RANDOM DAY SURVEY SYSTEM

(RDSS)

2016 USER MANUAL

Random Day Survey System (RDSS)

Medicaid Administrative Claiming

The federal government permits Medicaid agencies to claim reimbursement for activities that are necessary for the "proper and efficient administration" of the Oregon Medicaid State Plan as required by 1903(a)(7) of the Social Security Act, and the implementing regulations at 42 CFR 431.1 and 42 CFR 431.15 and 45 CFR Part 74 and 95. In addition, the Office of Management and Budget (OMB) circular A-87 (codified at 2 CFR) contains the cost principles for state, local and tribal governments for the administration of federal awards, states that "Governmental units are responsible for the efficient and effective administration of federal awards".

The Centers for Medicare and Medicaid Services (CMS) has identified a series of activities that must be claimed administratively through Medicaid Administrative Claiming (MAC) among these are outreach, utilization review, eligibility determination and activities that determine a consumer's need for Long Term Services and Supports.

CMS, the Administration for Community Living (ACL) and the Veterans' Health Administration (VHA) have provided further guidance regarding the "No Wrong Door" initiative which seeks to promote Public Outreach and Program Education, Person Centered Options Counseling, and Streamlined Eligibility for Public Programs delivered through a coordinated, seamless system such as the Aging and Disability Resource Connection.

The federal "No Wrong Door" guidance clarifies and expands the activities that are now approved under MAC which includes information and referral assistance, person-centered options counseling, and outreach and program education.

The Random Day Survey System (RDSS) is based on Random Moment Sampling, which is a statistical method used to determine the amount of effort spent by a group of employees on various activities. A Random Moment Sampling study consists of a number of individual observations of employee activities taken at random intervals. Based on these observations, the distribution of time for a

group of employees can be determined with a high degree of confidence, and will approximate the same results having observed employees' activities one hundred percent of the time.

Time Studies

Random Moment Sampling relies on the laws of probability which, in essence, demonstrate that a there is a high probability that a relatively small number of random observations will exhibit approximately the same characteristics as the overall universe from which the sampled was derived. An observation at a random moment is a sample of what is happening in a particular instant in time. The basic requirement in selecting a random sample is that every item in the universe be given an equal or known chance of being included in the sample.

Random Moment Time Studies are federally approved, statistically valid sampling techniques that are recognized as an accepted alternative to 100 percent time reporting. Oregon DHS has identified the allowable State and Federal funding sources for each program and related activity to be included in Random Day Sampling System. After compiling the results, based on an average of the previous 3 months with a 1 month lag time (May, June, and July determine the August expenditures), the approved costs for the sampled activities are then allocated to specific funding streams. These funding streams are usually federal awards such as Title XIX Medicaid, Older Americans Act, Supplemental Nutrition Assistance Program, Social Security Block Grants or state monies such as the General Fund.

The Random Day Sampling System is the approved study for determining the amount of time staff spend performing Medicaid and non-Medicaid functions on sampling days, which is then extrapolated to determine a reasonable estimate for reimbursement.

The reliability and success of Random Time Studies is based on the accuracy and participation of the staff who are being sampled. The purpose of this training manual is to introduce the basic concepts of random time studies, describe and categorize the types of activities and related funding streams

Random-Day Sampling System
(RDSS)

Each 15 minute segment can have only ONE activity selected within it. Staff should choose the activity code that is associated with the primary reason for the activity at that time. The following information is to assist in defining codes and making selections.

