Texas Medicaid Administrative Claiming

Participant Guide

Provider Finance Department Acute Care Services

Texas Health and Human Services Commission (HHSC)

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Introduction

The federal government permits state Medicaid agencies to claim reimbursement for activities performed that are necessary for the "proper and efficient administration" of the Texas Medicaid State Plan as stated in Section 1903(a)(7) of the Social Security Act (42 United States Code [U.S.C.] 1396b(a)(7)) and the implementing regulations at 42 Code of Federal Regulations (CFR) 431.1 and 42 CFR 431.15; and 45 CFR Parts 75 and 95. In addition, 2 CFR Part 200, Subpart E and 45 CFR Part 75, Subpart E contain the cost principles applicable to state, local, and Indian tribal governments for the administration of federal awards.

The Centers for Medicare & Medicaid Services (CMS) has identified a series of activities that may 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 care. Federal language clearly states that the range of activities allowable under MAC is not limited to those specifically identified by CMS in the Texas State Medicaid Plan.

As the Medicaid authority for Texas, the Texas Health and Human Services Commission (HHSC) implements the MAC program and has contracted with public entities to administer the Texas State Medicaid Plan in the most effective manner possible. The common interest of HHSC and the public entities is to ensure more effective and timely access of Texans to health care, the most appropriate utilization of Medicaid-covered services, and the promotion of activities and behaviors that reduce the risk of poor health outcomes for the state's most vulnerable populations.

Public entities interested in participating in the MAC program must comply with requirements set forth by HHSC. The public entity must review all requirements annually and continually make necessary changes to ensure their compliance.

MAC in Texas

Texas has operated the MAC project since 1995. MAC is the cost-based reimbursement methodology that Texas uses to draw down federal matching funds for activities that facilitate client access to medically necessary Medicaid-funded services. HHSC has partnered with local programs throughout Texas to implement MAC for providers of services to Medicaid recipients. Programs can be reimbursed for certain medical and health-related activities. For example, outreach services

delivered to clients within the community can be reimbursed, regardless of whether or not the client is Medicaid eligible, without impacting other similar services the patient may receive elsewhere. Outreach services may be provided to a client, the client's family, or both. Services may include activities such as coordinating, referring, or assisting the client, family, or both in accessing needed medical or mental health care services. Revenue generated from MAC claims is dedicated to the provision of health services. It may be used to enhance, improve, or expand the level and quality of health or medical services provided to clients within the community.

MAC in Texas is administered by the Acute Care section of HHSC's Provider Finance Department (PFD). Please see the MAC website for additional information about the program: https://pfd.hhs.texas.gov/medicaid-administrative-claiming

MAC is subject to the Texas Administrative Code (TAC), Rule §355.8095: https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=355&rl=8095

Medicaid Administrative Claiming Overview

MAC is a reimbursement methodology used to draw down federal matching funds (also known as Federal Financial Participation [FFP]) for Medicaid administrative activities such as Medicaid eligibility, outreach and informing, referral, coordination and monitoring, Medicaid translation and transportation, and Medicaid provider relations. Direct services are not allowable as part of the MAC claim, and the reimbursable administrative activities are restricted to those covered by the Texas State Medicaid Plan. The FFP rate is 50 percent, with an enhanced FFP rate of 75 percent available for certain services added by Section 201(b) of the Children's Health Insurance Program [CHIP] Reauthorization Act of 2009 (CHIPRA) (Pub. L. No. 111-3). Section 201(b) of CHIPRA amends Section 1903(a)(2) of the Social Security Act (42 U.S.C. 1396b(a)(2)) to allow states to claim increased administrative funding for translation or interpretation services provided under CHIP and Medicaid in connection with the enrollment, retention, and use of services by children of families for whom English is not their primary language. CMS clarified in 2011 (Center for Medicaid, CHIP and Survey & Certification [CMCS] Informational Bulletin "recent Developments in Medicaid," April 26, 2011) that the services claimed at the enhanced rate should be child- or family-centric.

Note: Currently, HHSC is not claiming the enhanced rate for skilled professional medical personnel (SPMP) for MAC. In addition, CMS has clarified that the enhanced rate for SPMP is no longer available specifically for the costs of activities performed by school-based SPMPs (see State Medicaid Director Letter [SMDL] #02-018, November 21, 2002, making the change effective January 1, 2003).

Texas MAC Programs

The following public entity types currently participate in MAC in the State of Texas:

- Early Childhood Intervention (ECI) programs: https://pfd.hhs.texas.gov/medicaid-administrative-claiming/mac-early-childhood-intervention-eci
- Independent School Districts (ISD), which for MAC also includes public charter schools or state schools: https://pfd.hhs.texas.gov/medicaid-administrative-claiming/mac-independent-school-districts-isd

- Local Health Department/District (LHD): https://pfd.hhs.texas.gov/medicaid-administrative-claiming/mac-local-health-districts-lhd

- Local authorities for Mental Health and/or Individuals with an Intellectual and Developmental Disability (MH/IDD): https://pfd.hhs.texas.gov/medicaid-administrative-claiming/mac-mental-healthindividuals-intellectual-and-developmental-disability-mhidd

A. Participation Requirements

To participate in MAC, public entities must first enter into a contract with HHSC. The agreement between the public entities and HHSC must be in effect on the first day of the quarter in which the first time study is initiated. The agreement includes a description of general terms, responsibilities, Medicaid administration, fiscal provisions, and amendments. Public entities participating in MAC may also enter into sub-agreements with their own contractors to perform reimbursable MAC activities, although only governmental entities can certify the expenditures. The designated governmental entity employee who certifies the expenditures must have legal and signature authority to certify financial information for the entity.

The actions below provide more detail on the required contract documents.

Contracting Actions

The entity submits all required forms and information to the HHSC Medicaid/CHIP Services Department (MCS), Contract Administration and Provider Monitoring (CAPM) office at the following e-mail address: CAPM_MedicaidAdministrativeClaimsContracts@hhsc.state.tx.us

CAPM will use the information submitted by the entity to complete a contract packet that will be routed via DocuSign to the Signature Authority, copying the Contract Point of Contact. After this packet is received and completed by the entity and HHSC signs the contract in DocuSign, a contract number will be assigned, and the executed contract will be sent to the Signature Authority and Contract Point of Contact.

If your entity requires additional contract reviewers or signers in addition to the Signature Authority and Contract Point of Contact, please let us know via e-mail. We will do our best to accommodate you.

The required forms and information to assemble the contract packet include items 1-5 listed below. (Item 6 is to be completed by ISDs only.) You may direct any questions regarding documents 1 to 5 to CAPM:

Security and Privacy Inquiry (SPI) Form

Each MAC Contract must be accompanied by a completed Security and Privacy Inquiry (SPI) form. The SPI is a questionnaire that includes a list of minimum Texas Health and Human Services (HHS) information security and privacy requirements needed for accessing HHS confidential information.

The form, with instructions for completion, can be downloaded from the HHS SPI web page.

Notes:

- If answering No to #1, please skip to the end of the form and sign and date.
- If answering Yes to #1, each subcontractor you add in #4 must sign a subcontractor Data Use Agreement. Please let us know about subcontractors as soon as possible, and we will send you the current version.
- If you have questions about completing the document, please review the form's instructions on pages 13 to 18.

Unique Entity ID (UEID)

As of April 4, 2022, the federal government is no longer using the Data Universal Numbering System (DUNS) number to uniquely identify entities registered in the System for Award Management (SAM). Entities doing business with the federal government will now use a Unique Entity ID (UEID) created in SAM.gov and no longer have to go to a third-party website to obtain their identifier. New entities will send their UEID instead of DUNS as of this date.

