2025

Alaska No Wrong Door (NWD) Medicaid Administrative Claiming (MAC) Operations Manual

Alaska Department of Health, Division of Senior & Disabilities Services

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CONTENTS

Introduction and Overview

The Alaska Department of Health (DOH), Division of Senior & Disabilities Services (SDS) is the lead agency coordinating the statewide No Wrong Door (NWD) network. This network includes the Aging & Disability Resource Centers (ADRCs), Developmental Disability Resource Connections (DDRCs), the Infant Learning Program (ILP), and other agencies. The goal of the NWD network is to streamline navigation of and access to long term services and supports (LTSS) and other disability services. This includes providing information and assistance (I&A), LTSS options counseling, service coordination and monitoring, application assistance, and more.

Because Medicaid is funded at both the State and federal levels, SDS and the NWD agencies are eligible for Medicaid Administrative Claiming (MAC), which reimburses for a portion of the costs of activities that support the efficient administration of Alaska's Medicaid system.

To participate in MAC, SDS determines what portion of an employee's time is Medicaid related using a random moment time study (RMTS) and compiles expenditure information provided by the NWD agencies. This expenditure information documents fully loaded staff time as defined within the *Cost Categories* section of this document.

Overview of the Random Moment Time Study (RMTS)

SDS documents the portion of time that is Medicaid related using an RMTS. A stratified random sample approach is used, under which each time study participant receives one emailed survey during the morning hours and another during the afternoon hours of each working day. The survey contains codes that document the activity staff were performing at the random moment and identify whether it was Medicaid related.

The RMTS is used not only to provide a statewide estimate of Medicaid-related activities, but also to provide accurate payments to each of the agencies participating in the time study and to assist in overseeing the performance of individual time study participants. Because a simple randomized sampling approach would result in clusters of samples and gaps in data for other analyses, a stratified random sampling methodology was selected. The survey stratification methodology allows for the random sample to be obtained twice per day at any minute within the agency's operating hours.

The SDS RMTS sampling methodology is constructed to exceed a confidence level of 95 percent with precision level of ±2 percent, which would require a minimum sample of 2,401 observations per quarter. The sample size obtained from the twice daily random moment sample approach far exceeds sampling standards used for other MAC RMTS. SDS is sampling at this level for NWD because 1) participants are able to more accurately code time when they are sampled on a daily basis and 2) the sampling framework allows for analyses at the agency and

employee level that play a role in the quality assurance process. A stratified random sampling approach is also used to ensure that surveys are received at regular intervals and avoid clustering.

SDS summarizes the data on a monthly and quarterly basis and provides management reports to each of the participating agencies to help ensure that the data are accurate.

Overview of the Cost Pool

At the end of each quarter, each NWD agency completes a cost report for all staff participating in the RMTS. Each NWD agency will be required to use the methodology defined within this manual to report individual staff costs using the standardized MAC cost pool spreadsheet. These individual staff costs are aggregated into an agency cost pool within the spreadsheet.

SDS then aggregates these reports into the statewide cost pool and translates this information into the statewide quarterly claim report. This report:

1. Tabulates and summarizes the time study data to identify the percentage of time participants spent performing federally-approved claimable activities;
2. Identifies the proportion of cost pool expenditures that are eligible for reimbursement and determines whether there is sufficient match; and
3. Calculates the quarterly statewide claim that will be submitted to the Centers for Medicare & Medicaid Services (CMS) for reimbursement.

Prior to filing SDS' quarterly claim, an authorized SDS official reviews the submissions and certifies the claim calculation.

Random Moment Time Study

Participating Staff

Staff at each of the NWD agencies who perform activities included within the RMTS coding taxonomy participate in the RMTS. Each agency and SDS will coordinate to identify staff to participate in the RMTS. Additionally, SDS conducts quality reviews of RMTS participant responses and works with the NWD agencies to make sure that staff participation is accurate and appropriate.

Staff participating in the RMTS include staff performing intake and screening, service coordinators, aging specialists, supervisors, front desk staff who perform triage for the agency, and other staff performing reimbursable activities.

Random Sampling Precision and Required Confidence Level

The SDS NWD RMTS sampling methodology is constructed to exceed a confidence level of 95 percent with a precision level of ±2 percent, which would require a minimum sample of 2,401

observations per quarter. Each time study participant receives two surveys a day; one sent at a random moment during the morning hours and one during afternoon hours. While the actual sample size varies depending upon the number of staff participating, the quarterly sample size with 50 NWD staff would be approximately 6,000 observations (50 staff X 40 surveys per month per staff X 3 months per quarter).

RMTS quarters are defined as:

- January-March
- April-June
- July-September
- October-December

The RMTS is ongoing, and agencies submit a new cost pool that reflects the costs associated with each staff participating in the RMTS each quarter. A single statewide quarterly cost report is derived from the RMTS and cost pool each quarter.

Completing the RMTS

A. Time Study Codes

Exhibit 1 provides the time study codes, which have been broken down into nine higher level codes.

Most of the activity codes include at least two sub-codes to assist with identifying whether the activity performed by staff is Medicaid related. There are two categories of sub-codes:

- **Medicaid Related -** This sub-code type is used for activities including Application Assistance, Outreach, Staff Training, and Program Administration. Many discussions that occur as part of these activities cover a breadth of topics. If Medicaid was part of the discussion or support with accessing Medicaid occurred, the entire activity is considered Medicaid related.
    - **Sub-code 1: Medicaid Related-** Includes a discussion of Medicaid or a service covered under Medicaid or support accessing a Medicaid service under one of the qualifying activities.
    - **Sub-code 2: Not Medicaid Considered/Related-** Discussion of or access to programs not funded by Medicaid or a service not covered under Medicaid.
    - **Sub-code 3: Not Tied to a Specific Program-** Did not discuss or provide access to a specific program or service and cannot attach to Medicaid or non-Medicaid**.**
- **Enrolled in Medicaid -** This is used for activities including Information & Assistance, Options Counseling, Service Coordination & Monitoring, Special Instruction: Individual, and Interdisciplinary Coordination. The breakout of the sub-codes varies by the activity, however the general summary includes:
    - **Sub-code 1: Enrolled in Medicaid-** Assisting an individual who is currently enrolled in or applying for Medicaid.
    - **Sub-code 2: At risk of spenddown/institutionalization-** Assistance may prevent or delay the individual from entering a nursing facility or other Medicaid-funded institution. It must be documented that the individual meets the Spenddown Worksheet criteria. More information about this can be found in subsequent sections.
    - **Sub-code 3: At Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs-** Select NWD agencies work with children and families to develop skills that will likely reduce costs to the Medicaid system later in the child's life. Time spent providing this support that is not otherwise reimbursed is eligible for MAC. More information about this can be found in subsequent sections.

