a random sample to cover 10% of the claimed amounts per quarter, up to the maximum of 25%. If the initial review uncovers significant and/or systemic problems, additional reviews may be performed.

The MAC unit maintains the data used to prepare the claim, which includes the coding sheets or electronic files that document the time study and the expenditure information of CDD. The field monitoring includes review of time study results, Implementation Plan compliance, claiming unit functions, and invoices.

If the field monitoring results in the identification of an invoice overpayment, HSD will require reimbursement from the CDD in the amount of the overpayment. Additional steps may be required such as additional training, procedure changes, and internal audits.

The claiming agency (CDD) will maintain the original time study logs. The claiming agency will maintain the payroll records that document the salary and benefits of all persons designated as performing Medicaid administrative activities. Only staffs that participated in the quarterly time study training and participated in the time study are included in the claim. CDD is responsible for maintaining and storing its own documentation and records.

Quality Assurance Activities

The MAC unit must maintain a MAC plan quality assurance as part of the Implementation Plan to ensure accuracy of the data. The responsibilities of the MAC unit for claim development includes, but is not limited to:

1. Establishing guidelines for audit files and archiving claiming plans, signed original time studies, MAC claims, and applicable documentation.
2. Participating in MAC reviews and monitoring.
3. Establishing and operating a quality assurance system for assessing compliance with MAC policies and procedures through desk reviews, onsite reviews, and technical assistance.
4. Excluding from the claim the costs associated with a staff member that did not complete their time study. For example, if a staff member did not fully complete the time study form for the day or cannot produce their time study log, then the associated costs would be labeled as Code 7: Non-response: Non-Medicaid.

Review Procedures Conducted by HSD

HSD has direct monitoring and oversight responsibility of claims submitted by the CDD MAC unit. The MAC unit has direct monitoring and review responsibility of the claims submitted by CDD participating in the MAC.

HSD will verify the mathematical accuracy of all claims submitted by the CDD's MAC unit. Quarterly, HSD in its monitoring and oversight capacity will perform a complete review and evaluation of a selected claim submitted by the MAC unit. During the first two quarters of claim submission following CMS approval of the MAC methodology, this complete review and evaluation will include two quarterly claims. These reviews will include a thorough examination of expenditure reporting.

Also, HSD will select one additional claiming category not previously selected from which to review in detail such as:

- Indirect Cost Rate
- Training

- Payroll
- Invoice/Expenditures
- Time Study
- Revenue
- Third Party Liability

As historic claiming data is collected, HSD will review claims submitted by each MAC unit based on variations between periods and other claiming entities. HSD will gather data to highlight trends and variations between periods. Should HSD discover significant and consistent problems with submitted claims it may request that HSD's auditing entity, Office of Inspector General (OIG) to conduct an audit.

HSD will review the CDD MAC unit's review methodology for adequacy. HSD will select for its own review the results of the MAC unit's review of claims submitted by CDD. If the review uncovers significant and/or systemic problems additional review may be performed.

HSD will not process or submit for FFP reimbursement of any MAC claim that has been determined by the HSD to have errors. Such claims will be returned to the MAC unit for review and correction.

Attestation by CDD Designees

The MAC unit at CDD will review MAC invoices and documents to ensure that submissions to the MAC unit are appropriate and reasonable. In addition, the designee at the CDD will attest by signature to the accuracy of the claim invoices submitted to HSD. For each claim submitted to HSD, the CDD designee on behalf of CDD will attest to the following:

1. I am the designee of the CDD authorized to submit this claim.
2. This claim only includes expenditures under the Medicaid program under Title XIX of the Social Security Act (the Act), that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies, and the state plan approved by the Secretary and in effect during the period of the claim under Title XIX of the Act for the Medicaid Program.
3. The expenditures included in this claim are based on actual recorded expenditures.
4. The required amount of state and/or local public funds were available and used to match the state's allowable expenditures included in this claim, and such state and/or local public funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures.
5. Federal matching funds are not being claimed to match any expenditure under any Federal program that has not been approved by the Secretary effective for the period of the claim.
6. The information above and in this claim is correct to the best of my knowledge and belief based on reasonably available information. Also, I have notice that this information is to be used for filing a claim with the Federal Government for federal funds, and the knowing misrepresentation constitutes violation of the Federal False Claims Act.

