



# **Ohio Department of Health**

## **Medicaid Administrative Claiming (MAC)**

### **Methodology Guide**

**March 30, 2007**

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# **PART I: CLAIM CALCULATION METHODOLOGY**

## **INTRODUCTION**

### **Medicaid Administrative Claiming in Public Health Agencies**

The Ohio Department of Health (ODH) and Ohio Department of Job and Family Services (ODJFS) Medicaid Program share a focus on improving access to health care for low income Ohioans. The most vulnerable of Ohio's citizens experience difficulty in accessing needed health care because of a lack of health insurance, poverty, limited transportation, language barriers, and job instability resulting in inconsistent health care coverage.

Through Medicaid Administrative Claiming (MAC) state and local public health departments can be reimbursed in part for activities that assist low income Ohioans in enrolling in Medicaid and accessing Medicaid-covered services. Medicaid-covered medical, dental, and mental health services contribute to the elimination of disparities and can improve the overall health of the high risk population. Both are fundamental goals of public health.

### **Administrative Structure for the Management of the Program**

The administrative structure for the management of the Medicaid Administrative Claiming (MAC) program for the Ohio Department of Health (ODH) involves two state agencies and up to 136 local public health departments. The public health activities which are reimbursable under Medicaid Administrative Claiming are performed by staff within the Ohio Department of Health and at local public health departments. As a result, parts of the management of this program lie with each of the governmental entities. Each entity has specific responsibilities that will be further delineated in interagency agreements and contracts. 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 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 establishes reviews and monitoring protocols.

ODJFS, through an Interagency Agreement, delegates day-to-day administration of the MAC program to ODH and retains an oversight responsibility which is two-fold. ODJFS monitors ODH in its claiming of activities conducted by state agency staff in the Bureaus. ODJFS also oversees ODH in its processing and monitoring of claims from local public health departments. ODJFS reserves the right to withhold payment of claims if ODH or any claiming unit fails to comply with the approved methodology, or other state or federal regulations.

### **Ohio Department of Health (ODH)**

The ODH MAC Unit is assigned the day-to-day responsibility for the administration of the ODH Medicaid Administrative Claiming program. The MAC Unit functions in two distinct capacities. It oversees and monitors the claiming units within ODH, as well as provides oversight and monitoring of the claims and MAC operations of the local public health departments. ODH will request 50% reimbursement for the operational costs of the ODH MAC Unit. ODH will sign a certification statement every quarter to assure 100% of costs of the MAC Unit are MAC related. The reimbursement will be for salary, fringe, federally-approved indirect cost, travel, and training expenses.

ODH will develop a rollout plan for all claiming units that ensures timely implementation of the MAC process. The ODH MAC philosophy is to invest considerable attention to training, technical assistance and oversight from the initiation of claiming entities through the submission of claims (invoices). At the orientation meeting with a potential claiming unit, ODH provides the Implementation Plan format which has been approved by ODJFS. The Implementation Plan then is completed by the claiming unit and approved by ODH prior to their participation.

The ODH MAC Unit reviews quarterly claims and submits them to ODJFS. The Unit ensures the expenditure of adequate and appropriate matching funds; reviews and monitors claims in accordance with protocols developed by ODH and approved by ODJFS, and directs the time studies. The MAC Unit conducts training and technical assistance for claiming units at ODH and local public health departments to ensure the proper use of the Activity Codes, ensure the accurate preparation of claims, and proper maintenance of files. The Unit also reviews and approves all claiming unit Implementation Plans prior to their participation in MAC.

### **Ohio Department of Health Claiming Units**

ODH is organized into three programmatic divisions, each with multiple bureaus. ODH's claiming units are either a bureau in total, or one or more programs within a bureau. Examples of ODH bureaus include, but are not limited to: Bureau for Children with Medical Handicaps, Bureau of Child and Family Health Services, Bureau of Early Intervention Services. Each ODH claiming unit that proposes to participate in MAC is required to complete an Implementation Plan for review and approval by the ODH MAC Unit. Each approved claiming unit must participate in the quarterly time study.

### **Local Public Health Departments (LPHDs)**

Local public health departments operate independently from the Ohio Department of Health. LPHDs will be performing MAC activities at their sites and in other settings with the exception that Medicaid Outreach code (Code 3) can not be used in the home setting.

A local public health department can have one or more claiming units within the department. Multiple claiming units are needed when organizationally there are separate program areas that have unique age and gender specific populations to be served. The LPHDs are responsible for conducting the quarterly time studies, collecting and

compiling time study and financial data, preparing the quarterly claims, and maintaining files. Each LPHD is the point of contact for ODJFS and ODH for reviews, monitoring and claim questions. Each LPHD that proposes to participate in MAC is required to complete an Implementation Plan for review and approval by the ODH MAC Unit. The interagency agreement between ODH and each LPHD will include an approved Implementation Plan for each claiming unit. All interagency agreements between ODH and local public health departments must contain language specified in the Interagency Agreement between ODH and ODJFS.

## **CALCULATION OF THE ADMINISTRATIVE CLAIM**

### **Four Components of a claim**

This Medicaid Administrative Claiming methodology is based on four key 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 expenditures; and
- The calculation of the Medicaid Eligibility Rate.

These four components are the building blocks for the claim calculation.

### **Personnel**

Medicaid administrative claims are based on staff activity and actual expenditures related to staff that perform allowable MAC activities. Each ODH and local public health department claiming unit completes an Implementation Plan that identifies staff to be claimed. The rosters of participating staff are updated on a quarterly basis by each claiming unit.

### **Time Study**

Each MAC participant to be claimed must time study for the entire time study week. This is not a sampling or random moment approach. A time allocation methodology (time study) is applied to determine the appropriate percentage of personnel time dedicated to Medicaid administrative activities during the claiming period. Time studies are performed once each quarter for a seven consecutive day period. The time study captures information to distinguish allowable administrative costs from non-allowable costs. See Part II for an explanation of the time study methodology.

### **Determination of Actual Expenditures**

#### **Collection of the Actual Expenditure Data**

Financial information is collected from all participating entities each quarter. 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 types

of expenditures are: salaries; fringe benefits; indirect cost; personal service contracts; supplies; and others. Each financial accounting system from which the expenditure data are obtained must adhere to Generally Accepted Accounting Principles (GAAP) and the following five principles apply to the preparation of the claim:

- 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 application of the time study results. The appropriate MER is applied for each MAC code.
- The process minimizes the time spent by financial personnel to meet the reporting requirements while maintaining assurance of the accuracy of the data.
- 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, ODH, 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 three years from the last quarter of the federal fiscal year of reimbursement. ODH will adhere to the federal regulation 45CFR Subtitle A § 92.42 which states: "If any pending litigation involving the records has been started before the expiration of the three year period, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular 3-year period, whichever is later."

Because MAC represents a claim for federal reimbursement, any federal revenue directly or indirectly related to the Medicaid administrative functions and positions is offset to avoid potential duplicate claiming. Each claiming entity must maintain documentation to show the proper offset of federal revenues has been applied. All sources of funds must be included in order to assure any funds directly or indirectly related to federal funds are listed and not included in the claim.

### **Financial Expenditure Form Requirements**

ODH supplies financial reporting schedules (forms) and training materials to all participating claiming units to facilitate the collection of their quarterly expenditures. Each claiming unit submits financial expenditure forms to ODH as part of the review and approval process. The forms are used to report the following information:

- The name of the agency or bureau, and the claiming unit;
- The name and phone number of the person completing the form;
- The quarter for which the expenditures are being reported;
- The actual expenditures listed by type; and
- All sources of funds, including the availability of matching funds.

