

**Ohio Department of Mental
Retardation and Developmental
Disabilities**

**Medicaid Administrative Claiming
(MAC)**

Methodology Guide

October 2007

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PART I: CLAIM CALCULATION METHODOLOGY

INTRODUCTION

Medicaid Administrative Claiming

The Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD) and Ohio Department of Job and Family Services (ODJFS) share a focus on improving access to health care and supportive services for Ohioans with mental retardation and developmental disabilities.

Through Medicaid Administrative Claiming (MAC), ODMRDD, county boards of mental retardation and developmental disabilities (referred to hereafter as CBs), and councils of government (referred to hereafter as COGs) can be reimbursed in part for activities that assist individuals served in enrolling in Medicaid and in accessing Medicaid-covered services. Medicaid-covered services assist in contributing to the elimination of disparities facing individuals we serve and can improve the overall health of the population. 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 MR/DD or other governing groups pursuant to ORC 167.01. Under the MAC Program, either 1) the participating COGS seek direct reimbursement from ODMRDD for administrative Medicaid services or 2) the local CB a COG has a contractual relationship with will seek reimbursement from ODMRDD for CB Medicaid related administrative expenses. 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 ODMRDD does not submit duplicate claims for the same administrative expenses.

Administrative Structure for the Management of the Program

The administrative structure for the management of the Medicaid Administrative Claiming (MAC) program for ODMRDD involves two state agencies and up to 88 CBs and 8 COGs. Staff within the ODMRDD, the CBs and COGs performs the activities, which are reimbursable under Medicaid Administrative Claiming. 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:

Ohio Department of Job and Family Services (ODJFS)

ODJFS, as the Single State Agency for administering the Title XIX Medicaid Program in Ohio, has ultimate responsibility to the Centers for Medicare & Medicaid Services (CMS) to ensure the program is in compliance with federal Medicaid regulations. In this role, ODJFS has final oversight responsibility for all aspects of the MAC program. ODJFS is the point of contact with CMS for all communications, including claiming, federal audits, state plan amendments, and CMS approval of modifications to this methodology. ODJFS reviews and approves administrative claims and draws down federal financial participation (FFP) from CMS. ODJFS also establishes reviews and monitoring protocols.

ODJFS, through an Interagency Agreement, delegates day-to-day administration of the MAC program to ODMRDD. ODJFS retains oversight responsibility on two levels: 1) ODJFS monitors ODMRDD in its claiming of activities conducted by state agency staff; and 2) ODJFS also oversees ODMRDD in its processing and monitoring of claims from CBs and COGs. ODJFS reserves the right to withhold payment of claims if ODMRDD or any claiming unit fails to comply with the approved methodology, or other state or federal regulations.

Ohio Department of Mental Retardation and Developmental Disabilities (ODMRDD)

The ODMRDD MAC Unit is assigned the day-to-day responsibility for administering the ODMRDD Medicaid Administrative Claiming program. The ODMRDD MAC Unit functions in two distinct capacities. It oversees and monitors the claiming entities within ODMRDD, and provides oversight and monitoring of participating CBs' and COGs' MAC claims and operations.

ODMRDD will request 50% reimbursement for the ODMRDD MAC Unit's personnel costs. The reimbursement will cover salary and fringe benefits expenses.

ODMRDD's MAC philosophy is to invest considerable attention to training, technical assistance and oversight from the initiation of claiming entities through the submission of MAC claims. Upon receiving initial interest from a CB/COG, ODMRDD trains the new CB/COG claiming unit's MAC participants. ODMRDD also provides the MAC Implementation Plan format ODJFS has approved (Please see Attachment C for an example of a MAC Implementation Plan). The claiming unit completes and submits the MAC Implementation Plan and receives ODMRDD technical assistance when requested. The MAC Implementation Plan must be approved by ODMRDD prior to participation.

The ODMRDD MAC Unit reviews quarterly claims and submits them to ODJFS. The ODMRDD MAC Unit ensures a 100% expenditure occurred in accordance with all applicable federal requirements for the non-federal share match of expenditures before claim submission reviews and monitors claims in accordance with protocols developed by ODMRDD and approved by ODJFS, and directs the time studies. ODMRDD/CB/COG's ancillary costs (estimated at ten percent of the claimable payroll and fringe benefits) will be included in the quarterly claim and reconciled against the corresponding calendar year cost reports annually. The ODMRDD MAC Unit provides training and technical assistance for claiming entities at ODMRDD, CBs and COGs to ensure the proper use of MAC Activity Codes. The MAC Unit also ensures the accurate preparation of claims and proper maintenance of files. The ODMRDD MAC Unit also reviews and approves all claiming entities' MAC Implementation Plans prior to their participation in the MAC program.

Ohio Department of MR/DD Claiming Units

All ODMRDD divisions participate in the MAC program. The ODJFS-ODMRDD interagency agreement language allowing ODMRDD to participate in MAC covers each division.

Ohio County Boards of MR/DD and Councils of Government

CBs and COGs operate independently of ODMRDD. Each CB and COG may elect to participate in the MAC program.

All participating CBs and COGs are responsible for conducting quarterly time studies, collecting and compiling time study and financial data, preparing quarterly claims and maintaining relevant MAC files. Each CB or COG must designate a local MAC coordinator to serve as their contact person for ODJFS and ODMRDD reviews, monitoring efforts and claim questions.

Each CB or COG proposing to participate in MAC must complete a MAC Implementation Plan that the ODMRDD MAC Unit reviews and approves (please see Attachment C for an example of a MAC Implementation Plan). The ODMRDD MAC Unit will retain each claiming unit's Implementation Plans for a full calendar year. An approved Implementation Plan grants a claiming unit authority to participate in MAC during the affected calendar year.

CALCULATION OF THE ADMINISTRATIVE CLAIM

Four Components of a Claim

This Medicaid Administrative Claiming methodology is based on four key claim calculation components:

- The Personnel who perform the administrative functions;
- The time study which documents the proportion of personnel time spent on administrative activities;
- The use of actual allowable expenditures; and
- The calculation of the Medicaid Eligibility Rate.

Personnel

Medicaid administrative claims are based on staff activity and actual fiscal expenditures related to staff that perform allowable MAC activities. The Claim Calculation Example listed later in Part I of this guide addresses this topic in detail. Each CB and COG claiming unit completes a MAC Implementation Plan that identifies staff the unit intends to include in the claim. Each claiming unit updates its MAC roster of participating staff on a quarterly basis, indicating which personnel must complete time studies, which are 100% MAC, and which are contractors. The roster must include a date time study participants completed the quarterly training. Quarterly rosters of participating MAC staff are submitted to the ODMRDD MAC Unit Coordinator two weeks prior to the time study week for each quarter.

Service and support administrators (SSAs) do not participate in MAC time studies. First-line SSA supervisors and above may participate in MAC time studies, given any direct care (TCM-related) activities they perform are charged to Code 2, Targeted Case Management Activities.

Professional services staff (e.g. PT, OT) may participate in MAC time studies if the local MAC coordinator and CB/COG management determine that aspects of professional services staff's work involves activities divorced from direct services but that are allowable MAC activities and require advanced training related to the profession.

For any professional services staff petitioning for participation in MAC, his/her position description on file must clearly delineate roles and responsibilities of the employee. The position description must apportion the percentage of time typically spent on direct care activities and the portion of time spent on other MAC claimable activities.

Prior to participation in a MAC time study, the local MAC coordinator must submit the employee's position description for review and approval by the ODMRDD MAC coordinator (and subject to review by ODJFS). Position descriptions for these employees must be submitted via the claiming entity's MAC Implementation Plan, and will be part of the review process of the claiming

entity's MAC Implementation Plan, which is conducted by the ODMRDD MAC coordinator.

An example of acceptable MAC claimable activities performed by professional staff would be a registered nurse performing quality assurance reviews. If a nurse is performing activities related to direct care, or assessment work related to an individual only part of the time, he or she may participate in MAC time studies. However, when providing direct care or assessment work related to direct care, the nurse must use Code 1, Direct Care. When the same nurse is performing quality assurance reviews considered to be MAC claimable, he or she would use Codes 11 or 12, Program Planning, Development and Interagency Coordination of Medicaid Services/Non-Medicaid Services.

Time Study

A time allocation methodology (time study) is applied to determine the appropriate percentage of personnel time dedicated to MAC activities during the claiming period. Time studies are performed once each quarter for a seven consecutive day period. The time study captures work activity information to distinguish allowable administrative costs from non-allowable costs. See Part II for an explanation of the time study methodology.

All personnel who perform activities that can be claimed under the MAC program must complete a time study. The only exception to this is for staff that spends 100% of their activities dedicated to Medicaid Administration. Such staff is exempt from the time study. If a claiming unit has such staff, a position description must be submitted and approved through review of the claiming unit's MAC Implementation Plan. These 100% Medicaid staff are exempt from the time study process, but are included in the claiming unit's quarterly claim to ODMRDD.

ODMRDD's Table of Organization has segregated work units/divisions that work on or provide primarily or solely Medicaid Administrative related tasks and services. To determine prospective 100% Medicaid staff, the MAC Unit performs the following steps: 1) Asks each division's Deputy Director (DD) to identify any staff whose work scope covered 100% Medicaid Administrative tasks. 2) Have DDs exclude staff who work with multiple programs and/or with both Medicaid and non-Medicaid eligible individuals from consideration as 100% Medicaid staff, 3) Asks division Deputy Directors to next exclude staff from the MAC Program who work solely on developmental center programs, 5) Reviews the remaining prospective 100% Medicaid Administrative staff's person's position descriptions to confirm whether staff are 100% Medicaid, and 6) Asks DDs to have staff with position descriptions that didn't reflect 100% Medicaid status to time study. If the DD states that the submitted position description is outdated, they resubmit an updated position description (PD) to Human Resources and to the MAC Unit for review. If the amended position description accurately reflects the affected staff person's current duties and address exclusively Medicaid

Administrative program work functions, the MAC Unit designates the position as 100% Medicaid under the MAC Program.

ODMRDD also requires county board/council of governments to submit position descriptions for all staff they considered 100% Medicaid. MAC Unit staff reviews each submitted PD to confirm whether the affected MAC participants' job duties are 100% Medicaid Administrative. Job descriptions must not only mirror actual job duties, but must also confirm that the MAC participant exclusively performs Medicaid tasks. If a job description does not meet these criteria, ODMRDD requires the affected claim entities to have the staff person time study or resubmit an updated position description that accurately represents that affected staffs' current duties are 100% Medicaid Administrative.

In addition, both Department and local claiming entities' 100% staff must attest each quarter in the on-line system that they are 100% Medicaid Administrative and their immediate supervisor must approve the attestation document. ODMRDD will send 100% Medicaid Administrative participants' PDs to CMS for review upon request.

Determination of Actual Expenditures

Collection of the Actual Expenditure Data

Financial information is collected from all participating entities each quarter via an on-line MAC data entry system. The financial data used to calculate the claim is based upon actual detailed expenditures obtained directly from the participating entity's financial accounting system. The detailed expenditures types cover salaries, fringe benefits, and personal service contract costs. 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.

All supporting documentation will be made available by the claiming entity for audit by the State of Ohio (including ODJFS, ODMRDD, 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.

Financial Expenditure Form Requirements

ODMRDD administers an on-line claiming system to facilitate the collection of time study data and appropriate related salary and benefit information on a quarterly basis.

In addition, ODMRDD supplies an income and expense report (including forms and training), which is used to reconcile MAC costs on an annual basis. Each CB claiming unit submits an income and expense report annually as part of the regulatory requirements set forth by ODMRDD for reconciling. ODMRDD will provide COGs with similar schedules, forms and training used to reconcile MAC costs.

