NWD Medicaid Administrative Claiming Workbook

Contents

Purpose

The Centers for Medicare & Medicaid Services (CMS), in conjunction with the Administration for Community Living (ACL), made available on the CMS website a document entitled, "*No Wrong Door (NWD) System Reference Document for Medicaid Administrative Claiming*" (referred to as the *Reference Document* in this workbook).[1] This document outlines the basics of how states can draw down Medicaid administrative Federal Financial Participation (FFP) for NWD Systems.

What is Medicaid administrative claiming?

"Title XIX of the Social Security Act (the Act) authorizes federal grants to states for a proportion of expenditures for medical assistance under an approved Medicaid state plan, **and for expenditures necessary for administration of the state plan**….Under section 1903(a)(7) of the Act, federal payment is available at a rate of 50% for amounts expended by a state "as found necessary by the Secretary for the proper and efficient administration of the state plan," per 42 Code of Federal Regulations (CFR) 433.15(b)(7)."

Source: Centers for Medicare & Medicaid Services

This workbook supplements the *Reference Document* by providing additional information about the steps necessary to draw down Medicaid administrative funds. The steps in this workbook align with the steps in Section C of the *Reference Document*, "*Steps for Securing Medicaid Administrative Federal Financial Participation (FFP) for No Wrong Door System Functions*."

While this workbook and the *Reference Document* can help states develop the groundwork necessary for administrative claiming or expand existing claiming, each state will need to customize this infrastructure to meet its own needs. The administrative claiming functions should support the larger goals of the NWD System, namely streamlining the process of accessing long-term services and supports (LTSS) and supporting a more person-centered system. A single NWD System has active involvement of multiple state agencies that administer programs that are for people who access LTSS, including the state Medicaid agency, state unit on aging (SUA), and other designated entities. The state Medicaid agency will take the lead in the infrastructure required to claim. This workbook identifies the different roles each NWD System partner has in administrative claiming. The *NWD System Key Elements* document on the website: https://nwd.acl.gov/pdf/NWD-National-Elements.pdf, provides additional information about the NWD System. Some states leverage Medicaid Administrative Claiming (MAC) to support their statewide NWD System using the type of infrastructure outlined in the *Reference Document* and this workbook. ACL obtained knowledge of these states from informal communications with state NWD System personnel, however, MAC claiming could be occurring in other states. State developed and specific resources are available on a private page on the *NWD technical assistance community website* (https://www.ta-community.com).[2]

