

MEDICAID ADMINISTRATIVE CLAIMING PARTICIPANT GUIDE



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

Effective October 1, 2010

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I. Introduction

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

The Center for Medicaid/Medicare Services (CMS) has identified a series of activities that must be claimed administratively through Medicaid Administrative Claiming (MAC) among these are outreach, utilization review, eligibility determination and activities that determine a consumer's need for care. Federal language has made it clear that the range of activities allowable under MAC is not limited to those specifically identified by CMS in the Texas State Medicaid Plan.

As the Medicaid authority for Texas, the Texas Health and Human Services Commission (HHSC) has coordinated with the Texas Department of Assistive and Rehabilitative Services (DARS), Texas Department of State Health Services (DSHS), Texas Department of Aging and Disability Services (DADS) and the Texas Education Agency (TEA), contracted with public entities to assist HHSC in administering the Texas State Medicaid Plan in the most effective manner possible. HHSC establishes all MAC requirements and has contracted with these public entities to implement the MAC program.

The common interest of HHSC and the public entities 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.

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

II. Medicaid Administrative Claiming Overview

MAC is a reimbursement methodology utilized to draw down federal matching funds (also known as Federal Financial Participation [FFP]) for Medicaid administrative activities, i.e., Medicaid eligibility, outreach and informing, referral, coordination and monitoring, Medicaid translation and transportation and Medicaid provider relations. The reimbursable administrative activities are restricted to those covered by the Texas State Medicaid Plan. The FFP rate is 50% with an enhanced FFP rate of 75% available for some services offered by skilled professional medical personnel (SPMP) who meet the criteria as defined by CMS and for Children's Health Insurance Program (CHIP) Reauthorization Act (CHIPRA) Services. Refer to the appendices for details on eligible Skilled Professional Medical Personnel (SPMP) classifications.

A. Participation Requirements

To participate in MAC, public entities must first enter into a contract with HHSC. The agreement between the public entities and HHSC must be in effect the first day of the quarter in which the initial time study is initiated. Contractually, public entities must agree to utilize the time study methodology selected by HHSC. A time study is a tool which is an accepted method of objectively allocating staff time to the various activities that are measured. The State of Texas utilizes a Random Moment Time Study (RMTS) methodology. RMTS is a federally approved, statistical sampling technique and is recognized as an accepted alternative to 100 percent time reporting.

The agreement between the department and the public entity includes a description of general terms, responsibilities, Medicaid administration, fiscal provisions, and amendments. Below is a list of the required participation documents:

- Intergovernmental Cooperation Agreement
- Business Associate Agreement
- Texas (Payee) Identification Number Application
- Vendor Direct Deposit Form
- Vendor Information Form

Public entities participating in MAC may also enter into sub-agreements with their own contractors for the performance of reimbursable MAC activities. Refer to each public entity's section for participation requirements.

B. Public Entity Roles and Responsibilities

Each public entity must designate an individual as an RMTS Coordinator/Contact and a MAC Financial Coordinator/Contact. These individuals within the public entity will provide oversight for the implementation and administration of MAC and ensure that policy decisions are implemented appropriately. The core responsibilities listed below have been developed for the public entity's RMTS and MAC Coordinators and must be specifically identified as part of the personnel's job description.

1. RMTS Coordinator/Contact

Functions

The RMTS Coordinator/Contact will attend mandated/required training provided by HHSC or its designee, understand the purpose of the RMTS, understand the importance of updating and/or certifying the participant list (PL), and ensure that the updates and certifications are completed by

the scheduled due dates. The Coordinator will ensure that all eligible participants are added to the HHSC State of Texas Automated Information Reporting System (STAIRS) at the beginning of each federal fiscal quarter, add/delete program contacts as appropriate to the contact list and provide required training to selected time study participants and ensure their availability to answer questions from sampled staff.

Training

The RMTS Coordinator/Contact will ensure that all applicable training requirements are met by all coordinators/contacts with primary and secondary roles and will ensure compliance with HHSC policy directives.

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

Initial versus refresher training

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

Oversight and Monitoring

The RMTS Coordinator/Contact will provide oversight of the RMTS and review the master participant list in STAIRS to ensure its accuracy prior to the beginning of each RMTS period. Necessary updates will be made to the participant list on STAIRS by the date the participant list closes for each quarter. Throughout the quarter, the entity will follow-up with staff members that have not completed their sampled moment within the allowed response period (7 calendar days from the sampled moment). Follow up activities may include a phone call, email or live discussion and must be documented. Questions and/or concerns raised by RMTS sampled staff will be answered promptly. Time study participants will be instructed to first go to their supervisors who will then contact the RMTS Coordinator/Contact regarding questions on which they need assistance and provide the information back to staff. In the event that a supervisor is not available, the RMTS Coordinator/Contact must be available for direct contact by time study participant staff. The RMTS Coordinator/Contact will ensure that the 85% participation/response requirement is met each quarter and will act as backup to the MAC Financial Coordinator/Contact when necessary. Questions regarding issues with the STAIRS system will be directed to the State's vendor for software support by the RMTS Coordinator/Contact or their assistant.

Documentation and Record Keeping

Supporting documentation of all training conducted will be kept in the public entity's quarterly supporting documentation file (audit file). Documentation for all follow-up activities, i.e., phone

calls, email or live discussion will be kept in the supporting documentation file for the quarter they are conducted. Federal regulations (see 42 CFR 433.32) require that records be kept for a minimum of three years after reimbursement of a claim or after the last revision of a particular claim. The records will be made available upon request from state and federal entities.

