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Washington STATE Community living connections

Medicaid Administrative Claiming

# 2023

 

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## Medicaid Administrative Claiming Introduction

The Administration for Community Living (ACL), the Centers for Medicare and Medicaid Services (CMS), and the Veterans Health Administration (VHA) have partnered for several years to support states’ efforts to develop coordinated systems of access to make it easier for consumers to learn about and access Long-Term Services and Supports (LTSS). This is known as the No Wrong Door System (NWD).

The NWD System vision is consistent with CMS’ efforts to work with state Medicaid agencies to implement a NWD System as part of their infrastructure requirements, including, but not solely, through efforts such as the Balancing Incentive Program. As a result, activities under the direct authority of the state Medicaid agency such as outreach, referral, assessment functional and financial eligibility are all part of the NWD system. Because of this partnership work, federal matching funds under Medicaid are available for costs incurred by the state for administrative activities that directly support efforts to identify and enroll potential eligible into Medicaid and that directly support the provision of medical services covered under the state Medicaid plan, when those activities are performed either directly by the state Medicaid agency or through contract or interagency agreement by another entity.

The purpose of this document is to inform Area Agencies on Aging (AAA) about the appropriate methods for claiming federal matching funds, known as Federal Financial Participation (FFP), for Medicaid administrative activities performed through NWD Systems, and to ensure non-duplication for any such claims. Claiming FFP for services assisting Medicaid recipients in gaining access to needed medical, social, educational, and other Medicaid covered services may be done for allowable Medicaid costs incurred by AAA/Aging and Disability Resource Centers (ADRC) for Information & Assistance (I&A) activities. AAA/ADRC entities are branded in Washington State as Community Living Connections (CLC). Claimed activities must be necessary for the proper and efficient administration of the Washington State Medicaid Plan as defined below. Activities must also be furnished to persons potentially eligible for Medicaid services, Medicaid applicants, and Medicaid recipients; and in some way relate to determining eligibility or administering services covered under the State Plan.

Medicaid Administrative funds cannot be claimed for activities paid for by Medicaid through other mechanisms. Therefore, it is not available for the cost of the actual Medicaid services to which an individual is referred or for services already provided by TXIX Case Management. Administrative Claiming cannot be used for activities that may be beneficial to the recipient, but are unrelated to Medicaid (e.g. assistance in locating suitable housing, food stamps, energy assistance, social services, wellness programs, etc.)

**Target Population**:

1. Current Medicaid recipients not already served by Aging & Long-Term Support Administration (ALTSA) Title XIX Case Management Programs.
2. Low income/asset individuals who are potentially eligible and in need of Medicaid services.

**All eligible activities claimed must serve members of the target population.**

When determining whether an activity is eligible for federal match as a Medicaid Administrative Cost, two basic rules apply:

1. Does the activity assist an individual to access a Medicaid service (of any kind)?

2. Is federal match already being received for this same activity (e.g., AAA TXIX Core case management, Medicaid brokered Transportation and Interpreter services)?

**Medicaid Administrative Claiming Procedures**

In order to ascertain the portion of time and activities that are related to administering the Medicaid program, each AAA/CLC must use a quantifiable measure of employee effort, or ***time study***, approved by the ALTSA State Unit on Aging (SUA). The time study must capture 100% of time worked and incorporate a comprehensive list of activities performed by staff whose costs are to be claimed under Medicaid. That is, the time study must reflect all the time and activities (whether allowable or unallowable under Medicaid) performed by employees whose time may be spent on claimable activities. It must also distinguish Medicaid activities from similar activities that are not Medicaid reimbursable. This can be accomplished by “parallel” time study activity codes. Direct tracking of the same level of information on daily time slips used for payroll is also an acceptable methodology in place of a time study.

**Time Study Frequency**

Programs must complete daily time studies one month out of every three-month period. Five business days prior to the month of the daily time study for Medicaid Administrative Claiming, ALTSA fiscal staff will inform AAAs which month the time studies must be completed for that quarter.

