

TEXAS

Health and Human Services Commission



Time Study and Medicaid Administrative Claiming Guide

March 30, 2012

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INTRODUCTION

As the Medicaid authority for Texas, the Texas Health and Human Services Commission (HHSC) is committed to providing efficient and effective Direct Service (DS) and Medicaid Administrative Claiming (MAC) programs.

This document provides two guides; One for Random Moment Time Study (RMTS) and one for MAC.

Each guide will include a core section that addresses general requirements common to all programs. This core section will be followed by sections that address requirements specific to the individual participating entities.

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Health and Human Services Commission



Time Study

March 30, 2012

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Introduction

As the Medicaid authority for Texas, the Texas Health and Human Services Commission (HHSC) is committed to providing efficient and effective Medicaid Administrative Claiming (MAC) programs. To receive federal matching funds for these programs, federal guidelines permit the use of statistical sampling as an option to monthly personnel activity reports to identify the proportion of administrative time reimbursable under the MAC program. HHSC has implemented a Random Moment Time Study (RMTS) methodology which is an permitted form of statistical sampling.

This time study guide includes a core section that addresses RMTS requirements common to all programs. This core section is followed by separate sections that address requirements specific to the individual participating entities.

Section One

Random Moment Time Study

Overview

A time study is a tool which is an accepted method of objectively allocating staff time to the various activities that are measured. It is based on objective, empirical data, and its results reflect how staff time is distributed across the range of activities. A time study should be a reasonable representation of staff activity during the specified time study period.

The State of Texas utilizes a Random Moment Time Study (RMTS) methodology. RMTS is a federally approved, statistical sampling technique and is recognized as an accepted alternative to 100 percent time reporting. The RMTS method provides a verifiable, statistically valid sampling technique that produces accurate labor distribution results by determining what portion of the selected group of participant's workload is spent performing all work 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 statewide population of participating staff over that same period.

RMTS eliminates the requirement for timesheets or daily time study logs and instead selects a "moment" in time for which three questions must be answered: 1) what were you doing; 2) who was with you; and 3) why were you performing this activity. An RMTS moment represents one minute at a particular time and moments are sampled and occur throughout each quarter. Additional questions may be asked to gather more specific information as needed. If sampled, the participant's only responsibility is to document what they were doing at that precise moment by answering the questions. Participants are not required to understand complicated Medicaid regulations or codes and the entire online process takes no more than a few minutes to complete.

State Wide Time Study

A fundamental step in the development of an appropriate RMTS is determining what staff should or should not participate in the time study process. To determine the time study sample Texas uses a statewide pool which includes employed and contracted staff that provide services which are primarily medical in nature and/or the administrative activities that are in support of services covered by Medicaid. This statewide pool would be made up of all provider entities participating in a specific program.

Once the list of time study participants is compiled statewide, randomly selected moments are then randomly matched to a staff participant. The sample moments are selected from each staff pool, along with the total number of eligible time study moments for each quarter. To ensure randomness in the selection

process, the staff name and the selected moment are returned to the overall sample pool after each moment selection so as to be available for selection again.

Time Study Methodology

The RMTS methodology will be used for different programs (e.g., ECI and LHD). Separate time studies exclusive to each program will be conducted so as to ensure there is no sampling overlap between the programs and no duplication of claims.

When determining the sample universe for a program, that is, who will participate in (be sampled under) the time-study, the composition of staff and purpose of the time study will be reviewed to determine whether a single staff pool or multiple staff pools will be used.

When multiple staff pools within a single program are used, the pools must be mutually exclusive (e.g., no staff may appear in both pools) and, the pools must be homogeneous in nature (e.g., the definition of which staff appear in each pool is internally consistent). In addition, mutually exclusive time studies must be conducted for each staff pool.

The sampling period must also be established. For the purposes of RMTS the sampling period is defined as the three-month period comprising each quarter of the Federal Fiscal Year calendar as follows.

- Federal Fiscal Quarters
 - 1st Quarter - October, November, December
 - 2nd Quarter - January, February, March
 - 3rd Quarter - April, May, June
 - 4th Quarter - July, August, September

Sampling Requirements

RMTS sampling methodology has been constructed to achieve a confidence level of 95 percent with precision level of +/- 5 percent.

+/- 5 Percent:

Statistical calculations show that a minimum sample of 384 completed moments each quarter, per time study staff pool, is adequate to obtain this precision when the total pool of moments is greater than 222,639. Additional moments are selected each quarter to account for any potential lost moments.

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

Correction for Finite Population

$$\text{ss} = \frac{Z^2 * (p) * (1-p)}{c^2}$$

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

where:

ss = sample size

Z = Z value (e.g. 1.96 for 95 percent confidence level)

p = percentage picking a choice, expressed as decimal
(.5 used for sample size needed)

c = confidence interval, expressed as decimal
(e.g., .05 = ± 5)

Pop = population

The following table shows the sample sizes necessary to ensure statistical validity at a 95 percent confidence level and tolerable error level of 5 percent. Additional moments will be selected to account for lost moments, as previously defined.

N=	Sample Size Required
10,000	370
20,000	377
30,000	379
40,000	381
50,000	381
75,000	382
100,000	383
>222,639	384

RMTS Process

The RMTS process consists of the following steps:

1. Identify total pool of time study participants;
 - a) Develop the RMTS participant list
 - b) Certify the participant list
 2. Identify total pool of time study moments;
 3. Randomly select moments;
 4. Randomly match each moment to a participant;
 5. Notify selected participants of their moment;
 6. Time study participants respond to their assigned moment; and
 7. Central coders code the moment
1. Identifying the pool of time study participants.

At the beginning of each quarter, participating entities must submit a comprehensive list of all staff (employed and contracted) eligible to participate in the RMTS. This list is referred to as the participant list (PL). From the PL, all participants are assigned into staff pools. When multiple staff pools are used, the pools must be mutually exclusive meaning that no participant is to be included in more than one staff pool.

A job title will be included for each person listed on the PL. The entity (contracted provider) must maintain a description on file for each job title listed on the PL.

Staff that do not participate in direct service or administrative activities are not to be included in the time study. Administrative staff such as executive directors, program directors, chief executive officers, chief financial officers, principals, assistant principals, special education directors, and other managers/supervisory staff as well as their associated clerical or administrative support staff are not to be included in the time study. These administrative staff will be included in the claiming process by allocating their time and appropriate costs based on the total time study effort.

Any contracted staff hired on a fixed rate/fee basis who do not perform any other administrative activity (for example, audiologists paid a set amount for each hearing test performed) are not to be included in the time study.

Each entity must certify that the PL of staff they are submitting to be included in the eligible staff pool are appropriate for inclusion in the time study and eventual claim. Any staff deemed inappropriate during the coding and state oversight processes will be removed from the time study and excluded from the eventual claim.

2. Identify total pool of time study moments.

The total pool of “moments” within the time study is represented by 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.

Using a statistically valid random sampling technique, the desired number of random moments is selected from the total pool of moments (see *Sampling Requirements* above). To ensure randomness, each time the selection of a minute occurs, the minute is 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 is available to be selected each time a selection occurs.

4. Randomly match each moment to a time study participant.

Each randomly selected moment is matched up, using a statistically valid random sampling technique, with an individual from the total pool of participants. 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. To ensure randomness, each time the selection of a staff participant’s name occurs, the participant’s name is 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 person is available to be selected each time a selection occurs.

5. Notify selected participants about their moment.

Time study participants are notified via email, or other method, of their requirement to participate in the time study and of their sampled moment.

- Sampled participants are notified of their sampled moment three days prior to the moment.

6. Time study participants respond to their assigned moment.

For the indicated moment, each sampled participant is required to record and submit their activity by answering three questions.