2. MAC Financial Coordinator/Contact

Functions

The MAC Financial Coordinator/Contact's function is to attend mandated/required training provided by HHSC or its designee, understand the purpose of the RMTS and the PL and their importance in the calculation of the MAC claim. The STAIRS system will be utilized by the public entity for calculation of the MAC claim. The MAC Financial Coordinator/Contact will ensure that the financial data included in the calculation of the claim is based on actual expenditures incurred during the quarter for which a claim will be submitted. Only direct costs and indirect costs as defined in OMB A-87 and approved by CMS will be entered into the claim. Expenditures included in the MAC claim and funded with federal funds will be offset or reduced from the claim prior to the determination of the federal share reimbursable for each claim. Once the claim is calculated, the MAC Financial Coordinator/Contact will ensure that the information entered into the STAIRS system is accurate by verifying and printing or electronically signing the Quarterly Summary Invoice (QSI) generated by/through the system. The Chief Financial Officer (CFO), Chief Executive Officer (CEO), Executive Director (ED), or other individual designated as the financial contact by the public entity will be required to certify the accuracy of the submitted claim and the availability of matching funds necessary. The certification statement will be included as part of the invoice and will meet the requirements of 42 CFR 433.51. MAC claims will be submitted on a quarterly basis via STAIRS within the required deadlines.

Training

The MAC Financial Coordinator/Contact will ensure that all applicable training requirements are met by all coordinators/contact with primary and secondary roles and will ensure compliance with HHSC policy directives.

Oversight/Monitoring

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

Documentation and Record Keeping

The MAC Financial Coordinator/Contact will ensure that all supporting documentation that appropriately identifies the certified funds used for MAC claiming is maintained. The documentation will identify all sources of funds used for certification and must ensure that said funds have not been used to match other federal funds. Supporting documentation will be kept in a quarterly supporting documentation file (audit file). The entity will provide a list of sources of funds used to complete a MAC claim upon request by HHSC. The MAC Financial Coordinator/Contact will coordinate with the RMTS Coordinator/Contact to ensure that the audit file contains all required documentation as specified in this guide and that the file will be maintained at the public entity's location. Federal regulations (see 42 CFR 433.32) require that records be kept for a minimum of three years after reimbursement of a claim or after the last

revision of a particular claim. The records will be made available upon request from state and federal entities.

3. State and Federal Audits

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

4. Training

RMTS Training

Annual training is mandatory for all RMTS Contacts. Training sessions are conducted by the HHSC.

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

1. Training materials

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

2. Training types

- **RMTS Contacts**

HHSC, in conjunction with the State's Vendor, will provide initial and refresher training for the RMTS Contacts. Training will include an overview of the RMTS process, software system and information on how to access and input information into the STAIRS system. It is essential for the RMTS Contacts to understand the purpose of the RMTS, the appropriate documentation and completion of the RMTS, the timeframes and deadlines for participation, and the consequences of non-compliance.

RMTS Contact initial and refresher training must be interactive and therefore must be conducted via face-to-face or webinar.

- **Sampled Staff Training**

RMTS Coordinators/Contacts who have completed the annual mandatory training requirement are responsible for providing initial and refresher training to sampled staff. Sampled staff training will focus on program requirements and the proper documentation

and completion of the RMTS sampled moment. It is essential for sampled staff to understand the purpose of the RMTS, the appropriate documentation and completion of the RMTS moment, the timeframes and deadlines for completion and return of the sampled moment, and the consequences of non-completion of the sampled moment.

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

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

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

MAC Financial Training

In addition to the RMTS training, annual training is also mandatory for the MAC Financial Coordinator/Contacts. Training sessions are conducted by HHSC. The MAC Financial Coordinator/Contact will be granted access to the web-based system, upon meeting the MAC training requirements. Until such requirements are met, the MAC Financial Coordinator/Contact will be granted view only access to STAIRS.

HHSC will provide initial and refresher training for the MAC Financial Coordinators/Contacts. Training will include an overview of the MAC process, STAIRS system and information on how to access and input information into the web-based system. HHSC will make accessible, via the HHSC website, MAC financial training materials used for both initial and refresher training.

D. Elements of a Claim

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

1. Allowable Medicaid Administrative Time

Time Study - To identify allowable Medicaid administrative costs within a given program, time studies will be conducted of staff persons that spend a portion of their time performing administrative activities.

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

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. This allows public entities to claim Medicaid reimbursement for administrative activities performed/provided to Medicaid clients. The time study results are utilized in calculating the administrative cost eligible for Medicaid reimbursement through the submission of a claim by public entities. The data is based on objective, empirical data, which reflects how staff time is distributed across the range of activities. A time study should be a reasonable representation of staff activity during the specified time study period.

Time Study Activities/Codes - The time study activity codes assist in the determination of time and associated costs that are related to and reimbursable under the Medicaid program. The time study codes have been designed to reflect all of the activities performed by time study participants per public entity. This assignment of the codes to time study activity will be determined by centralized coders contracted by the State.

- Outreach - Non-Medicaid
- Outreach - Medicaid
- Eligibility - Facilitating Non-Medicaid
- Eligibility - Facilitating Medicaid
- Other Non-Medicaid/Educational & Social Services
- Direct Medical Services
- Transportation Non-Medicaid
- Transportation Medicaid
- Translation Non-Medicaid
- Translation Medicaid
- Program Planning, Development and Interagency Coordination Non-Medical
- Program Planning, Development and Interagency Coordination Medical Program
- Planning, Development and Interagency Coordination Medical (SPMP Only)
- Non-Medical/Non-Medicaid related Training
- Medical/Medicaid related Training
- Referral, Coordination, and Monitoring Non-Medicaid Services
- Referral, Coordination, and Monitoring Medicaid Services
- Referral, Coordination, and Monitoring Medicaid Services (SPMP Only)
- General Administration
- Not Paid/Not Worked
- Non-Medical/Medicaid Provider Relations
- Medicaid Provider Relations

2. Cost Pool Construction

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

Time Study Participant Staff (Cost Pool 1 - Enhanced) - Costs, revenues, and time relating to the activities performed by a Skilled Professional Medical Personnel (SPMP) is compiled and included in Cost Pool 1.

Additionally, the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 (CHIPRA) contains guidance allowing increased administrative match for administrative expenditures for translation or interpretation services connected with the "enrollment of, retention of, or use of services" under Medicaid and CHIP. For MAC, HHSC will claim the increased match of 75 percent for translation and interpretation.

Time Study Participant Staff (Cost Pool 2 - Non-Enhanced) - Costs, revenues and time relating to activities performed by SPMPs and Non-SPMPs as well as the costs, revenues and time relating to activities performed by contracted staff for services that do not require an SPMP's specific professional skills and knowledge, education and training to perform certain job functions will be allocated to Cost Pool 2.