All claims will be submitted in a format specified by ODH and reviewed and pre-approved by ODJFS (see Attachment A). As ODH 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 Medicaid administrative activities are obtained from payroll records for the claiming period. All personnel costs are allocated to the Medicaid Administrative Claim based on the appropriate quarterly time study results.

### **Indirect Cost Rates**

Indirect Costs are only included in the claim calculation for claiming entities that have a federally-approved indirect cost rate. Each rate is examined to determine if it is a restricted or unrestricted rate. The rate will be applied in compliance to the federally-approved indirect cost agreement. Otherwise, indirect costs are not allowable. Each claim must clearly identify the federally-approved indirect cost rate. Indirect Costs will be reported separately.

### **Personal Services Contracts**

ODH and local public health department expenditures related to the performance of MAC activities by contract personnel are also obtained from the agency's financial system. All staff employed under a contract to be claimed will time study. All contract costs are allocated to the Medicaid Administrative Claim based on the appropriate quarterly time study results.

### **Other Costs**

All Other Costs (e.g., travel, materials and supplies) are obtained from the agency's financial system. All Other Costs are allocated to the Medicaid Administrative Claim based on the appropriate quarterly time study results. Indirect Costs are not included as Other Costs.

### **Exclusion of Federal Revenue**

Because the Medicaid Administrative Claiming program represents a claim for federal reimbursement, any federal revenues directly or indirectly related to the Medicaid administrative functions and positions are excluded to avoid potential duplicate claiming for federally funded positions. Federal funds that the Ohio Department of Health awards to the local public health departments and expenditures from those funds also are excluded. Only expenses supported by appropriate state and local 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 which 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. For example, state funds that are earmarked for health care for uninsured pregnant women and children may not be used for match in MAC. These funds would be considered unallowable as matching for MAC activities.
4. Insurance and other fees collected from non-governmental sources for non-MAC activities must be offset against claims for Medicaid funds.

The ODH MAC claims must strictly adhere to the OMB Circular A-87, Attachment A, Part C, Item 4.

#### **Exclusion of Provider-Related Donations and Health Care-Related Taxes**

Any provider-related donations and health care-related tax revenues are not allowed as revenue sources for any local public health department's Medicaid Administrative Claim. (42CFR §433.54)

#### **Claim Certification**

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 is certified by the controller, chief financial officer (or an appropriate designee) of each participating agency.

### **Medicaid Eligibility Rates (MER)**

#### **Methodology for Calculating MER**

Some of the Medicaid administrative activities performed by the Ohio Department of Health and the local public health departments benefits both Medicaid and non-Medicaid individuals and populations. Therefore, the costs associated with these activities must be allocated accordingly. This ensures that only the costs related to Medicaid administrative activities for Medicaid eligible individuals are claimed to Medicaid. Medicaid eligibles are individuals who have a current Medicaid card. This allocation of costs involves the development of the proportional Medicaid share, also referred to as the Medicaid Eligibility Rate (MER), Medicaid discount, or Medicaid percentage (See Attachment B: MER Methodology and FFP by Activity Code).

### **ODH Medicaid Eligibility Rates**

The population based methodology is specific to the ages and gender of the population of Medicaid eligibles served by the claiming unit as described in their Implementation Plan (e.g., pregnant women; children under age 18; all ages/genders). The specific age ranges and gender(s) of the population served by the claiming unit must be described. The claiming unit's Implementation Plan must clearly state that the population served is limited to that particular demographic. If the claiming unit conducts a variety of programs that collectively serve all ages and genders, then the whole state population must be used in the calculation.

The MER is calculated by dividing the number of Medicaid eligible individuals in the age range and/or gender served by the claiming unit (numerator) by the total number of individuals in the state in that age range or gender (denominator).

Number of Medicaid eligible individuals in the age range and/or gender residing in the state  
Number of individuals in the age range and/or gender residing in the state

The number of Medicaid eligible individuals in the age range and/or gender is provided by the Ohio Department of Job and Family Services from their Medicaid eligibility data for the time period. The number for the state population in the age range and/or gender is determined by the Ohio Department of Development for the most recent time period. ODH calculates the MER each year in May and distributes the relevant rate to each ODH claiming unit for the July 1<sup>st</sup> to June 30<sup>th</sup> fiscal year.

### **Local Public Health Department Medicaid Eligibility Rate**

The population based methodology is used for local public health departments. The population based methodology is specific to the ages and/or gender of the population of Medicaid eligibles served by the program as described in the Implementation Plan for the claiming unit (e.g., pregnant women, children under age 18, all ages/genders). The claiming unit's Implementation Plan must clearly state that the population served is limited to a particular demographic. The specific range of ages and/or gender(s) of the population served by the claiming unit must be described. If the claiming unit conducts a variety of programs that collectively serve all ages and genders, then the whole county population must be used in the calculation. Of the participating local public health departments, ODH anticipates approximately 90% will have claiming units whose programs collectively serve the full range of ages and/or genders. Those local public health departments will use the countywide Medicaid eligibility rate.

The MER is calculated by dividing the number of Medicaid eligible individuals in the age range and/or gender in the county served by the claiming unit (numerator) by the total number of individuals in the county in that age range or gender (denominator).

Number of Medicaid eligible individuals in the age range and/or gender in the county  
Number of individuals in the age range and/or gender in the county

The number of Medicaid eligible individuals in the age range and/or gender is provided by the Ohio Department of Job and Family Services from their Medicaid eligibility data for the time period. The number for the state population in the age range and/or gender is determined by the Ohio Department of Development for the most recent time period. ODH calculates the MER each year in May and distributes the relevant rate to each ODH claiming unit for the July 1<sup>st</sup> to June 30<sup>th</sup> fiscal year.

## **Monitoring Procedures**

### **Monitoring Procedures Conducted by Local Public Health Departments**

MAC associated staff at the local public health departments will review MAC invoices and documents to ensure that submissions to ODH are appropriate and reasonable. In addition, the chief financial officer at the local public health department will attest by signature to the accuracy of the claim invoices submitted to ODH. For each claim submitted to ODJFS, the local public health department as well as ODH's chief financial officer on behalf of their respective agency will attest to the following:

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

6. The information above and in this claim is correct to the best of my knowledge and belief based on reasonably available information. Also, I have notice that this information is to be used for filing a claim with the Federal Government for federal funds, and the knowing misrepresentation constitutes violation of the Federal False Claims Act.

### **Monitoring Procedures Conducted by ODH**

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

The ODH MAC Unit will review all claims submitted by the ODH claiming units and the local public health departments. There are three levels of review and monitoring of claims. ODH will review all claims for levels 1 and 2. For level 3 ODH will review a sampling of claims.

Level 1 is a technical review in which the mechanics of the claim, such as mathematical computations, the use of the proper MER, and presence of all required information are checked. 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.

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

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

Time study results with outliers of percentage of code usage weighted by the following order:

- Non-Discounted
- Discounted
- Reallocated;

History of errors or problems;

Claims with individuals included in the claiming plan that use code 16 (Time Not Documented); and

Number of claiming units

Level 3 is a full field review. At least 5% of the claiming units will be reviewed. Until ODH can establish a protocol of review based on historical claims data, ODH will perform a full field review of enough claiming entities to cover 50% of the claimed amounts submitted each quarter. ODH's initial review will be a minimum of one claim and a maximum of five claims. If the initial review uncovers significant and/or systemic problems additional review may be performed.

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

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

ODH will perform an initial limited review of the remaining claiming entities based on a random sample to cover 20% of the claimed amounts per quarter, up to the maximum of seven. If the initial review uncovers significant and/or systemic problems, additional reviews may be performed.

