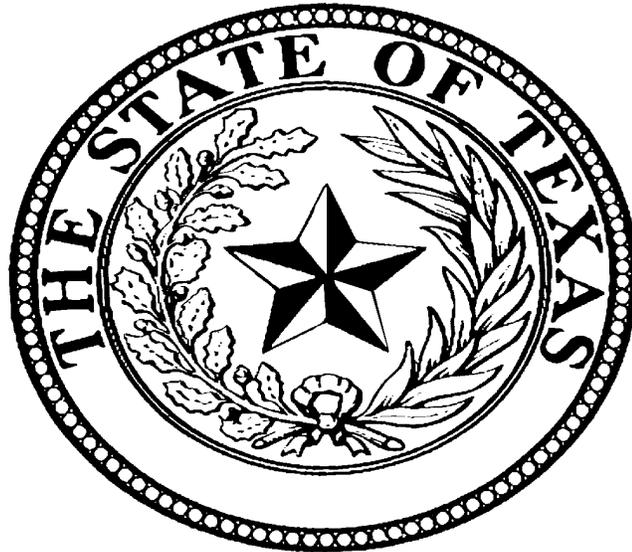


MEDICAID ADMINISTRATIVE CLAIMING:



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

A GUIDE FOR PARTICIPATING AGENCIES

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MEDICAID ADMINISTRATIVE CLAIMING

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I. IMPLEMENTING MEDICAID ADMINISTRATIVE CLAIMING

A. Overview

State and local agencies, including local education agencies, participating in Medicaid Administrative Claiming (MAC) in Texas need to meet a very specific set of requirements. Interagency agreements must be in place and a uniform time study and claiming methodology must be instated in every agency intending to draw down reimbursement through Medicaid administration. The types of contracts that must be in place are discussed below.

Detailed information on the time study and claiming methodologies is presented in a later section. Separate sections are included on all time study participants, including Skilled Professional Medical Personnel (SPMP). Methods to determine the Medicaid percentage and the components of an audit file are also considered separately. It is recommended that the agency designate at least one high level policy analyst to be the coordinator for MAC. It is also recommended that a reimbursement claims expert assist the coordinator.

Federal regulations, enforced by the Health Care Financing Administration (HCFA), require that an interagency agreement be in place between the single state agency responsible for Medicaid and the entity that will be performing Medicaid administration. This agreement needs to be effective the first day of the quarter in which the first time study is conducted. The Health and Human Services Commission (HHSC) has contracted with several state agencies participating in MAC, including the Department of State Health Services (DSHS), and through them, with local agencies and school districts to assist HHSC in more effectively administering the Texas State Medicaid Plan. These agencies may, in turn, enter into agreements with regional or local programs if the Medicaid administrative activities they perform are supported with state and local funds. The common interest of HHSC, the state agencies, and local agencies is to ensure more effective and timely access of individuals to health care, 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.

B. Contracts Needed to Implement Medicaid Administrative Claiming

1. The Agreement with Health and Human Services Commission

To participate in Medicaid Administrative Claiming, state agencies must first enter into a contract with the Health and Human Services Commission. This contract must be effective the first day of the quarter in which the first time study is undertaken. HHSC must also be assured that the state agencies are capable of administering the project and must approve the state agency's monitoring and oversight plan.

2. Contracts between a State Agency and a Local Agency

Once state agencies have effective contracts with the HHSC, they may enter into agreements with local agencies for the performance of Medicaid administrative activities. The local agencies may be public entities (such as health departments, Education Service Centers, or school districts) or private, non-profit agencies that are already in a contractual relationship with the state agency. These agencies must be receiving funds from the state to carry out certain functions and to meet the federal matching requirements.

Like the contract between the HHSC and a state agency, each of the agreements with local agencies must be effective the first day of the quarter in which the initial time study is conducted. HHSC and DSHS must be assured that the local agency is capable of administering the project and there must be a written Implementation Plan approved by DSHS's MAC coordinator. Contract continuation will be dependent on maintaining compliance on a continual basis with the contract and local Implementation Plan. (Copies of the contract between a State Agency and a Local Agency are included in Appendix B.)

Further, local agencies or school districts participating in MAC as the result of such an agreement with a state agency may enter into sub-agreements with their own contractors for the performance of claimable Medicaid administrative activities.

C. Strategies for Implementing Medicaid Administrative Claiming

From the experiences in implementing this program, the following strategies have been developed. Local agencies participating in MAC are required to submit an Implementation Plan that is approved at the state agency level. Approval of this plan is necessary prior to reimbursement for any claim submitted. Continued approval of the Implementation Plan is based on evidence obtained during on-site reviews.

- Adequate training at the state and local agency level of time study participants is required.
- Establishing a network or networks of participating agencies to discuss implementation issues is beneficial. Newer participants would learn more quickly and it could result in more innovative thinking about difficult or problematic issues. It would also serve as an interagency forum to discuss common financing and program policies.
- On-going technical assistance and support concerning implementation issues is essential. State agency staff has a critical role in providing this assistance so that consistency is maintained. Requests for technical assistance, if necessary, should be directed to the local agency coordinator first, and then to the state agency coordinator.
- Regional or program-specific training sessions on special topics are useful for addressing common problems or technical assistance needs.

D. Core Responsibilities for the Local Agency MAC Coordinator

An individual is designated within an agency to take on an oversight role to implement MAC and to see that procedures are implemented and performed appropriately. It is highly recommended that an assistant MAC coordinator be appointed as well. A list of core responsibilities for the agency coordinator has been developed. This list is attached as Appendix D and should be written into the employee's job description.

II. THE TIME STUDY

A. Time Study: The Core of Medicaid Administrative Claiming

1. Overview

A time study is a tool which has become HCFA's accepted method of objectively allocating staff time to the various activities that are measured for claimability. 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 given quarter. For example, a time study during the week between Christmas and New Year's would not accurately represent how staff time is normally spent. A minimum of five days of time study per quarter are required. The five day minimum does not preclude the amount of required valid Worker-Day-Logs (WDLs).

The local agency MAC coordinator selects the start date for each federal fiscal quarter, and verifies that date with DSHS's MAC coordinator. The start day will be selected randomly from all workdays in a quarter using a commonly accepted methodology for random selection. The duration of the time study will run for consecutive days long enough to meet requirements.

The MAC coordinator at each participating local agency also documents the list of days selected and arranges for the distribution and collection of time study forms. Refresher or initial personnel training is completed and documented. This training documentation is placed in the audit file. Be sure that the training roster and agenda are included in the training documentation.

2. The SPMP Codes

Only staff who qualify as SPMPs may use three of the codes (3, 7, and 12). These codes can be reimbursed at 75% **only when skilled professional medical knowledge and education are required**. If an SPMP is performing an activity that does not require the use of skilled professional medical knowledge or training, then he or she would use any of the other nine activity codes. If someone other than an SPMP can perform the duty, these codes are not to be used.

3. Codes for All Staff

Staff who do not qualify as SPMPs may not use codes 3, 7, and 12. All staff (SPMP and NON-SPMP) may use Codes 1, 2, 4, 5, 6, 8, 9, 10, 11, 13, 14, 15 and the lunch code as appropriate.

4. Copies of the Time Study Logs

Time study logs are included in Appendix H of this guide. One log consists of all activity codes and is required from SPMP staff. Another has been designed for use by staff who are not SPMP and excludes codes reserved for use by the SPMPs.

5. Targeted Case Management and Medicaid Administrative Claiming

Most agencies participating in MAC already claim reimbursements for direct services by either charging a fee-for-service or capitated rate (Targeted Case Management, Managed Care, etc.). All activities associated with direct services should be coded as #13. However, there are certain administrative activities which are outside the scope of fee-for-service programs, and these could be claimed as administrative costs. Care must be taken to avoid “double-dipping”. If an activity associated with a direct service is included in the fee-for-service rate, it cannot be coded to claimable Medicaid Administrative codes. Staff who do not provide direct services can participate in the administrative time study with no risk of “double-dipping”.

B. Time Study Alternatives

HHSC's Cost Allocation Plan provides that claims for Medicaid administration will be based on time studies approved by the Single State Agency (Health and Human Services Commission). The two time study methodologies approved by DSHS, HHSC, and HCFA are the Worker-Day-Log and the Mid-month time studies.

1. The Worker-Day-Log Method

The Worker-Day-Log (WDL) method requires each staff member participating in the time study to complete a daily log over a specified period of time. The daily log is divided into 15-minute segments and participants enter a code for each of those periods which best describes the activity or function performed during the interval. One WDL means the completion of the time study for the duration of one workday. A valid WDL is one that has been accurately completed using proper coding, signed and dated.

HHSC requires each agency submitting claims for reimbursement through Medicaid administration to complete a minimum of 750 valid or accurate WDLs for each period. Given a standard variance for the occurrence of errors in a sample of this size (incomplete time study, incorrect code used, etc.), 750 “completed” time studies may not all be valid. Therefore, it is DSHS policy to require each agency to complete and submit a minimum of 800 WDLs per quarter to insure a valid sample.

2. Mid-Month Method

Some agencies or programs may not have enough participants in the time study to generate 800 WDLs during the designated period for the time study. In such cases, those agencies should use the mid-month method, where all agency personnel who participate in the time study do so for all working days during the middle month of the quarter. This alternative sampling methodology may result in fewer than 800 WDLs; however, it is considered to be an acceptable and reasonable sample size.

These time study methodologies are federally approved and should produce statistically valid samples or an accurate representation of the entire quarter. The decision as to which method to use is largely a question of which will be least burdensome to agency staff and meet HHSC requirements. It is advisable to obtain prior approval from DSHS’s MAC coordinator.

C. The Time Study Log

Participants in the time study are to record their time on a daily log. Samples are included in Appendix H. Some agencies, especially those with a large number of staff participating in the time study, are beginning to use scannable forms for the time study log form. All forms of time study logs require approval from DSHS's MAC coordinator.

In completing a valid time study log, the following information is especially important:

- Participants should record their time in fifteen minute intervals, choosing the one function in each fifteen minute segment that is most representative of their time.
- Time should be tracked as close to the fifteen minute intervals as possible; workers should not wait until the end of the day to fill out the form, but neither are they expected to stop what they are doing every fifteen minutes and enter a function. It is recommended time be coded at the end of each specific activity.
- Only paid time should be recorded.
- 100% of the paid work day should be time studied, beginning with the time a worker is scheduled to begin work and ending at the time the worker is scheduled to stop working. The work day includes breaks, meals, and any form of paid leave.
- The time study log requires the date, the original signature of the time study participant and the supervisor's signature. If a weekly log is used in place of a daily log, then original signatures and dates are also required on these forms. All signatures must be in ink.
- The log represents the participants' best judgment as to the kind of activities performed during the day. Supervisors should not cross out codes with which they do not agree. Rather, they should discuss the way the time study log was filled out with the participant to see if the codes have been understood and allow the participant to correct any errors using accepted document correction procedures (i.e., line through error and initial). White-out is not acceptable.
- At the conclusion of all the designated time study days for the quarter, either the worker or support staff should total the 15-minute segments of time by function. This information is then entered on the time study log form together with other required identifying information.
- The worker then signs the time study log form and delivers it to the supervisor to review and sign. Signatures of worker and supervisor attest to the accuracy of the time study log form to the best of their knowledge and belief. The supervisor forwards the completed forms in a timely fashion to the local agency's MAC coordinator. As a general rule, supervisors must sign within one week to ensure accuracy.

D. Filling Out the Time Study Log

Guidelines for filling out the time study log are included in Appendix I.

E. Time Study Training

It is important to train time study participants prior to each time study period. The purpose of the training is to familiarize them with the codes and the use of the daily log. A series of guidelines and tips to consider for time study training is included in Appendix I.

Experience has shown the value of "refresher" training on the time study codes prior to each federal fiscal quarter a time study is completed and is therefore **required**.

III. TIME STUDY PARTICIPANTS

A. Who Should Time Study?

The general rule for determining whether a staff person should be in the time study is as follows:

- All staff in the participating agency who spend at least 10% of their work time performing any of the administrative activities in the listing of time study functions (the SPMP and All Staff activities) described in Section II should participate in the time study.
- Clerical staff, supervisory staff and administrators who provide direct support exclusively to the time study participants usually do not participate in the time study. Their costs will be allocated based on the time study results.
- With the possible exception of clerical staff providing direct support to SPMPs, support staff will be claimed at 50%.
- While administrative staff who provide indirect support to the time study participants (such as finance officers, personnel specialists, and agency directors) do not as a rule time study, their costs may be included to the extent they are properly allocated across all employees in the agency to whom they provide indirect support.
- Contract personnel may participate in the time study, but are only eligible for reimbursement at the non-enhanced rate (50%).

It will never be possible to anticipate all the questions which may arise with regard to inclusion in, or exclusion from, a time study sample. However, local MAC coordinators can make these decisions based on an understanding of the purpose and principles of the time study, with technical assistance from the DSHS's MAC coordinator.

Direct service delivery or program staff who perform no activities claimable to Medicaid administration do not time study. Their costs (salary, benefits, travel, proportionate overhead share, and other operating expenses) are placed in Cost Pool #3.

Questions often arise about inclusion of temporary, part-time, or unpaid trainee or intern, or volunteer/stipend workers of the agency in the time study. Since voluntary staff receive no pay, there is no cost to the agency and no basis for claim. The costs of paid part-time or temporary staff may be included in the appropriate cost pool and can be time studied when appropriate. If a paid employee is hired for only one month of a quarter, for example, and was not employed at the time of the time study, their costs should nevertheless be included in the appropriate cost pool.

B. What Time Should be Time Studied?

1. A time study is a sampling of worker activities designed to reflect the administrative costs of the agency and its staff, and should fairly reflect the costs of the activities represented.
2. All staff whose costs are included in Cost Pools #1 and #2 (with the exception of clerical and supervisory staff who provide exclusive support to these staff) must time study during the sample period. This means that there cannot be any random sampling (or

"cherry picking") of the time study participants. All must participate in the time study sample.

Only paid time should be time studied, since it is allocated for reimbursement. Overtime is considered paid time, and these activities should be properly coded. Activities performed during non-compensated hours, such as catching up on paperwork and taking work home, are not time studied. Compensatory time earned is time studied; compensatory time used is not.

C. Skilled Professional Medical Personnel

1. Introduction

Federal regulations permit states to claim reimbursement at the enhanced rate of 75% for those administrative activities which are performed by staff who have the education and training to qualify as Skilled Professional Medical Personnel (SPMP). Under certain circumstances, the costs of staff providing direct clerical support to SPMPs may also be reimbursed at 75%. SPMPs must be able to justify and explain how their medical knowledge and education was necessary to perform their duties when using codes 3, 7, and 12. However, claiming reimbursement for administrative activities at the enhanced rate may often result in extensive reviews by HCFA. It is highly recommended that documentation is kept when using SPMP codes. Numerous disallowances received by states regarding reimbursement of costs for SPMP activities have resulted in both HCFA and the Departmental Appeals Board (referred to as the DAB or the Board) developing a set of criteria for determining which staff qualify as SPMP. (See SPMP Questionnaire in Appendix G).

2. Background and Authorization for SPMP

Provisions in the Social Security Act at Section 1903 (a)(2) allow for an enhanced rate of FFP (75%) for a state's Medicaid costs for the compensation, travel, and training of skilled medical professionals. Authorizing regulations are found at 42 CFR 432.50 (b)(1)(1986).

Skilled Professional Medical Personnel (SPMP) are defined at 42 CFR 432.2 as:

“. . . physicians, dentists, nurses and other specialized medical personnel who have professional education and training in the field of medical care or appropriate medical practice and who are in an employer-employee relationship with the Medicaid agency. It does not include other non-medical health professionals such as public administrators, medical analysts, lobbyists, senior managers or administrators of public assistance programs or the Medicaid program.”

3. The Standard for Determining SPMP Status

The federal standards for determining SPMP have emerged around key phrases in this definition. First to be considered is the requirement that an SPMP must be in an employer-employee relationship with the Medicaid agency (HHSC) or its designee (i.e., one of the state agencies participating in MAC).

a. Employer-Employee Relationship

Federal regulations have been consistently interpreted as authorizing enhanced FFP only for skilled medical personnel and their directly supporting clerical staff employed by the state Medicaid agency, or other public agency having a contractual linkage to the state Medicaid agency. This means, for the most part, enhanced FFP does not apply to contracts with private organizations or independent contractors. SPMPs on contract do not qualify as SPMP and they can not use the SPMP codes.

The November 12, 1985 Federal Register, at page 46656, states that in instances in which it is common practice to secure the services of SPMPs through contract rather than merit hiring, the agency must be able to demonstrate that a documented employer-employee relationship exists.

b. Professional Education and Training

Given that an individual is an employee of a public agency, the determination of whether he or she qualifies as SPMP then is based on two conditions - professional education (including training as part of academic work) and job function.

In 1986, HCFA implemented regulation 42 CFR 432.50, which defined professional education as

“ . . . the completion of a 2-year or longer program leading to an academic degree or certification in a medically related profession. This is demonstrated by possession of a medical license, certificate, or other document issued by a recognized National and State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. Experience in the administration, direction or implementation of the Medicaid program is not considered the equivalent of professional training in the field of medical care.”

Traditionally, physicians, physician assistants, registered nurses, dentists, dental hygienists, registered dietitians, and licensed vocational nurses (who have completed a 2-year or longer program) have been classified as SPMPs. Licensed vocation nurses who received their licenses in Texas after completing a one year program do not qualify as SPMPs.

In the late 1980s, a number of states received disallowances from HCFA for having claimed reimbursement for the costs of staff they believed were qualified as SPMPs. HCFA scrutinized the claims of states who claimed 75% for professionals in health related fields who were not traditional medical personnel and disallowed their related costs.

The states receiving the disallowances all appealed their cases to the Departmental Appeals Board. The decisions that the Board has rendered in these appeals has clarified the intent of the SPMP language in 42 CFR 432. In particular, social workers and psychologists have been the subject of review by the Departmental Appeals Board. In three decisions that the Board handed down reversing much of the disallowances given Montana (Decision #1024), Utah (Decision #1032), and Washington (Decision #1033) for claiming certain social workers and psychologists at 75%, standards were articulated for determining when health care professionals were eligible for reimbursement at 75%.

i. Social Workers

In regard to social work, the Board's central decision was laid out in Montana as follows:

" . . . the Board concluded that an individual with a Master's degree in Social Work from an accredited two-year graduate program and whose education (including training received as part of academic work) has specifically included health care and/or medical application of social work meets the requirements of 42 CFR 432.50(d)(1)(ii) for professional education and training in a medically related field."

It is noteworthy that the Departmental Appeals Board, in Montana, did not decide what combinations of academic degrees and clinical work qualify or do not qualify a graduate-level social worker as SPMP.

One of the arguments supporting the Board's decision to uphold the states' position in Montana that certain social workers could qualify as SPMP under the "educational limitation " was the specializations such as medical and psychiatric social worker were . . . "an integral part of this country's health care delivery system." It used this argument in upholding Washington's argument that psychologists meet the educational limitation for qualification as SPMPs.

The general eligibility of social workers as SPMPs was addressed in a decision responding to an appeal by West Virginia (Decision #1107). Here, West Virginia had been disallowed the enhanced rate for area welfare office services workers.