- **Sub-code 4: Not Enrolled in Medicaid or at risk of spenddown and institutionalization-** Assisting an individual who is not currently enrolled in or applying to Medicaid AND is not at risk for spenddown and/or institutionalization.

In *Exhibit 1*, codes highlighted in yellow are Medicaid related and MAC reimbursable. Codes highlighted in teal are not Medicaid related and not MAC reimbursable. Codes highlighted in gray are neutral General Administration codes.

Exhibit 1: MAC Time Study Codes

1. Activities reimbursable directly by another source
1a. Reimbursable directly by another source- Occupational Therapy
1b. Reimbursable directly by another source- Physical Therapy
1c. Reimbursable directly by another source- Speech/Language Therapy
1d. Reimbursable Directly by Another Source- Other
2. Information & Assistance (I&A)
2a. Medicaid Enrolled
2b. Not Medicaid Enrolled- Medicaid Considered
2c. Not Medicaid Enrolled- Medicaid Not Considered
2d. Medicaid Enrollment Status Unknown- Medicaid Considered
2e. Medicaid Enrollment Status Unknown- Medicaid Not Considered
3. Person Centered Intake (PCI)
4. Options Counseling
4a. Medicaid Enrolled
4b. Medicaid considered as an option
4c. At risk of spenddown & institutionalization
4d. Child at Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs
4e. Not Medicaid Enrolled or Considered
5. Service Coordination & Monitoring
5a. Referred to ILP or Seeking ILP Services
5a.1 Medicaid Enrolled – Enrolled in ILP
5a.2 Medicaid Enrolled- NOT Enrolled in ILP
5a.3 Child at Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs
5a.4 Not Medicaid enrolled
5b. Not Referred to ILP or Seeking ILP Services
5b.1 Medicaid Enrolled
5b.2 At risk of spenddown & institutionalization
5b.3 Child at Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs

5b.2 Not Medicaid Enrolled
6. Special Instruction: Individual
6a. Enrolled in Medicaid
6b. Child at Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs
6c. Non-Medicaid
7. Application Assistance
7a. Medicaid Related
7b. At risk of spenddown & institutionalization and program will keep person in the community
7c. Child at Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs and program will keep person in the community
7d. Not Medicaid Related
8. Interdisciplinary Coordination
8a. Medicaid Enrolled – Enrolled in ILP
8b. Medicaid Enrolled- NOT Enrolled in ILP
8c. Child at Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs
8d. Not at risk of going onto Medicaid
9. Travel Time
9a. Associated with an activity that is Medicaid related
9b. Associated with an activity that is NOT Medicaid related
10. Outreach/Group Special Instruction
10a. Medicaid Related
10b. Not Medicaid Related
10c. Not Tied to a Specific Program
11. Staff Training
11a. Related to Medicaid or a Medicaid Funded Service
11b. Related to a program or service that is not funded by Medicaid
11c. Not tied to a specific program
12. Program Planning or Administration
12a. Related to Medicaid or a Medicaid Funded Service
12b. Related to a program or service that is not funded by Medicaid
12c. Not tied to a specific program
13. Activities Related to Medicaid Administrative Claiming (MAC)
14. General Administration
15. Other

B. At Risk of Medicaid Spenddown

A major function of the NWD agencies is to work with people with LTSS and other disability support needs who are not yet enrolled in Medicaid to help them find resources and develop a plan for remaining in the community. This assistance prevents or delays the use of Medicaid-funded LTSS and other supports in many cases. Therefore, the NWD agencies have a standardized methodology to identify people who are at risk of spending down to Medicaid because they are at risk of going into an institution.

There are two types of at-risk categories:

- **At Risk of Medicaid Spenddown and Institutionalization-** Used with participants age 19 and older, the participant is not yet eligible for Medicaid but a six-month nursing facility stay would deplete their income and assets to the point where they would be financially eligible for Medicaid. Must have one or more documented activity of daily living (ADL) or instrumental activity of daily living (IADL) impairment and meet spenddown criteria
- **At Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs-** Used with participants under the age of 19. Because Alaska operates the TEFRA program, which disregards parental income and assets, participants meet this category if they 1) are not on Medicaid; 2) meet functional criteria; and 3) meet financial criteria for TEFRA

At Risk of Medicaid Spenddown & Institutionalization- Ages 19+

Time spent helping these individuals remain in the community are tracked using "At risk of Medicaid spenddown and institutionalization" sub-codes. To use this subcode, staff participating in the time study make sure that there is documentation that the individual needing LTSS has impairment in at least one ADL or IADL and has income and countable assets that would be depleted by a private pay nursing stay of six months or longer.

Considerations for financial thresholds include the minimum monthly maintenance needs, community spouse minimum and maximum standards, six-month nursing facility costs for a private room, personal needs allowance, medical assistance individual asset disregard, and Medicare premiums. The underlying assumptions for calculating these amounts are updated on an annual basis.

NWD staff should document the income and asset information that established risk of spenddown in the Microsoft Excel-based spenddown spreadsheet.

At Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs- Less Than Age 19

NWD agencies work with children and families to develop skills that will likely reduce costs to the Medicaid system later in the child's life. Time spent providing this support that is not otherwise reimbursed is eligible for MAC.

