Ohio Department of Developmental Disabilities

Guide to
Medicaid Administrative Claiming (MAC)
using the
Random Moment Time Studies (RMTS)
Methodology

Updated
April 2012

Table of Contents

I. INTRODUCTION

The purpose of this guide is to provide direction for conducting Medicaid Administrative Claiming for the Ohio Department of Developmental Disabilities (DODD) and the participating county boards of developmental disabilities (CBs), and Councils of Government (COGs). The guide explains the structure, methodology and processes required for conducting random moment time studies to support claiming of administrative activities associated with Medicaid.

Medicaid Administrative Claiming and Random Moment Time Studies (RMTS)

Through Medicaid Administrative Claiming (MAC), DODD Central Office, CBs, and COGs may be reimbursed in part by Federal Medicaid funds for activities that assist individuals served in enrolling on Medicaid and in accessing Medicaid-covered services. These activities include, but are not limited to: Medicaid outreach; facilitating Medicaid eligibility determinations; translations related to Medicaid services; program planning, policy development and interagency coordination related to medical services; investigations of major unusual incidents (MUIs); referral, coordination and monitoring of Medicaid services. The amount that a developmental disability (DD) entity may bill for administrative activities is based on a time study model approved by the Centers for Medicare and Medicaid Services (CMS).

A time study is a tool used to analyze work being done by employees/contractors over a specified time period. The end result of the time study is a series of percentages reflecting the proportion of time spent on the various types of activities performed by employees/contractors. When the time study is conducted across a sample of employees/contractors, the results are used to extrapolate to the entire specified population of employees/contractors.

Upon CMS approval, DODD will utilize a Random Moment Time Study (RMTS) methodology starting with the July 2010 quarter, at which time all participating entities will be required to use. Two distinct time studies will be conducted: one to capture the activities of DODD Central Office (RMTS group 1) and another for CBs and COGs (RMTS group 2). The two time study groups are mutually exclusive with its own pool of participants and available moments. Using the same methodology, sampling will be selected from each time study group and results will be calculated separately.

RMTS is a federally accepted method for tracking employee effort. According to OMB Circular A-87 (revised 5/10/04), and its accompanying implementation guide ASMB C-10, “Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limit to, random moment sampling….”

RMTS is particularly useful, because:

- It uses a verifiable, statistically valid random sampling technique that produces accurate labor distribution results, and
- It greatly reduces the amount of staff time needed to record an individual time study participant's 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 eligible staff over that same period. The RMTS method provides a statistically valid means of determining what portion of the selected group of participant's workload is spent performing activities that are reimbursable by Medicaid.

The time study information collected as part of the process described in this guide will be used to support Medicaid Administrative Claiming (MAC) made by the participants. Four key components go into the development of a MAC claim.

- The total allowable MAC expenditures computed for each RMTS group;
- The time study percentage applied to each RMTS group;
- The calculation and application of the Medicaid Eligibility Rate (MER); and
- The application of indirect costs.

The MER is a population-based methodology, calculated annually, and equal to the number of Medicaid eligible individuals being served divided by the total number of individuals served by the respective claiming entity.

The result of the interaction of these factors is the amount that DODD Central Office, CBs, and COGs can claim for federal reimbursement as administrative costs related to providing Medicaid-funded medical services to individuals with DD.

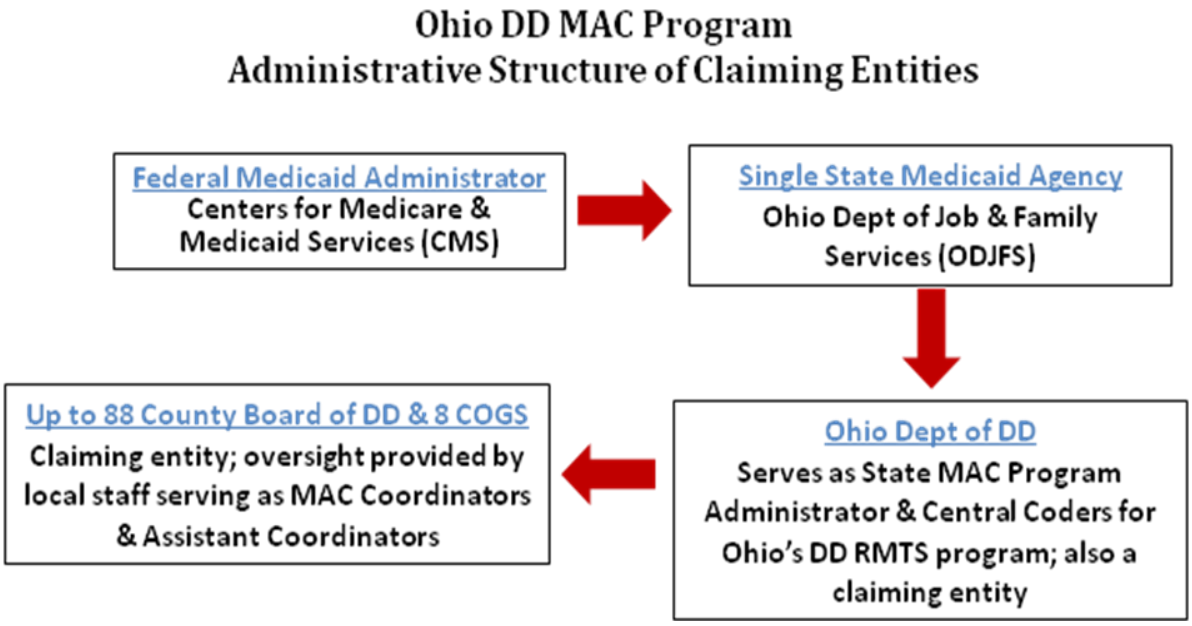
Administrative Structure for the Management of the Program

The administrative structure for the management of the MAC program for DODD involves two state agencies and up to 88 CBs and 8 COGs. The time study will be administered by DODD Central Office using a web-based program customized by the University of Massachusetts. As a result, parts of the management of this program lie with each of the participating governmental entities. Each entity has specific responsibilities that will be further delineated in interagency agreements and/or MAC Implementation Plans. Those responsibilities include the following:

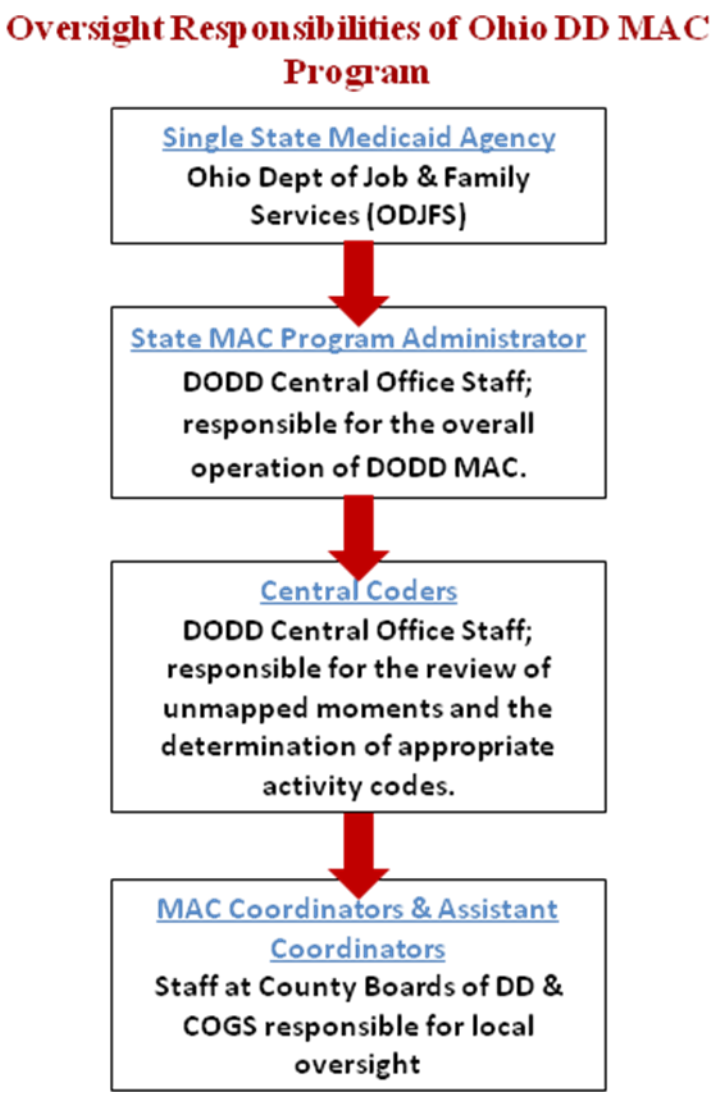
- ODJFS as the single state Medicaid agency will provide oversight of the time study administration and technical assistance regarding time study requirements and implementation issues. ODJFS has the final authority for the approval of all claims.
- DODD Central Office, through staff designated as the State MAC Program Administrator, manages the developmental disabilities MAC program and provides day-to-day administration, monitors the claiming entities within DODD

Central Office and participating CBs and COGs, and provides training and technical assistance.

- Participating CBs and COGs, through the local MAC Coordinators, will provide required participant and calendar information on formatted templates within stated deadlines to the State MAC Program Administrator, and maintain relevant MAC files and will administer the program in accordance with the implementation plan and this Guide.



A CB's role as a "648" board is discussed in OAC 145-1-49. Councils of Government (COGs) involved in the MAC program are governing entities that cover two or more Ohio counties who enter into an agreement with one another or with governing bodies of any county board of DD or other governing groups pursuant to ORC 167.01. Under the MAC Program, either 1) the participating COGS seek direct reimbursement from DODD for administrative Medicaid services or 2) the local CB that has contracted with a COG will seek reimbursement from DODD for Medicaid-related administrative expenses incurred on its behalf. This decision on whether the CB or COG seeks reimbursement for administrative expenses incurred in support of Medicaid programs is outlined in the participating CB(s) and COGs' annual implementation plans. Defining which MAC entity will seek reimbursement is done to ensure that DODD does not submit duplicate claims for the same administrative expenses.



MAC Implementation Plan

Prior to the start of each calendar year, each participating entity must complete an annual MAC Implementation Plan developed by the State MAC Program Administrator that reflects how the program will be administered. Once approved, Implementation Plans remain in effect for one calendar year -- January 1 through December 31 -- unless a revision must be made. Revisions must be submitted to the State MAC Program Administrator and are not effective until approved by the State MAC Program Administrator.

The Implementation Plan must include:

- Identification of and contact information for the MAC Coordinator and Assistant Coordinator
- Organizational chart of the claiming entity that clearly shows where and to whom the local MAC Coordinator and Assistant MAC Coordinator report

- A list of personal service contracts included in the MAC program, along with copies of those contracts
- A list of the specific responsibilities of the MAC Coordinator
- Required fiscal information

The State MAC Program Administrator will approve and retain the annual Implementation Plan.

Time Study Participants

Prior to the end of each quarter, the State MAC Program Administrator will send each MAC Coordinator the Participant List template. The MAC Coordinators will complete the template and submit the Participant List by the deadline indicated by the State MAC Program Administrator to ensure inclusion in the next quarter's time study. Late submissions will be accepted at the discretion of the MAC Administrator. Participant Lists will not be available for editing during the quarter they are active. The MAC Coordinator must certify that the list of staff they are submitting to be included in the RMTS group are appropriate for inclusion in the time study and eventual claim. Staff deemed inappropriate during review of time study responses will be removed from the time study and excluded from the claim. Prior to the start each quarter, the State MAC Program Administrator will upload updated and approved Participant Lists into the RMTS web-based program.

All staff that support Medicaid-funded programs for individuals with DD should participate in the MAC program. Medicaid-funded activities include, but are not limited to: Medicaid outreach; facilitating Medicaid eligibility determinations; translations related to Medicaid services; program planning, policy development and interagency coordination related to medical services; investigations of major unusual incidents (MUIs); referral, coordination and monitoring of Medicaid services.