Appendix A

Licensure	Position	Brief Job Description
Clinical Psychologist	Assistant Professor	psychological services; referral, coordination and monitoring as well as program planning, development and interagency coordination with focus on Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorder, Intellectual Disability or Early Childhood services; teaching
Clinical Psychologist	Associate Professor	psychological services; referral, coordination and monitoring as well as program planning, development and interagency coordination with focus on Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorder, Intellectual Disability or Early Childhood services; teaching
Registered Nurse	Program Ops Manager	outreach, referral and coordination of Medicaid services for MFCMP, program planning and coordination
Speech Therapist	SLP	Speech and language services; referral, coordination and monitoring as well as program planning, development and interagency coordination with focus on Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorder, Intellectual Disability or Early Childhood services
Licensed Independent Social Worker	Sr. Program therapist	Social work services; referral, coordination and monitoring as well as program planning, development and interagency coordination with focus on Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorder, Intellectual Disability or Early Childhood services
Licensed Independent Social Worker	Counselor	Social work services; referral, coordination and monitoring as well as program planning, development and interagency coordination with focus on Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorder, Intellectual Disability or Early Childhood services
Registered Nurse	Sr. RN Case Manager	outreach, referral and coordination of Medicaid services for MFCMP, program planning and coordination
Registered Nurse	RN Case Manager	outreach, referral and coordination of Medicaid services for MFCMP, program planning and coordination
Physician	Assistant Professor	Pediatric services; teaching; referral, coordination and monitoring as well as program planning, development and interagency coordination with focus on Autism

Appendix A

		Spectrum Disorders, Fetal Alcohol Spectrum Disorder, Intellectual Disability or Early Childhood services
Physician	Associate Professor	Pediatric services; teaching; referral, coordination and monitoring as well as program planning, development and interagency coordination with focus on Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorder, Intellectual Disability or Early Childhood services
Occupational Therapist	Clinical Therapy Specialist	Occupational therapy services; teaching; referral, coordination and monitoring as well as program planning, development and interagency coordination with focus on Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorder, Intellectual Disability or Early Childhood services
Occupational Therapist	Lecturer	Occupational therapy services; teaching; referral, coordination and monitoring as well as program planning, development and interagency coordination with focus on Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorder, Intellectual Disability or Early Childhood services
Physician	Psychiatrist	Psychiatric services; teaching; referral, coordination and monitoring as well as program planning, development and interagency coordination with focus on Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorder, Intellectual Disability or Early Childhood services

OFFICE OF RESEARCH

Richard S. Larson, MD,
PhD Vice Chancellor for
Research

Updated 9-19-12

To: HSC Faculty & Staff

From: Richard Larson, MD, PhD

**Re: Facility & Administrative (F&A) Rates for IHS / VA Purchase Orders, and
State/Local Agreements with HSC**

This memo clarifies the F&A rates for IHS & VA Fee Based, non-Research, Purchase Orders, and State and Local agencies that will be applied on HSC projects.

HSC Faculty who wish to be granted these special rates are to request an F&A reduction waiver through the HSC Office of Research prior to proposal submittal or bid to the agency. This includes contracts & purchase orders negotiated by Clinical Contracting, Pre-Award, or billed through the Non-Student Accounts Receivable (NSAR) or the UNMMG.

Please note that federal flow-through (all grants or contracts that are funded to a state/local agency from federal agencies) will be required to include the **normal F&A rate of 51%** (or 26% for research conducted in off-campus facilities).

To support the research mission at HSC, it is critical that we obtain the appropriate F&A.

<u>Agency</u>	<u>Rate (unless Federal Flow Through)</u>
Administrative Office of the Courts	20% All
NM School Districts, including APS	10% Higher
Education Department	0%

Children, Youth and Families Department	5.5%
Commission on Info and Comm. Mgmt.	20%
Corporation Commission	20%
Developmental Disabilities Planning Council	20%
Department of Finance and Administration	0%
Department of Corrections	20%
Department of Game and Fish	20%
Department of Health	5.5%
Department of Labor	20%
Energy, Minerals, and Natural Resources Dept.	20%
Economic Development	20%
Health Care Initiative	20%
Health Policy Administration	20%
Historical Preservation Division	20%
Health & Human Services Department	5.5%
Interstate Stream Commission	20%
Museum of New Mexico	20%
New Mexico Arts Division	0%
New Mexico Water Research Institute	0%
Public Education Department	5.5%
New Mexico Endowment for the Humanities	0%
National Children's Advocacy Center	20%
Office of Cultural Affairs	20%
Small Business Development Center	0%
Aging and Long-Term-Services Department	5.5%

State Engineering Office	20%
State Highway & Transportation Department	20%
State Justice Institute	20%
Supreme Court	20%
Taxation and Revenue Department	20%
Traffic Safety Bureau	20%
Optum Health (State Provider Contractor)	10%
City of Albuquerque	20%
Bernalillo County	20%
Other State and Local Governments	20%