1. **Not Used**
2. **Supplemental Nutrition Assistance Program (SNAP)** – previously known as Food Stamps.
3. **Non-Medicaid State Programs**
    - 3A Oregon Project Independence
    - 3B Other General Fund only programs
4. **Older American Act (OAA) Programs**
5. **Other Programs**
    - Examples include county-funded programs, energy assistance, emergency funds, housing and urban development, etc.
6. **NWD (No Wrong Door) for use only by ADRC, AAA, CIL and other partners**
    - 6A Outreach and Program Education (do not use)
    - 6B Information Referral and Assistance

- Facilitation activities related to assisting individuals or families with the application process to obtain LTSS, Medicaid, SNAP, Veterans', OAA or other benefits that support the individual in their current setting, delay or prevent the enrollment into Medicaid, or supplement their existing level of benefits.
- Information referral includes providing information about Medicaid, LTSS, OAA, OPI and other related programs that may prevent or delay the enrollment in Medicaid.
- APD Medicaid beneficiaries should be redirected to their servicing APD/AAA local office for questions related to their eligibility, benefits, or LTSS needs.

- All other individuals, including individuals that receive Medicaid from the Oregon Health Authority, DHS Self-Sufficiency or Child Welfare, may receive IR&A services and appropriately claim federal match.

- Related tasks such as explaining eligibility rules and processes to individuals, family members or other chosen representatives are included in this Code. Tasks related to this Code include, but are not limited to: assistance with collecting/gathering required program information, assistance with application completion including necessary follow-up monitoring for successful applications, activities that assist in maintaining current benefits during the redetermination process, activities that support the completion of eligibility requirements (such as the requirement to pursue assets for example non-State health coverage, Veterans' benefits, child support, Social Security Administration benefits) and the provision of necessary forms or other required eligibility materials.

- Other tasks related to this Code: data entry, clerical (scheduling, printing, copying, initiating or replying to correspondence), travel time to and from locations as well as logistical planning, and consultation with supervisors, program experts and outside agencies.

    - 6C Person Centered Options Counseling

- Activities performed by a qualified Person-Centered Options Counselor that include assisting with any immediate LTSS need, conducting conversations to confirm who should be part of the process, and identifying the Individual's goals, strengths and preferences. Activities also include a comprehensive review of private resources and informal supports as well as the development of the Person-Centered Plan. Facilitates the implementation of the plan by engaging private or informal resources and when applicable, making application for public LTSS, including follow-up activities. May facilitate diversion and transition activities including hospital to home and post-secondary school to post-secondary life.

- Other tasks related to this Code: data entry, clerical (scheduling, printing, copying, initiating or replying to correspondence), travel time to and from locations as well as logistical planning, and consultation with supervisors, program experts and outside agencies.

    - 6D NWD Training

- Staff attendance and participation in Department approved and/or sponsored trainings that provide instruction on the availability, scope, requirements and eligibility policies related to Medicaid and/or Long-Term Services and Support in Oregon.
- Tasks related to this code include travel time to and from training location

7. Outreach

Outreach includes activities to inform and provide options for current consumers and potential consumers to enter into services through one of the DHS-administered programs below. Outreach primarily includes active discussion of the benefits offered by the various programs administered by DHS, using prepared materials as appropriate.

- 7A Medicaid Outreach
  Examples include: Current Medicaid recipients who have additional unmet needs, outreach is done to provide options regarding further utilization of Medicaid services or for potential consumers, outreach may include discussions aimed at overcoming barriers to submitting an initial application for Medicaid at a local AAA or APD office.
  Medicaid outreach **ends** upon referral of a current recipient to their case manager, screener in an APD/AAA office, or eligibility worker; or referral of potential consumer to a local APD/AAA office for possible referral for Medicaid.
  Note: This activity does not include work done by case managers that should be coded to waivered or non-waivered case management or activities such as intake, application, or eligibility processing which should be coded to Medicaid Eligibility.
- 7B SNAP Outreach
- 7C OAA Outreach
- 7D MMA Outreach
- 7E Other Outreach- examples: OPI, local program outreach

8. **Initial Screening**

Initial Screening includes activities to screen potential consumers for appropriate referral to a worker for an eligibility decision in the programs listed below.

