TEXAS TIMESTUDY
IMPLEMENTATION GUIDE FOR DIRECT SERVICES AND MEDICAID ADMINISTRATIVE CLAIMING
EFFECTIVE APRIL 25, 2007

Vision

The State of Texas Health and Human Services Commission (HHSC) is committed to providing efficient and effective Direct Service (DS) and Medicaid Administrative Claiming (MAC) Programs, to ensure the optimum delivery of services to our clients. In keeping with this vision, HHSC will implement a Random Moment Time Study methodology for the DS and MAC programs.

Introduction

Texas has operated an approved Medicaid Administrative Claiming program since 1995. The most current guidelines for the Texas program were issued in the October 1, 2003, Medicaid Administrative Claiming Implementation Plan, as approved by CMS. The purpose of this guide is to update the current Medicaid Administrative Claiming program to maintain compliance with federal requirements. This guide will describe the methodology the state will use to implement the new program and the requirements that participants must follow.

Health and Human Services Commission (HHSC) has partnered with school districts to implement both Direct Service and Medicaid Administrative Claiming Programs in Texas. The purpose of these agreements is to assist HHSC in providing effective and timely access to care for Medicaid recipients, more appropriate utilization of Medicaid covered services, and to promote activities that reduce the risk of poor health outcomes for the state's most vulnerable populations.

Statewide Time Study

HHSC may enter into interagency agreements with Local Independent School Districts (ISD's) to participate in the Random Moment Time Study. The agency-provider agreement must be effective the first day of the quarter in which the initial time study is to be conducted. HHSC must be assured that the provider is capable of administering the project and must have a written Program Operating Plan approved by the HHSC MAC Coordinator. Interagency agreement continuation will be dependent on maintaining compliance with the agreement and the Operating Plan.

Enrollment Criteria

Interagency Agreements

Historically HHSC entered into interagency agreements with Local ISD's for their participation in the program. Effective April 2007, ISDs must begin operating under the federal guidelines as outlined in the state's revised Time Study Implementation Guide. Once federal approval of

the state's Time Study Implementation Guide is obtained, ISDs will be required to enter into a new agreement for continued participation in the MAC program. This agreement, including an approved Program Operating Plan, must be in place prior to the end of the first quarter of participation after federal approval has been granted.

Program Operating Plan

All ISD's that choose to participate in the MAC program must submit to HHSC an Operating Plan and receive approval prior to the end of the first quarter of participation under the new approved Texas Time Study Implementation Guide. The Operating Plan will be a plan submitted by the local agency to the State and should include information on how the provider will carry out the DS and MAC functions as required by the interagency agreement, it will include contact information, document due dates and self-evaluation plans for program improvements. The operating plan is to be submitted for review and approval to:

For courier delivery mail to:

HHSC Rate Analysis Department
Medicaid Administrative Claiming
Braker Center, Building H
Mail Code H360
11209 Metric Blvd
Austin, TX 78758-4021

For regular mail delivery mail to:

HHSC Rate Analysis Department
Medicaid Administrative Claiming
Mail Code H360
PO Box 85200
Austin, TX 78708-5200

The Operating Plan is to be submitted on district letterhead and is to include the name and signature of the superintendent or executive director, the chief financial officer, and the project coordinator (MAC Coordinator).

Time Study Methodology

The purpose of the Texas statewide time study is to (1) identify the proportion of administrative time allowable and reimbursable under the MAC program and (2) identify the proportion of direct service time allowable and reimbursable under Medicaid to be used for Direct Service cost reporting to enable the State of Texas to conduct a cost settlement at the end of the fiscal year in the SHARS program. Staff performing Medicaid related activities in an ISD seeking reimbursement will participate in a time study using the approved Random Moment Time Study methodology.

In the event there is a "state of emergency" or other disaster declared in the State of Texas that results in prolonged school closures that impact the statistical validity of the RMTS as defined in Section III under sampling precision and confidence level, HHSC will apply the summer quarter claiming methodology to statistically invalid quarters occurring during the "state of emergency" including the quarter in which the state of emergency is declared and the quarter in which the state of emergency period ends. This means no RMTS will be ran during the impacted quarter(s) and claiming will be based on the average of the quarters that were completed. Texas will notify CMCS within 15 days of determining that a quarter is statistically invalid, including the reason for the determination, along with details and dates of the declaration of emergency.

Time Study Participants

All ISDs that participate in the Time Study will identify allowable Medicaid direct service and administrative costs within a given ISD by having staff who spend their time performing those activities participate in a quarterly time study. These ISDs must certify that any staff providing services or participating in the time study meet the educational, experiential and regulatory requirements.

The following categories of staff have been identified as appropriate participants for the Texas time studies. Additions to the list may be made depending upon job duties. The decision and approval to include additional staff will be made on a case-by-case basis by and other participants as consequently approved by CMS coverage in any additional State Plan Amendments still to be approved will also be included in the list at a future time.

All staff will be reported into one of two cost pools: a "Direct Service and Administrative

Providers" cost pool and an "Administrative Services Provider Only" cost pool. The two cost pools are mutually exclusive, i.e., no staff should be included in both pools. The following provides an overview of the eligible categories in each cost pool.

Direct Service and Administrative Cost Pool

TEA = Texas Education Agency
SBEC = State Board of Educator Certification
ASHA = American Speech-Language-Hearing Association

- Registered Nurses (RN)
- Licensed Vocational/Practical Nurses (LPN/LVN)
- Advanced Practice Nurses (APNs), including Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs) [One example of a CNS is Psychiatric Mental Health Nurses (PMHNs).]
- Delegated Nursing Services Provider (e.g., clinic aides, home health aides, certified nurse aides, certified medication aides, and school health aides)
- Physicians [medical doctors (MDs); doctors of osteopathy (DOs)]
- Licensed Audiologist
- Licensed Assistant in Audiology
- Licensed Occupational Therapist (OT)
- Certified Occupational Therapy Assistant (COTA)
- Licensed Physical Therapist (PT)
- Licensed Physical Therapy Assistant (LPTA)
- Licensed Psychologist
- Licensed Specialist in School Psychology (LSSP)
- Licensed Psychiatrist
- ASHA-Equivalent SLP with Texas license and master's degree
- ASHA SLPs with Texas Licenses
- Grandfathered SLP with Texas License and no master's degree
- TEA- or SBEC-Certified Speech Therapists
- Licensed Assistant in SLP
- Licensed SLP Intern
- Licensed Professional Counselor (LPC)

- Licensed Marriage and Family Therapist (LMFT)
- Licensed Clinical Social Worker (LCSW)
- Personal Care Service Providers (e.g., special education teacher, special education teacher's aide, and bus aide/monitor)

Administrative Services Only Cost Pool

- Physician Assistant
- Licensed Bachelor of Social Work
- Licensed Master of Social Work
- Service Coordinator/Case Managers
- Interpreter/Translator/Bilingual Specialist
- Pregnancy, Education & Parenting Program Personnel
- Orientation & Mobility Specialist
- Outreach Workers
- Psychology Intern
- Behavioral Counselor

ISD personnel who are chosen to participate in the time study must be assigned to job categories that describe their job function rather than a generic title that encompasses numerous types of personnel (i.e., pupil support personnel). A miscellaneous group is not acceptable. If a category does include a limited mix of job functions and titles, the functional (or working) job title must be listed beside each person's name. The ISD must maintain a complete job description on file for each of these eligible positions.

The ISDs must certify that the list of staff they are submitting to be included in the eligible staff pool are appropriate for inclusion in the time study and eventual claim. Staff deemed inappropriate during review of time study quarters will be removed from the time study and excluded from the claim.

Administrative staff such as executive directors, program directors, principals, assistant principals, special education directors, and other managers/supervisory staff are not to be included in the time study. Likewise, there should be no clerical or administrative support staff included. These staff will be included in the claiming process by allocating their time and appropriate costs based on the total time study effort.

Two mutually exclusive time studies, described below, will be conducted for the Direct Services and MAC programs. Although some staff may perform both direct and MAC related activities, they will only be allowed to participate in one of the two time studies. For Direct Service staff that also performs MAC activities, the direct services time study will be used to identify the claimable activities for both programs. MAC claimable time will only be included on a MAC cost report and will no be reimbursed through the Direct Services Program.

- The first time study and associated cost pool is comprised of direct service staff, including those who conduct both direct services and administrative activities as well as direct service staff only, and the respective costs for the staff.
- The second time study and associated cost pool is comprised of administrative claiming staff only and the respective costs for these staff.

Therefore, the two universes of time study participants and associated cost pools are mutually exclusive and the only direct costs that can be claimed under Medicaid related to this program are derived from the two cost pools above.

Upon CMS approval, the State will utilize a Random Moment time Study (RMTS) methodology at which time all ISDs who participate in the MAC and SHARS programs will be required to participate in the statewide RMTS methodology of time study.

Random Moment Time Study Methodology (April-June 2007 Quarter Only)

For the purposes of the ISD's participation in both the SHARS and MAC programs, HHSC has indicated it plans to implement RMTS for the April-June 2007 quarter, and has worked collaboratively with CMS towards that goal. Since approval from CMS is forthcoming, HHSC proposes to conduct the April-June 2007 time study period from April 16th (or upon approval by CMS) until June 6th, 2007.