**Time Study Procedures**

1. Each time study participant must document **all** activities performed during the time study period whether allowable or unallowable under Medicaid. Total paid time off (breaks, sick leave, and holidays/vacations) must also be tracked. The Agency may choose to develop and use their own time study forms with approval from ALTSA. Time must be tracked in fifteen-minute increments. Pre-approved optional ALTSA forms, including an Individual Time Study; and Individual and Agency Time Study Summaries, are attached and available at <http://adsaweb.dshs.wa.gov/aaa/BF/Billing/>. The Time Study Summaries have hidden columns for additional activities as needed.
2. Staff members will be responsible for classifying their activities and coding them appropriately (see next section for definitions, Medicaid reimbursable and non-reimbursable code categories). It is very important to assure that each staff applies the activity definitions consistently. Prior to conducting a time study, training of staff should occur to assure that definitions and activities are uniformly understood.
3. To complete the Time Study Sheet each employee must:
4. Track time in quarter-hour increments.
5. For each activity, record the date, a brief description of the eligible activity, including client name or identifier, enter it in the appropriate activity section, and record the duration (e.g., 1.25 hours, .5 hours).
6. Paid time off (break time, paid holidays, vacation, and sick leave) must be tracked. Paid time off must be reallocated across all other activity codes on a pro rata basis.
7. Unpaid lunch time or any other non-paid time will not be coded or counted.
8. Tally the totals for each category and report data to the appropriate local agency staff person for compilation.
9. The agency must compile the results of all the Individual Time Studies and Agency Time Study Summary for each period indicated in the agency contract. As an option, the total time per category on the Individual Time Studies can be entered into Individual Time Study Summaries before being compiled onto an Agency Time Study Summary.
10. The Agency Time Study Summary is used to determine the actual proportion of claimable staff time spent on activities eligible for Medicaid match. The Total Time in Medicaid reimbursable Activities is the Total Hours Claimable. When the time study is complete, the percent of time spent on claimable activities will be determined by dividing the total claimable hours by the total working hours in the time study period.
11. Claimable costs are calculated using the percentage applied to the wages, benefits, and other costs appropriately allocated to support the time study participants in the agency accounting records for the billing period.
12. Federal matching dollars can cover half of the claimable costs. The Agency must provide allowable local/state funding to match the Federal dollars.
13. The Agency Time Study Summary must be used to calculate billings. The Agency Time Study Summary and Individual Time Study Sheets must be kept on file by the agency for audit purposes.

## Time Study Activity Code Descriptions and Codes:

**Staff should document time spent on each of the following activities:**

|  |  |  |
| --- | --- | --- |
| **CODE** | **INFORMATION & ASSISTANCE (I&A) ACTIVITY** | **INDICATOR** |
|  | **NON-MEDICAID I&A ACTIVITIES (A-L)** |
| A |  Aging Network I&A | UA |
| B-L | Additional Non-Medicaid Activity performed by I&A Staff | UA |
|  |  |  |
|  | **MEDICAID I&A ACTIVITIES (M-)** |
| M | Medicaid Outreach | AA |
| N | Referral, Coordination, and Monitoring of Medicaid Services | AA |
| O | Facilitating Medicaid Functional and Financial Eligibility | AA |
| P  | Medicaid Related Training | AA |
| Q  | Program Planning, Interagency Coordination and Service Delivery Improvement | AA |
|  |  |  |
|  | **OTHER I&A ACTIVITIES** |
| R | General Activities | RA |

**The indicators below, which follow each Code, provide the application of the FFP rate, the allowability or non-allowability designation, and the proportional Medicaid share status of the Code.**

Unallowable Activities

UA Refers to an activity that is unallowable as administration under the Medicaid program. This is regardless of whether or not the population served includes Medicaid eligible individuals.

Allowable Activities

AA Refers to an activity that is 100 percent allowable as administration under the Medicaid program and claimable at the 50 percent non-enhanced FFP rate

Reallocated Activities

RA Refers to those general allocable activities performed by time study participants which must be reallocated across all other activity codes on a pro rata basis. These reallocated activities are reported under Code L (meetings, breaks, leave, etc.).