- 8A Medicaid Screening should be marked on Medicaid Eligibility. If screening didn't produce a prime number then it should be Medicaid Outreach.
- 8B SNAP
- 8C OAA
- 8D NOT USED
- 8E Other

9. **Medicaid Administration- Enter Prime Number: _____**

(not case number)

A prime number is required for all activities in category 9, except some of the activities captured under 9E, such as batch coding, consultation, training, and non-case specific quality assurance.

Allowable administrative activities as those that "are necessary for the proper and efficient administration of the Medicaid State Plan (or waiver) services". CMS allows federal financial participation (FFP) to be claimed against salary or other compensation, fringe benefits, travel, per diem, services and supplies and training at rates determined on the basis of the individual's position. The FFP claims include an appropriate proportion of general administrative charges, consistent with Department policy and OMB A-87 principles.

The following administrative activity categories of MMIS, SPMP, PASRR, OHP, Administration, and Medicaid Case Management are available for activities related to Medicaid State Plan or waiver services provided to Medicaid-enrolled clients:

□ 9A**. Medicaid Management Information System (MMIS)**

Data coding, data entry and other activities that initiate payment or update the accuracy of the Medicaid payment system for managed care enrollment and provider enrollment (Example: entering providers into

the MMIS system). Making program management decisions **on specific suspended claims** are allowed, as are program management decisions on specific claims entered into MMIS that have suspended (Note: code prior authorizations for services, entry of pay-ins on SFMU, and generic claim research as general Medicaid Administration (Code **9E**)).

Use only the time spent on the screens, forms, or systems listed below to charge the enhanced MMIS match rate:

Managed Care Enrollment and Exemption

PHP Enrollment Screen
415H Medical Resources Form

Provider Enrollment

Oregon ACCESS HCW Enrollment and authorization
Provider Enrollment Screens: PRV8 (Review)
SDS 736 –Provider Enrollment
7262H-Direct Deposit Enrollment

Prior Authorization and Payment – Data entry functions related to processing Home Care Worker (HCW) vouchers, payments, and adjustments. Data entry and suspense resolution related to Community Based Care (CBC) authorizations, payments, and adjustments. Data entry and functions related to processing claims through the DHS claims systems.

CEP Payment System Screens: HINQ, AATH, HATH, APAY, HPAY, HFIQ

SDS 598B - Agreement, Authorization and Provider Invoice (computer generated only)

CBC Payment System Screens: SMRQ, SMRF, SERF, SEFP, SEFS, SNRS, RATZ, SADD, FNAR, SBEG, DISB, SCFD, SMSG, SCFS, SCFP, PESM, PUTL, MRAT

SDS 512 – Community Based Care Provider Payment Authorization and Invoice (computer generated only)

Form SDS 599A – Agency Provider Invoice – In Home Services

Medical Payment Processing - Data entry and functions related to processing claims through DMAP and the AFS/SPD claims/payment systems.

Form DHS 437 – Authorization for Cash Payment
DMAP 405T – Medical Transportation Order (payment directly to provider)

DMAP 409 – Medical Transportation Screening/Input document (payment to client or attendant)
MMIS POC-Nursing Facility Payment Plan of Care

□ **9B. Skilled Professional Medical Personnel (SPMP)**

You must be authorized to use this code. You, or the SPMP you support, as well as the services provided, must meet the following criteria:

i) The expenditures are for activities directly related to the administration of the Medicaid program, including medical assessment, and as such do not include expenditures for direct medical care.

ii) The SPMP have professional education and training in the field of medical care or appropriate medical practice. "Professional education and training" means the completion of a 2-year or longer program leading to an academic degree or certificate in a medically related profession. SPMP possess a medical license, certificate, or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. (Note: Experience in the administration, direction, or implementation of the Medicaid program is not considered the equivalent of professional training in a field of medical care);

iii) The SPMP are in positions that have duties and responsibilities that require the use of professional medical knowledge and skills;

iv) A State-documented employer-employee relationship exists between the Medicaid agency and the SPMP and directly supporting staff; and

v) Any direct support staff (such as secretarial, stenographic and copying as well as file and records clerks) perform duties that are directly necessary for the completion of the professional medical responsibilities and functions of the SPMP medical staff. The SPMP

staff must directly supervise the supporting staff and the performance of the supporting staff's work.