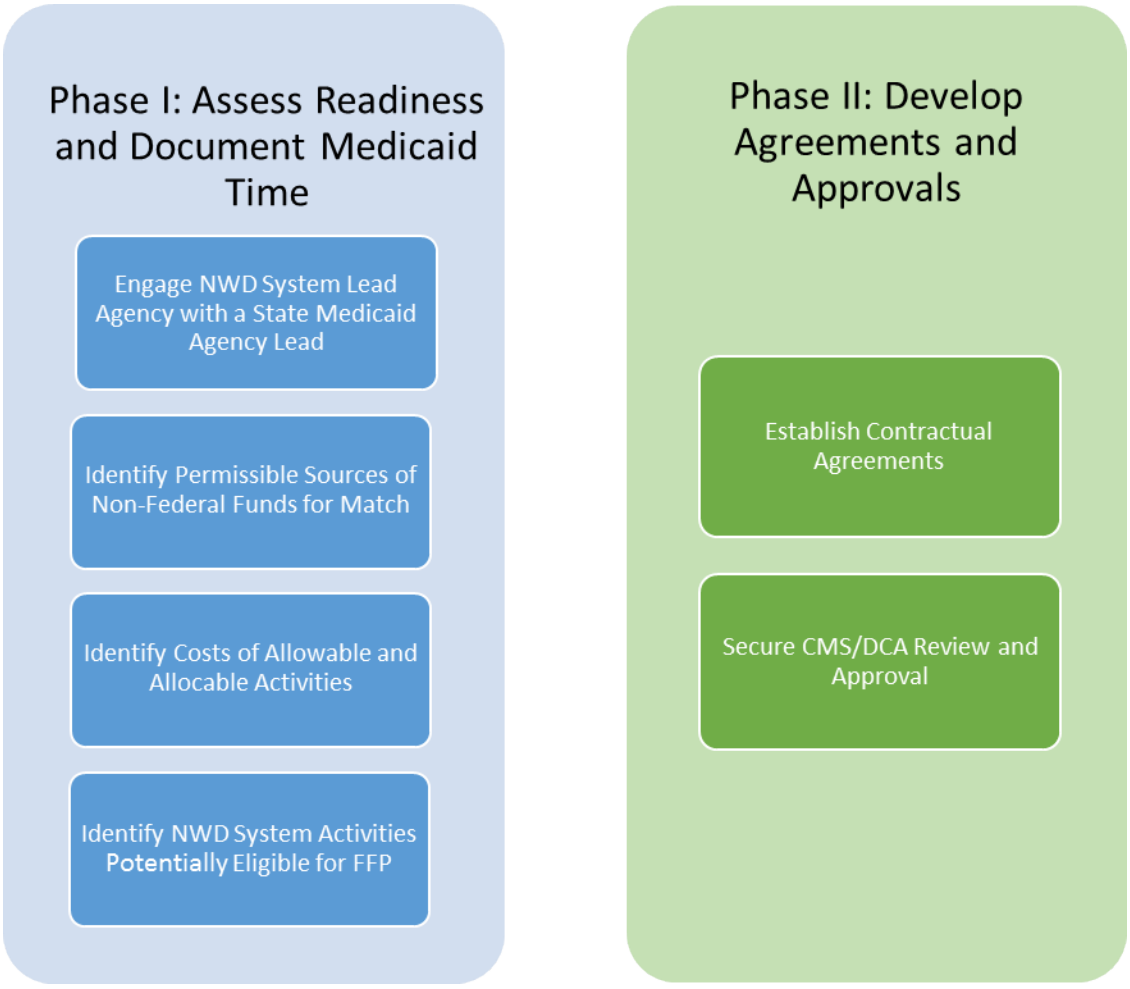
[1] This document can be found at: https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/no- wrong-door-guidance.pdf

[2] For access to this page, please email: nowrongdoor@acl.hhs.gov

Overview of Phases for Administrative Claiming

The ability for states to claim Medicaid administrative funds will ensure ongoing funding for agencies providing essential services and supports for older adults and individuals with disabilities. The *Reference Document* details the steps necessary to meet this objective. The structure and related tools of this workbook align with the *Reference Document* to support these steps across two phases of NWD System MAC development. Phase I involves assessing readiness to implement Medicaid claiming and documenting Medicaid-related time. Phase II involves developing agreements and obtaining needed approvals. States not ready to enter into Phase II can begin critical groundwork by engaging in Phase I activities. Phase I activities can identify the potential return from Medicaid claiming as it gives states the opportunity to broadly identify staff-associated costs and develop streamlined workflows and referral processes. Exhibit 1 displays how the steps from the *Reference Document* fit into the phases.

Exhibit 1: Phases for Implementing Administrative Claiming



Tools

This workbook provides tools to help states navigate through the steps in Phases I and II.

Phase 1 Tools: Establish Costs and Document Medicaid Time

- Tool One – Project Work Plan
- Tool Two – Presentation for State Level Partner Agencies
- Tool Three – Presentation for Stakeholders
- Tool Four – Cost Simulator
- Tool Five – Code Development Guidance

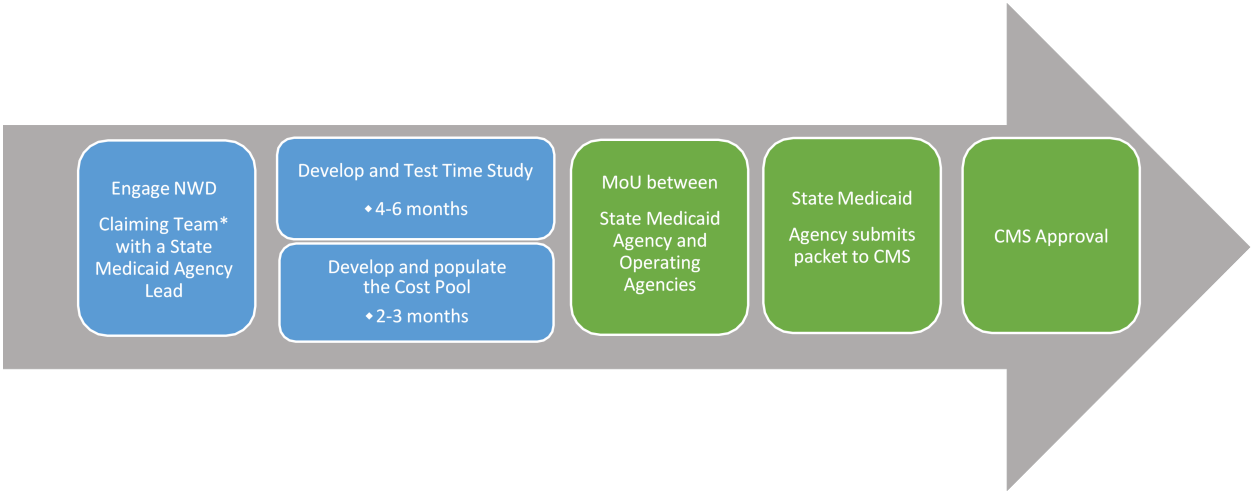
Phase 2 Tools: Develop Agreements and Approvals