To receive MAC reimbursement, it must be documented that these three criteria are all met:

1) The child is not enrolled in Medicaid;
2) The child meets one or more of the following criteria
    a. Has a developmental disability or delay AND
        i. is not meeting developmental milestones; **or**
        ii. is diagnosed with a serious health condition that would require frequent healthcare interventions on a daily to weekly basis
    b. Has a genetic disorder and/or medical condition that limits their ability to perform one or more activities or daily living compared to a child of a similar age without the genetic disorder or medical condition
3) The child meets the financial criteria for TEFRA- Disabled children at home as promulgated by the Alaska Division of Public Assistance. This criteria only considers the income and resources of a child, NOT the parents or other responsible adults.

All income and resource information is based on family self-report. Note that any payments received as part of the Alaska Permanent Fund Dividend (PFD) **do not** count towards the child's financial income or resources as referenced in the Alaska Division of Public Assistance guidance found at http://dpaweb.hss.state.ak.us/manuals/adltc/adltc.htm#t=addenda%2Faddendum_3.htm&rhsearch=permanent%20fund%20dividend&ux=search

If a child meets these criteria, the "Child at Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs" sub-code should be selected. If these criteria are not met and the child is not on Medicaid, the child has not met the at-risk requirements and should be coded as "not Medicaid enrolled".

C. Definition of Codes

The following table provides the draft code definitions.

Exhibit 2: Alaska MAC Activity Codes and Definitions

1. Activities Reimbursed Directly by Another Source
Use when performing an activity that is directly reimbursed by another source, such as Medicaid or private insurance. Only use this code if this activity is explicitly tied to payment (e.g., the worker bills directly for the time). **Activities Include:** • Direct services reimbursable on a unit or encounter basis

- Occupational Therapy that is directly reimbursed by Medicaid, private insurance, or another source
- Physical Therapy that is directly reimbursed by Medicaid, private insurance, or another source
- Speech Therapy that is directly reimbursed by Medicaid, private insurance, or another source

Do <u>not</u> use this code to account for situations in which a portion of the staff member's salary is paid for by another source (this will be addressed as part of establishing the cost pool).

2. Information & Assistance (I&A)

This code includes all activities related to providing the participant with basic and brief information and referral to another resource.

Activities include:

- Searching an information and referral database
- Following up with other agencies, staff, or supervisors to identify appropriate referral point
- Documenting referrals in an electronic referral tracking database
- Monitoring the status of referrals

This code should be used for all activities related to I&A, including:

- Paperwork
- Clerical activities, including making copies of related materials and faxing related information
- Time spent reviewing voicemails or emails
- Conducting research on related topics
- Time spent consulting with a supervisor or co-workers or supervising
- Time spent arranging travel but excluding travel time
- Time spent entering information about the activity into a database or software program
- Calls, emails, or other communications to obtain clarification of an inquiry

2a. Medicaid Enrolled- Assisting an individual who is currently enrolled in or applying for Medicaid.

2b. Not Medicaid Enrolled- Medicaid Considered- Assisting an individual who is not currently enrolled in or applying for Medicaid AND considering a referral for Medicaid or any Medicaid-funded service as part of the interaction. It is not necessary to make a referral.

2c. Not Medicaid Enrolled- Medicaid Not Considered- Assisting an individual who is not currently enrolled in or applying for Medicaid AND not considering any referrals to Medicaid or a Medicaid-funded service as part of the interaction.

2d. Medicaid Enrollment Status Unknown- Medicaid Considered- Assisting an individual and their Medicaid enrollment status is not known AND considering a referral for Medicaid or any Medicaid-funded service as part of the interaction. It is not necessary to make a referral.

2e. Medicaid Enrollment Status Unknown- Medicaid Not Considered- Assisting an individual and their Medicaid enrollment status is not known AND not considering any referrals to Medicaid or a Medicaid-funded service as part of the interaction.

3. Person Centered Intake (PCI)

Working with the family, supports, health care practitioners, and other sources of information to complete the PCI. The PCI is intended to screen for services provided by Medicaid, such as waiver, Community First Choice (CFC), and State Plan services, as well as resources funded by other sources.

All tasks related to the PCI should be considered, including:

- Scheduling a PCI appointment
- Completing the PCI
- Entering PCI information into an automated system
- Following-up with supports to obtain additional information
- Finalizing PCI information and next steps

This code should be used for all activities related to the PCI, including:

- Paperwork
- Clerical activities, including making copies of related materials and faxing related information
- Time spent reviewing voicemails or emails
- Conducting research on related topics
- Time spent consulting with a supervisor or co-workers or supervising
- Time spent arranging travel but excluding travel time
- Time spent entering information about the activity into a database or software program
- Calls, emails, or other communications to obtain clarification of an inquiry

4. Options Counseling

Assisting an eligible individual in need of long-term services and supports (LTSS) and their representatives to make informed choices about the services and settings which best meet his or her long-term care needs and encourages the widest possible use of community-based

options to allow an eligible individual to live as independently as possible in the setting of their choice.

This code should be used for all activities related to options counseling, including:

- Paperwork
- Clerical activities, including making copies of related materials and faxing related information
- Time spent reviewing voicemails or emails
- Conducting research on related topics
- Time spent consulting with a supervisor or co-workers or supervising
- Time spent arranging travel but excluding travel time
- Time spent entering information about the activity into a database or software program
- Calls, emails, or other communications to obtain clarification of an inquiry

4a. Medicaid Enrolled- Assisting an individual who is currently enrolled in or applying for Medicaid.

4b. Medicaid Considered- Working with a participant who is NOT on Medicaid and considering a referral for Medicaid or any Medicaid-funded service as part of the interaction. It is not necessary to make a referral.

4c. At Risk of Spenddown & Institutionalization: Age 19+- Assisting an individual in accessing supports that may prevent or delay the individual from entering a nursing facility or other Medicaid-funded institution. It must be documented that the individual meets the Spenddown Worksheet criteria.