- Who was with you?
- What were you doing?
- Why were you performing this activity?

Required response times and follow-up for moments not completed are as follows.

- Sampled participants are notified of their sampled moment three days prior to the moment.
- Sampled participants have seven calendar days from the sampled moment to complete and submit their response.
- Reminders are sent via e-mail to sampled participants who have not completed their sampled moment at intervals of 24, 48 and 72 hours after the sampled moment.
- On a weekly basis, notification is sent via e-mail to the designated RMTS Contact containing a list of all moments for which their sampled staff participants have not completed.
- The RMTS Contact is responsible for contacting sampled staff participants that have not completed their sampled moment to prompt the required response.
- For any moment not completed within five working days of the sampled moment date:
 - The RMTS Contact will obtain an explanation from the non-compliant sampled staff participant as to why the moment was not completed.; and,
 - The moment will not be coded.

7. Central coders code the moment.

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

Sampled moments must be coded within three weeks after the sampled moment date. Each moment selected from the pool is included in the time study and coded according to the responses submitted by the sampled participant.

Central coders employed by the State or its contractor review the time study participant responses and, with adequate information, assign the appropriate activity code. All moments will be coded independently by at least two central coders as part of a quality assurance process.

Every effort will be made to assign the appropriate time study activity code. If sufficient information is not provided, the central coder will contact the time study participant and the designated RMTS Contact and request additional information. If sufficient information is not received within three weeks after the sampled moment date, the moment will be coded as a non-Medicaid activity.

Time Study Return Compliance

HHSC will require a state-wide compliance rate for the time study survey of at least 85 percent. The compliance rate is defined as the percent of valid, certified moments. If the minimum 85 percent valid response rate is not met, then all not returned moments (a response that has not been submitted/certified) will be coded as non-Medicaid time and will be included in the time study results. If the 85 percent valid response rate is met without having to code to non-Medicaid time, the not returned moments will be ignored since they are compensated by over sampling.

HHSC will monitor each entity to ensure they are properly returning sample moments. If the statewide compliance rate for a quarter does not achieve at least 90 percent, HHSC will send out non-compliance warning letters to all entities that did not achieve a 85 percent compliance rate, but only if they also have not returned moments of greater than five moments.

For entities that are issued a warning letter, HHSC will monitor the next consecutive quarter to ensure compliance, as defined above, is achieved. If not achieved, HHSC will implement the following sanctions:

- Entity will not be able to claim for MAC for the remainder of the federal fiscal year (October to September) beginning with the second quarter of non-compliance.
- Entity will not be able to participate in the time study for DS for the remainder of the federal fiscal year (October to September).
- Entity will not be able to claim for DS for the remainder of the federal fiscal year (October to September). Any payments sent to the entity for DS services provided during that fiscal year will be recouped by the State and returned to the Federal government.

Quality Assurance

Coding results will be reviewed by HHSC on a quarterly basis. HHSC will review a sample of the completed coding results and original staff participant responses to ensure the codes selected for sampled moments are valid and accurate. HHSC will discuss and resolve any discrepancies identified in the quarterly review. In addition to the quarterly review, at its discretion, HHSC may review the completed coding and original staff participant responses at any time throughout the claim process or as needed for further review or audit purposes.

A validity check of the time study results will be completed each quarter prior to the calculation of the claim. The validity check ensures that the minimum

number of responses is received to meet the required confidence level as discussed in the *Sampling Requirements* section above. 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 claim.

At the end of each quarter, once all RMTS 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.

RMTS Training

Annual training is mandatory for all contacts designated by the entity as a RMTS Contact. The RMTS Contacts are responsible for ensuring the entity complies with all RMTS requirements. Training sessions are conducted by the HHSC.

Until such time that a designated RMTS Contact completes the mandatory training they will be given view-only access to the RMTS PL and will not have the ability to access, input, or update the RMTS PL.

Failure by an entity to certify its RMTS PL will result in non-compliance with RMTS requirements and will cause the entity to become ineligible to participate in DS and MAC for the specified period.

1. Initial versus refresher training.

- Initial training - Those who have never attended RMTS training must attend an initial training. Initial training must be interactive and therefore must be conducted via face-to-face, webinar or teleconference.
- Refresher training – Those who have ever attended an initial training may attend refresher training or may attend an initial training again. Refresher training may be conducted via CD's, videos, web-based and self-paced training.

2. Training materials.

HHSC will make accessible, via the HHSC website, RMTS training materials used for both initial and refresher training. Entities are encouraged to use and distribute to designated RMTS Contacts and time study participants materials provided by HHSC regarding the time study.

3. Training types.

- RMTS Contact (designated by the entity).

HHSC will provide training sessions for RMTS Contacts quarterly. Training will include an overview of the RMTS process, software system and information on how to access and input information into the RMTS system. It is essential for the RMTS Contacts to understand the purpose of the RMTS, the appropriate documentation and completion of the RMTS, the timeframes and deadlines for participation, and the consequences of non-compliance.

- Sampled staff training.

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

Sampled staff training must be made available quarterly. Sampled staff must receive annual training prior to the completion of their sampled moment. Sampled staff that has not completed annual sampled staff training cannot participate in the RMTS.

RMTS Contacts are responsible for documenting and maintaining training records to prove that sampled staff received mandatory training prior to the completion of the sampled moment.

In addition, prior to completing their moment, sampled staff participants are required to read a brief set of online instructions that are intended to supplement prior training.

- Central coder training.

HHSC will provide training to the central coding staff annually, and on an as needed basis. Training will discuss issues regarding the coding of moments. Training will include an overview of activity codes, samples of activities, appropriate processes for making coding determinations, program updates, process modifications, and compliance issues.

Section Two

Participating Entities

Early Childhood Intervention (ECI)

Introduction

The use of the RMTS methodology for the ECI program is implemented effective October 1, 2010.

A time study exclusive only to the ECI program will be conducted. The results of the ECI time study will be used to claim for MAC administrative services only.

The time study will identify the portion of the RMTS participant's time:

- Related to providing MAC administrative activities;
- Directly or indirectly related to providing State Plan covered direct services (DS) activities (i.e. Targeted Case Management and Specialized Rehabilitation Services), and
- Related to other activities.

Staff Pools

Two staff pools will be used. Separate time studies will be conducted for each staff pool. The time studies will be mutually exclusive meaning that no staff will be included in more than one staff pool.

Staff Pool 1

- Comprised of staff that participate in administrative activities only and do not participate in DS activities.

Participants in this pool may include:

Early Intervention Specialist
Nurse – Registered and Licensed Vocational
Parent Educator
Pre-enrollment staff
Program Director / Assistant Director
Program Supervisor
Public Outreach / Child Find Staff
Service Coordinator
Site Manager / Assistant Manager
Social Worker
Teacher of the Auditory or Visual Impaired
Team Leader
Trainer / Coordinator
Translator / Interpreter
Other staff that routinely interact with children and families

Staff Pool 2

- Comprised of staff that participate in both administrative activities and DS activities.
- Because the time study results will be used to claim only for MAC administrative services, not all DS staff will be time studied. Only DS staff that provide administrative activities as part of their regular duties and on a regular basis will be included.

Participants in this pool may include:

Applied Behavior Analysis Specialist
Audiologist
Counselor
Dietitian
Licensed Marriage and Family Therapist
Nurse – Advanced Practice
Occupational Therapist
Physical Therapist
Psychological Associate
Psychologist
Social Worker – Licensed Clinical
Speech Language Pathologist

Precision Level

Refer to *Sampling Requirements* in Section One. Because the time study results will be used to claim for MAC administrative services only, the +/- 5 percent precision level will be used for the ECI program.