ODMRDD will develop an annual Department cost report listing all Department costs by program and allocating ancillary costs to these programs. Department costs will be obtained from the State accounting system on a cash basis.

All claims will be submitted in a format specified by ODMRDD and reviewed and pre-approved by ODJFS (see Attachment A). As ODMRDD improves or updates the format, ODJFS will review and approve prior to use. Any substantive change will be sent from ODJFS to CMS for review.

Allocation of Expenditures for Salaries and Fringe Benefits of Personnel

Actual salaries and fringe benefits of personnel performing allowable MAC activities are obtained from payroll records for the claiming period.

All personnel costs are allocated to the MAC claim based on the appropriate quarterly time study results.

Ancillary Costs

The county boards of MRDD are required to prepare an annual cost report to reconcile their certified public expenditure (CPE) programs, of which the Medicaid Administrative Claiming is one. As a part of this reconciliation model, the county boards of MRDD must complete a cost report worksheet for ancillary costs. This worksheet is referred to as "Worksheet 2". "Worksheet 2" allocates the ancillary costs using direct costs from the programs to which those ancillary costs support as the basis for the allocation. In essence, this methodology uses current direct costs to allocate current ancillary costs equitably to the programs, as opposed to, an indirect cost plan that is developed using two year old information. The cost report that includes this ancillary allocation methodology has been preliminarily accepted for use by CMS.

Payment to the county boards of MRDD for costs incurred will occur quarterly with the CPE reconciliation to actual cost occurring annually. Since this program

is just starting and there was no historical data from which to estimate ancillary costs, an estimate of 10% of payroll costs was used as the basis to calculate the quarterly reimbursement of the ancillary costs. The 10% was used as a basis because it is the standard as established in A-87-ASMB-10, Attachment A, Item G for indirect interagency activities. It was felt that the 10% was a good starting point for quarterly payment then the payments would be reconciled to actual cost at year end.

The A-87 source referenced above also discussed specific cases under which an entity would be permitted to include a flat 10% of salaries and wages in lieu of determining actual indirect costs. Section 2-21 specifically states the following:

“A number of agencies do not receive Federal awards and therefore have no need to obtain an indirect cost (IDC) rate from a cognizant agency. From time to time, these agencies might provide a reimbursable service to another agency which does receive awards. OMB opted to allow the 10% of salaries and wages, which is viewed as nominal rather than requiring such agencies to go through the burden of developing indirect cost rates for relatively insignificant activities. If an agency providing services has an IDC rate, that rate must be used in lieu of the flat 10% rate if its application results in less reimbursement.”

Ancillary costs are defined as a portion of program supervision, capital, building service costs and indirect costs allocable to the MAC program through a claiming entity's cost report. These costs are reimbursable quarterly. The quarterly reimbursement of indirect/ancillary costs is estimated at ten percent (10%) of the claimable payroll and fringe benefits charged by the claiming unit (CBs, COGs, ODMRDD) for that quarter.

Quarterly paid indirect/ancillary costs to county boards will be reconciled to actual calendar year costs annually. Differences will be due to or due from the claiming entity as determined in the annual reconciliation of the cost report. To more accurately reflect the ancillary cost percent, the cost percentage will be adjusted annually for each participating claiming entity after confirming actual calendar year cost report expenditures. This will entail developing an ODMRDD cost report listing Department costs, either on a calendar or fiscal year basis. ODMRDD will perform subrecipient monitoring of quarterly reimbursed indirect/ancillary costs and an audit of participating entities' annual cost reports.

All other miscellaneous and ancillary costs are obtained from the claiming entity's financial system. While miscellaneous and ancillary estimates are included in the quarterly time study, the actual miscellaneous and ancillary reported expenses are listed on an annual basis through the cost report.

These indirect/ancillary costs may include costs to maintain and perform the accounting function, payroll function, information system function (data processing) and other costs that are common to multiple programs

Examples of such miscellaneous and ancillary cost include miscellaneous office and hardware supplies, postage, Internet service, miscellaneous office equipment, equipment repair, software costs, and telephone service costs. Allowable miscellaneous and ancillary costs charged quarterly to the MAC program must comply with and be consistent with cost principles addressed in OMB Circular A-87, Attachment B.

Personal Services Contracts

If a claiming entity has contractors they wish to have participate in the MAC program that, in the normal execution of contract duties, performs Medicaid administrative activities, a claiming entity may be allowed to include those contractors in the MAC Implementation Plan. Exceptions/limitations to contractors' involvement in the MAC program include the following:

No contractor, or employee of a contractor, who also serves as an ODMRDD program direct service provider shall be included in the MAC program.

No contractor, or employee of a contractor, shall serve as a MAC Coordinator for any claiming entity.

ODMRDD contractor costs are not reimbursed on a contingency basis. ODMRDD and local CB/COG legal agreements with contractors are not contingent in basis for the following reasons: 1) Specific agreed upon outputs will be delivered, 2) The contractor makes commitments to provide deliverable/measurable outputs during a specified timeframe, 3) The claiming entity and the contractor commit to adhere to applicable federal, state and local laws, rules and code, 4) These contracts have defined start and end dates, 5) The claiming entity commits to pay the contractor when the agreed upon outputs are provided and 6) Claiming entities use contracts to either supplement or substitute for the existing entity staff available to provide the requested service.

Some Councils of Government (COGs) provide contracted services to county boards of MRDD 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, local county boards and COGs spell out in their MAC annual implementation plans which party will request reimbursement from ODMRDD for these services. The MAC Unit also examines county board and COG claim information to confirm whether county boards or COGs request reimbursement for these activities. During the initial (1Q CY'07) claiming period, no participating county boards requested reimbursement

for COG related contracts. Instead, the participating COGs sought reimbursement directly from ODMRDD for services performed on behalf of county boards.

ODMRDD and CB/COG expenditures related to the performance of MAC activities by approved contract personnel are also obtained from the agency's financial system and supported by time study information administered and maintained by the CB/COG. All personnel, including contractual personnel, must be listed in the claiming entity's Implementation Plan, and subsequent quarterly roster submissions, as detailed in Part II Time Study Methodology, Personal Services Contracts Section of this Guide.

All personnel under a contract to be claimed will document MAC and non-MAC duties performed. Time documentation completed by approved contract personnel will not be entered into the ODMRDD on-line MAC system as time study entries. Rather, contractors will be required to document time spent on activities performed for the claiming entity, by 15-minute increments, by activity code. The local MAC Coordinator (or designated data entry person at the claiming entity) will enter the total units, by code, billed to the claiming entity during the quarter. In addition, the local MAC Coordinator (or designated data entry person) will enter the total dollar amount invoiced to the claiming entity for the quarter. The on-line MAC system will calculate the total amount allowed to be claimed, based on total units charged to the claiming entity. This amount will be included in the claiming entity's quarterly claim to ODMRDD. Documentation (including invoices from contractor to the claiming entity) must be maintained at the CB/COG and made available for desk reviews and audits performed by state and federal agencies.

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 ODMRDD 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. These

funds would be considered unallowable as matching for MAC activities.

4. Insurance and other fees collected from non-governmental sources must be offset against claims, where applicable, for federal funds.

The ODMRDD MAC claims must adhere to the OMB Circular A-87, Attachment A, Part C, Item 4 (Applicable Credits).

Exclusion of Provider-Related Donations

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

Claim Certification

As part of the quarterly claim submission process to ODJFS, the ODMRDD chief financial officer (or an appropriate designee) attests to the statement listed on the next paragraph. Likewise, Superintendent, Executive Director or an appropriate designee of each participating agency certifies the accuracy of the submitted financial information and availability of sufficient state and local revenue to meet federal match requirement guidelines as outlined in 42 CFR 433.51.

Certification Language:

1. "I am the executive officer of the state agency or his/her designee authorized by the state to submit this letter accompanying this ISTV.
2. This ISTV only includes expenditures under the Medicaid program under Title XIX of the Social Security Act (the Act), and as applicable, under the State Children's Health Insurance Program (SCHIP) under Title XXI of the Act, that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies, and the state plan approved by the Secretary and in effect during the period of the attached ISTV under Title XIX of the Act for the Medicaid program, and as applicable under Title XXI of the Act for the SCHIP.
3. The expenditures included in this ISTV are based on the state's accounting of actual recorded expenditures.
4. The required amount of state and/or local public funds were available and used to match the state's allowable expenditures included in this ISTV, and such state and/or local public funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures.
5. Federal matching funds are not being claimed on this ISTV to match any expenditure under any Medicaid and/or SCHIP state plan amendment that was submitted after January 2, 2001, and that has not been approved by the Secretary effective for the period of the attached ISTV.

The information above and on the attached ISTV is correct to the best of my knowledge and belief based on reasonably available information."

Medicaid Eligibility Rates (MER)

Methodology for Calculating MER

Some of the MAC activities performed by ODMRDD 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 to Medicaid. This allocation of costs involves developing a proportional Medicaid share, also referred to as the Medicaid Eligibility Rate (MER). (See Attachment B: Medicaid Rate by Activity Code).

ODMRDD Medicaid Eligibility Rate

A population-based methodology, calculated annually, is used in determining the MER. The MER calculation is based on the population served. It is calculated by dividing the number of Medicaid eligible individuals by the total number of individuals served by the ODMRDD.

On November 30th of each year, ODMRDD's Division of Information Technology Services (ITS) obtains data to determine the total number of individuals with MRDD served in Ohio. That information is pulled from the Individual Information Form (IIF) for each county. The total IIF count is then compared to ODJFS Medicaid eligibility files ITS obtains. Only those individuals with current eligibility are included in the Medicaid eligibility count. Based on the day data was collected, the MER will count only persons reported by the CB/COG who are active in the IIF system (not deceased or terminated) and are not waiting list only. The calculated MER is used for the following calendar year. Each year, the process repeats itself, resulting in an annual MER rate.

The IIF represents ODMRDD's census for the MR/DD community service system. ODMRDD uses this information every day to respond to requests for information, to study the way people use services currently and to plan effectively for future services. Local MAC participants' Superintendents/Executive Directors certify that the information provided on submitted IIFs accurately represent the status of eligible individuals during a specific week. ORC 5126.12 through 5126.15 and ORC 5126.18 address ADM eligibility requirements and other annual reporting requirements.

The following formula is applied in determining the ODMRDD MER.

$$\frac{\text{No. of **Medicaid-eligible** individuals with MRDD served statewide}}{\text{Total no. of **individuals** with MRDD **served** statewide}}$$

CB/COG Medicaid Eligibility Rate

A population-based methodology, calculated annually, is used in determining the MER. The MER calculation is based on the population served. It is calculated by dividing the number of Medicaid eligible individuals by the total number of individuals served by the respective claiming entity (CB or COG).

On November 30th of each year, ODMRDD's Division of Information Technology Services (ITS) obtains data to determine the total number of individuals with MRDD served in Ohio. That information is pulled from the Individual Information Form (IIF) for each county. The total IIF count is then compared to ODJFS Medicaid eligibility files that ITS obtains. Only those individuals with current eligibility are included in the Medicaid eligibility count. Based on the day data was collected, the MER will count only persons reported by the CB/COG who are active in the IIF system (not deceased or terminated) and are not waiting list only. The calculated MER is used for the following calendar year. Each year, the process repeats itself, resulting in an annual MER rate.

$$\frac{\text{No. of **Medicaid-eligible** individuals with MRDD served countywide}}{\text{Total no. of **individuals** with MRDD **served** countywide}}$$

Each COG has a MER based on the specific population (as identified in contracts between the CB and COG) they serve, which is compared to the IIF listing all MRDD identified individuals in their COG. In order to be included in a COG MER, the individual being served must be listed appropriately in the IIF and also be Medicaid eligible as identified in the ODJFS Medicaid eligibility file obtained by ODMRDD.