The DAB re-affirmed in this decision what it had stated in the Montana decision that " . . . personal qualifications are a key factor in determining whether social workers are SPMP under the 1986 regulations found in 42 CFR 432.50(d)(1)(ii)." The social workers' job descriptions in West Virginia are described as "generic"; they did not explicitly say "medical" social workers. The Board reiterates that states " . . . bear the ultimate responsibility to identify and document claims for enhanced reimbursement . . ."

The following quote from the West Virginia decision may be helpful in understanding the way in which the DAB determines the SPMP status of social workers:

"Thus, we uphold the disallowance because we find that the position descriptions provide sufficient support for HCFA's finding that the incumbents did not have the requisite qualifications for SPMP status, and we find that the State failed to respond with evidence of such qualifications. The position descriptions do not require, by their terms, that incumbents hold graduate social work degrees or be within the definition of a medical social worker. Thus, the position descriptions alone do not demonstrate that all of the disputed position incumbents were medical social workers or otherwise qualified for SPMP status given the requisite educational qualifications."

The opening around the combination of academic degrees and clinical work which was left in Montana was, in part, the basis for the Board's decision in a 1993 case (Decision #1434) involving medical social workers.

In New Jersey, HCFA disallowed certain medical social work positions for SPMP status because a Master's degree in Social Work was not required for the positions (i.e., the positions could be filled by an individual with a Bachelor's degree who had certain types of experience or an individual with a Master's degree).

The Board concluded that regardless of whether an employee qualifies for a position by experience or possession of a Master's degree does not mean that the position is not medical (i.e., would not meet the functional limitation). The Board reiterates its position from Washington that either the educational limitation or the functional limitation could be treated as a threshold requirement, as both must be met, but failure to meet one limitation does not necessarily preclude meeting the other.

While holding that a Bachelor's or Master's degree in Social Work would not alone meet the educational and training limitation, the Board concluded that HCFA had erred in focusing only on educational requirements for the positions. The Board went on to consider whether the incumbents with Bachelor's degrees in Social Work had the requisite experience or training in another field of medical care or appropriate practice or significant medical training, in addition to their degrees, that would satisfy the educational limitation. Again, the burden was on the state to prove that the incumbents had the qualifying experience or training for SPMP status.

In considering whether incumbents with Master's degrees in Social Work met the educational limitation, the Board gave considerable weight to employees' fieldwork assignments and in some cases reversed the disallowance on the basis of extensive fieldwork in the medical field. Fieldwork is considered part of a two-year program that leads to a certificate in a medically-related position, while on-the-job-training is not given the same consideration.

ii. Psychologists

In Decision #1033, the Board responded to a disallowance given to Washington for claiming psychologists at the enhanced rate. It stated that ". . . there is recognition in the medical arena that psychologists have an important and expanding role in the provision of mental health services . . ." The Board went on to note the ways in which HCFA already recognized psychologists as medical providers.

After this discussion, the Board concluded that ". . . a Ph.D. in Psychology together with a state license to practice as a psychologist meets the educational limitation for SPMP status."

Interestingly, the Board also stated in New Jersey, that a Master's degree in Psychology is an academic degree in a medically related profession. This

suggests that further exploration should be done in regard to qualifying Master's level psychologists, who may also meet the functional limitation for SPMP.

iii. Counselors

The Washington decision also discussed whether an individual with a Master's degree in Counseling would qualify as an SPMP. In its analysis, the Board stated that it did not have sufficient information to show that counseling was a "medically-related profession." It suggested that tests it had used for determining the SPMP status of social workers and psychologists could not be applied. (These tests resulted in the determination that the profession was an integral part of the country's health delivery system as well as the job title's listing in the Directory of Occupational Titles.)

c. Job Function

The second condition which determines an individual's classification as an SPMP is whether his or her job functions meet the basic criteria of an SPMP, as stated in the preamble to the final (1986) regulation on this matter.

The following preamble explains the definition of the SPMP in relation to the individual's job responsibilities:

“. . . the law [Section 1903 (a)(2) of the Act] did not intend to provide 75% FFP merely to any staff person who has qualifying medical education and training and experience, without regard to his actual responsibilities. Rather, the function performed by the skilled professional medical personnel must be one that requires that level of medical expertise in order to be performed effectively. Consequently, 75% FFP is only available for those positions that require professional medical knowledge and skills, as evidenced by position descriptions, job announcements, or job classification.”

The preamble specifies examples of the functions that meet the basic criteria as follows:

- Acting as liaison on the medical aspects of the program with providers of services and other agencies that provide medical care;
- Furnishing expert medical opinions for the adjustments of administrative appeals;
- Reviewing complex physician billings;
- Providing technical assistance and drug abuse screening on pharmacy billings;
- Participating in medical review or independent professional review team activities;
- Assessing the necessity for the adequate medical care and services provided, as in utilization review;

- Assessing the adequacy of medical care services required by individual recipients.

4. Authorization for Directly Supporting Clerical Staff

The November 12, 1985 Federal Register clarified issues concerning claiming directly supporting clerical staff at the enhanced FFP rate.

The federal language further described who the qualifying clerical staff could be and reiterated that these clerical staff must meet the criteria of "directly supporting staff."

" . . . The directly supporting staff are secretarial, stenographic, and copying personnel and file and record clerks who provide clerical services that are directly necessary for the completion of the responsibilities and functions of the skilled professional medical staff. There must be documentation showing that the clerical services provided by the supporting staff are directly related and necessary to the execution of the skilled professional medical personnel's responsibilities. In order for the clerical services to be directly related to skilled professional responsibilities, the SPMP must be immediately responsible for the work performed by the clerical staff and must directly supervise (immediate first-level supervision) the supporting staff and the performance of the supporting staff's work."

The supervision of directly supporting clerical staff was considered in a DAB decision involving New Jersey (Decision #845). At issue here was a disallowance made by HCFA because of the supervision requirements for support staff. The board cited an Action Transmittal (SRS-AT-76-66-April 20, 1976.)

A supervisory relationship on a day-to-day basis between the skilled medical professional and support staff is not necessary and not always relevant. The critical factor determining direct support is that the non-professional be responsible for performing functions directly necessary for the carrying out of the professional's duties. The Board went on to say that:

". . . the import of this provision is that a support person may be supervised in a personnel reporting sense by someone other than a SPMP and still perform work under the substantive direction of a SPMP which directly supports SPMP functions."

In a California case (DAB Decision #1236), the state appealed a disallowance on the enhanced FFP rate for clerical staff. Here again, the Board reiterated that states have the burden of substantiation in their claims for enhanced reimbursement. Specifically, the Board stated that the state

". . . had the burden to provide evidence to demonstrate the existence of the immediate and direct nexus between the duties of the clerical support staff and SPMP; i.e., evidence about specific work assignments initiated by the SPMP in a SPMP role."

D. Summary and Recommendations

As the various agencies who employ social workers and other allied health professionals claim reimbursement through Title XIX Medicaid administration, they will need to give special attention to which staff are claimed as SPMPs. Likewise, the claiming of directly supporting clerical staff warrants consideration.

The Health and Human Services Commission has prepared a document outlining the requirements of claiming enhanced Federal Financial Participation, which is included in Appendix G. However, even with

these guidelines, the qualifications of the individuals to be claimed as SPMPs should be determined on a case-by-case basis. The following recommendations are offered.

1. For Skilled Professional Medical Personnel

- Staff not already classified as SPMPs (whose education or training is not clearly in a medical field) should be queried to find out whether they
 - have completed an educational program that was at least two years duration and which led to licensure or certification or have graduated from an academic institution where the field of study was accredited by an appropriate entity;
 - have medical or health-related training within their professional education;
 - have job descriptions or classification which include a requirement of "medical" knowledge or skills.
- Job descriptions of staff who qualify as SPMPs should be reviewed to ensure that language describing allowable SPMP activities is included. The job classification must require some work of an SPMP nature.
- Documentation related to the qualification of staff as SPMPs is retained in the agency's Medicaid administration audit file.
- A questionnaire has been developed to document the requisite components for verifying SPMP status. Required elements include, as appropriate, licenses, degrees, or certificates issued by accredited academic organizations. Documentation is kept in the audit file.
- For non-traditional medical professionals, such as medical social workers or clinical psychologists, verification of the individual's health-related course work or fieldwork (e.g., college or university transcript or course description) must also be included.

2. For Staff providing Direct Clerical Support to SPMPs

- To support enhanced claiming for directly supporting clerical staff, an organizational chart showing the lines of supervision between SPMPs and their supporting staff should be included in the agency's audit file.
- Job descriptions of staff providing direct clerical staff support to SPMPs should be reviewed to make sure the language includes evidence that their work is in direct support of an SPMP carrying out an SPMP function.

IV. MEDICAID ADMINISTRATIVE CLAIMING

A. Introduction

The federal government permits state Medicaid agencies to claim reimbursement for activities performed that are necessary for the "proper and efficient administration" of the State Medicaid Plan. Historically, the Health Care Financing Administration (HCFA) has provided some latitude to states in determining the kinds of activities for which they may seek reimbursement. Over time, HCFA has identified a series of activities that must be claimed administratively. Among these are outreach, utilization review, eligibility determination, and activities which determine an individual's need for care. Case Management has also been identified as an activity that may be reimbursed either as an administrative or a fee-for-service activity. Federal language has also made it clear that the range of activities allowable under Medicaid administration is not limited to those identified by HCFA in the State Medicaid Manual.

This issue is discussed in a Departmental Appeals Board (DAB) decision handed down in relation to a disallowance given to the West Virginia Department of Health and Human Resources (Docket No. 91-52, Decision Number 1316, March 20, 1992). The DAB states:

"We agree with the State that (HCFA) incorrectly read that section as limiting allowable administrative activities to those in the Manual provision. Nothing on the face of Section 4302.2(F) [of the State Medicaid Manual] limits the case management activities that may be charged at the administrative rate. Instead, that section lists the types of activities that may not be charged at the FMAP [Federal Medical Assistance Participation] rate."

B. The Elements of a Claim

In order to accomplish these objectives, a uniform methodology has been developed for Medicaid Administrative Claiming across all participating agencies.

1. Changes to the Cost Allocation Plan

The Texas HHSC amended its Cost Allocation Plan effective April 1, 1994, to reflect the performance of Medicaid administrative activities by state and local agencies.

2. Identifying the Scope of Activities considered for Medicaid Administration

All entities participating in MAC allocate their time to a common set of activity codes through the use of a time study. These activity codes are based on time study functions that have been reviewed and discussed with regional and national HCFA offices.

Fifteen activity codes and a code for lunch are currently used for time study purposes. Nine of these activities are claimable.

The fifteen codes are:

1. Facilitating Medicaid Eligibility Determinations (All Staff)
2. Facilitating NON-Medicaid Eligibility Determinations (All Staff)
3. Medicaid Outreach (SPMP)
4. Medicaid Outreach (All Staff)
5. Outreach NON-Medicaid (All Staff)

6. Referral, Coordination, and Monitoring of Medicaid Services (All Staff)
7. Referral, Coordination, and Monitoring of Medicaid Services (SPMP)
8. Referral, Coordination, and Monitoring of NON-Medicaid Services (All Staff)
9. Medicaid Transportation and Translation (All Staff)
10. Medicaid Provider Relations (All Staff)
11. Program Planning, Development, and Interagency Coordination (All Staff)
12. Program Planning, Development, and Interagency Coordination (SPMP)
13. Direct Services (All Staff)
14. NON-Medicaid, Other Educational and Social Services (All Staff)
15. General Administration (All Staff)
- L. Lunch (All Staff)

This set of codes will be used uniformly across all agencies, although it is anticipated that not all of them will apply to all programs.

3. The Purpose of the Time Study

To identify allowable Medicaid administrative costs within a given program, time studies will be conducted of staff who spend at least 10% of their time performing the above administrative activities. One purpose of the time study is to allocate or assign the costs to an appropriate funding source. Another purpose of the time study is to identify the proportion of administrative time allowable and reimbursable under Medicaid. Staff performing health related activities in a program seeking reimbursement through MAC will time study by using Worker-Day-Log or Mid-month time study.

4. Submitting a Claim for Medicaid Administration

The claim that is submitted to the state for reimbursement has four components: cost pool construction, allowable Medicaid administrative time, the federal financial participating rate (FFP), and the percentage of the population that is actually Medicaid eligible. The claim is submitted quarterly on a uniform document each federal fiscal quarter.

5. The Medicaid Percentage

Another factor required to determine the amount of the claim is the Medicaid percentage. Because this factor is a critical component of the claim, the methods that may be used are discussed in a separate section.

6. Federal Financial Participation Rate (FFP)

After the results of the time study are multiplied by the cost pool (described below), they are then multiplied by either 75% or 50%, depending on whether certain staff have job responsibilities, education, and training that would qualify them as SPMP and are performing activities that require this expertise.

C. Calculating the Claim

Each of the above factors is multiplied by the cost pool (the actual costs incurred for the quarter being claimed) to determine the amount of the federal portion of the claim. The participating program or entity will certify at the time the claim is submitted that there were sufficient non-federal (state, county, or local) funds to meet matching requirements and that the claim only includes actual costs incurred for the quarter.

In very general terms, the federal share of the claim for Medicaid administration is calculated by:

costs pools multiplied by

% time claimable to Medicaid administration multiplied by

the Medicaid percentage (the percentage of Medicaid eligibles in the service population) multiplied by

% FFP (50% for some costs; 75% for others) equals the amount of the federal request

D. Codes by Cost Pool

<u>Cost Pool 1</u> SPMP		<u>Cost Pool 2</u> All Staff		<u>Cost Pool 3</u> Non-Claimable	<u>Cost Pool 4 *</u> General Admin
<u>Discounted</u>	<u>Non-Discounted</u>	<u>Discounted</u>	<u>Non-Discounted</u>	<u>Not Time Studied/</u> <u>Not Applicable</u>	<u>Administrative Support</u>
Code 7 Code 12	Code 3	Code 6 Code 9 Code 11	Code 1 Code 4 Code 10	Code 2 Code 5 Code 8 Code 13 Code 14 Code L	Code 15 Allocated across Cost Pools 1, 2, and 3

* Cost Pool 4 includes all non-time studied staff who provide administrative support such as human resources, payroll, etc.

E. Accepted Uses for Medicaid Administrative Reimbursements

As stated in the local affiliate contract, Section B of the General Provisions (Part I), the contractor agrees to spend the federal match dollars generated from Medicaid administrative activities for health-related services for clients. A detailed list of general allowable and unallowable expenditures of MAC funds is included as Appendix N. An annual cost report showing expenditures of MAC funds is required by the end of August each year. It is recommended by DSHS that the funds are used for allowable MAC activities in order to increase services to Medicaid or prospective Medicaid clients. In the long run, reinvesting reimbursed funds in eligibility determination, outreach, provider relations and other MAC claimable activities will result in a higher return.

V. DETERMINING THE MEDICAID PERCENTAGE

A. Overview

One of the most critical factors in determining the portion of a program's costs that can be claimed to Medicaid administration is the Medicaid percentage. This one factor, or fraction, is multiplied against most all other factors in the formula for constructing a claim, and thus affects nearly every dollar claimed.

For example, if the Medicaid percentage is 15%, the Medicaid administrative claim will be about half as large as it would be if the Medicaid percentage were 30%, and one-quarter as large as it would be if the percentage were 60%.

B. Calculating the Medicaid Percentage

The federal language on methods for determining the Medicaid percentage is sparse. Although the rules for determining Medicaid eligibility are well established in federal regulations, there is little federal guidance on how to calculate the Medicaid percentage for purposes of constructing a Medicaid administrative claim. The guidelines do require, however, that the methods used to figure this percentage be "statistically valid".

Therefore, agencies claiming reimbursement through Medicaid administration should not expect federal auditors to accept "staff judgment" or "management decisions" as the basis for calculating the Medicaid percentage, no matter how well informed these individuals might be. Rather, auditors will demand some objective, documented basis for the Medicaid percentage that is used in the claim. Efforts should be made to have the Medicaid percentage be reflective of the quarter claimed and should be regularly updated.

A number of methods for determining the Medicaid percentage are possible. Each agency needs to use a methodology that best fits its own data sources. Once a methodology is selected, the agency needs to be consistent in using it from quarter to quarter.

C. Methodologies

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 or student population.

The following summary reflects the methodologies that may be used to determine the Medicaid percentage.

1. Identifying the Medicaid Percentage on a Case-by-Case Basis

This methodology is most commonly used in agencies or programs that collect fairly specific data on the client population.

The Medicaid percentage is a fraction, the numerator of which consists of all persons in the agency's or program's caseload or service population who are actual Medicaid recipients. The denominator of the fraction is the total number of persons served by the agency or program during the claim period minus the Medicaid pending clients. The resulting fraction, or percentage of Medicaid recipients in the caseload, should be as current to the quarter of the claim as possible (with the exception of the schools, as noted below). Where this is not feasible, the nearest possible determination should be made.

Thus, a person who would be Medicaid eligible but either has not applied, has not been issued a Medicaid card, or whose status is "pending" is not to be counted in the numerator. In addition, individuals for whom there is evidence of "pending" Medicaid status may be removed from the denominator. This guide uses the term "eligible" to mean that the individual has gone through a formal eligibility determination process and that the Department of Human Services has determined him/her to be eligible to receive medical assistance.

a. Tracking Medicaid Eligibility as Part of the Intake Process

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

With this information in hand, the agency can calculate its Medicaid percentage. The calculation is based on individuals (an unduplicated count), where the formula would be as follows:

unduplicated list of Medicaid clients divided by the total list of clients in the program.

b. Using a Tape Match

Another strategy is to collate agency Medicaid population data with data kept by the Department of Human Services (DHS). To be efficient, this could be done through electronic tape matches. This tape match data would need to be available within a reasonable time after the end of a federal fiscal quarter in order to process any claims. DHS charges a fee for the service of providing a tape match.

The Texas Education Agency is using a tape match to identify the percentage of students in each local education agency who are Medicaid eligible.

A tape match has greater reliability when there are several fields (or sets of identifying information) that can be matched. For example, a match based only on name and birth date may not produce precise results. Names may be misspelled, or in some instances, individuals may go by more than one name. A match that is based on several fields such as name, birth date, and social security number will give more reliable results.

It is also important to remember that the tape match is possible only when the agency needing the data provides the Department of Human Services with a list of its population (and includes the agreed upon identifying information). DDS can either provide a single number (the percentage of the population for whom there was a Medicaid "match") or provide a "yes-no" confirmation on a case-by-case basis.

2. Using the Lowest Common Denominator - a State or Countywide Percentage

An agency may have no ready method of determining the Medicaid percentage. Obtaining information about a population's Medicaid status may be deemed overly intrusive or inefficient from the agency's point of view. In these cases, the agency could use the percentage of the state or county's general population which is Medicaid eligible for its own Medicaid percentage.

3. Using a Zip Code Proportional Match

In instances where the agency serves a population that lives within a given set of zip codes, the zip code proportional method can be used to determine the Medicaid percentage. This methodology is actually a variation of the "lowest common denominator". It differs from the countywide average only in that a smaller geographic area is used and that a more discrete Medicaid population may be used in the numerator.

For each zip code in which clients live, the proportion of the population that is Medicaid eligible is divided by the total population. Once a percentage for each zip code is established, the overall Medicaid percentage is then weighted by the number of clients from the zip code.