RMTS Sampling Periods

HHSC will evaluate ECI entity calendars to determine operational hours each quarter for which staff is compensated for providing ECI services. Based on federal fiscal year quarters, HHSC will determine the most common begin and end dates for statewide sampling purposes. All days and times of operation will be included in the potential days to be chosen for the quarterly time study.

Participation and Eligibility Requirements

Failure by an entity to certify its RMTS PL will result in non-compliance with RMTS requirements and will cause the entity to become ineligible to participate in administrative claiming for the specified period.

For MAC:

An ECI entity must participate in all four time study quarters conducted during the federal fiscal year in order to claim MAC costs for all four of those quarters.

Failure to participate in a time study quarter will make the ECI entity ineligible to claim MAC costs for that quarter.

Local Health Departments (LHD)

Introduction

The use of the RMTS methodology for the LHD program is implemented effective October 1, 2010.

A time study exclusive only to the LHD program will be conducted. The results of the LHD time study will be used to claim for MAC administrative services only.

The time study will identify the portion of the RMTS participant's time:

- Related to providing MAC administrative activities;
- Directly or indirectly related to providing direct service (DS) activities, and
- Related to other activities.

Staff Pools

A single staff pool will be used.

Staff Pool 1

- Comprised of staff that participate in administrative activities only and staff that participate in DS activities and also administrative activities as part of their regular duties and on a regular basis.

Participants in this pool may include:

- Aide / Assistant
- Case Manager / Case Worker
- Clerk
- Community Relations Specialist
- Coordinator
- Counselor
- Dental Hygienist
- Dentist
- Dietician
- Interpreter / Translator / Bilingual Specialist
- Nurse
- Occupational Therapist
- Outreach Worker
- Physical Therapist
- Physician
- Psychiatrist
- Psychologist

Psychology – Licensed Intern
Receptionist / Telephone Operator
Service Coordinator
Social Worker
Specialist
Speech Language Pathologist
Technician

Precision Level

Refer to *Sampling Requirements* in Section One. Because the time study results will be used to claim for MAC administrative services only, the +/- 5 percent precision level will be used for the LHD program.

RMTS Sampling Periods

HHSC will evaluate LHD entity calendars to determine operational hours each federal quarter for which staff is compensated for providing LHD services. Based on federal fiscal year quarters, HHSC will determine the most common begin and end dates for statewide sampling purposes. All days and times of operation will be included in the potential days to be chosen for the quarterly time study.

Participation and Eligibility Requirements

Failure by an entity to certify its RMTS PL will result in non-compliance with RMTS requirements and will cause the entity to become ineligible to participate in administrative claiming for the specified period.

For MAC:

An LHD entity must participate in all four time study quarters conducted during the federal fiscal year in order to claim MAC costs for all four of those quarters. Failure to participate in a time study quarter will make the LHD entity ineligible to claim MAC costs for that quarter.

Mental Health and Mental Retardation (MHMR)

Introduction

The use of the RMTS methodology for the MHMR program is implemented effective October 1, 2011.

A time study exclusive only to the MHMR program will be conducted. The results of the time study will be used to claim for MAC administrative services only.

The time study will identify the portion of the RMTS participant's time:

- Related to providing MAC administrative activities;
- Directly or indirectly related to providing direct service (DS) activities, and
- Related to other activities.

Staff Pools

A single staff pool will be used.

Staff Pool 1

- Comprised of staff that participate in administrative activities only and staff that participate in direct service activities and also in administrative activities as part of their regular duties and on a regular basis.

Participants in this pool may include:

Aide / Assistant
Benefits Staff
Case Manager / Case Worker
Clerk
Community Relations Specialist
Coordinator
Counselor
Eligibility Staff
Enrollment Specialist
Habilitation / Rehabilitation Specialist
Information Line Staff
Intake Specialist
Interpreter / Translator / Bilingual Specialist
Licensed Medical Personnel
Manager / Supervisor
Outreach Worker
Pre-enrollment staff
Program Director / Assistant Director
Program Supervisor
Public Outreach
Quality Assurance
Receptionist / Telephone Operator
Service Coordinator
Site Manager / Assistant Manger
Social Worker
Specialist
Team Leader
Technician
Trainer / Coordinator
Translator / Interpreter
Transportation / Van Driver

Precision Level

Refer to *Sampling Requirements* in Section One. Because the time study results will be used to claim for MAC administrative services only, the +/- 5 percent precision level will be used for the LHD program.

RMTS Sampling Periods

HHSC will evaluate MHMR entity calendars to determine operational hours each federal quarter for which staff is compensated for providing MHMR services. Based on federal fiscal year quarters, HHSC will determine the most common begin and end dates for statewide sampling purposes. All days and times of operation will be included in the potential days to be chosen for the quarterly time study.

Participation and Eligibility Requirements

Failure by an entity to certify its RMTS PL will result in non-compliance with RMTS requirements and will cause the entity to become ineligible to participate in administrative claiming for the specified period.

For MAC:

An MHMR entity must participate in all four time study quarters conducted during the federal fiscal year in order to claim MAC costs for all four of those quarters. Failure to participate in a time study quarter will make the MHMR entity ineligible to claim MAC costs for that quarter.

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Health and Human Services Commission



Time Study Activity Codes

March 30, 2012

TIME STUDY ACTIVITY CODES

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TIME STUDY ACTIVITIY CODES

Activity codes have been standardized for use with the ECI and LHD programs except for where otherwise indicated.

Code	Activity
1.a	Outreach - Non-Medicaid
1.b	Outreach – Medicaid
2.a	Eligibility - Non-Medicaid
2.b	Eligibility - Medicaid
3	Educational and Social Activities – Non-Medicaid
4	Direct Medical Services
5.a	Transportation - Non-Medicaid
5.b	Transportation – Medicaid
6.a	Translation - Non-Medicaid
6.b	Translation – Medicaid
7.a	Program Planning, Development and Interagency Coordination - Non-Medical
7.b	Program Planning, Development and Interagency Coordination - Medical
8.a	Training - Non-Medical / Non-Medicaid Related
8.b	Training – Medical / Medicaid Related
9.a	Referral, Coordination, and Monitoring - Non-Medicaid Services
9.b	Referral, Coordination, and Monitoring - Medicaid Services
10	General Administration
11	Not Paid / Not Worked
12.a	Provider Relations - Non-Medical / Non-Medicaid Related
12.b	Provider Relations – Medical / Medicaid Related

RMTS ACTIVITY CODE DESCRIPTIONS

CODE 1.a. OUTREACH - NON-MEDICAID

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, or staff travel required to perform these activities.

General examples.

- Informing individual or family about wellness programs and how to access them.
- 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 hygiene, 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 IDEA child-find activities (e.g. screening and evaluation designed to locate, identify, and refer as early as possible young children with disabilities and/or who are at risk for developmental delay that are in need of early intervention).
- 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. OUTREACH - MEDICAID

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. Both written and oral methods may be used. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples.

- Informing Medicaid eligible and potential Medicaid eligible individual or

- family about the benefits and availability of services provided by Medicaid (including preventive treatment, and screening).
- 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 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.
 - Providing information about Medicaid screening that will help identify medical conditions that can be diagnosed and treated early (e.g., dental, vision), before they become more serious and the treatment more costly;
 - Helping individual or family use health resources, including their own talents and knowledge, effectively and efficiently.
 - Developing and/or compiling materials to inform individual or family the Medicaid program and how and where to obtain those benefits. This activity should not be used when Medicaid-related materials are already available (such as through the Medicaid agency). As appropriate, developed outreach materials should have prior approval of the Medicaid agency.
 - Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid program.
 - Contacting pregnant and parenting teenagers about the availability of Medicaid prenatal and well baby care programs and services, and family planning services.
 - Informing individuals with disabilities about the availability of Medicaid services.
 - Present information on medical services at health fairs.
 - Visiting a daycare to do outreach related to ECI medical services.
 - A nurse speaking at a community function about early detection of health problems.
 - A psychologist talking to a parenting group about mental illness and signs to look for in adolescents.