Monitoring Procedures

Monitoring Procedures Conducted by CBs and COGs

CB and COG MAC staff participate in monitoring MAC time studies and claims to ensure submissions to ODMRDD are appropriate and reasonable. CB and COG employees serving as MAC supervisors (those who are responsible for supervising employees participating in the MAC time study) will review and approve, when appropriate, all MAC time study entries in the on-line MAC system. In addition, the local MAC coordinator will attest by electronic signature to the accuracy of the claims submitted to ODMRDD. For each claim submitted to ODJFS, the superintendent of a CB, the executive director of a COG, or the appointed designee will attest to the following:

CBs Certification

Intentional misrepresentation or falsification of any information contained in this claim may be punishable by fine and/or imprisonment under federal and state laws. As part of the quarterly claim submission process to

ODJFS, the superintendent (or an appropriate designee) attests to the statement listed on the next paragraph.

I hereby certify that I have read the above statement, and that I have examined the accompanying claim(s) and supporting documents for the billing period noted above, and that to the best of my knowledge and belief it is a true, correct and complete statement prepared from the books and records of the agency in accordance with applicable instruction, excepted as noted. I also hereby certify that there are sufficient matching funds that meets the Federal matching funds definition as set forth in 42 CFR 433.

COGs Certification

Intentional misrepresentation or falsification of any information contained in this claim may be punishable by fine and/or imprisonment under federal and state laws.

The services contained within this claim have been paid for with public funds. As part of the quarterly claim submission process to ODJFS, the COG's chief executive officer (or an appropriate designee) attests to the statement listed on the next paragraph.

I hereby certify that I have read the above statement, and that I have examined the accompanying claim(s) and supporting documents for the billing period noted above, and that to the best of my knowledge and belief it is a true, correct and complete statement prepared from the books and records of the agency in accordance with applicable instruction, excepted as noted. I also hereby certify that there are sufficient matching funds that meets the Federal matching funds definition as set forth in 42 CFR 433.

ODMRDD Monitoring Procedures

ODMRDD reviews all MAC program claims to assure their accuracy and to determine whether appropriate documentation exists to support the claims. MAC oversight includes, but is not limited to, reviewing documentation to assure that time study entries are complete, accurately coded, contains local MAC Coordinator's approval and is electronically submitted in a timely manner. ODMRDD also reviews MAC program documentation necessary to confirm that claimed expenditures comply with state and federal program requirements.

The ODMRDD MAC Unit will review all claims submitted by the ODMRDD divisions and CBs/COGs. There are three levels of claims review and monitoring. ODMRDD will perform levels 1 and 2 reviews of all claims. ODMRDD will evaluate a sampling of claims for level 3 reviews.

Level 1 is a technical review of the automated information in the on-line MAC system. It includes verifying mathematical computation accuracy, using the proper MER, and confirming the inclusion of all required program information. This level of review is conducted on all claims prior to submission to ODJFS. The mathematical accuracy of 100% of each quarter's claims will be performed before submission to ODJFS for reimbursement. Examples of Level 1 technical review components are listed in the following paragraph.

Level 1 reviews check participant MAC access roles (MACEmployee, MACSupervisor, etc.), require "active" members for Quarterly Roster staff position insertions and demand an entry type (time study, 100% Medicaid, or contractor) and job title in an entity's Quarterly Roster. Successful claim submission requires matching fund attestation while claim validation requires all Quarterly Roster members to provide completed and approved time study entries and local coordinators to have entered participant specific salary information. For contractor attestation, applicable invoice costs must be entered in the MAC on-line system to be included in an entity's claim.

Level 2 involves a desk review of ODMRDD, CB and COG claims. The data for any particular claim are compared to past claim data to look for claiming patterns that deviate from normal ranges. This review will also examine 1) the description information provided to support time study activity codes used, 2) potential data entry errors of salary/fringe information, 3) confirmation that duplicate claiming did not result for CB and COG claims where COG contractors are claiming, and 4) adequate offset information and other claim validation information is provided. The review also performs internal comparisons of activities reported and cost data to identify any combinations of time spent on a given activity and activity rate costs that seem out of an acceptable range.

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

- Staff utilization of codes;
- Non-Discounted, discounted and reallocated;
- History of errors or problems; and
- Reporting of Documented Non-Medicaid Time code 19.

Level 3 is a full field review. At least 5% of the claiming entities will be reviewed. The initial review will include a minimum of one claiming entity review and a maximum of 5 claiming entity reviews. The number selected for a full field review will also be influenced by the risk factors associated with the:

- Inaccuracies detected during the Level 1 review; and
- Issues identified via the Level 2 review.

This review will evaluate support documentation addressed in the annual Implementation Plan checklist. Support documentation to be reviewed would include quarterly MAC training elements, applicable time study week back up information, contractor invoices, participants' quarterly payroll data components and quarterly claim detail. The local MAC claiming entity maintains all applicable supporting data used to prepare the claim, such as CB/COG specific expenditure information. The on-line MAC system automatically creates history of code usage and comments describing codes used by personnel. ODMRDD field monitoring covers time study results, claiming unit functions, claims reviews, Implementation Plan compliance, and training rosters.

If the field monitoring results in the identification of a claim overpayment, ODMRDD will require reimbursement from the claiming unit of the overpaid amount. Additional steps may be required such as providing additional training, recommending procedure changes, performing internal audits and reviewing claiming entity documentation.

The claiming entity will maintain the payroll records that document the salary and benefits of all CB/COG persons designated as performing MAC authorized activities. Only staff that participated in the quarterly time study training and participated in the quarterly time study can be included in the claim. To be considered 100% Medicaid under the MAC Program, entity participants must submit a current position description to the ODMRDD MAC Unit for review and approval. The submitted position descriptions for these 100% Medicaid staff must confirm that the MAC participants solely perform administrative functions supporting Medicaid programs. The ODMRDD MAC Unit reviews require submission of approved position descriptions with the entity's annual Implementation Plan submission for all such 100% Medicaid positions. Entity staff positions determined to not be 100% Medicaid will require the affected participants to completed quarterly time studies. ODMRDD and individual CBs/COGs are responsible for maintaining and storing their own MAC Program documentation and records.

ODJFS Monitoring Procedures

ODJFS performs reviews and monitoring on claims submitted by ODMRDD and reviews ODMRDD monitoring and oversight activities of CBs and COGs. ODMRDD has direct monitoring and oversight responsibility for CBs and COGs claims submissions. ODMRDD is also a claiming entity with responsibility for submitting accurate claims to ODJFS for reimbursement. ODJFS also has direct monitoring and oversight responsibility of ODMRDD claims submissions.

ODJFS will verify the mathematical accuracy of all claims ODMRDD submits as well as a sample of up to eight CBs and COGs claims submissions. On a quarterly basis, ODJFS will perform a complete review and evaluation of a selected claim submitted by ODMRDD. During the first two quarters of claim submission following CMS approval of the MAC methodology, this complete review and evaluation will include selection of time studies representing the value of up to 10% of all ODMRDD claims. These reviews will include a thorough examination of expenditure reporting.

Also, ODJFS will select one additional ODMRDD claiming entity not previously selected from which to review in detail one claim component from the list below of ODMRDD's claim:

- Indirect Cost Rate
- Training
- Payroll
- Invoice/Expenditures
- Time Study
- Revenue
- Third Party Liability

As historic claiming data is collected, ODJFS will review ODMRDD submitted claims based on variations between periods. ODJFS will gather data to highlight trends and track variations between periods and across the claiming entity population. Should ODJFS discover significant and consistent problems with submitted claims it may request that ODJFS's auditing entity (The Office of Research, Assessment, and Accountability) conduct an audit.

Before the ODMRDD MAC Unit begins the review of claims submitted by CBs and COGs, ODJFS will examine ODMRDD's review methodology for adequacy. ODJFS will evaluate the results of ODMRDD's review of claims submitted by CBs and COGs.

ODJFS will select 5% of the reviews performed by ODMRDD (at least one review per quarter). If the calculation produces more than 10 reviews, ODJFS will limit its initial review to 10 reviews. If the initial review uncovers significant and/or systemic problems, ODJFS may perform additional reviews.

ODJFS will not process or submit any MAC claim for FFP reimbursement that the ODMRDD MAC Unit or ODJFS have determined contains claiming errors. ODJFS will return such claims to ODMRDD for review and correction.

The chart below summarizes the monitoring activities to be carried out by each organization.

Oversight and Monitoring of the ODMRDD MAC Program

CBs & COGs	ODMRDD	Ohio Department of Job & Family Services
Staff will review materials to ensure appropriateness and responsibility.	All claims reviewed for math accuracy.	All claims from ODMRDD and a sample of up to 8 CB/COG claims reviewed for math accuracy.
CB Superintendents, COG Directors or agency designee will attest to accuracy of claim.	All claims reviewed through two levels: <ol style="list-style-type: none"> 1. Technical review 2. Desk review including comparisons to past claims. 	Complete review and evaluation of one claim from an ODMRDD division. During first 2 quarters of MAC plan approval, 2 claims representing up to 10% of claimed amount will be reviewed.
	At least 5% of claiming entities (up to 5 claims) will receive a level 3 review which is a full field review.	One additional ODMRDD sample claim will have one claim component reviewed intensely.
		Will review 5% up to 10 of the reviews conducted by ODMRDD of CB/COG claims.
		ODJFS has option to request that ODJFS auditing office, ORAA, audit claims if severe problems exist.

MAJOR UNUSUAL INCIDENTS/ UNUSUAL INCIDENTS INVESTIGATIONS FOR THE MRDD

Major Unusual Incidents are alleged, suspected, or actual occurrences of incidents that affect the health and safety of individuals served in our system. The incidents include, but are not limited to Abuse, Neglect, Misappropriation, and Death. Ohio reports on 17 different categories. The system for reporting incidents has been around more than 20 years.

In 1999, Ohio began to build its current system based on concerns from the federal government with the Residential Facility Waiver and newspaper reports about serious incidents that were happening. One of the basic assurances of the waiver is for the health and welfare of individuals. In addition, ICF/MRs have been required to protect individuals in their care since the 1970s. In order to ensure that all people in our system are health and safe, Ohio developed strong reporting, investigation, and prevention planning requirements.

Ohio built into its Administrative Code, strict guidelines for reporting and follow-up on incidents. Compliance to the OAC requirements is assessed annually for each county board and developmental center. All initial reports are reviewed by the Department to ensure individuals are safe from further harm while an investigation is conducted. In addition, to the annual assessments, the Department provides daily technical assistance to the county board regarding incidents.

The Department also reviews all the more serious categories once they are recommended for closure by the county board who conducted the investigation into the incident. The cases are reviewed for thoroughness and preventive measures to address the cause(s) of the incident.

The construction of ODMRDD Activity Code types take into account that the circumstances of the people we work with and the environment we work in varies somewhat from the conditions outlined in the 2003 CMS Education Model. ODMRDD uses Discounted activity codes (D) when a mixed population is involved and an Unallowable (U) code is available when non-Medicaid tasks are performed. In response to outside reviewer comments, the non-discounted MUI/UI code (AC 15-Major Unusual Incidents and Unusual Incidents Investigations for Medicaid Population) will not be applicable for either CB/COG or ODMRDD participants in future claiming periods.