April 16th has been selected as the first date of the time study period since the RMTS process cannot begin before CMS provides approval on the implementation plan. Assuming that CMS provides that approval this week, HHSC plans to select a sample for the period that begins on the following Monday, April 16th. In addition, June 6th has been selected as the final day of the time study since the Texas school year ends at this time or prior to this date for school districts. This survey design is in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide, on page 42, Example 4, Specifically:

> *"If the school year ends in the middle of a calendar quarter (for example, sometime in June, the last time study for the school year should include all days through the end of the school year. Therefore, if the school year ends June 25th, then all days through and including June 25th must be included among the potential days to be chosen for the time study."*

In subsequent years, HHSC will begin the April – June quarter on April 1, but will annually determine the last day of the quarter in which most schools will be in session. Since school calendars change on an annual basis, HHSC will evaluate the school calendars on an annual basis.

The sampling periods are designed to be in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide, on page 42, Example 4, Specifically:

> *"If the school year ends in the middle of a calendar quarter (for example, sometime in June, the last time study for the school year should include all days through the end of the school year. Therefore, if the school year ends June 25th, then all days through and including June 25th must be included among the potential days to be chosen for the time study."*

Each federal quarter, HHSC will determine the dates that school districts will be in session and for which their staff members are compensated. District staff members are paid to work during those dates that districts are in session; as an example, districts may end the school year sometime in May each year. All days including and through the end of the school year would be included in the potential days to be chosen for the time study. It is important to understand that although districts may end the school year prior to the close of the federal quarter staff members are paid for services provided through the end of the federal fiscal quarter. Districts typically spread staff compensation over the entire calendar year even when staff members are not working. The district considers this compensation reimbursement for time when staff

members actually work rather than compensation for the staff members time off during the summer months.

HHSC will review district calendars each quarter to determine those dates that the schools pay for their staff to work, and those dates will be included in the sample. Since school calendars change on an annual basis, HHSC will also evaluate the school calendars on an annual basis, determine the period to be sampled each quarter, and document this process annually.

Since HHSC is conducting a statewide time study sample, each quarter HHSC will review a representative sample of district calendars to determine the most common begin and end dates for statewide sampling purposes. HHSC will review and document their review of district calendars on an annual basis. At a minimum, the eligible sample dates will be based off of the calendars for at least 25% of statewide district staff.

Random Moment Time Study (RMTS)

Sometimes referred to as Random Moment Sampling, RMTS is a federally accepted method for tracking employee time within ISDs. According to OMB Circular A-87 (revised 5/10/04), and its accompanying implementation guide ASMB C-10, "Substitute systems for allocating salaries and wages to Federal awards may be used in place of activity reports. These systems are subject to approval if required by the cognizant agency. Such systems may include, but are not limit to, random moment sampling…."

Random moment sampling or RMTS is particularly useful, because:

- It uses a verifiable, statistically valid random sampling technique that produces accurate labor distribution results, and
- It greatly reduces the amount of staff time needed to record an individual time study participant's activities.

The RMTS method polls participants on an individual basis at random time intervals over a given time period and totals the results to determine work effort for the entire population of eligible staff over that same period. The RMTS method provides a statistically valid means of determining what portion of the selected group of participant's workload is spent performing activities that are reimbursable by Medicaid.

Sampling Requirements (RMTS)

In order to achieve statistical validity, maintain program efficiencies and reduce unnecessary district administrative burden, HHSC intends to implement a consistent sampling methodology for all activity codes and groups to be used. HHSC has constructed the RMTS sampling methodology to achieve a level of precision of +/- 2% (two percent) with a 95% (ninety-five percent) confidence level for activities. While the 2003 Guide specifically allows for a 5% precision level and this level meets both the Guide requirements and HHSC's goals for an efficient and simplified sampling process, the HHSC sampling methodology is constructed at the 2% precision level based on preferences stated by the CMS statistician.

As stated, the HHSC RMTS sampling methodology is designed to permit a level of precision of +/- 2% (two percent) with a 95% (ninety-five percent) confidence level for activities. Statistical calculations show that a minimum sample of 2401 completed moments each quarter, per cost pool, is adequate to obtain this precision when the total pool of moments is greater than 3,839,197. Additional moments are selected each quarter to account for any lost moments. Lost moments are observations that cannot be used for analysis, i.e., incomplete moments or moments selected for staff no longer at the ISD.

The following formula is used to calculate the number of moments sampled for each time study cost pool:

$$ss = \frac{Z2 * (p) * (1-p)}{c2}$$

where:

Z = Z value (e.g. 1.96 for 95% confidence level)
p = percentage picking a choice, expressed as decimal
(.5 used for sample size needed)
c = confidence interval, expressed as decimal
(e.g., .02 = ±2)

Correction for Finite Population

$$\text{new ss} = \frac{ss}{1 + \frac{ss-1}{pop}}$$

where:

pop = population

The following table shows the sample sizes necessary to assure statistical validity at a 95% confidence level and tolerable error level of 2%. Additional moments will be selected to account for unusable moments, as previously defined. An over sample of 15% will be used to account for unusable moments.

N=	Sample Size Required	Sample Size plus 15% Oversample
100,000	2345	2697
200,000	2373	2729
300,000	2382	2739
400,000	2387	2845

500,000	2390	2849
750,000	2393	2852
1,000,000	2395	2854
3,000,000	2399	2859
>3,839,197	2401	2860

RMTS Process

The RMTS process is described here as four steps:

1. Identify total pool of time study participants
2. Identify total pool of time study moments
3. Randomly select moments and then randomly match each moment to a participant
4. Notify selected participants about their selection

1. Identify Total Pool of Time Study Participants

   At the beginning of each quarter, participating ISDs provide a staff roster (Participant List) to HHSC providing a comprehensive list of staff eligible to participate in the RMTS time study. This list of names is subsequently grouped into job categories (that describe their job function), and from that list all job categories are assigned into one of two "cost pools" for each ISD participating in the time study. There will be two cost pools.

2. Identify Total Pool of Time Study Moments

   The total pool of "moments" within the time study is represented by the calculating the number of working days in the sample period, times the number of work hours of each day, times the number of minutes per hour, and times the number of participants within the time study. The total pool of moments for the quarter is reduced by the exclusion of weekends, holidays and hours during which employees are not scheduled to work.

3. Randomly Select Moments and Randomly Match Each Moment to a Participant

   Once compiled statewide, each cost pool is sampled to identify participants in the RMTS time study. The sample is selected from each statewide cost pool, along with the total number of eligible time study moments for the quarter. Using a statistically valid random sampling technique, the desired number of random moments is selected from the total pool of moments. Next, each randomly selected moment is matched up, using a statistically valid random sampling technique, with an individual from the total pool of participants.

   Each time the selection of a minute and the selection of a name occurs, both the minute and the name are returned to the overall sample pool to be available for selection again. In other words, the random selection process is done with replacement so that each minute and each person are available to be selected each time a selection occurs. This step guarantees the randomness of the selection process.

Each selected moment is defined as a specific one-minute unit of a specific day from the total pool of time study moments and is assigned to a specific time study participant. Each moment selected from the pool is included in the time study and coded according to the documentation submitted by the employee.

The sampling period is defined as the three-month period comprising each quarter of the Federal Fiscal Year calendar. The following are the Federal quarters followed for the MAC program:

- January 1-March 31
- April 1-June 30
- July 1-September 30
- October 1-December 31

The sampling periods are designed to be in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide, on page 42, Example 4, Specifically:

> *"If the school year ends in the middle of a calendar quarter (for example, sometime in June, the last time study for the school year should include all days through the end of the school year. Therefore, if the school year ends June 25th, then all days through and including June 25th must be included among the potential days to be chosen for the time study."*

Each federal quarter, HHSC will determine the dates that school districts will be in session and for which their staff members are compensated. District staff members are paid to work during those dates that districts are in session; as an example, districts may end the school year sometime in May each year. All days including and through the end of the school year would be included in the potential days to be chosen for the time study. It is important to understand that although districts may end the school year prior to the close of the federal quarter staff members are paid for services provided through the end of the federal fiscal quarter. Districts typically spread staff compensation over the entire calendar year even when staff members are not working. The district considers this compensation reimbursement for time when staff members actually work rather than compensation for the staff members time off during the summer months.

HHSC will review district calendars each quarter to determine those dates that the schools pay for their staff to work, and those dates will be included in the sample. Since school calendars change on an annual basis, HHSC will also evaluate the school calendars on an annual basis, determine the period to be sampled each quarter, and document this process annually.

Since activities and services are not provided in the ISDs when school is not in session, HHSC will not conduct a July – September time study, but will rather use an average of the three previous quarters to calculate a claim for the July – September period. This is in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide, page 42. Specifically:

> "*…the results of the time studies performed during the regular school year would be applied to allocate the associated salary costs paid during the summer. In general, this is acceptable if administrative activities are not actually performed during the summer break, but salaries (reflecting activities performed during the regular school year) are prorated over the year and paid during the summer break."*

HHSC has determined that activities are not performed in the summer time when districts are not in session.

Since HHSC is conducting a statewide time study sample, each quarter HHSC will review a representative sample of district calendars to determine the most common begin and end dates for statewide sampling purposes. HHSC will review and document their review of district calendars on an annual basis. At a minimum, the eligible sample dates will be based off of the calendars for at least 25% of statewide district staff.