Staff who perform direct or professional services and whose activities are reimbursed through other federal programs may **not** participate in the MAC program. In some cases, SSA supervisors and other professional staff may participate in MAC time studies if aspects of their work involve activities that are allowable MAC activities, so long as any direct care or TCM-related activities they perform are appropriately charged to Code 1, Direct Services, or Code 2, Targeted Case Management Activities. SSA Supervisors and professional services staff may not claim administrative activities that are related to the direct service that are compensated through the administrative components of service rates. Only activities completely separate from direct services and allowable under MAC can be claimed. For this reason, service and support administrators (SSAs) may not participate in MAC time studies.

Prior to participation by SSA supervisors and professional services staff in the MAC program, the local MAC Coordinator must submit the position description to the State MAC Program Administrator at DODD for approval (subject to review by ODJFS). The position description must clearly delineate roles and responsibilities of the employee

and reflect the percentage of time typically spent on direct care activities and the portion of time spent on other MAC claimable activities.

To ensure participants in the MAC program are not reimbursed for the same activities through other federal programs, CBs are required to submit an annual cost report to reconcile certified public expenditures that includes a worksheet (known as Worksheet 6) to identify MAC administrative costs incurred.

All staff will be reported into one of two statewide time study groups:

- ***Time Study Group 1*** – Employees who perform any amount of administrative activities for DODD Central Office.
- ***Time Study Group 2*** – Employees who perform any amount of administrative activities or direct services for county boards or COGs.

The two RMTS groups are mutually exclusive, i.e., no staff should be included in more than one group.

The two time studies, described below, will be held concurrently:

- One time study is comprised of DODD Central Office employees who perform administrative tasks in support of Medicaid-funded services provided by the department, and the respective costs for the staff.
- Another time study is comprised of county board and COG employees who perform administrative tasks in support of Medicaid-funded services by the local entity, and the respective costs for the staff. It may also include employees that conduct a combination of direct services, targeted case management, and/or administrative activities if approved by the State MAC Program Administrator.

The time study participants and associated expenditures for the two time study groups are mutually exclusive. Using the same methodology, sampling will be selected from each time study group and results will be calculated separately. The only administrative costs that can be claimed under Medicaid related to this program are derived from the two time study groups above.

RMTS Sampling Requirements

In order to achieve statistical validity, maintain program efficiencies and reduce unnecessary administrative burden, DODD intends to implement a consistent sampling methodology for all activity codes and groups to be used. DODD will use a RMTS sampling methodology to achieve a 95% (ninety-five percent) confidence level for all activities with a confidence interval of +/- 2% (two percent).

Statistical calculations show that a minimum sample of 2401 completed moments each quarter, per RMTS group, is adequate to obtain this precision when the total pool of moments is greater than 3,839,197. Additional moments are selected each quarter to account for any lost moments. Lost moments are observations that cannot be used for analysis, i.e., incomplete moments or moments selected for staff no longer employed at the participating entity.

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

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

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:

$$\text{New ss} = \frac{Ss}{1+\frac{ss-1}{Pop}}$$

where: pop = population

The following table shows the sample sizes necessary to assure statistical validity at a 95% confidence level with a confidence interval of 2%. An over sample of 15% will be used to account for lost moments, as previously defined.

Number of Participants in RMTS Group	N= (pool of moments available)	Sample Size Required	Sample Size plus 15% over sample
100	623,520	2392	2751
200	1,247,040	2396	2756
300	1,870,560	2398	2758
400	2,494,080	2399	2758
500	3,117,600	2399	2759
600	3,741,120	2399	2759
>600	>3,839,197	2401	2761

II. METHODOLOGY

RMTS Process

The RMTS process is described here as four steps:

1. Identify total pool of time study participants
2. Identify total pool of time study moments
3. Randomly select moments and then randomly match each moment to a participant
4. Notify selected participants about their selection moments

1. Identify Total Pool of Time Study Participants

   Prior to the start of each quarter, the local MAC Coordinators will provide a comprehensive list of staff eligible to participate in the RMTS time study (Participant List) to the State MAC Program Administrator. (The State MAC Program Administrator identifies DODD Central participants.) These lists of names are subsequently used to group the entities into either state or local participating entity and assigned into one of two RMTS groups.

2. Identify Total Pool of Time Study Moments

   The total pool of "moments" within the time study is represented by the following calculation:

   Number of working days in the sample period
   X
   Number of work hours of each day
   X
   Number of minutes per hour
   X
   Number of participants within the time study

   Prior to each quarter, the State MAC Program Administrator will identify the dates and times that work is scheduled and for which staff members are compensate for each time study group. With respect to time study group 2, the State MAC Program Administrator will consult with CB/COGs to identify the most common calendar for each quarter.

   The calendar for both time study groups will exclude holidays and weekends and be limited to the core business hours of 9 am to 3 pm, in order to assure sampling occurs during the times when most participants are scheduled to work. In general, participants' schedules extend before and beyond the core hours. All minutes within the identified calendar will be included in the potential days to be chosen for the time study.

The total pool of moments for the quarter does not include weekends, holidays, and hours during which employees are not scheduled to work.

The sampling period is defined as a three-month period comprising each quarter of the year:

- First Quarter: January 1-March 31
- Second Quarter: April 1-June 30
- Third Quarter: July 1-September 30
- Fourth Quarter: October 1-December 31

3. Randomly Select Moments and Randomly Match Each Moment to a Participant

   Once the total pools of time study participants and time study moments are determined for each RMTS group, they are matched using a statistically valid random sampling technique. The process involves selecting a random moment from the total pool of moments. Each selected moment is defined as a specific one-minute unit of a specific day from the total pool of time study moments. Next, the selected moment is randomly matched up with an individual from the total pool of participants. Then both the minute and the name are returned to the overall sample pool to be available for selection again. This step guarantees the randomness of the selection process. This process is repeated until the desired number of moments has been selected for each RMTS group.

   Each moment selected from the pool is included in the time study and coded according to the documentation submitted by the employee.

4. Notify Participants about their Selected Moments

Time study participants are notified via email (or other means if they are unable to receive email) of their requirement to participate in the time study and of their sampled moment. Sampled participants will be notified **one business day prior** to and at the moment of their sampled moment. At the prescribed moment, each sampled participant is asked to record and submit his/her activity for that particular moment. Sampled participants will log onto a web-based system and answer questions about their work activity using a drop-down box or write in a description. Sampled participants have 5 business days to complete or amend the moment. After this grace period has passed, the moment cannot be accessed.

Response and Documentation of Random Moment

All responses to sampled moments ***must be returned within five business days*** after the sampled date. Responses not received within the required time frame cannot be used in the calculation of the necessary number of moments needed to satisfy the 95% (ninety-five percent) confidence level with a confidence interval of +/- 2% (two percent).

Responses of sampled moments must be sufficient to provide answers to three questions needed for accurate coding:

- What type of activity were you doing?
- What were you specifically doing in this category?
- Who were you working with?

In addition, sampled staff will certify the accuracy of their response prior to submission.

Sampled participants must maintain source documentation to support the activity they selected or provided for their sampled moment. Appropriate documentation should provide the detail needed to support the activity selected for the sample moment and clearly identify the date and time corresponding to the sampled moment. Participants are encouraged to include notes on their documentation to provide more detail of their activities, allowing them to recall and support their selected responses in the event of an audit.

If the participant is using leave or not scheduled to work during a sampled moment, there is no need to maintain source documentation. However, records to support the absence of the participant should be accessible in electronic or paper form from the entity's time keeping system.

<u>Examples of acceptable documentation include</u>:

- A computer screen shot of a file list that shows a document being created or modified at the sampled moment with notation from the participant of how that file relates to the response.
- A computer screen shot of an email box that shows emails read or sent at the sampled moment with notation from the participant that explains how the email relates to the response.
- Calendar entry (either Outlook screen short or scanned schedule book entry) that shows details of activity performed at the sampled date and time.
- Travel logs that reflect the date and time span including the sampled moment with notes regarding the purpose of the travel.
- Phone logs that reflect the date and time span including the sampled moment with notes regarding the topic of phone conversation.
- A meeting agenda with notation of the topic being discussed at the sampled moment.
- Electronic evidence (e-mail or other form) of activity during the that provides details of the activity performed and, if possible, additional documentation to support the details.
- An email to yourself that provides details of the activity performed and, if possible, some other documentation to support the details.
- A note for the file that describes the activity, preferably with documentation attached.

Examples of unacceptable documentation include:

- Unclear or vague documentation that does not sufficiently support the response to the sampled moment.
- Documentation that does not reflect the appropriate date and time of the sampled moment.
- No documentation

Time study moments are subject to internal and external review and/or audit. Therefore, it is imperative that sufficient documentation is maintained and available whenever a review and/or audit is conducted. This documentation should be maintained in a central location that can be accessed by the entity's MAC Coordinator or other authorized entities.

Additional documentation maintained by the State MAC Program Administrator will include:

- Sampling and selection methods used,
- Identification of the moment being sampled,
- Timeliness of the submitted time study moment documentation, and
- Annual review of state and county calendars.

Non-returned moments are moments left unanswered by participants. Every effort will be made to obtain the corrected valid moment from the participant within the 5-day grace period.

Validation Method

DODD is committed to collecting complete and accurate information through its statewide RMTS. As such, it will require that 5% of all moments be validated by the MAC Coordinator or Assistant MAC Coordinator.

After the initial generation of moments, the State MAC Program Administrator will generate a sub-sample of 5% of the moments flagged for validation for each cost group. Identified moments for cost group 2 (county boards and COGs) will be shared with the affected MAC Coordinators. When a participant flagged for validation responds to a moment in the sub-sample, the local MAC Coordinator or Assistant MAC Coordinator will validate the response as accurate and complete.

Validation must occur within grace period of the selected moment. The validation cannot be conducted by the same person or entity that codes the responses.

Time Study Return Compliance

A *validity check* of the time study results will be completed by the State MAC Program Administrator each quarter prior to the calculation of the claim. The validity check ensures that the minimum number of responses is received each quarter to meet the required confidence level by analyzing the number of completed and returned time study moments. Once the validity of the sample has been confirmed, the time study

results are calculated in preparation for the quarterly claim. The State MAC Program Administrator will provide ODJFS with a series of quarterly reports which include coding that was completed for a randomly selected percentage of responses. In addition, the State MAC Program Administrator will provide ad hoc reports upon request.

At the end of each quarter, once all Random Moment 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.

Ohio will require a response rate for each time study survey of at least 85%. All non-returned moments will be included and coded as non-Medicaid time. If the 85% compliance rate is reached without having to utilize non-returned moments, then non-returned moments will be ignored since they are compensated by the 15% over sampling of the sample size. A report of returned and non-returned moments will be prepared by the State MAC Program Administrator within 30 days of the end each quarter and shared with ODJFS.

To assist in reaching the time study survey goal of 85% compliance, the State MAC Program Administrator will monitor the CB and COGs to ensure they are properly returning sample moments, including analyzing the return percentage for each quarter. If an individual county board or COG has non-returns greater than 15% and greater than five (5) moments for a quarter, the county board or COG shall be deemed in default. The MAC Coordinator, the local superintendent or executive director, and ODJFS will receive a warning letter from the State MAC Program Administrator. If a participating entity is in default more than one quarter in a rolling claim year, it will not be allowed to participate in the time study for **one quarter** and a notice of non-participation will be sent to the MAC coordinator, the local superintendent or executive director, and ODJFS. If any participating entity demonstrates a recurring problem with meeting the compliance goal, the State MAC Program Administrator will send a notice of noncompliance with appropriate sanctions and plan of correction to the local MAC Coordinator and the local superintendent or executive director.

The State MAC Program Administrator will identify on a weekly basis all non-returned moments and make every effort to find out why the moments were not returned. A list of these non-returned moments will be sent to the appropriate local MAC Coordinators for a response. Participants will be asked to explain why the moment was not completed and returned, and will also be asked what they were doing at the time of the moment in question to the best of their recollection. The State MAC Program Administrator will then analyze this data to ensure that the non-returns are reflective of the time study results. This data will not be included in the claiming process but will be used only to ensure that participating entities are not purposely withholding non-Medicaid related moments.

Time Study Activities Definition and Codes

The time study codes assist in the determination of time spent on any particular activity and the associated costs that are reimbursable under the Medicaid program.