- Tool Six – Cost Pool Guidance
  - Tool Six(a) – Cost Pool Spreadsheet
- Tool Seven – Sample MOU Language

Timeline for Developing the Administrative Claiming Infrastructure

Exhibit 2 displays an optimal timeline for developing this claiming infrastructure. The first three actions can run concurrently. Theoretically, it is possible to develop and submit the claiming infrastructure in less than six months. However, many factors, notably obtaining agreements and approvals internally within a state, can extend this timeline.

Exhibit 2: Medicaid Administrative Claiming Development Optimal Timeline



* The claiming team includes the State Medicaid Agency and other NWD System entities as outlined in the NWD Key Elements.

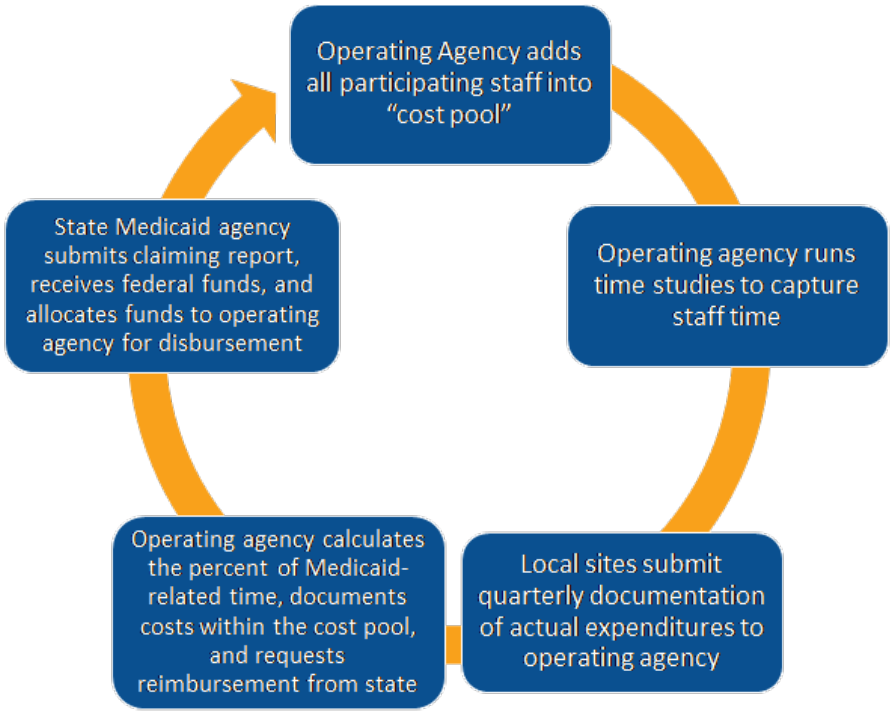
Phase 1: Assess Readiness and Document Medicaid Time

Step 1: Engage NWD Claiming Team

Developing the administrative claiming process involves building multiple pieces of infrastructure and securing agreements from multiple entities of the NWD System. States need to develop a clear project plan that identifies the necessary tasks and resources. This plan should provide an overview of the key steps for developing the administrative claiming infrastructure and obtaining state and federal approval, the timeframes for each of these steps, and the individuals/entities responsible for completing them.

Exhibit 3 provides an overview of how MAC works on an ongoing basis.