CODE 2.a. ELIGIBILITY - NON-MEDICAID

Use this code when helping an individual to become eligible for non-Medicaid programs. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples.

- Explaining eligibility processes to prospective applicants for non-Medicaid programs such as In-Home and Family Support, Temporary Assistance for

Needy Families (TANF), food stamps, Children's Health Insurance Program (CHIP), Women, Infants, and Children (WIC), Children with Special Health Care Needs (CSHCN), Chronically Ill and Disabled Children (C IDC), Free and Reduced Lunch Program, Head Start, day care, Community Oriented Primary Care, County Indigent Health Care and Low Energy Assistance Program (LEAP) for non-Medicaid eligibility.

- Developing and verifying initial and continuing eligibility for non-Medicaid programs.
- Assisting an applicant in completing the application for non-Medicaid programs.
- Assisting the individual or family collect/gather information and documents for the non-Medicaid program application.
- Assisting individuals to provide third party resource information at non-Medicaid eligibility intake.
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.
- Assisting an applicant fill out an eligibility application for In Home Family Support (IHFS).
- A mental health worker assisting an individual enroll in literacy classes.

CODE 2.b. ELIGIBILITY - MEDICAID

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

General examples.

- Verifying current Medicaid eligibility status.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process.
- Referring individual or family to the local Assistance Office to make application for Medicaid benefits.
- Tracking referred clients/students to substantiate completion of the Medicaid application process and offering assistance.
- Assisting to complete a Medicaid eligibility application.
- Assisting in collecting/gathering required information and documents for the Medicaid application.
- Assisting to provide third party resource information at Medicaid eligibility intake.
- Participating as a Medicaid eligibility outreach outstation, but does not include determining eligibility.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.

CODE 3. EDUCATIONAL AND SOCIAL ACTIVITIES – NON-MEDICAID

Use this code when performing activity related to social services, educational services, employment services, job training, child care, housing and other services. Include any paperwork, clerical activities or staff travel required to perform these activities.

General examples.

- 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.
- Family education services.
- Parent support groups.
- Career counseling.
- Employment and job training.
- Nutrition services.
- Counseling.
- Behavioral (discipline).
- IHFS reports and administrative activities.
- Appearing in court on behalf of consumer trying to maintain custody of her children.

CODE 4. DIRECT MEDICAL SERVICES

Use this code when staff (employees or contracted staff) is providing direct medical services. This code includes pre and post activities associated with the actual delivery of the direct client medical services, e.g., paperwork or staff travel required to perform these services.

General examples.

- Medical screenings (including scoliosis), vision screenings, hearing screenings, dental screenings, EPSDT screenings, and nurse consults.
- Administering first aid.
- Administering medication or providing immunizations.
- Individual and group psychotherapy. (LHD)
- Individual and group counseling about issues of physical and mental health or substance abuse. (LHD)
- Targeted case management activities. (ECI, LHD)

- Specialized rehabilitation services. (ECI)
- Developmental assessments and diagnostic testing. (ECI, LHD)
- Parental skills training and counseling. (ECI, LHD)
- Technical assistance which contribute to client advocacy and family empowerment. (ECI, LHD)
- Direct clinical and treatment services (LHD):
 - Obtaining or reviewing medical history information.
 - Performing physical examinations.
 - Determining diagnosis.
 - Reviewing test results.
 - Referring for specialized medical services.
 - Dispensing medications or supplies.
 - Educating and counseling about management of medication routine.
- Time spent providing Rehabilitation Services other than crisis intervention services without authorization.

CODE 5.a. TRANSPORTATION – NON-MEDICAID

Use this code when assisting an individual to obtain transportation to services not 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 or staff travel required to perform these activities.

General examples.

- Scheduling or arranging transportation for social, vocational, and/or educational programs and activities.
- Accompanying the client to services not covered by Medicaid.

CODE 5.b. TRANSPORTATION – MEDICAID

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, or staff travel required to perform these activities.

General examples.

- Scheduling or arranging transportation to Medicaid covered services.

1. Arranging for a taxi to the doctor.
2. Scheduling Medicaid transportation to the doctor.

CODE 6.a. TRANSLATION – NON-MEDICAID

Use this code when providing translation services for non-Medicaid activities. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples.

- Arranging for or providing translation services for the purpose to access and understand social, educational and vocational services.
- Arranging for or providing translation services including oral and signing services.
- Developing translation materials to assist in accessing and/or understanding social, educational and vocational services.

CODE 6.b. TRANSLATION - MEDICAID

Use this code when assisting to obtain translation services for the purpose of accessing Medicaid services. Include related paperwork, clerical activities, or staff travel required to perform these activities. Translation may be allowable as an administrative activity, but only if it not included and paid for as part of a direct medical service (which would be assigned Code 4 – Direct Medical 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.
- Serving as a translator on how to access Medicaid services. This includes alternative languages, Braille, sign languages, and translation due to illiteracy.
- Arranging for or providing translation services (oral or signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid.
- Developing translation materials that assist to access and understand necessary care or treatment covered by Medicaid.

CODE 7.a. PROGRAM PLANNING, DEVELOPMENT, AND INTERAGENCY COORDINATION - NON-MEDICAL

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. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples.

- Identifying gaps or duplication of non-medical services (e.g., social, vocational, educational and mandated general health care programs) to children and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of non-medical programs.
- Monitoring the non-medical delivery systems.
- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services. Note: the actual tracking of requests would be coded under code 9.
- 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 or social problems.
- Defining the scope of each agency's non-medical services in relation to other services.
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services and state-mandated health screenings.
- Developing non-medical referral sources.
- Coordinating with interagency committees to identify, promote and develop non-medical services.

CODE 7.b. PROGRAM PLANNING, DEVELOPMENT, AND INTERAGENCY COORDINATION - MEDICAL

Use this code 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. Include related paperwork, clerical activities or staff travel required to perform these activities.

General examples.

- Identifying gaps or duplication of medical/dental/mental services to children and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of medical/dental/mental health programs.
- Monitoring the medical/dental/mental health delivery systems.
- Developing procedures for tracking families' requests for assistance with medical/dental/mental services and providers, including Medicaid.
- 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 medical/dental/mental health programs.
- Defining the scope of each agency's Medicaid service in relation to other services.
- Working with Medicaid resources, such as the Medicaid agency and Medicaid managed care plans, to make good faith efforts to locate and develop health services referral relationships.
- Developing advisory or work groups of health professionals to provide consultation and advice regarding the delivery of health care services.
- 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 that will provide services to targeted population groups.
- Coordinating with interagency committees to identify, promote and develop medical services to children.
- Containing Medicaid costs and improving services to children as part of program goals.
- Developing resource directories of Medicaid services.
- Working with other agencies providing Medicaid services to improve coordination and delivery of services, to expand access to specific populations of Medicaid eligible clients, and to improve collaboration around the early identification of medical problems.

- Focusing Medicaid services on specific populations based upon recent epidemiological data with the intent of reducing the need for long-term or more costly Medicaid services.
- Defining the scope of each agency's Medicaid service in relation to other services.
- Developing strategies to increase Medicaid system capacity and close Medicaid service gaps by in-depth analysis of Medical data related to a specific program or specific group.
- Interagency coordination to improve delivery of Medicaid services.
- A group of local physicians working together to develop a triage and referral instrument that will be used throughout the service area to reduce inappropriate referrals and intake redundancy for Medicaid funded services (e.g., physical health, mental health).