4d. Child at Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs- Performing options counseling for a child not currently enrolled in Medicaid AND meets both the following functional and financial criteria:

- **Functional:** It must be documented that the child meets one or more of the Child at Risk of Adverse Outcomes criteria
- **Financial:** Meets the financial eligibility criteria for the TEFRA program (TEFRA functional criteria not considered for this purpose)

4e. Not Medicaid Enrolled or Considered- Assisting an individual in accessing supports who is NOT currently enrolled in or applying for Medicaid; does not meet spenddown or at-risk criteria; and did not consider a referral for Medicaid or any Medicaid-funded service as part of the interaction.

5. Service Coordination and Monitoring

Includes activities to assist/enable a participant to receive rights, procedural safeguards, and services within the NWD network and related state agencies and community providers. Also

includes short term assistance, ongoing support, and monitoring of the outcomes of referrals and services to ensure they are appropriately accessed.

This code should be used for all **activities related to service coordination and monitoring**, including:

- Paperwork
- Clerical activities, including making copies of related materials and faxing related information
- Time spent reviewing voicemails or emails
- Conducting research on related activities
- Time spent arranging travel but excluding travel time
- Time spent consulting with a supervisor or supervising
- Time spent entering information about the activity into a database or software program

5a. Referred to ILP or Seeking ILP Services

5a.1 Medicaid Enrolled – Enrolled in ILP- Providing service coordination and monitoring to a family of a child who is both actively enrolled in Medicaid and ILP.

5a.2 Medicaid Enrolled- NOT Enrolled in ILP- Providing service coordination and monitoring to a family of a child who is actively enrolled in Medicaid but is not currently enrolled in ILP. This includes pre-enrollment support, such as discussing eligibility criteria, service options, and enrollment guidance.

5a.3 Child at Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs- Providing service coordination and monitoring support to a family of a child not currently enrolled in Medicaid AND meets both the following functional and financial criteria:

- **Functional:** It must be documented that the child meets one or more of the Child at Risk of Adverse Outcomes criteria
- **Financial:** Meets the financial eligibility criteria for the TEFRA program (TEFRA functional criteria not considered for this purpose)

5a.4 Not at risk of going onto Medicaid - Providing service coordination and monitoring to a family of a child who is not actively enrolled in Medicaid or ILP and does not meet the Child at Risk of Adverse Outcomes criteria.

5b. Not Referred to ILP or Seeking ILP Services

5b.1 Medicaid Enrolled- Providing service coordination and monitoring to an individual who is currently enrolled in or applying for Medicaid.

5b.2. At Risk of Spenddown & Institutionalization: Age 19+- Providing service coordination and monitoring to an individual in accessing supports that may prevent or delay the individual from entering a nursing facility or other Medicaid-funded institution. It must be documented that the individual meets the Spenddown Worksheet criteria.

5b.3. Child at Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs- Providing service coordination and monitoring for a child not currently enrolled in Medicaid AND meets both the following functional and financial criteria:

- **Functional:** It must be documented that the child meets one or more of the Child at Risk of Adverse Outcomes criteria
- **Financial:** Meets the financial eligibility criteria for the TEFRA program (TEFRA functional criteria not considered for this purpose)

5b.4. Not Medicaid Enrolled or Considered- Providing service coordination and monitoring for an individual in accessing supports who is NOT currently enrolled in or applying for Medicaid; does not meet spenddown or at-risk criteria; and did not consider a referral for Medicaid or any Medicaid-funded service as part of the interaction.

6. Special Instruction: Individual

Includes design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, including cognitive, social emotional, communication, self-help and motor skills.

This code should also be used when OT, PT, or speech services are provided for individuals who do not have insurance coverage, and the activity is not reimbursed by Medicaid, private insurance, or another source. Services that are reimbursed directly by Medicaid, private insurance, or another source should be coded under *Reimbursed directly by another source*.

Activities Include:

- Planning interaction of personnel, materials, and time and space, that leads to achieving outcomes in the child's IFSP
- Providing families with information, skills and support related to enhancing skill development of the child
- Working with the child to enhance child's development.

This code should be used for all **activities related to Special Instruction**, including:

- Paperwork
- Clerical activities, including making copies of related materials and faxing related information
- Time spent reviewing voicemails or emails
- Conducting research on related topics
- Time spent consulting with a supervisor or co-workers or supervising
- Time spent arranging travel but excluding travel time
- Time spent entering information about the activity into a database or software program
- Calls, emails, or other communications to obtain clarification of an inquiry

6a. Enrolled in Medicaid- Assisting an individual who is currently enrolled or applying for Medicaid.

6b. Child at Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs- Providing support to a family of a child **not currently enrolled in Medicaid** AND meets both the following functional and financial criteria:

- **Functional:** It must be documented that the child meets one or more of the Child at Risk of Adverse Outcomes criteria
- **Financial:** Meets the financial eligibility criteria for the TEFRA program (TEFRA functional criteria not considered for this purpose)

6c. Non-Medicaid- Assisting an individual who is not currently enrolled in or applying to Medicaid AND does not meet the Child at Risk of Adverse Outcomes criteria.

7. Application Assistance

Includes activities related to assisting individuals or families with the application process for LTSS, health care services, and other supports that may assist an individual to remain in the community (e.g., income supports, energy assistance, etc.). Relevant activities include:

- Explaining the eligibility rules and process to individuals, family members, or other representatives.
- Assisting an individual or family member to collect/gather information and documents for program applications.
- Assisting an individual or family in completing program applications.
- Activities that assist in the initial and continuing eligibility for programs.
- Providing necessary forms and other materials in preparation for eligibility determination.