Exhibit 3: Ongoing Administrative Claiming and Reimbursement Process



In order to ensure buy-in for the planning and implementation and that partners in the NWD System understand their roles, at a minimum, the effort must engage and obtain active participation from the following entities:

- The State Medicaid agency
- The operating agency (or NWD lead agency) overseeing the claiming effort (if not the Medicaid agency)
- Local agencies for whom FFP will be claimed

For all three of these agencies, it is important to engage programmatic staff who oversee the NWD functions and fiscal staff. The Medicaid agency will advise the planning group on the administrative details that need to be set up in order to establish a claiming structure. In some cases, states may choose an administrative contract to cover claimable activities and in others it will require an amendment to the state's Public Assistance Cost Allocation Plan (PACAP).

 **Workbook Tool One: Project Work Plan.** This work plan provides the high-level steps required for administrative claiming development, including timeframes and staff responsible for each task. Entities using this work plan template should alter this plan to reflect their operations and desired outcomes. Users should treat the plan as a living document to update as needed.

 **Workbook Tool Two: Administrative Claiming PowerPoint Presentation for State Level Partner Agencies.** This PowerPoint presentation specifically targets engagement of state level partners, such as the Medicaid agency, SUA fiscal and policy staff, or other partners in the NWD System. The presentation template provides a basic outline of information the NWD lead agency could cover. States should adapt these presentations to reflect their own circumstances and desired content. **Red** text needs to change to reflect state-specific information.

 **Workbook Tool Three: Administrative Claiming PowerPoint Presentation for Stakeholders.** This PowerPoint presentation targets stakeholders and participants of the NWD System, such as lead directors and fiscal officers from the local operating agencies. The NWD lead agency can present this tool as an introduction for local agencies and partners that may participate in MAC. States should adapt these presentations to reflect their own circumstances and desired content. **Red** text needs to change to reflect state- specific information.

Step 2: Identify Permissible Sources of Non-Federal Funds for Match

States must have non-federal dollars to match the FFP as described in the *Reference Document*. Involving fiscal and administrative staff from the onset will assist in identifying these funds.

State or local government can provide matching dollars. In some cases, private funding, such as foundation support, can provide matching dollars. However, states will want to take care not to violate federal requirements, such as those included in 42 CFR 433.51.

 **Workbook Tool Four: Cost Simulator.** This tool provides a method for identifying sources of matching funds and simulates the potential FFP reimbursement. In completing this spreadsheet, states should look carefully at staff salary funding sources, especially for those

who conduct potentially claimable tasks, to ensure diversification of funding streams across all staff. This will enable NWD staff who have a portion of their salary and other costs paid for using federal or non-matchable dollars to participate in administrative claiming. In order to ensure sufficient matching requirements are met and all NWD staff who perform claiming activities are eligible to participate, it is important for the NWD agency to diversify funding streams across all staff. To replicate this approach, states may consider completing Tool Four for each individual NWD System site, then calculating a sum for state-level estimates. Phase Two of this workbook includes further discussion on identifying and reporting matching funds.

Step 3: Identify NWD System Activities Potentially Eligible for Medicaid Administrative Funding

This section describes the process for identifying activities eligible for Medicaid claiming and the methodologies for calculating the percentage of time associated with Medicaid-related activities.

The first step involved is identifying which staff should participate in the time study. Staff fall into two general categories: 1) those who conduct the "front line" NWD work (e.g., staff conducting person-centered counseling, information and assistance, etc.); and 2) staff providing support to and/or overseeing these staff (e.g., supervisors, administrative assistants, fiscal staff, etc.).

Developing Time Study Codes

To establish the percentage of Medicaid-related time, the operating agency will need to classify the activities frontline staff perform into categories. As a guide, states should consider:

- Sample codes provided as *Exhibit 3* within Section D of the *Reference Document*; and
- Codes developed by other states that have been previously approved by CMS.

Because operations for providing LTSS within each state differ, previously approved codes may need modification to reflect state-specific processes.

To develop the time study codes, the state agency charged with operating the ongoing time study should work with local agency staff to develop draft code categories and definitions. The code categories and definitions should: 1) reflect *all* the activities staff perform; and 2) make sense to staff participating in claiming. In setting up a claiming structure, states will want to think through all parts of the NWD System that may be doing some Medicaid-related work. For example, care transitions coaches may be helping individuals apply for Medicaid in the course of offering care transitions support. The time spent doing those activities should be claimable.