For example, suppose that the Medicaid percentage in zip code 1 is 50% of the population and in zip code 2 is 10% of the population. If 80% of the individuals served by the agency live in zip code 1 and 20% live in zip code 2, then calculating the overall Medicaid percentage would be as follows:

$$\begin{array}{l} [(80\%) \times (50\%)] + [(20\%) \times (10\%)] = 42\% \text{ overall Medicaid percentage} \\ \text{Zip Code 1} \qquad \text{Zip Code 2} \end{array}$$

IV. RECORD KEEPING, DOCUMENTATION AND AUDITS

A. Overview

Medicaid Administrative Claiming (MAC) is not a fee-for-service activity. Consequently, records of individual client contacts need not be kept as they would be maintained in the agency's current record keeping or case file system.

The heart of MAC is the time study. Federal regulations require that records be kept for three years after the last revision to a particular claim. It is recommended that the original time studies be kept for this amount of time. The time studies may be kept in a central office or in a program.

Similarly, the documents that support the construction of an administrative claim need to be kept for three years after the last claim revision as well. These documents include the documentation that supports the percentage of Medicaid recipients, the basis of the cost pools, the identification of SPMPs, their job descriptions and/or duty statements, as well as the job descriptions and/or duty statements of technical and clerical staff providing direct support to SPMPs.

B. Building and Maintaining an Audit File

Each agency or program must establish an audit file for each time study period. A checklist has been developed to assist staff in this task. It is included as Appendix J.

Gathering the necessary documentation needed in the event of an audit is much simpler as the time study is being done and the claim is being prepared. Good documentation is also essential when staff who were originally responsible for the time study or the claim leave, and when new staff must take on this responsibility.

APPENDIX A

Mandatory Participation Requirements

Medicaid Administrative Claiming (MAC) Project Mandatory Participation

I. Introduction

State and local entities participating in Medicaid Administrative Claiming (MAC) must meet all participation requirements. The Health and Human Services Commission (HHSC) establishes all MAC requirements and has contracted with several agencies, and through them, local entities to implement the MAC project. The purpose of the MAC project is to assist eligible and potentially eligible Medicaid individuals in accessing services covered by the Medicaid program by using activities such as outreach, referral, case coordination, and follow up.

New Entities in the project must comply with the participation requirements before participating in the MAC project. Current participants must review their present program, make any necessary adjustments and ensure HHSC of compliance with all participation requirements.

The participation requirements include the following components:

A. Project Management (State and Local)

1. State Project Coordinator:

Each participating state agency must designate a state project coordinator who will be responsible for management of MAC at the state agency level. The staff resources required to manage, monitor, and oversee the numerous local entities in the project is at least one high level policy analyst and usually a reimbursement claims expert. The state project coordinator should be a program manager level, with a strong background in Medicaid services performed within their agency.

The state project coordinator will receive all correspondence and request for information on the project for their agency. The state project coordinator is responsible for developing and implementing the monitoring and oversight plan which must be approved by HHSC. The coordinator must ensure that all local entities meet participation requirements including the development of approvable local implementation plans. The coordinator must ensure that local entities receive thorough and comprehensive training on the project and time study codes. The state project coordinator issues agency policy and procedures, conducts statewide and local monitoring of claims and time studies, and maintains contracts and coordinates internal and external project activities. The state project coordinator is responsible for ensuring that federal payments claimed meet all the MAC project requirements.

2. Local Project Coordinator:

Each participating local entity must designate a local project coordinator who will be responsible for management of the MAC project at the local level. The local project coordinator will receive all correspondence and requests for information on the project for their agency. The local project coordinator must ensure all participation requirements are met including the development of an approvable implementation plan on how they will manage their

project. The coordinator must ensure that all time study participation receive thorough and comprehensive training on the project and the time study codes. The local project coordinator issues local agency policy and procedures, ensures accurate and verifiable time study logs, ensures accurate claim preparation within designated time frames, maintains documentation in support of claims, monitors contract compliance, and coordinates internal and external project activities.

B. Contracts

To participate in the project, HHSC must agree to contract with the state agency. This contract must be effective the first day of the quarter in which the first time study is undertaken. HHSC must also be assured that the state agency is capable of administering the project and must approve the state agency's monitoring and oversight plan.

In addition, a contract between the local entities and the state agency must be approved and be in place prior to participation in the project. A standard local contract agreement is included with the contract between HHSC and the state agency. The contract agreement includes a description of general responsibilities, Medicaid administration, fiscal provisions, amendments, and terms. Each contract with the local entity must be effect the first day of the quarter in which the initial time study is initiated. Contract continuation will be dependent on maintaining compliance on a continual basis.

II. MONITORING AND OVERSIGHT

A. State Agency Responsibilities

Each state agency must have a monitoring and oversight plan approved by HHSC in order to receive federal funds for the MAC project. The state agency contracting with HHSC is responsible for ensuring that the local entities are complying with the MAC participation requirements. The monitoring and oversight plan must describe how the state will ensure the local entities are complying with the MAC participation requirements and must also include the state agency policies and procedures for implementing corrective actions if there are problems with the local entities' projects.

The state agency is responsible for ensuring that each claim submitted from the local entities is accurate with correct back-up documentation before reimbursing the claim. The claim cannot be considered accurate unless each time study participant has completed a correct time study sheet with documentation of proper training on the time study codes.

The state agency is responsible for submitting quarterly reports to HHSC regarding the results of the monitoring and oversight activities and findings form those activities.

The monitoring and oversight plan must include the following components:

1. State project coordinator's role and responsibilities.
2. State agency staff involved in monitoring and oversight activities (describe the staff, their individual roles, and other related information).
3. Monitoring and oversight plan for reviewing each local project (schedule, agenda, and details on who will be interviewed, what documentation will be examined, and how local time study

participants will be interviewed). Each local project must have an onsite review conducted on an annual or bi-annual basis.

4. Monitoring and oversight of each local claim.
5. Corrective action plans for handling problems identified.
6. Monitoring and site visit reports

B. Local Entity Responsibility

The local entity must follow its approved implementation plan which includes policies and procedures for monitoring and oversight of the project. The following activities must be examined:

1. Training and follow-up training on the time study codes and detailed documentation of all training.
2. Detailed reviews of each time study sheet.
3. Follow up interviews and individual training sessions with each local participant in the time study who has incorrect time study sheets.
4. Detailed reviews and checks on each claim and back-up documentation submitted to the state agency.

The local project coordinator must take immediate action to correct any findings that impact the accuracy of the time study and claim. For example, if the local project coordinator finds that certain participants in the study are not performing Medicaid administrative activities, then these participants should not be included in the claim and subsequent time studies.

C. Maintenance of Records

1. State Project Coordinator:

The state project coordinator must maintain required documentation to support development and submission of the agency claim to HCFA. The coordinator will establish and maintain specific files for each participating local agency and general agency files as needed (policy and procedures, claims submitted, etc.).

2. Local Project Coordinator:

The local project coordinator must maintain required documentation to support development and submission of the claim to HCFA. The local project coordinator will ensure that the time study participants have documentation to support the time study with enough detail to describe the activities performed during the time study. The local project coordinator will establish and maintain files on each submitted claim that conform to the audit file content as listed in the implementation plan and MAC Guidebook. The local project coordinator will complete and enter summary self-evaluation reports of required project performance reviews to the record file on at least an annual basis. The local project coordinator will conduct periodic reviews (at least annually) to ensure that files are current, complete, accessible, and secure.

D. Participation in State and Federal Audits

1. State Project Coordinator

The state project coordinator is responsible for ensuring that the local entity understands the importance and seriousness of a federal and state audit. The state project coordinator must ensure the local project coordinator know his or her responsibilities in being fully prepared for the audit. The state project coordinator will assist the federal or state staff in coordinating the audit, obtaining the necessary documentation in advance, scheduling, etc. The state project coordinator must review findings of the audit and prepare a written report for the local entity with a copy for HHSC. The report must include summary of findings and the corrective actions needed. The report must be sent to the local entity and HHSC no later than 15 days after the audit.

2. Local Project Coordinator

The local project coordinator must ensure that the local entity cooperates completely with the state and federal audits. The local project coordinator must provide the state and federal staff with the requested documentation in a timely manner. The local project coordinator must provide the state and federal staff with a project overview with an emphasis on the training provided to the time study participants and the local monitoring of the time studies to ensure the time studies are accurate. The local project coordinator must accept the findings and must implement corrective actions needed as a result of the audit. The local project coordinator must provide a report of the corrective actions implemented within three (3) months of receiving the state report.

E. Local Implementation Plan

Current participating entities must have an implementation plan approved by the state agency. Any new entities wishing to enter into the project must have an approved plan in place prior to participation in the project.

The implementation plan must be descriptive enough so that the participating entity can ensure the state agency that there is a system in place that organizes and manages the project, in a manner acceptable to HHSC and the state agency, at the local level. Once approved, implementation plans will remain in effect for one year unless a substantive change is made to the local project. These changes will require written notifications to the state project coordinator for those sections of the implementation plan requiring revisions.

1. Guidelines for Content of Implementation Plan

Local entities will use the following guidelines and descriptions when completing implementation plans. The local project coordinator should contact their state project coordinator with questions related to the development of these plans.

a. Local Project Coordinator

The local project coordinator is responsible for the overall organization and management of the MAC project at the local level and will ensure all project participation requirements are met. The implementation plan must include a detailed job description of the local project coordinator. It must also include an organizational chart of the local entity and identify where and to whom the local project coordinator is assigned.

b. Time Study Participation

Provide a detailed description of the participants in the time study. Include in your description of each participant a list of activities that are considered allowable MAC activities. Indicate the estimated percentage of time each participant usually spends on each MAC activity.

Subject to state agency approval, describe any activities that could be completed by contract personnel.

List the job titles or classifications of individuals who will be participating in the time study and the reasons they are included (allowable MAC activities, etc.). List the approximate number of staff you will be time studying in each position.

c. Skilled Professional Medical Personnel (SPMP)

Qualifications for participation are listed in the MAC Guide for Participating Agencies and traditional SPMPs are defined at 42 CFR 432.2 as:

“...physicians, dentists, nurses, and other specialized medical personnel who have professional education and training in the field of medical care or appropriate medical practice and who are in an employer-employee relationship with the Medicaid agency...”

Please refer to the MAC Guide for Participating Agencies for qualifications of NON-traditional SPMPs (social workers, etc.). The local agency coordinator must be familiar with the SPMP Qualifications since claiming reimbursement for administrative activities at the enhanced SPMP rate may result in extensive reviews by HCFA.

List any job classifications that qualify for Skilled Professional Medical Personnel. Include the number of staff in each position who will be designated SPMPs. The responsibility for determining a participant meets the qualifications to participate as an

SPMP lies with the local project coordinator. Assistance can be obtained from the state project coordinator but it is not the responsibility of the state to make the determination for each individual.

d. Training

The coordinator and at least one additional employee with a working knowledge of MAC are required to attend the administering state agency's training program approved by HHSC. The local project coordinator is responsible for ensuring that a mandatory training session on the time study codes and how to complete time studies is provided for all participants. Local project training is expected to provide in-depth and comprehensive instruction to provide participants with a basic understanding of the Medicaid program, Medicaid covered services, the role of the HHSC and the purpose of the MAC project. This training must include completion of time study logs, an exercise in practice coding of programs activities, and provide adequate opportunity for a question and answer session. The local project coordinator must ensure that all participants have a thorough understanding of the types of daily activities they perform that are MAC activities and how to code them.

Describe your plan to train staff in the time study. Discuss initial and follow-up training schedules. Include in your description a plan to deal with individuals who, after submitting incorrect logs, will require one-on-one training. Discuss plans to address staff turnover in the pool of time study participants as it related to training on the codes. The local project coordinator must have documentation that each participant in the time study received appropriate training.

e. Time Study Methodology

List what method will be used to time study. Describe the process used for distribution of the logs, who will collect the logs, who will add the totals, and who will check the logs for accuracy each week. Describe plans for reviewing the time study sheets for errors and inconsistencies. Describe the procedures you will use to ensure all staff have a designated contact person to call when they have questions about the time study codes.

HHSC suggests, whenever feasible, that participants keep back-up documentation with enough detail to support time study logs (daily planners, transportation logs, etc.).

f. Fiscal Information

Describe how you will ensure that the claim is prepared correctly, is checked for errors, submitted to the State within the designated time frames, and how the Medicaid eligibility percentage is calculated.

List the source of funds to be used as "match" in language that is easily understandable (do not use acronyms). List the expense categories included as allowable costs. Indicate whether accounting is done on a cost or modified accrual basis, and your methodology for determining indirect costs.

g. Audit File

Describe your plan for ensuring all documentation to support the claim is gathered according to the MAC Guidebook audit file checklist and provide information on where the files are physically located and secured.

List the name or names of the persons responsible for maintaining and updating the audit file.

h. Effective Dates (Renew Annually)

List the effective dates of the implementation plan. This plan is to be reviewed at least annually by the local project coordinator for the required changes. Implementation plans are renewable prior to the expiration date. Effective dates are determined by the state agency project coordinator.

i. Authorizing Signatures

The implementation plan is to be submitted on agency letterhead and is to include the name, data, and signature of the agency Chief Executive Officer who has oversight of the project, the local project coordinator, and any other designated staff with direct responsibility for the project (financial officer, etc.).

The implementation plan is to be submitted for review and approval to your state agency project coordinator. Entities will be notified by mail when their plans have been reviewed and approved for participation. A copy of the approved implementation plan will be sent to the Health and Human Services Commission project coordinator.

APPENDIX B

Agreement Between State and Local Agency

**AGREEMENT BETWEEN
TEXAS DEPARTMENT OF HEALTH
AND (NAME OF LOCAL AFFILIATE)**

The Texas Department of Health, hereinafter called TDH, and the (Name of local affiliate), hereinafter called (Contractor), hereby make this Agreement to implement certain parts of the Medicaid State Plan under Title XIX of the Social Security Act (Medicaid). TDH recognizes that the Health and Human Services Commission, hereinafter known as the Commission, is the Medicaid Single State Agency in Texas under Title XIX of the Social Security Act and Texas Revised Civil Statutes, Article 4413 (502) Section 16 and that TDH enters into this Agreement with (Contractor) pursuant to a similar Agreement with the Commission.

**I.
GENERAL RESPONSIBILITY**

- A. TDH has agreed to provide assistance to the Commission in administering its Medicaid State Plan.
- B. Both the Commission and TDH recognize the unique relationship that (Contractor), and the affiliated entities operating under contract or memorandum of understanding with it, has with its Medicaid eligible clients. The Commission and TDH further recognize the expertise of (Contractor) in identifying and assessing the health care needs of Medicaid eligible clients it serves and in planning, coordinating, and monitoring the delivery of preventive and treatment services to meet their needs. TDH, in order to take advantage of this expertise and relationship and to promote the proper and efficient administration of the State Medicaid Plan, has entered into this agreement with (Contractor) effective (Date).
- C. TDH and (Contractor) enter into this agreement with full recognition of its relationship to any other agreements that the Commission or TDH may have developed for services to Title XIX eligible clients living in Texas and which are currently included in the Title XIX Medicaid State Plan

II.
MEDICAID ADMINISTRATION

A. TDH agrees to:

1. Designate an employee to act as liaison with (Contractor) for issues concerning this agreement.
2. Pass through to (Contractor) no less than 95 percent of Title XIX federal share of actual and reasonable costs for Medicaid Administration provided by its staff or by staff in agencies with which it has subcontracted for administrative activities under this agreement. TDHS reserves the right to retain no more than five percent of the Title XIX federal share of actual and reasonable costs for said Medicaid administration for TDH's own administrative costs, training and technical assistance as required by the Health Care Financing Administration (HCFA), and to establish and maintain an audit reserve fund. These costs shall be based upon a time accounting system which is in accordance with the provisions of OMB Circular A-87 and 45 CFR Parts 74 and 95, the expense and equipment costs necessary to collect data, disseminate information and carry out the staff functions outlined in this agreement.
 - (a) The rate of reimbursement for allowable administrative activities performed by personnel other than Skilled Professional Medical Personnel (SPMP) shall be 50 percent of such costs. The rate of reimbursement for activities qualifying under regulations applying to SPMP and their direct supporting clerical staff shall be 75 percent of such costs for activities identified as "enhanced" or 50 percent for activities identified as "non-enhanced." Categories of costs eligible for 75 percent reimbursement include the following items only: compensation and applicable fringe benefits, travel and training of SPMP and their direct supporting clerical staff.
 - (b) Changes in any federal regulation affecting the matching percentage, or costs eligible for enhanced or administrative match, which become effective subsequent to the execution of the agreement, will be applied herein as provided in such changes in applicable federal regulations. As TDH becomes aware of changes in applicable federal regulations, it will provide such information to (Contractor)

3. Include (Contractor)'s expenditures for Medicaid administration in the claim it submits to the Commission (or its designee) that will be forwarded to the Centers for Medicare and Medicaid Services for Title XIX federal participation.

B. (Contractor) agrees to:

1. Perform or coordinate its subcontractors' performance of Medicaid administrative activities on behalf of TDH to improve the availability, accessibility, coordination and appropriate utilization of preventive and remedial health care resources to Medicaid eligible clients and their families. These activities will be in accordance with the policies and procedures set forth in the Medicaid Administration Claiming Guidelines referred to in Attachment A. Allowable activities under Medicaid administration are described in detail in the time study referred to in exhibit A, attached hereto and incorporated herein for all purposes.
2. Account for the activities of staff providing Medicaid administration in accordance with the provisions of OMB Circular A-87 and 45 CFR Part 74 and 95 and the Medicaid Administrative Claiming Project Mandatory Participation Requirements and with the written guidelines issued by the Commission.
3. Submit its claim for reimbursement on a standardized invoice that will be provided to TDH by the Commission.
4. Provide TDH the expenditure information to include in the quarterly claim it submits to the Commission, or its designee, in the manner and written timeframes described in the Medicaid Administrative Claiming Guidelines.
5. Spend the federal match dollars generated from Medicaid administrative activities for health-related services for clients.
6. Designate an employee to act as liaison with TDH for issues concerning this agreement.
7. Adhere to approved Implementation Plan, Exhibit C, attached hereto & incorporated herein for all purposes, which shall be updated on an annual basis.

III.
FISCAL PROVISION

Payment provisions under this Agreement shall be made in the following manner:

- A. Upon (Contractor) compliance with its responsibilities pursuant to Section II of this agreement in a satisfactory manner and after TDH has received federal reimbursement for a quarterly claim from the Commission, or its designee, TDH agrees to pass through to (Contractor) an no less than 95 percent of the federal share of costs as demonstrated by actual costs incurred in (Contractor) cost centers and appropriation accounts that are paid by the federal government. TDH reserves the right to retain a negotiated portion equal to no more that 5% of the total reimbursement payment to cover costs related to administration of the programs
- B. In addition, TDH agrees to reimburse claims for Medicaid administration from (Contractor) only if (Contractor) or its subcontractors certify that sufficient funds are available to support the non-federal share of the cost of the claim (or "match"). This agreement is also subject to any additional restrictions, limitations or conditions required by federal or state government which may affect the provisions, term or funding of this agreement in any manner.
- C. This agreement will terminate at the end of any federal fiscal year in the event funds are not appropriated by the U.S. Congress for the next succeeding federal fiscal year. If funds are appropriated for a portion of the fiscal year, this agreement will terminate at the end of the term for which funds are appropriated.
- D. TDH's obligation to transfer these funds is contingent upon the availability of Federal Financial Participation.
- E. Any audit exception, deferral or denial taken against this Agreement by the Centers for Medicare and Medicaid Services will be the responsibility of (Contractor), unless said exception, deferral, or denial is the direct result of instructions given in writing by the Commission or TDHS.