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

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

The claiming agency (ODH or the local public health department) will maintain the original time study logs. The claiming agency will maintain the payroll records that document the salary and benefits of all persons designated as performing Medicaid administrative activities. Only staffs that participated in the quarterly time study training and participated in the quarterly time study are included in the claim. ODH and individual local public health departments are responsible for maintaining and storing their own documentation and records.

### **Monitoring Procedures Conducted by ODJFS**

ODJFS performs reviews and monitoring on claims submitted by ODH claiming units and reviews monitoring and oversight activities performed by ODH of the local public health departments. ODH is the entity that has direct monitoring and oversight responsibility for claims submitted by local public health departments. ODH is also a claiming entity with responsibility for submitting accurate claims to ODJFS for reimbursement.

ODJFS has direct monitoring and oversight responsibility of claims submitted by ODH claiming units. ODH has direct monitoring and review responsibility of the claims submitted by the local public health departments participating in MAC.

ODJFS will verify the mathematical accuracy of all claims submitted by ODH claiming units as well as eight of the claims submitted by the local public health departments. Quarterly, ODJFS in its monitoring and oversight capacity will perform a complete review and evaluation of a selected claim submitted by an ODH claiming unit. During the first two quarters of claim submission following CMS approval of the MAC methodology, this complete review and evaluation will include two submitted claims representing the value of at least 60% of all claims. These reviews will include a thorough examination of expenditure reporting.

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

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

As historic claiming data is collected, ODJFS will review claims submitted by ODH claiming units based on variations between periods and other claiming entities. ODJFS will gather data to highlight trends and 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 ODH begins their review of claims submitted by local public health departments, ODJFS will review ODH's review methodology for adequacy. ODJFS will select for its own review the results of ODH's review of claims submitted by local public health departments.

ODJFS will select 5% of the reviews performed by ODH (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 additional review may be performed.

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

A chart starting on the next page summarizes the monitoring activities to be carried out by each organization.

<b>Oversight and Monitoring of the ODH MAC Program</b>		
<b>Local Public Health Departments</b>	<b>Ohio Department of Health</b>	<b>Ohio Department of Job &amp; Family Services</b>
Staff will review materials to ensure appropriateness and responsibility.	All claims reviewed for math accuracy.	All claims from ODH units and a sample of up to 8 LPHD claims reviewed for math accuracy.
Financial officer will attest to accuracy of claim invoice.	All claims reviewed through two levels: <ol style="list-style-type: none"> <li>1. Technical review</li> <li>2. Desk review including comparisons to past claims.</li> </ol>	Complete review and evaluation of one claim from ODH unit. During first 2 quarters of MAC plan approval, 2 claims representing 60% of claimed amount will be reviewed.
	At least 5% of claiming units (up to 5 claims) will receive a level 3 review which is a full field review. Early in the MAC program 50% of claimed amounts will be reviewed.	One additional ODH unit claim will have one claim component reviewed intensely.
	Of the claims not previously reviewed, claims equaling 20% of claimed amount (up to 7 claims) will be selected for review.	Will review 5% up to 10 of the reviews conducted by ODH of LPHD claims.
		ODJFS has option to request that ODJFS auditing office, ORAA, audit claims if severe problems exist.

### **Quality Assurance Activities**

Local public health departments and ODH claiming units must submit to the ODH MAC Unit a quality assurance plan as part of the Implementation Plan to ensure accuracy of the data. The responsibilities of each claiming unit for claim development includes, but is not limited to:

1. Establishing guidelines for audit files and archiving claiming plans, signed original time studies, MAC claims, and applicable documentation.
2. Participating with the ODH MAC Unit in MAC reviews and monitoring.
3. Establishing and operating a quality assurance system for assessing compliance with MAC policies and procedures through desk reviews, onsite reviews, and technical assistance.

4. Excluding from the claim the costs associated with a staff member that did not complete their time study. For example, if a staff member did not fully complete the time study form for the day or cannot produce their time study log, then the associated costs would be labeled as Code16: Time Not Documented.

### **CLAIM CALCULATION EXAMPLE**

In general, the claim is calculated by activity code, administrative category, and reimbursement type. The total claim is simply the sum of these calculations across all allowable activity codes. The claim associated with any particular activity is based on the following factors:

- Gross reported 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;
  - ✓ Reconciliation of those activities that are non-allowable; and
  - ✓ Allocation of allowable general administration off as described in code 15.

There are four reimbursement types:

1. **Non-Discounted (Type ND)** activities are MAC activities that are 100% Medicaid applicable and reimbursable. Medicaid eligibility percentages are not applied to these activities.
2. **Discounted (Type D)** activities are administrative activities that are only reimbursable for the Medicaid eligibles for the claiming unit. The costs associated with these activities will be reduced according to the Medicaid Eligibility Rate 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 participants' time. These activities are unallowable regardless of whether or not the population served includes Medicaid eligible individuals. As required in OMB A-87, the full spectrum of activities performed by the participants is measured in order to accurately account for all of the study participants' time.
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. None of the reallocated time can be reimbursed at enhanced rates.

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.

**TABLE A: Map of Reimbursement Type to Activity Code**

Reimbursement Type	Activity codes to which this calculation applies
ND	3 and 5
D	7, 9,11 , 13
U	1, 2, 4, 6, 8, 10, 12, 14 and 16
R	15

**Gross Claim Calculation**

**Table B** is an example of calculations for Activity Codes 1, 3, 7 and 15 for the Personnel category of expenses. The grand total of expenses for Salary and Fringe Benefits is assumed to be \$1000 for each category.

**TABLE B: Claim Calculation**

Activity Code	Gross Cost	Time Study %	Rate Factor	Size of MAC Activities	FFP	Claim
1 (Direct Care)	\$1000	40%	0% Unallowable	\$ 0	0%	\$0
3 (Medicaid Outreach)	\$1000	10%	100% (no discount)	\$100	50%	\$50
7 (Referral, Coordination)	\$1000	25%	20% (MER)	\$50	50%	\$25
15 (General Admin)	\$1000	25%	20% (step 2)	\$50	50%	\$25
<b>Total</b>		<b>100%</b>	<b>-</b>	<b>\$200-</b>		<b>\$100</b>

- **Type ND:** The example uses Activity Code 3 to demonstrate the calculation applicable for any Type ND code (codes 3 and 5). These codes are not impacted by the Medicaid Eligibility Rate so the gross claim is simply the product of allocated time study percentage times the gross MAC expenditures. (10% x 100% x \$1000 = \$100)
- **Type D:** The example uses Activity Code 7 to demonstrate the calculation applicable for any Type D activity code (codes 7, 9, 11 and 13). These codes must be reduced by the Medicaid Eligibility Rate. The example uses a Medicaid Eligibility Rate of 20%. Thus, the gross claim for Activity 7 is equivalent to the

product of the reallocated time study percentage times the Medicaid rate times the gross MAC expenditures for Activity Code 7 ( $20\% \times 25\% \times \$1000 = \$50$ ).

- Type U:** The example uses Activity Code 1 to demonstrate the calculation applicable for any Type U activity code (codes 1, 2, 4, 6, 8, 10, 12, 14, and 16). These codes are unallowable and are not reimbursed. Thus, the gross claim equals \$0.
- Type R:** The example uses Activity Code 15 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 15). The claimable percentage of time equals the time study percentage multiplied by the reimbursement rate for that activity (e.g., 100% for ND and 20% 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 15 would be as follows:

**Table C:** Calculation of Claimable Percentages for Allocation of Type R Codes

Activity Code	Time Study %	Rate Factor	Claimable %
1 (Direct Care)	40%	0% Unallowable	0%
3 (Medicaid Outreach)	10%	100% (no discount)	10%
7 (Referral, Coordination)	25%	20% (MER)	5%
<b>SUM</b>	75%	<b>15% / 75% = 20%</b>	15%

The allocation rate factor for Activity Code 15 is equal to:  
 (Sum of Claimable % for Other Activities) divided by (Sum of total time spent on other activities)  $15\% / 75\% = 20\%$

**Annual Claim Reconciliation**

All claiming agencies have financial audits either by local, state, or federal auditors. When a financial audit is conducted on the claiming agency, all filed administrative claims must be reconciled to the audited financial findings. The adjustments, both negative and positive, must be reported on a separate special schedule. 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 ODH and Local public health departments have no time restrictions regarding repayment to CMS. The adjustment will be processed on the next available claim after adjustments are communicated.