This code should be used for all activities related to facilitating applications, including:

- Paperwork
- Clerical activities, including making copies of related materials and faxing related information
- Time spent reviewing voicemails or emails
- Conducting research on related topics
- Time spent consulting with a supervisor or co-workers or supervising
- Time spent arranging travel but excluding travel time
- Time spent entering information about the activity into a database or software program
- Calls, emails, or other communications to obtain clarification of an inquiry

7a. Medicaid Related- Use when assisting with applications for Medicaid or referring individuals/families/other representatives to the appropriate agency to complete an application regardless of their ultimate Medicaid eligibility. Applies to assisting participants

with verification of current Medicaid status and working with an individual to maintain Medicaid eligibility. Also use this code when assisting with completing an application that determines eligibility for multiple programs, one of which is Medicaid.

7b. At risk of spenddown & institutionalization and program will keep person in the community- Providing application assistance to an individual in accessing supports that allow the individual to remain in the community and avoid entering an institution. It must be documented that the individual meets the Spenddown Worksheet criteria.

7c. Child at Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs and program will keep person in the community- Providing application assistance to an individual in accessing supports that allow the individual to remain in the community and avoid entering an institution. Individual must meet both of the following functional and financial criteria:

- **Functional:** It must be documented that the child meets one or more of the Child at Risk of Adverse Outcomes criteria
- **Financial:** Meets the financial eligibility criteria for the TEFRA program (TEFRA functional criteria not considered for this purpose)

7d. Not Medicaid Related- Use when assisting an individual or family to complete an application for non-Medicaid program that do not directly support the individual with remaining in the community and avoiding institutionalization or referring them to the appropriate agency to complete an application for those programs.

8. Interdisciplinary Coordination- Case review and discussion performed by relevant professionals (e.g., OT/PT/SLP/SW/Developmental Therapist) to improve outcomes and access to resources for individuals.

Examples:

- IFSP development and discussion
- Treatment team meetings
- Transition meetings
- Child Outcome Summary process

This code should be used for all **activities related to interdisciplinary coordination**, including:

- Paperwork
- Clerical activities, including making copies of related materials and faxing related information
- Time spent reviewing voicemails or emails
- Conducting research on related topics
- Time spent consulting with a supervisor or co-worker or supervising
- Time spent arranging travel but excluding travel time
- Time spent entering information about the activity into a database or software program
- Calls, emails, or other communications to obtain clarification of an inquiry

8a. Medicaid Enrolled – Enrolled in ILP- Performing interdisciplinary coordination for child who is both actively enrolled in Medicaid and ILP.

8b. Medicaid Enrolled- NOT Enrolled in ILP- Performing interdisciplinary coordination for a child who is actively enrolled in Medicaid but is not currently enrolled in ILP.

8c. Child at Risk of Adverse Outcomes that Likely Increase Future Medicaid Costs- Performing interdisciplinary coordination for a child not currently enrolled in Medicaid AND meets both the following functional and financial criteria:

- **Functional:** It must be documented that the child meets one or more of the Child at Risk of Adverse Outcomes criteria
- **Financial:** Meets the financial eligibility criteria for the TEFRA program (TEFRA functional criteria not considered for this purpose)

8d. Not at risk of going onto Medicaid - Performing interdisciplinary coordination for a child who is not actively enrolled in Medicaid or ILP and does not meet the Child at Risk of Adverse Outcomes criteria.

9. Travel Time

Time spent actively traveling on behalf of the Alaska Division of Senior and Disabilities Services (SDS) or No Wrong Door (NWD) agency, including to perform tasks or provide support as part of responsibilities under a grant, contracted role, or other agreement with SDS or the NWD agency.

9a. Associated with an activity that is Medicaid related- Time spent actively traveling on for a Medicaid related activity or encounter with an individual who is Medicaid enrolled.

9b. Associated with an activity that is NOT Medicaid related- Time spent actively traveling for an activity that is not Medicaid related or an encounter with an individual who is not Medicaid enrolled.

10. Outreach/Group Special Instruction

An interactive activity that conveys information about available services and supports. This also includes group special instruction activities that engage the community, support child development, and teach parents skills to help their child develop and learn.

Outreach activities include:

- Informing individuals and family members of the benefits offered by different programs.
- Assisting in identifying participants who could benefit from program offerings or other relevant services. This includes developmental screening events, such as vision and hearing screening.
- Disseminating or presenting program information to inform individuals and family members and partners about services and where to obtain services.
- Developing marketing/program education materials, such as brochures, or other materials needed to support outreach events and activities.

- Providing information and education about Medicaid.

Group special instruction activities include:

- Planning, preparing, and facilitating playgroups.
- Planning, preparing, and facilitating outings or field trips to community locations.
- Planning, preparing, and facilitating special events for family participation.
- Planning, preparing, and facilitating parent education classes to teach skills related to supporting a child with a disability or other relevant topics.

This code should be used for all activities **related to outreach and group special instruction**, including:

- Paperwork
- Clerical activities, including making copies of related materials and faxing related information
- Time spent reviewing voicemails or emails
- Conducting research on related topics
- Time spent consulting with a supervisor or co-workers or supervising
- Time spent arranging travel but excluding travel time
- Time spent entering information about the activity into a database or software program
- Calls, emails, or other communications to obtain clarification of an inquiry

10a. Medicaid Related- Includes any activity listed above that includes a discussion of Medicaid or a service covered under Medicaid or group special instruction activities for which one or more individuals enrolled in Medicaid participate.

10b. Not Medicaid Related- Includes activities that only discuss programs not funded by Medicaid or a service covered under Medicaid or group special instruction activities for which no individuals enrolled in Medicaid participate. For example, presentations that only discuss non-Medicaid services or provide a general discussion of an issue, but do not discuss how that issue relates to Medicaid.

10c. Not Tied to a Specific Program- Includes outreach efforts that do not discuss a specific program.

11. Staff Training

Applies to coordinating, conducting, or participating in training and seminars. Relevant activities include:

- Participating in or coordinating training which enhances the quality of intake, assessment, or other components of the service delivery process.
- Participating in or coordinating training which improves the delivery of services.

- Participating in, presenting or coordinating training designed to address the specific administrative and reporting requirements associated with program services.
- Attending training to maintain requirements to provide services.
- Attending training not related to the provision of service, but on improving the skills of the employee (e.g., first aid, human resources)
- Establishing and maintaining documentation or internal processes for providing training.