**IV.
AMENDMENT**

This agreement may be amended at any time by mutual consent of the parties of this agreement. Either party may also terminate this agreement without cause by delivery of written notice of termination to the other party at least thirty (30) days prior to the effective date of termination.

**V.
TERM OF CONTRACT**

This agreement begins (Date), and shall continue indefinitely. This Agreement is executed by the undersigned in their capacities as stated below.

TEXAS DEPARTMENT OF HEALTH (CONTRACTOR

By _____

By _____

Title _____

Title _____

Date _____

Date _____

APPENDIX C

Local Implementation Plan and Checklist

LOCAL AGENCY IMPLEMENTATION PLAN OUTLINE

A. Introduction

Local agencies participating in the Medicaid Administrative Claiming (MAC) project must complete the following outline and have an approved local agency Implementation Plan. This plan is based on the Mandatory Participation Requirements of HHSC and state agency policies. The Implementation Plan is to be submitted for review and approval by the state agency coordinator and continues approval of the plan is based on the results of on-site reviews.

Send all Implementation Plans to:

Deborah Lewis
Coordinator, Medicaid Administrative Claiming
Texas Department of Health
Bureau of Financial Services
1100 W. 49th Street
Austin, Texas 78756

The first page of the implementation plan is to be submitted on agency letterhead and is to include the name, signature, and date of the agency CEO who has oversight of the project, as well as the project coordinator (MAC Agency Coordinator).

B. The Outline

Note: Each of the following items must be completed.

1. **Medicaid Administrative Claiming Agency Coordinator**

List the name, address, telephone, and fax number of the individual who will have the operational authority and overall responsibility for the Medicaid administration project. Also, include a complete job description for the MAC Coordinator. If a separate individual is responsible for either the time study (programmatic) or the preparation of the claim (financial), please indicate and include their names, addresses, phone/fax numbers and list their functions.

A complete organizational chart of the local entity showing where and to whom the MAC Coordinator is assigned must be included with the Implementation Plan.

(EXAMPLE)

I. **Local Project Coordinator**

a. **Elizabeth Taylor, Director Case Management**
Texas State Center
P.O. Box 5000
Anywhere, Texas 12345-6708
902/910-1112 (office)
902/910-1314 (fax)

- 1. Include a copy of the local project coordinator's job description. Make sure the job includes all duties in Appendix D – Agency MAC Coordinator Core Responsibilities.**

- b. **Vivian Leigh, Assistant MAC Coordinator**
Texas State Center
P.O. Box 5000
Anywhere, Texas 12345-6708
902/910-1112 (office)
902/910-1314 (fax)

- 1. **Job functions and responsibilities:** The Assistant MAC Coordinator is responsible for assisting in the time study participant training, final collection of time study logs (from supervisors), reviewing time study logs after received, individual training when necessary, contacting individual supervisors when corrections need to be made on time study logs, and participating on the question/answer team for MAC.

- c. **Richard Burton, Chief Accountant**
Texas State Center
P.O. Box 5000
Anywhere, Texas 12345-6708
902/910-1112 (office)
902/910-1314 (fax)

- 1. **Job functions and responsibilities:** The chief accountant is responsible for coordination and preparation of all financial aspects of the Medicaid Administrative Claim.

- d. **A complete organizational chart showing where and when to whom the MAC Coordinator is assigned is attached.**

2. Service Programs Involved in Time Study

List the service programs within the agency whose staff will be participating in the time study.

(EXAMPLE)

- II. **The following service program staff participate in the time studies: Family Health Services, Personal Health services, Dental Health Services, Disease Prevention and Control, etc.**

3. Time Study Participants

List the job titles or classifications of staff who will be participating in the time study as a group (1 or more) and the reason they are included. Indicate the approximate number of staff you will be time studying for each job description or classification. List the activities that are considered MAC activities, the MAC code applicable to the specific MAC activity, and the estimated percentage of time each participant usually spends on each MAC activity.

*NOTE: While it is expected that all of the individuals within a given job class will participate in the time study, local agencies have the option of time studying clusters of staff with similar functions. For example, all licensed nurses make up a job class but local agencies may choose to time study only nurses II and III. Also, a state agency may require specific staff to participate in the time study.

Describe any activities that could be completed by contract.

(EXAMPLE)

III. Time Study Participants

Employees: (Based on evaluation of coding)

Classifications	Approximate No. of Participants	Allowable MAC or Required Activities	Codes Used	Estimated % of Time
Case Managers (Required to be Included)	5	Referral, Coordination, and Monitoring	6, 8	20%
		Targeted Case Management	13	60%
		Administration	15	20%
Admin Tech IV	3	Referral, Coordination, and Monitoring	6, 8	10%
		Outreach		10%
		Facilitating Eligibility	4, 5	30%
		Administration	1, 2	50%

Contract Personnel:

***Note: Contract personnel can be time studied but they cannot be qualified as SPMP.**

4. Skilled Professional Medical Personnel (SPMP)

List any job classifications that meet the qualifications of Skilled Professional Medical Personnel (SPMP). Indicate the number of staff in each position who will be designated SPMPs.

(EXAMPLE)

IV. Employees qualified for Skilled Professional Medical Personnel (SPMP)

- A. Nurse II – Three (3) positions**
- B. Nurse IV – One (1) position**

5. Training

The coordinator and at least one additional employee with a working knowledge of MAC are required to attend the administering state agency’s training approved by HHSC.

Describe your plans for mandatory ongoing or refresher training. The local project coordinator is responsible for ensuring that training on the time study codes and how to complete time studies is provided for all participants.

Discuss initial and follow-up training schedules. Describe how often each specific training will be held and what will be discussed in these trainings (both the initial and the follow up). The MAC Coordinator must have documentation that each participant in the time study received appropriate training prior to each time study.

Describe how you will train staff for the time study. Training must provide in-depth and comprehensive instruction with a basic understanding of the Medicaid programs, Medicaid covered services, the role of HHSC and the purpose of the MAC project. The completion of time study logs, an exercise in practice coding of program activities, and providing adequate opportunity for a question and answer session must also be provided in the local agency training.

Indicate how you will work with staff who have had trouble with the time study (one-on-one training).

Explain how staff turnover will be handled in the pool of time study participants as it relates to training on the codes. Describe how your agency ensures that those participants who are newly hired or have recently moved into a new position that requires them to time study are trained prior to time studying.

Explain what type of documentation will be kept to verify that all participants that are time studying (for each quarter) were trained prior to the start date.

(EXAMPLE)

V. Training

The Coordinator and at least one additional employee with a working knowledge of MAC will be required to attend the administering state agency's training approved by HHSC.

The local project coordinator is responsible for ensuring that mandatory training sessions on the time study codes and how to complete time studies is provided to all participants. All training will provide in-depth and comprehensive instruction with a basic understanding of the Medicaid program, Medicaid covered services, the role of HHSC and the purpose of the MAC project.

Samples of how to complete the Time Study Log will be demonstrated on the overhead projector. An emphasis will be placed on completing the logs throughout the day at the end of each activity.

Prior to each time study a list is obtained from the personnel office listing any new employees with their job descriptions. We also receive a list of any internal job changes and the updated job description. The MAC team members will get together and review any changes to determine whether staff are eligible to time study according to the state guidelines. At this time, we will also review percentages of codes and the codes used by groups of people in the same job classification and function currently in the time study to determine if they should continue to time study.

Staff that are determined as participants in the MAC time study will be required to attend one of five refresher training classes offered. Any staff that do not attend a training class will be identified.

It will then become the responsibility of the staff member and their supervisor to arrange a time for the staff member to be trained by either a supervisor or a member of the Medicaid Administration Claiming Committee. Any individual training must be similar in content to scheduled refresher classes and completed prior to the time study start date with supporting documentation.

At all these trainings there will be a sign-in roster sheet that will be used to document the required staff training. These rosters will then be forwarded to the MAC Coordinator's office to be kept in that quarter's file. Rosters of individual training will also be added to the file.

Refresher training will be scheduled at least one week prior to the start date. Initial training will be held on an as-needed or scheduled basis.

In the training each staff will be provided a packet with blank examples of the Time Study Log. Each staff will also be provided the following agenda:

ADMINISTRATIVE CLAIMING
Training Agenda

- I. Introduction
 - A. Importance/Effect/Changes
 - B. Introduction of Medicaid Administrative Claiming Committee
- II. Administrative Claiming
 - A. Codes (Overhead and Handout)
 - 1. Explanation/Definition
 - 2. SPMP- Enhanced Codes (available to SPMP and Supervisors)
 - B. Log (Overhead and Handout)
 - 1. Example Log – how to code
 - a. Definition of Direct/Indirect
 - b. Differences in certain codes
 - 2. Sample Log – fill out together (step by step)
 - a. Identifying Information
 - i. 1st Blank
 - ii. 2nd Blank
 - iii. 3rd – Blank
 - iv. 4th – Blank
 - v. 5th – Blank
 - vi. 6th – Blank
 - vii. 7th – Blank
 - b. Weekly Log (Rows)
 - i. Time Frames (examples shown)
 - (a). Arrival
 - (b). At end of the day write OFF
 - (c). When off for the day for holiday, vacation, sick, etc (CODE 15)

c. How to total (examples)

C. Questions (committee members)

- 1. Open Floor for Questions**
- 2. Schedule Follow Up Training**

Staff will be trained in each code and the definitions (handout in packet). This will allow them to identify their job duties in the codes. Questions and answers will occur throughout the training, in an open discussion format.

Staff who have problems completing the log will be able to contact their supervisors (who sign off on their time study logs) or the MAC committee members for assistance. If the supervisors notice problems with coding and/or log completion they are required to contact a MAC team member so they can both work with the employee until they become confident with what they are doing.

6. Time Study Methodology

Describe your plan for the time study and how it will work: what method will be used to complete the time study each quarter (750 valid WDLs or the entire mid month); how logs will be distributed, who will collect the logs, and who will be responsible to add totals on each log; how supervisors check the time study logs for accuracy each week; and describe how the local agency coordinator will review the time study sheets for errors and inconsistencies. All quality assurance techniques must be included.

Describe the procedure for time study participants to contact someone when they have questions about the time study.

Indicate whether your agency's participants are required to keep back up documentation.

(EXAMPLE)

VI. Time Study Methodology

- A. Number of days each quarter or Mid-month each quarter**
- B. How logs will be distributed, collected, and compiled: Supervisors will distribute logs and collect logs from the time study participants they are responsible for. Participants will be responsible for adding up their totals; and these totals will be checked by both their individual supervisors and by the assistant MAC coordinator.**
- C. Review of time study sheets. Reviews will be ongoing: The supervisors are the first line quality assurance checks. We have set up a check-list for the time study logs and the supervisors are required to review these logs (no later than seven (7) days after the last date on each time study log) for complete information and correct code usage. The logs are then signed and dated by the supervisor and sent on to the assistant coordinator who also uses the same check list to review the time study logs. Any codes that are questionable are discussed with the time study participant and their supervisor.**

- D. Describe the MAC Coordinator’s Quarterly Status Report for the agency’s CEO signature and date. (Minimum: current status of the claim or claims, reimbursement expected, areas of concern, improvement plans.)**
- E. Contact Personnel: If time study participants have questions they are to first go to their supervisors. If needed, the supervisor contacts a member of the MAC team. If the MAC team member is not able to answer the question, our whole team comes together and the question is answered in a memo to all participants.**
- F. Back-Up Documentation: Currently, Texas Centers do not require back-up documentation be kept by all participants of the time study. If staff choose to keep additional documentation, some examples of items used for back-up are calendars and daily planners.**

7. Fiscal Information

Explain how your agency will ensure the claim is prepared correctly; check for errors; and how you will ensure the claim is submitted to the state within the designated time frames.

List the type of time study log the agency will use to record data (manual, automated – Scantron, etc.). Also, list by name and version number all software and identify by name/model number any hardware used to compile the MAC Claims.

Describe how the Medicaid eligibility percentage is calculated.

List the source of funds to be used as “match”, the expense categories to be included as allowable costs on the claim, whether accounting is done on cash or modified accrual basis, and your methodology for determining indirect costs.

(EXAMPLE)

VII. Fiscal Information

- A. Source of funds. State General Revenue funds are used for match. Expense categories to be included as allowable costs on the claims are: salary, fringe benefits, travel and other. Accounting is done on a modified accrual basis.**
- B. Method of determining indirect costs. The indirect costs are determined by an analysis of each department’s functions. Generally speaking, non-programmatic departments’ costs are considered indirect.**

- C. **Claim.** Texas Centers will always have at least two (2) people employed who are able to do a complete, accurate claim.

Our agency will use automated time study logs (Scantime) on a Scantime Scanner (Model #1234). This data will be compiled on ESP software (version 1.234) with edits for accuracy prior to interface with TDH Software. Salary and other required information will be directly entered into the spreadsheet.

In order to make sure we have the claim before the deadline our agency has set up intermediate deadlines.

- D. **Medicaid Eligibility Percentage.** The quarterly Medicaid Percentage will be calculated on a case-by-case basis. An unduplicated listing of persons served and their correspondence payor information is derived from the agency database. On a case-by-case basis the agency coordinator verifies the current quarter status of each recorded Medicaid number, and corresponding social security number and date of birth. Medicaid information is verified through on-line DHS Client Eligibility Information Access or Medifax.

The unduplicated count of verified Medicaid Eligible recipients is divided by report of unduplicated persons served within the quarter, less persons in “Medicaid Applied For” status.

Persons in “applied for” status are tracked and reported by the agency consumer benefits unit. The agency audit file will contain back-up documentation of the name, date of birth, social security number and point of process status for each person identified to be in “applied for status” on each submitted quarterly claim.

8. **Audit File**

List the name of the person responsible for maintaining and updating the audit file according to the MAC Guidebook audit file checklist. Describe the contents of the audit file and where it will be kept.

(EXAMPLE)

VIII. **Audit File**

- A. **Person responsible for maintaining and updating audit file.**
1. **Elizabeth Taylor, Administrative Claiming Coordinator**
 2. **Richard Burton, Chief Accountant**

B. Contents of the audit file include:

1. Signed original time study logs that have also been signed by the worker's supervisor.
2. Copy of automated summary of time study forms report generated from original time study logs (if applicable).
3. A written statement describing how the time study days were selected.
4. If used, copies of workers' time cards for the time study period.
5. Copies of computations used to calculate the percentage of time claimable to Medicaid Administration.
6. Copies of any worksheets or spreadsheets used in developing the claim.
7. Copy of the methodology used to establish the agency's indirect cost rate.
8. A listing of other costs.
9. A detailed listing of all revenues offset from the claim, by source.
10. Copy of methodology used to reconcile the claims to the facility general ledger.
11. Signed copy of the Approved Annual Implementation Plan in effect for this quarter.
12. Copies of all training materials given to staff, dated for the quarter they were used.
13. A list of personnel by name, employee identification number, physical office address, and SPMP status who participated in this study.
14. A written statement describing how the Medicaid percentage was determined for the federal fiscal quarter ending _____.
15. Completed "Quarterly Invoice Checklist.
16. Completed Administrative Claim.
17. MAC Coordinator's job description
18. MAC Coordinator's Quarterly Status Report to the CEO.
19. Any MAC review reports for this quarter.
20. Local agency Annual Self-Evaluation Reports. (4th Quarter Only)
21. Affiliate Agency Annual Report. (4th Quarter Only)

C. The contents of the individual SPMP audit files are as follows:

1. The job class specifications or job descriptions.
2. A copy of the SPMP survey.
3. A copy of any appropriate license or certificate and documentation of any educational fieldwork that is medically related. This doesn't include on the job training that occurred in a medically related environment.

D. Location of File

**Administrative Claiming Coordinator's Office
Elizabeth Taylor, Director Case Management
Texas State Center
1234 Yellow Rose Road
Anywhere, TX 12345**

9. Effective Dates (Renew Annually)

List the effective dates of the implementation plan. This plan is to be reviewed at least annually, and is renewable prior to the expiration date. The dates for the initial plan for all agencies is July 1, Current Year – June 30, Following Year.

(EXAMPLE)

IX. Effective Dates July 1, 1997 – June 30, 1998; Renew Annually

10. Authorizing Signature/Dates

Include the name, date, and signatures of the agency Chief Executive Officer who has oversight of the Medicaid administration project as well as all other individuals and their titles who have direct responsibility for the project (MAC Agency Coordinator, Financial Officer, etc.).

(EXAMPLE)

X. Authorizing Signatures

_____	_____
Chief Executive Officer	Date
_____	_____
Administrative Claiming Agency Coordinator	Date
_____	_____
Financial Officer	Date
_____	_____
Medicaid Administrative Claiming Committee Member	Date
_____	_____
Medicaid Administrative Claiming Committee Member	Date
_____	_____
Medicaid Administrative Claiming Committee Member	Date

NAME OF FACILITY: _____
REVIEW DATE: _____

Implementation Plan Check List

Please note that any items that are NOT checked off indicates that the items were either not found in your agency's Implementation Plan or a thorough explanation of the procedure was not provided.

I. Local Project Coordinator

- _____ Detailed job description of the local project coordinator.
- _____ An organizational chart of the local entity and identify where and to whom the local project coordinator is assigned.
- _____ List the name, address, and telephone/fax number of the local project coordinator.
- _____ List the name, address, telephone/fax number, and function of other individuals responsible for the time study or preparation of the claim.

II. Time Study Participants

- _____ A list of activities that are considered MAC activities.
- _____ In parentheses the MAC code applicable to the specific MAC activity.
- _____ Estimated percentage of time each participant usually spends on each MAC activity.
- _____ Describe any activities that could be completed by contract personnel.
- _____ List the service programs within the agency whose staff will be participating in the time study and the reason they are included.
- _____ List the job titles or classifications of individuals who will be participating in the time study and the reasons they are included.
- _____ List the approximate number of staff you will be time studying in each position.

III. Skilled Professional medical Personnel (SPMP)

- _____ List any job classifications that qualify for SPMP.
- _____ Include number of staff in each position who will be designated as SPMPs.

IV. Training

- _____ The coordinator and at least one additional employee with a working knowledge of MAC are required to attend the administering state agency's training approved by the Health and Human Services Commission (HHSC).

- _____ The local project coordinator is responsible for ensuring that mandatory training sessions on the study codes and how to complete time studies is provided for all participants.
- _____ Provide in-depth and comprehensive instruction to provide participants with a basic understanding of the Medicaid program, Medicaid covered services, the role of the HHSC and the purpose of the MAC project.
- _____ Completion of the time study logs, an exercise in practice coding of program activities, and provide adequate opportunity for a question and answer session.
- _____ Discuss initial and follow-up training schedules.
- _____ A plan to deal with individuals who, after submitting incorrect logs, will require one-on-one training.
- _____ Staff turnover in the pool of time study participants as it relates to training on the codes.
- _____ Coordinator must have documentation that each participant in the time study receive appropriate training.