**Periodicity**

ODH and LPHDs submit claims quarterly. The claim is initially due to ODJFS per the chart below. The claims are submitted through the Ohio Department of Health to the Ohio Department of Job and Family Services. The quarterly claim submission to ODH is due per the following schedule:

<b>Schedule for the Claims Submission</b>	
<b>Quarter</b>	<b>Claim Submission Due Date to ODJFS</b>
January-March	July 15
April-June	October 15
July-September	January 15
October- December	April 15

All claims are submitted by ODH to ODJFS no later than 15 months after the 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 LPHD by ODH 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 dedicated to the performance of Medicaid Administrative functions by claiming units at the Ohio Department of Health and local public health departments for allocating the costs related to Medicaid reimbursable activities and functions. This methodology is applied each quarter for purposes of supporting the calculation of the Medicaid Administrative claim amounts for the Ohio Department of Health and local public health departments.

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

## **Implementation Plan**

The Implementation Plan completed by each claiming unit at ODH and local public health departments is used as an application and aids in organizing each administrative claiming unit. The Implementation Plan provides support for the MAC reimbursement. The Implementation Plan identifies the types of staff (by job title) who participate in the time study and the MAC activities they perform. The Implementation Plan must be completed and approved by the ODH MAC Unit prior to the start of a quarter for which a claim is submitted. It provides all involved parties with a common document and ensures consistency in the claiming process. Implementation Plans submitted by local public health departments are approved by the ODH MAC Unit. ODJFS reviews and approves Implementation Plans submitted by ODH claiming units. Any revisions to the Implementation Plan must be approved prior to the quarter for which the claim is to be submitted.

## **Time Study Approach**

The time study is used to allocate the fair share of staff costs to Medicaid administration. Time study participants include staff whose job functions include activities that can be reimbursed under Medicaid administration. Job functions, rather than job title, determine an individual's inclusion in the administrative time study. Staff must participate in the time study each quarter in order to claim reimbursement for that quarter.

If administrative staffs have job functions that encompass activities reimbursable under Medicaid administration, then they must do the time study.

## **Time Study Week and Time Study Participants**

A workweek (seven consecutive days Sunday through Saturday) per quarter is randomly selected by ODJFS. All time study participants will use the same workweek as the observation period for determining how time is allocated. A seven day, self-administered time study tool is used to document the activities during the randomly selected week.

To determine the universe of weeks eligible for time study, the weeks of the quarter are reviewed for full weeks. The Ohio Department of Job and Family Services or its designee then makes a random selection of the time study week. This selection process is documented and maintained on file. The Time Study is conducted four times a year, in

the following quarters: January – March, April – June, July – September, and October – December.

During the time study week, each participant codes and documents all of his or her work related activities for each day of the seven-day study week, in compliance with OMB A-87 guidelines requiring capture of 100% of the individual's time including the use of code 16 (Time Not Documented). Time study participants code their daily activities to a prescribed set of Activity Codes in 15-minute increments.

Each participant is required to complete the study instrument daily. The study instrument is submitted to the participant's supervisor or claiming unit time study coordinator. The supervisor or claiming unit coordinator signs and dates the study instrument to attest to the date the forms were received from the participant. If during their review of the time study the supervisor or claiming unit coordinator determines any part of the time study to not have documented time, they will change such time to Code 16 (Time Not Documented). All forms must be signed in ink by the participant and supervisor. All electronic entries are to be completed by the end of the third week following the time study period and all hard copy forms are dated and signed by the participant and supervisor to the date completed. If the time study form is completed later than date of the activity, then the entire day is coded to Code 16 (Time Not Documented).

All time study participants will provide a brief description of the activity and corresponding Activity Code on the study instrument for each of the seven days of the study week. The written descriptions on the study instrument should be brief, but need to clearly reflect the activity that was performed.

#### **Time Study Activity Definition**

Many different sources were used to support the development of detailed definitions for Medicaid Administrative functions. The sources include administrative function definitions in the 42 CFR Part 441, Subpart B, and HCFA/CMS approved and/or reviewed Medicaid administrative claiming materials employed in several other states.

The Activity Code descriptions for Ohio are listed, starting on the next page.

The following are the Activity Code descriptions for Ohio:

Activity Code	Activity Description
1	Direct Patient Care
2	Non-Medicaid Other Programs and Social Services 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	Transportation and Translation for Medicaid Services
10	Transportation and Translation for Non-Medicaid Services
11	Program Planning, Development and Interagency Coordination of Medical Services
12	Program Planning, Development and Interagency Coordination of Non- Medical Services
13	Medical Related Provider Relations
14	Non-Medical Provider Relations
15	General Administration
16	Time Not Documented

Detailed definitions of the MAC activities can be found in Attachment C: Medicaid Administrative Claiming Activity Codes.

### **Time Study Instrument**

The time study instrument approved by ODJFS is designed to capture the full complement of activities and functions performed by the time study participants during the course of the randomly selected week, including Medicaid administrative activities, Medicaid direct service activities and non-Medicaid administrative activities. The 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. All overtime is to be approved by the supervisor. The time study instrument is designed to be functional for the participants while still capturing the necessary level of detail required to appropriately allocate costs. The time study instruments are compiled electronically, either by computer readable form, web-based, or other electronic method.

The time study instrument is self-administered and captures participant activities in 15-minute increments for each day of the seven day study period. Activities are recorded into one of 16 Activity Codes, which include allowable MAC activities and non-allowable MAC activities. Collectively, the categories of activities identified in the time study document account for the diverse range of activities performed by ODH and local public health department staff.

Upon completion of the time study period, all time study documents are accounted for and maintained by ODH and the local public health departments, as required for audit purposes. Activity data recorded in the time study document are used in the allocation of activities by personnel category and later used in the calculation of the claim amount.

### **Time Study Training**

Training of time study coordinators and time study participants is key to the successful implementation of Medicaid administrative claiming. Initial training of the time study coordinators and time study participants is conducted for each participating agency by the ODH MAC Unit. Subsequent quarterly trainings are conducted using a train-the-trainer format. The ODH MAC Unit trains the time study coordinators, who in turn train the time study participants. The MAC Unit contacts trainers quarterly on a statewide or regional basis, depending on the number and location of participating agencies. Training focuses on the time study procedures and the proper use of the Activity Codes. All time study coordinators use a uniform set of training materials.

Each claiming unit is responsible for training all of its time study participants prior to the time study period. All time study participants will be informed of the time study week no earlier than three weeks prior to the time study period. On-site comprehensive training for new participants will occur no earlier than three weeks prior to the time study period. Participants who have previous comprehensive training will be provided updates and a review of MAC. Each claiming unit maintains documentation of its training schedules, attendance, and materials used.

Attendance at the quarterly training is mandatory for new time study participants who are employed at the time of the training. Otherwise, their time study results are not included

in the compilation of the time study instruments. Costs for new staff that do not attend the training and/or do not participate in the time study are unallowable.

### **Time Study Monitoring**

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

ODH MAC Unit provides technical assistance to address any issues identified during monitoring process.