**The following activity codes represent a model set of administrative activity categories. The agency must use codes for categories that match those used in their approved cost allocation methodology.**

**NON-MEDICAID I&A ACTIVITIES (UA):**

**A. Aging Network I&A** –All information, assistance and referralfunctions of staff, as described in the Community Living Connections (CLC) Program Standards, help inform individuals about programs financed by local, state, and Non-Medicaid federal (e.g. OAA) resources and assist eligible persons to gain access to these programs, including in-service training. These activities may include:

1. Information Giving
2. Assistance Referral
3. Follow-up
4. Resource Database Development and Maintenance
5. Client Advocacy
6. Case Finding
7. Program Publicity/Outreach

**B-L. Additional Non-Medicaid Activity Performed by I&A Staff** –The local AAA/CLC can include as many Non-Medicaid activities/functions as they determine appropriate for the efficient and accurate accounting of time for tasks are performed by CLC staff. Codes B-L refer to additional Non-Medicaid programs/functions performed by staff participating in the time study that are beyond the scope of Information, Assistance, and Referral. Appropriate activities might include Family Caregiver Support, Kinship Caregiver Support, Care Transitions, MIPPA/SHIBA Helpline, Health Promotion/Disease Prevention, Senior Drug Education, and additional functions, special projects or initiatives. The AAA/CLC must use categories that are consistent with their approved cost allocation methodology and assign codes reflective of these same categories. Note: Additional columns are available for these activities in the ALTSA Time Study Individual and Agency Summary worksheets but are currently hidden.

**MEDICAID I&A ACTIVITIES AA:**

**M. Medicaid Outreach** CLC staff should use this code when performing activities that inform Medicaid eligible or potentially eligible individuals about Medicaid, how to access Medicaid and medically related devices and the importance of accessing these services. Examples include:

1. Engaging in a conversation with individuals, families or groups about preferences, strengths, needs and available resources to determine initial interest in and potential eligibility for Medicaid.
2. Interactions with individuals to learn information about them relating to potential Medicaid eligibility (specifically their functional capacity and/or limitations and their finances), but not including financial or medical related counseling.
3. Informing individuals, their representatives and/or groups about their potential eligibility for Medicaid programs, including their rights and responsibilities and the benefits and services offered under different Medicaid LTSS programs.
4. Time spent on the telephone, in-person, or via a website obtaining information to fill out a Medicaid pre-screen.
5. Time spent contacting additional individuals, such as physicians or other family members, to complete or verify information included on a Medicaid pre-screen.
6. Time spent traveling to and from a Medicaid pre-screen that is conducted in person.
7. Time spent conducting administrative activities necessary to complete a Medicaid pre-screens, such as
	1. Identifying correct contact information
	2. Entering data into an electronic system
	3. Answering questions about the purpose and nature of the screen
	4. Providing results of the screen and making appropriate referrals
	5. Setting up translation or signing services.
8. Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective Medicaid applicants or groups of potential Medicaid applicants.
9. Discussing the pros and cons of applying for Medicaid relative to an individual’s preferences, support system, resources, needs and any other factor the individual wants to address.

 Disseminating Medicaid outreach materials to inform individuals and groups about accessing Medicaid LTSS through the NWD system.

**N. Referral, Coordination and Monitoring of Medicaid Services** – CLC staff should use this code when providing assistance related to Medicaid Services and supports. This code should only be used when making referrals for, coordinating and/or monitoring the delivery of health related/medical services when an individual is not receiving Medicaid Case Management. Examples include:

1. Making referrals for and coordinating the delivery of Medicaid services (includes acute, primary, mental health and LTSS).
2. Providing follow-up contact to ensure that the individual received the coordination of Medicaid services identified as needed and available.
3. Developing referral resources of Medicaid providers for the individual to use (developing general referral resources, not specific to Medicaid, is not allowable).
4. Informing or arranging for Medicaid transportation that assist an individual to access Medicaid services, or for interpreter services to access Medicaid services or NWD Medicaid activities.
5. Gathering any information that may be required in advance of referrals, evaluations and treatment for Medicaid LTSS.
6. Coordinating an individual’s plan of LTSS for health care by informing and explaining the individual’s LTSS plan to family members, other providers, or personnel.
7. Assisting individuals to move from one location to another to assure continuity of care.