Direct Support Staff Non-Time Studied (Cost Pools 1 and 2) – Costs and revenues related to direct support staff who did not participate in the quarterly time study will be allocated to Cost Pools 1 and 2 based on salary allocation percentages from staff participating in the time study.

Unstudied Staff (Cost Pool 3) - Costs, revenues, and time derived from activities by both SPMPs and Non-SPMPs which are non-Medicaid related or those which are direct service activities, neither of which are claimable as administrative activities. Staff who were not time studied and who provide services that are not medically related and do not provide general administrative services for the whole public entity are also included. Additionally, this cost pool would include staff whose staff costs are predominately supported by a federal grant.

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

3. Medicaid Eligibility Percentage

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

There are various methods for determining the Medicaid Eligibility Percentage. Deciding which Medicaid Eligibility 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 population. For MAC purposes, the calculation for the MER shall be based on an unduplicated client count.

The Medicaid Eligibility Percentage is a fraction. The numerator 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. In the event that this may not be 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 HHSC or its designee has determined him/her to be eligible to receive medical assistance.

Tracking Medicaid Eligibility as Part of the Intake Process

Using this method, the public entity 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. The Medicaid Eligibility Percentage of the public entity is determined by dividing the total unduplicated clients served for the quarter who are Medicaid eligible (numerator) by the total unduplicated clients served for the quarter (denominator).

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

The calculation method used by public entities will be discussed in each entities section of this guide.

4. Federal Financial Participation Rate

MAC is a reimbursement methodology to draw down federal matching funds (also known as Federal Financial Participation [FFP]) for Medicaid outreach and administrative activities prior to participation in health related medical services. The medical services available within each category are restricted to services covered by the Texas State Medicaid Plan. The FFP rate is 50% with an enhanced FFP rate of 75% available for some services offered by Skilled Professional Medical Personnel (SPMP). Additionally, Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 (CHIPRA) contains guidance that allows states to claim the enhanced rate of 75% for administrative expenditures for translation or interpretation services connected with the "enrollment of retention of, or use of services" under Medicaid and CHIP.

The results of the time study are multiplied by the administrative costs at either 50% or 75% FFP, depending on whether time study participants have the job responsibilities, education, and training that would qualify them as SPMPs, and are performing the activities that require this expertise. Refer to each entity's section for details on eligible SPMP classifications.

5. Revenue Offset

There are two types of revenue sources for the purpose of the claim: recognized and unrecognized revenues. In determining the share of the costs for which CMS is willing to pay, a public entity is generally expected to utilize its own income to offset costs, lowering the amount for which CMS is responsible. A detailed explanation of these two types of revenues and the revenues that may be used to offset costs may be found in each public entity's section of this guide.

6. Direct Charge

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

Public entity's utilizing the direct charge will identify the individual's "Functional Category", enter the individual's name, salary, benefits, mileage, and operating cost for the individual claiming direct charge. The STAIRS system will automatically reduce the direct charge amount from cost reported under step 3.c. Other Cost. The adjustment will be reflected on step 5. Verify section of the STAIRS system.

E. HHSC and Public Entity's Responsibilities

1. MAC Claim Desk Review

The MAC claim desk review is utilized to ensure the integrity and accuracy of all data on the Quarterly Summary Invoice (QSI). Desk reviews will be completed quarterly for all public entities unless otherwise specified by the department MAC Coordinator and/or HHSC. All data on the QSI will be verified, using the information retrieved from STAIRS for the quarter being reviewed, prior to any payment of MAC claims.

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

2. The Desk Review Process Utilizing STAIRS Data

STAIRS includes edits that assist with the desk review process. Additionally, these edits provide each entity with a trend analysis based on history that allows the entity to manage the financial information that is entered into the system for each quarterly claim submission. The public entity is required to respond to the system edits as part of the desk review process.

Section Three- Local Health Department/Districts (LHD)

A. Introduction

Texas has operated the MAC project since 1995. MAC is the cost-based reimbursement methodology that Texas uses to draw down federal matching funds for activities that facilitate client access to medically necessary Medicaid funded services. HHSC has partnered with local Health Departments throughout Texas to implement MAC in order to assist HHSC in providing effective and timely access to care for Medicaid recipients, more appropriate utilization of Medicaid covered services, and to promote activities that reduce the risk of poor health outcomes for the state's most vulnerable populations.

In order for the cost to be allowable and reimbursable under Medicaid, the activities must be found to be necessary for the proper and efficient administration under the Texas Medicaid State Plan, and must adhere to applicable requirements as defined in State and Federal law.

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

B. Required Participation Documents.

Refer to the HHSC Acute Care MAC website for the following participation documents.

- Intergovernmental Cooperation Agreement
- Business Associate Agreement
- Texas (Payee) Identification Number Application
- Vendor Direct Deposit Form
- Vendor Information Form

Public entities participating in MAC may also enter into sub-agreements with their own contractors for the performance of reimbursable MAC activities. Samples of the Intergovernmental Cooperation Agreement and the Business Associate Agreement may be found in this section. For samples of the Texas (Payee) Identification Number Application, Vendor Direct Deposit Form, and Vendor Information Form refer to the appendices in this guide.

1. Intergovernmental Cooperation Agreement

THE STATE OF TEXAS
COUNTY OF TRAVIS

HHSC Contract Number

INTERGOVERNMENTAL COOPERATION AGREEMENT

THIS AGREEMENT is entered into by and between the state agencies shown below as contracting parties, pursuant to the authority granted and in compliance with the provisions of the Interagency Cooperation Act, Chapters 771 and 791, Texas Government Code.

I. MEDICAID ADMINISTRATION

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

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

The LHD agrees to submit its quarterly time study calculations for claiming purposes. All claims shall be submitted using the HHSC standardized invoice included in Attachment B. All claims shall be submitted on the 15th of the second month following the claim period; unless the 15th falls on a weekend in such instance, the claim will be due the next business day.

The LHD agrees to provide the expenditures information to include in the quarterly data it submits to HHSC, or its designee, in the manner and timeframes described in the Texas Department of Health Medicaid Administrative Claiming Guide.