## **ATTACHMENT A: CLAIM AND INSTRUCTIONS**

**MEDICAID ADMINISTRATIVE CLAIMING (MAC) ACTIVITIES  
CLAIM WORKSHEET**

Claiming Entity	<input type="text"/>	Claiming Date:	<input type="text" value="3/30/2007"/>
Claiming Unit	<input type="text"/>		
Claiming Number	<input type="text"/>	Preparer:	<input type="text"/>
Period of Services	<input type="text"/>		
Tax Identification Number	<input type="text"/>	Phone Number:	<input type="text"/>

SOURCE DESCRIPTION	SALARY AND FRINGE	TRAVEL AND TRAINING	OTHER COSTS	PERSONAL SERVICE CONTRACTS	INDIRECT COST	TOTALS
<b>FEDERAL GRANTS &amp; MATCH</b>	\$500	\$0	\$0	\$0	\$0	\$500
<b>MAC MATCH</b>	\$500	\$0	\$0	\$0	\$0	\$500
<b>GRAND TOTAL</b>	\$1,000	\$0	\$0	\$0	\$0	\$1,000

TIME STUDY ACTIVITIES		MER%	TIME STUDY %	FFP
DIRECT PATIENT CARE	<b>1</b>	0.00%	40.00%	0%
NON-MEDICAID OTHER PROGRAM AND SOCIAL SERVICE ACTIVITIES	<b>2</b>	0.00%	0.00%	0%
MEDICAID OUTREACH (NOT DISCOUNTED)	<b>3</b>	100.00%	10.00%	50%
NON - MEDICAID OUTREACH	<b>4</b>	0.00%	0.00%	0%
FACILITATING MEDICAID ELIGIBILITY DETERMINATIONS (NOT DISCOUNTED)	<b>5</b>	100.00%	0.00%	50%
FACILITATING ELIGIBILITY FOR NON-MEDICAID PROGRAMS	<b>6</b>	0.00%	0.00%	0%
REFERRAL, COORDINATION & MONITORING OF MEDICAID COVERED SERVICES	<b>7</b>	20.00%	25.00%	50%
REFERRAL, COORDINATION & MONITORING OF NON-MEDICAID SERVICES	<b>8</b>	0.00%	0.00%	0%
TRANSPORTATION AND TRANSLATION FOR MEDICAID SERVICES	<b>9</b>	20.00%	0.00%	50%
TRANSPORTATION AND TRANSLATION FOR NON-MEDICAID SERVICES	<b>10</b>	0.00%	0.00%	0%
PROGRAM PLANNING, DEVELOPMENT & INTERAGENCY COORDINATION OF MEDICAL SERVICES	<b>11</b>	20.00%	0.00%	50%
PROGRAM PLANNING, DEVELOPMENT & INTERAGENCY COORDINATION OF NON-MEDICAL SERVICE	<b>12</b>	0.00%	0.00%	0%
MEDICAL RELATED PROVIDER RELATIONS	<b>13</b>	20.00%	0.00%	50%
NON-MEDICAL RELATED PROVIDER RELATIONS	<b>14</b>	0.00%	0.00%	0%
GENERAL ADMINISTRATION	<b>15</b>	20.00%	25.00%	50%
TIME NOT DOCUMENTED	<b>16</b>	0.00%	0.00%	0%
<b>TOTAL TIME</b>			<b>100.00%</b>	

REALLOCATION DENOMINATOR 75.00%

QUARTER CLAIM \$ 100

PRIOR PERIOD  
ADJUSTMENT \$ -

**TOTAL CLAIM \$ 100**

COMPOSITE RATES

EXPENDITURES

CALCULATION

Level of MAC Activities		MAC % of time	%	COMPARISON %
20.00%	<b>10.00%</b>		35%	47%
1,000	<b>1,000</b>	NON-MAC time	40%	
200	<b>100</b>	Reallocated % of time	25%	
		Total %	<b>100%</b>	

I hereby certify the following:

- I am the designee of the State Department of Health authorized to submit this claim.
- This claim only includes expenditures under the Medicaid program under Title XIX of the Social Security Act (the Act), that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies, and the state plan approved by the Secretary and in effect during the period of the claim under Title XIX of the Act for the Medicaid Program.





## LOCAL CLAIM PREPARATION

March 30, 2007

### Supporting Documents:

Prior to preparing an invoice five items are needed. They are:

- **The unit's MAC Implementation Plan.** Within this plan includes a listing of MAC Personnel. The plan should also include a table of organization (T.O.) to help document the relationships between all personnel.
- **The quarter's Medical Eligibility Rate (MER)** should be for the quarter you are preparing the invoice. ODH will calculate and distribute the MER annually.
- **The quarter's payroll data** from appropriate local reports. Actual payroll expenditures are to be used. Use standard local reporting methods when generating this information. The costs for each person must be separated by each source of funds.
- **The quarter's time-study results** for the claiming unit.
- **The quarter's list of trained time-study personnel** for the claiming unit.

### 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 can not be included in the claim and their time study results are removed.
- If a position is in the plan but did not go to the time-study training and/or participate in the time study, then their time-study results should be coded to MAC code 16 (Time Not Documented). Their costs end up being backed out via the time study results.
- If a position is in the plan but was vacant or on disability leave during the training and/or time study week, the costs are to remain. Their costs end up being allocated upon the appropriate time study results.
- If a position is in the plan, but is on leave during the time study week, their costs are to remain, and they should use code 15 (General Administration). If the leave is predetermined by a contractual agreement (i.e., school nurses agreeing to work 9 months a year and being paid over 12 months for a summer leave), the costs are to remain and their costs end up being allocated upon the average of the previous three time-study periods.

- If a position is funded 100% with federal funds and related match revenue, then the costs are not included and their time study results are removed.
- Positions are approved in the plan, *not* people. Compare names to titles. If a person changed positions the make sure the time-study results and costs are associated with the correct position.

### Opening the invoice:

The invoice is to be sent by the Department of Health. An e-mail with an Excel file called “Local Claim Template” and a sample will be sent to. Save both in your computer in a separate folder.

### Naming of Claim File:

To generate an invoice for a claiming unit, go directly to the “Local Claim Template”, open it and immediately do a “File Save As” in another folder. In order to have consistent file names the naming sequence is for the January to March, 2008 quarter for Buckeye County Health Department’s Division of RNs Claim. The lower case “y” represents year and the lower case “q” represents the quarter, followed by the “Claiming Agency” name, a dash (-), “Claiming Unit” name. **Quarter numbers are on the calendar basis.** The file name for the quarter mentioned above would be: y08q1 Buckeye County Health Department – Division of RNs.

### Invoice Overview:

Information can **only** be entered in “White Cells”. All others are locked.

Current worksheets of the claim are as follows:

- **Claim** – this is the main worksheet. All other worksheets are either linked to or provide supporting information to this worksheet. Detailed instructions are outlined later.
- **Revenue Descriptions** – this worksheet breaks information into revenue categories. Detailed instructions are outlined later.
- **Payroll** – use this tab to import all local payroll supporting information.
- **Non-Payroll** – use this tab to import all local non-payroll supporting information.
- **Time Study % Summary** – use these tabs to import time-study results. “Copy and Paste” the results into the appropriate worksheet. If the review of supporting documents results in changes of category assignments then supporting data must

be updated. For example, if the time study results include a person that did not attend training then their data must be removed from the time study.

- **Checklist** – this is a checklist of all the items that should be retained in a file in case of an audit.