Active registrants will have their UEID assigned and viewable within SAM.gov; there is no action for registered entities to take at this time.

The stated effect of this transition is to allow the U.S. General Services Administration (GSA) to streamline the entity identification and validation process, making it easier and less burdensome for entities to do business with the federal government. See https://www.gsa.gov/about-us/organization/federal-acquisition-

service/office-of-systems-management/integrated-award-environment-iae/iae-systems-information-kit/unique-entity-identifier-update for more information.

Register or check the status of your UEID on the System for Award Management (SAM) website.

Application for Texas Identification Number (.pdf):

- A Texas Identification Number (TIN) is an eleven-digit number, accompanied by a three-digit Mail Code, assigned by the Texas Comptroller of Public Accounts to identify any party receiving a payment from the State of Texas.
- Using this number on all billings will reduce the time required to process billings to the State of Texas.
- Print, review, and complete the Application for the Texas Identification Number. The instructions are included in the document.

Vendor Direct Deposit Form (.pdf):

- Print and complete the Vendor Direct Deposit Form.
- The form must be resubmitted if the entity changes financial institution, accounts, or account type. Instructions are included in the document.

Vendor Information Form (.pdf):

- Print and complete the Vendor Information Form (VIF).
- View the Vendor Information Form Instructions (.pdf).

Program Operating Plan (for ISDs only)

An approved MAC Program Operating Plan (POP) is required for ISDs choosing to participate and receive reimbursement from the MAC program. In addition to submitting the MAC POP, the ISD is required to update and maintain all contact information in the Fairbanks cost reporting system (Fairbanks LLC MAC Login). Once a MAC POP has been approved by HHSC, the ISD is required to update Fairbanks should program contacts change. To submit the POP, follow the instructions below:

- View the MAC POP with Instructions (.pdf).
- Review the instructions.
- Draft a cover letter and complete the POP as indicated.
- Send the completed and signed cover letter and MAC POP to the HHSC Provider Finance Department at the following e-mail address:
  - MedicaidAdministrativeClaiming@hhs.texas.gov

NOTE: You may send questions regarding the cover letter, POP, or other MAC non-contract-related questions to the HHSC Provider Finance Department e-mail listed above.

The MAC Contracting information in this section is also available at the link below: https://pfd.hhs.texas.gov/medicaid-administrative-claiming/mac-contracting-information

B. Public Entity's Roles and Responsibilities

Each public entity must designate employees of the entity as the Primary Random Moment Time Study (RMTS) Contact and the Primary MAC Financial Contact. These individuals will provide oversight for the administration of MAC and ensure policy decisions are implemented appropriately. The core responsibilities listed below have been developed for the public entity's RMTS and MAC Financial Contacts and must be specifically identified as part of the personnel's job description.

1. RMTS Contact Functions

The RMTS Contact will attend required training provided by HHSC or its designee; understand the purpose of the RMTS; recognize the importance of updating and certifying the participant list (PL); and ensure updates and certifications are completed by the scheduled due dates. The Contact will ensure that all eligible participants are added to Fairbanks at the beginning of each federal fiscal quarter, update program contacts on the contact list by adding, editing, or deleting contacts as appropriate, provide required training to selected time study participants, and ensure their availability to answer questions from sampled staff. See Appendix A for more information.

2. MAC Financial Contact Functions

The MAC Financial Contact's function is to attend the required training provided by HHSC or its designee and understand the purpose and importance of the RMTS and PL in calculating the MAC claim. The Fairbanks cost reporting platform is maintained by HHSC's contractor, Fairbanks, LLC, and will be used by the public entity to calculate the MAC claim. The MAC Financial Contact will ensure that the financial data included in the calculation of the claim is based on actual expenditures incurred during the quarter for which a claim will be submitted.

Only costs fitting both of the following conditions will be entered into the claim.

1. Direct costs and indirect costs as defined in:
    - 2 CFR Part 200, Subpart E; and
    - 45 CFR Part 75, Subpart E; and
2. Approved by CMS.

Expenditures included in the MAC claim and funded with federal funds will be offset or reduced from the claim prior to the determination of the federal share reimbursable for each claim. Once the claim is calculated, the MAC Financial Contact will ensure that the information entered into Fairbanks is accurate by verifying and printing, or electronically signing, the Quarterly Summary Invoice (QSI) generated by the system. The Chief Financial Officer (CFO), Chief Executive Officer (CEO), Executive Director (ED), or other individual designated as the financial contact by the public entity will be required to certify the accuracy of the submitted claim and the availability of matching funds necessary. The certification statement will be included as part of the invoice and will meet the requirements of 42 CFR 433.51. MAC claims will be submitted on a quarterly basis within the required deadlines via Fairbanks.

The MAC Financial Contact will provide oversight and monitoring and coordinate with the RMTS Contact to ensure that the quarterly participant list data is accurate and appropriate for inclusion in the quarterly MAC claim, financial data submitted for the quarter is true and accurate, and appropriate documentation is maintained to support the time study (i.e., participant training) and the claim. The MAC Financial Contact must take immediate action to correct any findings that impact the accuracy of the claim.

3. Documentation and Record-Keeping

The MAC Financial Contact will ensure that all supporting documentation appropriately identifying the certified funds used for MAC claiming is maintained in a quarterly supporting documentation file (audit file). The MAC Financial Contact will coordinate with the RMTS Contact to ensure that the audit file contains all required documentation as specified in this Guide and that the file will be maintained at the public entity's location. Federal regulations (see 45 CFR 75.361) require that records be kept for a minimum of three years from the date of submission of the final expenditure report or, for Federal awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report, respectively. In the case of an audit during the first three retention years, the records must be retained three years after the close of the audit. The records will be made available upon request from state and federal entities.

A school district must retain participation documents for a period of no less than five years, but in the case of an audit during the first five retention years, the records must be retained five years after the close of the audit.

The documentation will identify all sources of funds used for certification and ensure that said funds have not been used to match other federal funds. The public entity will provide a list of funding sources used to complete a MAC claim upon request by HHSC.

See Appendix B for more information about the required documentation.

4. State and Federal Audits

The RMTS and MAC Financial Contacts must ensure that the public entity cooperates entirely with state and federal audits. It is the entity's responsibility to assist state or federal personnel in coordinating the audit or review. Coordination includes obtaining the necessary documentation in advance and scheduling, compiling, and preparing a corrective action plan of the audit or review findings. The entity must provide and submit evidence supporting the plan of correction within the timeframes established in the audit report.

5. Training

Annual training is mandatory for all RMTS and MAC Financial Contacts who need full access to manage the time study and MAC cost report, including the respective

Primary Contacts. The Primary RMTS and MAC Financial Contacts are responsible for maintaining compliance with all training requirements for the public entity and ensuring that all entity employees who need training credit attend the required training. This Guide primarily addresses requirements and relevant information for MAC Financial Contacts, but more information about RMTS training is available in Appendix A.

HHSC conducts training sessions. The MAC Financial Contact will be granted access to the web-based system upon meeting the MAC training requirements. Until such requirements are met, the MAC Financial Contact will be granted view-only access to Fairbanks.

Training will include an overview of the MAC process and information on how to access and input information into the web-based Fairbanks platform. HHSC will make MAC Financial training materials accessible via the HHSC website (https://pfd.hhs.texas.gov/medicaid-administrative-claiming).