4. Notify Participants about their Selected Moments

   Time study participants are notified via paper, email or other method, of their requirement to participate in the time study and of their sampled moment. Sampled participants will be notified of their sampled moment three days prior to their sampled moment. At the prescribed moment, each sampled participant is asked to record and submit his/her activity for that particular moment.

A validity check of the time study results is completed each quarter prior to the calculation of the claim. The validity check ensures that the minimum number of responses is received each quarter to meet the required confidence level. The number of completed and returned time study moments is analyzed to confirm that the confidence level requirements have been met. Once the validity of the sample has been confirmed, the time study results are calculated and prepared for the calculation of the quarterly claim.

At the end of each quarter, once all Random Moment data has been received and Time Study results have been calculated, statistical compliance reports will be generated to serve as documentation that the sample results have met the necessary statistical requirements.

Training Types & Overview

Three types of training will be conducted for RMTS (1) Program Contact Training, (2) Central Coding Staff Training and (3) Sampled Staff Training. The following is an overview of each training type.

Program Contact Training (RMTS)

HHSC in conjunction with the State's vendor will provide initial training for the ISDs' Coordinators, which will include an overview of the RMTS software system and information on how to access and input information into said system. These program coordinators will then be responsible for conducting training of the selected time study participants in their ISDs. It is essential for the ISDs' Coordinators to understand the purpose of the time studies, the appropriate completion of the RMTS, the timeframes and deadlines for participation, and that their role is crucial to the success of the program. Participants are to be provided detailed information and instructions for completing and submitting the time study documentation of the sampled moment. All training materials will be accessible to Program Coordinators initially via the Fairbanks LLC website and subsequently the HHSC website. In addition, annual training will be provided to the Program Coordinators to cover topics such as MAC program updates, process modifications and compliance issues.

Central Coding Staff Training (Activity Coding)

Central Coders will be employed by the State's vendor and will review the documentation of participant activities performed during the selected moments and determine the appropriate activity code. In a situation when insufficient information is provided to determine the appropriate activity code, the central coder will contact the Program Coordinator at the individual ISD and request submission of additional information about the moment. Once the information is received the moment will be coded and included in the final time study percentage calculation. All moments will be coded separately by at least two coders as part of a quality assurance process. The moments and the assigned codes will be reviewed for consistency and adherence to the state approved activity codes.

HHSC will provide training to the coding staff on an as needed basis, but at a minimum annually to discuss issues surrounding the coding of moments. Training will include an overview of activity codes, samples of activities, and appropriate processes for making coding determinations. On a quarterly basis, HHSC will review a sample of the coding process and original participant documentation for Quality Assurance to show the data submitted in the time study questionnaires support the code selected and therefore show the codes are valid and accurate. In addition to the quarterly review, at its discretion, HHSC can review the completed coding and original participant documentation at any time throughout the claim process or as needed for further review or audit purposes.

Sampled Staff Training

The Program Coordinator for each ISD must ensure that sampled staff receive training prior to their completion of the RMTS for their sampled moment. Since all RMTS responses will be reviewed by Central Coders, and these Coders will subsequently select the appropriate activity code, the staff training will focus on program requirements and the completion of the RMTS survey. The staff training will not include an overview of activity codes since all coding will be completed by Central Coders. The following items must be included in staff training:

- Overview of the required process to participate in RMTS
- Review the standards for RMTS documentation submitted by staff
- Methods for requesting additional documentation from time study participants when insufficient information is provided to centralized coders to determine the appropriate activity code.
- The training must be provided quarterly, staff that has not received training can not participate in the RMTS.
- ISDs must maintain documentation, that all staff participating in each quarter's time study received training.
- It is required that any training materials used by ISDs be submitted for review and comment to HHSC.
- ISDs are encouraged to use and distribute any materials provided by the state regarding the time study.
- ISDs may use a variety of staff training methodologies. Some of these methods include, but are not limited to, on-site trainings, video conferencing, web-based, CD's, videos, and self-training (only after the completion of some form of interactive training has been completed).

All training materials used by ISDs must be submitted for review and comment to HHSC.

Documentation (RMTS)

All documentation of sampled moments must be returned within three weeks after the sampled date. Documentation of moments not received within the required time frame cannot be used in the calculation of the necessary number of moments needed to satisfy the level of precision of +/- 2% (two percent) with a 95% (ninety-five percent) confidence interval.

Documentation of sampled moments must be sufficient to provide answers to three questions needed for accurate coding:

- Who was with you?
- What were you doing?
- Why were you performing this activity?
- In addition, sampled staff will certify the accuracy of their response prior to submission

Additional documentation maintained by the State and its vendor will include:

a) Sampling and selection methods used,
b) Identification of the moment being sampled, and
c) Timeliness of the submitted time study moment documentation.

Invalid moments are moments not returned by the ISD or moments that were not accurately coded by the coders based on the review by HHSC staff. Moments that have been inaccurately coded will be returned to the vendor for correction, and every effort will be made by HHSC to obtain the corrected valid moment from the vendor.

Time Study Return Compliance

HHSC will require a state-wide response rate for the time study survey of at least 85%, and all non-returned moments will be included and coded as non-Medicaid time until an 85% compliance rate is obtained. If the 85% compliance rate is reached without having to code to non-Medicaid time, then non-returned moments will be ignored since they are compensated by the 15% over sampling of the sample size.

To assist in reaching the statewide goal of 85% compliance, HHSC will monitor the ISDs to ensure they are properly returning sample moments and the ISD's return percentage for each quarter will be analyzed by HHSC. If an individual district has non-returns greater than 15% and greater than five (5) moments for a quarter, the ISD will receive a warning letter from HHSC. If the same ISD is in default (as defined previously) the next quarter after being warned, they will not be able to participate in the time study for a one year period of time. For instance, if an ISD has non-returns greater than 15% and greater than five (5) moments for the quarter ended September 30, 2007 and December 31, 2007, the ISD will not be able to claim for the Fiscal Year Ending September 30, 2008, and will need to return any interim payments sent to the ISD for the fiscal year under the Direct Services Program.

HHSC will identify all non returned moments and make every effort to find out why the moments were not returned. HHSC staff will identify on a weekly basis the non returned moments and sort by ISD. A list of these non returned moments will be sent to the ISD's Program Coordinator for response. Participants will be asked to explain why the moment was not completed and returned, and will also be asked what they were doing at the time of the

moment in question to the best of their recollection. HHSC will then analyze this data to ensure that the non-returns are reflective of the time study results. This data will not be included in the claiming process but will be used only to insure that ISDs are not purposely withholding non Medicaid related moments.

Time Study Activities/Codes

The time study codes assist in the determination of time and associated costs that are related to and reimbursable under the Medicaid program. The time study codes have been designed to reflect all of the activities performed by time study participants per ISD.

The time study codes are assigned indicators that determine its allowability, federal financial participation (FFP) rate, and Medicaid share. A code may have one or more indicators associated with it. These indicators should not be provided to time study participants.

The time study code indicators are:

Application of FFP rate	50 percent	Refers to an activity that is allowable as administration under the Medicaid program and claimable at the 50 percent non-enhanced FFP rate.
Allowability & Application of Medicaid Share	U	Unallowable – refers to an activity that is unallowable as administration under the Medicaid program. This is regardless of whether or not the population served includes Medicaid eligible individuals.
	TM	Total Medicaid – refers to an activity that is 100 percent allowable as administration under the Medicaid program.
	PM	Proportional Medicaid – refers to an activity, which is allowable as Medicaid administration under the Medicaid program, but for which the allocable share of costs must be determined by the application of the proportional Medicaid share (the Medicaid eligibility rate). The Medicaid share is determined as the ratio of Medicaid eligible students to total students.
	R	Reallocated – refers to those general administrative activities which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under Code 15, General Administration.

Effective April, 2007 the following time study codes are to be used for the Random Moment Time Study:

Code	Activity	MAC Indicator(s)	Direct Service Indicators
1.a	Non-Medicaid Outreach (All Staff)	U	
1.b	Medicaid Outreach (All Staff)	TM/50%	
2.a	Facilitating Non-Medicaid Eligibility (All Staff)	U	
2.b	Facilitating Medicaid Eligibility (All Staff)	TM/50%	
3	School Related & Educational Activities	U	
4.a	Direct Medical Services - IEP		
4.b	Direct Medical Services – Non IEP		
5.a	Medicaid Transportation Non-Medicaid (All Staff)	U	
5.b	Medicaid Transportation (All Staff)	PM/50%	
6.a	Medicaid Translation Non-Medicaid	U	
6.b	Medicaid Translation	50%	
7.a	Program Planning, Development and Interagency Coordination Non-Medical(All Staff)	U	
7.b	Program Planning, Development and Interagency Coordination Medical (All Staff)	PM/50%	
8.a	Non-Medical/Non-Medicaid related Training	U	
8.b	Medical/Medicaid related Training	PM/50%	
9.a	Referral, Coordination, and Monitoring Non-Medicaid Services (All Staff)	U	
9.b	Referral, Coordination, and Monitoring Medicaid Services (All Staff)	PM/50%	
10	General Administration	R	
11	Not Paid/Not Worked	U	

These activity codes represent administrative and direct service activity categories that are used to code all categories of claims. For all activity codes and examples, if an activity is provided as part of, or an extension of, a direct medical service, it may not be claimed as Medicaid administration. As required under new federal guidelines, none of the activity codes are reimbursable at the 75 percent FFP rate.