**O. Facilitating Medicaid Functional and Financial Eligibility** – CLC staff should use this code when assisting an individual or family in gathering information and/or referring them to the appropriate local Medicaid agency for a Medicaid application as well as assisting an individual to maintain Medicaid eligibility. Medicare insurance or other insurance are not considered Medicaid related activities unless the request is related to a Medicaid application activity. Examples include:

1. Verifying an individual’s current Medicaid eligibility status.
2. Assisting individuals or families in gathering information related to the Medicaid application and eligibility determination for an individual, including resources information, medical information, and third-party liability information, as a prelude to submitting a formal Medicaid application.
3. Collecting additional functional data needed to inform functional eligibility determination.
4. Assisting individuals, for whom a disability determination is needed, in gathering information related for Medicaid eligibility.
5. Providing necessary Medicaid forms, assisting the individual in completing Medicaid forms and packaging all Medicaid forms in preparation for the Medicaid eligibility determination.
6. Time spent referring an individual or family to the local assistance office to make application for Medicaid benefits; including time spent setting up appointments for the individual or family with the local assistance office.

**P. Training Medicaid Related** – CLC staff should use this code when coordinating, conducting, or participating in training and seminars regarding Medicaid related LTSS, health care services, and other supports that may assist an individual to remain in the community, return to the community, or otherwise enhance the person’s quality of life. Examples include:

1. Participating in Medicaid related training which enhances the quality of screening, one-on-one person centered counseling or other components of the Medicaid eligibility processes.
2. Training in application assistance for the Medicaid program or training to qualify as a certified application counselor for the Medicaid program.
3. Participation in, coordinating, or presenting Medicaid related training designed to address the specific administrative and reporting requirements associated with Medicaid program services for providers and NWD System personnel.

**Q. Program Planning, Interagency Coordination and Service Delivery Improvement** – CLC staff should use this code when completing activities related to establishing and maintaining documentation, internal processes, quality oversight and policies related to the provision of Medicaid LTSS, health care services, and other supports that may assist an individual to remain in the community, return to the community, or otherwise enhance the person’s quality of life, as well as working with other partner agencies to improve the coordination and delivery of services, and performing collaborative activities with other agencies to provide services. Examples include:

1. Coordination with state initiatives such as Money Follows the Person (MFP) to promote for continuity of care.
2. Analyze Medicaid data related to the NWD system to inform service delivery improvement of the NWD system.
3. Participating in an advisory group for the Medicaid agency to provide consultation and advice regarding improvements in the delivery of Medicaid services to the NWD system/MFP population.
4. Working directly with the Medicaid agency to improve coordination and collaboration to improve the delivery of Medicaid services for the NWD system.

**OTHER I&A ACTIVITIES (RA):**

**R. General Activities–** functions performed by staff who do allocable Medicaid activities that are in support of, but not directly assignable to Non-Medicaid or Medicaid activities. Functions include related paperwork, clerical activities or staff travel required to perform these activities. Certain administrative functions, such as payroll, maintaining inventories, developing budgets, executive direction, etc., are not included in this category. Below are typical examples of general activities, but they are not all inclusive.

1. Paid Leave: Breaks, Medical Leave, Annual Leave, Holidays, or other paid time not at work; but not including non-paid lunch period.
2. Establishing goals and objectives for planning purposes
3. Reviewing agency and/or program procedures and rules
4. Attending, providing, or facilitating staff meetings, training, or board meetings
5. Performing administrative or clerical activities related to CLC functions or operations and including tabulation of daily time study data during the time study periods (limited to 15 minutes per day).