DODD used many different sources to support the development of detailed definitions for MAC functions. These sources included administrative function definitions found in the 42 CFR Part 441, Subpart B, as well as HCFA/CMS approved and/or reviewed Medicaid administrative claiming materials employed in several other states. The time study codes have been designed to reflect all of the activities performed by time study participants in the two RMTS groups.

Each activity is categorized into various types that determine its allowability, federal financial participation (FFP) rate, and Medicaid share. These types are as follows:

I. **Non-Discounted (Type ND)** activities are MAC activities that are 100% Medicaid applicable and reimbursable. Medicaid Eligibility Rate (MER) percentages are not applied to these activities.
II. **Discounted (Type D**) activities are administrative activities that are only reimbursable for the Medicaid eligible individuals for the claming unit. The costs associated with these activities will be reduced according to the MER percentage in the claims calculation.
III. **Unallowable (Type U)** activities are unallowable activities under the Medicaid Administrative claim, but account for the balance of the time study participants' time. The costs for these activities are unallowable regardless of whether or not the population served includes Medicaid eligible individuals. As required in OMB A-87, the full spectrum of activities performed by the sampled participants is measured in order to accurately account for all of the study participants' time.
IV. **Reallocated (Type R)** applies to the activity code for general allocable administrative activities. Time allocated to this activity is reallocated across the other activities, including those that are unallowable.

The gross amount of each reimbursement type (i.e. ND, D, and R) has the appropriate FFP rate applied to determine the amount of reimbursement. A summary of activity code descriptions and reimbursement types for DODD Central Office, CBs, and COGS are listed in **Attachment A: Summary of Activity Codes**. Detailed definitions of the time study activities can be found in **Attachment B: Time Study Activity Codes.**

The RMTS system will calculate the reimbursement associated with any time study activities from the following factors:

- Actual salary and fringe costs of participants as provided by the MAC Coordinators or State MAC Program Administrator
- Percentage of time distribution for each activity, as determined by the time study
- Application of reimbursement level factors:
    - Application of Medicaid Eligibility Rate for Activity Codes;
    - Exclusion of those activities that are non-allowable
    - Reallocation of allowable general administration as described in Activity Code 18, General Administration
- Application of the allowable FFP

The MAC Coordinator is responsible for entering qualified contract expenses to the RMTS system and identifying any offset costs. This information will be incorporated into the claim calculations to determine the total claim amount.

The State MAC Program Administrator is responsible for reviewing all claim calculations for accuracy.

Medicaid Eligibility Rates (MER)

Some of the MAC activities performed by DODD Central Office and the CBs/COGs benefit both Medicaid and non-Medicaid populations. Therefore, the costs associated with these activities must be allocated accordingly. This ensures that only the costs related to MAC activities for Medicaid-eligible individuals (those possessing a current Medicaid card) are claimed. This allocation of costs involves developing a proportional Medicaid share, also referred to as the Medicaid Eligibility Rate (MER). The MER is a population-based calculation derived by dividing the number of Medicaid-eligible individuals by the total number of individuals served by the respective claiming entity:

$$\frac{\text{No. of } \textbf{Medicaid-eligible} \text{ individuals with DD served}}{\text{Total no. of } \textbf{individuals} \text{ with DD } \textbf{served}}$$

Each CB and COG has a MER based on the specific population they serve. DODD Central Office's MER is based on a statewide census. There is no overlap in the administrative responsibilities carried out by DODD Central Office and the CB/COGs.

In the first month of the calendar year, DODD will calculate each participating entity's MER rate for that year using client information entered by the CB/COGs into the Individual Data System (IDS) and the ODJFS Medicaid eligibility files obtained by DODD's Division of Information Technology Services (ITS). DODD will use the December 31st data in IDS to determine the total number of individuals with DD served in each county. This data is then compared to the ODJFS eligibility files to identify those individuals who are Medicaid-eligible on that same date.

Only those individuals with current eligibility on December 31st are included in the Medicaid eligibility count. The MER will count only persons reported by the CB/COG who are active in the IDS system and are receiving at least one service from the CB/COG. Those designated as deceased or terminated, or waiting list only are excluded from the calculation. The calculated MER is to be used for that calendar year. Each year, the process repeats itself, resulting in an annual MER rate.

Financial reporting

Financial information used to claim reimbursement is based upon actual expenditures obtained directly from the participating entities' financial accounting system. MAC Coordinators are responsible for providing detailed expenditures on salaries, fringe benefits, and personal service contract costs each quarter by the deadline established

by the State MAC Program Administrator. Each financial accounting system from which the expenditure data are obtained must adhere to the following four principles:

- The methodology and calculated financial data are fully consistent with the requirements of OMB Circular A-87 and adhere to Medicaid principles of reimbursement as stated in CMS Publication 15-1.
- The financial information is classified in a format that facilitates the time study application and results. The appropriate Medicaid Eligibility Rate (MER) is applied for each MAC code.
- The time study process minimizes the time spent by financial personnel to meet the reporting requirements while maintaining assurance of data accuracy.
- Expenditure reporting is on a cash basis and will include actual salary and fringe benefits incurred on pay days that fall within the quarter.

All supporting documentation will be made available by the claiming entity for audit by the State of Ohio (including ODJFS, DODD, the Auditor of the State of Ohio, the Inspector General of Ohio, or any duly authorized law enforcement officials) and by agencies of the United States Government. All supporting documentation is retained by the claiming entity for seven years from date of receipt of payment or for six years after any initiated audit is completed and adjudicated, whichever is longer. If any claims are resubmitted, the seven years restarts with the date the claim is resubmitted.

Personal Services Contracts

Claiming entities may include expenditures related to performance of Medicaid administrative activities by contractors. Exceptions/limitations to contractors' involvement in the MAC program include the following:

- No contractor, or employee of a contractor, who also serves as a direct service provider shall be included in the MAC program.
- No contractor, or employee of a contractor, shall serve as a local MAC Coordinator or assistant coordinator for any claiming entity.

Some COGs provide contracted services to county boards of DD regardless of whether the county boards participate in the MAC Program. Examples of services COGS provide to county boards include Payment Authorization Waiver System (PAWS) management, Level of Care tracking, other Medicaid waiver administration tasks, Major Unusual Incident (MUI) investigations, and quality assurance for Supported Living. To ensure that there is no duplicate billing for these services, CBs and COGs must spell out in their MAC annual implementation plans which party will request reimbursement from DODD for these services. The State MAC Program Administrator will also examine county board and COG claim information to confirm whether CBs or COGs request reimbursement for these activities. Contracts deemed inappropriate during review and preparation of claims will be excluded.

All contract personnel must submit an invoice to the claiming entity that documents all activities performed (both MAC and non-MAC), time spent on each, and charges. The local MAC Coordinator (or designated data entry person at the claiming entity) for the

claiming entity will identify the appropriate activity code(s) for the work performed by the contractor and submit this information with their claim, including actual expenditures for services obtained from the agency's financial system. The allowable amount will be calculated from this information and included in the claiming entity's quarterly claim to DODD.

Indirect Cost Rates

All participating entities will be paid an interim indirect cost rate of 10%.

The actual indirect cost for DODD Central Office (Time Study Group 1) will be established based on an indirect cost rate proposal submitted by DODD to ODJFS and subsequently approved.

The actual indirect cost rate for CB and COGs (Time Study Group 2) will be established using a CMS-accepted annual cost reports. Indirect costs incurred by these entities will be allocated to various cost centers, including MAC, based on accumulated costs and in accordance with OMB Circular A-87. The calculated actual indirect cost will be reconciled against the interim payment made and amount due to or due from the claiming entity will be settled.

Exclusion of Federal Revenue

Because the Medicaid Administrative Claiming program represents a claim for federal reimbursement, **any federal revenues directly or indirectly related to Medicaid administrative functions and positions are excluded to avoid potential duplicate claiming for federally funded positions**. Federal funds that DODD awards to the CBs/COGs and expenditures from those funds also are excluded. Only expenses supported by appropriate state and local public funding sources are included for reimbursement in the claim calculation. The following are examples of funds that must be excluded:

1. All federal funds, and any state/local matching funds as required by a federal grant;
2. All state expenditures that have been previously matched by the federal government (including Medicaid funds for medical assistance).
3. State funds, which are required to be specifically targeted or earmarked for the delivery of non-MAC activities, must be used for the purpose for which they are targeted or earmarked and cannot be used to match other expenditures.
4. Insurance and other fees collected from non-governmental sources must be offset against claims, where applicable, for federal funds.

Any provider-related donations are not allowed as revenue sources for any CB or COG Medicaid Administrative Claim. (42CFR §433.54)

The DODD MAC claims must adhere to the OMB Circular A-87, Attachment A, Part C, Item 4 (Applicable Credits). Participating entities will be required to report information

about such revenue to be offset against their claims each quarter when submitting their salary/fringe costs and contract costs to the State MAC Program Administrator.

Claims Submission

The State MAC Program Administrator is responsible for compiling time study information from the RMTS online system and financial data from each participating entity to prepare and submit separate quarterly claims to ODJFS (one for each RMTS group). The MAC Coordinator at each participating county board or COG is responsible for submitting the required financial information to the State MAC Program Administrator for claim calculations by the deadline provided in order to be included in the group's claim.

If, for any reason, a claiming unit does not meet the quarterly submission deadline, the State MAC Program Administrator will process the claim without that unit's quarterly claim. Any petition by a claiming entity for including a late submission in the claim will be decided at the discretion of the MAC Administrator at DODD.

ODJFS is responsible for the final review and approval of the submitted claims, then will request reimbursement from CMS. Reimbursement for a claim is made to the CB/COG by DODD following receipt of federal funds from ODJFS.

All submitted claims are subject to review by the State MAC Program Administrator and/or ODJFS prior to payment. If a county board or COG claim is reviewed and found to contain significant errors, payment may be delayed to that county board or COG.

The table below summarizes the schedule for claims submission and payment.

Schedule for the Claims Submission & Payment				
Quarter	**Claim submission deadline to DODD**	**DODD submission deadline to ODJFS**	**Approval deadline (by ODJFS)**	**Payment to claiming entity**
January-March	June 30	August 31	September 30	October 31
April-June	September 30	November 30	December 31	January 31
July-September	December 31	February 28	March 31	April 30
October- December	March 31	May 31	*June 30	*July 31

*Note: Due to constraints with the state fiscal year reporting requirements that cause the state central accounting system to be unavailable to agencies for several weeks every June, approval and payment to claiming entities may be delayed for this quarter only.

III. TRAINING

Three types of training will be conducted for RMTS: (1) Program Contact Training, (2) Central Coding Staff Training and (3) Sampled Staff Training. The following is an overview of each training type.

1. Program Contact Training

The State MAC Program Administrator will provide initial training for the local MAC Coordinators which will include an overview of the RMTS program and its purpose, the appropriate completion of the RMTS (how to access and utilize data input mechanisms), the timeframes and deadlines for participation, and the responsibilities of the local MAC Coordinator's role. The State MAC Program Administrator will also provide mandatory annual training to local MAC Coordinators to cover topics such as MAC program updates, process modifications and compliance issues.

DODD requires both the local MAC Coordinator and Assistant Coordinator attend the initial RMTS training and all subsequent mandatory training sessions as scheduled by the State MAC Program Administrator. Failure to attend the required training will result in the following consequences:

- First absence – Local agency will be moved forward on the RMTS Review schedule;
- Second absence – Recoup 5 percent of next submitted and approved claim;
- Third absence – Recoup 5 percent of next submitted and approved claim;
- Fourth absence – Recoup 5 percent of next four submitted and approved claims; and
- Fifth absence – Removal from the MAC program and no payment on claims.

2. Central Coding Staff Training (Activity Coding)

Selected staff at DODD Central Office will serve as Central Coders who will review the documentation of participant activities performed during the selected moments and determine the appropriate activity code. In a situation when insufficient information is provided to determine the appropriate activity code, a Central Coder will contact the local MAC Coordinator of the participating entity or the supervisor of the Central Office participant and request submission of additional information about the moment. Once the information is received, the moment will be coded and included in the final time study percentage calculation. <u>All</u> moments coded by a Central Coder will be reviewed by the State MAC Program Administrator as part of a quality assurance process for consistency and adherence to the state-approved activity codes.