The detail code definitions and examples may be found in Appendix A.

MAC Claim Development

Participating MAC ISDs will submit quarterly claims to HHSC. These claims will be based on the quarterly costs, the time study, the Medicaid eligibility rate, the provider participation rate, and the FFP.

Medicaid Eligibility Rates (MER) Calculation

For most of the Medicaid administrative activities that school district personnel perform, the costs associated with these activities are only reimbursable to the extent that they are allocable to the Medicaid enrolled population. Therefore, these activities are adjusted by the Medicaid Enrollment Rate. This adjustment factor or "discount" reflects the nature of the outreach activity and the targeted population to which the effort is directed.

Each quarter, an MER will be calculated for each district. At the beginning of each school year, districts submit enrollment data for a particular school year to TEA. The first enrollment submission in the school year will be used for purposes of MER calculation, and provides a snapshot of each district's enrollment as of a particular date. This enrollment data will be used as the "denominator" of the MER calculation each quarter. In order to determine the quarterly MER, the current year's enrollment data will be matched to a Medicaid eligibility file each quarter.

The process for developing the ISD MER is as follows:

- The PEIMS enrollment data for the current school year is submitted to TEA by each district, and a snapshot is taken at the beginning of each school year.
- The Medicaid eligibility files for each quarterly period is gathered
- The Medicaid eligibility data is forwarded to TEA for use in the developing the MER. Authorization to provide detailed eligibility information has been received from the State Medicaid Director.
- TEA develops an unduplicated Medicaid eligibility file from the monthly files provided by HHSC
- The unduplicated Medicaid eligibility file is matched against the PEIMS enrollment data. There are 2 matches performed – 1) first is a match based on SSN, 2) for those who do not match based on SSN, a second run is performed based on first name, last name and date of birth.
- The total number of matches divided by the total number of enrolled students (by district) becomes the district's quarterly MER.

Provider Participation Rate

The CMS guide states that in order for administrative services related to a referral to be reimbursed, the referral for these services must be made to a participating provider. The state may develop a proportional provider participation rate to represent the percentage of referrals to participating providers.

Federal Financial Participation (FFP)

Effective October 1, 2003, school based programs were no longer allowed to claim expenditures at the enhanced rate for Skilled Professional Medical Personnel (SPMP). All Medicaid reimbursable expenditures are reimbursed at the 50 percent rate.

Financial Data

The financial data to be included in the calculation of the MAC claim are to be based on actual expenditures incurred during the quarter. These costs must be obtained from actual detailed expenditure reports generated by the provider's financial accounting system. Claims may not be based on quarterly budgets.

OMB Circular A-87 specifically defines the types of costs: direct costs, indirect costs and allocable costs that can be included in the program. Sections 1 through 42 provide principles to be applied in establishing the allowability or unallowability of certain items of cost. These principles apply whether a cost is treated as direct or indirect. The following items are considered allowable costs as defined and cited below by A-87.

Direct Costs

Typical direct costs identified in A-87 include:

- Compensation of employees
- Cost of materials acquired, consumed, or expended
- Equipment
- Travel expenses incurred

Indirect Costs

Indirect costs included in the claim are computed by multiplying the costs by the ISDs' approved unrestricted indirect cost rate. These indirect rates are developed by the ISDs state cognizant agency, Texas Education Agency (TEA), and are updated annually. The methodology used by the respective state cognizant agency to develop the indirect rates has been approved by the cognizant federal agency, as required by the CMS guide. Indirect costs are included in the claim as reallocated costs.

HHSC will ensure that costs included in the MAC financial data are not included in the district's unrestricted indirect cost rate, and no costs will be accounted for more than once.

Unallowable Costs

Costs that may not be included in the claim are:

Direct costs related to staff that are not identified as eligible time study participants (i.e., costs related to teachers, cafeteria, transportation, and all other non-Medicaid administrative areas)
Costs that are paid with 100 percent federal funds
Any costs that have already been fully paid by other revenue sources (federal, state/federal, recoveries, etc.)

Revenue Offset

Expenditures included in the MAC claim are often funded with several sources of revenue. Some of these revenue sources require that expenditures be offset, or reduced, prior to determining the federal share reimbursable by Medicaid. These “recognized” revenue sources requiring an offset of expenditures are:

- Federal funds (both directly received by the district and pass through from state or local agencies)
- State expenditures that have been matched with federal funds (including SHARS). Both the state and federal share must be used in the offset of expenditures.
- Third party recoveries and other insurance recoveries

Claim Certification

ISDs will only be reimbursed the federal share of any MAC billings. The Chief Financial Officer (CFO), Chief Executive Officer (CEO), Executive Director (ED), Superintendent (SI) or other individual designated as the financial contact by the ISD 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.

ISDs will be required to maintain documentation that appropriately identifies the certified funds used for MAC claiming. The documentation must also clearly illustrate that the funds used for certification have not been used to match other federal funds. Failure to appropriately document the certified funds could result in non-payment of claims.

Claim Submission and Timeframes

Claims for MAC are to be submitted on a quarterly basis and will be signed by each individual ISDs CFO, CEO, ED, SI or other individual designated as the financial contact by the ISD. A template containing the detailed spreadsheet and the certification form will be provided to all participating ISDs.

Documentation & Recordkeeping Requirements

It is required that all MAC ISDs maintain documentation supporting the administrative claim. The ISDs must maintain and have available upon request by state or federal entities the contract with the state to participate in the MAC program and the ISD’s approved Operating Plan for MAC.

Some documentation must be maintained quarterly. This information must be available upon request by state or federal entities. The quarterly requirements are outlined below.

Each participating ISD will maintain a quarterly audit file containing, at a minimum, the following information:

- A roster of eligible individuals, by category, submitted for inclusion in the participant sample pool
- Verification of compliance with training requirements by time study participants
- Financial data used to develop the expenditures and revenues for the claim calculations including state/local match used for certification
- Documentation of the district's approved indirect rate (if applicable)
- A copy of the completed and signed certification form

Retention period

Documentation must be retained for the minimum federally required time period. Federal guidelines (42 CFR 433.32) state the retention period is three years unless there is an outstanding audit. The state's requirement is for ISDs to maintain the administrative claiming documentation for five years or until such time all outstanding audit issues are resolved.

MAC Claim Desk Review

The MAC Claim Desk Review is utilized to ensure the integrity and accuracy of all of the claim data. Desk reviews will be completed quarterly for all entities unless otherwise specified by the HHSC MAC Coordinator. All data on the claim will be verified, using the information retrieved from the RMTS and MAC financial cost reporting for the quarter being reviewed, prior to any authorization of MAC Claims.

Requests for extensions will be considered on a case by case basis. However, all applicable late submission consequences will apply. Upon completion of the HHSC review of the materials sent by the ISD, any discrepancies will be brought to the attention of the Program Coordinator. HHSC will contact the ISD by e-mail requesting explanation, clarification, and/or correction of discrepancies. Items included in the desk review include:

- District participation in HHSC's required Program Contact training in order to participate in RMTS
- Submission and certification of quarterly Participant List
- Review of RMTS compliance rate, ensure each district meets the 85% compliance level requirement
- Submission and certification of MAC financial cost reporting
- Review of applied IDCR and MER
- Submission and review of individual district claim

All return correspondence from the ISD must be in writing on agency letterhead and received by HHSC within 5 business days of the request.

Oversight and Monitoring

Federal guidelines require the oversight and monitoring of the administrative claiming programs. This oversight and monitoring must be done at both the ISD and the state level.

HHSC/State Level Oversight and Monitoring

The state is charged with performing appropriate oversight and monitoring of the Time Study and MAC programs to ensure compliance with state and federal guidelines. HHSC is the responsible agency for this required monitoring and oversight effort.

HHSC Areas of Review

The state will monitor and review various components of the MAC programs operating in the state. The areas of review include, but are not limited to,

- Participant List - ensure only eligible categories of staff are reported on the participant list based on the approved RMTS categories in the implementation plan
- RMTS Time Study – sampling methodology, the sample, and time study results
- RMTS Central coding - review a sample of the completed coding and original participant documentation for coding accuracy and validation.
- Training - Compliance with training requirements: program contact, central coder and district staff
- Financial Reporting – Costs are only reported for eligible cost categories and meet reporting requirements
- Documentation compliance

Frequency

All MAC programs are monitored at least once per year. This monitoring will consist of either an on-site, desk, or combination review. For this annual monitoring process, one quarter will be selected for in-depth review. Participating ISDs will be required to fully cooperate in providing information and access to necessary staff in a timely manner to facilitate these efforts. ISDs that do not fully cooperate in the review process may be subject to sanctions.

For other quarters, trends will be examined, for example, total costs in the claim, time study results, and reimbursement levels. Any significant variations from historical trending will be communicated to the ISDs for explanation of the variance.

The state will pursue remedial action for ISDs that fail to meet MAC program requirements or fail to correct problems identified during review. Examples of actions that will cause implementation of sanctions include, but are not limited to:

- Repeated and/or uncorrected errors in financial reporting, including failure to use the state provided financial reporting templates
- Failure to cooperate with state and/or federal staff during reviews or other requests for information

- Failure to maintain adequate documentation
- Failure to provide accurate and timely information the state's RMTS vendor as required

Sanctions the state may impose include placing ISDs on "payment hold", conducting more frequent monitoring reviews, recoupment of funds, and ultimately, cancellation of the ISD's interagency agreement.