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

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

Any audit exception, deferral or denial taken against this agreement will be the responsibility of The LHD.

II. BASIS FOR CALCULATING REIMBURSABLE COSTS

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

HHSC agrees to reimburse The LHD subject to the terms of the Texas Department of Health Medicaid Administrative Claiming Guide. The rate of reimbursement for allowable administrative activities performed by personnel other than Skilled Professional Medical Personnel (SPMP) personnel shall be fifty percent (50%) of such costs.

When made aware of changes in federal regulations affecting the matching percentage, or costs eligible for enhanced or administrative match, which become effective subsequent to the execution of the Agreement, HHSC will apply such changes to comply with federal regulations. As HHSC becomes aware of changes in applicable regulations, it will provide such information to The LHD and this Agreement will be amended to reflect the applicable changes in federal regulations.

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

HHSC agrees to reimburse claims for Medicaid administration from The LHD only if The LHD certifies that sufficient funds are available to support the non-federal share of the cost of the claim (or "match"). Agreement is also subject to any additional restrictions, limitations or conditions required by federal or state laws, rules or regulations.

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

III. TERM OF AGREEMENT

This agreement is to begin October 1, 2007 and shall continue until terminated by either HHSC or the LHD.

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

IV. CERTIFICATIONS

The undersigned contracting parties certify that:

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

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

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

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

RECEIVING AGENCY

HEALTH & HUMAN SERVICES COMMISSION

By: _____

Billie Millwee

Associate Commissioner for Medicaid & CHIP

Date: _____

PERFORMING AGENCY

LOCAL HEALTH DEPARTMENT

By: _____

Executive Director/CEO

Date: _____

2. Business Associate Agreement

STATE OF TEXAS
COUNTY OF TRAVIS

HHSC

AGREEMENT
BETWEEN THE
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
AND

BUSINESS ASSOCIATE AGREEMENT

Compliance with Health Insurance Portability and Accountability Act of 1996
("HIPAA") (42 U.S.C. §§1320d-1320d-8)

This Business Associate Agreement relates to the Agreement between the Health and Human Services Commission ("HHSC") and ____ ("CONTRACTOR"). It is incorporated by reference into the Intergovernmental Agreement.

(a) Background.

(1) All terms used in this Business Associate Agreement that are not otherwise defined in this Agreement have the same meaning as those terms in the Privacy Rule, 45 C.F.R. parts 160 and 164;

(2) Under the terms of this Agreement, HHSC may provide or make available to CONTRACTOR, or CONTRACTOR may create or receive on behalf of HHSC, certain Confidential Information that is and must be afforded special treatment and protection under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") (42 U.S.C. §§1320d-1320d-8) in conjunction with goods or services that are being provided to HHSC by CONTRACTOR;

(3) CONTRACTOR will have access to or receive from HHSC or create receive on behalf of HHSC certain electronic protected health information that must be safeguarded in accordance with this Agreement and the security rules adopted by the U.S. Department of Health and Human Services (HHS) under HIPAA, 45 C.F.R. §§ 164.302-.318. CONTRACTOR is a Business Associate as that term is defined in the HIPAA security rules, 45 C.F.R. § 160.103.

(4) CONTRACTOR is a Business Associate of HHSC.

(5) The obligations of CONTRACTOR under this section are in addition to the duties of CONTRACTOR with respect to Confidential Information described elsewhere in this Agreement.

(b) Uses and Disclosures.

Except as otherwise limited by this Agreement, CONTRACTOR may:

(1) Use or disclose Protected Health Information to perform the Services and accomplish the purposes of this Agreement, provided that:

(A) Such use or disclosure would not violate the Privacy Rule if the disclosure were made by HHSC; and

(B) Such use or disclosure is limited to the minimum necessary to accomplish the purposes of the use or disclosure;

(2) Use Protected Health Information for the proper management and administration of CONTRACTOR or to carry out CONTRACTOR's legal responsibilities;

(3) Disclose Protected Health Information for the proper management and administration of CONTRACTOR or to carry out CONTRACTOR's legal responsibilities if:

(A) Disclosure is required by law; or

(B) CONTRACTOR obtains assurances from the person to whom the information is disclosed that the person will:

(i) Maintain the confidentiality of the Protected Health Information;

(ii) Use or further disclose the information only as required by law or for the purpose for which it was disclosed to the person; and

(iii) Notify CONTRACTOR of any breaches of confidentiality of which the person is aware; and

(4) Use Protected Health Information to provide data aggregation services to HHSC, as that term is defined at 45 C.F.R. §164.501 and permitted by 45 C.F.R. §164.504(e)(2)(i)(B).

(c) CONTRACTOR's commitment and obligations.

CONTRACTOR agrees that it will:

(1) Not use or disclose Protected Health Information provided by, made available by, or created or received on behalf of HHSC other than as permitted or required by this Agreement or as required by law;

(2) Establish and maintain appropriate safeguards to prevent any use or disclosure of Protected Health Information other than as provided for by this Agreement;

(3) Have procedures in place for mitigating, to the maximum extent practicable, any harmful effect of a use or disclosure of Protected Health Information that is contrary to this Agreement or the Privacy Rule;

(4) Immediately report to HHSC any use or disclosure of Protected Health Information not provided for or allowed by this Agreement of which CONTRACTOR becomes aware;

(5) Enter into a subcontract anytime CONTRACTOR proposes to provide or make available Protected Health Information to any subcontractor or agent. Such subcontract or agreement must:

(A) Contain the same terms, conditions, and restrictions on the use and disclosure of Protected Health Information and restrictions on the security of information as contained in this Agreement; and

(B) Be approved as to the form of the terms, conditions, and restrictions by HHSC prior to entering into any such agreement;

(6) Make Protected Health Information in a designated records set available to HHSC or, as directed by HHSC, to the subject of the Protected Health Information, in compliance with the requirements of 45 C.F.R. §164.524.

(7) Make Protected Health Information in a designated records set available for amendment and will incorporate any amendments to this information that HHSC directs or agrees to pursuant to 45 C.F.R. §164.526.

(8) Document and make available to HHSC the Protected Health Information required to provide an accounting of disclosures, in accordance with 45 C.F.R. §164.528.

