WHAT IS MEDICAID ADMINISTRATIVE CLAIMING?

The purpose of the Medicaid Administrative Claiming (MAC) program is to provide State affiliated public agencies such as Local Health Departments (LHDs) in Texas the opportunity to submit reimbursement claims for administrative activities that support the Medicaid program. In order for the cost to be allowable and reimbursable under Medicaid, the activities must be found to be necessary for the proper and efficient administration under the Texas Medicaid State Plan, and must adhere to applicable requirements as defined in State and Federal Law.

LHDs can be reimbursed for certain medical and health-related activities such as outreach services delivered to clients within the community, regardless of whether the client is Medicaid eligible or not, and without any impact on other similar services the patient may receive elsewhere. Outreach services may be provided to a client and/or the client's family and may include activities such as coordinating, referring, or assisting the client/family in accessing needed medical/health or mental care services.

Revenue generated from MAC claims is dedicated to the provision of health services and may be used to enhance, improve and/or expand the level and quality of health/medical services provided to clients within the community.

"WHAT TYPE OF ACTIVITY IS CONSIDERED REIMBURSABLE"?

A variety of staff in LHDs currently provide health-related administrative activities that benefit their clients. These include services such as Medicaid eligibility determination, outreach and informing including referral, coordination and monitoring of Medicaid services. For example, front desk personnel may provide detailed information on the Medicaid eligibility process and assistance in filling out the Medicaid application. Social Workers and/or Outreach workers may coordinate and participate in Outreach campaigns directed to the entire population to encourage potential Medicaid eligible individuals to apply for Medicaid. Administrators often coordinate and/or become involved in community groups or councils and work to identify gaps or improve the delivery of health-related services to their community.

Front line staff often perform a range of case management and case coordination functions to ensure that clients with health-related needs access care in a timely and appropriate manner. LHD staff often provide families with health-related information to facilitate health care in the community. Staff members identify health concerns and provide outreach and information to clients and their families to ensure access to care and to provide referrals to other federal and state programs to help promote healthy lifestyles and outcomes. Referrals are made to Medicaid when it is suspected that a family may be eligible for services. Other staff within the agency may facilitate Supplemental Security Income (SSI) applications for clients and families as needed. Staff members may also provide information to clients and their families about the risk of drug and alcohol usage and the signs of abuse or dependency.

Social Workers, clerical staff and front office receptionists serving in various divisions of the LHD are often the first to identify a client or a family's need for medical assistance and the need to refer them for diagnosis, treatment, or follow-up health, mental health, or substance abuse services. Psychologists or counselors commonly provide crisis intervention and perform case management activities with families to ensure access to mental health or substance abuse treatment services.

HOW DOES THE DISTRICT OBTAIN REIMBURSEMENT?

Prior to submission and reimbursement of any claims, participating agencies seeking to submit MAC claims for reimbursement must first enter into a contractual agreement with Health and Human Services Commission (HHSC) and participate in a Random Moment Time Study (RMTS) which is used to determine the amount of time spent in providing MAC services. RMTS is a statistical sampling technique, federally approved by the Centers for Medicare and Medicaid Services (CMS), that is recognized as an acceptable alternative to the older worker day log method which required 100 percent time reporting. That method required staff to complete time sheets to account for every minute of the workday for periods of up to 30 days each quarter. RMTS eliminates this requirement and replaces it with a "moment" in which three questions are asked: 1) what were you doing; 2) who was with you; 3) why were you performing this activity. RMTS moments each represent one minute at a particular point in time and are

sampled throughout the quarter. The RMTS process starts with local health departments identifying staff that performs Medicaid allowable activities. Participating staff are then asked to complete a RMTS that measures the amount of time spent on all activities being conducted. This includes all MAC reimbursable activities as well as direct medical services. Sampled participants' only responsibility is to document what they were doing at that precise moment by answering the three questions via an online system. Unlike the old method of time study, participants are not required to understand complicated Medicaid codes, and the whole online process takes no more than a few minutes to complete. Once the time study is completed and the results are compiled, they are used to calculate the MAC quarterly claim.

HOW IS THE REIMBURSEMENT DETERMINED?

Section 1903(a) of the Social Security Act directs payment of Federal Financial Participation (FFP), at different matching rates, for amounts "found necessary by the Secretary for the proper and efficient administration of the State plan." Claims held under this authority must be directly related to the administration of the Medicaid program. In addition, payment may only be made for the percentage of time spent which is actually attributable to Medicaid eligible individuals.

Local Health Agencies identify staff that performs Medicaid allowable administrative activities. These staff are eligible to participate in the RMTS and the results are used in the calculation of the MAC Claim.

A claim will be constructed based on the following formula:

- The percent of allowable time based on the RMTS results.
- The percent of clients in the district who are Medicaid eligible.
- The number of RMTS participating staff.
- The quarterly cost of staff who participate in the RMTS.

For additional information regarding the Medicaid Administrative Claiming (MAC) Project, please send your inquiry to MAC@hhsc.state.tx.us.

Additional information regarding RMTS can be found at the following website link.
https://rad.hhs.texas.gov/time-study