Local ISD Level Oversight and Monitoring

Each participating MAC program must submit and receive approval of an Operating Plan. The plan must describe how the MAC program will be implemented and oversight and monitoring actions that will be taken to ensure compliance with MAC requirements.

Actions must be taken to ensure, at a minimum, that:

- The time study is performed correctly
- The time study results are valid
- The financial data submitted is true and correct
- Training requirements are met
- Appropriate documentation is maintained to support the time study and the claim

The Operating Plan must include the following elements:

Description of the procedures and methods that will be used by the district in operating their MAC program including:

- Local project coordinator and responsibilities
- Time study participants
- Training requirements and methods
- Fiscal information
- Audit file/documentation methodology
- Effective dates
- Authorizing signatures

A list of personnel responsible for the administration of the MAC program

Local Agency MAC Coordinator's Quarterly Status Report to SI/CEO/ED

HHSC requires that a written Annual Status Report be given to the CEO/ED identifying any progress, problems, improvements, and status of the MAC claim. Additional information can and should be added as the Local Agency MAC Coordinator and the SI/CEO/ED see fit. This status report is required to be completed in writing and must be signed by the SI/CEO/ED annually.

Annual Self-Evaluation Report

Local Agency Time Study and/or MAC Coordinators are required to review their local agency's policies and procedures that have been implemented for the time study at least annually. The purpose of this review is to ensure that all the mandatory participation requirements are being

covered in the manner as required by HHSC. The self-evaluation must be completed in writing every FFY during the 4th quarter and must be signed and dated by the Program Coordinator and the SI/CEO/ED.

To conduct the self-evaluation, Program Coordinators must review the time study process at their local agency. The Program Coordinator must review the effectiveness of the strategies delineated in the Operating Plan. The Program Coordinator must document any items identified, at this time or throughout the year, as ineffective.

Documentation must include an explanation as to why the strategy was not effective. The self-evaluation must contain an explanation of the revised policy and/or procedure and the anticipated outcomes. If the policy and/or procedures have already been implemented, the documentation must include the outcomes thus far.

Program Coordinators must also determine if there are any mandatory requirements that are not being completed and document how those items will be addressed during the following FFY.

Program Coordinators will review the following items:

- Accurate submission of quarterly participant list, based on the approved RMTS categories in the implementation plan
- Quarterly certification of the Participant List for accuracy
- Documentation that sampled staff that participate in RMTS complete training
- Compliance rate for returned RMTS moments to meet at least 85%
- Accurate submission of quarterly financial costs, based on approved cost reporting categories
- Quarterly certification of financial cost reporting and certification of funds

Required Personnel

Each ISD must designate an employee as the Program Coordinator. This single individual is designated within a local agency to provide oversight for the implementation of the time study and to ensure that policy decisions are implemented appropriately. The local agency must also designate an Assistant Program Coordinator to provide back-up support for time study responsibilities.

Required Attendance of the Program Coordinators and Assistant Program Coordinators

HHSC requires one Program Coordinator attend the initial RMTS training. A minimum of two people with a working knowledge of MAC are required to attend all mandatory HHSC training sessions, following the initial training, as scheduled by HHSC. This includes the Program Coordinator and/or the Assistant Program Coordinator or at least one additional local agency personnel with a working knowledge of MAC.

Failure to attend the required training will result in the following consequences:

a). First absence – Local agency will be moved forward on the RMTS Review schedule;

b). Second absence – Recoup 5 percent of next submitted and approved claim;
c). Third absence – Recoup 5 percent of next submitted and approved claim;
d). Fourth absence – Recoup 5 percent of next four submitted and approved claims; and
e). Fifth absence – Removal of the Interagency Agreement (no payment on claim) but still are required to participate in the RMTS for rate setting purposes. .

APPENDIX A

Medicaid Administrative Claiming Time Study Codes Effective April 2007

Effective April 2007, the following codes are to be used for the Texas Time Study:

1.a	Non-Medicaid Outreach (All Staff)
1.b	Medicaid Outreach (All Staff)
2.a	Facilitating Non-Medicaid Eligibility (All Staff)
2.b	Facilitating Medicaid Eligibility (All Staff)
3	School Related & Educational Activities
4.a	Direct Medical Services - IEP
4.b	Direct Medical Services – Non IEP
5.a	Medicaid Transportation Non-Medicaid (All Staff)
5.b	Medicaid Transportation (All Staff)
6.a	Medicaid Translation Non-Medicaid
6.b	Medicaid Translation
7.a	Program Planning, Development and Interagency Coordination Non-Medical(All Staff)
7.b	Program Planning, Development and Interagency Coordination Medical (All Staff)
8.a	Non-Medical/Non-Medicaid related Training
8.b	Medical/Medicaid related Training
9.a	Referral, Coordination, and Monitoring Non-Medicaid Services (All Staff)
9.b	Referral, Coordination, and Monitoring Medicaid Services (All Staff)
10	General Administration
11	Non-worked/Non-paid

These activity codes represent administrative and direct service activity categories that are used in the school setting. For all the activity codes and examples listed below, if an activity is provided as part of, or an extension of, a direct medical service, it may not be claimed as Medicaid administration. Any costs related to medical services should be claimed as Code 6., Direct Medical Services. As required under new federal guidelines, none of the activity codes listed below allow for the application of the 75 percent enhanced FFP rate.

CODE 1.a. NON-MEDICAID OUTREACH (All Staff) - U

Staff should use this code when performing activities that inform individuals about their eligibility for non-Medicaid social, vocational and educational programs (including special education) and how to access them; describing the range of benefits covered under these programs and how to obtain them. Both written and oral methods may be used. Include related paperwork, clerical activities, translation, or staff travel required to perform these activities.

General Examples:

- Informing families about wellness programs and how to access these programs.
- Scheduling and promoting activities that educate individuals about the benefits of healthy life-styles and practices.
- Conducting general health education programs or campaigns that address life-style changes in the general population (e.g., dental prevention, anti-smoking, alcohol reduction, etc.).
- Conducting outreach campaigns that encourage persons to access social, educational, legal or other services not covered by Medicaid.
- Assisting in early identification of children with special medical/dental/mental health needs through various child-find activities.
- Outreach activities in support of programs that are 100 percent funded by state general revenue.
- Developing outreach materials such as brochures or handbooks for these programs.
- Distributing outreach materials regarding the benefits and availability of these programs.

CODE 1.b. MEDICAID OUTREACH (All Staff) – TM/50 Percent FFP

Staff should use this code when performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access the program. Such activities include bringing potential eligible's into the Medicaid system for the purpose of the eligibility process. Include related paperwork, clerical activities, translation, or staff travel required to perform these activities.

General Examples:

- Informing Medicaid eligible and potential Medicaid eligible children and families about the benefits and availability of services provided by Medicaid (including preventive treatment, and screening) including services provided through the EPSDT program.
- Developing and/or compiling materials to inform individuals about the Medicaid program (including EPSDT) and how and where to obtain those benefits. Note: This activity should not be used when Medicaid-related materials are already available to the schools (such as through the Medicaid agency). As appropriate, school developed outreach materials should have prior approval of the Medicaid agency.
- Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program, including EPSDT.
- Assisting the Medicaid agency to fulfill the outreach objectives of the Medicaid program by informing individuals, students and their families about health resources available

through the Medicaid program.
- Providing information about Medicaid EPSDT screening (e.g., dental, vision) in schools that will help identify medical conditions that can be corrected or improved by services offered through the Medicaid program.
- Contacting pregnant and parenting teenagers about the availability of Medicaid prenatal, and well baby care programs and services.
- Providing information regarding Medicaid managed care programs and health plans to individuals and families and how to access that system.
- Encouraging families to access medical/dental/mental health services provided by the Medicaid program.

CODE 2.a. FACILITATING APPLICATION FOR NON-MEDICAID ELIGIBILITY (All Staff) – U

This code should be used by staff when informing an individual or family about programs such as Temporary Assistance for Needy Families (TANF), Food Stamps, Women, Infants, and Children (WIC), day care, legal aid, and other social or educational programs and referring them to the appropriate agency to make application. Include related paperwork, clerical activities, translation, or staff travel required to perform these activities.

General Examples:

- Explaining the eligibility process for non-Medicaid programs, including IDEA.
- Assisting the individual or family collect/gather information and documents for the non-Medicaid program application.
- Assisting the individual or family in completing the application, including necessary translation activities.
- Developing and verifying initial and continuing eligibility for the Free and Reduced Lunch Program.
- Developing and verifying initial and continuing eligibility for non-Medicaid programs.
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

CODE 2.b. FACILITATING MEDICAID ELIGIBILITY (All Staff) – TM/50 Percent FFP

Staff should use this code when assisting an individual in the Medicaid eligibility process. Include related paperwork, clerical activities, translation, or staff travel required to perform these activities. This activity does not include the actual determination of Medicaid eligibility.

General Examples:

- Verifying an individual’s current Medicaid eligibility status for purposes of the Medicaid eligibility process.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Assisting individuals or families to complete a Medicaid eligibility application.
- Gathering information related to the application and eligibility determination for an

individual, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.
- Referring an individual or family to the local Assistance Office to make application for Medicaid benefits.
- Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application.
- Participating as a Medicaid eligibility outreach outstation, but does not include determining eligibility.