(9) Make internal practices, books, and records relating to the use or disclosure of Protected Health Information received from, or created or received by CONTRACTOR on behalf of HHSC, available to the Secretary of Health and Human Services or the Secretary's designee for purposes of determining compliance with the privacy regulations.

(10) Return, destroy, or continue to maintain appropriate safeguards for all Protected Health Information received from HHSC or created or received on behalf of HHSC once CONTRACTOR finishes providing goods or services under this Agreement:

(A) If CONTRACTOR destroys the information, it must certify to HHSC that the information has been destroyed;

(B) CONTRACTOR may not elect to destroy information that must be retained under federal or state law; and

(C) CONTRACTOR must maintain appropriate safeguards for the information as long as CONTRACTOR has such Protected Health Information;

(11) Develop and implement a system of sanctions for any employee, subcontractor, or agent who violates this Agreement or the Privacy Rule.

(12) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of HHSC as required by 45 C.F.R. §§ 164.302-.318.

(13) Immediately report to HHSC any security incident of which it becomes aware.

(14) Make internal practices, books, and records relating to the security of information received from or created or received by CONTRACTOR on behalf of HHSC available to the Secretary of Health and Human Services or the Secretary's designee for purposes of determining compliance with the security rules.

(15) Develop and implement a system of sanctions for any employee, subcontractor or agent who violates this agreement or the security rules.

(d) Ownership of Protected Health Information.

(1) The Protected Health Information shall be and remain the property of HHSC.

(2) CONTRACTOR agrees it acquires no title or rights to the information, including any de-identified information, as a result of this Agreement.

(e) Injunctive relief; survival of terms.

(1) Notwithstanding any rights or remedies provided for in the contract, HHSC retains all rights to seek injunctive relief to prevent or stop the unauthorized use or disclosure of Protected Health Information or a violation of the security rules by CONTRACTOR or any agent, subcontractor, or third party that received information from CONTRACTOR.

(2) The duties and obligations imposed on CONTRACTOR under this section of this Agreement will survive the expiration of the Agreement until all Protected Health Information

provided by HHSC to CONTRACTOR, or created or received by CONTRACTOR on behalf of HHSC, is destroyed or returned to HHSC.

(f) Definitions.

(1) For purposes of this Business Associate Agreement: a “Business Associate” has the meaning given the term under 45 C.F.R. §160.103.

(2) For purposes of this Business Associate Agreement, “Protected Health Information” has the meaning given the term in 45 C.F.R. §164.501, limited to the information created or received by CONTRACTOR from or on behalf of HHSC.

(g) General Terms

(1) Except as otherwise specified in the contract, if any legal action or other proceeding is brought for the enforcement of the contract, or because of an alleged dispute, breach, default, misrepresentation, or injunctive action, in connection with any of the provisions of the contract, each party will bear their own legal expenses and all other costs incurred in that action or proceeding.

(2) The contract consists of this document and the base contract and constitutes the entire agreement between the parties. There are no understandings or agreements relating to this agreement or the base contract that are not fully expressed in the contract and no change, waiver, or discharge of obligations arising under the contract will be valid unless in writing and executed by the party against whom such change, waiver, or discharge is sought to be enforced.

(3) Any violation by CONTRACTOR of a material term of this agreement will be considered a breach of contract if CONTRACTOR knew of the violation and failed to immediately take reasonable steps to cure it.

(4) HHSC has a right to immediately terminate this agreement and the base contract and seek relief in a court of competent jurisdiction in Travis County, Texas, if HHSC determines that CONTRACTOR has violated a material term of this agreement.

SIGNED this ____ day of ____ 20 ____.

CONTRACTOR

By: _____

Printed Name and Title

C. Medicaid Covered Services

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

Refer to the appendices for a list of Medicaid covered services.

D. SPMP Classification

Refer to the appendices for the authority and guidance of SPMP classifications allowed to claim an enhanced rate for Medicaid administrative services.

E. MAC Financials - Claiming Reimbursement

The claim submitted to the state for reimbursement has several elements: allowable Medicaid administrative time, cost pool construction, Medicaid Eligibility Percentage, federal financial participation (FFP) rate and revenue offset.

1. Allocation Methodology

Expenditures

Cost included in the MAC claim shall be in accordance with the provisions of OMB Circular A-87 and 45 CFR Part 74 and 95 and other pertinent Department regulations and instructions. OMB Circular A-87 specifically defines the types of costs: direct costs, indirect costs and allocable costs that can be included in the program. Sections 1 through 42 of the circular provide principles to be applied in establishing the allowability or un-allowability of certain items of cost. These principles apply whether a cost is treated as direct or indirect.

OMB Circular A-87 is to be used for determining allowable and unallowable status of all expenses. Refer to the appendices for program-specific allowable and unallowable costs.

Revenues

The two types of revenue sources utilized in the MAC claim are recognized and unrecognized revenue. A public entity is generally expected to utilize its own income to offset costs, lowering the amount for which CMS is responsible.

Recognized Revenues

These are income sources that must be adjusted (offset) against the costs of the public entity, and they are collected based on an analysis of the revenue source. The general rule for determining placement is that revenue must follow the activity by which it is earned or the expense for which it is a reimbursement.

Examples include:

Medicaid Fees + Match (FFP) includes all Title XIX reimbursements and, where

required, the State Matching Funds.

Federal Grants + Match (FFP) is income that may pass through one or more state agencies, but is still federal money. This includes federal pass through from counties and cities as well. A federal grant may pass through one or more state agencies, but it is still federal funds. A federal grant will always have a Catalog of Federal Domestic Assistance (CFDA) Number and will be listed on the audit report on the "Schedule of State and Federal Assistance." Each grant has its own match percentages and contractual requirements. These must be individually analyzed by the public entity preparing the claim. Inputting and adding the match must be done separately for each grant. Properly reporting these funds requires identifying the expenditures the grant covers.

For example, if grant funds (revenue) are used to pay for a time study participant's salary and the participant is classified as an SPMP, then the funds received from the grant and the respective match to pay for the participant's salary must be placed in the same revenue pool in proportion to the expenses paid. Remaining Grant funds may be placed in General Administrative Revenue (Cost Pool #4) and will be allocated in proportion to the time study results for the period of service that the time study took place in. Other than MAC reimbursements, federal grants will always be reported as recognized revenue and they will always have a CFDA number.