V. Time Study Methodology

- _____ What method will be used to time study (750 **valid** worker-day-logs or entire mid-month quarter).
- _____ Describe the process used for distribution of the logs.
- _____ Who will collect the logs.
- _____ Who will add the totals.
- _____ How will supervisors check the logs for accuracy each week.
- _____ Describe plans for reviewing the time study logs for errors and inconsistencies.
- _____ Describe the MAC Coordinator's Quarterly Status Report content.
- _____ Describe procedures used to ensure all staff have a designated contact person to call when they have questions about the time study codes.
- _____ HHSC suggests, whenever feasible, that participants keep back-up documentation with enough detail to support time study logs (daily planners, transportation logs, etc.). (Please document in your agency's Implementation Plan whether this is required or not.)

VI. Fiscal Information

- _____ Describe how you will ensure that the claim is prepared correctly.
- _____ Describe how you will ensure that the claim is checked for errors.
- _____ Describe how you will ensure that the claim is submitted to the state within the designated time frames.
- _____ Type of time study log, software, and hardware used to develop the claim described.
- _____ How the Medicaid eligibility percentage is calculated.
- _____ List the source of funds to be used as "match".
- _____ List the expense categories included as allowable costs.
- _____ Indicate whether accounting is done on a cost or modified accrual basis.
- _____ Indicate your methodology for determining indirect cost.

VII. Audit File

- ___ Agency Audit File Checklist (MAC GUIDEBOOK Appendix J)
 - ___ Signed original time study logs that have also been signed by the worker's supervisor.
 - ___ Copy of automated summary of time study forms report generated from original time study log (if applicable).
 - ___ A written statement describing how the time study days were selected.
 - ___ If used, copies of workers' time cards for the time study period.
 - ___ Copies of computations used to calculate the percentage of time claimable to Medicaid administration.
 - ___ Copies of any worksheets or spreadsheets used in developing the claim.
 - ___ Copy of the methodology used to establish the agency's indirect cost rate.
 - ___ A listing of other costs.
 - ___ A detailed listing of all revenues offset from the claim, by source and cost pool.
 - ___ Copy of the methodology used to reconcile claims to the facility general ledger.
 - ___ A written statement describing how the Medicaid percentage was determined for the federal fiscal quarter ending _____.
 - ___ Signed copies of the approved annual implementation plan in effect for this quarter.
 - ___ Copies of all training materials given to staff, dated for the quarter they were used.
 - ___ A list of personnel by name, employee identification number, physical office address, and SPMP status who participated in this study.
 - ___ Completed "Quarterly Invoice Checklist".
 - ___ Completed Administrative Claim.
 - ___ Copy of MAC Coordinator's job description.
 - ___ MAC Coordinator's Quarterly Status Report to the CEO.
 - ___ Any MAC Review Reports for this specific quarter.
 - ___ Affiliate Agency Annual Report (4th Quarter Only).
 - ___ Annual Self-Evaluation Report of required project performance review (4th Quarter Only).

- ___ Skilled Professional Medical Personnel (SPMP) Audit File Checklist (MAC Guidebook)
 - ___ The class specification or job description.
 - ___ A duty statement, if the job description is too generic to describe the individual's actual job responsibilities.
 - ___ A copy of the SPMP survey.
 - ___ A copy of any appropriate license or certificate and documentation of any educational fieldwork that is medically related. This doesn't include on the job training that occurred in a medically related environment.
 - ___ A table of organization showing the relationship of SPMPs to their direct supporting clerical staff, if the costs of three clerical staff are being claimed at 75%.

- ___ Provide Information on when the files are physically located and secured.

- ___ List the name or names of the persons responsible for maintaining and updating the audit file.

VIII. Effective Dates (Renew Annually)

_____ Current Dates on the Implementation Plans Should Be:
July 1, current year through June 30, following year.

IX. Authorizing Signatures

_____ Submitted on agency letterhead.

_____ Include name, date, and signature of the:

_____ Agency Chief Executive Officer who has oversight of the project.

_____ The Local project coordinator.

_____ Any other designated staff with direct responsibility for the project (financial officer, etc.) with title.

APPENDIX D

Local Agency MAC Coordinator Core Responsibilities

LOCAL AGENCY OR PROGRAM MEDICAID ADMINISTRATIVE CLAIMING COORDINATOR CORE RESPONSIBILITIES

These coordinator responsibilities are to be listed in the job description for the individual selected and they are required job functions.

1. Information Flow

- Receives all correspondence and requests for information regarding MAC from the state agency.
- Ensures that all programs or contractors claiming reimbursement through MAC receive copies of applicable correspondence.

2. Policy

- Ensures the agency or program and contractor instructions are based on information contained in the Medicaid Administrative Claiming Guide and consistent with statewide policy for Medicaid administrative claiming: participants in the time study, time study formats, the designation of Skilled Professional Medical Personnel, methodologies used to determine the percentage of Medicaid recipients, constructing a claim, and establishing an audit trail.
- Assist program or contract agency MAC coordinators in defining their roles and responsibilities.
- Disseminates policy or program information to all programs and contractors participating in MAC.
- Clarifies policy, program or fiscal questions raised by staff or contractors; refers any requests for assistance or further clarification to the state agency.

3. Staff Training

- Identifies training needs among staff and contractors
- Ensures that training is provided quarterly to maintain compliance with the procedures established in the Medicaid Administrative Claiming Guide.
- Notifies statewide coordinator of needs for the statewide or regional training.

4. Invoice Review

- Uses the “Invoice Checklist” to ensure that invoices for Medicaid administrative claims are consistent with the Medicaid Administrative Claiming Guide criteria before they are submitted to the state agency.
- Ensure that the methodology used to calculate the Medicaid percentage has been properly applied.
- Obtains any information that may be required by state staff about the invoice.

5. Contacts

- Ensure the processing of agreements or memoranda of understanding with any contractors participating in MAC.
- Maintains interagency agreement or memoranda of understating with the state agency, and oversees the processing of any amendments needs to revise the maximum claiming amount.

6. Audits

- Develop guidelines for establishing and maintaining agency wide audit files that are consistent with procedures outlined by the state agency.
- Assist program or contract agency coordinators in establishing and maintaining audit files; may conduct periodic review to ensure that files are current.

7. General

- Ensure no duplicate billings occur within the agency.
- Encourages interdepartmental coordination and cooperation to improve program efficiency and effectiveness.

APPENDIX E

MEDICAID COVERED SERVICES

MEDICAID COVERED SERVICES

The purpose of the Medicaid administration project is to ensure access of eligible individuals to Medicaid services. “Medicaid services” refers to medically related services covered under the Texas State Medicaid Plan. The following list identifies services used most frequently by recipients.

- Physicians’ services
- Hospital review
- Clinic services for children under 21
- Limited maternity care clinics
- Lab and X-ray services
- Home health care
- THSteps/EPSTDT screens and services
- Medically needed oral surgery and dentistry for adults (not routine dentistry)
- Pharmacy services (prescription drugs)
- Rehabilitative mental health and mental retardation services (provided by the Texas Department of Mental Health and Mental Retardation and its contract agencies, including local mental health and metal retardation services programs)
- Family planning
- Services provided by licensed clinical psychologist, licensed clinical social workers, and licensed professional counselors
- Comprehensive Care Program (CCP) services for children under 21 including services by private duty nurses, physical, occupational, and speech therapy, durable medical equipment, medical supplies, psychiatric hospital care, and services by dieticians
- School Health and Related Services (SHARS)
- Targeted Case Management for pregnant women and children under 1
- Hearing aids and related audiologists’ services
- Diagnostic assessment services for person with mental retardations and mental illness
- Optometry and eyeglasses
- Emergency medical services
- Private duty nursing for children under 21
- Intermediate care facilities for the mentally retarded
- Physical therapy
- Rehabilitation services for chronic medical conditions
- Hospice services
- Day Activity and Health Services (DAHS)

APPENDIX F

**TIME STUDY CODES
TEXAS DEPARTMENT OF HEALTH**

TEXAS DEPARTMENT OF HEALTH
STATE AFFILIATED LOCAL HEALTH DEPARTMENTS
APPROVED – APRIL 4, 1997

CODE 1. FACILITATING MEDICAID ELIGIBILITY DETERMINATIONS
(Not Enhanced)

Staff should use this code when assisting an individual in becoming eligible for Medicaid. Include related paperwork, clerical activities or staff travel required to perform these activities.

This activity does not include the actual Medicaid eligibility determination.

Examples of activities reported under this code:

- Informing individuals and families about the Medicaid program and referring them to the Texas Department of Human Services to submit an application.
- Assisting families to provide third party resource information at Medicaid eligibility intake.
- Verifying an individual's and/or family's current Medicaid eligibility status.
- Explaining Medicaid eligibility rules and the Medicaid eligibility status.
- Assisting an applicant to fill out a Medicaid eligibility application
- Gathering information related to the application and eligibility determination from an individual or family, including resource information and third party liability information, as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.
- Tracking clients referred to Medicaid to substantiate completion of the Medicaid application process and offering assistance.

CODE 2. FACILITATING NON-MEDICAID ELIGIBILITY DETERMINATIONS

Staff should use this code when helping individuals and families to become eligible for NON-Medicaid programs. Include related paperwork, clerical activities or staff travel required to perform these activities.

Examples of activities reported under this code:

- Informing individuals and/or families about programs such as AFDC, food stamps, WIC, Community Oriented Primary Care, County Indigent Health Care, and any other health and social support services/programs and referring them to the appropriate agency to submit an application.
- Developing and verifying initial and continuing eligibility for the Chronically Ill and Disabled Children (CIDC) and the Program for Children With Special Health Care Needs (CSHCN).
- Explaining eligibility rules and the eligibility process for the AFDC, food stamps, WIC, and other non-Medicaid programs to prospective applicants.
- Assisting individuals or families to fill out eligibility application for such non-Medicaid programs as AFDC, WIC, and food stamps.
- Gathering information related to the application and eligibility determination for non-Medicaid programs from an individual.
- Providing necessary forms and packaging such forms in preparation for the non-Medicaid eligibility determination.

CODE 3. MEDICAID OUTREACH (Enhanced)

This code is used only by staff who are Skilled Professional Medical Personnel and only when skilled professional medical knowledge is required to identify medically at-risk individuals and persuade recipients or potential recipients to enter care through the Medicaid system. Include related paperwork or staff travel required to perform these activities.

Outreach campaigns directed to the entire population to encourage potential Medicaid eligible individuals to apply for Medicaid are allowable, and the costs do not have to be discounted by the Medicaid percentage. These campaigns are essentially eligibility outreach campaigns. Outreach campaigns directed toward bringing Medicaid eligible individuals into Medicaid covered services are allowable and the costs do not have to be discounted by the Medicaid percentage. These campaigns are service campaigns targeted on specific Medicaid services, such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or the Comprehensive Care Program (CCP).

A health education program or campaign may be allowable as a Medicaid administrative cost if it is targeted specifically to Medicaid services and for Medicaid eligible individuals such as an

educational campaign on immunization addressed to parents of EPSDT children. If the entire campaign is focused on Medicaid, the costs need not be discounted.

Outreach consists of discrete campaigns or may be an ongoing activity such as sending teams of employees into the community to identify children with special needs through child find activities; contacting pregnant and parenting teenagers about the availability of prenatal and well-child care; establishing a telephone or walk-in service for referring persons to Medicaid services or eligibility offices; operating a drop-in community center for underserved populations such as minority teenagers where Medicaid eligibility and service information is disseminated. Certain outreach campaigns may also be directed toward a specific high risk population; for example, bringing children with special health care needs into appropriate health care services. **Report under this code only that portion of time spent in these activities which specifically address Medicaid outreach. Report the non-Medicaid portion of these outreach campaigns under Code 5 (for example, general health education programs).**

Examples of activities reported under this code (Medicaid portion only):

- Designing and implementing strategies to identify pregnant women who may be at high risk of poor health outcomes because of drug usage, poor nutrition, or lack of appropriate prenatal care.
- Designing and implementing strategies to identify with children with special needs who may be at high-risk of poor health outcomes because of abuse or neglect.
- Contacting pregnant and parenting teens about the availability of prenatal, family planning and child health care services available under Medicaid.

CODE 4. MEDICAID OUTREACH (Not-Enhanced)

Staff should use this code when performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access it. This code should also be used when describing the range of services covered under Medicaid, how to obtain them, and the benefits of Medicaid preventative services. Both written and oral methods may be used. Include related paperwork, clerical activities, and/or staff travel required to perform these activities.

Outreach campaigns directed to the entire population to encourage potential Medicaid eligible individuals to apply for Medicaid are allowable, and the cost do not have to be discounted by the Medicaid percentage. These campaigns are essentially eligibility outreach campaigns. Outreach campaigns directed towards bringing Medicaid eligible individuals into Medicaid covered services are allowable and the costs do not have to be discounted by the Medicaid percentage. These campaigns are services campaigns, targeted on specific Medicaid services, such as Early and Periodic Screening, Diagnosis and Treatment (EPSDT) or the Comprehensive Care Program (CCP).

A health education program or campaign may be allowable as a Medicaid administrative cost if it is targeted specifically to Medicaid services and for Medicaid eligible individuals such as an educational campaign on immunization addressed to parents of EPSDT children. If the entire campaign is focused on Medicaid, the costs need not be discounted.

Outreach may consist of discrete campaigns or may be an ongoing activity such as: sending teams of employees into the community to identify children with special needs through child find activities; contacting pregnant and parenting teenagers about the availability of prenatal and well-child care; establishing a telephone or walk-in services for referring persons to Medicaid services of eligibility offices; operating a drop-in community center for underserved populations such as minority teenagers where Medicaid eligibility and service information is disseminated. Certain outreach campaigns may also be directed toward a specific high risk population; for example, bringing children with special health care needs into appropriate health care services. **Report under this code only that portion of time spent in these activities which specifically address Medicaid outreach. Report the non-Medicaid portion of these outreach campaigns under Code 5 (for example, general health education programs).**

Examples of activities reported under this code (Medicaid portion only):

- Informing individuals and/or families about the availability of Medicaid services, such as EPSDT medical and dental services and CCP.
- Informing women about the availability of specific Medicaid services such as prenatal care and family planning services.
- Facilitating Medicaid objectives of the EPSDT program by:
 - Informing Medicaid eligible individuals about preventative health services of the Medicaid program.
 - Informing children and their families on how to use health resources and maintain their involvement in the EPSDT.

- Informing individuals with disabilities about the availability of Medicaid services

CODE 5. OUTREACH NON-MEDICAID

Staff should use this code when performing activities that inform eligible or potentially eligible individuals about NON-Medicaid programs and how to access them. This code should also be used when describing the range of benefits covered under the NON-Medicaid 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.

Examples of activities reported under this code:

- General health education programs or campaigns addressed to the general population (e.g., dental hygiene, anti-smoking, alcohol reduction, etc.).
- Outreach campaigns directed toward encouraging individuals and/or families to access social, educational, legal or other services not covered by Medicaid.
- Health fairs addressing issues of healthy lifestyles.
- Non-Medicaid portions of general outreach campaigns (see discussion under Codes 3 and 4).

CODE 6. REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES (Not-Enhanced)

Staff should use this code when making referrals for, coordinating, and/or monitoring the delivery of Medicaid covered services. This code is used by all staff when skilled professional medical knowledge and training are not required and when a non-SPMP is assisting a SPMP. Include related paperwork, clerical activities and/or staff travel required to perform these activities.

Examples of activities reported under this code:

- Making referrals for and/or coordinating medical examinations.
- Making referrals for and/or coordinating dental examinations (for under age 21 only).

- Providing information about, making referrals for, and/or scheduling EPSDT screens and appropriate immunizations.
- Working with children and pregnant women or, on their behalf, with staff and other providers to identify, arrange for and coordinate services covered under Medicaid that may be required as the result of screens, evaluations or examinations.
- Gathering any information that may be required in advance of these referrals or evaluations.
- Participating in inter/intra-agency meetings to coordinate or review a child's or pregnant woman's need for Medicaid covered services.
- Providing follow-up contact to ensure that a child or pregnant woman has received the prescribed services.
- Coordinating the completion of the prescribed services, termination of services, and the referral and transition of the child or pregnant woman to other Medicaid service providers as may be required to provide continuity of care.
- Providing information to other staff and/or providers on the medical plans and services for the child or pregnant woman.

**CODE 7: REFERRAL, COORDINATION, AND MONITORING OF
MEDICAID SERVICES (Enhanced)**

SPMP staff should use this code when making referrals for, coordination, and/or monitoring the delivery of Medicaid covered services that require skilled professional medical knowledge and training. Include related paperwork and/or staff travel required to perform these activities.

Examples of activities requiring skilled professional medical knowledge and training include:

- Making referrals for and/or coordinating medical evaluations for clients with health problems or special health needs.
- Making referrals for and/or coordinating dental evaluations for clients (under age 21 only) with health problems or special health needs.
- 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.

- Gathering any information that may be required in advance of these referrals or evaluations.
- Participating in inter/intra-agency meetings to coordinate or review a child's or pregnant woman's need for Medicaid covered services.
- Providing follow-up contact to ensure that a child or pregnant woman has received the prescribed services.
- Coordinating the completion of the prescribed services, termination of services, and the referral and transition of the child or pregnant woman to either other Medicaid service providers as may be required to provide continuity of care.
- Providing information to other staff on the medical plans and services for the child or pregnant woman.

CODE8. REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES

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

Example of activities reported under this code:

- Screening and making referrals for, and coordinating access to, social and educational services such as child care, employment, job training, and housing.
- Providing follow-up contact to ensure that the client has followed through the referral and is receiving the needed non-Medicaid service.
- Scheduling, arranging and/or providing transportation and/or translation services to assist the client in accessing non-Medicaid services, such as grocery shopping, WIC appointments, housing, school etc.
- Making referrals to, coordinating and monitoring the delivery of medical services not covered by Medicaid (e.g. adult dental services).

CODE 9. MEDICAID TRANSPORTATION AND TRANSLATION – (Not-Enhanced)

Staff should use this code when assisting an individual to obtain transportation to services covered by Medicaid or obtaining translation services for the purpose of assessing Medicaid services. Include related paperwork, clerical activities or staff travel required to perform these activities.

Examples of activities reported under this code:

- Scheduling, arranging or providing client transportation to covered medical treatment services as the result of an evaluation or examination.
- Arranging for or providing translation services that assist the individual to access and understand necessary covered medical care or treatment services.

NOTE: Report non-Medicaid transportation and translation activities under Code 14.

CODE 10. MEDICAID PROVIDER RELATIONS (Not-Enhanced)

Staff should use this code when performing activities to secure and maintain the pool of eligible Medicaid providers. Include related paperwork, clerical activities or staff travel required to perform these activities.

Examples of activities reported under this code:

- Recruiting new Medicaid providers.
- Providing technical assistance and support to new providers about Medicaid.
- Providing information to providers on Medicaid policy and regulations.
- Developing Medicaid service/provider directories.

CODE 11. PROGRAM PLANNING, DEVELOPMENT, AND INTERAGENCY COORDINATION (Not-Enhanced)

Staff should use this code when the program planning, policy development and interagency coordination are performed full time by a unit of one or more employees whose task officially involve program planning and policy development and interagency coordination, according to their position descriptions. Include any paperwork, clerical activities or staff travel required to perform these activities.

Examples of activities reported under this code:

- Working with other agencies' staff providing Medicaid services to improve the coordination and delivery of services; to expand their access to specific populations of Medicaid eligibles; and to improve collaborations around the early identification of medical problems.