CLAIM CALCULATION EXAMPLE

In general, the claim is calculated by activity code, rate factor, Federal Financial Participation (FFP) and reimbursement type. The claim uses salary and benefit specific information associated with MAC time study participants for the reporting period. The total claim is the sum of these calculations across all allowable activity codes, adding in the estimated ancillary costs. The claim associated with any particular activity is based on the following factors:

- Actual salary and fringe costs; and
- Percentage of time distribution for that activity, as determined by the time study; and
- Application of reimbursement level factors:
 - ✓ Application of Medicaid Eligibility Rate for Activity Codes;
 - ✓ Exclusion of those activities that are non-allowable; and
 - ✓ Reallocation of allowable general administration as described in code 18, General Administration.

There are four MAC reimbursement types:

1. **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.
2. **Discounted (Type D)** activities are administrative activities that are only reimbursable for the Medicaid eligible individuals for the claiming unit. The costs associated with these activities will be reduced according to the MER percentage in the claims calculation.
3. **Unallowable (Type U)** activities are unallowable activities under the Medicaid Administrative claim, but these activities 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.
4. **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.

Table A presents the Activity Codes and the appropriate reimbursement type for each code.

Claim calculation example (continued)

TABLE A: Map of Reimbursement Type to Activity Code

Reimbursement Type	Activity codes to which this calculation applies
ND	State Level: Codes 3, 5,* CB/COGs: Codes 3, 5, 7 *
D	State Level: Codes 7, 9, 11, 13, 17 CB/COGs: Code 9, 11, 13, 17
U	State Level: Codes 1, 2, 4, 6, 8, 10, 12, 14, 16, 19 CB/COGs: Codes 1, 2, 4, 6, 8, 10, 12, 14, 16, 19
R	Code 18

* Code 15 is no longer applicable for the MAC Program

Gross Claim Calculation-CB/COG example

Table B is an example of calculations for Activity Codes 3, 4, 5, 6, 7, 8, 11, 12, 13, 14, and 18 for the Personnel category of expenses. The grand total of expenses for Salary and Fringe Benefits is assumed to be \$25,000 for each category.

TABLE B: Claim Calculation-using applicable CB/COG level codes

Activity Code	Salary & Fringe Cost	Time Study %	Rate Factor	Size of MAC Activities	FFP	Claim
3 (Medicaid Outreach)	\$25,000	5%	100% (no discount)	\$1,250	50%	\$625.
4 (Non-Medicaid Outreach)	\$25,000	5%	0% Unallowable	\$0	0%	\$0
5 (Medicaid Eligibility)	\$25,000	7.5%	100% (no discount)	\$1,875	50%	\$937.50
6 (Non-Medicaid Eligibility)	\$25,000	7.5%	0% Unallowable	\$0	0%	\$0
7 (Referral, Coordination of Medicaid Services)	\$25,000	10%	100% (no discount)	\$2,500	50%	\$1,250.00
8 (Referral, Coordination of Non-Medicaid Services)	\$25,000	5%	0% Unallowable	\$0	0%	\$0
11 Program Planning Coord. of Medicaid Services	\$25,000	10%	55% (MER)	\$1,375	50%	\$687.50
12 Program Planning Coord. of Non-Medicaid Services	\$25,000	10%	0% Unallowable	\$0	0%	\$0
13 Medicaid Related Provider Relations	\$25,000	10%	55% (MER)	\$1,375	50%	\$687.50
14 Non-Medicaid Related Provider Relations	\$25,000	10%	0% Unallowable	\$0	0%	\$0
18 General Administration	\$25,000	20%	41.88% (step 2)	\$2,093.75	50%	\$1,046.88
Total	\$25,000	100%	-	\$10,468.75		\$5,234.38

Claim calculation example (continued)

- **Type ND (Non-Discounted):** The CB/COG example uses Activity Codes 3, 5 and 7 (CB/COG only) to demonstrate the calculation applicable for any Type ND code (codes 3 and 5 for both State Level and CB/COG). These codes are not impacted by the Medicaid Eligibility Rate. For example, the gross claim for Activity Code 3 is simply the product of allocated time study percentage times the gross MAC expenditures. ($5\% \times 100\% \times \$25,000 = \$1,250$)
- **Type D (Discounted):** The CB/COG example uses Activity Codes 11 and 13 to demonstrate the calculation applicable for any Type D activity code (codes 7 [for State Level only], 9, 11, 13, and 17 for the State Level and CBs/COGs). These codes must be reduced by the Medicaid Eligibility Rate. The example uses a Medicaid Eligibility Rate of 55%. Thus, the gross claim for Activity 11 is equivalent to the product of the activity code time study percentage times the Medicaid rate times the gross MAC expenditures for Activity Code 11 ($10\% \times 55\% \times \$25,000 = \$1,375$).
- **Type U (Unallowable):** The example uses Activity Codes 4, 6, 8, ,12 and 14 to demonstrate the calculation applicable for any Type U activity code (codes 1, 2, 4, 6, 8, 10, 12, 14, 16 and 19). These codes are unallowable and are not reimbursed. Thus, the gross claim for these activity codes equals \$0.
- **Type R (Reallocated):** The example uses Activity Code 18 to demonstrate the calculation applicable to the only Type R Activity Code. Time allocated to this code is partially allowable, based upon the sum of the claimable percentage of time attributable to all of the other activity codes, as a percentage of the total time spent on all other activity codes (except 18). The claimable percentage of time equals the time study percentage multiplied by the reimbursement rate for that activity (e.g., 100% for ND and 55% for Type D). The example assumes the entire claim is built from the activities used here as examples, so the calculation of the gross claim distribution for Activity Code 18 would be as follows:

Table C: Calculation of Claimable Percentages for Allocation of Type R Codes- using CB/COG example.

Activity Code	Time Study %	Rate Factor	Claimable %
3 (Medicaid Outreach)	5%	100% (no discount)	5%
4 (Non-Medicaid Outreach)	5%	0% Unallowable	0%
5 (Medicaid Eligibility)	7.5%	100% (no discount)	7.50%
6 (Non-Medicaid Eligibility)	7.5%	0% Unallowable	0%
7 (Referral, Coordination-Medicaid Services)	10 %	100% (no discount)	10%
8 (Referral, Coordination-Non-Medicaid Services)	5%	0% Unallowable	0%
11 (Program Planning, Development for Medicaid Services)	10%	55% (MER)	5.50%
12 (Program Planning, Development for Non-Medicaid Services)	10%	0% Unallowable	0%
13 (Medicaid Provider Relations)	10%	55% (MER)	5.50%
14 (Non-Medicaid Provider Relations)	10%	0% Unallowable	0%
SUM	*80%	33.50% / 80% = 41.88%	33.50%

The allocation rate factor for Activity Code 18 is equal to the following:

(Sum of Claimable % for Other Activities) divided by (Sum of total time spent on other activities) 33.50% / 80% = 41.88

***The time study percentage (20%) for Activity Code 18 (Allocated) shown in Table B (Claim Calculation) is not included in Table C's time study column total (80%).**

Annual Claim Reconciliation

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 ODMRDD and CBs/COGs shall comply with time restrictions set forth in 42 CFR 433.312, "...the Medicaid agency has 60 days from the date of discovery (defined in 42 CFR 433.316(c)) of the overpayment to a provider before the Federal share must be refunded to [CMS]. The adjustment will be processed on the next available claim after adjustments are communicated."

Periodicity

ODMRDD, CBs and COGs submit MAC claims quarterly. The claims are submitted through ODMRDD to ODJFS. Quarterly claim submissions are due to ODMRDD and ODJFS per the following chart:

Schedule for the Claims Submission & Payment				
Quarter	Claim submission deadline to ODMRDD	ODMRDD 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.

ODMRDD submits one quarterly claim to ODJFS (including amounts claimed from all MAC claiming entities) according to the schedule above. Each claiming unit must submit its quarterly claim to ODMRDD by the end of the subsequent quarter in which the time study week fell. ODMRDD will compile all claims and submit one quarterly claim to ODJFS within five (5) months of the end of the quarter in which the time study week fell. ODJFS will review and approve the claim within six (6) months of the end of the quarter in which the time study week fell. Payment will be dispersed to CB/COG claiming entities within seven (7) months of the end of the quarter in which the time study week fell.

If, for any reason, a claiming unit does not meet the quarterly submission deadline, ODMRDD will process the claim without that unit's quarterly claim. There will be no further opportunity to claim for that claiming unit's MAC time for that quarter.

ODMRDD submits all MAC claims to ODJFS no later than 15 months after the claiming unit incurs actual expenditures. ODJFS will submit a claim within two years of the last month of the quarter which is being claimed. Reimbursement for a claim is made to the CB/COG by ODMRDD following receipt of federal funds from ODJFS.

PART II TIME STUDY METHODOLOGY

Overview

This section describes the methodology used to calculate the amount of time claiming entities (ODMRDD, CBs and COGs) dedicate to performing MAC functions for the purpose of allocating Medicaid reimbursable activities and associated costs. This methodology is applied each quarter for purposes of supporting ODMRDD, CBs and COGs Medicaid Administrative claim calculation amounts.

The following section is intended to provide a general overview of the basic principles and approach for the MAC methodology.

MAC Implementation Plan

The MAC Implementation Plan completed by each claiming unit is used as an application for MAC program participation and aids in organizing each administrative claiming unit. All MAC Implementation Plans must adhere to the principles set forth in this document. The MAC Implementation Plan provides support for submitting MAC claims. The Implementation Plan must be completed by each participating claiming entity and approved by the ODMRDD MAC Unit prior to the start of the calendar year to which it applies. The Implementation Plan provides all involved parties with a common reference document and ensures consistency in the claiming process. Revisions to any MAC Implementation Plan must be approved prior to the quarter for which the claim is to be submitted. The claiming unit requesting such revisions needs to submit copies of the revised Implementation Plan (highlighting changes made from the approved Implementation Plan already on file at ODMRDD) for ODMRDD MAC Unit review. [Please see Attachment C for a sample MAC Implementation Plan.]

The Implementation Plan identifies the specific staff and contractor positions (including name and job title) participating in the time study and list the MAC activities they perform, using the quarterly roster. This quarterly roster serves as the required first quarter list of employees, job titles, types of MAC staff (100%, time study and contractors), MAC codes to be used and dates trained. Subsequent quarterly rosters will be updated and submitted via the on-line MAC system to the ODMRDD MAC Unit two weeks prior to the start of each succeeding time study week.

The MAC Implementation Plan must be descriptive enough to show outside reviewers that the claiming entity has a system in place to organize and manage MAC in a manner acceptable to ODMRDD. Once approved, Implementation Plans remain in effect for one year, unless a revision must be made. Implementation Plan effective dates cover January 1 through December 31. Implementation Plans are renewable prior to the expiration date, but the effective end date remains the same.

ODMRDD will retain the approved Implementation Plan.

Time Study Approach

The time study is used to allocate the fair share of staff costs to Medicaid administration. Time study participants have job functions which contain activities that can be reimbursed under MAC. If administrative staff has job functions that encompass MAC reimbursable activities, then they must complete a time study. **Job functions**, rather than job title, determine a person's inclusion in the MAC time study.