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

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

Fees paid by or on behalf of clients for direct service. Typically, these fees would be placed in Unstudied/Unallowable Revenue (Cost Pool 3). Fees collected for copying client records for outside agencies are placed in General Administrative Revenue (Cost Pool 4).

Donations to Public Entity are only used by private entities and are generally placed in Unstudied/Unallowable Revenue (Cost Pool 3).

Other Revenues such as revenues for vocational production; from clients, families or other sources covering residential costs; and grants from private foundations, miscellaneous revenues not readily identifiable, onetime or unusual revenues, interest income, other business income, fundraising any other purely "Administrative" income are generally placed in the Unstudied/Unallowable Revenue (Cost Pool 3), although some may be assigned to General Administrative Revenue (Cost Pool 4) depending on the purpose and use of the income.

Ultimately, revenues that are not recognized by the federal Medicaid agency as revenue that can be used to offset costs, nor designated as matching funds necessary to draw down the federal support are designated as Unrecognized Revenues.

Unrecognized Revenues

These revenues have no effect on the calculation of the claim and are included solely for purposes of audit, verification of MAC match requirements as stated in CFR 433.51 and full reporting.

Examples Include:

Medicaid Administrative Reimbursement - The reimbursement received for this claim process is a significant source of unrecognized revenue. The funds have already been reduced for matching purposes in the preparation of the previous quarter's claim.

Other State Funds - These funds are general revenue and grants from state funds from all state agencies.

Local Government Funds - These funding sources include city, county, school districts and other local taxing authorities.

Donations to Public Agencies - All donations to public (legislatively mandated) agencies are placed in this category.

Federal Emergency Management Assistance Reimbursement (FEMA) (Title IV-A) - FEMA funds -Grants to States for Aid and Services to Needy Families with Children and for Child Welfare Services.

2. Time Study

As referenced in section C Elements of the claim, the purpose of the time study is to allocate or assign the costs to an appropriate funding source and to identify the proportion of administrative time allowable and reimbursable under Medicaid. This allows public entities to claim Medicaid reimbursement for administrative activities performed/provided to Medicaid clients. Additional information regarding RMTS may be found on the HHSC Time Study website.

Allowable and Allocable Time by Codes and Costs

<u>Cost Pool 1</u> <u>Enhanced Direct Service</u> <u>Staff and CHIPRA</u>		<u>Cost Pool 2</u> <u>Non Enhanced All Staff</u>		<u>Cost Pool 3</u> <u>Non-Claimable</u>	<u>Cost Pool 4 *</u> <u>General</u> <u>Admin</u>
<u>Discounted</u>	<u>Non-Discounted</u>	<u>Discounted</u>	<u>Non-Discounted</u>	<u>Not Time Studied/ Not Applicable</u>	<u>Administrative Support</u>
Code 7c Code 9c	Code 1c	Code 1b Code 5b Code 7b Code 8b Code 9b	Code 1 Code 2bCode 6b Code 12	Code 1a Code 2a Code 3 Code 4 Code 5a Code 6a Code 7a Code 8a Code 9a Code 11 Code L	Code 10 Allocated across Cost Pools 1, 2, and 3

* General Administrative (Cost Pool 4) includes all non-time studied staff that provides administrative support to the agency such as human resources, payroll, etc.

3. Medicaid Eligibility Percentage

In Elements of a Claim, Section C, the method for determining the Medicaid Eligibility Percentage is discussed. Deciding which Medicaid Eligibility 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 population. For MAC purposes, the calculation for the MER shall be based on an unduplicated client count.

The Medicaid Eligibility Percentage is a fraction. The numerator of which consists of all persons in the entities 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.

4. Federal Financial Participation Rate

Federal Financial Participation (FFP) rate was created as part of Title XIX, Social Security Act of 1965. The program's intention is to provide local services in support of Medicare and Medicaid by providing a cost match for personnel. There are two objectives that permit claims under FFP. They are: 1) to assist individuals eligible for Medicaid to enroll in the Medicaid program and/or 2) to assist individuals on Medicaid to access Medicaid providers and services. The medical services available within each category are restricted to services covered by the Texas State Medicaid Plan. The FFP rate is 50% with an enhanced FFP rate of 75% available for some services offered by Skilled Professional Medical Personnel (SPMP). Additionally, Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 (CHIPRA) contains guidance that allows states to claim the enhanced rate of 75% for administrative expenditures for translation or interpretation services connected with the "enrollment of retention of, or use of services" under Medicaid and CHIP.

5. Calculating the Claim

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

Participant staff costs	multiplied by
Percent of time claimable to Medicaid administration	multiplied by
Medicaid Eligibility Percentage (the percentage of Medicaid eligible's in the service population)	Plus
Allocated General Administrative costs	Equals
Subtotal	multiplied by
Percent of FFP (50% for some costs (Non-SPMP) and 75% for other costs (SPMP and CHRPA)	Equals
Subtotal	Plus
Direct Charge @ 50% FFP	equals
The amount of federal request	

Direct Charge

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

6. Claim Submission Timeline

Public entities must submit claims within the timelines set by HHSC. The open and close date for each claiming period within a federal fiscal year (October 1, through September 30) is included in the MAC Financial presentation found on the HHSC website for each pertinent federal fiscal year.

7. STAIRS – State of Texas Automated Information Reporting System

As indicated in Section One of this guide, the federal government permits state Medicaid agencies to claim reimbursement for activities performed that are necessary for the "proper and efficient administration" of the State Medicaid Plan. Local Health Departments participating in MAC will utilize STAIRS to complete their MAC Claims. Once this claim is completed, the Quarterly Summary Invoice will be printed, notarized and signed as required by HHSC and submitted to HHSC for further processing. This process may change if HHSC obtains approval for electronic signature and submission from CMS. In the event that approval is granted, public entities will be notified of the change.