The State MAC Program Administrator will provide initial training to the Central Coders prior to the roll-out of the RMTS program. Training will include an overview of activity codes, samples of activities, and appropriate processes for making coding determinations. Regular trainings will be scheduled as needed to discuss issues surrounding the coding of moments.

On a quarterly basis, ODJFS will review the coding process and original participant documentation of up to 4 claiming entities for Quality Assurance purposes to show the data submitted in the time study questionnaires support the code selected and therefore show the codes are valid and accurate. In addition to the quarterly review, ODJFS will conduct a more thorough review at least 1 claiming entity from either RMTS group. ODJFS reserves the right to review the completed coding and original participant documentation at any time throughout the claim process or as needed for further review or audit purposes.

3. Sampled Staff Training

The local MAC Coordinator must ensure that sampled staff (i.e., staff selected to respond to a random moment survey) receive training prior to their completion of their first RMTS. Once staff has received this training, no further training is required for future surveys. However, the local MAC Coordinator or the State MAC Program Administrator may require additional training if deemed necessary. Since RMTS responses are either selected from pre-coded activities or coded by trained Central Coders, the staff training will focus on solely on program requirements and the completion of the RMTS survey. The staff training will not include an overview of activity codes. The following items must be included in staff training:

- Overview of the required process to participate in RMTS
- Review the standards for RMTS documentation submitted by staff
- Methods for requesting additional documentation from time study participants when insufficient information is provided to centralized coders to determine the appropriate activity code.

Staff members that do not receive training cannot participate in the RMTS. Participating entities must maintain documentation that all staff participating in each quarter's time study received training. To ensure standardization of the MAC program, local MAC Coordinators are required to use training materials developed by the State MAC Program Administrator, subject to review by ODJFS, which will be available via the DODD's website. If local MAC Coordinators wish to supplement this training material with information more specific to the local entity, such training materials must be submitted to the State MAC Program Administrator for approval prior to its use.

IV. MONITORING

Local Level Oversight and Monitoring of Time Study Administration

Each CB/COG must designate an employee as the local MAC Coordinator to provide oversight for the implementation of the time study and to ensure that policy decisions are implemented appropriately. The local agency must also designate an Assistant MAC Coordinator to provide back-up support for time study responsibilities. The local MAC Coordinators participate in monitoring MAC time studies and claims to ensure submissions to DODD are appropriate and reasonable. The areas that the local MAC Coordinator will review include, but are not limited to the following:

- Participant List. The local MAC Coordinator will submit only eligible participants based on the approved RMTS plan.
- RMTS Time Study. The local MAC Coordinator will ensure that all employees participating in the time study complete their RMTS surveys within the specified time frame to ensure that non-responses are within the statewide goal of 85% compliance. The local MAC Coordinator will identify all non-responses to analyze why they were not returned and what solutions are needed to avoid future non-responses.
- Training. The local MAC Coordinator will assure that training requirements for participating staff are being met and provide technical assistance to participants as needed.
- Attestation. For each claim submitted to DODD, the local MAC Coordinator will ensure that the appropriate authority of the claiming entity attests via electronic signature to the accuracy of the claims and sufficient matching funds that meet the Federal matching funds definition as set forth in 42 CFR 433.
- Quarterly Status Report. The local MAC Coordinators will submit to DODD a quarterly status report in a format provided by the State MAC Program Administrator, noting the time study activities occurring that quarter and any difficulties with time study implementation.
- Documentation. The local MAC Coordinator will maintain all documentation in support of the quarterly claims as outlined in this Guide.

State Level Oversight and Monitoring of Time Study Administration

The State MAC Program Administrator will serve as the single point of accountability for monitoring the various components of the MAC program. The areas that the State MAC Program Administrator will review include, but are not limited to the following:

- Participant List. The State MAC Program Administrator will assure that local MAC Coordinators submit only eligible participants based on the approved RMTS plan. The State MAC Program Administrator will review any exclusion to the CB/COG participant listing.
- RMTS Time Study. The State MAC Program Administrator will be responsible for the sampling methodology, the sample, and the time study results and document the outcome of this review. The results of this review as well as any unresolved

questions or issues will be submitted to ODJFS as the single state Medicaid agency.

- RMTS Central Coding. The State MAC Program Administrator will review a sample of coding results (including excluded minutes) and the original participant documentation for coding accuracy and validation. The State MAC Program Administrator will use this analysis to identify needed improvements to the MAC program.
- Training. The State MAC Program Administrator will assure that training requirements for local MAC Coordinators, Central Coders and participating staff are being met by review of training materials and attendance at various training sessions.
- Quarterly Status Report. The State MAC Program Administrator will summarize the quarterly status reports from the participating local entities and forward the summaries with recommendations for improving the local implementation process to ODJFS for review. The State MAC Program Administrator will follow up on any review comments from ODJFS.
- Documentation Compliance. The State MAC Program Administrator will develop a documentation compliance plan and monitor its results.
- Claims Processing. ODJFS will not process or submit any MAC claim for FFP reimbursement that contains claiming errors. Such claims will be returned to the claiming entity for review and correction. If the State MAC Program Administrator identifies a claim overpayment, DODD will require reimbursement from the claiming unit of the overpaid amount.

Through its oversight and monitoring responsibilities, DODD or ODJFS may require any participating entity to take additional steps to improve performance in the MAC program. These steps may include providing additional training, recommending procedure changes, performing internal audits and reviewing claiming entity documentation.

Claim Reconciliation

The State MAC Program Administrator, in collaboration with ODJFS staff, will monitor all local MAC programs at least once annually. This monitoring will consist of either an on-site, desk or combination review. As part of this process, one quarter of the year being reviewed will be selected for in-depth examination. Participating entities will be required to fully cooperate in providing information and access to necessary staff in a timely manner to facilitate these efforts. MAC programs that do not fully cooperate in the review process may be subject to sanctions by ODJFS.

For other quarters, trends will be examined. For example, total costs in the claim, time study results, and reimbursement levels in relation to the entity's DD population. Any significant variation from historical trending will be communicated to the local MAC Coordinator for explanation of the variance.

All claiming agencies have financial audits performed either by state, private or federal auditors. When a financial audit is conducted on the claiming entity, all filed administrative claims must be reconciled to the audited cost report. Adjustments

resulting in underpayments can be reimbursed by CMS up to two years from the last quarter of the federal fiscal year the claim was submitted to CMS for reimbursement.

Adjustments resulting from overpayments to DODD Central Office and CBs/COGs shall comply with time restrictions set forth in section 6506 of the Affordable Care Act…"the Medicaid agency has up to one year from the date of discovery of the overpayment for Medicaid services to recover, or attempt to recover, such overpayment before making an adjustment to refund the Federal share of the overpayment."(State Medicaid Director Letter # 10-014) or the federal regulations that are in place at the time of the discovery of overpayment. The adjustment will be processed on the next available claim after adjustments are communicated."

Remedial Action and Sanctions

DODD will pursue remedial action for County Boards and COGs that fail to meet MAC program requirements or fail to correct problems identified during review. Examples of actions that will cause implementation of sanctions include, but are not limited to:

- Repeated and/or uncorrected errors in financial reporting, including failure to use the state provided financial reporting templates,
- Failure to cooperate with state and/or federal staff during reviews or other requests for information,
- Failure to submit quarterly reports or annual implementation plans,
- Failure to maintain adequate documentation, and
- Failure to provide accurate and timely information to the State MAC Program Administrator as required.

Sanctions that Ohio may impose include placing a claiming entity on "payment hold", conducting more frequent monitoring reviews and trainings, recovery of funds, or exclusion from participation. All county boards and COGS must agree to the terms and conditions imposed by this guide, including referenced local, state, and federal rules, regulations, guidelines and requirements as a requirement to participate in MAC.

ODJFS will pursue remedial action for DODD if it fails to comply with the terms and conditions imposed by this guide, including reference local, state and federal rules, regulations, guidelines and requirements.

Attachment A:
Summary of Activity Codes for State

Activity Code	Activity Description
1	Direct Care
2	Developmental Centers
2A	ICF/MR Administration & Oversight
3	Medicaid Outreach
4	Non-Medicaid Outreach
5	Facilitating Medicaid Eligibility Determinations
6	Facilitating Eligibility for Non-Medicaid Programs
7	Referral, Coordination and Monitoring of Medicaid Services
8	Referral, Coordination and Monitoring of Non-Medicaid Services
8A	DD Council
8B	Title XX
8G	PASRR
9	Translation for Medicaid Services
10	Translation for Non-Medicaid Services
11	Program Planning, Development and Interagency Coordination of Medicaid Services
12	Program Planning, Development and Interagency Coordination of Non- Medicaid Services
13	Medicaid Related Provider Relations
14	Non-Medicaid Provider Relations
16	Major Unusual Incidents and Unusual Incidents Investigations for non-Medicaid population
17	Major Unusual Incidents and Unusual Incidents Investigations for combined population
18	General Administration

Summary of Activity Codes for CB/COGs

Activity Code	Activity Description
1	Direct Care
2	Targeted Case Management Activities
3	Medicaid Outreach
4	Non-Medicaid Outreach
5	Facilitating Medicaid Eligibility Determinations
6	Facilitating Eligibility for Non-Medicaid Programs
7	Referral, Coordination and Monitoring of Medicaid Services
8	Referral, Coordination and Monitoring of Non-Medicaid Services
9	Translation for Medicaid Services
10	Translation for Non-Medicaid Services
11	Program Planning, Development and Interagency Coordination of Medicaid Services
12	Program Planning, Development and Interagency Coordination of Non- Medicaid Services
13	Medicaid Related Provider Relations
14	Non-Medicaid Provider Relations
16	Major Unusual Incidents and Unusual Incidents Investigations for non-Medicaid population
17	Major Unusual Incidents and Unusual Incidents Investigations for combined population
18	General Administration

Attachment B:
Time Study Activity Codes

This attachment (Attachment B: Time Study Activity Codes) contains two sets of narrative descriptions for MAC activity codes specific to activities performed by individuals in each RMTS group. The first set is to be used only by MAC staff at DODD Central Office. The second set is to be used by MAC staff at CBs and COGs.

(Note: Throughout this activity code descriptions, the term "Medical services" means those direct medical services that when provided to Medicaid eligible recipients are covered under a Medicaid program. While Medicaid covers the services for Medicaid-eligible individual, the services are also likely being provided in the normal course of business to non-Medicaid eligible individuals. The relevant codes should be used based on the activity definition – regardless of whether it is provided to Medicaid or non-Medicaid individuals. The "discounting" computational process will allocate these activity categories proportionally to Medicaid and non-Medicaid individuals.

OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES (DODD)
STATE LEVEL

MEDICAID ADMINISTRATIVE CLAIMING PROGRAM
ACTIVITY CODES

CODE 1: DIRECT CARE
Medicaid Rate: U (Unallowable)

All DODD Central Office MAC staff may use Code 1.

Providing client care, treatment and/or counseling services to an individual in order to correct or improve a specific condition. Includes the provision of direct services reimbursed through Medicaid, as well as direct services that are not reimbursed by Medicaid. Includes staff travel or training directly related to performing direct care activities.

Examples of activities reported under Code 1 include:

- Conducting developmental assessments.
- Developing individual service plans and plans of care.
- Other direct services including performing assessments/medical exams.
- Developing treatment plans.
- Providing transportation services.
- Providing therapy services;
- Health screenings and diagnostic evaluations (e.g., orthopedic evaluation, vision screen, and audiological testing services).
- Counseling/therapy services.
- Skills training for medical/dental/mental health services.
- Administering first aid, emergency care, medication, or immunizations.
- Participating in individual chart reviews that include Medicaid-covered services to ensure compliance with medical documentation and forms requirements. **This is NOT system quality assurance reviews. System-wide quality assurance reviews should be coded as Code 7, Monitoring of Medicaid Services.**

CODE 2: DEVELOPMENTAL CENTERS

Medicaid Rate: U (Unallowable)

All DODD Central Office MAC staff may use Code 2.