## Claim Worksheet

### Header Section:

The **Header Section**, along the top of the **Invoice Worksheet** provides information to help identify the specific **Invoice**. The **Header Section** includes:

- **Claiming Entity** – enter the name of the **agency** making the claim.
- **Claiming Unit** – enter the name of the **claiming unit**.
- **Period of Services** – claiming is completed quarterly. Enter the quarter of the claim as follows: January through March, 2008.
- **Claiming Number** – assign invoice number as the name of the file (e.g. y08q1 Buckeye County Health Department – Division of RNs).
- **Tax Identification Number** – enter the claiming agency's **Federal Tax ID number**.
- **Claiming Date** – enter the date that the invoice was prepared.
- **Preparer** – enter the name of the person preparing the claim.
- **Phone Number** - enter the phone number of the person preparing the claim. (Please include area code)

### Source Description Section:

This is where the **Actual Costs Total** is entered. Costs are to be segregated by MAC Match and Related Match. The determination of revenue classifications is determined by the MAC Revenue Qualifier Questionnaire in the Implementation Plan.

The line items listed below are to be completed, all others are calculated. Round all figures to the nearest whole dollar.

- **Salary and Fringe** – actual costs for this category are to be entered. The supporting documentation of the actual costs is to be detailed in the Payroll Worksheet.
- **Travel and Training** - actual costs for this category are to be entered. The supporting documentation of the actual costs is to be detailed in the Non-Payroll Worksheet.
- **Other Costs** – actual costs for this category are to be entered. The supporting documentation of the actual costs is to be detailed in the Non-Payroll Worksheet. This category includes all costs that are not included in other line items. It is required that an itemized listing of the **Other Costs** be provided in the **Non-Payroll Worksheet**. **Other Costs** listed must be completely allocable to the specific claiming unit staff. **Supply Costs**, at a broader level (e.g. bureau, division or program area level) can not be included.
- **Personal Service Contracts** – actual costs for this category are to be entered. The supporting documentation of the actual costs is to be detailed in the Non-Payroll Worksheet. Contracts and invoices must clearly distinguish MAC reimbursable activities along with all other activities. All contracts with or on behalf of personnel must time study. Include any supporting documentation of cost in the Non-Payroll worksheet.
- **Indirect Cost**: actual costs for this category are to be entered. The supporting documentation of the actual costs is to be detailed in the Non-Payroll Worksheet. Complete this only if a federally approved indirect cost rate already exists. The Indirect Cost rate must also be explained in the MAC Implementation Plan. A copy of the approval notice, along with the approved rate, is the source document. Apply the rate to the Salary and Fringe figures.

### **Time Study Activities and MER % Section:**

**MER % Column:** enter the discounted MER rate in MAC Activity Code 7. All other rates populate automatically. The MER is supplied by ODH annually.

**Time Study %:** the time study results for the quarter are to be entered in their appropriate column. **Special Note:** for percentages under 1%, enter zero, prior to the decimal point. For example: if you are entering one quarter of one percent (1/4 of 1%) you would enter 0.25.

After entering the percentages, double check that the time study results total 100%. There could be a rounding error. The rounding error is generally under 0.01%, so the total percentage could then d to only 99.99%. If the total is under 100%, then add the difference to Code 2 (Non-Mac) activities to eliminate the possibility of gaining reimbursement. If the total is over 100%, then the difference is subtracted from a MAC activity code that would gain the most reimbursement.

## Revenue Descriptions Worksheet:

### Descriptive Columns

Each source funds will have a row. To help a reviewer understand the source of funds, there are three (3) columns:

#### **Description**

#### **Agency Identifier**

#### **Source Type**

Description – in this column, provide the name of the source as used on the MAC Revenue Qualifier questionnaire.

Agency Identifier – this column is provided for those agencies that have a unique coding system to help identify the revenue source. If so, provide the identifier. If not, leave blank.

Source Type – this column uses a pull-down menu to offer a selection of sources that “best fit” (see definitions to help distinguish type of funds). To assist reviewers of the worksheet, group rows by types of sources and place a row between types.

**ATTACHMENT B: MER METHODOLOGY AND FFP BY  
ACTIVITY CODE**

## MER Methodology and FFP by Activity Code

<b>Code</b>	<b>Activity Description</b>	<b>FFP</b>	<b>MER Methodology</b>
<b>1</b>	Direct Patient Care	<b>0%</b>	Not Claimable
<b>2</b>	Non-Medicaid Other Program and Social Service Activities	<b>0%</b>	Not Claimable
<b>3</b>	Medicaid Outreach (not Discounted)	<b>50%</b>	100% claimable without applying a Medicaid Eligibility Rate discount
<b>4</b>	Non-Medicaid Outreach	<b>0%</b>	Not Claimable
<b>5</b>	Facilitating Medicaid Eligibility Determinations	<b>50%</b>	100% Claimable without applying a Medicaid Eligibility Rate discount
<b>6</b>	Facilitating Eligibility for Non-Medicaid Programs	<b>0%</b>	Not Claimable
<b>7</b>	Referral, Coordination & Monitoring of Medicaid Services	<b>50%</b>	Population Based
<b>8</b>	Referral, Coordination & Monitoring of Non-Medicaid Services	<b>0%</b>	Not Claimable
<b>9</b>	Transportation & Translation for Medicaid Services	<b>50%</b>	Population Based
<b>10</b>	Transportation & Translation for Non-Medicaid Services	<b>0%</b>	Not Claimable
<b>11</b>	Program Planning, Development & Interagency Coordination of Medical Services	<b>50%</b>	Population Based
<b>12</b>	Program Planning, Development & Interagency Coordination of Non-Medical Services	<b>0%</b>	Not Claimable
<b>13</b>	Medical Related Provider Relations	<b>50%</b>	Population Based
<b>14</b>	Non-Medical Provider Relations	<b>0%</b>	Not Claimable
<b>15</b>	General Administration		Reallocated to other codes using approved methodology
<b>16</b>	Time Not Documented	<b>0%</b>	Not Claimable

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

**OHIO DEPARTMENT OF HEALTH  
MEDICAID ADMINISTRATIVE CLAIMING PROGRAM  
ACTIVITY CODES**

**CODE 1: DIRECT PATIENT CARE**

**Medicaid Rate: U**

All staff may use this code.

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

Examples of activities reported under this code include:

- Direct clinical/treatment services including scheduling, collecting medical history, performing assessment/medical exams, and patient education that is part of a routine office visit;
- Developing treatment plan;
- Providing transportation to medical/dental/mental health services;
- Health screenings and diagnostic evaluations (e.g., orthopedic evaluation, vision screen, and audiological testing services);
- Screening and treating communicable diseases (e.g., STDs, HIV, TB);
- Counseling/therapy services;
- Skills training for medical/dental/mental health services;
- Administering first aid, emergency care, medication, or immunizations;
- Preparing for and cleaning up after screening or medical procedures;
- Submitting billing documents for patient care;
- Performing specialty clinic examinations;
- Performing pregnancy tests;
- Developmental assessments;

- Providing smoking cessation and/or breastfeeding education for pregnant women;  
and
- Participating in chart reviews that include Medicaid-covered services to ensure compliance with medical documentation and forms requirements.

**CODE 2: NON-MEDICAID OTHER PROGRAM AND SOCIAL SERVICE ACTIVITIES**

**Medicaid Rate: U**

All staff may use this code.