LHD MAC Financials Screen Shots (STAIRS Financial Module)

Slide 1

LHD MAC Financials

Screen Shots

May 9, 2011

The screenshot shows a web application interface for Fairbanks LLC. At the top left is the Fairbanks LLC logo. At the top right, it says "Welcome, [username] (Logout)". Below the logo is a navigation bar with tabs for "Dashboard", "Participant List", "MAC Financial Submission", and "Manage". The main heading is "Open Quarter: April - June 2011". A red error banner states "Your Financial Data is Not Verified for the Quarter: April - June 2011". Below this is a dropdown menu for "Open Quarter: April - June 2011" and a "Change Quarter" button. To the right, it says "(Training status: full access)". There are links for "Download list of Participants", "Print", and "Reference Materials". A section titled "Web Financial Steps" contains a list of 7 steps, each with a red 'X' icon indicating it is not completed: 1. MAC Provider Data, 2. General and Statistical Information, 3. Expense Data (with sub-steps a. Provider Specific Costs, b. Provider Summary Costs, c. Other Costs, d. Eligible Direct Charges), 4. Summary Revenue, 5. Verify, 6. Print Certification - Quarterly Summary Invoice (QSI), and 7. Attach Signed and Notarized QSI. At the bottom, there are sections for "RMIS Information" and "MAC Information", each with a link to their respective websites. The footer contains contact information for the Fairbanks LLC Client Information Center and a copyright notice.

FB FAIRBANKS LLC

Welcome, [username] (Logout)

Dashboard Participant List **MAC Financial Submission** Manage

Open Quarter: April - June 2011

Your Financial Data is Not Verified for the Quarter: April - June 2011

Open Quarter: April - June 2011 Change Quarter (Training status: full access)

[Download list of Participants](#) [Print](#) [Reference Materials](#)

Web Financial Steps

1. [MAC Provider Data](#)
2. [General and Statistical Information](#)
3. [Expense Data](#)
 - a. [Provider Specific Costs](#)
 - b. [Provider Summary Costs](#)
 - c. [Other Costs](#)
 - d. [Eligible Direct Charges](#)
4. [Summary Revenue](#)
5. [Verify](#)
6. [Print Certification - Quarterly Summary Invoice \(QSI\)](#)
7. [Attach Signed and Notarized QSI](#)

RMIS Information [RMIS Information Website \(TX - HHSC\)](#)

MAC Information [MAC Information Website \(TX - HHSC\)](#)

For questions, please contact Fairbanks LLC Client Information Center: (888) 321-1225 or info@fairbanksllc.com

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FB FAIRBANKS LLC Welcome (Logout)

Dashboard | Dashboard List | MAC Provider Submission | My Account

Open Quarter: April - June 2011

Open Quarter: April - June 2011 | Change Quarter | (Training status) Full Access

Downloaded of Payments | My Profile | My Account Manager

1. MAC Provider Data

Save and Return to Main Menu | Return to Main Menu

Entity Information

If any of these fields are incorrect, please contact Fairbanks LLC at (888) 321-1225 or info@fairbanksllc.com

Entity Name:
Health and Human Services Contract:
Administration & Tracking (HCAT) Number:
Program Code:
Agency Type:

MAC Entity Identification

Entity Name:
Phone:
Fax:
Email:
Street Address:
Mailing Address:
[Exp. Information](#)

Chief Executive Officer (CEO)

Name:
Job Title:
Entity Name:
Phone:
Fax:
Email:
Mailing Address:
[Exp. Information](#)

Report Preparer Identification

Name:
Job Title:
Entity Name:
Phone:
Fax:
Email:
Mailing Address:
[Exp. Information](#)

Primary MAC Financial Contact/Coordinator

Name:
Job Title:
Entity Name:
Phone:
Fax:
Email:
Mailing Address:
[Exp. Information](#)

Primary RPT's Contact/Coordinator

Name:
Job Title:
Entity Name:
Phone:
Fax:
Email:
Mailing Address:
[Exp. Information](#)

Location of Accounting records that Support this Report

Primary Physical Address:
[Exp. Information](#)

Save and Return to Main Menu | Return to Main Menu

RPT's Information | MAC Information

[RPT's Information \(File ID: 14100\)](#) | [MAC Information \(File ID: 14100\)](#)

For questions, please contact Fairbanks LLC Client Information Center (888) 321-1225 or info@fairbanksllc.com

FB FAIRBANKS LLC Welcome. (Logout)

Dashboard Participant List **MAC Financial Submission** Manage

1a. MAC Entity Identification

Entity Name:

Phone (123-456-7890): **Phone Extension:**

Fax (123-456-7890): **Fax Extension:** No Fax

Email:

Street Address Street 1:

Street Address Street 2:

Street Address City:

Street Address State:

Street Address Zip:

check this box if Mailing Address is same as above

Mailing Address Street 1:

Mailing Address Street 2:

Mailing Address City:

Mailing Address State:

Mailing Address Zip:

RMTS Information **MAC Information**

[RMTS Information Website \(TX - HHSC\)](#) [MAC Information Website \(TX - HHSC\)](#)

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FB FAIRBANKS LLC

Welcome, [User] (Logout)

Dashboard Participant List MAC Financial Submission Manage

1b. Chief Executive Officer (CEO)

First Name: _____
Last Name: _____
Job Title: _____
Entry Name: _____
Phone (123-456-7890): _____ Phone Extension: _____
Fax (123-456-7890): _____ Fax Extension: _____ No Fax
Email: _____
Mailing Address Street 1: _____
Mailing Address Street 2: _____
Mailing Address City: _____
Mailing Address State: -- --
Mailing Address Zip: _____

RMIS information [RMIS information Website \(TX - HHSQ\)](#) **MAC information** [MAC information Website \(TX - HHSQ\)](#)

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Welcome, [User] (Logout)

Dashboard Participant List **MAC Financial Submission** Manage

1c. Report Preparer Identification

First Name:
Last Name:
Job Title:
Entity Name:
Phone (123-456-7890): Phone Extension:
Fax (123-456-7890): Fax Extension: No Fax
Email:
Mailing Address Street 1:
Mailing Address Street 2:
Mailing Address City:
Mailing Address State:
Mailing Address Zip:

RMTS Information **MAC Information**
[RMTS Information Website \(TX - HHSC\)](#) [MAC Information Website \(TX - HHSC\)](#)