Examples:

- SPMP who make medical judgments or recommendations related to the quality and utilization of Medicaid covered services provided to Medicaid applicants or recipients;

- SPMP who advise and assist case management and medical workers in securing and interpreting essential medical data regarding client eligibility for Medicaid and for Medical Review Team documentation.

□ **9C. <u>Preadmission Screening/Resident Review (PASRR)</u>**

Costs directly allocable to PASRR activities.

PASRR is a system to screen all applicants to, or the residents of, Nursing Facilities:

- To assess whether the individual requires Nursing Facility services;
- To determine whether the individual may have mental illness or an intellectual/developmental disability; and
- If either conditions are confirmed, to determine whether the individual requires specialized services.

All other Medicaid activities (such as prior authorization, and determinations regarding individuals with the greatest need when limited beds are available) are tracked under Administration or Case Management.

Examples:

- SPMP Pre-admission Screening and Annual Resident Review for individuals with mental illness or an intellectual/developmental disability who request admission into a Medicaid-enrolled Nursing Facility or who are already in such a facility.

- Data coding of the PASRR screening form.

□ **9D. No longer used**

□ **9E. Medicaid Administration**

Examples:

Prior Authorization of Medicaid services;

Determination of payment amounts;

Medicaid data entry on Mainframe or into Oregon ACCESS, including pay-ins on SFMU;

Policy reviews, screen corrections, batch coding

Consultation on Medicaid issues which includes Medicaid staff training and non-client-specific quality assurance activities.

□ **9G Non- Waivered Case Management-**

Case Management services furnished to assist individuals residing in nursing facilities or gaining access to needed State Plan Personal Care, Independent Choices, 1915(k), PACE services, and 1915(c) case management waivered services, including the initial level of care and CAPS assessment:

Initial Eligibility-

Initial assessment for service eligibility (Nursing Facility, State Plan Personal Care, Independent Choices, 1915(k), PACE services, and 1915(c) waiver case management). **Note:** Reassessments for individuals in waivered services should be coded as waivered case management. Only the initial service eligibility assessment is billed to non-waivered case management.

Ongoing Case Management-

Assessment and periodic reassessment of individual needs, using the CAPS tool, to determine the level of need for nursing facility services, State Plan Personal Care, Independent Choices, 1915(k), PACE services;:

Development (and periodic revision) of a specific care plan for non-waivered individuals based on the information collected through the assessment.

Case Management may include contacts with individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs

Ongoing Case Management and other outreach activities for current Medicaid recipients not receiving waivered case management (e.g., State Plan Personal Care, Independent Choices, 1915(k), PACE services, Nursing Facility) who have additional unmet needs: providing information and discussion regarding further utilization of Medicaid, service plan modifications and service plan changes.

□ **9H: Waiver Case Management**

Case Management services furnished to assist individuals, eligible under the 1915(c) APD Waiver, who reside in a community setting, in gaining access to needed medical, social, educational, and other services that support an individual's independence, health and safety:

Periodic reassessment of individual needs, using the CAPS tool, to determine the need for medical, educational, social, or other services.

Note: The initial service eligibility assessment is billed to **9G** Non-waivered Case Management.

Ongoing Case Management activities include:

i. Taking client history;

ii. Evaluation of the extent and nature of recipient's needs (medical, social, educational and other services and completing related documentation;

iii. Gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

Ongoing development and periodic revision of a specific care plan that:

i. Is based on the information collected through the assessment.

ii. Specifies the goals and actions to address the medical, social, educational and other services needed by the individual.

iii. Includes activities such as ensuring active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop these goals.

iv. Identifies a course of action to respond to the assessed needs of the eligible individual.

Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

Interviews and discussions with the individual or the individual's provider about poor quality services or concerns about safety/well-being

Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of

the eligible individual. Contact may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, including at least one monthly direct or indirect contact and one quarterly direct contact, to help determine whether the following conditions are met:

i. Services are being furnished in accordance with the individual's care plan.

ii. Services in the care plan are adequate.

iii. If there are changes in the needs status of the eligible individual, necessary adjustments are made to the care plan and to service arrangements with providers. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

□ **9I: Medicaid Eligibility**

Eligibility/Re-Eligibility Determination: Securing information needed to make decisions on eligibility for the programs administered on behalf of the Department of Human Services. This category includes gathering applicant information, intake, coding eligibility, and re-determining eligibility.

This includes all work related to determining eligibility for Medicaid funded programs. This includes doing eligibility for the OSIPM programs, determining service eligibility for Medicaid Long-term care services (not related to waivered case management), MMA and Part D work, and screening for these Medicaid and MMA/Part D services.

10. Not Used

11. Supplemental Nutrition Assistance Program (SNAP)

□ 11A. Benefit Issuance

□ 11B. Maintenance

□ 11C. Fraud/Overpayments

□ 11D. Quality Control

□ 11E. Administration (Includes SNAP-specific staff training)

□ 11F. SNAP Case Management
Assisting persons eligible for SNAP in obtaining and using the benefits offered by the SNAP Program.

12. <u>Oregon Project Independence</u>

□ 12A. OPI Case Management
Assisting persons aged 60 and above to obtain and use services covered by the OPI Program. Includes CA/PS assessments for OPI purposes.

□ 12B. Other (Includes OPI-specific staff training)

13. <u>Older Americans Act</u>

□ 13A. OAA Case Management
Assisting persons aged 60 and above to obtain and use services covered by the OAA.

□ 13B. Other
Assisting persons in accessing services covered under the OAA, (such as senior legal services, family caregiver support program, or senior meals); includes OAA-specific staff training.

14. <u>Other Federal, State, or County-Funded Programs</u>
Assisting people in obtaining and using benefits and services not covered under Medicaid, Food Stamps, OPI or OAA (includes program-specific staff training)

□ 14A. Federal
Examples: Activities related to Veteran's Program assistance, HUD federal housing assistance, Vocational Rehabilitation, SSDI/SSI, Aging and Disability Resource Centers and assistance with Medicare benefits, not part of the MMA.

□ 14B. State

□ 14C. County

□ 14D. Other

Examples: City Programs, local non-profit programs, AAA funded programs, etc.

15. <u>Adult Protective Services</u>

□ 15A. APS Screening/Assessment/Consultation
This can include the following APS subcategories (see Oregon Administrative Rule 411-020-0000 for detailed definitions):

-Triage
-Risk Management
-APS Community Outreach and Education
-APS-related MDT Consultation and Assessment
-APS-specific staff training

□ 15B. Investigations/Reports

-Includes Legal/Court Procedures

16. <u>Adult Foster Home Licensing: Non- relative and Limited License</u>

Licensing and monitoring of Adult Foster Homes; including, conducting reviews of facilities and checking background information on facility owner(s) and staff to ensure the appropriateness for initial licensing or re-licensing.

□ 16A. Not in Use

□ 16B. Non-Relative

17. <u>Home Care Worker Activities</u>

□ 17A. Recruitment
Examples: Sending recruitment packets, doing criminal background checks, conducting orientations.

□ 17B. Other
Examples: Filing, advisory committee activities, monitoring Home Care Worker performance that is non-client specific.

Other Activities

18. Paid Break

19. Paid Leave (Sick leave, vacation time)

20. Non-Paid Leave (Lunch)

21. Training

Generic training only. Assign all program-specific training to the applicable program area code.

22. General Administration

Competing this timesheet survey, general meetings, etc.