This code should be used when performing any activities that are not health related, such as education, employment, job training, social services and other activities or services as well as non-Medicaid health related activities. Includes activities unrelated to the administration of the Medicaid program. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Developing funding proposals for non-Medicaid services;
- Activities related to immunization requirements for school attendance;
- Conducting any public health environmental investigation and education/case management for a child with an elevated blood lead level >9 micrograms/deciliter;
- Providing written lead hazard orders for reduction or abatement of lead hazards;
- Providing orders prohibiting use of a structure as a residence upon failure of a lead clearance examination;
- Providing lead poisoning prevention educational services to parents and guardians of lead poisoned children;
- Teaching first aid or CPR classes;
- Teaching individuals and their family members ways to improve or maintain their health status (e.g., nutrition, physical activity, weight reduction);
- Purchasing food, clothing or other supplies for a client;
- Investigating communicable diseases;
- Administering contracts for Medicaid and non-Medicaid services;
- Providing ODJFS with information about policies governing the WIC program;
- Sharing information with ODJFS on the evaluation of the Help Me Grow Helpline;

- Developing curriculum and training materials on child development for the Help Me Grow program;
- Meeting with child care providers to review state and county policies and procedures;
- Providing non-medical/dental/mental health technical assistance and monitoring of local programs; and
- Preparing for and attending court appearances and any court-related activity.

**CODE 3: MEDICAID OUTREACH**  
**Medicaid Rate: ND**

All staff may use this code. **This code can not be used in the home setting.**

A campaign, program or ongoing activity targeted to 1) bringing potential eligibles into the Medicaid system for the purpose of determining eligibility or 2) bringing Medicaid eligible individuals into specific Medicaid services. Activities may include informing Medicaid eligible or potentially eligible individuals, agencies, and community groups about the range of health services covered by the Medicaid program including preventive or remedial health care services offered by the Medicaid program that may benefit them. Oral or written informing methods may be used. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Use this code 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, such as Healthchek, Medicaid prenatal care, a Medicaid medical home, etc.

A health 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, such as an educational campaign on immunization addressed to parents of Medicaid eligible children. Health education programs or campaigns or component parts of health education programs or campaigns that are general in nature such as oral hygiene education programs, car passenger safety, or antismoking programs should be code 4.

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 for Code 4 (for example, general health education programs such as car passenger safety, lice control, etc).

Examples of activities reported under this code include:

- Providing information to the general population about the Medicaid program to encourage potential Medicaid eligibles to apply for Medicaid;
- Identifying Medicaid eligible pregnant women who are medically-at risk and referring them to seek services through the Medicaid system;
- Providing information to individuals, families, agencies and community groups about Medicaid covered services for the purpose of bringing Medicaid eligibles into Medicaid health care services;
- Providing and presenting materials to explain Medicaid services that are available to Medicaid eligible individuals, such as prenatal health care, or lead testing services for Medicaid eligible children; and

- Informing families with children about the availability of Medicaid services, such as Healthchek, and how to enroll in Medicaid.

**CODE 4: NON-MEDICAID OUTREACH**  
**Medicaid Rate: U**

All staff may use this code.

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

Examples of activities reported under this code include:

- Conducting outreach activities that inform individuals about non-Medicaid health programs and services (e.g., car passenger safety);
- Providing immunization information to the general public;
- Conducting general health education programs or campaigns addressed to the general population (e.g., dental hygiene, antismoking, alcohol reduction, victim assistance and domestic violence);
- Scheduling and promoting activities that educate individuals about the benefits of healthy lifestyles and practices;
- Conducting public health education campaigns on the non-Medicaid aspects of Help Me Grow;
- Providing information about child care resources;
- Activities related to immunization programs required by state law and the associated outreach campaigns; and
- Conducting outreach campaigns that encourage persons 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**

All staff may use this code.

Use this code when assisting an individual in becoming eligible for Medicaid. Includes paperwork, clerical activities, 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 this code include:

- Explaining Medicaid eligibility rules and the eligibility process to prospective applicants;
- Making referrals to local Department of Job and Family Services (DJFS) in order to encourage individuals who are potentially eligible to apply for Medicaid 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; and
- Providing or packaging necessary Medicaid forms needed for the Medicaid eligibility determination.

**CODE 6: FACILITATING ELIGIBILITY FOR NON-MEDICAID PROGRAMS**

**Medicaid Rate: U**

All 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 paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- 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; and
- 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**

All staff may use this code.

**For Medicaid eligible providers: Use Code 1 when conducting any screening, referral, coordination and monitoring that are part of a routine office visit or Targeted Case Management visit and reimbursed as part of the Medicaid program and Targeted Case Management. Activities that are part of direct services or an extension of medical services are not claimable as an administrative activity.**

Use when performing referral, coordination, and monitoring activities that facilitate access to and coordination of Medicaid covered services. Includes identifying the need for and types of medical care an individual needs, making referrals to Medicaid providers, and doing follow up or monitoring to assess individual's progress. This includes consultation with other providers to access Medicaid services for a client. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Gathering information that may be required in advance of- medical/dental/mental health referrals;
- Monitoring the implementation of the plan of care, e.g., appointments with referral specialists are completed, test results are forwarded to treating physician;
- Identifying and referring individuals who may be in need of Medicaid family planning services;
- Referring and/or coordinating scheduled medical or physical examinations and necessary medical/dental/mental health evaluations;
- Referring and/or scheduling Healthchek screens, interperiodic screens and appropriate immunizations;
- Arranging for any diagnostic or treatment services, which may be required as the result of a condition identified during the child's Healthchek screen;
- Working with children, their families, other staff and providers to identify, arrange for, and coordinate services covered under Medicaid that may be required as the result of screens, evaluations or examinations;
- Referring individuals for necessary medical health, dental, mental health or substance abuse services covered by Medicaid;

- Assisting families of medically fragile children to establish a “medical home” and to access other necessary medical/dental/mental health services;
- Providing follow-up contact to ensure that an individual has received the prescribed medical dental/mental health service and to provide feedback whether further medical services is required;
- Providing follow-along activities that ensure high-risk populations (e.g., substance abusing pregnant women or new mothers, frail elderly, individuals with tuberculosis, etc.) achieve positive health outcomes;
- Participating in case conferences or multi-disciplinary teams to review an individual’s health-related needs and plans and to coordinate medical and health-related care and services;
- Participating in consultation to individuals to assist them in understanding and identifying health problems or conditions and in recognizing the value of preventive and remedial health care when this activity is not an integral part or an extension of a medical service;
- Assessing, the need for and adequacy of medical care services, including related consultation with individuals and medical providers, when not part of a medical visit or other Medicaid billable service;
- Reviewing the results of medical/dental/mental health assessments and evaluations needed to coordinate and sequence services and to facilitate referrals that meet the client’s needs, when not part of a medical visit or other Medicaid billable service;
- Facilitating the exchange of relevant and timely information among providers and family members regarding the individual’s complex medical/dental/mental health problem, when not part of a medical visit or other Medicaid billable service;
- Consulting with other medical specialists, about the necessity for adequacy and sequencing of care or treatment of specific conditions;
- Consulting with the client to improve the client’s understanding of complex medical issues and how they relate to the coordination of services;
- Monitoring of individual medication management and service authorization for medical care covered by Medicaid when the provider is not billing Medicaid for these services;
- Monitoring the interdisciplinary care plan for medical services when the provider is not billing Medicaid for these services;

- Linking women to ongoing contraceptive care; and
- Assessing the necessity for and adequacy of medical care and services provided, as in quality improvement activities such as:
  - quality assurance reviews
  - peer reviews
  - special studies
  - standards of practice
  - best practices

**CODE 8: REFERRAL, COORDINATION AND MONITORING OF NON-MEDICAID SERVICES**  
**Medicaid Rate: U**

All staff may use this code.

Use when performing referrals, coordinating, and/or monitoring the delivery of social, educational, legal, or other services not covered by Medicaid. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Making referrals for and coordinating access to social and educational services such as child care, employment, job training, clothing assistance, and housing;
- Making referrals for, coordinating and monitoring the delivery of school and/or community based health screens (vision, hearing, scoliosis);
- Gathering information from individuals to determine the kinds of social services that may be needed;
- Providing information to another provider about non-Medicaid services being provided to an individual; and
- Providing follow up to ensure whether individuals received social services such as housing, income assistance, domestic violence services, after school services, and child care.