- Containing Medicaid costs and improving services to children as part of the goals of the EPSDT program.
- Reducing overlap and duplication in Medicaid services, and closing gaps in the availability of services.
- Focusing Medicaid services on specific populations or geographic regions.
Defining the scope of each agency's Medicaid service in relation to the other.
- Developing strategies to increase Medicaid system capacity and close Medicaid service gaps; includes analyzing Medicaid data related to a specific program or specific group.
- Interagency coordination to improve delivery of Medicaid services.
- Developing resource directories of Medicaid services.
- Coordinating EPSDT outreach activities with TDH central office and regional outreach programs.

CODE 12. PROGRAM PLANNING, DEVELOPMENT, AND INTERAGENCY COORDINATION – (Enhanced)

SPMP should use this code only when the program planning, policy development and interagency coordination are performed full time by a unit of one or more SPMP staff whose tasks officially involve program planning and policy development and interagency coordination according to their position description. These activities must require the use of skilled professional medical knowledge and training. Include any paperwork or staff travel required to perform these activities.

Examples of activities reported under this code:

- Working with other agencies providing Medicaid services to improve coordination and delivery of services, to expand access to specific populations of Medicaid eligibles, and to improve collaboration around the early identification of medical problems.
- Continuing Medicaid costs and improving services to children as part of the goals of the EPSDT program.

- Reducing overlap and duplication in Medicaid services, and closing gaps in the availability of services.
- Focusing Medicaid services on specific populations or geographic areas.
- Defining the scope of each agency's Medicaid service in relation to the other.
- Developing strategies to increase Medicaid system capacity and close Medicaid service gaps; including analyzing Medicaid data related to a specific program or specific group.
- Interagency coordination to improve delivery of Medicaid services.
- Developing resource directories of Medicaid services.

CODE 13. DIRECT SERVICES

Staff should use this code when providing client care, treatment and/or casework and counseling services to children, pregnant women, and families. This includes individual and group psychotherapy, parental skills and task training, and technical assistance which contributes to client advocacy and family empowerment. Include any paperwork, clerical activities or staff travel required to perform these activities.

Examples of activities reported under this code:

- Direct clinical and treatment services, such as:
 - Obtaining or reviewing medical history information.
 - Performing physical examinations.
 - Determining diagnosis.
 - Reviewing test results.
 - Referring for specialized medical services.
 - Dispensing medications or supplies.
 - Counseling and educating individuals about management of medication routine.
- Counseling and training individuals on parental skills.

- Targeted case management activities, such as individual screening and assessment, crisis intervention, medical services planning and coordination, and monitoring of adherence to individual medical plan.
- Developmental assessments and diagnostic testing.
- Individual and group counseling about issues of physical and mental health or substance abuse.

CODE 14. NON-MEDICAID, OTHER EDUCATIONAL AND SOCIAL SERVICES

This code should be used for direct client services which are not reimbursed by Medicaid such as social services, employment, job training, and non-health related education. Include any paperwork, clerical activities or staff travel required to perform these activities.

Examples of activities reported under this code:

- Providing family education services.
- Facilitating parent support groups.
- Conducting support groups.

CODE 15. GENERAL ADMINISTRATION

Staff should use this code when engaged in general administration activities. This code should also be used by all staff for breaks or any form of paid leave.

Examples of activities reported under this code:

- Providing general supervision of staff and evaluation of employee performance.
- Establishing goals and objectives on health-related programs as part of the TDH annual planning process.
- Staff training (as a participant or presenter).
- Reviewing program procedures and rules.
- Attending, facilitating or presenting local, regional, and state-wide meetings.
- Developing budgets and maintaining records.

- Performing general administrative and/or clerical activities related to TDH central or regional office functions or operations.
- Processing employee payroll and other employee-related forms.

CODE L. LUNCH

**TEXAS DEPARTMENT OF HEALTH
HEALTHY START/HEALTHY FAMILIES
APPROVED 7/24/97**

**CODE 1. FACILITATING MEDICAID ELIGIBILITY DETERMINATIONS –
(Not-Enhanced)**

Healthy Start staff should use this code when assisting an individual in becoming eligible for Medicaid. Include related paperwork, clerical activities or staff travel required to perform these activities.

This activity does not include the actual Medicaid eligibility determinations.

Examples of activities reported under this code:

- Informing individuals and families about the Medicaid program and referring them to the Department of Human Services to apply;
- Assisting individuals to provide third party resource information at Medicaid eligibility intake;
- Verifying a family's current Medicaid eligibility status;
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants;
- Assisting an individual to fill out a Medicaid eligibility application;
- Gathering information related to the application and eligibility determination from a *family*, including resource information and third party liability (TPL) information, as a prelude to submitting a formal Medicaid application; (i.e., verification of resources, SSN, citizenship);
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination;
- Tracking clients referred to Medicaid to substantiate completion of the Medicaid application process and offering assistance.

CODE 2. FACILITATING NON-MEDICAID ELIGIBILITY DETERMINATIONS

Healthy Start staff should 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.

Examples of activities reported under this code:

- Informing individuals and their family members about programs which provide financial assistance (AFDC, food stamps, food and housing assistance, WIC), as well as school readiness, child care, job training, family support services, substance abuse treatment, and domestic violence shelters, legal aid, literacy (LEAP), and other social and education programs and referring them to the appropriate agency to make an application;
- Explaining eligibility rules and the eligibility process for AFDC, food stamps, WIC, and other services described above to prospective applicants;
- Assisting an applicant to fill out eligibility applications for such non-Medicaid programs as AFDC, WIC, and food stamps.
- Gathering information related to the application and eligibility determination for non-Medicaid programs from a client;
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

CODE 3. MEDICAID OUTREACH (ENHANCED)

This code should be used only by Healthy Start employees who are Skilled Professional Medical Personnel (SPMP) and only when skilled professional medical knowledge is required to identify medically at-risk individuals and persuade recipients or potential recipients to enter care through the Medicaid system. Include related paperwork, clerical activities or staff travel required to perform these activities.

NOT DISCOUNTED: Outreach campaigns directed to the entire population to encourage potential Medicaid eligibles to apply for Medicaid are allowable, and the costs do not have to be discounted by the Medicaid percentage. These campaigns are essentially eligibility outreach campaigns. Outreach campaigns directed toward bringing Medicaid eligibles into Medicaid covered services are allowable and the cost also does not have to be discounted by the Medicaid percentage. These campaigns are service campaigns, targeted on specific Medicaid services, such as Texas Health Steps (THSteps). The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is now referred to as Texas Health Steps.

A health education program or campaign may be allowable as a Medicaid administrative cost if it is targeted specifically to Medicaid services and for Medicaid eligible individuals, such as an educational campaign on immunizations addressed to parents of

THSteps/EPSTD children. If the entire campaign is focused on Medicaid, the costs need not be discounted.

Outreach may consist of discrete campaigns or may be an ongoing activity, such as: sending teams of employees into the community to seek out and identify children with special needs through child find activities; contacting pregnant and parenting teenagers about the availability of prenatal and well-child care; or establishing a telephone or walk-in service for referring persons to Medicaid services or eligibility offices; operating a drop-in community center for underserved populations, such as minority teenagers, where Medicaid eligibility and service information is disseminated. Certain outreach campaigns may also be directed toward specific high risk populations, for example, bringing low income pregnant women or substance abusers into health care services. **Report under this code only that portion of time spent in these activities which specifically address Medicaid outreach. If the Medicaid outreach activities can be performed by a person who is not qualified as an SPMP, report the portion of time spent under Code 4. Report the non-Medicaid portion of these outreach campaigns under Code 5 (for example, general health education programs).**

Examples of activities reported under this code (Medicaid portion only):

- Registered Nurse, working with pregnant mothers at risk of poor health outcomes to help them access the Medicaid system;
- Designing and implementing strategies to identify pregnant women who may be at high risk of poor health outcomes because of drug usage, poor nutrition, or lack of appropriate prenatal care;
- Designing and implementing strategies to identify infants and toddlers with special needs who may be at high risk of poor health outcomes.

CODE 4. MEDICAID OUTREACH (Not Enhanced)

Staff should use this code when performing activities that inform eligible or potentially eligible individuals about Medicaid and how to access it. This code should also be used when describing the range of services covered under Medicaid, how to obtain them, and the benefits of Medicaid preventive services. Both written and oral methods may be used. Include related paperwork, clerical activities or staff travel required to perform these activities.

NOT DISCOUNTED: Outreach campaigns directed to the entire population to encourage potential Medicaid eligibles to apply for Medicaid are allowable, and the costs do not have to be discounted by the Medicaid percentage. These campaigns are essentially eligibility outreach campaigns. Outreach campaigns directed toward bringing Medicaid eligibles in Medicaid covered services are allowable and the costs also do not have to be discounted by the Medicaid percentage. These campaigns, targeted on specific Medicaid services, such as Early and Periodic Screening, Diagnosis and Treatment (EPSTD), now Texas Health Steps.

A health education program or campaign may be allowable as a Medicaid administrative cost if it is targeted specifically to Medicaid services and for Medicaid eligible individuals, such as an educational campaign on immunizations addressed to parents of THSteps/EPSDT children. If the entire campaign is focused on Medicaid, the costs need not be discounted.

Outreach may consist of discrete campaigns or may be an ongoing activity, such as: sending teams of employees into the community to seek out and identify children with special needs through child find activities; contacting pregnant and parenting teenagers about the availability of prenatal and well-child care; or establishing a telephone or walk-in service for referring persons to Medicaid services or eligibility offices. Certain outreach campaigns may be directed toward specific high risk populations, for example, bringing low income pregnant women or substance abusers into health care services. **Report under this code only that portion of time spent in these activities which specifically address Medicaid outreach. Report the non-Medicaid portion of these outreach campaigns under Code 5 (for example, general health education programs).**

Examples of activities reported under this code:

- Teaching families how Medicaid can help them to meet their children's medical needs.
- Informing families about the availability of Medicaid services, such as THSteps/EPSDT; specifically, contacting parents of newborns at time of birth or earlier;
- Developing and presenting materials to explain THSteps/EPSDT and other Medicaid services which are available to Medicaid-eligible children;
- Referring individuals who become pregnant to prenatal services and providing the necessary assistance to assure this care is obtained;
- Conducting groups to inform families about health related objectives which can be achieved through Medicaid services;
- Assisting the Medicaid agency to fulfill objectives of the THSteps/EPSDT program by:
 - Teaching families about child development, parent-child interaction (using P.A.T. curriculum) and how Medicaid services can enhance their child's development;
 - Educating families about the importance of a medical home and encouraging them to establish and use a medical home;
 - Emphasizing the importance of obtaining immunizations and assisting families to obtain them for their children;
 - Informing eligibles of the benefits of prevention, proper nutrition, and how high risk behaviors can lead to disease or poor health;

- helping children and their families use health resources, including their own talents and knowledge, effectively and efficiently;
- providing caretakers with information (both physical and developmental) that will facilitate prevention or early detection of potential problems;
- assuring that health problems found are diagnosed and treated early, before they become more serious and their treatment more costly.

CODE 5. OUTREACH NON-MEDICAID

Staff should use this code when performing activities that inform eligible or potentially eligible individuals about NON-Medicaid programs and how to access them. This code should also be used when describing the range of benefits covered under the NON-Medicaid 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.

Examples of activities reported under this code;

- Assessing all families at or before birth to systematically identify those most in need of services;
- Regular home visits which focus on family/social, educations, and transportation needs.
- Group activities for families which assist them to identify and access services which will help them accomplish goals related to helping them to be better parents, interact more effectively with their children, obtain the resources needed to raise a healthy family, and avoid abusing and/or neglecting their children;
- Scheduling and promoting activities which educate families about the benefits of healthy lifestyles and practices;
- General health education programs, fairs, or campaigns addressed to the general population (e.g., DARE, dental hygiene, anti-smoking, alcohol reduction, etc);
- Outreach campaigns directed toward encouraging persons to access social, educational, legal or other services not covered by Medicaid;
- Non-Medicaid portions of general outreach campaigns (see discussion under Codes 3 and 4).

CODE 6. REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES (Not-Enhanced)

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

Examples of activities reported under this code;

- Making referrals for and/or coordinating medical or physical examinations and necessary medical evaluations;
- Making referrals for and/or scheduling THSteps/EPSTDT screens, interperiodic screens and appropriate immunizations;
- Providing information about Medicaid THSteps/EPSTDT screening that will help identify medical conditions that can be corrected or ameliorated by services covered through Medicaid.
- Referring and advocating for individuals for necessary medical health, mental health, or substance abuse services covered by Medicaid;
- Arranging for any diagnostic or treatment services which may be required as the result of a condition identified during the child's THSteps/EPSTDT screen;
- Gathering any information that may be required in advance of these referrals or evaluations;
- Working with children, their families, other staff and providers to identify, arrange for, and coordinate services covered under Medicaid that may be required as the result of screens, evaluations or examinations;
- Participating in a meeting or conference to coordinate or review an individual's need for services covered by Medicaid;
- Coordinating the completion of the prescribed services, termination of services, and the referral of the child to other Medicaid service providers as may be required to provide continuity of care;
- Providing information to other staff on the child's medical services and plans.

CODE 7. REFERRAL COORDINATION AND MONITORING OF MEDICAID SERVICES (Enhanced)

SPMP Healthy Start employees should use this code when making referrals for, coordinating, and/or monitoring the delivery of Medicaid covered services that require skilled professional medical knowledge and training. Staff that use this code must meet the requirements under 42 CFR 433.50 for skilled professional medical personnel. Include related paperwork, clerical activities or staff travel required to perform these activities. **If the activity can be performed by someone who is not qualified as an SPMP, report under Code 6.**

Please use Code 13, when conducting any screening, referral, coordination, and monitoring activities that are part of a billable fee-for-services or capitated rate activity.

Examples of activities requiring skilled professional medical (SPMP) knowledge and training include:

- Making referrals for and/or coordinating medical or physical examinations and necessary medical evaluations;
- Making referrals for and/or scheduling THSteps/EPSTDT screens, interperiodic screens and appropriate immunizations;
- Providing information about Medicaid THSteps/EPSTDT screening (e.g., dental, vision) that will help identify medical conditions that can be corrected or ameliorated by services covered through Medicaid;
- Referring children for necessary medical health, mental health or substance abuse services covered by Medicaid, including THSteps/CCP (EPSTDT/CCP);
- Arranging for any diagnostic or treatment services which may be required as a result of a condition identified during the child's THSteps/EPSTDT screen;
- Gathering any information that may be required in advance of these referrals or evaluations;
- Working with children, their families, other staff and providers to identify, arrange for, and coordinate services covered under Medicaid that may be required as the result of screens, evaluations or examinations;
- Participating in a meeting to coordinate or review a child's needs for services covered by Medicaid;
- Providing follow-up contact and tracking activities to ensure that a child has received the prescribed medical service and to provide feedback whether further treatment or modification of existing treatment are required;
- Coordinating the delivery of community-based medical services for a child with severe health care needs.

CODE 8. REFERRAL COORDINATION AND MONITORING OF NON-MEDICAID SERVICES

Staff should 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.

Examples of activities reported under this code:

- Making referrals for and coordinating access to social and educational services such as a legal assistance, school readiness programs, domestic violence programs, child care, employment, job training, and housing;
- Making referrals for, coordinating and monitoring the delivery of child health screens (vision, hearing, scoliosis);
- Planning adult day care.

CODE 9. MEDICAID TRANSPORTATION AND TRANSLATION (Not-Enhanced)

Staff should use this code when assisting an individual to obtain transportation to services covered by Medicaid, or obtaining translation services for the purpose of accessing Medicaid services. Include related paperwork, clerical activities or staff travel required to perform these activities.

Generally, Non-Medicaid transportation and translation activities should be reported under Code 14 (NON-MEDICAID AND OTHER EDUCATION AND SOCIAL SERVICES).

Examples of activities reported under this code:

- Scheduling, arranging or providing recipient transportation to medical treatment required as the result of an evaluation or examination;
- Arranging for or providing translation services that assist the individual to access and understand necessary care or treatment.

CODE 10. MEDICAID PROVIDER RELATIONS (Not-Enhanced)

Staff should use this code when performing activities to secure and maintain the pool of eligible Medicaid providers. Include related paperwork, clerical activities or staff travel required to perform these activities.

Examples of activities reported under this code:

- Recruiting new Medicaid providers;

- Providing technical assistance and support to new providers about Medicaid;
- Providing or obtaining information to or from providers on Medicaid policy and regulations;
- Developing Medicaid service/provider directories.

CODE 11. PROGRAM PLANNING, DEVELOPMENT, AND INTERAGENCY COORDINATION – (Not Enhanced)

Healthy Start staff should use this code only when the program planning and policy development is performed full time by staff whose tasks officially involve program planning and policy development and interagency coordination, according to their position descriptions. Include any paperwork, clerical activities or staff travel required to perform these functions. This could include interagency activities involving Milestones, Children and Youth 2001, Child Abuse Task Force, Galveston County Children’s Consortium, etc.

Directors and program managers should use this code when performing these tasks. Other staff should report under Code 6 or 8 as appropriate.

Examples of activities reported under this code;

- Working with other agencies providing Medicaid services to improve the coordination and delivery of services, to expand their access to specific populations of Medicaid eligibles, and to improve collaboration around the early identification of medical problems.
- Containing Medicaid costs and improving services to children as part of the goals of the THSteps/EPSTD program;
- Reducing overlap and duplications in Medicaid services, and closing gaps in the availability of services, especially for children;
- Focusing Medicaid services on specific populations or geographic areas.
- Defining the scope of each agency’s Medicaid service in relation to the other.
- Developing strategies to increase Medicaid system capacity and close Medicaid service gaps; includes analyzing Medicaid data related to specific program or specific group;
- Interagency coordination to improve delivery of Medicaid services;
- Developing resource directories of Medicaid services.

CODE 12. PROGRAM PLANNING, DEVELOPMENT AND INTERAGENCY COORDINATION – (Enhanced)

SPMP should use this code only when the program planning, policy development and interagency coordination are performed full time by a unit of one or more SPMP staff whose tasks officially involve program planning and policy development and interagency coordination, according to their position descriptions. These activities must require the use of skilled professional medical knowledge and training. Staff using this code must meet the requirement under 42 CFR 433.50 for SPMPs. Include any paperwork, clerical activities or staff travel required to perform these functions. **If the activity can be performed by someone who is not qualified as an SPMP, report under code 11.**

Directors and program managers should use this code when performing these tasks. Other SPMP staff should report under Code 7 as appropriate.

Examples of activities reported under this code:

- Working with other agencies providing Medicaid services to improve the coordination and delivery of services, to expand their access to specific populations of Medicaid eligible, and to improve collaboration around the early identification of medical problems;
- Containing Medicaid costs and improving services to children as part of the goals on the THSteps/EPSTDT program;
- Reducing overlap and duplication in Medicaid services, and closing gaps in the availability of services, especially for children;
- Focusing Medicaid services on specific populations or geographic areas;
- Defining the scope of each agency's Medicaid service in relation to the other;
- Developing strategies to increase Medicaid system capacity and close Medicaid service gaps; includes analyzing Medicaid data related to a specific program or specific group;
- Interagency coordination to improve delivery of Medicaid services;
- Developing resource directories of Medicaid providers.

CODE 13. DIRECT MEDICAL SERVICES

This code should be used by all staff when providing client care, treatment and/or counseling services to an individual in order to correct or ameliorate a specific condition. Any fee-for-service or captivated rate billable activities should be included in this code.