Use Code 2 to document staff time spent on administrative activities for the developmental centers. OMB circular A-87 and 45 CFR Part 95, Subpart E requires DODD to submit a cost allocation plan that allocates all costs to each of the programs developmental centers operate. The time allocated to this code will be used for developing and implementing the cost allocation plan DODD uses to set the per diem rates for the developmental centers. Section 5123.03 of the Ohio Revised Code mandates that the DODD maintain, operate, manage, and govern all state institutions for the care, treatment, and training of the mentally retarded and have control of all institutions maintained in part by the state for the care, treatment, and training of the mentally retarded.

Examples of activities reported under Code 2 include:

- Meetings with superintendents of developmental centers.
- Capital Improvement/Facility Development activities for developmental centers.
- Developing and monitoring developmental center budgets and expenditure reports.
- Processing developmental center payroll/personnel-related documents.
- Providing technical assistance to developmental center staff.
- Reviewing or writing developmental center policies and procedures.
- Providing or attending developmental center training.
- Preparing for and conducting periodic Excel surveys of developmental centers (including follow up visits, report preparation, etc.)
- Conduct audits of developmental centers.
- All other administrative functions conducted on behalf of developmental centers**.**

CODE 2A: ICF/MR Administration & Oversight
Medicaid Rate: ND (Non-Discounted)

All DODD Central Office MAC staff may use Code 2A.

Use Code 2A for performing tasks related to coordinating and managing ICFs/MR (see OAC Chapter 5101:3-3). Includes staff travel or training directly related to performing ICF/MR administration and oversight.

Examples of activities reported under Code 2A include:

- Participating in ICF/MR stakeholder meetings, work groups, rule development and review groups aimed at improving the coordination and delivery of services, reducing duplication, and closing gaps in availability of services.

- Planning programs and services to meet identified needs of the ICF/MR population.

- Developing, reviewing and revising ICF/MR-specific policies and procedures

- Processing Individual Assessment Forms (IAF)

- Assessing the capacity of the ICFs/MR to deliver Medicaid-covered services; identifying potential barriers and needs. Inter- and intra-agency coordination to improve Medicaid services delivery.

- Developing and monitoring ICF/MR budgets and expenditure reports.

- Reviewing and approving new and ongoing placements in outlier facilities.

- Reviewing, monitoring, and processing ICF/MR service billings.

- Rate setting, rate modeling, and franchise fee calculations.

- Collecting and analyzing ICF/MR data in order to improve service coordination and delivery, forecasting, etc.; Claims research

- Monitoring effectiveness of ICF/MR programs, including client satisfaction surveys, preparation and review of financial and programmatic reports, and ongoing analysis of existing ICF/MR reimbursements.

- Providing technical assistance to ICF/MR staff, such as bed holds.

Code 2A (continued)

- Monitoring ICF/MR compliance with federal and state regulations through desk reviews; working with external agencies (ODJFS, CMS, AOS, etc.) to monitor ICFs/MR.

- Formulating agreements/contracts between ODJFS, DODD, and ICF/MR providers.

- All other administrative functions conducted on behalf of ICFs/MR**.**

.

CODE 3 MEDICAID OUTREACH

Medicaid Rate: ND (Non-Discounted)

All DODD Central Office MAC staff may use Code 3.

A campaign, program or ongoing activity targeted to 1) bring individuals into the Medicaid system for the purpose of determining eligibility or 2) bring Medicaid eligible individuals into specific Medicaid services. Activities may include informing (in writing or orally) Medicaid eligible or potentially eligible individuals, agencies, and community groups about the range of health services covered by the Medicaid program. Such services may include preventive or remedial health care services offered by the Medicaid program that may benefit eligible individuals.

Use code 3 when conducting outreach campaigns directed to the entire population to encourage potentially Medicaid eligible individuals to apply for Medicaid and outreach campaigns directed toward bringing Medicaid eligible individuals into Medicaid covered services, including Medicaid waivers (i.e. Individuals Options or Level I).

An education program or campaign may be allowable as a Medicaid outreach activity if it is targeted specifically to Medicaid services and for Medicaid eligible individuals. Education programs or campaigns that are general in nature, such as car passenger safety or antismoking programs, should be claimed under Code 4, Non-Medicaid Outreach.

Includes staff travel or training directly related to performing Medicaid outreach activities.

Report under this code only that portion of time spent in activities that specifically address Medicaid outreach. Report the non-Medicaid portion of these outreach campaigns under Code 4 such as providing information on family support services.

Examples of activities reported under Code 3 include:

- Providing oral or written information to the general population about the Medicaid program, including Medicaid waivers, to encourage individuals eligible for Medicaid to apply for Medicaid.

- Providing oral or written information to individuals, families, advocates, agencies and community groups about Medicaid covered services, including Medicaid waivers, for the purpose of bringing individuals eligible for Medicaid into Medicaid services.

Code 3 (continued)

- Providing and presenting materials to explain what Medicaid services are available to Medicaid eligible individuals, including Medicaid card services and services available through a waiver (Individual Options, Level I, etc.) program.

- Informing families, individuals and/or advocates about the availability of Medicaid services and describing how to enroll in the Medicaid program.

CODE 4: NON-MEDICAID OUTREACH

Medicaid Rate: U (Unallowable)

All DODD Central Office MAC staff may use Code 4.

Use Code 4 when informing individuals about social, educational, legal or other services not covered by Medicaid. Also use when conducting written or oral education programs addressed to the general population. Includes staff travel or training directly related to performing Non-Medicaid Outreach activities.

Examples of activities reported under Code 4 include:

- Conducting outreach activities that inform individuals about non-Medicaid programs and services (e.g. housing opportunities, family support services, supported living).

- Conducting general health or social education programs or campaigns addressed to the DD population.

- Scheduling and promoting activities that educate individuals with DD about the benefits of healthy lifestyles and practices.

- Providing information about general county board resources such as family support services.

- Conducting outreach campaigns that encourage individuals to access social, educational, legal or other services not covered by Medicaid such as clothing, food, child care, TANF, food stamps, WIC, Head Start, legal aid, housing, jobs, etc.

CODE 5: FACILITATING MEDICAID ELIGIBILITY DETERMINATIONS

Medicaid Rate: ND (Non-discounted)

All DODD Central Office MAC staff may use this code. Staff may use Code 5 when assisting an individual in becoming eligible for Medicaid or when performing a PAWS-related activity.

Includes staff travel or training directly related to performing these activities.

This activity does <u>not</u> include the actual Medicaid eligibility determination.

Examples of activities reported under code 5 include:

- Communicating with county boards and providers regarding PAWS issues.
- Reconciling match commitment with state reports and conducting PAWS utilization reviews.
- Performing Prior Authorization Request reviews for Medicaid approved individuals.
- Conducting ISP to PAWS comparison for persons with DD.
- Explaining Medicaid eligibility rules and the eligibility process to prospective applicants.
- Assisting in the waiver enrollment process for DODD administered waivers (e.g. Individual Options, Level I) and/or waiver services.
- Making referrals to local Department of Job and Family Services (DJFS) in order to encourage individuals who are potentially eligible to apply for Medicaid and HCBS waivers or Healthy Start.
- Gathering information from individuals used for Medicaid applications and eligibility determinations (or re-determinations). Pertinent data would include resource and third party liability (TPL) information used to prepare and/or submit formal Medicaid applications.
- Providing or packaging necessary Medicaid forms needed for the Medicaid eligibility determination.

CODE 6: FACILITATING ELIGIBILITY FOR NON-MEDICAID PROGRAMS

Medicaid Rate: U (Unallowable)

All DODD Central Office MAC staff may use Code 6.

Use when assisting an individual to become eligible for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc. Includes staff travel or training directly related to performing these activities.

Examples of activities reported under Code 6 include:

- Completing an individual's OEDI/COEDI form.
- Informing individuals about programs such as cash assistance, food stamps, WIC, day care, legal aid, and other social and educational programs and referring them to the appropriate agency to make an application.
- Explaining to prospective applicants the eligibility rules and process for non-Medicaid programs, such as supported living, family support services, transportation, school-based programs, community housing, etc.
- Helping an individual complete applications for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc.
- Gathering information related to the application and eligibility determination for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc…from a client.
- Providing necessary forms and packaging all forms in preparation for the eligibility determination for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc.

CODE 7: REFERRAL, COORDINATION AND MONITORING OF MEDICAID SERVICES

Medicaid Rate: D (Discounted)

All DODD Central Office MAC staff may use Code 7.

Use Code 7 when performing tasks related to coordinating and managing waivers (See OAC Chapters 5123:2-8, 5123:2-9, and 5123:2-13). Use when monitoring county boards of DD and services provided to persons with DD. Use when providing technical assistance to county boards of DD and other DD providers. Includes staff travel or training directly related to these activities. Use when conducting subrecipient monitoring activities for the Medicaid program.

Examples of activities reported under Code 7 include:

- Gathering information for and providing referral to existing waiver enrollees to other Medicaid programs/services.
- Developing the process and procedures required to administer waiting lists.
- Performing maintenance on waiting lists.
- Maintenance and management of the PICT and waiver slots.
- Providing technical assistance and support to county boards of DD.
- Accrediting county boards of DD (OAC 5123:2-4-01).
- Preparing, monitoring, or distributing financial reports.
- Maintenance and management of IIF.
- Process provider payments on community based waivers and other Medicaid (CAFS, TCM, etc.) settlements.
- Performing system-wide quality assurance reviews.
- Review and perform an ongoing analysis of existing waiver reimbursement system (OAC 5123:2-9-06), including an analysis of ODDP (not individual specific ODDP results), funding range placement models, rates, ratios, etc. ODDP is an assessment tool that assigns a funding range to Medicaid waiver recipients.
- Participating in external (e.g. ODJFS, CMS, etc.) monitoring reviews of entity's Medicaid programs or services.

Code 7 (continued)

- Providing technical assistance and support to Medicaid waiver/Non-Medicaid providers (includes review & certification process-OAC 5123:2-5-01).

- Monitoring effectiveness of programs providing Medicaid-covered/Non-Medicaid-covered services (especially waiver services), including client satisfaction surveys for medical/dental/mental health services.

CODE 8: REFERRAL, COORDINATION AND MONITORING OF NON-MEDICAID SERVICES

Medicaid Rate: U (Unallowable)

All DODD Central Office MAC staff may use Code 8.

Use when central office is performing referral, coordination and monitoring (e.g. grants and capital programs). Includes staff travel or training directly related to these activities. Use when conducting subrecipient monitoring activities for non-Medicaid federal grants.

Examples of activities reported under Code 8 include:

- All activities related to federal grants including Title XX, Early Intervention, Urban Youth Works, Medicaid Infrastructure Grant (MIG), etc.
- All activities related to DODD's role as fiscal agent for the Developmental Disabilities Council (DD Council).
- Coordination and monitoring of the community capital program.
- All nursing facility placement activities (assessments, correspondence, evaluations, rule development, appeal hearings, etc.) related to the PASRR program (OAC 5123:2-14).
- Preparing, monitoring, or distributing financial reports related to grants or the capital program.
- Work related to medication administration.

CODE 9: TRANSLATION FOR MEDICAID SERVICES

Medicaid Rate: D (Discounted)

All DODD Central Office MAC staff may use Code 9.

Use when arranging, obtaining or providing translation services for the purpose of **accessing Medicaid services** for individuals. Includes staff travel or training directly related to performing these activities.

Translation services furnished by a direct patient care provider (e.g., speech therapist, nurse, physician) during a direct patient care visit should be reported to Code 1-Direct Care.

Non-Medicaid translation services should be reported under Code 10, Translation for Non-Medicaid Services.

Examples of activities reported under Code 9 include:

- Arranging for or providing translation services (oral and/or signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid, including the level 1 and individual options waivers.

- Developing translation materials that assist individuals to access and understand necessary care or treatment covered by Medicaid.

CODE 10: TRANSLATION FOR NON-MEDICAID SERVICES

Medicaid Rate: U (Unallowable)

All DODD Central Office MAC staff may use Code 10.

Use when assisting an individual to **access non-Medicaid services** through arranging, obtaining or providing translation services. Includes staff travel or training directly related to performing these activities.