Training registration links for each program, as well as additional information and downloadable materials, are available at the following web addresses:

- RMTS – ECI: https://pfd.hhs.texas.gov/time-study/early-childhood-intervention-eci/time-study-eci-training-information
- RMTS – ISD: https://pfd.hhs.texas.gov/time-study/time-study-independent-school-districts-isd/time-study-isd-training-information
- RMTS – LHD: https://pfd.hhs.texas.gov/time-study/time-study-local-health-districts-lhd/time-study-lhd-training-information
- RMTS – MH/IDD: https://pfd.hhs.texas.gov/time-study/time-study-mental-healthintellectual-and-developmental-disability-mhidd/time-study-mhidd-training-information
- MAC Financial – ECI: https://pfd.hhs.texas.gov/medicaid-administrative-claiming/mac-early-childhood-intervention-eci-notices/mac-eci-training-information
- MAC Financial – ISD: https://pfd.hhs.texas.gov/medicaid-administrative-claiming/mac-independent-school-districts-isd/mac-isd-training-information
- MAC Financial – LHD: https://pfd.hhs.texas.gov/medicaid-administrative-claiming/mac-local-health-districts-lhd-notices/mac-lhd-training-information

- MAC Financial – MH/IDD: https://pfd.hhs.texas.gov/medicaid-administrative-claiming/mental-healthintellectual-and-developmental-disability-mhidd-notices/mac-mhidd-training-information

HHSC strongly recommends and may require that at least two employees of the public entity attend training for both Contact types each year to enable the claiming process to continue more efficiently in the event of employee turnover.

C. MAC Financial - Claiming Reimbursement

The claim submitted to the State for reimbursement has several elements: allowable Medicaid administrative time, cost pool construction and provider cost data, revenue data and revenue offset, Medicaid Eligibility Rate (MER), FFP rate, and direct charge.

1. Time Study

Time studies will be conducted of staff persons that spend a portion of their time performing administrative activities to identify allowable Medicaid administrative costs within a given program. The purpose of the time study is to allocate or assign the costs to an appropriate funding source and identify the proportion of administrative time allowable and reimbursable under Medicaid. This process allows public entities to claim Medicaid reimbursement for administrative activities performed or provided to Medicaid clients. The time study results are used in calculating the administrative cost eligible for Medicaid reimbursement through the submission of the claim. The study is based on objective, empirical data, which reflects how staff time is distributed across the range of activities. A time study should reasonably represent staff activity during the specified time study period.

Contractually, public entities must agree to use the time study methodology selected by HHSC. Time study is an accepted method of objectively allocating staff time to the various activities measured. The State of Texas uses a Random Moment Time Study (RMTS) methodology. RMTS is a federally approved, statistical sampling technique recognized as an accepted alternative to 100 percent time reporting. The RMTS method is a verifiable, statistically valid sampling technique that produces accurate labor distribution results by determining what portion of the selected group of participants' workloads are spent performing all work activities. The RMTS method polls individual participants at random time intervals over a given period

and totals the results to determine work effort for the entire population of participating staff over that same period.

Additional information regarding RMTS may be found on the HHSC Time Study website: https://pfd.hhs.texas.gov/time-study.

Time Study Activities/Codes - The time study activity codes assist in the determination of time and associated costs related to and reimbursable under the Medicaid program. The codes have been designed to reflect all the activities performed by time study participants per public entity. Centralized coders contracted by the State will determine the assignment of the codes to time study activity. The results of the time study activity will determine the allowable time allocated to each cost allocation. The activity codes are as follows:

1a. Outreach - Non-Medicaid

1b. Outreach - Medicaid

2a. Eligibility - Facilitating Non-Medicaid

2b. Eligibility - Facilitating Medicaid

3. Other Non-Medicaid/Educational and Social Services

4. Direct Medical Services

4a. Direct Medical Services – Individualized Education Program (IEP) (ISDs only)

4b. Direct Medical Services - Non-IEP (ISDs only)

5a. Transportation - Non-Medicaid

5b. Transportation - Medicaid

6a. Translation - Non-Medicaid

6b. Translation - Medicaid (For ISDs and ECI programs: Translation - Medicaid Enhanced CHIPRA)

6c. Translation - Medicaid Enhanced CHIPRA (Not applicable to ISDs and ECIs)

7a. Program Planning, Development, and Interagency Coordination - Non-Medical

7b. Program Planning, Development, and Interagency Coordination - Medical

8a. Non-Medical/Non-Medicaid related Training

8b. Medical/Medicaid related Training

9a. Referral, Coordination, and Monitoring - Non-Medicaid Services

9b. Referral, Coordination, and Monitoring - Medicaid Services

10. General Administration

11. Not Paid/Not Worked

12a. Non-Medical/Medicaid Provider Relations

12b. Medicaid Provider Relations

2. Provider Cost Data

Allowable and reimbursable costs under MAC must be activities found to be necessary for the proper and efficient administration of the Texas Medicaid State Plan. They must also adhere to applicable requirements defined in state and federal law. Costs included in the MAC claim shall be in accordance with the provisions of 2 CFR Part 200, Subpart E; 45 CFR Part 75, Subpart E; 45 CFR Part 95; and other pertinent federal and state regulations. The types of direct, indirect, and allocable costs that can be included in the program are specifically defined in 2 CFR Part 200, Subpart E and 45 CFR Part 75, Subpart E. These regulations specifically define the types of direct costs, indirect costs, and allocable costs that can be included in the program. They provide principles for establishing whether certain cost items are allowable or not. These principles apply to all expenses, regardless of whether the cost is treated as direct or indirect.

Providers can report expenditures for the MAC program either on a detailed basis (Provider Specific Costs) or on a summary basis (Provider Summary Costs).

Please note that ISDs do not have the same cost categories entered in the claim. ISDs have only two staff categories entered:

- Cost Pool #1 for staff performing both direct services and MAC services, and
- Cost Pool #2 for staff performing only MAC services.

These costs are added together for the net expenditures claim, with different claimable percentages applied. Additionally, ISDs do not enter "Other Costs," "Recognized Revenue," "Unrecognized Revenue," or "Eligible Direct Charges" in the MAC claim.

a. MAC Staff Category

HHSC has established four MAC Staff Categories to account for all direct and indirect costs of the public entity. All direct costs of the public entity are accounted for in the Time Study and Direct Support Staff or the Unstudied Staff sections. Indirect general administrative costs are entered in the General Administrative Staff section and are allocated to the Studied and Unstudied sections based on the percentage of total cost allocation of that section. Therefore, all costs of the public entity are captured in Fairbanks in a single cost area.

Time Study Participant Staff

Time Study Participant Staff are personnel included on the RMTS participant list. The results of the RMTS will drive the allocation of salary expenses allocating the appropriate percentage of the personnel's costs.

Time Study Participant Staff (Cost Pool 1, Enhanced) - Costs, revenues, and time relating to the CHIPRA-authorized activities performed for administrative expenditures for translation or interpretation services connected with the "enrollment of, retention of, or use of services" under Medicaid and CHIP will be compiled and included in Cost Pool 1. Generally, MAC services are reimbursed at a 50 percent FFP rate, but CMS authorizes certain translation or interpretation services to be reimbursed at a 75 percent FFP rate. CMS clarified in 2011 that these services are intended to be child- or family-centric in order to be claimed at the enhanced rate. Therefore, HHSC includes these particular services in Cost Pool 1 at the enhanced rate in accordance with CMS guidance. HHSC will automatically allow the increased match of 75 percent for translation and interpretation for all ISDs and ECI programs due to the services of these entity types being inherently child- or family-centric. For LHDs and MH/IDD programs, the RMTS will capture which translation and interpretation services are child- or family-centric and thus eligible for the increased match.