Examples of activities reported under this code:

- Direct clinical/treatment services;
- Administering first aid, emergency care, or prescribed injection or medication to an individual;
- Diagnostic testing or medical screens;
- Performing child health screens such as vision, hearing and scoliosis and THSteps/EPSTDT screens;
- Referral, coordination, and monitoring that is part of a medical service/office visit;
- Providing supportive guidance or counseling as part of a medical service/office visit;
- Development assessments, such as ICMQs;
- Professionally counseling a family or its members about a health, mental health, or substance abuse issue.

CODE 14. NON-MEDICAID, OTHER EDUCATIONAL AND SOCIAL SERVICES

This code should be used for any activities which are not health-related, such as employment, job training, and social services, as well as non-Medicaid health related.

Examples of activities reported under this code:

- Teaching families about the process of goal setting with individualized family support plans;
- Developing treatment plans associated with individualized family service plans;
- Regular home visits which focus on family/social, educational, and transportation needs;
- Developing a relationship with a family that facilitates the accomplishment of non-medical goals;
- Persistent, positive outreach efforts to build family trust;
- Initial home visit to newly enrolled Healthy Start participants in which client are advised of their rights and given information about how services will be delivered as well as what will be expected of a participant in accomplishing service delivery;

- Teaching parenting skills and healthier child raising;
- Teaching problem solving skills related to non-medical issues that will accomplish program goals.
- Assisting in child care (i.e., baby-sitting);
- Building motivation to address non-medical obstacles to effectively raising children;
- Teaching about non-medical issues that affect the care of children;
- Activities related to the development of and attending ARD meetings, LEAP, court appearances when subpoenaed;
- Facilitating parent support groups;
- Scheduling, arranging, or providing transportation for non-medical reasons;
- Providing translation services for non-medical reasons;
- Teaching problem solving regarding a medical service;
- Building motivation to comply with medical services;
- Teaching about medical care or treatment;

CODE 15. GENERAL ADMINISTRATION

Staff should use this code when engaged in general administrative activities. This code should also be used by staff when on break or on any form of **paid** leave. It should also be used when engaged in general administrative activities. *Do not use Code 15 when taking Compensatory time.*

Examples of activities reported under this code:

- Attending training seminars or workshops;
- Establishing goals and objectives of health-related programs as part of the program's annual or multi-year plan;
- Reviewing program procedures and rules;
- Attending or facilitating general program staff meetings or board meetings;

- Providing general supervision of staff, including supervision of volunteers, and evaluation of employee performance;
- Processing payroll/personnel-related documents;
- Maintaining inventories and ordering supplies;
- Developing budgets and maintaining records;
- Performing administrative or clerical activities related to general building or district functions or operations;
- Reviewing technical literature and research articles.

CODE L. LUNCH

APPENDIX G

Skilled Professional Medical Personnel Questionnaire for Claiming Status

APPENDIX H

Sample Time Study Logs

Excel Worksheets for the Appendix H Sample [Click Here](#)

APPENDIX I

Tips for Time Study Training and Completing a MAC Time Study Log

TIPS FOR TIME STUDY TRAINING

The following tips are offered for agency time study coordinators or other individuals who may be asked to provide time study training for their colleagues or other staff. The information may also serve as a helpful guide for anyone participating in the Medicaid Administration study.

WHO: It is ideal to train staff in clusters (e.g., in a school, train special education teachers, psychologists, speech therapist and principals in separate groups). Because of their common job classifications or responsibilities, it will be easier to train around common tasks. It will also be easier for participants to relate to questions and to feel more comfortable asking position-specific questions.

WHAT: It is important to give an initial overview that describes Medicaid Administrative Claiming and what is being asked of staff.

In general, staff are not being asked to do their jobs any differently. They are being asked to record on a time study log form, for a specified number of consecutive days each quarter, the types of activities they perform. This is done in order to claim reimbursement from the federal Medicaid program for the portion of costs already being spent by the agency or program on health-related administrative activities for Medicaid recipients.

Staff can better put this in perspective if they understand their agency's "role" in Medicaid administration. The time study requires staff to distinguish between activities that assist eligible individuals to access Medicaid services and activities that assist individuals to access services not covered under the Texas State Medicaid Plan. Day care, social services, housing, job training, legal aid, etc. are not Medicaid covered services.

WHEN: Training seems to be the most beneficial if it is provided during the week preceding the time study so that the information is fresh in the participants' minds. Equally as important is having a designated coordinator or "resource person" available to answer questions that arise during a time study. It will improve accuracy if misunderstanding or common errors are identified and addressed early on. Local coordinators can call TDH's MAC coordinator for additional clarification. Also, the response to one person's question may actually benefit all time study participants. Scheduling "refresher courses" after the first time study is required because participating in time studies is not an ongoing activity.

WHERE: The training should be held at a location and time convenient for the most participants to attend. Training is mandatory, not optional.

WHY: Staff want to know why they are being asked to participate in the time study. The more staff feel invested in the process, the more willing they will be to cooperate. Staff frequently want to know if they will have input how the money that is generated through MAC is spent. If there is already a plan, share it. For example, if the agency has desired to hire additional staff with new revenues, let the participants know so they have a tangible goal in sight. Keep staff informed of the process and how their cooperation has contributed to achieve the goal.

HOW: People want to know the basics: how to fill out the daily log forms, how often they have to do it, to whom and when it is turned in, and how the time study functions translate into what they do.

THE BASICS OF TIME STUDY

THE TIME STUDY ACCOUNTS FOR THE TIME AND ACTIVITY OF A GROUP OF PEOPLE. A TIME STUDY IS A FISCAL REPORT, NOT A PROGRAM DOCUMENT.

NO ADDITIONAL DOCUMENTATION IS REQUIRED. PARTICIPANTS DO NOT NEED TO SHOW WITH WHOM OR WHERE THE ACTIVITY WAS PERFORMED.

(However, for audit purposes, it is highly recommended that staff keep back-up documentation such as brief descriptions of what occurred, day planners, etc.)

THE TIME STUDY IS COMPLETED ONCE EACH QUARTER FOR THE NUMBER OF DAYS IT TAKES TO GENERATE A VALID SAMPLE OF 750 WORKER-DAY-LOGS (e.g. if 80 staff in an agency are participating in the time study, the time study period should be 10 working days to ensure there will be a sufficient number of valid WDLs).

IN SMALL AGENCIES (where 750 valid WDLs cannot be achieved in a month or less), AN ACCEPTABLE ALTERNATIVE TO THE 750 WDL RULE IS TO TIME STUDY FOR THE ENTIRE MID MONTH (i.e., 20 working days) OF THE QUARTER. MID MONTH TIME STUDIES SHOULD BE PERFORMED IN FEBRUARY, MAY, AUGUST AND NOVEMBER.

THE TIME STUDY IS ONLY ACCOUNTING FOR STAFF TIME AND ACTIVITY. PARTICIPANTS DO NOT NEED TO BE CONCERNED WITH THE MEDICAID STATUS OF AN INDIVIDUAL BUT THEY DO NEED TO KNOW WHAT ACTIVITIES IMPROVE AN INDIVIDUAL'S ACCESS TO MEDICAID COVERED SERVICES.

COMPLETING THE TIME STUDY LOG

COMPLETE ALL IDENTIFYING INFORMATION (e.g., NAME, JOB, TITLE, LOCATION, etc.) ON EACH LOG FORM.

RECORD 100% OF A PAID WORK DAY, STARTING AT THE TIME WHEN STAFF ARE SCHEDULED TO BEGIN WORK AND ENDING AT THE TIME THEY ARE SCHEDULED TO STOP WORKING ON THAT DAY. THIS INCLUDES ALL BREAKS AND MEALS.

SALARIED EMPLOYEES SHOULD RECORD THE HOURS THEY ARE REGULARLY EXPECTED TO BE ON THE JOB (e.g., 8AM-5PM). IF HOURS ARE DIFFERENT, CODE APPROPRIATELY AND DOCUMENT THE REASON.

RECORD PAID TIME ONLY. UNPAID TIME WORKED AFTER HOURS IS NOT TO BE COUNTED. COMPENSATORY TIME WHEN TAKEN OFF SHOULD NOT BE CODED AND THE REASON SHOULD BE DOCUMENTED.

- FULL TIME, PART TIME OR TEMPORARY EMPLOYEES MAY PARTICIPATE IN THE TIME STUDY
- CONTRACT STAFF MAY PARTICIPATE IN THE TIME STUDY (BUT ARE ONLY ELIGIBLE FOR THE 50% FFP).
- VOLUNTEER STAFF, STUDENT INTERNS OR OTHER UNPAID STAFF DO NOT PARTICIPATE IN THE TIME STUDY.

COMPLETE THE LOG IN FIFTEEN MINUTE INTERVALS FOR INCREASED ACCURACY AND EASE OF RECORDING. HOWEVER, IF A WORKER IS IN THE MIDST OF AN ACTIVITY, HE/SHE IS NOT EXPECTED TO STOP. ENTER THE PROPER CODE FOR THE ACTIVITY WHEN THE ACTIVITY IS FINISHED. RECORD THAT CODE THAT BEST REPRESENTS THE ACTIVITY PERFORMED AND TOOK THE MOST TIME IN THE 15 MINUTE PERIOD. ONLY ONE CODE SHOULD BE ENTERED IN EACH BOX. IF USING A SCANTRON FORM, ONLY ONE BUBBLE SHOULD BE FILLED IN FOR EACH 15 MINUTE PERIOD. ADDITIONALLY, THERE SHOULD BE NO GAPS IN TIME WITHOUT DOCUMENTATION.

IF PERFORMING THE SAME ACTIVITY OVER A PERIOD OF TIME, IT IS ACCEPTABLE TO WRITE THE APPLICABLE CODE IN THE BOX CORRESPONDING TO THE STARTING TIME AND DRAW AN ARROW THROUGH ALL THE BOXES FROM START TO END OF THE ACTIVITY.

UPON COMPLETION OF THE TIME STUDY PERIOD, COUNT THE NUMBER OF TIMES (15 MINUTE UNITS) EACH CODE WAS USED AND ENTER THIS NUMBER IN THE APPROPRIATE SECTION OF THE LOG FORM.

EACH LOG FORM MUST HAVE THE PARTICIPANT'S SIGNATURE IN INK AND DATED NO EARLIER THAN THE LAST DATE ON THE LOG. THE LOG FORM ALSO NEEDS TO BE SIGNED AND DATED IN INK BY THE PARTICIPANT'S IMMEDIATE SUPERVIOR. SUPERVISORS SHOULD REVIEW THE LOGS TO ENSURE ACCURACY, SIGN AND DATE NO LATER THAT ONE WEEK UNLESS THERE ARE EXTENUATING CIRCUMSTANCES WHICH CAN BE JUSTIFIED.

THE LOG REPRESENTS THE PARTICIPANT'S BEST JUDGEMENT AS TO THE KIND OF ACTIVITIES PERFORMED DURING THE DAY. AS SUCH, THERE IS ONLY ONE BEST ANSWER. SUPERVISORS SHOULD NOT CROSS OUT FUNCTIONS MARKED WITH WHICH THEY DO NOT AGREE. RATHER, THEY SHOULD DISCUSS THE WAY THE TIME STUDY LOG WAS FILLED OUT WITH THE PARTICIPANT TO SEE IF THE CODING NEEDS TO BE MORE ACCURATE. ONLY THE PARTICIPANT CAN CORRECT CODES, PROPER CORRECTION PROCEDURES ARE TO BE USED (INITIAL YOUR SIGNATURE, LINE OUT THE ERROR, CORRECT THE DATA, AND INITIAL THE CHANGE). WHITE OUT IS NOT ACCEPTABLE AND THERE SHOULD NOT BE ANY OTHER WRITING OR MARKS ON THE LOG FORM.

USING THE UNIFORM TIME STUDY CODES

EACH TIME STUDY PARTICIPANT SHOULD HAVE A SET OF THE UNIFORM TIME STUDY CODES FOR REFERENCE.

“HEALTH-RELATED” REFERS TO PHYSICAL HEALTH, DENTAL HEALTH, MENTAL HEALTH AND SUBSTANCE ABUSE.

IF MORE THAN ONE ACTIVITY WAS PERFORMED DURING THE 15 MINUTE PERIOD, RECORD THE ONE WHICH SEEMED TO TAKE THE GREATER AMOUNT OF TIME, BASED ON WORKER JUDGEMENT AND UNDERSTANDING OF THE TIME STUDY CODES.

IF AN ACTIVITY SEEMS TO FIT IN MORE THAN ONE TIME STUDY CODE, THINK ABOUT THE PURPOSE FOR WHICH IT WAS PERFORMED OR THE CONTEXT IN WHICH IT OCCURRED (e.g., staff may complete paperwork as part of various functions: as part of eligibility process (Code 1), the case planning function (Code 1 for SPMPs or Code 6 for non-SPMPs), or as part of a direct services which includes case documentation in the billable rate (Code 13)).

SKILLED PROFESSIONAL MEDICAL PERSONNEL (SPMPs) MAY USE ALL 15 CODES AND L. THREE CODES (3, 7, AND 12) ARE ENHANCED, MEANING THAT PROFESSIONAL MEDICAL KNOWLEDGE AND SKILLS ARE REQUIRED TO PERFORM THAT FUNCTION. IF SOMEONE WHO IS NOT QUALIFIED AS AN SPMP CAN PERFORM THE TASK DO NOT USE THESE CODES.

IF THE PERFORMANCE OF AN ADMINISTRATIVE ACTIVITY DOES NOT REQUIRE THE USE OF PROFESSIONAL MEDICAL TRAINING OR SKILLS, THE NON-ENHANCED CODES WOULD BE USED-EVEN BY SPMPs. SPMPs WOULD ALSO USE THE NON-CLAIMABLE CODES (Codes 2, 5, 8, 13, 14, and L) AS APPROPRIATE.

NON-SPMPs MAY ONLY USE THE TWELVE NON-ENHANCED CODES AND L (Codes 1, 2, 4, 5, 6, 8, 9, 10, 11, 13, 14, 15, and L). NON-SPMP MAY USE ALL CODES EXCEPT 3, 7, AND 12.

ALL SERVICES AND RELATED ACTIVITIES COVERED BY MEDICAID ARE RECORDED AS CODE 13.

PAID BREAKS (e.g., coffee breaks) AND PAID VACATION TIME, HOLIDAYS OR SICKS LEAVE ARE RECORDED AS CODE 15.

LUNCH TIME IS RECORDED AS AN “L” ON THE TIME STUDY, UNLESS STAFF ARE ACTUALLY PAID FOR THIS TIME. IF STAFF HAVE A PAID LUNCH, THEY WILL CODE WHATEVER ACTIVITY IS BEING PERFORMED AT THIS TIME AND DOCUMENT THE REASON

APPENDIX J

Record Keeping, Documentation And Audit Checklist

Record Keeping, Documentation and Audits

A. Overview

Medicaid Administrative Claiming (MAC) is not a fee-for-service activity. Consequently, records of individual client contacts need not be kept as they would be maintained in the agency's current record keeping or case file system.

The heart of MAC is the time study. Federal regulations require that records be kept for three years after the last revision to a particular claim. It is recommended that the original time studies be kept for this amount of time. The time studies may be kept in a central office or in a program.

Similarly, the documents that support the construction of an administrative claim need to be kept for three years after the last claim revision as well. These documents include the documentation that supports the percentage of Medicaid recipients, the basis of the cost pools, the identification of SPMPs, their job descriptions and/or duty statements, as well as the job descriptions and/or duty statements of technical and clerical staff providing direct support to SPMPs.

B. Building and Maintaining an Audit File

Each agency or program must establish an audit file for each time study period. A checklist has been developed to assist staff in this task. It is included with this appendix (attached).

Gathering the necessary documentation needed in the event of an audit is much simpler as the time study is being done and the claim is being prepared. Good documentation is also essential when staff who were originally responsible for the time study or the claim leave, and when new staff must take on this responsibility.

AUDIT FILE CHECKLIST

To be used by agency coordinators for Medicaid Administrative Claiming

- A. The following time study materials are in the audit file for the federal fiscal quarter ending _____.
- ___ 1. Signed original time study logs that have also been signed by the worker's supervisor. (If the supervisor signs later than 7 days, please provide explanation.)
 - ___ 2. Copy of automated summary of time study forms report generated from the original time study log (if applicable).
 - ___ 3. A written statement describing how the time study days were selected.
 - ___ 4. If used, copies of worker's time cards for the time study period.
 - ___ 5. Copies of computations used to calculate the percentage of time claimable to Medicaid administration.
 - ___ 6. Copies of any worksheets or spreadsheets used in developing the claim. (See invoice checklist for more details.)
 - ___ 7. A copy of the methodology used to establish the agency's indirect cost rate.
 - ___ 8. A listing of other costs.
 - ___ 9. A detailed listing of all revenues offset from the claim, by source and cost pool.
 - ___ 10. Copy of methodology used to reconcile claims to the facility general ledger.
 - ___ 11. A written statement describing how the Medicaid percentage was determined for the federal fiscal quarter ending _____.
 - ___ 12. Signed copies of the approved annual implementation plan in effect for this quarter.
 - ___ 13. Copies of all training materials given to staff, dated for the quarter they were used.

- ___ 14. A list of personnel by name, employee identification number, physical office address, and SPMP status who participated in this study.
 - ___ 15. A completed "Quarterly Invoice Checklist".
 - ___ 16. A completed MAC claim.
 - ___ 17. A copy of the MAC coordinator's job description.
 - ___ 18. A copy of the MAC coordinator's Quarterly Status Reports to CEO.
 - ___ 19. Any MAC Review Reports for this specific quarter.
 - ___ 20. Affiliate Agency Annual Report. (Fourth quarter agency file only.)
 - ___ 21. Annual self-evaluations report of required project performance review. (Fourth quarter agency file only.)
- B. The following materials are on file for each employee who is being claimed as a Skilled Professional Medical Personnel.
- ___ 1. The class specifications or job description.
 - ___ 2. A duty statement, if the job description is too generic to describe the individual's actual job responsibilities.
 - ___ 3. A copy of the SPMP survey.
 - ___ 4. A copy of any appropriate license or certificate and documentation of any educational fieldwork that is medically related. This does not include on the job training that occurred in a medically related environment.
 - ___ 5. A table of organization showing the relationship of SPMPs to their direct supporting clerical staff, if the costs of these clerical staff are being claimed at 75%.
- C. The following materials have been retained by each employee participating in the time study:
- ___ 1. Back up documentation (notes, day planners, etc.) to support the code entries in the time study log.

APPENDIX K

Quarterly Summary Invoice and Quarterly Invoice Checklist

Medicaid Administrative Claiming Submission Instructions

Please submit Quarterly Summary Invoice (QSI) on agency letterhead. Include a copy of the electronic invoice and electronic worksheets used to complete the claim.