This code should be used for all activities related to training, including:

- Paperwork
- Clerical activities, including making copies of related materials and faxing related information
- Time spent reviewing voicemails or emails
- Conducting research on related topics
- Time spent consulting with a supervisor or co-workers or supervising
- Time spent arranging travel but excluding travel time
- Time spent entering information about the activity into a database or software program
- Calls, emails, or other communications to obtain clarification of an inquiry

11a. Related to Medicaid or a Medicaid Funded Service- Applies to training activities that address (1) Medicaid; (2) a service covered under Medicaid; or (3) a process that supports the Medicaid program (e.g., application).

11b. Related to a program or service that is not funded by Medicaid- Applies to training activities that address a program, service, or related process that is not related to Medicaid.

11c. Not tied to a specific program- Applies to training activities that are not tied to a specific program or service, such as general training on human resources.

12. Program Planning or Administration- Includes activities related to establishing and maintaining documentation, internal processes, and policies as well as working with other partner agencies to improve the coordination and delivery of services and performing collaborative activities with other agencies to provide services.

Activities include:

Meetings

- Attending staff meetings
- Attending presentations and briefings or receiving emails and newsletters about LTSS, HCBS, NWD agency activities, health care, or other community supports.

Collaboration

- Collaborating with co-workers, partners, or other agencies via email or telephone about processes, polices, and procedures related to LTSS, HCBS, and NWD agency activities.
- Working with partners to improve the coordination and delivery of services, to expand access for populations, and to improve collaboration.
- Reducing overlaps and duplication of services.
- Coordinating with interagency committees to identify, promote and develop services.

Data and Monitoring

- Generating reports and other information for quality improvement purposes.
- Monitoring service providers.
- Analyzing data to identify and close service gaps.
- Collecting and entering data on program performance.
- Completing self assessment
- Completing quarterly narrative and financial reports

Administrative Oversight

- Assuring compliance with regulations, state requirements and improve delivery and efficacy of services.
- Developing advisory committees, interagency advisory committees, consumer/stakeholder work groups to provide consultation and advice regarding the delivery of services.
- Reviewing relevant procedures and standards.
- Developing, refining, or reviewing quality improvement procedures.

Financial

- Developing budgets and maintaining records.
- Billing for Medicaid and non-Medicaid services AND billing is not part of the service rate (if included in the service rate, *use code Activities reimbursable directly by another source*)

This code should be used for all **activities related to program administration**, including:

- Paperwork
- Clerical activities, including making copies of related materials and faxing related information
- Time spent reviewing voicemails or emails
- Conducting research on related topics
- Time spent consulting with a supervisor or co-worker or supervising
- Time spent arranging travel but excluding travel time
- Time spent entering information about the activity into a database or software program
- Calls, emails, or other communications to obtain clarification of an inquiry

12a. Related to Medicaid or a Medicaid Funded Service- Applies to program administration activities that address (1) Medicaid; (2) a service covered under Medicaid; or (3) a process that supports the Medicaid program (e.g., application).

12b. Related to a program or service that is not funded by Medicaid- Applies to program administration activities that address a program, service, or related process that is not related to Medicaid.

12c. Not tied to a specific program- Applies to program administration activities that are not tied to a specific program or service, such as developing a budget for the entire program.

13. Activities Related to Medicaid Administrative Claiming (MAC)- Use this code when either of the following activities are being performed:

- Completing the Time Study Survey- At the time of receiving the time study survey staff were completing a previous time study survey. For example, when a staff received the time study survey on Tuesday afternoon, they were completing their Tuesday morning time study survey
- Attending Training or Coordinating Meetings Around the random moment time study (RMTS)- Time spent attending training or coordinating calls about the RMTS or Cost Pool or coordinating with staff, supervisors, or the survey administrator.
- Reviewing Management Reports from RMTS- Time spent by supervisors, quality review, and other staff reviewing RMTS management reports
- Completing the Cost Pool Spreadsheet- Activities related to documenting staff and programs costs for the purposes of completing the Medicaid Administrative Claiming (MAC) Cost Pool Spreadsheet. This may include:
    1. Obtaining financial data and completing cost reports used to inform the Cost Pool Spreadsheet
    2. Time spent entering information into the Cost Pool Spreadsheet
    3. Time spent reviewing voicemails or emails
    4. Time spent consulting with other agency staff
    5. Clerical activities, such as making copies
    6. Calls, emails, or other communications to obtain clarification of an inquiry

18. General Administration

This code should only be used if one of the other codes was not applicable. Examples of relevant activities include:

- Paid time off, such as breaks, lunch, vacation, illness, holidays, or any other type of leave.
- Providing general supervision of staff and evaluation of employee performance that is not related to an activity that could be included in another code.
- Processing payroll, filling out or reviewing timesheets (not as part of a MAC claiming time study), HR and other personnel-related documents.

- Resolving IT issues, such as problems or upgrades to computers or accessing the internet.
- Checking *personal* emails and voicemails.
- Updating work schedules.

Time spent on administrative activities such as reviewing emails, voicemails, making copies, etc. that were performed in support of an activity that is captured under another code should be classified under that code.

19. Other- This code should only be used if no other code appears applicable. Please provide a description of the activity. The description will be reviewed.

D. Time Study Structure

Over the course of the time study, participants will receive two emails daily with a custom link for the random moment emails. The first email is sent during the first half of the agency's operating hours (e.g., 8:00a-12:30p) and the second set during the second half of the agency's operating hours (e.g.,12:30-5:00p). For agencies that offer 24-hour staffing, surveys will be distributed in blocks that align with staff shifts and each shift will receive a first survey within the first half of the shift and a second survey in the second half of the shift (e.g. 8a-4p, 4p-12a, 12-8a). The links can be accessed using a web browser such as Microsoft Edge, Google Chrome, or Mozilla Firefox.