The only exception to this mandatory MAC time study requirement covers staff that spends 100% of their time exclusively on Medicaid administrative activities. If a claiming unit has one or more 100% Medicaid staff positions, the local MAC Coordinator must include a position description(s) with the claiming unit's MAC Implementation Plan. The ODMRDD MAC Unit will review these position descriptions as part of the Implementation Plan review process. These 100% Medicaid staff are exempt from the time study process, but are included in the claiming unit's quarterly claim to ODMRDD. Staff who falls into this category must certify each quarter, via the on-line MAC system, that their job functions consist of 100% Medicaid administrative activities.

Time Study Period and Time Study Participants

To determine the universe of days eligible for the quarterly time study universe, the days of the quarter are reviewed. Beginning with the period July – September 2007, a week will be defined as seven consecutive days. The time study week will be randomly selected for seven consecutive days out of the 91 (or 92) days in each quarter. ODJFS will make the selection between 48 and 40 days prior to the first day of the quarter.

The ODMR/DD MAC Unit will inform CB/COG and Department MAC Coordinators of the seven consecutive days' time study period selected for the following quarter's time study via email distribution. This email notification will offer local MAC Coordinators sufficient time to provide local participants quarterly follow up training and/or training updates prior to each quarter's quarterly roster "lock down" period. **The Departmental notification of the next quarter time study week to MAC time study participants will occur no more than one week prior to the quarterly time study period.** This selection process is documented and maintained on file with the ODMRDD MAC Unit. The time study, conducted four times a year, covers the following time periods: January – March, April – June, July – September, and October – December.

All MAC time study participants will use the same workweek as the time study observation period to determine how time is allocated. MAC time study participants must use the ODMRDD administered on-line MAC system to log their time study information.

During the time study period, each participant codes and documents all of his or her work-related activities, including paid time off, for each workday of the time

study period, in compliance with OMB Circular A-87 guidelines requiring capture of 100% of the participant's time. Time study participants code their daily activities to a prescribed set of Activity Codes in 15-minute increments. If participants perform more than one activity within the 15-minute increment, they will code to the most predominant activity, as discussed in the Department's training material. MAC time study participants are required to document their work activities on a daily basis by inputting activity code and description information into the MAC on-line system.

Each participant is required to complete an on-line time study form for quarterly designated MAC time study periods. The MAC time study form is submitted via the on-line system to the participant's supervisor for review and approval. If an employee codes more than 40 hours/week during the time study period, the participant's supervisor must approve such overtime. The quarterly time study (participant specific) salary information entered into on-line MAC system for all MAC participants on the quarterly claim will verify such authorization. Once approved by the supervisor, a participant's time study form is submitted via the on-line system to the local MAC coordinator for review, approval and submission to ODMRDD. The local MAC coordinator uses electronic signature within the on-line system to attest to the date and accuracy of the forms to be submitted to ODMRDD and/or ODJFS. ODMRDD, CBs and COGs must submit their MAC claims to the ODMRDD MAC Unit within the timeframes previously outlined in this Guide.

The ODMRDD MAC Unit will submit the entire MAC claim, including ODMRDD's time study claim, to ODJFS according to the Guide designated timeframes.

All MAC time study participants will provide a brief description of the activities and corresponding Activity Codes used on the study form for each workday during the time study period. While brief, written descriptions listed on the study form need to clearly reflect all activities performed during the seven day time study.

Time Study Activity Definition

ODMRDD 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. Recognizing the importance of consistency of programs within the same state, ODMRDD has developed its ODMRDD MAC program to closely resemble the Ohio Department of Health's MAC program.

The Activity Code descriptions for CBs, COGS and ODMRDD are listed on the following page.

Activity Code	Activity Description
1	Direct Care
*2	Developmental Center Code OR 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
***15	Major Unusual Incidents and Unusual Incidents Investigations for Medicaid population
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
19	Documented Non-Medicaid Time

* Please note: Code 2 is used as a Developmental Center Activity Code for ODMRDD staff only. For CB/COG staff, Code 2 is used for Targeted Case Management Activities. For further clarification, please reference detailed definitions of the MAC activities found in Attachment E: Medicaid Administrative Claiming Activity Codes.

** Denotes discounted CB/COG and ODMRDD State Level codes. These codes are discounted because the tasks involve working with combined (Medicaid and non-Medicaid) populations.

*** Code 15 (MUI Investigations for Medicaid Population), initially denoted as a non-discounted code, is no longer being used by MAC participating entities.

**** Code 7 (Referral, Coordination & Monitoring of Medicaid Services) is non-discounted for CB/COGs because the tasks involve working exclusively with a Medicaid population. For ODMRDD staff, code 7 is discounted because the tasks involve working with a combined (Medicaid and non-Medicaid) population.

Time Study Instrument

The on-line MAC time study system is designed to capture all activities and functions performed by MAC time study participants throughout the randomly selected week, including Medicaid administrative activities, Medicaid direct service activities and non-Medicaid administrative activities. MAC time study participants are required to account for all of their time during the course of the study week to reduce the possibility of over or under estimating time spent on administrative related or other activities. The time study instrument is designed to be functional for MAC participants while still capturing the necessary level of detail required to appropriately allocate costs. MAC time study instruments are compiled electronically, via the ODMRDD administered on-line system.

The time study instrument is self-administered and captures participant activities in 15-minute increments for each day of the time study period. Activities are recorded into one of 19 Activity Codes, covering allowable and non-allowable MAC activities. Collectively, the 19 activity categories identified in the time study document account for the diverse range of activities performed by ODMRDD, CB and COG staff.

Upon completion of the time study period, ODMRDD, the CBs and COGs account for and maintain all time study documents, as required for audit purposes. Activity data recorded in the on-line MAC system is used to allocate activities by personnel category and calculate each claiming unit's claim amount.

Time Study Training

Initial Training – Program Rollout

Recent training for local MAC coordinators and time study participants has been key to the MAC program's January – March 2007 time study implementation. The ODMRDD MAC Unit conducted initial training of local MAC coordinators and time study participants for each participating claiming entity. These trainings

were conducted in six designated regions throughout the state. Two MAC make-up sessions were held in Columbus for those participants unable to attend training in their own or neighboring regions. ODJFS staff attended all initial trainings as observers to insure continuity across training sessions. If staff were unable to attend the make-up sessions in Columbus, the local MAC coordinator could conduct a local training, provided 1) written permission has been granted by the ODMRDD MAC coordinator; and 2) the same materials used at the regional trainings are used by the local MAC coordinator. No more than 5% of the total number of MAC participants from any regularly scheduled training may be locally trained.

Ongoing MAC Trainings – Train the Trainer

Trainings subsequent to the initial first quarter 2007 rollout trainings for CB/COG MAC participants will be conducted employing a train-the-trainer approach. The ODMRDD MAC Unit offers training for the local MAC coordinators semi-annually. Each local MAC coordinator is required to attend at least one training annually. The ODMRDD MAC Unit will conduct ongoing trainings in the spring and fall each year. Training will include a thorough review of codes and activity code narrative descriptions. Training will also address a complete review of the ODMRDD on-line MAC system used for preparing and submitting quarterly claims.

Local MAC coordinators will be tested on competencies of all programmatic aspects of MAC to ensure that coordinators are prepared to adequately train local participants during subsequent trainings. Local MAC coordinators will also receive materials to be used for local MAC trainings to share with local time study participants. Training focuses on the time study procedures and the proper use of the Activity Codes. All local MAC coordinators are required to use a uniform set of training materials **and provide quarterly training material and/or MAC updates to all local CB/COG time study participants.**

Each claiming unit is responsible for ensuring adequate training for all of its time study participants prior to the time study period. On-site comprehensive training for new participants will occur prior to the time study period. All claiming entities' MAC training material must be approved by ODMRDD and is subject to review and approval by ODJFS. To ensure standardized training material is used for all MAC follow up trainings, local MAC Coordinators should use ODMRDD training material maintained on the Department's MAC webpage. Participants who have previous comprehensive training will be provided quarterly updates and a review of MAC, including review of notifications to MAC coordinators distributed by ODMRDD. Each claiming unit maintains documentation of its training schedules, attendance, and materials used. Each claiming unit must inform the ODMRDD MAC Unit four weeks prior to any scheduled MAC training.

Certification of adequate training (via the ODMRDD on-line MAC system) is required of each quarterly time study participant prior to his/her participation in the time study period. The on-line system requires all MAC users attest to having received training and/or updates relevant to the MAC program. If a MAC participant's time study training certification is not documented, then his/her time study results will reflect Code 19, Documented Non-Medicaid Time, for the entire time study period.

Time Study Monitoring

The ODMRDD MAC Unit monitors the time study process to ensure its accuracy and validity. The monitoring functions include, but are not limited to the following:

1. Periodically attending (unannounced), scheduled time study training sessions for claiming entities to ensure that the trainers are following the approved curriculum;
2. Randomly interviewing and/or testing trainers and time study participants for competence, consistency in training and understanding of Activity Codes, and time study procedures;
3. Ensuring that time study participants understand the training, notifications and FAQs and are correctly completing the time study (e.g., by randomly analyzing individual time study documentation and interviewing time study participants);
4. Reviewing and analyzing time study results for the first two quarters of participation for 5% of claiming entities, and subsequently conduct random reviews of selected time study results for the following:
 - i. Completeness of time study documentation (including supervisor's electronic signature);
 - ii. Reasonableness of individual results (e.g., coding appears appropriate for type of staff; identify outliers);
 - iii. Verification of staff attendance at/participation in training;
 - iv. Verification that the number of participating positions specified in the Implementation Plan is consistent with number of actual time study participants.
5. Performing trend analysis of time study with prior quarters (e.g., results by claiming unit).

ODMRDD's MAC Unit provides technical assistance to address any issues identified during the monitoring process. ODJFS will be notified at least two weeks in advance of each scheduled training and will attend, unannounced, a random sampling of such trainings throughout the year.

ATTACHMENT B: CLAIMS AND INSTRUCTIONS

LOCAL CLAIM PREPARATION

Supporting Documents:

Prior to preparing a claim, the following five items are needed:

- **The entity's approved MAC Implementation Plan.** The plan should include a listing of MAC Personnel and a table of organization (T.O.) to help document the relationships between all personnel listed in the quarterly roster.
- **The Medical Eligibility Rate (MER)** should correspond to the calendar year used to prepare the claim. ODMRDD will calculate and distribute an updated MER annually to all claiming entities.
- **The quarter's payroll data** from appropriate local reports. Employ actual payroll expenditures. Use standard local reporting methods when generating this information.
- The claiming entity's **quarterly time study results.**
- The claiming entity's **quarterly list of trained time study personnel.**

Review of Supporting Documents:

Upon receipt of the above items the first step is to compare the MAC Implementation Plan's personnel to the time study results and the sources of funding.

- Any position not in the plan or in the updated quarterly roster cannot be included in the claim and their time study results are removed. The names of all trained MAC participants will be compared to the positions listed in the claiming entity's quarterly roster to ensure that only trained staffs' time is reimbursed during the quarterly time study week.
- If a position is in the plan but a MAC time study participant did not certify having received time study trainings and/or MAC updates, his/her quarterly time study results will reflect Code 19 (Documented Non-Medicaid Time).
- If a position is in the plan but a MAC time study participant does not complete the time study, then his/her time-study results should be coded to MAC code 19 (Documented Non-Medicaid Time).

Review of supporting documents (continued)

- If a position is in the plan, staff received training, but the affected staff was on paid leave during the time study week, record their costs using code 18 (General Administration). If a staff is on unpaid leave and/or did not receive quarterly training, use code 19 (Documented Non-Medicaid Time) and note that staff is on unpaid leave.
- If a position is funded 100% with federal funds and related match revenue, then these costs are not included in the submitted claim and their time study results are removed from the claim.
- Positions are approved in the plan, *not* people. Compare names to titles. If a person changed positions then make sure the time-study results and costs are associated with the correct position. Reconciliation of trained MAC participant lists to quarterly roster detail will occur prior to submitting the ODMRDD quarterly claim.