Time Study Participant Staff (Cost Pool 2, Non-Enhanced) - Costs, revenues, and time relating to services rendered at the normal 50 percent FFP rate for MAC and not at the enhanced rate for certain CHIPRA authorized activities will be allocated to Cost Pool 2. This category includes activities performed by contracted staff.

Note for ISDs: As mentioned previously, the cost pools for Time Study Participant Staff who work for school districts are divided differently than listed in this section. Cost Pool 1 includes Direct Services and Administrative staff, whereas Cost Pool 2 includes Administrative Only staff. For both ISD cost pools, the Fairbanks system will use time study results to automatically calculate the claim at either the enhanced or the non-enhanced rate, depending on the services provided.

Direct Support Staff (Cost Pools 1 and 2)

Direct Support Staff personnel directly support time-studied personnel and do not qualify as general administrative personnel. Costs and revenues related to direct support staff who did not participate in the quarterly time study will be allocated to Cost Pools 1 and 2 based on salary allocation percentages from staff participating in the time study.

Note for ISDs: Direct Support Staff who were not time-studied are not included in the claim calculator for school districts. All district staff eligible for inclusion in the claim must be on the Participant List and included in the Time Study.

Unstudied Staff (Cost Pool 3)

Unstudied Staff are personnel who were not time studied and who provide services that are not medically related and do not provide general administrative services for the whole public entity. Additionally, this cost pool would include staff whose costs are predominantly supported by a federal grant. Costs, revenues, and time derived from activities that are non-Medicaid related, or those which are direct service activities, are not claimable as administrative activities.

Professional and contracted staff, not time studied, are included in the Unstudied Staff section. Professional services rendered by persons who are members of a particular profession or possess a special skill and are not officers or employees of the provider are allowable as referenced in 2 CFR Section 200.459 and 45 CFR Section 75.459.

Enter salaries and benefits for personnel not time studied or those not included in the "Time Study Participant Staff" and "Direct Support Staff" in the Unstudied Staff section. This section also does not include those personnel in the General Administrative Staff section identified below.

Note for ISDs: This cost pool is not part of the ISD claim calculator, and these costs are not captured as part of MAC Financial data collection for ISDs.

General Administrative Staff (Cost Pool 4)

General Administrative Staff personnel are not time studied and consist of general administrative personnel (e.g., CEO/ED, Personnel, Business Office, Management Information System [MIS], etc.). These personnel support the public entity as a whole, so their costs are allocated across all the appropriate cost areas. This MAC category also includes overhead costs, such as county or entity indirect costs. Also included are any costs that cannot be allocated more accurately, such as other "operating costs" that have not been entered in the Time Study, Direct Support Staff, or Unstudied Staff categories.

Note for ISDs: This cost pool is not part of the ISD claim calculator, and these costs are not captured as part of MAC Financial data collection for ISDs.

Types of Employees

Full-time employees generally work 38 hours per week and receive full weekly wages and conditions for working the hours identified in the hiring contract. This figure may not always be accurate for full-time ISD workers because most are contractual to a school day as defined in agreements. An employee should receive all wages and conditions under the hiring contract, including annual leave and extended service leave. If an employer-employee relationship exists between a public entity and an individual, then the individual is not an independent contractor.

Under 21 CFR Section 1.328 [Title 21 -- Food and Drugs; Chapter I -- Food and Drug Administration, Department of Health and Human Services], the number of full-time equivalent employees is determined by dividing the total number of hours of salary or wages paid directly to employees of the person and of all of its affiliates by the number of hours of work in 1 year, 2,080 hours (i.e., 40 hours x 52 weeks).

Part-time employees regularly work less than 40 hours per week. They are typically not eligible for the same benefits as full-time employees, such as vacation time,

sick pay, and unemployment compensation; they may not be eligible for benefits at all. The Fair Labor Standards Act (FLSA) (29 U.S.C. Chapter 8) does not define full-time or part-time employment. The employer generally defines this status. Whether an employee is considered full-time or part-time does not change the application of the FLSA. Local laws and employer policies should be consulted for applicability to your job.

Contracted staff who offer services to the general public in an independent trade, business, or profession are usually categorized as independent contractors. Examples include doctors, dentists, veterinarians, lawyers, accountants, contractors, subcontractors, public stenographers, or auctioneers. However, whether they are considered independent contractors or employees depends on the facts in each case. The general rule is that an individual is regarded as an independent contractor if the payer has the right to control or direct only the result of the work and not what will be done and how it will be done.

b. Cost Category

HHSC established the following cost categories to account for all costs of the public entity.

Employee Salaries

Salaries are wages for individuals employed by you and for whom you are required to make federal payroll tax payments under the Federal Insurance Contributions Act (FICA) (26 U.S.C. Chapter 21). Salaries include overtime, cash bonuses, and any cash incentives paid from which payroll taxes are (or should be) deducted.

Employee Benefits

Fringe benefits (including pension plans and other similar benefits) are allowable if the benefits are reasonable and required by law, a non-Federal entity-employee agreement, or an established policy of the non-Federal entity.

Employee Benefits include employer-paid health, life, or disability insurance premiums or employer-paid child daycare for children of employees paid as employee benefits on behalf of staff. Self-insurance paid claims should be direct costed and reported as employee benefits. Workers' compensation costs should also be reported as employee benefits.

Workers' compensation costs refer to expenses associated with employee on-the-job injuries. Costs must be reported with amounts accrued for premiums, modifiers, and surcharges and should exclude any refunds and discounts received or settlements paid during the same cost-reporting period. The premiums are accrued, but the refunds, discounts, or settlements are reported on a cash basis. Litigation expenses related to workers' compensation lawsuits are not allowable costs. Costs related to self-insurance are allowable on a claims-paid basis and are to be reported on a cash basis. Self-insurance is when a provider assumes the risk to protect itself from anticipated liabilities by providing funds to cover those liabilities. Self-insurance can also be described as uninsured. Contributions to self-insurance funds that do not represent payments based on current liabilities are unallowable costs.

Contracted Staff Costs

Contracted Staff performing any Direct Services (DS) or MAC activities must participate in the RMTS. The Contracted Staff costs reported under this section are for personnel performing DS and MAC activities that have participated in the RMTS. The provider is not responsible for the payment of payroll taxes (such as taxes under FICA, Federal Unemployment Tax Act [FUTA] (26 U.S.C. Chapter 23), and Texas Unemployment Compensation Act [TUCA]) (Chapter 201, Subtitle A of the Texas Labor Code) for contracted staff. Those who are not regular employees but perform the same functions routinely performed by employees are considered contracted staff. Contracted staff does not include consultants; however, it includes temporary workers, substitutes, and contract labor.

Other Costs

Travel and Training:

This category includes mileage reimbursements, airfare, per diem, lodging, seminar fees, payments to outside trainers, and other directly related costs. The cost of training provided for employee development is also an allowable cost. Enter travel and training costs assigned to each MAC Staff Category.

Costs incurred by employees and officers for travel shall be considered reasonable and allowable only to the extent such costs do not exceed charges normally allowed by the public entity in its regular operations according to its written travel policy. Expenses can include costs of lodging, other subsistence, and incidental expenses. Public entities without a written travel policy must adhere to all provisions of 5

U.S.C. 5701-11 (“Travel and Subsistence Expenses: Mileage Allowance”) when claiming travel costs under Federal awards (48 CFR 31.205-46(a)).