States will need to classify each of the codes into the broader categories described in Section D of the *Reference Document*:

- **Unallowable (U) -** The activity is unallowable as administration under the Medicaid program.

- **100% Medicaid Share (TM) -** The activity is solely attributable to the Medicaid program and as such is not subject to the application of the Medicaid Eligibility Ratio (this is sometimes referred to as "not discounted") or Total Medicaid (TM).
- **Proportional Medicaid (PM) Share -** The activity is allowable as administration under the Medicaid program, but the allocable share of costs must be determined by applying the percentage of the Medicaid eligible population included in the time study.

States should consider structuring codes in such a way that for PM activities such as referral, coordination and monitoring), the eligibility status of the individual is documented. For instance, a time study methodology tracks the Medicaid-related time based on the **activities** NWD staff conduct. However, the eligibility status of the **individuals** benefitting from the activity must also be determined. This can be built into the time study through the coding structure or calculated after the time study by applying a Medicaid Eligibility Rate (MER). However, for TM activities such as outreach and facilitating application activities that are performed to *identify potentially Medicaid eligible individuals*, the state would not need to apply an MER.

Additionally, during code development and piloting, it may make sense to include an "other" code category to capture activities that staff do not feel the codes adequately represent. States can then add additional codes or adjust the code definitions for clarity as they obtain feedback from the "other" category. Staff from the operating agency should monitor responses to the "other" code during the pilot to ensure that the activity could not have been coded within any other category.

 **Workbook Tool Five: Code Development Guidance.** This tool provides guidance for developing state-specific codes, including examples of approved time study codes, and guidance for developing and using a decision tree to inform accurate coding.

Designing the Time Study

In addition to developing the codes, states will need to establish the structure of the time study and determine the sampling frame.

Structure of the Time Study

Time studies previously approved by CMS use two primary approaches: 1) random moment survey (RMS); and 2) 100%-time documentation. ***Exhibit 4*** explores the benefits and drawbacks of each of these approaches.

The random moment time study approach requires staff to code the activity they perform at a randomly selected moment in time. States will need to set up a system for generating and distributing surveys, typically via email, at random moments.

The 100%-time documentation approach requires staff to code 100% of their time in 15-minute intervals throughout the day. Each staff submits a daily report of the activity that best represents each 15-minute time period.

Exhibit 4: Pros and Cons of the RMS and 100% Documentation Time Study Approaches

Time Study Method	Pros	Cons
Random Moment (RMS)	**Minimal burden –** Staff only have to respond to a short survey at a point in the day **High accuracy –** Staff only asked to code for and remember a specific moment in time rather than their entire day **CMS familiarity –** CMS is very familiar with and has consistently approved RMS	**Setting up the system –** States will need to purchase special software, procure a vendor, or internally set up the randomization process **Time intensive –** If performed internally, the randomization effort can be time consuming
100% Time Documentation	**Simple tool –** The tool would only need to be able to track daily time in 15-minute increments. Could deploy using a spreadsheet and submit via email	**Burdensome on staff –** Staff need to remember and document activities throughout an entire day **Low accuracy –** Staff will need to dissect the activities performed in a 15-minute period to determine which was most representative of that period

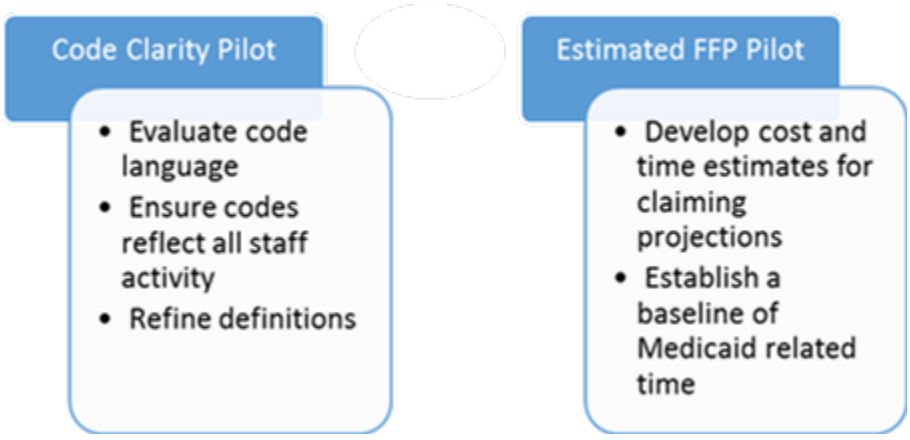
CMS has also approved alternate approaches, such as documenting 100% of staff time for a sample of days during a quarter. These approaches may prove less burdensome to staff than the ongoing 100%-time documentation and less complex than the random moment time study.