Online System:

CBs/COGS and ODMRDD MAC participants submit their local claims electronically to ODMRDD via the online MAC system.

The time study participants will enter their time studies on the online system using a unique username and protected password. Local MAC Coordinators will verify via the quarterly roster online system if/when MAC participants received MAC training and/or the most recent MAC updates.

After the time study entry is completed, each time study participant will forward the electronic time study to their supervisor for approval. The supervisor will either send the time study back to the participant if errors are spotted or electronically approve the time study.

A locally designated MAC data entry staff person, or the local MAC Coordinator, will enter the payroll information for time study participants using actual costs. The MER percentage is automatically included in the claim calculation as it is stored in the online system for each claiming entity.

Prior to sending the claim to ODMRDD, the local MAC coordinator/designee must enter any revenue offsets and any personal service contract costs. The local MAC coordinator/designee must select supervisor-approved time studies to include with the MAC claim. The local MAC coordinator/designee then submits the quarterly claim to ODMRDD via the online system.

Before sending the claim to ODMRDD, the superintendent, COG Director or designee certifies that: "I have examined the accompanying claim(s) and supporting documents for

the billing period noted above, and that to the best of my knowledge and belief it is a true, correct and complete statement prepared from the books and records of the agency in accordance with applicable instruction, excepted as noted. I also hereby certify that there are sufficient matching funds that meets the Federal matching funds definition as set forth in 42 CFR 433.”

Medicaid Administrative Claiming (MAC) Activities Claim Worksheet

Claiming Entity: CB/COG
 Claiming Unit:
 Claiming Number:
 Period of Services: 1/1/07--3/31/07

Claiming D

 Preparer:

Quarterly Salary and Fringe Benefits	\$ 25,000.00
Offsets	\$ 0.00
Total	\$ 25,000.00

Time Study Activities		MER %	Time Stu
Direct Care	1	0%	0.00%
Targeted Case Management Activities	2	0%	0.00%
Medicaid Outreach	3	100%	5.00%
Non-Medicaid Outreach	4	0%	5.00%
Facilitating Medicaid Eligibility Determinations	5	100%	7.50%
Facilitating Eligibility for Non-Medicaid Programs	6	0%	7.50%
Referral, Coordination and Monitoring of Medicaid Services	7	100%	10.00%
Referral, Coordination and Monitoring of Non-Medicaid Services	8	0%	5.00%
Translation for Medicaid Services	9	55%	0.00%
Translation for Non-Medicaid Services	10	0%	0.00%
Program Planning, Development and Interagency Coordination of Medicaid Services	11	55%	10.00%
Program Planning, Development and Interagency Coordination of Non-Medicaid Services	12	0%	10.00%
Medicaid Related Provider Relations	13	55%	10.00%
Non-Medicaid Provider Relations	14	0%	10.00%
Major Unusual Incidents and Unusual Incidents Investigations for Medicaid population N/A	15	100%	0.00%
Major Unusual Incidents and Unusual Incidents Investigations for non-Medicaid population	16	0%	0.00%
Major Unusual Incidents and Unusual Incidents Investigations for combined population	17	55%	0.00%
General Administration	18	41.88% (reallocated rate)	20.00%
Documented Non-Medicaid Time	19	0%	0.00%

Total Time

100.00%

55% (MER% Discount example)

Time Study FFP:	\$ 5,234.38
100% Medicaid FFP:	\$ 500.00
Contractor FFP:	\$ 450.00
Gross Claim Amount:	\$ 6,184.38
Ancillary Costs:	\$ 618.44
Total Claim Amount:	\$ 6,802.82

I hereby certify that there are sufficient matching funds that meet the Federal matching funds definition as set forth in 42 CFR 433.

(Electronic)
 Signature

Intentional misrepresentation or falsification of any information contained in this claim may be punishable by fine and/or imprisonment under federal and state law. I have read the above statement, and that I have examined the accom

(Electronic)
 Signature

ATTACHMENT C: MEDICAID RATE BY ACTIVITY CODE

**Medicaid Rate by Activity Code
Ohio Department of MR/DD**

State Level

Code	Activity Description	FFP	Medicaid Rate
1	Direct Care	0%	U
2	Developmental Centers	0%	U
3	Medicaid Outreach	50%	N
4	Non-Medicaid Outreach	0%	U
5	Facilitating Medicaid Eligibility Determinations	50%	N
6	Facilitating Eligibility for Non-Medicaid Programs	0%	U
7	Referral, Coordination & Monitoring of Medicaid Services	50%	D
8	Referral, Coordination & Monitoring of Non-Medicaid Services	0%	U
9	Translation for Medicaid Services	50%	D
10	Translation for Non-Medicaid Services	0%	U
11	Program Planning, Development & Interagency Coordination of Medicaid Services	50%	D
12	Program Planning, Development & Interagency Coordination of Non-Medicaid Services	0%	U
13	Medicaid Related Provider Relations	50%	D
14	Non-Medicaid Related Provider Relations	0%	U
15	Major Unusual Incidents and Unusual Incidents Investigations for Medicaid population- N/A	50%	N
16	Major Unusual Incidents and Unusual Incidents Investigations for non-Medicaid population	0%	U
17	Major Unusual Incidents and Unusual Incidents Investigations for combined populations	50%	D
18	General Administration	50%	R
19	Documented Non-Medicaid Time	0%	U

U denotes Unallowable Medicaid reimbursement rate
 N denotes Non-Discounted Medicaid reimbursement rate
 D denotes Discounted Medicaid reimbursement rate
 R denotes Reallocated Medicaid reimbursement rate

Medicaid Rate by Activity Code

CB/COG

Code	Activity Description	FFP	Medicaid Rate
1	Direct Care	0%	U
2	Targeted Case Management Activities	0%	U
3	Medicaid Outreach	50%	N
4	Non-Medicaid Outreach	0%	U
5	Facilitating Medicaid Eligibility Determinations	50%	N
6	Facilitating Eligibility for Non-Medicaid Programs	0%	U
7	Referral, Coordination & Monitoring of Medicaid Services	50%	N
8	Referral, Coordination & Monitoring of Non-Medicaid Services	0%	U
9	Translation for Medicaid Services	50%	D
10	Translation for Non-Medicaid Services	0%	U
11	Program Planning, Development & Interagency Coordination of Medicaid Services	50%	D
12	Program Planning, Development & Interagency Coordination of Non-Medicaid Services	0%	U
13	Medicaid Related Provider Relations	50%	D
14	Non-Medicaid Provider Relations	0%	U
15	Major Unusual Incidents and Unusual Incidents Investigations for Medicaid population N/A	50%	N
16	Major Unusual Incidents and Unusual Incidents Investigations for non-Medicaid population	0%	U
17	Major Unusual Incidents and Unusual Incidents Investigations for combined populations	50%	D
18	General Administration	50%	R
19	Documented Non-Medicaid Time	0%	U

U denotes Unallowable Medicaid reimbursement rate

N denotes Non-Discounted Medicaid reimbursement rate

D denotes Discounted Medicaid reimbursement rate

R denotes Reallocated Medicaid reimbursement rate

ATTACHMENT D:
MAC SAMPLE IMPLEMENTATION PLAN

Example Implementation Plan

Note: The first page must be a transmittal page on CBMRDD/COG letterhead.

I. MAC Coordinator

Employee1, MAC Coordinator
Sample CBMR/DD
234 Anywhere Street
Anywhere, Ohio 12345-5000
(740) 345.3456 (office)
(740) 345.3457 (fax)
employee1@samplemrdd.org (email)
Attachment A is Employee1's job description.

Attachment B is a complete organizational chart showing where and to whom the MAC primary positions report.

II. Medicaid Administrative Claiming Activity Study Personnel

Employees whose time is being allocated or reimbursed through the MAC program are required to be listed in one of the following categories detailing the required information (as outlined in Attachment E of the ODMRDD MAC Guide):

100% Employees

Name (optional)	Title	Staff Type	Codes	Date trained/updates rec'd
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Time Study Methodology Employees

Name	Title	Staff Type	Codes	Date trained/updates rec'd
------	-------	------------	-------	----------------------------

Contractors Performing MAC Activities

Name/Agency (optional)	Title	Staff Type	Codes	Date trained/updates rec'd
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Please see Attachment C, Quarterly Roster, for list of employees and contractors participating in MAC time studies. This roster serves as the required first quarter list of employees, job titles, duties, MAC codes to be used and dates trained. Subsequent quarterly rosters will be updated and submitted to the ODMRDD MAC Unit two weeks prior to the start of each time study week.

III. MAC Activity Study Methodology

- A. Time studies occur one week each quarter as specified by ODJFS, as discussed on page 27 of the ODMRDD MAC Claiming Guide (Time Study Week and Time Study Participants).
- B. The MAC Coordinator and all MAC time study participants will attend the initial training presented by the ODMRDD as established in Part II, Time Study Methodology, of the Medicaid Administrative Claiming Guide. After initial program training has occurred across the state, the local MAC Coordinator shall then train the local claiming unit's employees participating in the MAC program based on that training.

The information that will be presented as the in-house training is as follows:

- MAC program updates (if applicable);
- Introduction to Medicaid Administrative Claiming;
- Activity Codes – Explanation and Definitions;
- MAC On-line system – How to Record Time Spent on Activities, how to record leave time;
- Responsibilities of the Employee in completing the time study;
- Responsibilities of the Supervisor in approving the time study;
- Where to go for Help; and
- Questions and Answers.

Newly hired employees will be individually trained prior to participation in the MAC time study week. See Item G. for additional information on new hires.

- C. How participants access the on-line MAC system. Each participating time study employee must complete an on-line systems security affidavits provided by ODMRDD. The appropriate level of access must be denoted on the security affidavits (e.g. MAC – Coordinator, MAC – Supervisor, MAC – Employee, or MAC – data entry).
- D. Review of time study entries. Reviews will be ongoing. Supervisors are the first-line quality assurance checkers. Supervisors review time study entries to verify complete information and correct code usage. The supervisors then approve the on-line time study entry in preparation for submission to ODMRDD. The local MAC coordinator then reviews all supervisor-approved time study entries for completeness and accuracy. Any questionable issues are discussed with the employee who prepared the time study entry and his/her supervisor. Once all time study entries are complete, the local MAC coordinator approves and submits them to ODMRDD via the on-line system.

- E. Contacts. If MAC time study personnel have questions they are directed to ask their supervisors for assistance. If needed, the supervisor consults with the local MAC coordinator for assistance. If the local MAC coordinator is not able to answer the question, he/she will contact the ODMRDD MAC Unit coordinator for guidance.
- F. Back up Documentation. Each MAC time study personnel will use comment boxes behind each 15-minute period in the on-line MAC system to provide an explanation for the specific activity performed that supports the corresponding MAC activity code.
- G. New Hires. New hires may participate in MAC time study weeks, after completing the MAC time study training provided by the local MAC coordinator. Supervision of the employee's time study will be extensive to ensure that the on-line entry is correctly completed.