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

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, 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.
- Participating in or coordinating training that improves relationships between and among local agencies.
- Participation in training to improve computer skills for data collection
- Training regarding non-medical social service issues.
- Training regarding educational issues.

CODE 8.b. TRAINING - MEDICAL/MEDICAID RELATED

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, 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).
- Coordinating training to assist families to access Medicaid services.
- Participating in training for outreach and eligibility assistance.
- Outreach workers being trained on the provision of direct services so that they can inform potential service recipients.
- Participating in or presenting training that improves the quality of identification, referral, treatment and care of children, e.g., talking to new staff about the EPSDT referral process or available EPSDT and health-related services.
- Participating in or coordinating training that improves the medical knowledge and skills of medical personnel.
- Conducting seminars and presentations to parents, community members, teachers on:
 - Identification of physical disabilities and other medical conditions that can be corrected or ameliorated by services covered through Medicaid.
 - Providing training on where and how to seek assistance through the Medicaid system.

CODE 9.a. REFERRAL, COORDINATION, AND MONITORING - NON-MEDICAID SERVICES

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

General examples.

- Screening and 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 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 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.
- Follow up monitoring with a client referred to a homeless shelter.
- A non-mental retardation service coordinator transitioning an individual from a state hospital to the community.

CODE 9.b. REFERRAL, COORDINATION, AND MONITORING - MEDICAID SERVICES

Use this code when making referrals for, coordinating, and/or monitoring the delivery of medical (Medicaid covered) services. Include related paperwork, clerical activities, or staff travel necessary to perform these activities.

General examples.

- Making referrals for and/or coordinating medical or physical examinations and necessary medical/mental health evaluations.
- Making referrals for and/or coordinating dental examinations (for under age 21 only).
- Making referrals for and/or scheduling EPSDT screens, inter-periodic screens, and appropriate immunizations.
- Making or 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.
- Referring clients/students for necessary medical health, mental health, or substance abuse services covered by Medicaid.
- Gathering any information that may be required in advance of medical/dental/mental health referrals.
- Participating in a meeting/discussion to coordinate or review needs for health-related services covered by Medicaid.
- Following-up to ensure the prescribed medical/dental/mental health services covered by Medicaid.
- Providing follow-up contact to provide feedback whether further treatment or modification of existing treatment are required.
- 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 referral to other Medicaid service providers as may be required to provide continuity of care.
- Providing information to other staff on the 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.
 - Making referrals for and/or coordinating medical evaluations that are not delegated by a physician.
 - Making referrals for and/or coordinating dental evaluations that are not the result of an appointment with a dentist.
 - Providing information about, making referrals for, and/or scheduling EPSDT screens, exception to periodicity screens and appropriate immunizations for children who are not on schedule and/or who have special needs or health problems.
 - Using medical expertise in providing information to other personnel or health care providers on the child's medical services and plans.
 - Gathering and/or reviewing medical-based information in advance of referrals to or evaluations with other medically trained professionals.
 - Participating in inter/intra-agency meetings to coordinate or review a need for Medicaid covered services.
 - Providing follow-up contact to ensure the prescribed services were received.
 - Coordinating the completion of medical services to ensure the services are provided according to standard medical protocol and evidence-based practices.
 - Using medical expertise in ensuring continuity of care between providers of medical services.
 - Linking individuals with mental illness to crisis intervention.
 - Writing the Determination of Mental Retardation (DMR) report.
 - Initial treatment planning for an individual prior to the determination of eligibility for mental retardation service coordination.

CODE 10. GENERAL ADMINISTRATION

Use this code when engaged in general administration activities or performing activities that are not directly assignable to program activities. Include related paperwork, clerical activities, or staff travel required to perform these activities.

General examples.

- Taking paid lunch, breaks, leave, or other paid time not at work.
- Providing general supervision of staff and evaluation of employee performance, including licensure supervision.
- Processing employee payroll and other employee-related forms.
- Developing budgets and maintaining records.
- Maintaining inventories and ordering supplies.

- Establishing goals and objectives of programs as part of the agencies annual or multi-year plan.
- Reviewing procedures and rules.
- Attending or facilitating staff meetings, staff training, or board meetings.
- Performing administrative or clerical activities related to general 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.
- Performing general administrative and/or clerical activities related to central or regional office functions or operations.
- Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.
- Activities related to conducting a Death Review.

CODE 11. NOT PAID / NOT WORKED

Non-worked/non-paid time is time 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

CODE 12.a PROVIDER RELATIONS - NON-MEDICAL / NON-MEDICAID RELATED

Use this code when performing activities related to securing and maintaining the pool of non-health related providers. Includes related paperwork, clerical activities or staff travel required to performing these activities.

General examples.

- Recruiting non-medical providers providers.

- Recruiting with outside agencies regarding social and education programs (e.g., agencies that assist with childcare and housing assistance).
- Providing technical assistance and support to new non-medical staff, including orientation.
- Developing service/provider directories.
- Developing non-medical referral sources.

CODE 12.b PROVIDER RELATIONS - MEDICAL / MEDICAID RELATED

Use this code when performing activities to secure and maintain the pool of eligible Medicaid providers. Includes paperwork, clerical activities and staff travel directly related to performing these activities.

General examples.

- Recruiting new Medicaid providers.
- Developing future referral capacity with specialty medical care providers by discussing medical health programs, including client needs and service delivery requirements.
- Developing medical service/provider directories.
- Working with medical resources such as managed care plans to locate and develop health services referral relationships.
- Monitoring effectiveness of programs providing Medicaid-covered services, including client satisfaction surveys for medical/dental/mental health services.
- Providing information and technical support to providers on Medicaid policy and regulations.
- Explaining Medicaid policy and regulations to an adaptive equipment vendor.

TEXAS

Health and Human Services Commission



Medicaid Administrative Claiming

March 30, 2012

MEDICAID ADMINISTRATIVE CLAIMING GUIDE

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SECTION ONE IMPLEMENTING MEDICAID ADMINISTRATIVE CLAIMING (MAC)

Overview

The federal government permits state Medicaid agencies to claim reimbursement for activities performed that are necessary for the “proper and efficient administration” of the Medicaid State Plan as stated in Medicaid statute section 1903(a)(7) of the Social Security Act and the implementing regulations at Code of Federal Regulation (CRF) Title 42 (CFR, 431.1 and 42 CFR 431.15, and 45 CFR Part 74 and 95). In addition, Office of Management and Budget (OMB) A-87 which contains the cost principals for state, local, and Indian tribal governments for the administration of federal awards states that “Governmental units are responsible for the efficient and effective administration of federal awards.”

The Centers for Medicare and Medicaid Services (CMS) has identified a series of activities, such as outreach, utilization review, and eligibility determination that are entitled to be claimed administratively through the Medicaid Administrative Claiming (MAC) program.

As the Medicaid authority for Texas, the Texas Health and Human Services Commission (HHSC) has coordinated with other state agencies and contracted with public entities to assist HHSC in administering the Texas State Medicaid Plan in the most effective manner possible.

The common interest of HHSC and the public entities is to ensure more effective and timely access of individuals to health care, to obtain the most appropriate utilization of Medicaid covered services, and to promote activities and behaviors that reduce the risk of poor health outcomes for the state's most vulnerable populations.

Public entities interested in participating in the MAC program must comply with requirements set forth by HHSC. Public entities must review all requirements annually and make any necessary changes to ensure HHSC of their compliance on a continual basis.

Health and Human Services Commission Required Participation Documents

To participate in the MAC program, public entities must establish and maintain an Intergovernmental Cooperation Agreement (ICA) and Business Associate Agreement (BAA) with HHSC.