Note for ISDs: This cost category is not included in the ISD claim calculation.

Materials and Supplies:

This category includes costs incurred for materials, supplies, and fabricated parts necessary to carry out the public entity’s services. Purchased materials and supplies shall be charged at their actual prices, minus applicable credits. Withdrawals from general stores or stockrooms should be charged at their actual net cost under any recognized method of pricing inventory withdrawals, consistently applied. Incoming transportation charges are an acceptable part of materials and supplies costs. Federally donated or furnished materials can be used in performing the Federal award without charge.

Note for ISDs: This cost category is not included in the ISD claim calculation.

Equipment and Other Operating Costs:

Equipment is an article of nonexpendable, tangible personal property having a useful life of more than one year and an acquisition cost which equals or exceeds the lesser of the capitalization level established by the public entity for financial statement purposes, or $5,000. Equipment is not limited to research, medical, scientific, or other technical activities. Examples include office equipment and furnishings, modular offices, telephone networks, information technology equipment and systems, air conditioning equipment, reproduction and printing equipment, and motor vehicles.

Note for ISDs: This cost category is not included in the ISD claim calculation.

3. Provider Revenue Data

There are two types of revenue sources for the Medicaid Administrative Claim. The federal Medicaid agency does not recognize some revenues as revenue that can be used to offset costs but rather are designated as the matching funds necessary to draw down the federal support. These funds are designated as Unrecognized Revenues. To determine the share of the costs the federal government is willing to pay, they generally expect a public entity to use its own income to offset costs,

lowering the amount the federal government is responsible for managing. These revenues are referred to as Recognized Revenues.

Please note that these revenues are not entered as part of the MAC claim for ISDs.

a. Unrecognized Revenues

Ultimately, revenues that the federal Medicaid agency does not recognize as revenue to offset costs are designated as Unrecognized Revenues. These revenues do not affect the calculation of the claim and are included solely for audit purposes, verification of MAC match requirements as stated in 42 CFR Section 433.51, and full reporting. Enter the following MAC revenue categories:

Donations to Public Agency

This category includes all donations to public (legislatively mandated) agencies.

Federal Emergency Assistance Reimbursement

These reimbursements are Federal Emergency Management Assistance funds and Emergency Assistance funding under the Temporary Assistance for Needy Families (TANF) program.

Federal IV-E Reimbursement

These funds are granted under Title IV-E of the Social Security Act (42 U.S.C. Chapter 7 Section 670-679c). Title IV-E of the Social Security Act provides funds for states and tribes to provide foster care, transitional independent living programs for children, guardianship assistance, and adoption assistance for children with special needs.

Local Government Funds

These are funding sources that include city, county, school districts, and other local taxing authorities.

Medicaid Admin Reimbursement

The reimbursement received for this claim process is a significant source of unrecognized revenue. The funds have already been reduced to prepare the

previous quarter's claim for matching purposes. This section is used to verify MAC match requirements as stated in 42 CFR 433.51 and full reporting.

Other State Funds

These are general revenue and grants from state funds from all state agencies.

b. Recognized Revenues

These revenues are income sources that must be adjusted (offset) against the costs of the public entity and are collected in either the Unstudied Staff or General Administrative Staff Revenue categories based on an analysis of the revenue source. The general rule for determining placement is that revenue must follow the activity by which it is earned or the expense for which it is a reimbursement.

Donations to Contractors

This category is used only by private entities. Costs are generally placed in Unstudied/Unallowable Revenue (Cost Pool #3).

Federal Grants + Match

It is important to differentiate between federal and state funding sources. A federal grant may pass through one or more state agencies, but it is still federal money. This category includes the federal pass-through from counties and cities as well. A federal grant, including a grant passing through another federal or state entity, must include information identifying the federal grant. It should include the federal award identification, the Federal Award Identification Number (FAIN), and the Catalogue of Federal Domestic Assistance (CFDA) Number and Title.

Each grant has its own match percentages and contractual requirements. These must be individually analyzed by the public entity preparing the claim. Inputting and adding the match must be done separately for each grant. Placing these funds into the correct cost pool requires determining what expenditures the grant covers. If the grant funds the entire salary of a time studied person, then the portion of the grant pertaining to the expenses of that person must be placed in General Administrative Revenue (Cost Pool #4) to allocate to all the cost pools, just as those expenditures are allocated. If the grant covers only specific direct service activities of a time studied person or specifically excludes such activities, then the

grant receipts for the person may be placed in the Unstudied/Unallowed Revenue (Cost Pool #3).

If the expenditures covered by the grant (e.g., the Department of Housing and Urban Development [HUD] grants for residential costs, grants used to purchase drugs, or homeless grants) are collected in the Unstudied/Unallowed Revenue (Cost Pool #3), then the grant and cost of the grant personnel should also be placed in the Unstudied/Unallowed Revenue (Cost Pool #3).

Place grant revenues that are recognized in time studied units and cover broad expenditures in General Administrative Revenue (Cost Pool #4). If the expenditures are specifically designated within the accounting system, place the expenditures in the Unstudied or Unallowed Revenue (Cost Pool #3) as program-specific expenses.

This category excludes MAC reimbursements.

Fees

These are typically fees for direct services paid by or on behalf of clients. Place such revenues in the Unstudied/Unallowed Revenue (Cost Pool #3). If fees are collected for copying client records for outside agencies, place them in General Administrative Revenue (Cost Pool #4).

Insurance

Generally, insurance receipts are entered in the Unstudied/Unallowed Revenue (Cost Pool #3). An exception might be for receipts for casualty insurance (e.g., fire, auto, etc.), which exceeded replacement/repair costs. These would be entered in General Administrative Revenue (Cost Pool #4).

Medicaid Fees + Match

This section includes all payments received for medical services provided under Title XIX of the Social Security Act (42 U.S.C. Subchapter XIX, Medicaid, and CHIP) and, where required, the State Matching Funds. To calculate the matching funds, divide the receipts by the Federal Participation Rate to get the total of reimbursements and match. All Medicaid funds are placed in the Unstudied/Unallowed Revenue (Cost Pool #3), because they are earned by direct service activities.

Medicare

Medicare revenues are direct service-related and placed in the Unstudied/Unallowed Revenue (Cost Pool #3).

Other Revenue

This category includes all revenue sources not previously mentioned. Revenues for vocational production; revenues from clients, families, or other sources covering residential costs; grants from private foundations; miscellaneous revenues not readily identifiable; one-time or unusual revenues; interest income; other business income; fundraising; or any other purely "Administrative" income are generally placed in the Unstudied/Unallowed Revenue (Cost Pool 3). However, some revenues may be assigned to General Administrative Revenue (Cost Pool 4) depending on the purpose and use of the income. This category could include income not designated for a specific Unstudied Cost Pool activity.

4. Medicaid Eligibility Rate

A factor required to determine the claim amount is the Medicaid Eligibility Rate (MER). The MER calculation is a fraction based on an unduplicated client count. The numerator consists of all actual Medicaid recipients in the public entity's caseload or service population. The denominator is the total number of persons served by the public entity during the claim period. The resulting fraction, or percentage of Medicaid recipients in the caseload, should be as current to the quarter of the claim as possible. If not feasible to be current, the nearest possible determination should be made.

$$\frac{\text{Medicaid-eligible total unduplicated clients served for the quarter}}{\text{Total unduplicated clients served for the quarter}}$$

A person served by the entity who would be Medicaid eligible but has not applied, has not been issued a Medicaid card, or whose status is "pending" is not to be counted in the numerator. These individuals must only be included in the denominator. This Guide uses the term "eligible" to mean that the individual has

gone through a formal eligibility determination process and HHSC or its designee has determined him or her to be eligible for medical assistance.