IV. Fiscal Information

- A. Expense Categories to be included as allowable costs. The agency only includes costs that are in accordance with the ODMRDD MAC Guide, as approved by the Ohio Department of Job and Family Services (ODJFS) and the Centers for Medicare and Medicaid Services (CMS). All MAC claims and the cost report are prepared on the cash basis of accounting.
- B. Contracted Services. As noted in Section II, the CBMRDD contracted with _____ COG to perform _____ services on behalf of the CBMRDD. In order for there to be an accurate accounting of the costs, the CBMRDD will not request reimbursement from ODMRDD for the _____ services performed. _____ COG will request reimbursement from ODMRDD for those services. List applicable county boards or COGs that entity has contractual relations with. List the services/deliverables contractor provides. If a county board or COG is seeking reimbursement from a non county board or COG entity, list the contractor name(s) and services provided. Submit a copy of entity-contractor contracts to the MAC Unit with the annual Implementation Plan under the following circumstances: 1) COG is providing services to county board and county board will request reimbursement for COG contractor costs, 2) COG is requesting reimbursement from an independent contractor or agency not employed by a county board, and 3) County Board is requesting reimbursement from an independent contractor or agency not employed by a county board.
- C. Method for Determining Ancillary Costs. The MAC on-line system calculates agency ancillary costs on a quarterly basis. Current indirect costs are estimated at ten percent of the gross claim amount. Estimated ancillary costs are then reconciled at year end by completing cost report schedule 2.

- D. Claim Preparation. The County Board always has at least 2 people employed that attend all training and that can produce a complete and an accurate claim. When a question or problem is identified concerning the claim, they are to contact ODMRDD through email at:

mac.coordinator@odmrdd.state.oh.us

Once the claim has been completed, all totals will be checked against the General Ledger. Any discrepancies will be immediately verified and corrected as needed. The local agency MAC Coordinator reviews and approves the claim prior to it being sent to ODMRDD.

In order to ensure the claim is completed and submitted before the deadline as established in the MAC Guide's Periodicity/Claim Submission & Payment section, our County Board developed an intermediate deadline of _____ to have the claim completed and ready for review and certification.

- E. Source of Funds to be Used as Match. Non-federal public funds will be used for match.
- F. Wages and salaries will be allocated to the MAC claim using cash basis. The amounts used to go in the claim are the quarterly amount for salary and fringe benefits.

V. Agency Review File

- A. Person responsible for maintaining and updating Agency Review File:
1. Employee1, local agency MAC Coordinator
- B. Contents of the Agency Review Files are:
1. Implementation Plan
 2. ODMRDD notice of approval of Implementation Plan
 3. Agency Review File Checklist
 4. Copies of quarterly rosters of time study personnel
 5. Copies of quarterly in-service/training rosters
 6. Copies of the MAC Claim
 7. Copies of MAC on-line time study reports
 8. Documentation to support the payroll costs and fringe benefits
 9. Documentation to support contractor costs the claiming entity seeks reimbursement for under the MAC program
 10. Any and all other documentation that is necessary to justify actions taken in the implementation of the MAC project and the submission of the MAC claim
 11. ODMRDD policy clarifications, letters, or memos

12. Documentation such as claims, purchase orders, cancelled warrants, cancelled checks, cost allocation methodology and calculations, etc. to support the overhead costs submitted for reimbursement for the December reporting month.

C. Location of files:

Local Agency MAC Coordinator's Office
Employee1, Director, Service Coordination
Sample CB MR/DD
234 Anywhere Street
Anywhere, Ohio 12345

VI Effective Dates January 1, 2007 – December 31, 2007; Renew: Annually

VII Authorizing Signatures:

Executive1, Superintendent Date

Employee1, Director of Service Coordination and MAC Coordinator Date

Implementation Plan Checklist

Name of CBMRDD/COG _____

Review Date: ____/____/____

Any item shown below that is not checked during a Level 3 review indicates an item that was not found in the Implementation Plan, lacked thorough explanation to be considered complete, or was not included in the claiming entity's support documentation made available for outside review.

I. MAC Coordinator

- ___ Name, address, telephone number, fax number, and email address of the local agency MAC Coordinator.
- ___ Detailed job description of the local agency MAC Coordinator.
- ___ Organizational chart of the local agency. Identify where and to whom the local agency MAC Coordinator is assigned.

II. MAC Activity Study Personnel

- A. List of the employees that are considered 100%: Include a job description.
 - ___ Employee name
 - ___ Employee Job Title
 - ___ Employee Duties (MAC activity codes authorized to be used)
 - ___ Dates trained/updates received
- B. List of the employees that will complete the MAC time study:
 - ___ Employee name
 - ___ Employee Job Title
 - ___ Employee Duties (MAC activity codes authorized to be used)
 - ___ Dates trained/updates received
- C. List of contractors performing MAC services:
 - ___ Agency
 - ___ Employee name
 - ___ Copy of contract outlining duties performed by contractor whom the claiming entity seeks reimbursement for under the MAC Program.
 - ___ MAC Codes authorized to be used

Implementation Plan Checklist

Continued

III. MAC Activity Study Methodology

- ___ Description of how employees participating in the MAC program will be trained.
- ___ Description of how newly hired employees will be trained including a timeline for how long after the employee is hired that they will attend training.
- ___ Description of the frequency of follow-up training to all employees.
- ___ Description of the training documentation that will be maintained for each employee and the training curriculum that will be presented.
- ___ Description of the process used for distribution of the logs.
- ___ Description of the process used for collection of the logs.
- ___ Who (list position title) will add the totals.
- ___ Description of how supervisors will check the logs for accuracy.
- ___ Description of the procedures used to ensure all personnel have a designated contact person within the CBMRDD/COG to call when they have questions about the time study.
- ___ Description of the type of backup documentation maintained by the CBMRDD/COG.
- ___ Description of how new hires MAC activity studies will be handled.

IV. Fiscal Information

- ___ List the expense categories included as allowable costs.
- ___ Reference the COG listed in Section II with which the CBMRDD has contracted.
- ___ State whether the CBMRDD or COG will request reimbursement from ODMRDD.
- ___ Description of the methodology for handling indirect costs.
- ___ Describe how the claim is prepared including how it will be checked for accuracy.
- ___ Description of method to calculate the wages and salary information to be used on the MAC claim.
- ___ Description of the source of funds to be used as matching funds.

V. Agency Review File

- ___ List the name or names of the persons responsible for maintaining and updating the Agency Review File.
- ___ Inclusion of the Implementation Plan Checklist.
- ___ Inclusion of the Implementation Plan.
- ___ Inclusion of the ODMRDD notice of approval of the Implementation Plan.
- ___ Inclusion of the Agency Review File Checklist.
- ___ Inclusion of copies of the MAC Claim.

Implementation Plan Checklist

Continued

V. Agency Review File - continued

- Inclusion of copies of the MAC forms.
- Inclusion of documentation to support the payroll costs and fringe.
- Inclusion of ODMRDD policy clarifications, letters, or memos.
- Inclusion of such documentation to support the non-payroll costs.

VI. Location of Files

- Description of the location of all supporting documentation in the Agency Review File.

VII. Effective Dates (Renew Annually)

- Inclusion of the effective dates of for the Implementation Plan (Must indicate month, day and year).

VIII. Authorizing Signatures

- Inclusion of the CBMRDD Superintendent or COG Executive Director.
- Inclusion of the local agency MAC Coordinator.

**ATTACHMENT E:
MEDICAID ADMINISTRATIVE
CLAIMING PROGRAM ACTIVITY
CODES**

This attachment (Attachment E: MAC Program Activity Codes) contains two sets of narrative descriptions for MAC activity codes. The first set is to be used only by MAC staff at ODMRDD. This set of narrative codes is specific to activities related to job functions performed by ODMRDD, and not necessarily to those performed by employees of CBs and COGs.

The second set is to be used by MAC staff at CBs and COGs. This set of narrative codes is specific to activities related to job functions performed by CBs/COGs, and not necessarily to those performed by employees of ODMRDD.

OHIO DEPARTMENT OF MR/DD (ODMRDD)
STATE LEVEL

MEDICAID ADMINISTRATIVE CLAIMING PROGRAM
ACTIVITY CODES

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

All ODMRDD 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 ODMRDD 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 ODMRDD 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 ODMRDD uses to set the per diem rates for the developmental centers. Section 5123.03 of the Ohio Revised Code mandates that the state department of mrdd 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 3 MEDICAID OUTREACH
Medicaid Rate: ND (Non-Discounted)

All ODMRDD 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. Includes staff travel or training directly related to performing Medicaid outreach activities. Home visit outreach activities are not reimbursable under the MAC program.

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.

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 ODMRDD 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. Home visit outreach activities are not reimbursable under the MAC program.

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 mrdd population.
- Scheduling and promoting activities that educate individuals with mrdd 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 ODMRDD MAC staff may use this code. Staff may use Code 5 when assisting an individual in becoming eligible for Medicaid. Includes staff travel or training directly related to performing these activities.

This activity does **not** include the actual Medicaid eligibility determination.

Examples of activities reported under code 5 include:

- Explaining Medicaid eligibility rules and the eligibility process to prospective applicants.
- Assisting in the waiver enrollment process for ODMRDD 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 ODMRDD MAC staff may use Code 6.

Use when assisting an individual to become eligible for non-Medicaid programs such as food stamps, SSI, TANF, WIC, Section 8 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 supported living, 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, food stamps, TANF, WIC, SSI, etc.
- Helping an individual complete applications for non-Medicaid programs such as supported living, food stamps, TANF, WIC, SSI, etc.
- Gathering information related to the application and eligibility determination for non-Medicaid programs from a client.
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

**CODE 7: REFERRAL, COORDINATION AND MONITORING OF
MEDICAID SERVICES
Medicaid Rate: D (Discounted)**

All ODMRDD MAC staff may use Code 7.

Use Code 7 when performing tasks related to coordinating and managing waivers (See OAC 5123:1-2-08). Use when monitoring county boards of mrdd and services provided to persons with mr/dd. Use when providing technical assistance to county boards of mrdd and other mrdd providers. Includes staff travel or training directly related to these activities. Use when conducting subrecipient monitoring activities unless for a grant specifically identified in Code 8.

Examples of activities reported under Code 7 include:

- Gathering information for and providing referral to individuals to other Medicaid programs/services.
- Communicating with county boards and providers regarding PAWS issues.
- Reconciling match commitment with state reports and conducting PAWS utilization reviews.
- Developing the process and procedures required to administer waiting lists.
- Performing maintenance on waiting lists.
- Conducting ISP to PAWS comparison for persons with mr/dd.
- Maintenance and management of the PICT and waiver slots.
- Providing technical assistance and support to county boards of mrdd.
- Accrediting county boards of mrdd (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.

Code 7 (continued)

- Performing Prior Authorization Request reviews for Medicaid approved individuals.
- 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.
- 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 ODMRDD 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.

Examples of activities reported under Code 8 include:

- All activities related to non-Medicaid federal grants including Title XX, foster grandparent, and early intervention.
- Coordinating the community capital program.
- Monitoring 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).

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

All ODMRDD 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 ODMRDD 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.
- Developing translation materials that assist individuals to access and understand non-Medicaid social, educational, and vocational services.

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

Medicaid Rate: D (Discounted)

All ODMRDD 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/mrdd 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 (mrdd and mental illness).
- Assessing the capacity of the agency and its mrdd 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 mrdd 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 ODMRDD and its mrdd providers.
- Inter- and intra-agency coordination to improve Medicaid services delivery.
- Formulating agreements/contracts between claiming entity and ODMRDD, 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 mrdd 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/mrdd 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.
- Serving as liaison or consulting with other Medicaid administrative claiming programs at the local, state or federal level regarding administrative claiming issues. (Use of this part of the code is limited to MAC Coordinator and State MAC Unit)
- Participating in Medicaid-related stakeholder meetings, work groups, rule development and review groups.
- Developing, reviewing and revising Medicaid specific policies and procedures.
- Participating in rate setting.