The random moment time study requires the participant to report on the activity **during the time specified in the timestamp included with the survey email.**

The following steps occur as part of the time study process:

1. Staff receive an email at the time of their random moment that designates the date and time of their random moment. The email contains a link to a unique survey that is affiliated with the staff
2. Staff complete the time study, including:
    a. Indicating whether the random moment fell within their normal working hours or when they were working for the agency outside of normal working hours
    b. Selecting the activity code that reflects the activity staff were performing at the time of their random moment
    c. When applicable, selecting the activity sub-code to reflect whether the time was reimbursable
    d. Providing description of the activity that justifies why the code was selected and provides sufficient information for supervisors to complete their five percent sample review
3. Staff submit the completed survey

E. Monitoring RMTS Participation

Each month, management reports are compiled for each NWD agency. The management reports spreadsheet provides a summary of the survey responses and information captured by the random moment time study. These reports include a summary of the survey response rate; a summary of survey responses; and a supervisor review of staff survey responses. All survey responses will also be shared.

A random sample of five percent of survey responses for each agency will be reviewed on a monthly basis to ensure staff are coding their time correctly and providing descriptions that

match the code and subcode they have selected based on the activity they were performing at the time of the random moment.

For each identified activity, reviews will identify whether staff were performing the identified activity at the random moment, whether the code selected matches the activity described, and any remediation steps that were taken to address errors.

F. RMTS Training

All staff participating in the RMTS receive live training prior to initiation in the RMTS. Staff will also be required to participate in this training, and refresher trainings are offered on an ad-hoc basis, at least annually.

SDS facilitates workgroup meetings with the agencies to answer questions, identify and discuss issues, and discuss data. These meetings are attended by local agency staff including supervisors and administrators, SDS staff, and other staff identified by their agency's leadership.

Quarterly Cost Pool

Agencies participating in MAC will provide summaries of the costs for all of the staff included in the time study on a quarterly basis using a standardized spreadsheet created by SDS. Costs categories comply with the guidance included in the US Office of Management and Budget (OMB) 2 CFR 200 super circular. The costs should represent the total actual costs for the time study participants for the fiscal quarter.

Agencies participating in MAC will submit cost reports to SDS using the approved format. SDS will then compile the cost reports for all agencies and combine this information with the results of the time study to establish the federal claim. The agency costs will be multiplied by the percentage of time spent on Medicaid related activities from the RMTS and then multiplied by 50 percent to identify the costs to be claimed.

Cost Categories

Costs are calculated by using the following categories that align with the Alaska Grants and Contracts guidelines found below:

https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=131738

For costs that are shared across multiple staff, such as supplies, telecommunication, and utilities, staff entering cost information into the cost pool should:

1. Establish the total cost being reported for the cost category
2. Identify the number of FTEs across the ***entire agency*** (not just the staff included in the cost pool) that the cost applies to

3. Divide the total cost by the number of FTEs to obtain a per FTE cost
4. For each staff included with the cost pool, assign the cost based on the reported FTE for that staff within the cost pool (e.g., a staff with a .5 FTE would be assigned 50% of the FTE cost for the category)

Exhibit 3: Cost Category Definitions

Cost Category	Example/Definition
Category 1: Personnel Services	
Salaries & Wages	Regular and overtime salaries and wages for project staff, temporary, and occasional employees.
Fringe Benefits	Includes employer payroll taxes and other benefits that may be provided, such as FICA, Employee retirement plans, and health insurance
Workers Compensation	May be included as a fringe benefit or in Other Direct Costs (Cost Category Other Cost) under insurance and bonding.
Category 2: Travel Costs Travel when directly related to the delivery of services as well as travel to conferences, seminars, and trainings	
Airfare	Airfare must be less than first class rate whenever available
Mileage	When staff are required to use a personal vehicle to conduct business, excluding travel to/from work. The state's current mileage reimbursement rate can be found here: https://doa.alaska.gov/dof/travel/trav_acct.html
Taxi fare or Auto Rental	When directly related to the delivery of services, or in the case of training or a conference, if it is program related, contributes to the project staff member's staff development, and is related to his/her assigned job duties
Lodging	Lodging costs must be moderately priced accommodations
Per Diem	Per diem for all travel outside the local community. Rates presently allowed can be found here: https://doa.alaska.gov/dof/travel/trav_acct.html
Category 3: Facility Costs	
Facility Rental/Lease	May not exceed reasonable costs for rent or leases in the proposed service location. A rental/lease agreement may include space rent, utilities and maintenance costs. If utilities and/or maintenance costs are not included in the rental agreement/lease, utilities and maintenance costs are properly listed separately from the costs for the space itself.
Communications	Includes telephone, internet, and radio communication expenses. Long distance telephone charges are allowable, but it is expected that these costs will be minimal in community-oriented projects.

Utilities	Utilities include heat, electric, custodial, water, sewer, and trash removal costs, when not included in the space rental cost.
Minor Repairs, Maintenance and Renovation not included in the space rental costs.	Janitorial Services by an outside firm is allowable. If project staff perform such services, the cost must be listed in Personal Services. Minor repairs such as replacement of broken windows are to be distinguished from more expensive renovations and alterations. Renovation costs, including labor and materials, include the installation of sprinkler systems, fire or smoke detectors, showers, bathrooms, partitions, etc.
Category 4: Supplies	
Office Supplies	Pens, pencils, stationary, postage stamps, poster board, blank CDs, paper, staplers, in-house printing supplies, desk supplies, etc.
Program Supplies	Recreation and craft supplies; posters, pamphlets, brochures, and program related literature for distribution to clients, schools, or community agencies; educational and reference books for use by staff and clients; film/video/DVD rental and purchase costs.
Household Supplies	Cleaning supplies, including laundry, janitorial and housekeeping supplies, kitchen and bed linens, non-food kitchen supplies, and any other household supplies necessary to the project.
Medical Supplies	Prescription and non-prescription drugs and medical supplies.
Food	Food is only an allowable cost when provided for direct project operations.
Other	Any supplies which do not fall within the scope those described above. Do not include dues, subscriptions, outside printing, or advertising costs. Such costs are included in the "Other" direct costs.
Category 5: Equipment	
Equipment Maintenance and Repairs	Includes costs associated with the maintenance and/or repair of equipment owned, leased, or rented. Those costs to be included under Office Equipment include service agreements for the maintenance and repair of photocopy machines, printers, etc.; miscellaneous repair costs for desks, chairs, filing cabinets, etc. Vehicle costs to be included are fuel, oil, spare parts, batteries, chains, tires, labor and parts costs for service calls, and major repairs performed by an outside entity.
Equipment Lease and/or Rental	Includes costs for leasing or renting project equipment such as copy machines, vehicles used in the day-to-day project operations, occasional rental of trucks or vans used for purposes not normally performed by project vehicles, and occasional rental of audio-visual equipment.
Equipment Purchase	Must include product specifications for any goods budgeted in the Equipment cost category and must be shown to be necessary for program operations. Equipment is defined as those items with a unit