VA & IHS Fee for Service Purchase Orders, for clinics, provider services, training services, autopsy services, which are non-research related - service performance only

- | | |
|--|------|
| <input type="checkbox"/> NM Veteran's Administration (VA) | 10% |
| <input type="checkbox"/> DHHS Indian Health Services (IHS) | 5.5% |

Intergovernmental Personnel Agreements (IPA's) 0%

Notes:

- If the state or local agency is submitting a proposal to the federal government, UNM's full negotiated F&A rate should be included as part of the UNM subcontract costs, unless F&A is capped by the Federal sponsor.
- There may be specific program guidelines that specify the allowable F&A on a specific project. Faculty must include a copy of these guidelines with the proposal as justification for a different rate and submit an F&A waiver to the Office of Research.
- There will be no additional F&A modifiers on the direct cost line items. Total Direct Charge (TDC) method will be applied.

- F&A is computed by taking the direct cost needed to complete the project and multiplying the F&A percentage. ($\$25,000 \text{ direct} * 5.5\% \text{ rate} = \$1,375 \text{ F\&A}$)
Contract value is the SUM of Direct + F&A. ($\$25,000 + \$1,375 = \$26,375$)

(i.e. Do **Not** multiply bottom line times the rate (~~$\$26,375 * 5.5\%$~~) as this is incorrect.)

- This memo will be posted on the PreAward website. If rates change, this memo may be updated, showing the revision date.

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CDD Training for Medicaid Administrative Claiming

Cate McClain, MD

Medical Director

Center for Development and Disability

University of New Mexico

Title XIX of the Social Security 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 Medicaid state plan
(Centennial Care)

Federal agency: Center for Medicare and Medicaid Services (CMS)

State agency: Human Services Division (HSD)

Medicaid Administrative Claiming (MAC)

Also called:

Federal Financial Participation (FFP)

“Medicaid Match”

Non-federal funding sources are used to match federal dollars at either 50:50 or 25:75

MAC guide approved by CMS

Outlines specific activities that can be covered as well as documentation needed

UNM CDD contract with NM HSD

- Engage in activities that increase Medicaid system capacity, close Medicaid service gaps, and improve Medicaid services.
- Expand access to participating Medicaid providers for individuals with developmental disabilities, including Autism Spectrum Disorder.
- Increase the use of quality, evidence-based improvement methods among participating Medicaid providers
- Address systems change and increase provider utilization of best practices
- Enhance knowledge of specific best practices and build capacity for improved care
- Provide case management or care coordination services for specific populations of children with and at risk for developmental disabilities and their families.

UNM CDD contract with NM HSD

(1) Fetal Alcohol Syndrome Disorder (FASD)

Programs: improve access and quality of early identification and treatment of children with FASD by improving the ability of health care providers to recognize possible FASD, to refer early to appropriate services and to provide interventions that are evidence based.

(2) Autism Spectrum Disorders (ASD) Programs -

Improve access to and quality of care for Medicaid-eligible individuals with Autism Spectrum Disorders through improved coordination of services, addressing challenging behaviors early and through increased use of evidence-based interventions by Medicaid providers.

(3) Medically Fragile Programs -

Improve access to quality care for Medicaid-eligible children who are medically fragile by improving coordination of services and through increased use of evidence-based interventions by Medicaid providers.

UNM CDD contract with NM HSD

(4) ***Early Childhood Programs:*** Improve access to quality care for Medicaid-eligible infants and toddlers with developmental disabilities, delays, or who are at risk for developmental disabilities, by improving coordination of services and through increased use of evidence-based interventions by Medicaid providers.

(5) ***Treatment Foster Care Program:*** Work with Medicaid Treatment Foster Care providers and their foster families to improve the identification and treatment of Medicaid-eligible children in the foster care system following severe neglect and/or abuse who are at risk for developmental delays. Increase the use of best practice assessments and interventions addressing attachment, behavior and educational challenges.