Submit claims to:

Medicaid Administrative Claiming
Mail Code H360
Health & Human Services Commission
Rate Analysis Department
11209 Metric Blvd., Bldg. H
Austin, Texas 78758

Excel Worksheets for Appendix K [Click here](#)

APPENDIX L

Claiming Reimbursement

CLAIMING REIMBURSEMENT

I. Introduction

Time study results, expenditure and revenue data, and the Medicaid percentage can all be entered in a spreadsheet which will produce the final two pages of the Medicaid Administrative Claim form:

Page 1 Quarterly Summary Invoice
Page 2 Detailed Quarterly Invoice

- A. Time is tracked during a time study based on the approved codes for the Texas Medicaid Administrative Claiming Project. These time studies are the basis for allocating individual Salaries and Fringe Benefits. These allocations, in turn are utilized to allocate the Travel and Training, Clerical Support and Operating costs for the personnel included in the time study. All costs attributable to personnel who do not time study are entered in a section for Unstudied Staff. Therefore, all direct costs of the entity are accounted for in either the studied or unstudied sections. Indirect general administrative costs are entered in a separate section and allocated to the time studied and unstudied sections based on the percentage of total Salary/Benefits and Travel/Training of that section.
- B. Revenues are categorized as Recognized or Unrecognized and entered accordingly to follow the activity or the expense for which they were reimbursed or earned.
- C. For purposes of the Agency Invoice, expenditures and revenues are placed in one of four Cost Pools.

Cost Pool #1 – This is where agency costs, revenues, and time relating to the activities performed by SPMP personnel is compiled. This includes Code 3 (which is not discounted by the Medicaid percentage) and Codes 7 and 12 (which are discounted by the Medicaid percentage). Also included in this cost pool are the costs related to any staff providing “direct clerical support” to SPMPs. “Direct clerical support” staff may or may not have participated in the time study.

Cost Pool #2 – This is where costs, revenues and time relating to activities performed by SPMPs and Non-SPMPs using Codes 1, 4, and 10 (which are not discounted by the Medicaid percentage) and 6,9, and 11 (which are discounted by the Medicaid percentage).

Cost Pool #3 – For time study participants there are those costs, revenues, and time derived from activities by both SPMPs and Non-SPMPs which are non-Medicaid related (Codes 2, 5, and 8) or those which are direct service activities (Codes 13, and 14), 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 agency as a whole are also included. Additionally, this cost pool would include staff whose staff costs are predominately

supported by a federal grant. Staff who are paid with federal funds do not participate in the time study.

Cost Pool #4 – This pool contains costs, revenues, and time for General Administrative services (code 15), staff who provide General Administration to the whole agency and were not time studied, as well as costs which cannot be allocated in more accurate fashion. This cost pool included any over head costs such as county or agency indirect costs and other “Operating Costs” that have not been entered in Cost Pools 1, 2, and 3.

All entries in Cost Pool #4 will be distributed across Cost Pools #1, #2, and #3 in proportion to the Salary and Benefits of staff or contractors. This applies throughout the spreadsheet; even revenues placed into Cost Pool #4 will be distributed to Cost Pools #1, #2, and #3 based on staff salaries and benefits.

Whenever data is directly entered in Cost Pool #1, #2, #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 audit file, and must be based on empirical demonstrable information.

For example: Salaries and benefits assigned to SPMPs by entry into Cost Pool #1 should be evidenced by payroll documentation showing the expenditure of such salaries and benefits on individuals who qualify as SPMPs. If travel or training cost data is entered directly into Cost Pool #1, evidence linking such training or travel to specific SPMP staff must be maintained.

All costs and revenues of the agency during the claim quarter must appear in one of the four columns labeled “Cost Pool #1, #2, #3, or #4.” It is critical that the user understand the significance of these cost pools throughout the claim. If a cost or revenue amount is known to be associated exclusively with the particular staff identified in one of the four cost pools as described above, that cost or revenue should be entered into that cost pool. If, however, the cost or revenue is not specifically associated with one cost pool but rather applies to more than one cost pool, it should be entered into Cost Pool #4 to be redistributed by the spreadsheet.

II Preparing the Claim

A. Entering Identifying Information

1. Contract #;
2. Service Period (for which the claim is filed);
3. Program (name);
4. Invoice # (per state instructions);
5. Enter the number 1 if the claiming agency is a Private Contractor of a government agency. Enter the number 2 if the claiming agency is itself a government agency (including school districts). Only government agencies, not private contractors, can claim 75% FFP for enhanced services by a Skilled Professional Medical Personnel.

B. Entering the Percent of Medicaid Recipients

1. Enter the percent of Medicaid recipients served by your program during the claim quarter. This amount must be computed and documented outside this claim form.

C. Entering Staff Costs

1. Enter all information from SPMP staff time studies in the SPMP section;
2. Enter all information from non-SPMP staff time studies in the non-SPMP section.
3. Enter Salaries and Fringe Benefits (The coding of the individual's time study logs drives the allocation of salary and benefit expenses. Costs which are drawn to Code 15 will be reallocated to all other codes based on the percentage of time in codes 1-14.);
4. Enter Clerical Salary and Benefits (The salary and benefits costs for those administrative support personnel who directly support SPMPs should be entered in the SPMP section and the salary and benefit costs for those administrative support personnel who support time studied personnel (SPMP and/or Non-SPMP) and who do not qualify as "SPMP direct support" are entered in the Non-SPMP section.);
5. Enter Travel and Training Costs (If such costs cannot be identified to groups of employees represented by the four cost pools, enter the entire amount of such travel and training costs for all employees into Cost Pool #4. This will cause such costs to be distributed proportionate to Salaries and Benefits.);
6. Entering Operating Costs (Enter those costs associated with individuals who can be identified with specific Cost Pools, or enter non-specified operating costs into Cost Pool #4.);
7. Enter all costs mentioned above for all staff who did not time study in the unstudied staff section.

Salaries should be entered as precisely as possible, based on agency payroll accounting. Benefits should be entered according to the standard conventions of your accounting system. If benefits are normally computed as a percentage of Salaries, use this method. If your agency uses more exact accounting for Benefits associated with individual employees, use such an approach. For each section, SPMP and Non-SPMP, the costs for all participants will be totaled to provide a basis for calculating an overall percentage of time/cost for each activity code. These percentages are then used to allocate the remaining costs for the time studied personnel (.i.e. Travel and Training, Clerical and Operating).

D. Entering Revenues

There are two types of revenue sources for the purpose of the Medicaid Administrative Claim.

1. “Unrecognized” revenues are not seen by the HCFA as “revenue” which should be used to offset costs, but rather as the matching funds necessary to claim FFP. These revenues have no effect on the calculation of the claim and are included for purposes of audit and full reporting. Enter all such revenues under Cost Pool #4 unless you have documentation clearly linking the revenues exclusively to Cost Pool #1, #2 or #3.
 - a. Medicaid Administrative Reimbursement is the reimbursement received for this claim process;
 - b. Other State Funds are General Revenue and grants from state funds;
 - c. Local Government funds from city, county, school district, and other local taxing authorities;
 - d. Donations to Public Agencies are legislatively mandated donations received;
 - e. Federal Emergency Assistance Reimbursement (Title IV-A)/FEMA funds;
 - f. Federal Title IV-E reimbursement (child Welfare Program funds).

2. “Recognized” revenues are income sources that must be adjusted (offset) against the costs of the agency. They are collected in either Cost Pool #3 or Cost Pool #4, based on an analysis of the revenue source. The general rule for determining placement is that a revenue must follow the activity by which it is earned or the expense for which it is a reimbursement.
 - a. Medicaid Fees + Match includes all Title XIX reimbursements and, where required, the State Matching Funds. All Medicaid funds are placed in Cost Pool #3 as they are earned by direct services activities.
 - b. Federal Grants + Match 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. Other than Medicaid Administrative Claiming reimbursements, federal grants will always be reported as recognized revenue and they will always have CFDA #. Each grant has its own match and other contractual requirements; therefore, inputting and adding the match must be done separately for each grant. Placing these funds into the correct Cost Pool requires determining what expenditures the grant covers. If the expenditures covered by the grant are collected in Cost Pool #3 (i.e. HUD grants for residential costs, grants used to purchase drugs, homeless grants whose staff do not time study, etc), the then grant should be placed there as well. Grant revenues which are recognized in time-studied units and are broad in nature of what expenditures they will cover will have to be placed in Cost Pool #4;

- c. Medicare is related to a direct service and is placed in Cost Pool #3;
- d. Insurance receipts are generally entered in cost Pool #3. An exception might be for receipts for causality insurance (fire, auto, etc.) which exceeded replacement/repair cost. These would be entered in Cost Pool #4;
- e. Fees paid by or on behalf of clients for direct service would be placed in Cost Pool #3;
- f. Donations to Contractor are only used by private entities;
- g. Other Revenues is where all revenue sources not previously mentioned are placed and will go into Cost Pool #3 or Cost Pool #4. Revenues for vocational production; from clients, families or other sources covering residential costs; and grants from private foundations go in CP#3. Miscellaneous revenues not readily identifiable, onetime or unusual revenues are placed on CP#4, along with Interest Income, Other Business Income, Fundraising Income not specifically designated for a specific CP#3 activity, and any other purely "Administrative" income.

Medicaid fees and federal revenues to be included as recognized Revenues include the match associated with such grants. Thus, the entire amount of Medicaid fee-for-services funding received from the state (which includes both the state funds and the federal match) are to be included. Medicaid fee-for-service funding is recognized revenue and Medicaid Administrative Claiming reimbursement is unrecognized revenue. Certain federal grants, such as research or special-purpose grants, require non-federal match in some ratio. That matching amount must be included, with the federal grant amount. Since that non-federal money has already been used to "draw down" federal match, it cannot be used again to draw Medicaid administrative funding.

Revenues assigned to Cost Pool #3 will eventually be offset costs which will not be claimed as Medicaid administrative costs. Therefore, it is best to identify to Cost Pool #3 any revenues which can be documented as associated exclusively with the Cost Pool. Check to see that the total amount of all recognized revenues in Cost Pool #3 is less than the total cost of direct services shown in CP#3. If CP#3 revenues are higher than CP#3 costs, the difference represents net service revenue which must be added to total unrecognized revenues Cost Pools #1 and #2 proportionately. The reason for this is that an agency making a "profit" (net revenue) on its direct services is required to offset its administrative costs with such profit before claiming federal administrative assistance.

III. Procedures for Submitting Adjustments or Corrections

- A.** Recompute the invoice amount using the invoice/revenue form applicable to the appropriate fiscal year.
- B.** Indicate that this is a REVISED invoice by inserting the word “REVISED” before the invoice number.
- C.** The invoice number must be consistent with the number used on the original invoice.
- D.** The invoice must be submitted on appropriate letterhead.
- E.** The certification statement must be on each Quarterly Summary Invoice, and must be signed and dated by the appropriate agency official.
- F.** Submit the original invoice and identify it as the original.

CLAIMING REIMBURSEMENT ON RETROACTIVE CLAIMS

In order to be eligible to claim retroactive claims for Medicaid Administrative Claiming, the program must meet several requirements. Documentation which verifies that the program has met these requirements must be contained in the audit file and in the information submitted to TDH for payment.

- A.** Evidence that the program time studied for the periods that will be recomputed (e.g., copies of the original MAC invoice be attached);
- B.** Copies of the invoices for the two “new” quarters which will be used to compute the averages;
- C.** Worksheets showing the computations of the average percentages and the recomputed invoices. The revised invoice that the program prepares will meet this criteria. With the invoice, include details on any corrections/changes made to the cost pool amounts as originally reported. For example, if the earlier time studies included types of staff who no longer time study, the program must document how the cost pool information was modified to handle this change. Or, if types of staff were added to the current time study who were not included in the previous time study, the program must document how the current time study data was modified to exclude those time study hits from the calculations. This adjustment applies only to the inclusion or removal of a class of staff, not for general expansion or reduction of a type of staff (e.g. increase or decrease in the number of caseworkers);
- D.** Written assurance from each program that the “recomputed” periods and the “new” time study periods are similar enough to warrant the use of the “new” period as a proxy for the “recomputed” period (e.g., no major organizational changes, activities performed, etc.). This written assurance must be from someone in the program authorized to make such a statement;
- E.** Documentation showing when the training on the “revised” codes was provided to the time stud participants (e.g., sign-in sheets, agendas, training materials, etc.).

APPENDIX M

Clarification of Uses for MAC Reimbursements

CLARIFICATION OF USES FOR MAC REIMBURSEMENT

According to the contractual agreement between agencies, reimbursed funds generated from Medicaid Administrative Claiming activities may only be used for health related services for clients. The contract also specifies that an annual cost report is required that shows how MAC funds were spent. The following is a listing of general allowable and unallowable expenditures of MAC funds.

Generable Allowable Expenditures:

Cost associated with the implementation of the MAC project in the facility such as:

- Computer/office equipment dedicated to the MAC project;
- Salary/benefits/travel expenses for MAC administrative staff.

Costs associated with the addition of direct service staff to clients such as:

- Salary/benefits/travel expenses for direct service staff such as clinical nurses, social workers, case managers, counselors, etc.
- Computer/office equipment of direct service staff used for administration or implementation of direct services.

Expansion of health services to clients such as:

- Providing health-related assessments;
- Outreach activities, including print costs;
- Providing transportation to health services;
- Purchasing vehicles to transport clients to health services;
- Payment to drivers for transportation of clients to facilities for health services;
- Purchasing of medical equipment;
- Expanding arrays of health services offered to clients;
- Cost of clinic operations such as first aid and minor injury care, dispensing limited prescriptions, diagnosis and treatment of simple illnesses, basic laboratory services;
- Pre-natal instruction;
- Health instructional materials;
- Opening new health-related sites.

Unacceptable Expenditures Include:

- Fixed assets (unrelated to health services);
- General administrative/operating costs unrelated to MAC;
- Computer/accounting services unrelated to MAC;
- Salary/benefits/travel expenses for administrative staff unrelated to MAC;
- ISDs – TAAS remediation materials, instructional services, extra-curricular activities.

APPENDIX N

Affiliate Agency Annual Report

Medicaid Administrative Claiming (MAC) Affiliate Agency Annual Report

Purpose:

The report data will be used for coordinating and planning activities for the Medicaid Administrative Claiming (MAC) Project. This annual report is required from each contracted agency for any Federal Fiscal year (October 1 – September 30) that a claim was submitted by the agency.

Annual Report Due:

Complete and return the annual report on official agency letterhead to the TDH State Agency MAC Coordinator **no later than the end of December** following any Federal Fiscal year that a claim was submitted by the agency.

Instructions for Completing the Annual Report:

- Item 1. Self-explanatory
- Item 2. List the top five priorities for which MAC revenues were used at your agency this Federal Fiscal year. (Examples of priorities include increasing Medicaid eligibility activities or personnel, specific outreach campaigns, increased Medicaid provider recruiting, etc.).
- Item 3. List the top five anticipated priorities for use of MAC revenues in the next Federal Fiscal year (increase transportation resources – buy three new 10 passenger vans, hire one full-time Medicaid eligibility worker, etc.).
- Item 4. List the name, title, work phone, and fax number of the individual who completed your agency's administrative claims.
- Item 5. Federal Fiscal Year MAC Financial Statement – Summarize revenues received from administrative claims and specifically list how your agency has reinvested those revenues to expand Medicaid health-related services. ***Note:** You must briefly describe those expenditures on the lines under each expense category (salary for MAC Coordinator, benefits for MAC Coordinator, hired one Medicaid eligibility worker, bought 10 Ford vans, etc.). Provide your best estimate of how your expenditures breakdown into one of the two columns listed: Administrative/Claims processing (costs of administering the project, such as salary of the MAC Coordinator) and Medicaid Health Related Support Activities (actual support activities purchased, such as 10 passenger vans). Refer to the explanation of the columns on page N-4.
- Item 6. Certify that the financial statement is correct with the signature and date of the Chief Executive Officer or Chief Financial Officer.
- Item 7. Technical Assistance
Deborah Lewis, State Agency MAC Coordinator, TDH, (512)458-7781.

**AFFILIATE AGENCY MEDICAID ADMINISTRATIVE CLAIMING (MAC)
ANNUAL REPORT:
FEDERAL FISCAL YEAR _____**

1. Agency Name: _____

Address: _____

Phone : (_____) _____ Fax : (_____) _____

Name of CEO: _____

Name of MAC Coordinator: _____

2. Top five priorities for which the MAC revenues were used in this Federal Fiscal year.

A. _____

B. _____

C. _____

D. _____

E. _____

3. Top five anticipated priorities for use of MAC revenues in the next Federal Fiscal year.

A. _____

B. _____

C. _____

D. _____

E. _____

4. Who completes the Medicaid Administrative Claim?

Name/Title: _____

Phone : (_____) _____ FAX : (_____) _____

5. Revenue Statement (October 1 – September 30), Federal Fiscal Year: _____

AGENCY MAC REVENUES

Amount

Total Revenue received during Federal Fiscal Year \$ _____

Expenditures

(See Legend on Pg. 3)

	Administration/ Claims Processing	Medicaid Health- Related Support Activities	Total
Non-Classified Salaries	\$	\$	\$
Classified Salaries	\$	\$	\$
Employee Benefits	\$	\$	\$
Books and Supplies	\$	\$	\$
Other Operating Expenses	\$	\$	\$
Other Expenditures	\$	\$	\$

Total Expenditure
 \$ _____ \$ _____ \$ _____

Ending Balance as of September 30 (Revenues less expenditures) \$ _____

Amount of any unexpended MAC revenues \$ _____

Description of future use of unexpended revenues:

6. I certify that the financial information reported is a true and correct accounting of the revenues and expenditures of the Agency's participation in Medicaid Administrative Claiming.

Signature of Chief Executive Officer (CEO)
or Chief Financial Officer (CFO)

Date

Legend:

Administration/Claims Processing:

Expenditures for administering and processing claims includes record keeping transferring records onto claim forms, mailing, sending in claims, processing checks, etc.

Medicaid Health Related Support Activities

Expenditures in support of Medicaid health related services for individuals.

EXAMPLE ONLY

**AFFILIATE AGENCY MEDICAID ADMINISTRATIVE CLAIMING (MAC)
ANNUAL REPORT:
FEDERAL FISCAL YEAR 1996**

1. Agency Name: ABC County Health Department
Address: P.O. Box 123
Anywhere, TX 12345
Phone: (123) 456-7898 Fax: (123) 456-7899
Name of CEO: Iman Charge, CEO
Name of MAC Coordinator: Elizabeth Taylor
2. Top five priorities for which the MAC revenues were used in this Federal Fiscal year.
A. Increase Medically Related Transportation
B. Increase Rural Physician Services
C. Increase Medicaid Eligibility Worker Activities
D. Increase Rural Registered Nurse Services
E. Develop Timelog Data Entry System for MAC
3. Top five anticipated priorities for use of MAC revenues in the next Federal Fiscal year.
A. Increase Medically Related Transportation
B. Increase the Number of Medicaid Service Providers
C. Increase Medicaid Outreach Campaigns
D. Increase Service Coordination with Regional Agencies
E. Develop Electronic Data Entry for Center Service Logs
4. Who completes the Medicaid Administrative Claim?
Name/Title: I.B Smart, Chief Financial Officer

Phone : (123) 567-8999 FAX : (123) 678-9876
5. Revenue Statement (October 1 – September 30), Federal Fiscal Year: 1996

AGENCY MAC REVENUES

Amount

EXAMPLE ONLY

I certify that the financial information reported is a true and correct accounting of the revenues and expenditures of the Agency's participation in Medicaid Administrative Claiming.

(SEND IN DOCUMENT WITH ORIGINAL SIGNATURE AND DATE)

Signature of Chief Executive Officer (CEO)
or Chief Financial Officer (CFO)

Date

Legend:

Administration/Claims Processing:

Expenditures for administering and processing claims includes record keeping transferring records onto claim forms, mailing, sending in claims, processing checks, etc.

Medicaid Health Related Support Activities

Expenditures in support of Medicaid health related services for individuals.