CODE 3. SCHOOL RELATED & EDUCATIONAL ACTIVITIES – U

Staff should use this code when performing activity related to social services, educational services, teaching services, employment services, job training, child care, housing and other services.

General examples:

- Providing classroom instruction (including working on lesson planning).
- Testing and/or correcting papers.
- Compiling attendance reports.
- Providing general supervision of students (e.g., playground, lunchroom).
- Carrying out discipline.
- Participating in or presenting training relating to job searches.
- Screening or making referrals for childcare, housing, or employment/job training services.
- Facilitating family support groups.

CODE 4.a. DIRECT MEDICAL SERVICES – (SHARS - IEP)

This code will be assigned when school district staff (employees or contracted staff) provides direct client services as covered services delivered by school districts under the School Health and Related Services (SHARS) Program. These direct client services may be delivered to an individual and/or group in order to ameliorate a specific condition and are performed in the presence of the student(s). This code includes the provision of all IDEA/IEP medical (i.e., health-related) services. It also includes functions performed pre and post of the actual direct client services (when the student may not be present), for example, paperwork, or staff travel directly related to the direct client services. Note, some of the following activities may be subject to the free care principle:

Examples of activities reported under this code:

All IDEA/IEP direct client services with the Student/Client present including:

- Audiologist services, including evaluation and therapy services (only if included in the student's IEP);

- Physical Therapy services, including evaluation and therapy services (only if included in the student's IEP);
- Occupational Therapy services, including evaluation and therapy services (only if included in the student's IEP);
- Speech Language Pathology Therapy services, including evaluation and therapy services (only if included in the student's IEP);
- Psychological Services, including assessment and therapy services (only if included in the student's IEP); [The assessment services are not in the client's IEP because assessments are performed before the student's IEP is developed.]
- Counseling Services, including therapy services (only if included in the student's IEP);
- Nursing Services, including skilled nursing services on the IEP and time spent administering/monitoring medication only if it is included as part of an IEP and documented in the IEP. Medicaid administration would not include those that are provided to the entire student population, i.e. administration of aspirin, but are specifically those called for in the IEP;
- Physician Services, including diagnostic and evaluation services; [Physician services are not always included in the student's IEP because these are performed before the student's IEP is developed. These physician services form the bases of the referral for various medical services, e.g., OT and PT.]
- Personal Care Services, including services delivered at the school, home, or on the bus (only if included in the student's IEP); and
- Specialized Transportation Services (only if included in the student's IEP).

This code also includes pre and post time directly related to providing direct client care services when the student/client is not present. Examples of pre and post time activities when the student/client is not present include: time to complete all paperwork related to the specific direct client care service, such as preparation of progress notes, translation of session notes, review of evaluation testing/observation, planning activities for the therapy session, travel to/from the therapy session, or completion of billing activities.

General Examples that are considered pre and post time:

- Pre and post activities associated with physical therapy services, for example, time to build a customized standing frame for a student or time to modify a student's wheelchair desk for improved freedom of movement for the client.
- Pre and post activities associated with speech language pathology services, for example, preparing lessons for a client to use with an augmentative communicative device or preparing worksheets for use in group therapy sessions.
- Updating the medical/health-related service goals and objectives of the IEP.
- Travel to the direct service/therapy.
- Paperwork associated with the delivery of the direct care service, as long as the student/client is not present. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities.
- Interpretation of the evaluation results and/or preparation of written evaluations, when student/client is not present. [Assessment services are billed for testing time when the student is present, for interpretation time when the student is not present, and for report writing when the student is not present.)

CODE 4.b. DIRECT MEDICAL SERVICES (SHARS – Non-IEP)

This code will be assigned by a Central Coder when school district staff (employees or contracte staff) are providing direct client care services that are not IDEA and/or not IEP services. This cod includes the provision of all non IDEA/IEP medical services reimbursed through Early and Period Screening Diagnosis, and Treatment (EPSDT) services. This code includes pre and post activitie associated with the actual delivery of the direct client care services, e.g., paperwork or staff trav required to perform these services.

Examples of activities reported under this code:

All non IDEA and/or non-IEP direct client care services as follows:

- Medical Screenings (including scoliosis), Vision Screenings, Hearing Screenings, Dental Screenings, EPSDT Screenings, and nurse consults for non-SHARS services;
- Administering first aid;
- Administering medication other than those medications outlined in the IEP as direct client care nursing services under SHARS, e.g., providing immunizations;
- Making referrals for and/or coordinating medical or physical examinations and necessary medical evaluations not covered as direct client care services under SHARS, as a result of a direct medical service;
- Provision of counseling services by a school-certified counselor, since school-certified counselors are not approved providers of SHARS counseling services;
- Provision of assessment services by a school-certified educational diagnostician, since school-certified counselors are not approved providers of SHARS assessment services;
- Provision of or assistance with activities of daily living (ADLs) or instrumental ADLs (IADLs) for students for whom these tasks are age appropriate and, as such, do not meet the definition of SHARS personal care services; and
- Transporting a client that does not require specialized transportation services.

CODE 5.a. MEDICAID TRANSPORTATION NON-MEDICAID (All Staff) – U

All staff should use this code when assisting an individual to obtain transportation to services not covered by Medicaid, or accompanying the individual to services not covered by Medicaid. Include related paperwork, translation, clerical activities or staff travel required to perform these activities.

General Examples:

- Scheduling or arranging transportation for social, vocational, and/or educational programs and activities.
- Scheduling, arranging and/or providing transportation assist the client in accessing non-Medicaid services, such as grocery shopping, WIC appointment, housing, school, etc.

CODE 5.b. MEDICAID TRANSPORTATION (All Staff) – PM/50 Percent FFP

All staff should use this code when assisting an individual to obtain transportation to services covered by Medicaid. This does not include the provision of the actual transportation service or the direct costs of the transportation (bus fare, taxi fare, etc.), but rather the administrative activities involved in providing transportation. Include related paperwork, clerical activities, translation or staff travel required to perform these activities.

General Examples:

- Scheduling or arranging transportation to Medicaid covered services. (Arranging for a taxi to take a student to the doctor; scheduling Medicaid Transportation to take a student to the doctor.)

CODE 6.a. MEDICAID TRANSLATION NON-MEDICAID – U

All staff should use this code when assisting an individual to obtain translation services for services not covered by Medicaid, or accompanying the individual to services not covered by Medicaid.

General Examples:

- Related paperwork, translation, clerical activities or staff travel required to assist the client in accessing non-Medicaid services, such as grocery shopping, WIC appointments, housing, school, etc.

CODE 6.b. MEDICAID TRANSLATION - TM/50 Percent FFP

All staff should use this code when assisting a client/student/family to obtain translation services for the purpose of accessing Medicaid services. A list of Medicaid covered services is attached. Include related paperwork, clerical activities, or staff travel required to perform these activities. Arranging for or providing translation services that assist the individual to access and understand necessary care or treatment. Translation may be allowable as an administrative activity, but only if it not included and paid for as part of a medical assistance service.

General Examples:

- Accompanying a child/family to the physician's office to translate from Spanish to English medically related information between the MD and the individual is Code 6.b.
- Serving as a translator on how to access Medicaid services is Code 9. This includes alternative languages, Braille, sign languages, and translation due to illiteracy.

CODE 7.a. PROGRAM PLANNING, DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO NON-MEDICAL SERVICES (All Staff) - U

Staff should use this code when performing activities associated with developing strategies to improve the coordination and delivery of non-medical services. Non-medical services may include social services, educational services, vocational services, and state or state-education mandated child health screenings provided to the general school population. Employees whose position descriptions include program planning, policy development and interagency coordination may use this code. Include related paperwork, clerical activities, translation, or staff travel required to perform these activities.

General Examples:

- Identifying gaps or duplication of non-medical services (e.g., social, vocational educational and state mandated general health care programs) to school age children and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of non-medical school programs.
- Monitoring the non-medical delivery systems in schools.
- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services.
- Evaluating the need for non-medical services in relation to specific populations or geographic areas.
- Analyzing non-medical data related to a specific program, population, or geographic area.
- Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems.
- Defining the relationship of each agency's non-medical services to one another.
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services and state-mandated health screenings to the school populations.
- Developing non-medical referral sources.
- Coordinating with interagency committees to identify, promote and develop non-medical services in the school system.

CODE 7.b. PROGRAM PLANNING, DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO MEDICAL SERVICES (All Staff) – PM/50 percent FFP

This code should be used by staff when performing activities associated with the development of strategies to improve the coordination and delivery of medical/dental/mental health services to clients/students, and when performing collaborative activities with other agencies and/or providers. Employees whose position descriptions include program planning, policy development, and interagency coordination may use this code. This code refers to activities such as planning and developing procedures to track requests for services; the actual tracking of requests for Medicaid services would be coded under Code 9.b., Referral, Coordination and Monitoring of Medicaid Services. Include related paperwork, translation, clerical activities or staff travel required to perform these activities.