The ICA must be in effect by the first day of the quarter in which the first time study takes place. HHSC must be assured that the public entities are capable of administering the project and must meet the state and federal matching requirements. Participation continuance will be dependent on maintaining compliance on a continual basis with the requirements specified in the documents and other HHSC requirements. Further, public entities participating in MAC may enter into sub-agreements with their own contractors for the performance of claimable Medicaid administrative activities.

Public Entities' Responsibilities for Participation in MAC

Public entities are required to oversee their MAC program to ensure that procedures are implemented and performed appropriately. It is highly recommended that two individuals be appointed and trained to manage the oversight responsibilities for the participating public entity. The following list of core responsibilities has been developed to assist public entities:

Information Flow - Receive correspondence and requests for information regarding MAC from HHSC and ensure that the information is disseminated to all appropriate staff and contractors; encourages interdepartmental coordination and cooperation to improve program efficiency and effectiveness.

Policy - Ensure policy directives and instructions are consistent with statewide policy for MAC. Assign MAC program coordinators and assist them in defining their roles and responsibilities to include: development of an appropriate data used to determine the percentage of Medicaid clients, construction of the MAC claim (known hereafter as the claim), and establishment of a supporting documentation file. Clarify policy, program or fiscal questions raised by staff or contractors, and refer any requests for assistance or further clarification to HHSC.

Staff Training – Identify required training among staff and contractors to ensure compliance established by HHSC.

Quality Review - Ensure no duplicate billings occur and invoices for the claim are consistent with the criteria established before the claim is certified and submitted to HHSC. Ensure the data used to calculate the Medicaid percentage is properly entered into the system and will provide any information requested by HHSC regarding the claim.

HHSC Required Participating Documents - Maintain the ICA and BAA with HHSC and ensure the processing of agreements or memoranda of understanding with any sub-contractors participating in MAC.

Audits/Reviews - Develop guidelines for establishing and maintaining supporting documentation files that are consistent with procedures outlined by HHSC. Assist public entity coordinators and/or their designees in maintaining supporting documentation files containing documents supporting the development of the claims. Conduct periodic reviews of the supporting documentation file to ensure that the files are current with all applicable HHSC directives.

SECTION TWO MEDICAID ADMINISTRATIVE CLAIMING

Overview

The federal government permits state Medicaid agencies to claim reimbursement for activities performed that are necessary for the "proper and efficient administration" of the State Medicaid Plan. Historically, CMS has provided some latitude to states in determining the kinds of activities for which they may seek reimbursement. CMS has identified a series of activities, such as outreach, utilization review, eligibility determination, and activities which determine an individual's need for care, that are entitled to be claimed through the MAC program. Case Management has also been identified as an activity that may be reimbursed either as an administrative or a fee-for-service activity.

The Elements of the Claim

The claim submitted to the state for reimbursement has five elements: allowable Medicaid administrative time, cost pool construction, Medicaid percentage, federal financial participation (FFP), and revenue offset. The following describes each:

Allowable Medicaid Administrative Time

Time Study Activities/Codes

The time study activity codes assist in the determination of time and associated costs that are related to and reimbursable through Medicaid. The time study activity codes have been designed to reflect all of the activities performed by time study participants per public entity. Time study activity codes can be found in Section 2.1 of this Texas Time Study and MAC Guide.

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

The time study activity code indicators are:

Application of FFP rate	50 or 75 percent	Refers to an activity that is allowable as administration through Medicaid and claimable at the 50 or 75 percent FFP rate.
Allowability & Application of Medicaid Share	U	Unallowable – refers to an activity that is unallowable as administration through Medicaid. This is regardless of whether or not the population served includes Medicaid eligible individuals.
	TM	Total Medicaid – refers to an activity that is allowable under Medicaid as administration but for which the costs are not limited to the proportion of Medicaid eligible's served
	PM	Proportional Medicaid – refers to an activity, which is allowable as Medicaid administration under Medicaid, but for

		which the costs are limited to the proportion if Medicaid eligible's served.
	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.

The results of the time study activity shown below will determine the allowable time allocated to each cost pool. Costs for all activities will be allocated as shown below under Cost Pool Construction.

Cost Pool Construction

To identify allowable Medicaid administrative costs within a given program, time studies will be conducted of staff persons that spend a portion of their time performing administrative activities. To identify the proportion of administrative time allowable and reimbursable under Medicaid, the time-study results will be utilized to allocate or assign the costs as shown below to an appropriate cost pool.

Cost Pool 1 - Costs, revenues, and time relating to the activities relating to the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 (CHIPRA). CHIPRA contains guidance allowing increased administrative match for administrative expenditures for translation or interpretation services connected with the "enrollment of, retention of, or use of services" under Medicaid and CHIP. For MAC, HHSC will claim the increased match of 75 percent for translation and interpretation as described in Code 6.b. (which is reduced by the Medicaid percentage).

Cost Pool 2 - Costs, revenues and time relating to Medicaid related activities using Codes, 1.b., 2.b., and 12.b., (which are not reduced by the Medicaid percentage) and 5.b., 7.b., 8.b., and 9.b., (which are reduced by the Medicaid percentage). As in Cost Pool 1, the costs related to any staff that did not participate in the time study but provided "direct clerical support" will be included in Cost Pool 2. (Direct clerical support cost applicable to ECI only.)

Cost Pool 3 - Costs, revenues, and time derived from activities which are non-Medicaid related (Codes 1.a., 2.a, 3, 5a., 6a., 7.a., 8.a., 9.a. , 11 and 12.a.) or those which are direct service activities (Codes 4), neither of which are claimable as administrative activities. Staff who were not time studied and who provide services that are not medically related and do not provide general administrative services for the whole public entity are also included. Additionally, this cost pool would include staff whose staff costs are predominately supported by a federal grant (ECI, and LHD entities).

Cost Pool 4 - Costs, revenues, and time for general administrative services (code 10), staff that provide general administration to the whole public entity and were not time studied, as well as costs which cannot be allocated in more accurate fashion. This cost pool includes any overhead costs such as county or entity indirect costs and other "operating costs" that have not been entered in Cost Pools 1, 2, or 3 (ECI, LHD entities).

Whenever data is directly entered in Cost Pool 1, 2, and 3, this indicates that the user has documented evidence linking that cost or revenue to that specific cost pool. Such evidence should be maintained in the supporting documentation file and must be based on empirical verifiable information.

Code	Activity	MAC Indicators	Staff Activity Allocation by Cost Pool
1.a	Outreach - Non-Medicaid (All Staff)	U	Cost Pool 3
1.b	Outreach - Medicaid (All Staff)	TM (50%)	Cost Pool 2
2.a	Eligibility - Facilitating Non-Medicaid (All Staff)	U	Cost Pool 3
2.b	Eligibility - Facilitating Medicaid (All Staff)	TM (50%)	Cost Pool 2
3	Other Non-Medicaid/Educational & Social Services	U	Cost Pool 3
4	Direct Medical Services	U	Cost Pool 3
5.a	Transportation Non-Medicaid (All Staff)	U	Cost Pool 3
5.b	Transportation Medicaid (All Staff)	PM (50%)	Cost Pool 2
6.a	Translation Non-Medicaid	U	Cost Pool 3
6.b	Translation Medicaid	PM (75%)	Cost Pool 1
7.a.	Program Planning, Development and Interagency Coordination Non-Medical (All Staff)	U	Cost Pool 3
7.b.	Program Planning, Development and Interagency Coordination Medical (All Staff)	PM (50%)	Cost Pool 2
8.a	Non-Medical/Non-Medicaid related Training	U	Cost Pool 3
8.b	Medical/Medicaid related Training	PM (50%)	
9.a.	Referral, Coordination, and Monitoring Non-Medicaid Services (All Staff)	U	Cost Pool 3
9.b.	Referral, Coordination, and Monitoring Medicaid Services (All Staff)	PM (50%)	Cost Pool 2
10	General Administration	R	Cost Pool 2 and 3
11	Not Paid/Not Worked	U	Unallowable
12.a.	Provider Relations - Non-Medical / Non-Medicaid Related	U	Cost Pool 3
12.b.	Provider Relations - Medical / Medicaid Related	TM (50%)	Cost Pool 2

The results of the time study activity shown above will determine the allowable time allocated to each cost pool. Costs for all activities will be allocated as shown below under Cost Pool Construction.