Maryland conducted a pilot in which they used a RMS and 100% approach simultaneously. This study found that the RMS approach produced more valid information. The study found that consistently coding 100% of staff time at each 15-minute increment led to inaccurate coding at the end of the workday. As a result, staff tended to default to the general administration code rather than accurately recalling their activity for each 15-minute period.

Testing and Refining the Time Study Codes

Piloting the time study codes can help refine the definitions and develop estimates for the amount to claim. A pilot can add greater clarity to the codes, reducing the burden on training in the future and helping to ensure accurate classification of time. ***Exhibit 5*** shows two different types of pilots that can lead to ongoing claiming.

Exhibit 5: Administrative Claiming Piloting Overview



Process and Purpose of the Code Clarity Pilot

States can choose to conduct the code clarity pilot either statewide or with a select group of pilot agencies. The pilot allows staff at the local agencies to become familiar with the process and codes and to obtain feedback about whether:

- The codes and definitions allow staff to make clear choices about how to classify their time
- The codes reflect all activities staff perform
- The time study process (frequency and method of distributing and collecting surveys) needs modification

Conducting this pilot provides information to refine the codes and code language to more appropriately reflect activities performed.

Process and Purpose of the Estimated FFP pilot

States can conduct a second pilot with all staff that will participate in the ongoing time study to:

- Establish a baseline for the types of staff considered Medicaid-related at both the agency and state levels in order to include in the PACAP. Page 11 of the *Reference Document* provides additional information on the PACAP.
- Allow the state to make recommendations about staff to include in time studies at each agency to maximize the reimbursement for the amount of time considered Medicaid-related.
- Develop strategies for determining costs associated with staff in order to estimate time spent on Medicaid-related activities.

A state can combine this pilot with the code clarity pilot. However, if substantial changes to the codes become necessary; this will likely affect cost estimates.

Determining the Percentage of Time Related to Medicaid

After the time study has occurred, staff at the operating agency will need to pool the results to establish time associated with Medicaid-related activities, non-Medicaid related activities, and general administration activities. For example, a code related to outreach could contain three sub-codes:

- 1a. Outreach and Program Education- Medicaid-related
- 1b. Outreach and Program Education- Not-related to Medicaid
- 1c. Outreach and Program Education- Not tied a specific program

Activities not tied to a specific program or general administration do not count towards nor do they detract from the percent of Medicaid-related time. This is a neutral category, and in the final summation only Medicaid vs. non-Medicaid time will be used to establish the Medicaid-related percentage.

Training and Monitoring

The operating agency will need to develop training materials to ensure that staff understand the time study codes and approach, and will also need to provide oversight to ensure the appropriate submission of surveys.

Training

Training for the pilot(s) (if applicable) and/or the ongoing time study should allow staff to become familiar with the time study codes and the definitions, the methodology for the time study (e.g., daily log, 100%-time documentation), and the format used to collect code responses.

The training presentation should include:

- **Purpose of the pilot and/or ongoing time study –** Explain why staff will participate in the time study, how the time study will impact their day to day operations, and the benefits of drawing down Medicaid administrative funds.
- **Planned approach –** Include an overview of the time study method, the expected time it will take staff to complete the survey, and how staff will code their time. If the operating agency conducts a pilot, training should include the timeline for the pilot process (e.g., training, survey collection, data analysis, etc.).
- **Code definitions –** Consider a discussion of a code decision tree to provide an overview of what the coding methodology looks like. After this discussion, provide a general, simplified definition for each of the codes with examples and provide an opportunity for questions. A training manual handout can provide the detailed definitions for the codes as a reference.