General Examples:

- Identifying gaps or duplication of medical/dental/mental services to school age children and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of school medical/dental/mental health programs.
- Monitoring the medical/dental/mental health delivery systems in schools.
- Developing procedures for tracking families' requests for assistance with medical/dental/mental services and providers, including Medicaid. (This does not include the actual tracking of requests for Medicaid services.)
- Evaluating the need for medical/dental/mental services in relation to specific populations or geographic areas.
- Analyzing Medicaid data related to a specific program, population, or geographic area.
- Working with other agencies and/or providers that provide medical/dental/mental services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligible's, and to increase provider participation and improve provider relations.
- Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental problems.
- Developing strategies to assess or increase the cost effectiveness of school medical/dental/mental health programs.
- Defining the relationship of each agency's Medicaid services to one another.
- Working with Medicaid resources, such as the Medicaid agency and Medicaid managed care plans, to make good faith efforts to locate and develop EPSDT health services referral relationships.
- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services to the school populations.
- Working with the Medicaid agency to identify, recruit and promote the enrollment of potential Medicaid providers.
- Developing medical referral sources such as directories of Medicaid providers and managed care plans, who will provide services to targeted population groups, e.g., EPSDT children.
- Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system.

CODE 8.a. NON-MEDICAL/NON-MEDICAID RELATED TRAINING - U

Staff should use this code when coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefit of the programs other than the Medicaid program. For example, training may include how to assist families to access the services of education programs, WIC, housing, and how to more effectively refer clients/students for those services. Include related paperwork, clerical activities, translation, or staff travel required to perform these activities.

General Examples:

- Participating in or coordinating training that improves the delivery of services for programs other than Medicaid.

- Participating in or coordinating training that enhances IDEA child-find programs.
- In-service or staff meetings related to educational issues, such as curriculum, textbooks, standardized testing, or discipline.

CODE 8.b. MEDICAL/MEDICAID RELATED TRAINING – PM/50 Percent FFP

Staff should use this code when coordinating, conducting, or participating in training events and seminars for outreach staff regarding the benefits of medical/Medicaid related services, how to assist families to access such services, and how to more effectively refer clients/students for services. Include related paperwork, translation, clerical activities, or staff travel required to perform these activities.

General Examples:

- Participating in or coordinating training that improves the delivery of medical/Medicaid related services.
- Participating in or coordinating training that enhances early identification, intervention, screening and referral of students with special health needs to such services (e.g., Medicaid EPSDT services). (This is distinguished from IDEA child-find programs.)
- Participating in training for outreach and eligibility assistance.
- Attending training specifically related to the provision of direct care client services.
- Training and/or supervising staff in the performance of delegated nursing tasks (for example, a Registered Nurse training staff to perform tube feeding, medication administration or other delegated nursing task).
- Training and/or supervising staff in the performance of personal care services.

CODE 9.a. REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES (All Staff) - U

Staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of non-medical services. Include related paperwork, clerical activities, translation, or staff travel required to perform these activities.

General Examples:

- Making referrals for and coordinating access to social and educational services such as child care, employment, job training, and housing.
- Making referrals for, coordinating, and/or monitoring the delivery of state education agency mandated child health screens (e.g., vision, hearing, scoliosis).
- Making referrals for, coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.
- Gathering any information that may be required in advance of these non-Medicaid related referrals.
- Participating in a meeting/discussion to coordinate or review a student's need for scholastic, vocational, and non-health related services not covered by Medicaid.
- Monitoring and evaluating the non-medical components of the individualized plan as appropriate.

CODE 9.b. REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES (All Staff) – PM/50 Percent FFP

Staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. Referral, coordination and monitoring activities are reported in this code. Activities that are part of a direct service are not claimable as an administrative activity. Furthermore, activities that are an integral part of or an extension of a medical service (e.g., patient follow-up, patient assessment, patient counseling, patient education, patient consultation, billing activities) should be reported under Code 4. Direct Medical Services. Note that targeted case management, if provided or covered as a medical service under Medicaid, should be reported under Code 4.o., Targeted case Management, School Related and Educational Activities. Include related paperwork, clerical activities, translation, or staff travel necessary to perform these activities.

General Examples:

- Making referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations.
- Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunization, but NOT to include the state-mandated health services.
- Referring students for necessary medical health, mental health, or substance abuse services covered by Medicaid.
- Arranging for any Medicaid covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition.
- Gathering any information that may be required in advance of medical/dental/mental health referrals.
- Participating in a meeting/discussion to coordinate or review a student's needs for health-related services covered by Medicaid.
- Providing follow-up contact to ensure that a child has received the prescribed medical/dental/mental health services covered by Medicaid.
- Coordinating the delivery of community based medical/dental/mental health services for a child with special/severe health care needs.
- Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required to provide continuity of care.
- Providing information to other staff on the child's related medical/dental/mental health services and plans.
- Monitoring and evaluating the Medicaid service components of the IEP as appropriate.
- Coordinating medical/dental/mental health service provision with managed care plans as appropriate.

CODE 10. GENERAL ADMINISTRATION - R

This code should be used by time study participants when performing activities that are not directly assignable to program activities. Include related paperwork, translation, clerical activities, or staff travel required to perform these activities.

General Examples:

- Taking lunch, breaks, leave, or other paid time not at work.
- Establishing goals and objectives of programs as part of the agencies annual or multi-year plan.
- Reviewing school, district or agency procedures and rules.
- Attending or facilitating unit staff meetings, training, or board meetings.
- Performing administrative or clerical activities related to general building, agency or district functions or operations.
- Providing general supervision of staff, including supervision of student teachers or classroom volunteers, interns and evaluation of employee performance.
- Reviewing technical literature and research articles.
- Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

CODE 11. NON-WORKED/NON-PAID – U

Non-worked/Non-paid time is time during the workday for which a participant in the time study is not working AND is not being compensated.

General Examples:

- Part-time/Contracted staff whose sampled moment occurs during non-scheduled work hours.
- Staff member takes an unpaid day off during the sampled moment
- Non-paid sick time
- Non-paid leaves of absence
- No longer employed by the program

Appendix B
Sample (MAC) Operating Plan

Medicaid Administrative Claiming (MAC) Program Operating Plan (POP) as of FFY2010

Overview:
Districts participating in Medicaid Administrative Claiming (MAC) must submit and receive approval from the Health and Human Services Commission (HHSC) of a MAC Program Operating Plan (POP). The POP is based on the Medicaid Administrative Claiming Guidelines and other applicable state/federal policies. Starting with federal fiscal year (FFY 2010), HHSC has facilitated the MAC POP submission and approval process by developing a uniform POP for participating districts to complete and submit for approval. The MAC POP is to be submitted to the HHSC Rate Analysis Department for review and approval prior to the end of the first quarter of participation in the MAC Program as required by the Approved Texas Time Study Implementation Guide approved by the Centers for Medicaid Medicare Services. Once the MAC POP is approved, it will remain in effect indefinitely or until the State and/or the Independent School District (ISD) decide to terminate the contractual agreement required for Participation in MAC.

The following includes the information necessary for your district to submit the completed MAC POP Questionnaire.

Medicaid Administrative Claiming Program Operating Plan (MAC POP) Submission:
Send MAC POP's to:

For courier delivery mail to:

HHSC Rate Analysis Dept.
Medicaid Administrative Claiming
Mail Code H360
11209 Metric Blvd
Austin, TX 78758-4021

For regular mail delivery mail to:

HHSC Rate Analysis Dept.
Medicaid Administrative Claiming
Braker Center, Building H
Mail Code H360
PO Box 85200
Austin, TX 78708-5200

Instructions: The first page of the Operating Plan must be submitted **on district letterhead**. A sample of a cover page has been included on the following page. If the cover page is submitted with the POP, it must be copied on district letterhead for submission to HHSC. Subsequent pages of the MAC POP are not required to be printed on letterhead.

HHSC Rate Analysis Department
Medicaid Administrative Claiming
Braker Center, Building H
Mail Code H360
PO Box 85200
Austin, TX 78708-5200

(Date)

As required for participation in the Medicaid Administrative Claiming Program as specified in the current Texas Timestudy Implementation Guide for Direct Services and Medicaid Administrative Claiming, please accept_____ISD's MAC Program Operating Plan from the effective date on the attached MAC Program Operating Plan forward. The ISD understands that once the MAC POP is approved, it will remain in effect indefinitely or until the State and/or the ISD decide to terminate the contractual agreement required for Participation in MAC.

Signature:_____Title: _____

Medicaid Administrative Claiming Program Operating Plan (MAC POP)
District Contact Information

District Name:	HCAT #:	District ID

Please provide the following information.

RMTS Coordinator Name:		Title:
Mailing Address:	City:	Zip:
Phone:	Fax:	Optional Phone:
Email Address:		

MAC Financial Coordinator Name:		Title:
Mailing Address:	City:	Zip:
Phone:	Fax:	Optional Phone:
Email Address:		

Superintendent/Executive Director Contact Information:

Contact Name:		Title:
Mailing Address:	City:	Zip:
Phone:	Fax:	Optional Phone:
Email Address:		

Please note: MAC and RMTS contact information must be updated and maintained on the Fairbanks, LLC website.

Random Moment Time Study (RMTS) Roles and Responsibilities

By initialing at each Coordinator's section below the district agrees to the following:

_____ **RMTS Coordinator Roles and Responsibilities**
(initials)

Functions
The RMTS Coordinator will attend mandated/required training provided by HHSC or its designee, to understand the purpose of the RMTS, and understand the importance of updating and/or certifying the Participant List (PL), to ensure that the updates and certifications are completed by the scheduled due dates. The Coordinator will ensure that all eligible participants are added to the RMTS web-based system at the beginning of each federal fiscal year, add/delete program contacts as appropriate to the contact list and provide required training to selected time study participants and ensure their availability to answer questions from sampled staff as specified in the current Texas Timestudy Implementation Guide for Direct Services and Medicaid Administrative Claiming.