Translation services furnished by a direct patient care provider (e.g., speech therapist, nurse, physician) during a direct patient care visit should be reported to Code 1-Direct Care.

Examples of activities reported under Code 10 include:

- Arranging for or providing translation services (oral and/or signing services) that assist the individual to access and understand non-Medicaid social, educational, and vocational services such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Developing translation materials that assist individuals to access and understand non-Medicaid social, educational, and vocational services, such as supported living, family support services, transportation, school-based programs, community housing, etc.

CODE 11: PROGRAM PLANNING, DEVELOPMENT AND INTERAGENCY COORDINATION OF MEDICAID SERVICES

Medicaid Rate: D (Discounted)

All DODD Central Office MAC staff may use Code 11, except as noted below.

Planning and developing services, programs and resources that relate to Medicaid covered medical/dental/mental health/social services/waiver services. This includes development of policy, procedures and protocols for delivering and coordinating care to individuals. Use Code 11 for collaborative activities that involve planning and resource development with other agencies, which will improve the availability and quality of medical/dental/mental health/social services and the Medicaid program's cost-effectiveness. Includes staff travel or training directly related to performing program planning and development activities.

Examples of activities reported under Code 11 include:

- Working with other agencies that provide Medicaid services to improve the coordination and delivery of services, to expand their access to specific populations of Medicaid eligible individuals, and to improve collaboration around the protocol for persons with dual diagnoses (DD and mental illness).

- Assessing the capacity of the agency and its DD providers to deliver accessible Medicaid covered medical/dental/mental health/social assessment, treatment and care services to Medicaid eligible individuals and identifying potential barriers and needs.

- Reducing Medicaid services overlaps and duplication by DD providers and closing gaps in the availability of services.

- Planning programs and services to meet the identified needs of high-risk populations of Medicaid eligible individuals served by DODD and its DD providers.

- Inter- and intra-agency coordination to improve Medicaid services delivery.

- Formulating agreements/contracts between claiming entity and DODD, providers, and/or COGs.

Code 11 (continued)

- Collecting and analyzing Medicaid data related to general population groups (not individual specific) or geographic areas, including data gathered from chart reviews, in order to improve service coordination and delivery.

- Conducting needs assessments for Medicaid services for the entire DD Medicaid population.

- Developing plans for expanding Medicaid-covered services, especially waivers.

- Coordinating efforts to improve access to Medicaid covered medical/dental/mental health/social services/waiver services to specific under-served populations or geographic areas.

- Interpreting and using statistical data from Medicaid claims data and other health services data system to forecast services utilization, and close existing gaps in Medicaid services delivery.

- Participating in Medicaid-related stakeholder meetings, work groups, rule development and review groups.

- Developing, reviewing and revising Medicaid specific policies and procedures.

- Participating in the development of rates for waiver or TCM services.

CODE 12: PROGRAM PLANNING, DEVELOPMENT AND INTERAGENCY COORDINATION OF NON-MEDICAID SERVICES

Medicaid Rate: U (Unallowable)

All DODD Central Office MAC staff may use code 12.

Use when performing activities associated with developing strategies to improve the coordination and delivery of non-Medicaid services that include educational, social, vocational, and other services. This activity code includes paperwork, clerical activities, and staff travel or training related to performing program planning and development activities.

Examples of activities reported under code 12 include:

- Working with other agencies that provide non-Medicaid services to improve the coordination and delivery and expansion of non-Medicaid services such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Assessing the capacity of DODD and its DD providers to deliver accessible non-Medicaid services and to identify potential service delivery barriers and needs.

- Reducing non-Medicaid service overlaps and duplications by DD providers and closing gaps in services availability.

- Planning programs and services to meet the identified needs of high-risk populations of individuals served by DODD and its DD providers.

- Inter- and intra-agency coordination to improve the delivery of non-Medicaid services such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Formulating agreements/contracts between claiming entity and DODD, providers, and/or COGs.

- Evaluating the need for non-Medicaid services in relation to specific populations or geographic areas.

- Collecting and analyzing non-Medicaid data related to specific program, populations or geographic areas receiving these services.

- Participating in external monitoring of entity's non-Medicaid program (such as supported living, family support services, transportation, school-based programs, community housing, etc) or service reviews.

Code 12 (continued)

- Planning, developing, conducting and/or attending training that promotes community collaboration and development of non-Medicaid services (such as supported living, family support services, transportation, school-based programs, community housing, etc.) provided in the community.

- Developing, reviewing, and revising policies and procedures that are not specific to non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Participating in community planning efforts to close gaps in delivering services for non-Medicaid social programs dealing with housing, childcare, after school programs, etc.

- Writing proposals for non-Medicaid services such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Developing and participating in non-Medicaid related stakeholder meetings, work groups, rule development and review groups.

- Developing plans for expanding non-Medicaid-covered services such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Performing rate negotiations for non-Medicaid services such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Coordinating efforts to improve access to non-Medicaid services (such as supported living, family support services, transportation, school-based programs, community housing, etc.) to specific under-served populations or geographic areas.

- Interpreting and using statistical data from non-Medicaid data to forecast services utilization and to close existing gaps in non-Medicaid services delivery.

CODE 13: MEDICAID RELATED PROVIDER RELATIONS

Medicaid Rate: D (Discounted)

All DODD Central Office MAC staff may use code 13.

Use code 13 when performing activities to secure and maintain the pool of eligible Medicaid/Non-Medicaid DD providers. Includes staff travel or training directly related to performing these activities.

Examples of activities reported under code 13 include:

- Recruiting new providers into the Medicaid/Non-Medicaid program (including provider fairs).
- Providing information and technical support to DD providers on Medicaid/Non-Medicaid policy and regulations.
- Developing and distributing written materials to recruit potential Medicaid/Non-Medicaid providers.
- Performing activities related to provider certification.
- Implementing and reviewing outcomes of provider compliance and monitoring processes.
- Performing activities related to provider suspension or revocation process (OAC 5123:2-5-04).
- Maintaining information such as Medicaid/Non-Medicaid provider profiles.
- Assessing providers' capacity to deliver Medicaid/Non-Medicaid covered services.
- Developing Medicaid/Non Medicaid referral sources.
- Recruiting with outside agencies regarding social and education programs.

CODE 14: NON-MEDICAID PROVIDER RELATIONS

Medicaid Rate: U (Unallowable)

All DODD Central Office MAC staff may use code 14.

Use when performing activities related to securing and maintaining non-Medicaid providers. Includes staff travel or training directly related to performing provider relation activities.

Examples of activities reported under code 14 include:

- Recruiting providers for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Providing information and technical support to DD providers on non-Medicaid policy and regulations.

- Recruiting with outside agencies regarding non-Medicaid social and education programs such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Developing and distributing written materials to recruit potential providers for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Developing referral sources for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Providing technical assistance and support to providers of non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc. (including review and certification process).

- Implementing and reviewing outcomes of provider compliance and monitoring processes for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Performing activities related to provider suspension or revocation process for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc.

Code 14 (continued)

- Monitoring effectiveness of programs providing non-Medicaid-covered services such as supported living, family support services, transportation, school-based programs, community housing, etc., including client satisfaction surveys.

- Maintaining information such as provider profiles for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Assessing the capacity of providers to deliver non-Medicaid services such as supported living, family support services, transportation, school-based programs, community housing, etc.

CODE 16 INVESTIGATING UNUSUAL AND MAJOR UNUSUAL INCIDENTS

Medicaid Rate: U (Unallowable)

Use Code 16 for individuals who are not receiving Medicaid services for whom an MUI/UI is performed. The claiming entity may opt to use Code 17, which is a stepped-down charge using the Medicaid eligibility rate (MER), for all time spent performing MUI/UI functions.

Use Code 16 when completing proactive/prevention/filing of an incident; planning the investigation; gathering investigation information; analyzing the information; completing the written investigation report; and conducting any follow-up as part of the investigation. Use when compiling or monitoring related paperwork, utilizing the Incident Tracking System, and coordinating with county boards of DD (OAC 5123:2-17). Includes staff travel or training directly related to investigating an MUI activity for a non-eligible individual.

Examples of activities reported under Code 16 include:

- Performing proactive/prevention/filing for non-Medicaid services.
- Reviewing Unusual Incident Reports and assessing pattern/trend analysis for non-Medicaid services.
- Performing Pattern/Trend Analysis for non-Medicaid services.
- Filing allegation and preparing for/participating in reviews for non-Medicaid services.
- Notify required parties, including individuals, guardians, agencies, law enforcement, children services, county boards, and other oversight agencies for non-Medicaid services.
- Planning the investigation, reviewing any pertinent information, and coordinating the investigation for non-Medicaid services.
- Collecting pertinent information and coordinating with law enforcement for non-Medicaid services.
- Analyzing information to determine if incident is substantiated for non-Medicaid services.
- Completing the Investigation Report and final notifications for non-Medicaid services.

Code 16 (continued)

- Following up with pertinent parties and participating in hearings for non-Medicaid services.

- Collecting additional information and coordination regarding abuse registry cases for non-Medicaid services.

- Following up with pertinent parties, obtaining death certificate, autopsy finding if necessary, and completion of waiver disenrollment in the event of death for non-Medicaid services.

CODE 17 INVESTIGATING UNUSUAL AND MAJOR UNUSUAL INCIDENTS

Medicaid Rate: D (Discounted)

Use Code 17 for individuals who are receiving Medicaid services for whom an MUI/UI is performed. Code 17 is a stepped-down charge using the Medicaid eligibility rate (MER) for all time spent performing MUI/UI functions. Use this code when an investigation includes a Medicaid individual or when an investigation covers multiple individuals, some of which could be Medicaid and others Non-Medicaid. Also use this code for tasks (e.g. filing) involving combined groups.

Use Code 17 when completing proactive/prevention/filing of an incident; planning the investigation; gathering investigation information; analyzing the information; completing the written investigation report; and conducting any follow-up as part of the investigation. Use when compiling or monitoring related paperwork, utilizing the Incident Tracking System, and coordinating with county boards of DD (OAC 5123:2-17). Includes staff travel or training directly related to investigating an MUI activity for Medicaid-eligible individuals or combined groups.

Examples of activities reported under Code 17 include:

- Performing proactive/prevention/filing for Medicaid services.
- Reviewing Unusual Incident Reports and assessing pattern/trend analysis for Medicaid services.
- Performing Pattern/Trend Analysis for Medicaid services.
- Filing allegation and preparing for/participating in reviews for Medicaid services.
- Notify required parties, including individuals, guardians, agencies, law enforcement, children services, county boards, and other oversight agencies for Medicaid services.
- Planning the investigation, reviewing any pertinent information, and coordinating the investigation for Medicaid services.
- Collecting pertinent information and coordinating with law enforcement for Medicaid services.
- Analyzing information to determine if incident is substantiated for Medicaid services.
- Completing the Investigation Report and final notifications for Medicaid services.

Code 17 (continued)

- Following up with pertinent parties and participating in hearings for Medicaid services.

- Collecting additional information and coordination regarding abuse registry cases involving Medicaid-eligible individuals or a multiple individuals.

- Following up with pertinent parties, obtaining death certificate, autopsy finding if necessary, and completion of waiver disenrollment in the event of death.

CODE 18: GENERAL ADMINISTRATION
Medicaid Rate: R (Reallocated)

Except where noted, all DODD Central Office MAC staff may use code 18. Performing general administrative activities (i.e., those that are not specific to any identified function or that relate to multiple DODD functions).

Examples of activities reported under code 18 include:

- Attending or facilitating general agency or unit staff meetings or board meetings.
- Developing and monitoring DODD or program budgets.
- Supervising staff and conducting employee performance reviews.
- Processing payroll/personnel-related documents.
- Developing, reviewing or revising agency, departmental, unit or other policies and procedures (e.g. Human Resources).
- Providing or attending training.
- Providing or attending general in-services or training, including new employee orientation or supervision or computer training.
- Paid breaks.
- Paid leave (including *paid* jury duty, vacation, personal leave, medical leave, holiday time).
- Entering time keeping information, including time study information.
- Overseeing, compiling, preparing, reviewing, submitting and monitoring Medicaid administrative claims or working with local, state, or federal entities regarding Medicaid administrative claiming issues (**use of this part of the code is limited to MAC coordinators, assistant MAC coordinators and staff with MAC-administrative security access**).
- Development of strategic plans.