- **Test scenarios –** States have emphasized that providing a variety of activity scenarios and examples provide the best strategy for staff to understand how to accurately code their time. Staff may interpret the code names and definitions differently, therefore relating each code to a typical scenario (i.e. typical phone call example, types of outreach, general examples of workflow/referral processes, etc.) clarifies coding during training.
- **How to report staff time –** Provide a step-by-step walkthrough of the time study reporting methodology (e.g., automated survey system, fillable PDF), including screenshots for any electronic tools used.
- **Other resources –** Provide an overview of the other resources that the operating agency has developed. This may include a training manual or informational blog.
- **Next steps –** Outline when the pilot and/or ongoing time study will begin and what is expected of staff.

The NWD technical assistance community website (https://www.ta-community.com/category/nwd-adrc-grantee-community) provides additional training resources and samples.

Monitoring

The operating agency will play a crucial role in ensuring that staff code accurately and efficiently for the time study surveys. Responsibilities include:

- **Answering questions –** The agency should have a designated point of contact for questions during the pilot and ongoing time study.
- **Monitoring responses –** As staff learn how to properly code their activities, the operating agency needs to monitor the responses to ensure accuracy. Errors most commonly occur with the general administration and "other" codes, as staff tend to treat these codes as a default if unsure regarding which code to choose. Requiring staff to describe the activity they performed when using these two codes can allow the operating agency to determine the need for greater clarity or potential updates to the activity codes. Staff should receive regular reminders and training regarding over-coding into the general administration and "other" codes.

  Many time study software systems have validation features that allow supervisors to review a small sample of the time study responses to ensure staff have coded their time accurately.
- **Follow-up on missing data –** For a variety of reasons, staff may not complete the time study report in a timely manner. The operating agency should establish an appropriate timeframe for submission. If surveys are not received during this timeframe, the operating agency should follow-up with the staff to remind them to complete the survey and answer any questions they may have.

Establishing the Sampling Framework

If a state selects a time study methodology that involves sampling, such as a RMS, it will need to develop a statistically valid sampling framework. CMS has approved sample sizes that will result in an estimate that has a 95% confidence level that is within two percentage points of the actual amount. To get to this amount, the time study methodology should include about 2,700 surveys per quarter (this amount assumes that a few hundred of the surveys will not result in observations because of non-responses and other factors). When the number of people participating in the time study and/or the amount of funding involved is low, CMS has accepted sampling frameworks that produce estimates that are within five percentage points at a 95% confidence level. This would require approximately 500 surveys.

To determine sample size and confidence level, states can consider using tools, such as sampling calculators. An online sampling calculator can be found at http://www.calculator.net/sample- size-calculator.html.

Step 4: Identify Costs of Allowable and Allocable Activities

Entities participating in claiming must develop a valid administrative claiming methodology that:

- Identifies eligible and non-eligible activities (such as the time studies mentioned above),
- Identifies the individuals served (for activities subject to the Proportional Medicaid Share ONLY), either by capturing information about an individual's Medicaid eligibility through the time study structure and activity codes (see examples in *Step 3* above) or by applying a Medicaid Eligibility Rate (MER). The MER is the ratio of Medicaid eligible population to total population.
- Includes procedures to identify, allocate, document, and report the costs of all those activities. These costs should represent the total actual costs for the staff participating in claiming and should comply with the guidance included in the *Reference Document*. Costs should include all indirect costs, such as rent, capital costs, insurance, etc. They can also include costs associated with other staff that provide support to and/or oversee the staff participating in the time study (e.g., supervisors, administrative assistances, leadership staff, etc.).

Both the operating agency and the Medicaid agency should approve the format and process of cost reports. The operating agency will compile the cost reports for all sites and combine this information with the results of the time study to establish the federal claim. In order to calculate the claim on a quarterly basis, the costs will be multiplied by the percentage of time spent on Medicaid-related activities from the time study and then divided by two (to reflect the 50% administrative match):

(Total Overall Costs x Medicaid %)/2 = FFP Reimbursement

Method for Reporting Costs

States may have varying methods for reporting and collecting costs on a quarterly basis. This may be reported electronically through existing fiscal systems, through cools pool calculations made internally, standardized spreadsheets that documents costs, etc. States may choose to utilize existing methodologies to report on costs and/or may allow this process to occur internally at the local level. The Medicaid agency and the operating agency, if not the Medicaid agency, will need to establish procedures for reviewing and approving costs. Entities should consult with staff at each relevant agency to understand how they meet the review requirements and expectations.

This workbook provides one option, tool six, that can be used as a template if states choose to have a standardized method for reporting costs.