	cost of $5,000 or more, however, equipment costing less than $5,000, but with a useful life expectancy of more than one year may be included in this cost category, particularly where a bundled purchase exceeds the $5,000 threshold. Examples include office furniture, computers, file cabinets, audio-visual equipment, medical equipment and household furniture and appliances. Purchase costs for computers should include peripheral equipment, such as printers, cables and power supplies purchased with the computers. Include estimated shipping costs where appropriate. Purchasing equipment defined as nonexpendable personal property in 7 AAC 78.950(25), must also comply with purchasing practices and procedures in 7AAC 78.270; and property management requirements of 7 AAC 78.280.
Depreciation on Major Equipment	Depreciation is allowed only for equipment not purchased with grant funds.
Category 6: Other Costs	
Subcontracts	If allowable under the specific solicitation, and which the applicant agency proposes to utilize for the provision of services, designed to meet goals and objectives outlined in the applicant's project proposal. See 7 AAC 78.180 and 7 AAC 78.250 for conditions that apply to all subcontracts. The procurement of subcontracts under any award is subject to the provisions of 7 AAC 78.270, and agencies must have DOH approval prior to entering into the subcontract. The agency is administratively and financially responsible for subcontractor performance and ensuring that subcontractors conform to the same laws, regulations, and program requirements regarding the use of any funds.
Professional Services	Professional fees and program consultant costs may be allowed when an outside firm provides these services; accounting and audit services; medical and legal fees. Include all costs in the consulting contract, including transportation, lodging, and per diem costs if consultant's travel is included.
Insurance and Bonding	Includes insurance premiums for employee hazard, malpractice and other liability insurance for personnel, vehicles, facilities, and authorized activities of the project including bonding costs. Workers Compensation costs may be included if not budgeted in Personal Services.
Subscriptions	Subscriptions to professional magazines, journals, or publications of a program nature; agency membership dues in a program-related professional organization.
Printing and Advertising	Costs for printing program literature or stationary when performed by an outside firm. Newspaper, radio, online or television advertising costs related to personnel recruitment, program operations, or program services.

Category 7: Indirect Costs
1. Indirect costs are those incurred by an applicant agency that administers activities under various programs and, as a result, incurs costs which are either difficult or impossible to attribute to a single program activity. Indirect costs include general administrative expenses as well as operation and maintenance of facilities and equipment. 2. For the calculation of allowable Indirect Costs, unless otherwise specified in the solicitation, DOH will accept the applicant agency's federally approved indirect cost rate that is in effect at the time of award. Indirect costs must be supported with a complete, current, signed copy of the proposing agency's current federally approved indirect cost rate agreement. An applicant agency that does not have a current cost rate agreement on file with DOH Grants and Contracts must submit a complete copy of the agency's signed rate agreement. 3. If your agency does not have a current indirect cost agreement with a Federal agency, DOH regulations permit recovery of certain administrative costs by direct charges to the agency. All such charges must be detailed and justified, and must be itemized separately in the appropriate cost line items. See 7 AAC 78.160 (p), (q) and (r) concerning allowable direct and indirect costs.

SDS Oversight of the Cost Pool

Each quarter SDS is responsible for developing and submitting the statewide cost pool for submission to CMS, which is comprised of cost pools from each agency. As the oversight agency, SDS has the following responsibilities in relation to the cost pool:

- Claim only for actual expenditures incurred and paid by SDS and the NWD network using the approved cost allocation methodology and only for the specified administrative functions
- Maintain a complete audit trail, traceable to appropriate cost ledgers, payroll runs, and other appropriate financial statements, for all expenditures submitted for claiming
- Identify and memorialize the fiscal responsibility for any deferrals and disallowances arising from Medicaid administrative claims
- Assure that any costs claimed do not duplicate costs claimed through an approved indirect cost methodology or any other federal claiming process

Calculating the Quarterly Claim

All claims are calculated using a standardized spreadsheet. This spreadsheet compiles the percentage of Medicaid related time for each agency for the quarter using data captured within the automated RMTS system. It also includes all quarterly cost pools submitted by each agency.

Each quarter, SDS completes the following steps to put together the quarterly claim:

- Inputs the data captured by the RMTS system to establish the agency and statewide percentage of Medicaid related time
- Review and approve the quarterly cost pools submitted by the NWD agencies and input them into the claiming spreadsheet
- Identify the proposed potential MAC claim based on the 50/50 match rate
- Determine whether there is sufficient State and local match to justify the claim request
- Determine the State-based claim amount
- Adjust the State-based claim amount to correct the agency-based claim amount, or the amount that should be shared with the NWD agencies
- Aggregate the total statewide expenditures, percentage of Medicaid related time, available State and local match, and requested claim into a single table

Claim Submission

An authorized representative from SDS will review the quarterly claim worksheet to verify the accuracy of all reported costs and figures and work with the NWD agencies to answer questions and remediate any issues. Following this review, SDS will incorporate the reimbursement request into the submission to CMS as part of the State's quarterly claim.

All relevant records will be maintained for audit or review purposes.