Training
The RMTS Coordinator will ensure that sampled staff receives training prior to the completion of the RMTS for their sampled moment; therefore, mandatory training will be made available to selected time study participant staff. Staff identified to participate in a time study for the first time will be provided Interactive training. Refresher training will be provided to staff that has attended interactive training and has been selected to participate in the time study. As new staff are added to the PL and selected for the time study, they will be trained in adherence with all training requirements. Training materials either issued by HHSC or approved by HHSC will be used. Districts utilizing training materials not issued by HHSC will submit them for approval 30 days prior to the scheduled training.

Oversight/*Monitoring*
The RMTS Coordinator will provide oversight of the RMTS and review the master participant list in the RMTS system to ensure its accuracy prior to the beginning of each RMTS period. Necessary updates will be made to the participant list on the RMTS website by the date the participant list closes for each quarter. Throughout the quarter, the district will follow-up with staff members that have not completed their sampled moment within the allowed response period (one week from the sampled moment). Follow up activities may include a phone call, email or live discussion and must be documented. Questions and/or concerns raised by RMTS sampled staff will be answered promptly. Time study participants will be instructed to first go to their supervisors who will then contact the Program Coordinator regarding questions on which they need assistance and provide the information back to staff. In the event that a supervisor is not available, the Program Coordinator must be available for direct contact by time study participant staff. The RMTS Coordinator will ensure that the 85% participation/response requirement is met each quarter and will act as backup to the MAC Financial Program Coordinator when necessary. Questions regarding issues with the RMTS website will be directed to the State's vendor for software support by the Program Coordinator or their assistant.

Documentation and Record Keeping

Supporting documentation of all training conducted will be kept in the ISD's quarterly supporting documentation file. Documentation for all follow-up activities, i.e., phone calls, email or live discussion will be kept in the supporting documentation file for the quarter they are conducted. The supporting documentation file will maintained for a minimum of five years by the RMTS Coordinator and will be made available upon request from state and federal entities.

_____ **MAC Financial Coordinator Roles and Responsibilities**

(initials)

Functions

The MAC Financial Coordinator's function is to attend mandated/required training provided by HHSC or its designee, understand the purpose of the RMTS and the PL and their importance in the calculation of the MAC Claim. The RMTS web system will be utilized by the ISD for calculation of the MAC Claim. MAC Financial Coordinator 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 direct costs and indirect costs as defined in OMB A-87 and approved by CMS will be entered into the claim. 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 Program Coordinator will ensure that the information entered into the web-based system is accurate by certifying and printing the Quarterly Summary Invoice (QSI) generated by the system. The Chief Financial Officer (CFO), or other individual designated as the financial contact by the ISD 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 via the web based system within two (2) quarter's of the end of the claim period in order for the claim to be calculated.

Training

The MAC Financial Coordinator ensures that all applicable training requirements are met and that a minimum of two individuals with working knowledge of MAC attend all mandatory trainings and ensure compliance with policy directives.

Oversight/*Monitoring*

The MAC Financial Coordinator will provide oversight and monitoring and coordinate with the RMTS Coordinator to ensure the quarterly participant list data is accurate and appropriate for inclusion on the quarterly MAC Claim, the certification of financial costs are true and accurate, the time study results are valid, financial data submitted for the quarter is true and accurate, and that appropriate documentation is maintained to support the time study and the claim each quarter.

Documentation and Record Keeping

The MAC Financial Coordinator will ensure that supporting documentation is maintained that appropriately identifies the certified funds used for MAC claiming. The documentation will identify all sources of funds used for certification and must ensure that said funds have not been used to match other federal funds. Supporting documentation will be kept in a quarterly supporting documentation file (audit file). The district will provide a list of sources of funds used to complete a MAC claim upon request by HHSC. The MAC Financial Coordinator will coordinate with the RMTS Coordinator to ensure the Supporting Documentation File (audit file) contains all required documentation as specified in the current Texas Timestudy Implementation Guide for Direct Services and Medicaid Administrative Claiming and that the file will be maintained at the ISD's financial office, special education office or Medicaid office.

Term of the MAC Program Operating Plan

This plan will be effective October 1, 2009 and shall continue indefinitely or until the State and/or the ISD change the MAC POP processes or terminate the contractual agreement required for participation in MAC.

Authorized Signatures

_____	_____
Superintendent/Chief Executive Officer	Date
_____	_____
MAC Program Coordinator	Date
_____	_____
MAC Financial Coordinator/Officer	Date

Appendix C
Sample MAC Interagency Cooperation Agreement

THE STATE OF TEXAS HHSC Contract Number
COUNTY OF TRAVIS

INTERAGENCY COOPERATION AGREEMENT

THIS AGREEMENT is entered into by and between the state agencies shown below as contracting parties, pursuant to the authority granted and in compliance with the provisions of the Interagency Cooperation Act, Chapter 771, Texas Government Code.

I. MEDICAID ADMINISTRATION

_____ Independent School District hereafter referenced as "ISD" agrees to perform Medicaid Administrative activities on behalf of the Health and Human Services Commission (HHSC) to improve the availability, accessibility, coordination and appropriate utilization of preventive and remedial health care resources to Medicaid eligible students and their families. These activities will be in accordance with the policies and procedures set forth in the State of Texas Implementation Guide and its appendices issued by HHSC. Allowable activities under Medicaid administration are described in detail in Attachment A, Attachments A and B are attached hereto and incorporated herein for all purposes.

The ISD agrees to account for the activities of staff providing Medicaid administration in accordance with the provisions of OMB Circular A-87 and 45 CFR Part 74 and 95, and with the written guidelines issued by HHSC.

The ISD agrees to submit its quarterly participation data using the HHSC standardized Random Moment Time Study (RMTS) system, including a quarterly Participant List, Time Study reporting, Financial expenditure reporting, and Certification form. All financial expenditure data must be submitted to HHSC via the RMTS system within 2 quarter of the end of the claim period, in order for the ISDs claim to be calculated.

The ISD agrees to provide the expenditures information to include in the quarterly data it submits to HHSC, or its designee, in the manner and written timeframes described in the State of Texas Implementation Guide, as approved by the Center for Medicaid and Medicare Services (CMS).

The ISD agrees to spend the State General Revenue, in an amount equal to the federal match received, for health-related services for clients.

The ISD agrees to designate an employee to act as a liaison with HHSC for issues concerning this Agreement.

II. BASIS FOR CALCULATING REIMBURSABLE COSTS

HHSC agrees to pass through to the ISD no less than ninety-five percent (95%) of Title XIX federal share of actual and reasonable costs for Medicaid Administration provided by its staff for Medicaid administrative activities under this agreement. HHSC reserves the right to retain five percent of the Title XIX federal share of actual and reasonable costs for said Medicaid administration for HHSC's own administrative costs, technical assistance and to establish and maintain an audit reserve fund. These costs shall be based upon a time accounting system which is in accordance with the provisions of OMB Circular A-87 and 45 CFR 74 and 95, the expense and equipment costs necessary to collect date, disseminate information and carry out the staff functions outlined in this Agreement.

HHSC agrees to reimburse the ISD subject to the terms of MAC Claim Development subsection of incorporated Implementation Guide, the rate of reimbursement for allowable administrative activities performed by personnel shall be fifty percent (50%) of such costs.

HHSC when made aware of changes in federal regulations affecting matching percentage or costs eligible for enhanced or administrative match, which become effective subsequent to the execution of the Agreement, will be applied herein as provided in such changes applicable federal regulations. As HHSC becomes aware of changes in applicable regulations, it will provide such information to LPISD and this Agreement will be amended to reflect the applicable changes in federal regulations.

HHSC agrees to include the ISD's expenditures for Medicaid administration in the claim it submits to CMS for Title XIX federal participation, if said claim is submitted in accordance with written timeframes as laid out in this agreement and the current State of Texas Implementation Guide.

HHSC agrees to designate an employee to act as liaison with the ISD for issues concerning this agreement.

III. TERM OF AGREEMENT

This agreement is to begin upon execution and shall terminate on September 30, 2007.

This agreement may be terminated by consent of either RECEIVING AGENCY or PERFORMING AGENCY upon thirty (30) days notice in writing delivered in person or by certified mail.

IV. CERTIFICATIONS

The undersigned contracting parties certify that:

- the services specified above are necessary and essential for activities that are properly within the statutory functions and programs of the affected agencies of state government;
- the proposed arrangements serve the interest of efficient and economical administration of state government; and
- the services contracted for are not required by Section 21, article XVI of the Texas Constitution to be supplied under a contract awarded to the lowest responsible bidder.

PERFORMING AGENCY further certifies that it has sufficient statutory authority to contract for the services described in this contract under Chapter 12, Texas Health and Safety Code.

RECEIVING AGENCY further certifies that it has sufficient statutory authority to contract for the services described in this contract under Chapter 531, Texas Government Code.

This agreement is executed by the parties in their capacities as stated below.

RECEIVING AGENCY	**PERFORMING AGENCY**
HEALTH & HUMAN SERVICES COMMISSION	_____ INDEPENDENT SCHOOL DISTRICT
By:_____	By:_____
Albert Hawkins	
Executive Commissioner	Superintendent
Date:_____	Date:_____