NOTE: Code 18 addresses all administrative functions that are not specific to any identified function or all administrative functions that relate to multiple functions of the agency (**use code 2 for developmental centers**).

COUNTY BOARDS & COUNCILS OF GOVERNMENT (CBs/COGs)

MEDICAID ADMINISTRATIVE CLAIMING PROGRAM
ACTIVITY CODES

CODE 1: DIRECT CARE
Medicaid Rate: U (Unallowable)

All CB/COG MAC staff may use Code 1.

Providing client care, treatment and/or counseling services to an individual in order to correct or improve a specific condition. Includes the provision of direct services reimbursed through Medicaid, as well as direct services that are not reimbursed by Medicaid. **Targeted Case Management activities should be included in Activity Code 2, Targeted Case Management.** Includes staff travel or training directly related to performing these activities.

Examples of activities reported under Code 1 include:

- Conducting developmental assessments.
- Developing individual service plans and plans of care.
- Other direct services including performing assessments/medical exams.
- Developing treatment plans.
- Providing transportation services.
- Providing therapy services.
- Health screenings and diagnostic evaluations (e.g., orthopedic evaluation, vision screen, and audiological testing services).
- Counseling/therapy services.
- Skills training for medical/dental/mental health services.
- Administering first aid, emergency care, medication, or immunizations.
- Participating in individual chart reviews that include Medicaid-covered services to ensure compliance with medical documentation and forms requirements. **This is NOT system quality assurance reviews. System-wide quality assurance reviews are coded to Code 7, Monitoring of Medicaid Services.**

CODE 2: TARGETED CASE MANAGEMENT
Medicaid Rate: U (Unallowable)
This code is reserved for service and support administrators (SSAs) participating in MAC time studies. Use Code 2 when performing targeted case management activities.

Examples of activities reported under Code 2 include:

- Making arrangements to obtain initial and on-going assessments from therapists and appropriately qualified persons of an eligible individual's need for any medical, educational, social, and other services.
- Eligibility assessment activities that provide the basis for the recommendation of an eligible individual's need for DODD administered HCBS waiver services.
- Recommending an eligible individual's initial and on-going need for services and associated costs for those individuals eligible for DODD administered HCBS waiver services.
- Ensuring active participation of the eligible individual and working with the eligible individual and others to develop goals and identify a course of action to respond to the assessed needs of the eligible individual. These activities result in the development, monitoring, and on-going revision of an individualized service plan (ISP).
- Help link eligible individuals with medical, social, educational providers and/or other programs and services that are capable of providing needed services.
- Contacts needed to ensure that the ISP is effectively implemented and adequately addresses an eligible individual’s needs.
- Conducting quality assurance reviews on behalf of a specific eligible individual and incorporating the quality assurance review results into ISP amendments.
- Reviewing the individual trends and patterns resulting from reports of investigations of unusual incidents and MUIs and integrating prevention plans into ISP amendments.
- Ensuring that services are provided in accordance with the ISP and that needed ISP services are effectively coordinated with and communicated to service providers.
- Contacts needed to ensure that guardians and eligible individuals receive appropriate notification and communication of unusual incidents and MUIs.
- Assists an eligible individual in preparing for a state hearing related to the reduction, termination or denial of an ISP identified service.

CODE 3: MEDICAID OUTREACH

Medicaid Rate: ND (Non-Discounted)

All CB/COG MAC staff may use Code 3.

A campaign, program or ongoing activity targeted to 1) bringing individuals into the Medicaid system for the purpose of determining eligibility or 2) bringing Medicaid eligible individuals into specific Medicaid services. Activities may include informing (in writing or orally) Medicaid eligible or potentially eligible individuals, agencies, and community groups about the range of health services covered by the Medicaid program. Such services may include preventive or remedial health care services offered by the Medicaid program that may benefit eligible individuals.

Use code 3 when conducting outreach campaigns directed to the entire population to encourage potentially Medicaid eligible individuals to apply for Medicaid and outreach campaigns directed toward bringing Medicaid eligible individuals into Medicaid covered services, including Medicaid waivers (i.e. Individuals Options or Level I).

An education program or campaign may be allowable as a Medicaid outreach activity if it is targeted specifically to Medicaid services and for Medicaid eligible individuals. Education programs or campaigns that are general in nature, such as car passenger safety or antismoking programs, should be claimed under Code 4, Non-Medicaid Outreach.

Includes staff travel or training directly related to performing Medicaid outreach activities.

Report under this code only that portion of time spent in activities that specifically address Medicaid outreach. Report the non-Medicaid portion of these outreach campaigns under Code 4 such as providing information on family support services.

Examples of activities reported under Code 3 include:

- Providing oral or written information to the general population about the Medicaid program, including Medicaid waivers, to encourage individuals eligible for Medicaid to apply for Medicaid.

- Providing oral or written information to individuals, families, advocates, agencies and community groups about Medicaid covered services, including Medicaid waivers, for the purpose of bringing individuals eligible for Medicaid into Medicaid services.

Code 3 (continued)

- Providing and presenting materials to explain what Medicaid services are available to Medicaid eligible individuals, including Medicaid card services and services through a waiver (Individual Options, Level I, etc.).

- Informing families, individuals and/or advocates about the availability of Medicaid services and describes how to enroll in the Medicaid program.

CODE 4: NON-MEDICAID OUTREACH

Medicaid Rate: U (Unallowable)

All CB/COG MAC staff may use Code 4.

Use when informing individuals about social, educational, legal or other services not covered by Medicaid. Also use when conducting education programs addressed to the general population. Oral or written methods may be used. Includes staff travel or training directly related to performing these activities.

Examples of activities reported under Code 4 include:

- Conducting outreach activities that inform individuals about non-Medicaid programs and services (e.g., housing opportunities).
- Providing information about family support services.
- Conducting general health or social education programs or campaigns addressed to the general population.
- Scheduling and promoting activities that educate individuals about the benefits of healthy lifestyles and practices.
- Conducting public health education campaigns on Help Me Grow.
- Providing information about general county board resources such as family support services.
- Conducting outreach campaigns that encourage individuals to access social, educational, legal or other services not covered by Medicaid such as clothing, food, child care, TANF, food stamps, WIC, Head Start, legal aid, housing, jobs, etc.

CODE 5: FACILITATING MEDICAID ELIGIBILITY DETERMINATIONS
Medicaid Rate: ND (Non-Discounted)

With the exception of service and support administrators (SSAs), all CB/COG MAC staff may use this code. SSAs who participate in MAC time studies must use Code 2, Targeted Case Management Activities, when performing activities considered part of targeted case management (TCM).

Non-SSA staff may use Code 5 when assisting an individual in becoming eligible for Medicaid or when performing a PAWS-related activity.

Includes staff travel or training directly related to performing these activities.

This activity does <u>not</u> include the actual Medicaid eligibility determination.

Examples of activities reported under Code 5 include:

- Maintaining and distributing DODD generated PAWS information.
- Communicating with DODD regarding PAWS issues.
- Reconciling match commitment with state reports and conducting PAWS utilization reviews.
- Gathering, preparing and submitting relevant information to DODD to be summarized on the PAWS document or to be entered into the web-based PAWS system.
- Calculating the number of units stated on the individual service plan into an allowable format for the PAWS system (e.g. completion of 2020, which is a tool that translates service information into costs for needed services).
- Explaining Medicaid eligibility rules and the eligibility process to prospective applicants.
- Assisting in the waiver enrollment process for DODD administered waivers (e.g. Individual Options, Level I) and/or waiver services.
- Making referrals to local Department of Job and Family Services (DJFS) in order to encourage individuals who are potentially eligible to apply for Medicaid and HCBS waivers or Healthy Start.
- Assisting an applicant to fill out a Medicaid eligibility application.
- Accompanying individual to local DJFS office to apply for Medicaid.

Code 5 (continued)

- Assisting an individual to provide third party resource information at Medicaid eligibility intake.

- Gathering information related to the Medicaid application and eligibility determination (or re-determination) from an individual, including resource information and third party liability (TPL) information, in preparation for submitting a formal Medicaid application.

- Providing or packaging necessary Medicaid forms needed for the Medicaid eligibility determination.

CODE 6: FACILITATING ELIGIBILITY FOR NON-MEDICAID PROGRAMS
Medicaid Rate: U (Unallowable)

All CB/COG MAC staff may use this code.

Use when assisting an individual to become eligible for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc. Includes staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Completion of the OEDI/COEDI.

- Informing individuals about programs such as cash assistance, food stamps, WIC, day care, legal aid, and other social and educational programs and referring them to the appropriate agency to make an application.

- Providing information to prospective applicants about eligibility rules and the eligibility process for non-Medicaid programs, such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Helping an individual complete applications for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Gathering information related to the application and eligibility determination for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc…from a client.

- Providing necessary forms and packaging all forms in preparation for the eligibility determination for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc.

CODE 7: REFERRAL, COORDINATION AND MONITORING OF MEDICAID SERVICES

Medicaid Rate: D (Discounted)

For first-line supervisors of SSA staff: Use Code 2 when conducting any screening, referral, coordination and monitoring that are part of SSA duties, including Targeted Case Management. Activities that are part of direct services or an extension of medical services are not claimable as an administrative activity.

Use Code 7 when administering Medicaid (and, in particular, waiver) programs (See OAC Chapters 5123:2-8, 5123:2-9, and 5123:2-13). The listed activities do not benefit the administration of other program, but instead are unique to Medicaid programs. Includes staff travel or training directly related to these activities.

Examples of activities reported under Code 7 include:

- Scheduling evaluations/assessments.
- Gathering information that may be required in advance of assessments or evaluations for Medicaid services.
- Gathering information for and providing referral to existing waiver enrollees to other Medicaid programs/services.
- Reviewing plans to ensure administrative and fiscal accuracy and completeness.
- Performing duties to notify providers and other entities of the approved ISP, PAWS information, and DODD confirmation.
- Developing the process and procedures to administer waiting list for Medicaid waivers.
- Performing maintenance on waiting list for Medicaid waivers.
- Developing, updating, and distributing lists of alternate Medicaid services to individuals and their families.
- Distributing mass mailings of the waiting list for Medicaid waivers.
- Maintenance and management of the PICT. The PICT is an IT system that manages present and future waiver slot allocations and waiver enrollment opportunities.
- Develop and submit payments for community based waiver and other Medicaid programs.

Code 7 (continued)

- Performing Medicaid system quality assurance reviews. **SSA staff may not code this activity.**

- Preparing required Prior Authorization Request forms and supporting materials for Medicaid Waiver approved individuals.

- Review and perform ongoing analysis of existing waiver reimbursement system (OAC 5123:2-9-06), including an analysis of ODDP, funding range placement models, rates, ratios, etc. ODDP is an assessment tool that assigns a funding range to Medicaid waiver recipients.

- Participating in external monitoring of entity's (e.g. ODJFS, CMS, etc.) Medicaid Service reviews.

- Providing information and technical support to providers on Medicaid policy and regulations.

- Providing technical assistance and support to Medicaid waiver providers (including the certification process OAC 5123:2-5-01).

- Implementing and reviewing outcomes of waiver provider compliance and monitoring processes per OAC 5123 2-9-08.

CODE 8: REFERRAL, COORDINATION AND MONITORING OF NON-MEDICAID SERVICES

Medicaid Rate: U (Unallowable)

All CB/COG MAC staff may use Code 8.

Use when conducting activities related to scheduling evaluations for non-Medicaid services. Use when working on fiscal information for non-Medicaid services. Use when performing non-Medicaid covered tasks related to managing waiting lists, service substitution and the long-term service planning registry by a CB or for CBs by a COG. Includes staff travel or training directly related to these activities.