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

Medicaid Rate: U (Unallowable)

All ODMRDD 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.
- Assessing the capacity of ODMRDD and its mrdd providers to deliver accessible non-Medicaid services and to identify potential service delivery barriers and needs.
- Reducing non-Medicaid service overlaps and duplications by mrdd providers and closing gaps in services availability.
- Planning programs and services to meet the identified needs of high-risk populations of individuals served by ODMRDD and its mrdd providers.
- Inter- and intra-agency coordination to improve the delivery of non-Medicaid services.
- Formulating agreements/contracts between claiming entity and ODMRDD, 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 or service reviews.

Code 12 (continued)

- Planning, developing, conducting and/or attending training that promotes community collaboration and development of non-Medicaid services provided in the community.
- Developing, reviewing, and revising policies and procedures that are not specific to non-Medicaid programs.
- 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.
- Developing and participating in non-Medicaid related stakeholder meetings, work groups, rule development and review groups.
- Developing plans for expanding non-Medicaid-covered services.
- Performing rate negotiations for non-Medicaid services.
- Coordinating efforts to improve access to non-Medicaid services 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 ODMRDD MAC staff may use code 13.

Use code 13 when performing activities to secure and maintain the pool of eligible Medicaid/Non-Medicaid mrdd 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 mrdd 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 ODMRDD 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 non-Medicaid providers into Non-Medicaid programs.
- Providing information and technical support to mrdd providers on non-Medicaid policy and regulations.
- Recruiting with outside agencies regarding non-Medicaid social and education programs.
- Developing and distributing written materials to recruit potential non-Medicaid providers.
- Developing non-Medicaid referral sources.
- Providing technical assistance and support to non-Medicaid providers (including review and certification process).
- Implementing and reviewing outcomes of provider compliance and monitoring processes.
- Performing activities related to provider suspension or revocation process.
- Monitoring effectiveness of programs providing non-Medicaid-covered services, including client satisfaction surveys.
- Maintaining information such as non-Medicaid provider profiles.
- Assessing the capacity of providers to deliver non-Medicaid services.

**CODE 15 INVESTIGATING UNUSUAL AND MAJOR UNUSUAL
INCIDENTS**

- **Medicaid Rate: N/A. This code is not applicable for central office use.**

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 mrdd (OAC 5123:2-17).

Examples of activities reported under Code 16 include:

- Performing proactive/prevention/filing.
- Reviewing Unusual Incident Reports and assessing pattern/trend analysis.
- Performing Pattern/Trend Analysis.
- Filing allegation and preparing for/participating in reviews.
- Notify required parties, including individuals, guardians, agencies, law enforcement, children services, county boards, and other oversight agencies.
- Planning the investigation, reviewing any pertinent information, and coordinating the investigation.

Code 16 (continued)

- Collecting pertinent information and coordinating with law enforcement.
- Analyzing information to determine if incident is substantiated.
- Completing the Investigation Report and final notifications.
- Following up with pertinent parties and participating in hearings.
- Collecting additional information and coordination regarding abuse registry cases.
- Following up with pertinent parties, obtaining death certificate, autopsy finding if necessary, and completion of waiver disenrollment in the event of death.
- Traveling done to provide a Code 16 activity.

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 mrdd (OAC 5123:2-17).

Examples of activities reported under Code 17 include:

- Performing proactive/prevention/filing.
- Reviewing Unusual Incident Reports and assessing pattern/trend analysis.
- Performing Pattern/Trend Analysis.
- Filing allegation and preparing for/participating in reviews.
- Notify required parties, including individuals, guardians, agencies, law enforcement, children services, county boards, and other oversight agencies.
- Planning the investigation, reviewing any pertinent information, and coordinating the investigation.

Code 17 (continued)

- Collecting pertinent information and coordinating with law enforcement.
- Analyzing information to determine if incident is substantiated.
- Completing the Investigation Report and final notifications.
- Following up with pertinent parties and participating in hearings.
- Collecting additional information and coordination regarding abuse registry cases.
- Following up with pertinent parties, obtaining death certificate, autopsy finding if necessary, and completion of waiver disenrollment in the event of death.
- Traveling done to provide a Code 17 activity.

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

Except where noted, all ODMRDD 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 ODMRDD functions).

Examples of activities reported under code 18 include:

- Attending or facilitating general agency or unit staff meetings or board meetings.
- Developing and monitoring ODMRDD 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, submitting and monitoring Medicaid administrative claims (**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**). Unpaid leave should be listed as code 19 (Documented Non-Medicaid Time).

CODE 19: DOCUMENTED NON-MEDICAID TIME
Medicaid Rate: U (Unallowable)

All ODMRDD MAC staff may use Code 19.

Use Code 19 to document the time of staff identified as time study participants when staff either does not complete the time study, does not attend training (when a time study staff type), performs administrative tasks that do not support Medicaid programs, take unpaid leave, or cannot produce their time study log for the claiming period.

COUNTY BOARDS & COUNCILS OF GOVERNMENT (CBs/COGs)

MAC 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 ODMRDD administered HCBS waiver services.
- Recommending an eligible individual's initial and on-going need for services and associated costs for those individuals eligible for ODMRDD 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. Includes staff travel or training directly related to performing Medicaid Outreach activities. Home visit outreach activities are not reimbursable under the MAC program.

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.

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. Home visit outreach activities are not reimbursable under the MAC program.

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

This activity does not include the actual Medicaid eligibility determination.

Examples of activities reported under Code 5 include:

- Explaining Medicaid eligibility rules and the eligibility process to prospective applicants.
- Assisting in the waiver enrollment process for ODMRDD 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.
- 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 food stamps, SSI, TANF, WIC, Section 8 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.
- Providing information on family support services eligibility.
- 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 eligibility rules and the eligibility process for non-Medicaid programs, such as food stamps, TANF, WIC, SSI, etc., to prospective applicants.
- Assisting an individual to complete an application for a non-Medicaid program such as food stamps, TANF, WIC, SSI, etc.
- Gathering information related to the application and eligibility determination for non-Medicaid programs from a client.
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

**CODE 7: REFERRAL, COORDINATION AND MONITORING OF
MEDICAID SERVICES**

Medicaid Rate: ND (Non-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 of the activities referenced in this code are required to be performed by County Boards of MR/DD in administering Medicaid (and in particular Waiver) programs. The listed activities do not benefit the administration of other program, but instead are unique to Medicaid programs.

Use Code 7 when conducting allowable MAC activities related to scheduling evaluations for Medicaid services (See OAC 5123:1-2-08). Use when working on all phases of Payment Authorization for Waiver Services (PAWS) and other related fiscal information (e.g. 2020), including gathering information for PAWS preparation or authority of local funds, completing paperwork, and recouping over-committed PAWS or local funds. Use when performing tasks related to managing waiting lists (OAC 5123:2-1-08) for Medicaid services. 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 individuals to other Medicaid programs/services.
- Reviewing plans to ensure administrative and fiscal accuracy and completeness.
- Gathering, preparing and submitting relevant information to ODMRDD 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).

Code 7 (continued)

- Performing duties to notify providers and other entities of the approved ISP, PAWS information, and ODMRDD confirmation.
- Maintaining and distributing ODMRDD generated PAWS information.
- Communicating with ODMRDD regarding PAWS issues.
- Reconciling match commitment with state reports and conducting PAWS utilization reviews.
- 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.
- 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.
- Developing translation materials that assist individuals to access and understand non-Medicaid social, educational, and vocational services.

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/mrdd 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/mrdd 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/mrdd 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.
- Serving as liaison or consulting with other Medicaid administrative claiming programs at the local, state, or federal level regarding administrative claiming issues (**limited to members of the Department's MAC Committee**).
- 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 receiving and monitoring non-Medicaid programs or services reviews.
- Planning, developing, conducting and/or attending training that promotes community collaboration and development of non-Medicaid services provided in the community.
- Developing interagency policies and procedures for non-Medicaid programs and services.
- 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.
- 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.
- Performing rate negotiations for non-Medicaid services.

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 non-Medicaid providers.
- Recruiting with outside agencies regarding non-Medicaid social and education programs.
- Developing non-Medicaid referral sources.

**CODE 15 INVESTIGATING UNUSUAL AND MAJOR UNUSUAL
INCIDENTS**

- **Medicaid Rate: N/A. This code is not applicable for CB/COG use.**

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 mrdd (OAC 5123:2-17).

Examples of activities reported under Code 16 include:

- Performing proactive/prevention/filing.
- Reviewing Unusual Incident Reports and assessing pattern/trend analysis.
- Performing Pattern/Trend Analysis.
- Filing allegation and preparing for/participating in reviews.
- Notify required parties, including individuals, guardians, agencies, law enforcement, children services, county boards, and other oversight agencies.
- Planning the investigation, reviewing any pertinent information, and coordinating the investigation.

Code 16 (continued)

- Collecting pertinent information and coordinating with law enforcement.
- Analyzing information to determine if incident is substantiated.
- Completing the Investigation Report and final notifications.
- Following up with pertinent parties and participating in hearings.
- Collecting additional information and coordination regarding abuse registry cases.
- Following up with pertinent parties, obtaining death certificate, autopsy finding if necessary, and completion of waiver disenrollment in the event of death.
- Traveling done to provide a Code 16 activity.

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 mrdd (OAC 5123:2-17).

Examples of activities reported under Code 17 include:

- Performing proactive/prevention/filing.
- Reviewing Unusual Incident Reports and assessing pattern/trend analysis.
- Performing Pattern/Trend Analysis.
- Filing allegation and preparing for/participating in reviews.
- Notify required parties, including individuals, guardians, agencies, law enforcement, children services, county boards, and other oversight agencies.
- Planning the investigation, reviewing any pertinent information, and coordinating the investigation.

Code 17 (continued)

- Collecting pertinent information and coordinating with law enforcement.
- Analyzing information to determine if incident is substantiated.
- Completing the Investigation Report and final notifications.
- Following up with pertinent parties and participating in hearings.
- Collecting additional information and coordination regarding abuse registry cases.
- Following up with pertinent parties, obtaining death certificate, autopsy finding if necessary, and completion of waiver disenrollment in the event of death.
- Traveling done to provide a Code 17 activity.

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, submitting and monitoring Medicaid administrative claims (**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. Unpaid leave should be listed as code 19 (Documented Non-Medicaid Time).

CODE 19: DOCUMENTED NON-MEDICAID TIME
Medicaid Rate: U (Unallowable)

All CB/COG MAC staff may use Code 19.

Use Code 19 to document the time of staff identified as time study participants when staff either does not complete the time study, does not attend training (when a time study staff type), performs administrative tasks that do not support Medicaid programs, take unpaid leave, or cannot produce their time study log for the claiming period.

ATTACHMENT F:

**Quarterly Roster Layout
for ODMRDD, CBs and COGs**

ODMRDD MAC Quarterly Roster Layout

<i>100% Employees</i>				
<u>Name</u>	<u>Title</u>	<u>Staff Type</u>		<u>Dates Trained/Updates rec'd (Optional)</u>
<i>Time Study Employees</i>				
<u>Name</u>	<u>Title</u>	<u>Staff Type</u>	<u>Codes</u>	<u>Dates Trained/Updates rec'd</u>
<i>Contractors</i>				
<u>Name</u>	<u>Title</u>	<u>Staff Type</u>	<u>Codes</u>	<u>Dates Trained/Updates rec'd (Optional)</u>