Cost Pool Construction

Time study activity code descriptions may be found in Section 2.1 of this Texas Time Study and MAC Guide. The allocable percentage of the public entity's activity codes are referenced in each individual public entity's section of the MAC guide.

Medicaid Percentage

Another factor required to determine the amount of the claim is the Medicaid percentage, sometimes referred to as the Medicaid Eligibility Rate (MER). The Medicaid percentage is determined based on the total unduplicated Medicaid client/student count for the quarter divided by the total unduplicated client/student count for the quarter.

There are various methods for determining the Medicaid percentage. Deciding which Medicaid percentage method to use is determined primarily by the nature of the program being time studied and by the kind of data that is collected on the client/student population. The calculation is based on individuals (an unduplicated count), where the formula would be as follows:

Unduplicated list of Medicaid clients divided by the unduplicated total list of clients in the program:

$$\frac{\text{Total unduplicated Medicaid client/student count for the quarter}}{\text{Total unduplicated client/student count for the quarter}}$$

= Medicaid Percentage for the quarter

Federal Financial Participation (FFP) Rate

Costs incurred for the quarter being claimed are multiplied by the results of the time study to arrive at the allowable claimable costs. These costs are then multiplied at either 50 percent or 75 percent FFP to determine the amount of the federal allowable portion to be reimbursed.

Revenue Offset

There are two types of revenue sources for the purpose of the claim: recognized and unrecognized revenues. In determining the share of the costs for which CMS is willing to pay, a public entity is generally expected to utilize its own income to offset costs, lowering the amount which CMS is responsible for. These revenues are referred to as recognized revenues.

Examples include:

Medicaid Fees + Match (FFP) includes all Title XIX reimbursements and, where required, the State Matching Funds.

Federal Grants + Match (FFP) is income that may pass through one or more state agencies, but is still federal money. This includes federal pass through from counties and cities as well (IDEA Part A, B, and C, TB/HIV/STD Federal Grants, etc).

Other than Medicaid Administrative Claiming reimbursements, federal grants will always be reported as recognized revenue and they will always have a CFDA number.

Insurance receipts

Fees paid by or on behalf of clients for direct service

Donations to Public Entity are only used by private entities

Other Revenues such revenues for vocational production; from clients, families or other sources covering residential costs; and grants from private foundations, miscellaneous revenues not readily identifiable, onetime or unusual revenues, interest income, other business income, fundraising any other purely "Administrative" income

Some revenues are not recognized by CMS as revenue that can be used to offset costs, but rather are designated as the matching funds necessary to draw down the federal support. These funds are referred to as unrecognized revenues.

Examples include:

Medicaid Administrative Reimbursement is the reimbursement received for this claim process

Other State Funds are General Revenue and grants from state funds

Local Government funds from city, county, school district, and other local taxing authorities

Donations to Public Agencies are legislatively mandated donations received

Federal Emergency Assistance Reimbursement (Title IV-A)/FEMA funds

Federal Title IV-E reimbursement (child Welfare Program funds)

Revenues are categorized as recognized or unrecognized and reported to follow either the activity by which they are earned or the expense for which they are a reimbursement.

Direct Charge

Direct charges may be claimed for costs that are directly related to the preparation of time study participants, and the preparation and submission of the MAC claim for LHD and ECI public entities. Detailed documentation logs must be kept on any MAC related

activity that will be used for direct charges. Costs eligible for direct charge are salary, benefits, travel, training and operating costs. An allocation methodology will be utilized on eligible direct costs based on the following formula:

<u>Formula</u>	<u>Example</u>
(Salary + Benefits)/Regular Hours worked in Claim Period = Hourly Wage	\$9,253 / 520 = \$17.79
Hourly Wage X Number of hours to direct charge = Costs Eligible	= \$17.79 x 68 = \$1,209.72 (68 hours from staff time records)
Add direct travel, training and operating costs associated with staff responsible for training time study staff, and preparing and submitting the MAC Claim Cost that cannot be directly identified must be included in General Administration Cost Pool 4 and allocated as appropriate	= \$274.00 Travel = \$ 50.00 RMTS MAC Training Supplies = \$ 0 Operating Costs
Subtotal	\$1,533.72 Note: subtract this amount from administrative cost pool
Subtotal X 50% = Total Direct Charge	\$1,533.72 x .50 = \$741.86
*Total Direct Charge	\$766.86

Calculating the Claim

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

Participant staff costs multiplied by

Percent of time claimable to Medicaid administration multiplied by

Medicaid percentage (the percentage of Medicaid eligible's in the service population) plus

Direct Charge plus

Percent of FFP (50% for some costs and 75% for other costs) equals

The amount of federal request

Financial Data

As stated in the ICA the public entity agrees to spend the federal match dollars generated from Medicaid administrative activities for health-related services for clients. 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.

Cost included in the MAC claim must be in accordance with the provisions of OMB Circular A-87 and 45 CFR Part 74 and 95 and other pertinent US Office of Management and Budget departmental regulations and instructions. 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 un-allowability of certain items of cost. These principles apply whether a cost is treated as direct or indirect.

The following items are considered allowable costs and may be included in the MAC claim:

Direct Costs

Compensation of employees and Contractor and Direct Clerical Support Costs
Cost of materials acquired, consumed, or expended

Equipment

Travel and training expenses incurred

Other Operating Costs

Indirect Costs

Indirect costs included in the claim are computed by multiplying the costs by the public entity's approved unrestricted indirect cost rate. These indirect rates are developed by the entity's state cognizant agency 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. If an approved indirect cost rate is not available for a participating entity from its cognizant agency, the participating public entity's indirect cost rate will be capped at ten percent (10%).

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.

Allocated Costs

General administrative personnel costs for staff that support the public entity as a whole will be included in the MAC Claim. These costs will be allocated across the appropriate costs pools based on HHSC's approved allocation methodology. The allocation method used will ensure non duplication of costs at the public entity.

The following items are considered un-allowable costs and may not be included in the MAC claim:

Unallowable Costs

Costs related to staff that are not identified as eligible time study participants or in support of time study participants

Costs paid with 100 percent federal funds, federal matching funds, recoveries, etc.

Claim Certification

Public Entities will only be reimbursed the federal share of any MAC claims billed. The Chief Financial Officer (CFO), Chief Executive Officer (CEO), Executive Director (ED) or other individual designated by the public entity as the financial contact 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 45 CFR parts 74 and 95.

Public Entities 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

**SECTION THREE
RECORD KEEPING, DOCUMENTATION AND AUDITS/REVIEWS****Overview**

Title 42 CFR 433.32 requires that records be kept for three years after the last revision to a particular claim. Additionally, the documents that support the construction of a claim must also be kept for at least three years after the last claim revision. These documents include the documentation that supports the percentage of Medicaid clients and the basis of the cost pools., Original time study results will be kept as part of the web-based system; therefore public entities will not be required to keep maintain this data in a centralized location.

Building and Maintaining a Supporting Documentation File

Each public entity is responsible for establishing and maintaining a supporting documentation file for audit purposes on each time study and quarterly claim submission.