 **Workbook Tool Six: Cost Pool Guidance and Six(a) Spreadsheet Template.** These tools include a standardized spreadsheet, the Cost Pool Spreadsheet, which reports on the total costs associated with each time study participant and instructions on completing the spreadsheet.

Entities developing the claiming infrastructure should adapt this spreadsheet to reflect accounting categories and practices in their state. The guidance for filling out the spreadsheet can be adapted to serve as training for agency fiscal staff responsible for completing the spreadsheet on a quarterly basis.

Ongoing Cost Reporting- Roles and Responsibilities for Operating and Local Agencies

During the ongoing time study, the operating agency has the following roles and responsibilities:

- Run and oversee time studies
- Gather staff costs via identified methodology
- Ensure appropriate staff participate in the time studies
- Provide quarterly claims to the state Medicaid agency for reimbursement
- Disburse administrative funds to the local sites
- Develop quality assurance mechanisms to ensure compliance with fiscal and program expectations, including training, fiscal reviews, and time sample reviews

During the ongoing time study, the local agencies have the following roles and responsibilities:

- Ensure all appropriate staff performing reimbursable activities participate in the time study
- Complete fiscal spreadsheets each quarter to include all non-federal dollars allocated to supporting reimbursable tasks and staff

- Review and establish intake and triage workflows
- Attend trainings and participate in time studies

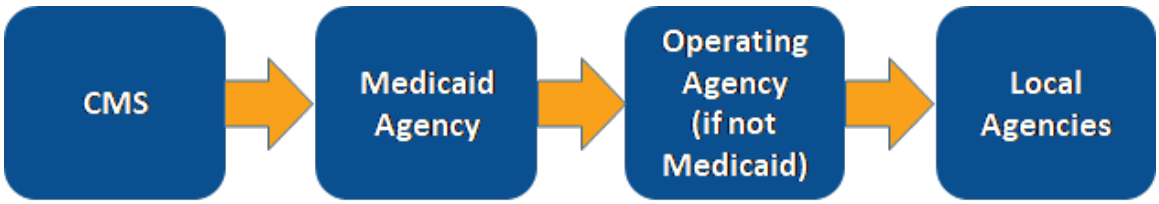
Phase 2: Develop Agreements and Approval

Step 5: Establish Contractual Agreements

In order to ensure that all agencies understand the roles and responsibilities to draw down administrative funds, the operating agency will need to develop formal contractual agreements.

At a minimum, an agreement between the operating agency and the state Medicaid agency must exist. Formal agreements, such as a contract or a MOU, must also exist between the operating agency and the local agencies drawing down administrative funds. These agreements should describe each entity's responsibilities and also funds disbursement. ***Exhibit 6*** provides the likely chain of agreements.

Exhibit 6: Recommended Chain of Agreements for Drawing Down Administrative Funds



Workbook Tool Seven: Template for Agreement between the Operating Agency and the Medicaid Agency. The workbook includes a document that can serve as a template for an agreement between an operating agency and the state Medicaid agency.

Entities developing the infrastructure for administrative claiming can incorporate the text from this document into a MOU format preferred or required by their state. Text in **Red** indicates language that will require updating. Text in *italics* provides guidance for staff updating the MOU.

Step 6: Secure CMS/DCA Review and Approval

The final step involves submitting the administrative claiming methodology and supporting documentation as an amendment to the state's PACAP to the CMS Regional Office[3] for review and approval. The PACAP provides a narrative description of the procedures that the state agency will use to identify, measure, and allocate costs, as specified in *Appendix V of 45 CFR part 75*. Note: In accordance with the statute, regulations and the Medicaid state plan, the state must maintain and retain source documentation to support Medicaid payments for administrative activities. CMS will determine if the proposal identifies and isolates allowable NWD System costs

[3] For a list of CMS Regional Offices see https://www.cms.gov/Medicare/Coding/ICD10/CMS-Regional-Offices

through the use of a valid allocation methodology. The methodology described in this Workbook is the time study approach which can be applied as part of a PACAP amendment or be described as a methodology in a contract/agreement with the State Medicaid agency. States shall consider if there are any existing claiming structures or existing agreements with the State Medicaid Agency to determine the best methodology for NWD claiming. Examples of other methodologies may be fixed fee contracts, or other methods determined by the State Medicaid agency.