Documentation for MAC

- Determined by the federal agency (CMS)
- Reported to the state agency (HSD)
- CDD leadership determines which personnel salaries meet the approved MAC requirements based on employee duties
- A roster of employees, both staff and faculty, will provide necessary documentation through a time study

TIME STUDY

- Be a **randomized two week study each quarter.**
- **Daily worker log:** required for all personnel costs charged to Medicaid Match contract
- Be an **after-the-fact** determination of the employee's actual effort;
- Account for **100% of activities** for which employees are compensated and which is required in fulfillment of their obligations to CDD
- Be **signed by the employee and a supervisor** with first-hand knowledge of the activities performed by the employee to assure accurate accounting of the actual time the employee spent on the project

CDD Time Study

- Notification at least 2 days before beginning of 2 week study
- Documentation using the daily worker log is mandatory
- 15 minute intervals for hours worked, includes breaks, lunch and leave time
- Undocumented time will be monitored by CDD leadership
- Submitted electronically by 5pm 3 working days after completion of time study

CDD Time Study

All activities included within approved categories:

- Medicaid Outreach
- Non-Medicaid Outreach
- Referral, Coordination, and Monitoring of Medicaid and Non-Medicaid Services
- Program Planning, Development, and Interagency Coordination, Medicaid and Non-Medicaid related
- Direct Medical Services
- Research and Teaching
- General Administrative

Medicaid Outreach Activities

Inform eligible or potentially eligible individuals about Medicaid, how to access Medicaid and the range of services offered through Medicaid.

- Related paperwork, clerical activities and/or staff travel
- Outreach activities directed toward bringing Medicaid eligible individuals into Medicaid covered services
- Health education program or activities targeted specifically to Medicaid services
- Identification of children with special needs
- Contacting pregnant women and parenting teens about prenatal and well-child care
- Designing and implementing strategies to identify pregnant women at risk for poor outcomes because of drug use, alcohol, poor nutrition, teens, lack of PNC
- Designing and implementing strategies to identify children with special needs
- Encouraging families to access medical/dental/mental health services provided by Medicaid

Non-Medicaid Outreach Activities

Inform individuals about **NON-Medicaid programs**, how to access them and their range of benefits. Non-Medicaid programs include

- General health campaigns
- Social, educational, legal and other services not covered by Medicaid
- Related paperwork, clerical activities and/or staff travel

Referral, Coordination, and Monitoring of Medicaid Services

Making referrals for, coordination and/or monitoring the delivery of Medicaid covered services.

- Related paperwork and/or staff travel to perform these activities
- Making referrals for and/or coordinating medical and/or dental evaluations for clients
- Gathering of information that may be required in advance of these referrals or evaluations
- Participating in inter/intra-agency meetings to coordinate need for Medicaid covered services.
- Coordinating the completion of the prescribed services, termination of services, and the referral and transition of the client to other Medicaid service as may be required to provide continuity of care.
- Providing information to other staff on medical/dental/mental health plans and services
- Targeted case management that is not a covered Medicaid service.

Referral, Coordination, and Monitoring of Non-Medicaid Services

- Used when making referrals, coordinating and/or monitoring the delivery of **NON-Medicaid** services, such as social, educational, legal and other services not covered by Medicaid.
- Related paperwork, clerical activities and/or staff travel.

Program Planning, Development, and Interagency Coordination-Medicaid related

- Related paperwork and/or staff travel required to perform these activities.
- Working with agencies providing Medicaid services to improve coordination and delivery of services, to expand access to specific populations of Medicaid eligible and to improve collaboration around the early identification of medical problems.
- Reducing overlap, duplication and gaps in available Medicaid services
- Focusing Medicaid services on specific populations or geographic areas.
- Defining the scope of each agency's Medicaid service in relation to the other.
- Developing strategies to increase Medicaid system capacity.
- Interagency coordination to improve delivery of Medicaid services.

Program Planning, Development, and Interagency Coordination- NON-Medicaid related

Program planning, policy development and interagency coordination **not related to Medicaid services** are performed by staff whose tasks officially involve program planning, policy development and interagency coordination according to their position description.

Direct Medical Services

Provision of direct client diagnostic testing, assessment, counseling and/or treatment covered under the state's Medicaid plan.

- Related paperwork, clerical activities and/or travel to perform these activities
- Medicaid and NON-Medicaid direct client services
- Reviewing medical histories and/or test results
- Physical exam and/or psychological testing
- Counseling, parent skill training, patient education
- Follow up with the client
- Billing activities

Research and Teaching

- Teaching university classes and mentoring university students.
- Any activities related to research

General Administrative

- For general administrative activities related to Medicaid services performed by the CDD. This code is also used for all staff breaks, lunch and/or any form of paid leave. Includes the following:
 - General supervision of staff
 - Evaluation of employee performance
 - Establishing goals and objective for health-related programs
 - Reviewing program procedures and rules.
 - Developing budgets and maintaining records
 - Performing general administrative and/or clerical activities
 - Processing employee payroll and other employee-related forms
 - Technology support

Conclusion

- Sample work activity scenarios with active review of CDD Daily Worker Log
- Questions??