Tracking Medicaid Eligibility as Part of the Intake Process

The public entity identifies the Medicaid status of its population on a case-by-case basis using this method. Information can be collected at the time of intake or using a statistically valid sample of the population served by the agency. The baseline information must include the client's Medicaid number.

Indirect Cost Rate

ISDs who participate in MAC are also subject to the Indirect Cost Rate (IDCR). This rate is specific to each district and is based on the indirect cost rate established by the Texas Education Agency (TEA) each year. Districts should always review the IDCR information preloaded into the MAC cost report and notify HHSC of any discrepancies from the information provided by TEA. More information about indirect cost rates, including instructions on how to request one, is available on this webpage: https://tea.texas.gov/finance-and-grants/grants/federal-fiscal-compliance-and-reporting/indirect-cost-rates.

The claimable percentage in the MAC ISD claim is calculated by multiplying state-wide aggregate time study results by the district's MER and IDCR.

5. Federal Financial Participation Rate

The FFP rate was created as part of Title XIX and provides a cost match for personnel of local services in support of Medicare and Medicaid. Two objectives permit claims under FFP. They are 1) to assist individuals eligible for Medicaid to enroll in the Medicaid program, and 2) to assist individuals on Medicaid to access Medicaid providers and services. The services available within each category are restricted to services covered by the Texas State Medicaid Plan.

As discussed previously in this Guide, the FFP rate is 50 percent, with an enhanced rate of 75 percent available for certain services. More details about these services are available at the beginning of the Medicaid Administrative Claiming Overview portion of this Guide.

6. Direct Charge

Direct charges may be claimed for costs directly related to the preparation of the time study participants and the preparation and submission of the MAC claim. Detailed documentation logs must be kept on any MAC-related activity used for direct charges. Costs eligible for direct charge are salary, benefits, travel (mileage), training, and operation, including materials and supplies.

Public entities using the direct charge will identify the individual's "Functional Category." They will then enter the individual's name, employment type, title, salary, benefits, hours worked in the claim period, hourly rate, number of hours to direct charge, travel costs, training costs, and other operating costs for the individual claiming direct charge. Fairbanks will automatically reduce the direct charge amount from the cost reported under Step 3c. Other Costs. The adjustment will be reflected in the Step 5. Verify section of Fairbanks. Please note that direct charges are not entered as part of the MAC claim for ISDs.

An allocation methodology will be used on eligible direct costs based on the following formula:

Direct Charge Formula
(Salary + Benefits)/Regular Hours worked in Claim Period = Hourly Wage
Hourly Wage x Number of hours to direct charge (from staff time records) = Costs Eligible
Add direct travel, training, and operating costs associated with staff responsible for training time study staff, and preparing and submitting the MAC Claim (costs that cannot be directly identified must be included in General Administrative Cost Pool 4 and allocated as appropriate)
Subtotal
Subtotal x 50% = Total Direct Charge

D. Claim Calculation and Submission

1. Calculating the Claim

Each element of the claim is multiplied by costs incurred for the quarter to determine the federal portion amount of the claim. When the claim is submitted, the participating entity will certify the actual cost incurred for the quarter and that matching requirements were met for sufficient non-federal funds (state, county, or local). The federal share of the claim is calculated as follows for all public entity types other than ISDs:

Participant staff costs	x
Percent of time claimable to Medicaid administration	x
MER (the percentage of Medicaid eligibles in the service population	+
Allocated General Administrative costs	=
Subtotal	x
Percent of FFP (50% for some costs and 75% for other costs)	=
Subtotal	+
Direct Charge @ 50% FFP	= The amount of federal request

Please note that all MAC claims are subject to a 5 percent retention rate for the State’s administrative expenses.

For ISDs, the MAC claim is calculated as follows:

Net Expenditures	x	Claimable %	=	Claim Amount
Claim Amount	x	FFP	=	Total Federal Share
Total Federal Share	x	5%	=	5% Retention
Total Federal Share	-	5% Retention	=	Net Claim

2. Claim Submission Timeline

Public entities must submit claims within the timelines set by HHSC. The open and close dates for each claiming period within a federal fiscal year (FFY), which runs from October 1 through September 30, are included in the MAC Financial presentation found on the HHSC website (https://pfd.hhs.texas.gov/medicaid-administrative-claiming) for each pertinent FFY.

The MAC Financial presentations for each program can be found at the following webpages by scrolling to the "Training Materials" section at the bottom of the page, and clicking the dropdown menu for the appropriate federal fiscal year:

ECI: https://pfd.hhs.texas.gov/medicaid-administrative-claiming/mac-early-childhood-intervention-eci-notices/mac-eci-training-information

ISD: https://pfd.hhs.texas.gov/medicaid-administrative-claiming/mac-independent-school-districts-isd/mac-isd-training-information

LHD: https://pfd.hhs.texas.gov/medicaid-administrative-claiming/mac-local-health-districts-lhd-notices/mac-lhd-training-information

MH/IDD: https://pfd.hhs.texas.gov/medicaid-administrative-claiming/mental-healthintellectual-and-developmental-disability-mhidd-notices/mac-mhidd-training-information

3. Fairbanks Cost Reporting System

As indicated in the Introduction of this Guide, the federal government permits state Medicaid agencies to claim reimbursement for activities performed that are necessary for the proper and efficient administration of the State Medicaid Plan. HHSC's vendor, Fairbanks, LLC, maintains the Fairbanks cost reporting platform. Public entities participating in MAC will use Fairbanks to complete their MAC claims. Once the claim is completed, the QSI will be printed, notarized, signed (as required by HHSC), and submitted to HHSC for further processing.

Instead of notarization, HHSC now also offers the option to submit the QSI with an electronic signature. The digital signature policy can be found at this link: https://pfd.hhs.texas.gov/rate-analysis-digital-signature-policy.

4. Quarterly Summary Invoice

The QSI for Medicaid Administration is the statement of expenditures that the undersigned certifies are allocable and allowable to the State Medicaid program under Title XIX of the Social Security Act and in accordance with all procedures, instructions, and guidance issued by HHSC. The QSI will be generated by Fairbanks. The designated employee of the provider is responsible for signing the QSI, which certifies that the following items are true and correct. Before signing and uploading into Fairbanks, please ensure the following:

- I am the officer authorized to submit this form; I have examined this statement, and to the best of my knowledge and belief, the expenditures included in this statement are based on the actual cost of recorded expenditures.
- The required amount of State and local funds were available and used to pay for the total computable allowable expenditures.
- This statement of expenditures that the undersigned certifies are allocable and allowable in the State Medicaid program.
- I understand that this information will be used as a basis for claims for Federal funds, and falsification and concealment of material fact may be prosecuted under Federal or State civil or criminal law.

Ensure that the Signer and Notary dates are the same. The notary language on the QSI reads, "This instrument was acknowledged before me." This statement means that the date signed by the Signer and the Notary must be the same.