State and Federal Audits/Reviews

It is the public entities responsibility to comply with state and federal audits. The public entities may do this by fully cooperating and assisting HHSC and/or state or federal personnel in coordinating the audit/review, obtaining the necessary documentation in advance, scheduling interviews, responding to questions or reports, etc.

SECTION FOUR PARTICIPATING ENTITIES

Early Childhood Intervention Program

Overview

The purpose of the MAC program is to provide public entities such as Early Childhood Intervention (ECI) programs in Texas the opportunity to submit reimbursement claims for administrative activities that support the Medicaid program. In order for the cost to be allowable and reimbursable under Medicaid, the activities must be found to be necessary for the proper and efficient administration under the Texas Medicaid State Plan, and must adhere to applicable requirements as defined in state and federal law.

MAC Financial Claiming Elements

The claim submitted to the state for reimbursement has five elements allowable Medicaid administrative time, cost pool construction, Medicaid percentage, federal financial participation (FFP) rate and revenue offset. The following is a description of each component of the claim:

Allowable Medicaid Administrative Time

Time study activities are utilized to determine the amount reimbursable through MAC. The list of activity codes that can be used are found in Section 2.1 of this Texas Time Study and MAC Guide. .

Cost Pool Construction

To identify allowable Medicaid administrative costs within a given program, time studies will be conducted of staff persons that spend a portion of their time performing administrative activities. To identify the proportion of administrative time allowable and reimbursable under Medicaid, the time-study results will be utilized to allocate or assign the costs to the MAC claim.

Medicaid Percentage

Identifying the Medicaid percentage on an individual client basis is the method used by the ECI program as explained in Section Two. The resulting percentage (calculated out to four decimal places) of Medicaid clients served by the public entity, should be as current to the quarter of the claim as possible. Where this is not feasible, the nearest possible determination should be made.

Using this method, the public entity identifies the Medicaid status of its population on an individual client basis. Client information can be collected at the time of first contact. The baseline information must include the client's name, date of birth and Medicaid number. With this information in hand, the public entity can calculate its Medicaid percentage.

Federal Financial Participation (FFP) Rate

Costs incurred for the quarter being claimed are multiplied by the results of the time study to arrive at the allowable claimable costs. These costs are then multiplied at either 50 percent or 75 percent FFP to determine the amount of the federal allowable portion to be reimbursed.

Revenue Offset

There are two types of revenue sources for the purpose of the claim: recognized and unrecognized revenues. ECI programs participating in MAC are required to report revenues pertinent to the compilation of the claim. Revenues are categorized as recognized or unrecognized and reported to follow either the activity by which they are earned or the expense for which they are a reimbursement. An explanation of how revenues are determined for reporting purposes may be found in Section Two.

Direct Charge

Direct charges may be claimed for costs that are directly related to the preparation of time study participants, and the preparation and submission of the MAC claim. Detailed documentation logs must be kept on any MAC related activity that will be used for direct charges. Costs eligible for direct charge are salary, benefits, travel, training and operating costs.

Local Health Departments

Overview

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

MAC Financial Claiming Elements

The claim submitted to the state for reimbursement has five elements: allowable Medicaid administrative time, the cost pool construction, Medicaid percentage, federal financial participating (FFP) rate and revenue offset. The following is a description of each component of the claim:

Allowable Medicaid Administrative Time

Time Study activity will be utilized to determine the amount reimbursable through MAC. The list of activity codes that will be used can be found in Section 2.1 of this Texas Time Study and MAC Guide.

Cost Pool Construction

To identify allowable Medicaid administrative costs within a given program, time studies will be conducted of staff persons that spend a portion of their time performing administrative activities. To identify the proportion of administrative time allowable and reimbursable under Medicaid, the time-study results will be utilized to allocate or assign the costs to the MAC claim.

Medicaid Percentage

Identifying the Medicaid percentage on a case-by-case is the method used by the LHD's as explained in section two. The resulting percentage (calculated out to four decimal places) of Medicaid clients served by the public entity, should be as current to the quarter of the Claim as possible. Where this is not feasible, the nearest possible determination should be made.

Using this method, the public entity identifies the Medicaid status of its population on a case-by-case basis. Client Information can be collected at the time of intake. The baseline information must include the client's name, date of birth and Medicaid number. With this information in hand, the public entity can calculate its Medicaid percentage.

Federal Financial Participation (FFP) Rate

Costs incurred for the quarter being claimed are multiplied by the results of the time study to arrive at the allowable claimable costs. These costs are then multiplied at either

50 percent or 75 percent FFP to determine the amount of the federal allowable portion to be reimbursed.

Revenue Offset

There are two types of revenue sources for the purpose of the Claim, recognized and unrecognized revenues. LHDs participating in MAC are required to report revenues pertinent to the compilation of the Claim. Revenues are categorized as recognized or unrecognized and reported to follow either the activity by which they are earned or the expense for which they are a reimbursement. An explanation of how revenues are determined for reporting purposes may be found in section two.

Direct Charge

Direct charges may be claimed for costs that are directly related to the preparation of time study participants, and the preparation and submission of the MAC claim. Detailed documentation logs must be kept on any MAC related activity that will be used for direct charges. Costs eligible for direct charge are salary, benefits, travel, training and operating costs.

Mental Health and Mental Retardation

Overview

The purpose of the MAC program is to provide public entities such as Mental Health and Mental Retardation (MHMR) in Texas the opportunity to submit reimbursement claims for administrative activities that support the Medicaid program. In order for the cost to be allowable and reimbursable under Medicaid, the activities must be found to be necessary for the proper and efficient administration under the Texas Medicaid State Plan, and must adhere to applicable requirements as defined in state and federal law.

MAC Financial Claiming Elements

The claim submitted to the state for reimbursement has five elements: allowable Medicaid administrative time, the cost pool construction, Medicaid percentage, federal financial participating (FFP) rate and revenue offset. The following is a description of each component of the claim:

Allowable Medicaid Administrative Time

Time Study activity will be utilized to determine the amount reimbursable through MAC. The list of activity codes that will be used can be found in Section 2.1 of this Texas Time Study and MAC Guide.

Cost Pool Construction

To identify allowable Medicaid administrative costs within a given program, time studies will be conducted of staff persons that spend a portion of their time performing administrative activities. To identify the proportion of administrative time allowable and reimbursable under Medicaid, the time-study results will be utilized to allocate or assign the costs to the MAC claim.

Medicaid Percentage

Identifying the Medicaid percentage on a case-by-case is the method used by the MHMRs as explained in section two. The resulting percentage (calculated out to four decimal places) of Medicaid clients served by the public entity, should be as current to the quarter of the Claim as possible. Where this is not feasible, the nearest possible determination should be made.

Using this method, the public entity identifies the Medicaid status of its population on a case-by-case basis. Client Information can be collected at the time of intake. The baseline information must include the client's name, date of birth and Medicaid number. With this information in hand, the public entity can calculate its Medicaid percentage.

Federal Financial Participation (FFP) Rate

Costs incurred for the quarter being claimed are multiplied by the results of the time study to arrive at the allowable claimable costs. These costs are then multiplied at either

50 percent or 75 percent FFP to determine the amount of the federal allowable portion to be reimbursed.

Revenue Offset

There are two types of revenue sources for the purpose of the Claim, recognized and unrecognized revenues. MHMRs participating in MAC are required to report revenues pertinent to the compilation of the Claim. Revenues are categorized as recognized or unrecognized and reported to follow either the activity by which they are earned or the expense for which they are a reimbursement. An explanation of how revenues are determined for reporting purposes may be found in section two.

Direct Charge

Direct charges may be claimed for costs that are directly related to the preparation of time study participants, and the preparation and submission of the MAC claim. Detailed documentation logs must be kept on any MAC related activity that will be used for direct charges. Costs eligible for direct charge are salary, benefits, travel, training and operating costs.