Examples of activities reported under Code 8 include:

- Providing information to another provider about non-Medicaid services being provided to an individual.
- All activities related to non-Medicaid federal grants including Title XX.
- Preparing, monitoring or distributing financial reports for family support services and other non-Medicaid programs.
- Preparing, monitoring or distributing financial reports for supported living services (OAC 5123:2-12-04).
- Develop and submit payments for Title XX and other non-Medicaid programs.
- Performing non-Medicaid system quality assurance reviews. **SSA staff may not code this activity.**

CODE 9: TRANSLATION FOR MEDICAID SERVICES
Medicaid Rate: D (Discounted)

All CB/COG MAC staff may use Code 9.

Use when arranging, obtaining or providing translation services for the purpose of accessing Medicaid services for individuals. Includes staff travel or training directly related to performing these activities.

Translation services furnished by a direct patient care provider (e.g., speech therapist, nurse, physician) during a direct patient care visit should be reported under Code 1, Direct Care.

Non-Medicaid translation services should be reported under Code 10, Translation for Non-Medicaid Services.

Examples of activities reported under Code 9 include:

- Arranging for or providing translation services (oral and/or signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid.

- Developing translation materials that assist individuals to access and understand necessary care or treatment covered by Medicaid.

CODE 10: TRANSLATION FOR NON-MEDICAID SERVICES
Medicaid Rate: U (Unallowable)

All CB/COG MAC staff may use Code 10.

Use when assisting an individual to **access non-Medicaid services** through arranging, obtaining or providing translation services**.** Includes staff travel or training directly related to performing these activities.

Translation services furnished by a direct patient care provider (e.g., speech therapist, nurse, physician) during a direct patient care visit should be reported to Code 1-Direct Care.

Examples of activities reported under Code 10 include:

- Arranging for or providing translation services (oral and/or signing services) that assist the individual to access and understand non-Medicaid social, educational, and vocational services such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Developing translation materials that assist individuals to access and understand non-Medicaid social, educational, and vocational services, such as supported living, family support services, transportation, school-based programs, community housing, etc.

CODE 11: PROGRAM PLANNING, DEVELOPMENT AND INTERAGENCY COORDINATION OF MEDICAID SERVICES

Medicaid Rate: D (Discounted)

For first-line supervisors of SSA staff: *Use Code 2 when conducting any screening, referral, coordination and monitoring that are part of SSA duties, including Targeted Case Management. Activities that are part of direct services or an extension of medical services are not claimable as an administrative activity.*

All CB/COG MAC staff may use Code 11, except as noted.

Planning and developing services, programs and resources that relate to Medicaid covered medical/dental/mental health/social services/waiver services. This includes development of policy, procedures and protocols for delivering and coordinating care to individuals. Use Code 11 for collaborative activities that involve planning and resource development with other agencies to 1) improve the availability and quality of medical/dental/mental health/social services and 2) enhance Medicaid programs cost-effectiveness. Includes staff travel or training directly related to performing program planning and development activities

Examples of activities reported under this code include:

- Working with other agencies that provide Medicaid services to improve the coordination and delivery of services, to expand their access to specific populations of Medicaid eligible individuals, and to improve collaboration around the early identification of medical/dental/mental health/social problems.

- Assessing the capacity of the CB/COG and its providers to deliver accessible Medicaid covered medical/dental/mental health/social assessment, treatment and care services to Medicaid eligible individuals and identifying potential barriers and needs.

- Reducing overlaps and duplication in Medicaid services, and closing gaps in the availability of services.

- Planning programs and services to meet the identified needs of high-risk populations of Medicaid eligible individuals served by the CB/COG and its providers.

- Inter-agency and intra-agency coordination to improve Medicaid services delivery.

Code 11 (continued)

- Collecting and analyzing Medicaid data related to general population group (not individual-specific) or geographic areas, including data gathered from chart reviews, in order to improve service coordination and delivery.

- Conducting needs assessments related to medical/dental/mental health/social services/waiver services including Medicaid services for the entire Medicaid population within a county.

- Developing plans for expanding Medicaid-covered services.

- Coordinating efforts to improve access to Medicaid covered medical/dental/mental health/social services/waiver services to specific under-served populations or geographic areas.

- Interpreting and using statistical data from Medicaid claims data and other health services data system to forecast services utilization and close existing gaps in Medicaid services delivery.

- Participating in Medicaid-related stakeholder meetings, work groups, and rule development and review groups.

- Developing, reviewing and revising Medicaid policies and procedures;

CODE 12: PROGRAM PLANNING, DEVELOPMENT AND INTERAGENCY COORDINATION OF NON-MEDICAID SERVICES

Medicaid Rate: U (Unallowable)

All CB/COG MAC staff may use Code 12.

Use when performing activities associated with developing strategies to improve the coordination and delivery of non-Medicaid services that include educational, social, vocational, and other services. This activity code includes paperwork, clerical activities, and staff travel or training related to performing program planning and development activities.

Examples of activities reported under Code 12 include:

- Evaluating the need for non-Medicaid services in relation to specific populations or geographic areas.
- Collecting and analyzing non-Medicaid data related to a specific program, population or geographic area of these services.
- Participating in external monitoring of entity's non-Medicaid program (such as supported living, family support services, transportation, school-based programs, community housing, etc) or service reviews.
- Planning, developing, conducting and/or attending training that promotes community collaboration and development of non-Medicaid services (such as supported living, family support services, transportation, school-based programs, community housing, etc.) provided in the community.
- Developing interagency policies and procedures for non-Medicaid programs and services such as supported living, family support services, transportation, school-based programs, community housing, etc.
- Participating in community planning efforts to close gaps in non-Medicaid social services such as housing, childcare, and after school programs.
- Writing proposals for non-Medicaid services such as supported living, family support services, transportation, school-based programs, community housing, etc.
- Developing and participating in non-Medicaid related stakeholder meetings, work groups, rule development and review groups.
- Developing and monitoring contracts and agreements for general services.

Code 12 (continued)

- Performing rate negotiations for non-Medicaid services such as supported living, family support services, transportation, school-based programs, community housing, etc.

CODE 13: MEDICAID RELATED PROVIDER RELATIONS

Medicaid Rate: D (Discounted)

All CB/COG MAC staff may use Code 13.

Use Code 13 when performing activities to secure and maintain the pool of eligible Medicaid providers. Includes staff travel or training directly related to performing these activities.

Examples of activities reported under Code 13 include:

- Recruiting new providers into the Medicaid program (including provider fairs).
- Developing and distributing written materials to recruit potential Medicaid providers.
- Performing activities related to provider suspension or revocation process (OAC 5123:2-5-04).
- Monitoring effectiveness of programs providing Medicaid-covered services, including client satisfaction surveys for medical/dental/mental health services.
- Maintaining information such as Medicaid provider profiles.
- Assessing the capacity of providers to deliver Medicaid covered services.

CODE 14: NON-MEDICAID PROVIDER RELATIONS

Medicaid Rate: U (Unallowable)

All CB/COG MAC staff may use Code 14.

Use when performing activities related to securing and maintaining non-Medicaid providers. Includes staff travel or training directly related to performing these activities.

Examples of activities reported under Code 14 include:

- Recruiting providers for non-Medicaid programs such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Recruiting with outside agencies regarding non-Medicaid social and education programs such as supported living, family support services, transportation, school-based programs, community housing, etc.

- Developing non-Medicaid referral sources.

CODE 16 INVESTIGATING UNUSUAL AND MAJOR UNUSUAL INCIDENTS
Medicaid Rate: U (Unallowable)

Use Code 16 for individuals who are not receiving Medicaid services for whom an MUI/UI is performed. The claiming entity may opt to use Code 17, which is a stepped-down charge using the Medicaid eligibility rate (MER), for all time spent performing MUI/UI functions.

Use Code 16 when completing proactive/prevention/filing of an incident; planning the investigation; gathering investigation information; analyzing the information; completing the written investigation report; and conducting any follow-up as part of the investigation. Use when compiling or monitoring related paperwork, utilizing the Incident Tracking System, and coordinating with county boards of DD (OAC 5123:2-17). Includes staff travel or training directly related to investigating an MUI activity for a non-eligible individual.

Examples of activities reported under Code 16 include:

- Performing proactive/prevention/filing for non-Medicaid services.
- Reviewing Unusual Incident Reports and assessing pattern/trend analysis for non-Medicaid services.
- Performing Pattern/Trend Analysis for non-Medicaid services.
- Filing allegation and preparing for/participating in reviews for non-Medicaid services.
- Notify required parties, including individuals, guardians, agencies, law enforcement, children services, county boards, and other oversight agencies for non-Medicaid services.
- Planning the investigation, reviewing any pertinent information, and coordinating the investigation for non-Medicaid services.
- Collecting pertinent information and coordinating with law enforcement for non-Medicaid services.
- Analyzing information to determine if incident is substantiated for non-Medicaid services.
- Completing the Investigation Report and final notifications for non-Medicaid services.

Code 16 (continued)

- Following up with pertinent parties, obtaining death certificate, autopsy finding if necessary, and completion of waiver disenrollment in the event of death for non-Medicaid services.

CODE 17 INVESTIGATING UNUSUAL AND MAJOR UNUSUAL INCIDENTS
Medicaid Rate: D (Discounted)

Use Code 17 for individuals who are receiving Medicaid services for whom an MUI/UI is performed. Code 17 is a stepped-down charge using the Medicaid eligibility rate (MER) for all time spent performing MUI/UI functions. Use this code when an investigation includes a Medicaid individual or when an investigation covers multiple individuals, some of which could be Medicaid and others Non-Medicaid. Also use this code for tasks (e.g. filing) involving combined groups.

Use Code 17 when completing proactive/prevention/filing of an incident; planning the investigation; gathering investigation information; analyzing the information; completing the written investigation report; and conducting any follow-up as part of the investigation. Use when compiling or monitoring related paperwork, utilizing the Incident Tracking System, and coordinating with county boards of DD (OAC 5123:2-17). Includes staff travel or training directly related to investigating an MUI activity for Medicaid-eligible individuals or combined groups.

Examples of activities reported under Code 17 include:

- Performing proactive/prevention/filing for Medicaid services.
- Reviewing Unusual Incident Reports and assessing pattern/trend analysis for Medicaid services.
- Performing Pattern/Trend Analysis for Medicaid services.
- Filing allegation and preparing for/participating in reviews for Medicaid services.
- Notify required parties, including individuals, guardians, agencies, law enforcement, children services, county boards, and other oversight agencies for Medicaid services.
- Planning the investigation, reviewing any pertinent information, and coordinating the investigation for Medicaid services.
- Collecting pertinent information and coordinating with law enforcement for Medicaid services.
- Analyzing information to determine if incident is substantiated for Medicaid services.
- Completing the Investigation Report and final notifications for Medicaid services.
- Following up with pertinent parties and participating in hearings for Medicaid services.

Code 17 (continued)

- Collecting additional information and coordination regarding abuse registry cases involving Medicaid-eligible individuals or a multiple individuals.

- Following up with pertinent parties, obtaining death certificate, autopsy finding if necessary, and completion of waiver disenrollment in the event of death.

CODE 18: GENERAL ADMINISTRATION

Medicaid Rate: R (Reallocated)

All CB/COG MAC staff may use Code 18.

Performing general administrative activities (i.e., those that are not specific to any identified function or that relate to multiple functions of the agency
Examples of activities reported under Code 18 include:

- Attending or facilitating general agency or unit staff meetings or board meetings.
- Developing and monitoring CB/COG program budgets.
- Supervising staff and conducting employee performance reviews.
- Processing payroll/personnel-related documents.
- Reviewing or writing agency, departmental or unit policies and procedures.
- Providing or attending training.
- Providing or attending general in-services or general training, including new employee orientation or supervision or computer training.
- Paid breaks.
- Paid leave (including paid jury duty, vacation, personal leave, medical leave, holiday time).
- Entering time keeping information, including time study information.
- Overseeing, compiling, preparing, reviewing, submitting and monitoring Medicaid administrative claims or working with local, state, or federal entities regarding Medicaid administrative claiming issues (**use of this part of the code is limited to MAC coordinators, assistant MAC coordinators and staff with MAC-administrative security access**).

NOTE: Code 18 addresses all administrative functions that are not specific to any identified function or all administrative functions that relate to multiple functions of the agency.