E. HHSC and Public Entity's Responsibilities

1. MAC Claim Desk Review

The MAC claim desk review is used to ensure the integrity and accuracy of all data on the QSI. Desk reviews will be completed quarterly for all public entities unless otherwise specified by the department MAC Financial Contact or HHSC. All data on the QSI will be verified using the information retrieved from Fairbanks for the quarter being reviewed prior to any payment of MAC claims.

Upon completion of HHSC's desk review of the materials sent by the public entity, any discrepancies found will be brought to the attention of the public entity. HHSC will contact the public entity by e-mail requesting an explanation, clarification, correction of discrepancies, or all three responses. All returned correspondence from the public entity must be in writing and received by HHSC within the timeframes specified in the request. In addition, HHSC will determine if the MAC claim submitted is accurate and reimbursable upon verification that all requirements have been met. Automatic deferment of the MAC claim for the reporting quarter will occur for any public entity not satisfying requests for explanation, clarification, or correction of unresolved claim issues. The public entity will receive written notice of MAC reimbursement deferment. The public entity is responsible for ensuring that each MAC reimbursement claim submitted is accurate and can provide the necessary backup documentation if requested by any state or federal agency.

2. The Desk Review Process Using Fairbanks Data

Fairbanks includes financial reporting system edits to assist with the desk review process. These prompt the public entity to include additional information or an explanation of the variance in the cost reported. The edits or audits may vary each quarter. These edits will often provide each entity with a historically based trend analysis that allows the entity to manage the financial information entered into the

system for each quarterly claim submission. The public entity must respond to the system edits for HHSC to conduct an appropriate desk review of the MAC claim.

Appendix A. RMTS Contact

Functions

The RMTS Contact will attend required training provided by HHSC or its designee, understand the purpose of the RMTS, understand the importance of updating and certifying the participant list (PL), and ensure that the updates and certifications are completed by the scheduled due dates. The Contact will ensure that all eligible participants are added to Fairbanks at the beginning of each federal fiscal quarter, add or delete program contacts as appropriate on the contact list, provide required training to selected time study participants, and ensure their availability to answer questions from sampled staff.

Oversight and Monitoring

The RMTS Contact will provide oversight of the RMTS and review the master participant list in Fairbanks to ensure its accuracy before the beginning of each RMTS period. Necessary updates will be made to the participant list on Fairbanks by the date the participant list closes for each quarter. Throughout the quarter, the entity will follow up with staff members that have not completed their sampled moment within the allowed response period (seven calendar days from the sampled moment). Follow-up activities may include a phone call, e-mail, or live discussion and must be documented. Questions or concerns raised by RMTS sampled staff will be answered promptly. Time study participants will be instructed to:

1. First, go to their supervisors with questions or concerns,
2. Next, the supervisor will contact the RMTS Contact regarding questions requiring assistance; and
3. Then the supervisor will provide the information back to the staff.

If a supervisor is not available, the RMTS Contact must be available to be contacted directly by the time study participant staff. The RMTS Contact will ensure that the 85 percent participation or response requirement is met each quarter and will act as a backup to the MAC Financial Contact when necessary. Questions regarding issues with Fairbanks will be directed to the State’s vendor for software support by the RMTS Contact or their assistant.

Documentation and Record-Keeping

Supporting documentation of all training conducted will be kept in the public entity's quarterly supporting documentation file (audit file). Documentation for all follow-up activities, such as phone calls, e-mails, or live discussions, will be kept in the supporting documentation file for that quarter. Federal regulations (see 45 CFR 75.361) require that records be kept for a minimum of three years from the date of submission of the final expenditure report. Or for Federal awards that are renewed quarterly or annually, from the date the quarterly or annual financial report is submitted, respectively. The records will be made available upon request from state and federal entities.

RMTS Training

HHSC conducts the annual training sessions mandatory for all RMTS Contacts. The RMTS Contact will ensure that all contacts with primary and secondary roles meet all applicable training requirements and ensure compliance with HHSC policy directives.

Additionally, the RMTS Contact will ensure that training is provided in adherence to all requirements to sampled staff who are added to the PL and selected for the time study.

Until an RMTS Contact completes the mandatory HHSC training, they will be given view-only access to the RMTS PL and will not have the ability to access, input, or update the RMTS PL. Failure by an entity to certify the RMTS PL will result in non-compliance with RMTS requirements and cause the entity to become ineligible to participate in DS and MAC claiming for the specified period.

1. Training materials

HHSC will make RMTS training materials accessible via the HHSC website. Entities are encouraged to use and distribute time study materials provided by HHSC to RMTS Contacts and time study participants. This material includes the Time Study Guides available on the HHSC website (https://pfd.hhs.texas.gov/time-study).

Training materials issued by HHSC or approved by HHSC will be used for sampled staff training. Public entities using training materials not issued by HHSC will submit them for approval 30 days prior to the scheduled training.

2. Training types

RMTS Contacts

In conjunction with the State's Vendor, HHSC will provide annual training for the RMTS Contacts. Training will include an overview of the RMTS process, software system, and information about accessing and inputting information into Fairbanks. The RMTS Contacts need to understand the purpose of the RMTS, the appropriate documentation and completion of the RMTS, the timeframes and deadlines for participation, and the consequences of non-compliance.

RMTS Contact training must be interactive. Therefore, training must be conducted face-to-face or via webinar.

Sampled Staff Training

RMTS Contacts who have completed the annual mandatory training requirement are responsible for training sampled staff. Sampled staff training will focus on program requirements and the proper documentation and completion of the RMTS sampled moment. Sampled staff need to understand the purpose of the RMTS, the appropriate documentation and completion of the RMTS moment, the timeframes and deadlines for completion and return of the sampled moment, and the consequences of non-completion of the sampled moment.

Sampled staff training must be made available quarterly. Sampled staff must receive annual training before completing their sampled moment. Sampled staff that have not completed annual sampled staff training cannot participate in the RMTS.

RMTS Contacts are responsible for documenting and maintaining training records to prove that sampled staff received mandatory training before completing the sampled moment. In addition, sampled staff participants must read a brief set of online instructions to supplement prior training before completing their moment.

Appendix B. Record-Keeping, Documentation, and Audit Checklist

To be used by agency contacts for Medicaid Administrative Claiming.

The following materials are in the audit file for the federal fiscal quarter ending _____:

- Copies of any worksheets or spreadsheets used in developing the claim.
- If applicable, a copy of the methodology used to establish the public entity's indirect cost rate.
- A listing of other costs.
- A detailed listing of all revenues offset from the claim by source and cost pool.
- Copy of methodology used to reconcile claims to the public entity's general ledger.
- A written statement describing how the MER was determined for the federal fiscal quarter ending _____.
- Copies of all training materials given to staff, dated for the quarter they were used.
- A list of personnel by name, employee identification number, and physical office address who participated in this study.
- A completed MAC claim.

Appendix C. MAC-Eligible Activities

The purpose of the Medicaid administration project is to ensure access of eligible individuals to Medicaid services, which are medically-related services covered under the Texas State Medicaid Plan. The following list, taken from the Texas Administrative Code, identifies eligible activities that can be claimed in MAC for the purpose of Medicaid administration.

To be claimed through the MAC program, administrative activities must:

- directly support efforts to identify, enroll, and maintain Medicaid eligibility for eligible and potentially-eligible children and adults; and
- directly support the provision of services covered under the Texas Medicaid State Plan.

The following activities have been identified by CMS as eligible for reimbursement:

- outreach;
- utilization review;
- eligibility determination;
- Medicaid referral, coordination, and monitoring;
- scheduling or arranging transportation to Medicaid covered services;
- translation services;
- program planning;
- development and interagency coordination;
- training;
- provider relations; and
- activities that determine a consumer's need for direct medical care.