**CODE 9: TRANSPORTATION AND TRANSLATION FOR MEDICAID SERVICES**

**Medicaid Rate: D**

All staff may use this code.

Use when assisting an individual to access services covered by Medicaid through arranging or scheduling (by car, taxi, van bus, etc., but not an ambulance) to a Medicaid covered service or accompanying the individual to a Medicaid service. Includes paperwork, clerical activities, 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.

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

Non-Medicaid transportation and translation services should be reported under Code 10.

Examples of activities reported under this code include:

- Scheduling and/or arranging recipient transportation to Medicaid covered services as the result of an evaluation or examination;
- Accompanying a Medicaid eligible individual to a medical appointment that is Medicaid covered service;
- 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; and
- Developing translation materials that assist individuals to access and understand necessary care or treatment covered by Medicaid.

**CODE 10: TRANSPORTATION AND TRANSLATION FOR NON-MEDICAID SERVICES**

**Medicaid Rate: U**

All staff may use this code.

Use when assisting an individual to access services not covered by Medicaid through arranging, scheduling or providing transportation, accompanying the individual to a non-Medicaid service, and obtaining translation services so the individual can access a non-Medicaid service.

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.

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

Examples of activities reported under this code include:

- Scheduling or arranging transportation to social, vocational, and/or educational programs;
- Scheduling weekly bus transportation for seniors to the senior center;
- Arranging transportation for a pregnant woman to WIC appointments;
- Arranging for or providing translation services (oral and/or signing services) that assist the individual to access and understand social, educational, and vocational services; and
- Developing translation materials that assist individuals to access and understand social, educational, and vocational services.

**CODE 11: PROGRAM PLANNING, DEVELOPMENT AND INTERAGENCY  
COORDINATION OF MEDICAL SERVICES**  
**Medicaid Rate: D**

All staff, whose job descriptions or duty statements include responsibilities for program planning, policy development, and interagency coordination, may use this code.

Planning and development of services, programs and resources that relate to Medicaid covered medical/dental/mental health services, such as the development of policy, procedures and protocols for the delivery and coordination of care to individuals. Use this code for collaborative activities that involve planning and resource development with other agencies, which will improve the availability and quality of medical/dental/mental health services and the cost-effectiveness of the health care delivery system. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Working with other agencies providing Medicaid services to improve the coordination and delivery of services, to expand their access to specific populations of Medicaid eligible, and to improve collaboration around the early identification of medical/dental/mental health problems;
- Assessing the capacity of the agency and its providers to deliver accessible Medicaid covered medical/dental/mental health assessment, treatment and care services to Medicaid eligibles and identifying potential barriers and needs;
- Assessing the capacity of providers to deliver Medicaid covered health assessment, preventive health services and medical care;
- Reducing overlaps and duplication in Medicaid services, and closing gaps in the availability of services, especially for children;
- Planning programs and services to meet the identified needs of high-risk populations of Medicaid eligibles served by the agency and its providers;
- Interagency coordination to improve the delivery of Medicaid services;
- Collecting and analyzing Medicaid data related to population group 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 services including Medicaid services within a community, such as identifying the need for and working with local providers to expand prenatal and obstetric services to Medicaid eligible individuals or ensuring that residents in a community where a Medicaid provider(s) is closing or leaving have ongoing access to medical care;
- Developing plans for expansion of Medicaid-covered services;
- Coordinating efforts to improve access to Medicaid covered medical/dental/mental health services to specific populations or geographic areas that are under-served;
- Interpreting and using medical statistical data from Medicaid claims data and other health services data system to forecast services utilization, and close gaps in medical services;
- Participating in interagency coordination efforts where medical expertise is needed to identify barriers to care and patient management issues around specific medical conditions;
- Participating in interagency coordination with other medical providers, to improve the medical aspects of Medicaid services, or to plan or monitor the delivery of Medicaid-covered medical services; and
- Developing strategies with other medical providers and other health care agencies to improve access to care and service utilization for high risk, high cost populations with complex medical needs;

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

**Medicaid Rate: U**

All staff may use this code.

Use when performing activities associated with the development of strategies to improve the coordination and delivery of non-medical services, including educational, social, vocational, and other services and when performing collaborative activities with other agencies. Includes paperwork, clerical activities, related staff travel or training.

Examples of activities reported under this code include:

- Identifying gaps or duplication of other non-medical services (e.g., social, vocational, and educational programs) and developing strategies to improve the coordination;
- Evaluating the need for non-medical services in relation to specific populations or geographic areas;
- Analyzing non-medical data related to a specific program, population or geographic area of these services;
- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services;
- Planning, developing, conducting and/or attending training that promotes community collaboration and developing non-medical services in the community;
- Developing interagency policies and procedures for non-medical programs and services;
- Participating in community planning efforts to close gaps in social services such as housing, childcare, and after school programs;
- Attending interagency meetings to develop strategies for increasing non-medical programs or services such as early child care and education programs;
- Writing proposals for non-medical care services such as smoking cessation and domestic violence;
- Conducting external relations (e.g., site visits to police departments, domestic violence services, nutrition programs);

- Coordinating with interagency committees to identify, promote and develop non-medical services; and
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services.

**CODE 13: MEDICAL RELATED PROVIDER RELATIONS**  
**Medicaid Rate: D**

All staff may use this code.

Use this code when performing activities to secure and maintain the pool of eligible Medicaid (medical/dental/mental health) providers. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Recruiting new medical/dental/mental health providers into the Medicaid Program;
- Providing information and technical support to providers on medical policy and regulations;
- Developing medical service/provider directories for those who provide services to targeted population groups e.g., Healthchek children, pregnant women;
- Providing technical assistance and support to providers;
- Working with medical resources, such as managed care plans, to locate and develop health services referral relationships;
- Monitoring effectiveness of programs providing Medicaid-covered services, including client satisfaction surveys for medical/dental/mental health services; and
- Developing future referral capacity with specialty medical care providers by discussing medical health programs, including client needs and service delivery requirements.

**CODE 14: NON-MEDICAL PROVIDER RELATIONS**  
**Medicaid Rate: U**

All staff may use this code.

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

Examples of activities reported under this code include:

- Recruiting non-medical providers, (e.g., child care, domestic violence, food pantry);
- Recruiting with outside agencies regarding social and education programs, for example agencies that assist with childcare and housing assistance;
- Providing technical assistance and support to new non-medical staff, including orientation;
- Developing staff directories; and
- Developing non-medical referral sources.

**CODE 15: GENERAL ADMINISTRATION**  
**Medicaid Rate: R**

All staff may use this code.

Performing general administrative activities (i.e., those that are not specific to any identified function or that relate to multiple functions of the agency) and paid time off. This coding is used by program staff that is not included in the federally approved indirect cost rate.

Examples of activities reported under this code include:

- Attending or facilitating general agency or unit staff meetings or board meetings;
- Developing and monitoring agency or program budgets;
- Providing general supervision of staff and employee performance reviews;
- Processing payroll/personnel-related documents;
- Maintaining inventories and ordering supplies;
- Reviewing or writing agency, departmental or unit policies and procedures;
- Conducting health promotion activities for staff;
- Providing or attending training;
- Providing or attending general in-services or training, including new employee orientation or supervision or computer training;
- Paid breaks;
- Paid jury duty;
- Vacation, sick leave, holiday time, compensatory time; and
- Filing out MAC time study.

**CODE 16: TIME NOT DOCUMENTED**  
**Medicaid Rate: U**

All staff may use this code. The time study participant's supervisor can use this code if there is time not documented.

- Use to document the time staff identified to participate in the time study either do not complete the time study or cannot produce their time study log.