Appendix D. Acronyms

The following is a list of acronyms that are used throughout this Guide.

CAPM	Contract Administration and Provider Monitoring
CEO	Chief Executive Officer
CFDA	Catalogue of Federal Domestic Assistance
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHIPRA	CHIP Reauthorization Act of 2009
CMCS	Center for Medicaid, CHIP and Survey & Certification
CMS	Centers for Medicare & Medicaid Services
DS	Direct Services
DUNS	Data Universal Numbering System
ECI	Early Childhood Intervention
ED	Executive Director
FAIN	Federal Award Identification Number
FFP	Federal Financial Participation
FFY	Federal Fiscal Year (October 1 through September 30)
FICA	Federal Insurance Contributions Act
FLSA	Fair Labor Standards Act
FUTA	Federal Unemployment Tax Act
GSA	General Services Administration
HHS	Health and Human Services

HHSC	Health and Human Services Commission
HUD	Department of Housing and Urban Development
IDCR	Indirect Cost Rate
IEP	Individualized Education Program
ISD	Independent School District
LHD	Local Health Department/District
MAC	Medicaid Administrative Claiming
MCS	Medicaid/CHIP Services Department
MER	Medicaid Eligibility Rate (a.k.a. Medicaid Eligibility Percentage)
MH/IDD	Mental Health/Individuals with an Intellectual and Developmental Disability
MIS	Management Information System
PFD	Provider Finance Department
PL	Participant List
POP	Program Operating Plan
QSI	Quarterly Summary Invoice
RMTS	Random Moment Time Study
SAM	System for Award Management
SMDL	State Medicaid Director Letter
SPI	Security and Privacy Inquiry
SPMP	Skilled Professional Medical Personnel
TAC	Texas Administrative Code
TANF	Temporary Assistance for Needy Families
TEA	Texas Education Agency

TIN Texas Identification Number

TUCA Texas Unemployment Compensation Act

UEID Unique Entity ID (a.k.a. UEI/Unique Entity Identifier)

U.S.C. United States Code

VIF Vendor Information Form

Appendix E. MAC Financial Definitions and Terms

Cost Pools are groupings of individual costs. Subsequent allocations are made of cost pools rather than individual costs. Costs are often pooled by departments, jobs, or behavior patterns. For example, overhead costs are accumulated by service departments in a factory and then allocated to production departments before multiple departmental overhead rates are developed for product costing purposes.

Direct Charge/Costs can be identified specifically with a particular final cost objective. For MAC purposes, these are costs directly related to the preparation of the time study participants and the preparation and submission of the MAC claim.

Direct Support Staff are public entity employees who directly support time studied staff who then provide services to entity clients or recipients.

Equipment Costs are expenses or costs incurred for an article of tangible nonexpendable personal property having a useful life of more than one year and an acquisition cost of $5,000 or more per unit, as defined in 45 CFR §75.439 and 2 CFR §200.439.

Functional knowledge means that the candidate can perform the activity involved and explain verbally or in writing what they are doing.

Hourly Rate is the amount of money paid for an hour worked.

Indirect Costs are (a) incurred for a common or joint purpose benefiting more than one cost objective and (b) not readily assignable to the cost objectives specifically benefitted, without effort disproportionate to the results achieved.

Job Categories are defined to distinguish differences in the quality of candidates' job-related competencies or knowledge, skills, and abilities (KSAs).

MAC Financials Claim is a claim submitted by a public entity to the State for reimbursement.

Materials and Supplies Costs are expenses or costs incurred for materials, supplies, and fabricated parts necessary to carry out a Federal award. Purchased materials and supplies shall be charged at their actual prices, net of applicable credits. Withdrawals from general stores or stockrooms should be charged at their actual net cost under any recognized method of pricing inventory withdrawals,

consistently applied. Incoming transportation charges are an acceptable part of materials and supplies costs.

Medicaid Eligibility Rate (MER) is also referred to as Medicaid Eligibility Percentage and is one of the factors required to determine the amount of a MAC claim. The public entity determines the MER by dividing the total unduplicated clients served for the quarter who are Medicaid eligible (numerator) by the total unduplicated clients served for the quarter (denominator).

Participant List (PL) is a list of public entity employees eligible to participate in a time study.

Random Moment Time Study (RMTS) is a federally approved statistical sampling technique and is recognized as an accepted alternative to 100 percent time reporting. The RMTS method provides a verifiable, statistically valid sampling technique that produces accurate labor distribution results by determining what portion of the selected group of participants' workload is spent performing all work activities.

Staff Pool is a group of individuals who perform like-kind functions.

Time Study is a tool used by public entities as an accepted method of objectively allocating staff time to the various activities measured. It is based on objective, empirical data, and its results reflect how staff time is distributed across the range of activities. A time study should reasonably represent staff activity during the specified quarter.

Time Study Staff are public entity employees or contract provider staff who provide services to clients and are eligible to be listed on the entity's participant list.

Training Costs are expenses or costs incurred by an employee for training received in the performance of the job and are usually reimbursed by the employer specifically to carry out the award.

Travel Costs are expenses or costs for transportation, lodging, subsistence, and related items incurred by employees in travel status on official business for the public entity.

Unduplicated Client Count is the total of unduplicated clients served within the claiming period (quarter).

Unduplicated Medicaid Client Count is the total of unduplicated Medicaid clients served within the claiming period (quarter).

Working knowledge is sufficient familiarity with the subject to know elementary principles and terminology, understand and solve simple problems, or enough knowledge to undertake a task but not thoroughly familiar.

Appendix F. Rules and Statutes

The federal government permits state Medicaid agencies to claim reimbursement for activities performed that are necessary for the proper and efficient administration of the Texas Medicaid State Plan. Public entities participating in MAC are subject to the following federal and state regulations:

CODE OF FEDERAL REGULATIONS TITLE 2—GRANTS AND AGREEMENTS

2 CFR Part 200 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards
https://ecfr.federalregister.gov/current/title-2/subtitle-A/chapter-II/part-200

CODE OF FEDERAL REGULATIONS TITLE 42—PUBLIC HEALTH

42 CFR 431.1 Purpose.
https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-C/part-431/section-431.1

42 CFR 431.15 Methods of administration.
https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-C/part-431/subpart-A/section-431.15

42 CFR 433.51
Part 433.51 Public funds as the State share of financial participation.
https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-C/part-433/subpart-B/section-433.51

CODE OF FEDERAL REGULATIONS TITLE 45—PUBLIC WELFARE

45 CFR Part 75 - Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards
https://ecfr.federalregister.gov/current/title-45/subtitle-A/subchapter-A/part-75

45 CFR Part 95 - General Administration - Grant Programs (Public Assistance, Medical Assistance and State Children's Health Insurance Programs)
https://ecfr.federalregister.gov/current/title-45/subtitle-A/subchapter-A/part-95

MEDICAID STATUTE SECTION OF THE SOCIAL SECURITY ACT

Social Security Act section 1903 – Payment to States
Sec. 1903 (a)(2).
https://www.ssa.gov/OP_Home/ssact/title19/1903.htm#act-1903-a-2

Sec. 1903 (a)(7).
https://www.ssa.gov/OP_Home/ssact/title19/1903.htm#act-1903-a-7

TEXAS ADMINISTRATIVE CODE

Texas Administrative Code (TAC) §355.8095,
Medicaid Administrative Claiming Program
https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=355&rl=8095