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FB FAIRBANKS LLC Welcome, [User Name] (Logout)

Dashboard Participant List **MAC Financial Submission** Manage

1d. Primary MAC Financial Contact/Coordinator

First Name:
Last Name:
Job Title:
Entity Name:
Phone (123-456-7890): **Phone Extension:**
Fax (123-456-7890): **Fax Extension:** No Fax
Email:
Mailing Address Street 1:
Mailing Address Street 2:
Mailing Address City:
Mailing Address State:
Mailing Address Zip:

RMETS Information **MAC Information**
[RMETS Information Website \(TX - HHSC\)](#) [MAC Information Website \(TX - HHSC\)](#)

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 FAIRBANKS LLC

Welcome, ([Logout](#))

[Dashboard](#) [Participant List](#) [MAC Financial Submission](#) [Manage](#)

1d. Primary MAC Financial Contact/Coordinator

First Name:

Last Name:

Job Title:

Entity Name:

Phone (123-456-7890): **Phone Extension:**

Fax (123-456-7890): **Fax Extension:** **No Fax**

Email:

Mailing Address Street 1:

Mailing Address Street 2:

Mailing Address City:

Mailing Address State:

Mailing Address Zip:

RMIS Information [RMIS information Website \(TX - HHSC\)](#)

MAC Information [MAC Information Website \(TX - HHSC\)](#)

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FB FAIRBANKS LLC Welcome: _____ (Logout)

Dashboard Participant List **MAC Financial Submission** Manage

1e. Primary RMTS Contact/Coordinator

First Name: _____
Last Name: _____
Job Title: _____
Entity Name: _____
Phone (123-456-7890): _____ Phone Extension: _____
Fax (123-456-7890): _____ Fax Extension: _____ No Fax
Email: _____
Mailing Address Street 1: _____
Mailing Address Street 2: _____
Mailing Address City: _____
Mailing Address State: _____
Mailing Address Zip: _____

RMTS Information [RMTS Information Website \(TX - HHSC\)](#)

MAC Information [MAC Information Website \(TX - HHSC\)](#)

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The screenshot displays the Fairbanks LLC web application interface. At the top left is the logo for Fairbanks LLC. At the top right, there is a user greeting: "Welcome, [redacted] (Logout)". Below the logo and greeting is a navigation menu with four items: "Dashboard", "Participant List", "MAC Financial Submission" (which is highlighted), and "Manage".

The main content area is titled "1f. Location of Accounting Records". It contains a form with the following fields:

- Primary Physical Address Street 1:
- Primary Physical Address Street 2:
- Primary Physical Address City:
- Primary Physical Address State:
- Primary Physical Address Zip:

Below the form are two buttons: "Save" and "Cancel".

At the bottom of the form area, there are two sections:

- RMTS Information**: [RMTS Information Website \(TX - HHSC\)](#)
- MAC Information**: [MAC Information Website \(TX - HHSC\)](#)

At the very bottom of the page, there is a footer with the text: "For questions, please contact Fairbanks LLC Client Information Center: (888) 321-1225 or info@fairbanksllc.com" and "Fairbanks LLC. All Rights Reserved."



Welcome, [Logout](#)

[Dashboard](#) [Participant List](#) [MAC Financial Submission](#) [Manage](#)

Open Quarter: April - June 2011

 Your Financial Data is Not Verified for the Quarter: April - June 2011

Open Quarter: April - June 2011 (Training status: [full access](#))

[Download list of Participants](#) [Print](#) [Reference Materials](#)

Web Financial Steps

-  [1. MAC Provider Data](#)
-  [2. General and Statistical Information](#)
- [3. Expense Data](#)
 -  [a. Provider Specific Costs](#)
 -  [b. Provider Summary Costs](#)
 -  [c. Other Costs](#)
 -  [d. Eligible Direct Charges](#)
-  [4. Summary Revenue](#)
-  [5. Verify](#)
-  [6. Print Certification - Quarterly Summary Invoice \(QSI\)](#)
-  [7. Attach Signed and Notarized QSI](#)

<p>RMITS Information</p> <p>RMITS Information Website (TX - HHSC)</p>	<p>MAC Information</p> <p>MAC Information Website (TX - HHSC)</p>
----------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------

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Open Quarter: April - June 2011

Open Quarter: April - June 2011 [Change Quarter](#) (Training status: [full access](#))

[Download List of Participants](#) [Print](#) [Reference Materials](#)

2. General and Statistical Information

[Save and Return to Main Menu](#) [Save](#) [Return to Main Menu](#)

Medicaid Eligibility Rate (MER)	
Unduplicated Medicaid Client Count	300
Unduplicated Client Count	1,500
Medicaid Eligibility Rate	20.00%

Time Study Summary

These numbers represent the total time study percentages within these categories across the ENTIRE statewide sampled population.

Time Study Activity	Percentage
Medicaid Eligibility	0.00%
Non-Medicaid Eligibility	0.00%
Medicaid Outreach (Outreach, Referral/Coordination, Transportation/Translation, Program Planning, Provider Relations)	10.93%
Non-Medicaid Outreach (Outreach, Referral/Coordination, Transportation/Translation, Program Planning, Provider Relations)	3.83%
Direct Service	84.15%
Non-Medical Direct Service	1.09%
Total	100.00%

[Save and Return to Main Menu](#) [Save](#) [Return to Main Menu](#)

RMTS Information

[RMTS Information Website \(TX - HHSC\)](#)

MAC Information

[MAC Information Website \(TX - HHSC\)](#)

FB FAIRBANKS LLC Welcome, [User] (Logout)

Dashboard Participant List **MAC Financial Submission** Manage

Open Quarter: April - June 2011

Your Financial Data is Not Verified for the Quarter: April - June 2011

Open Quarter: April - June 2011 [Change Quarter](#) (Training status: Full Access)

[Download list of Participants](#) [Print](#) [Reference Materials](#)

Web Financial Steps

- ✓ [1. MAC Provider Data](#)
- ✓ [2. General and Statistical Information](#)
- 3. Expense Data**
 - ✗ [a. Provider Specific Costs \(or Skip to Provider Summary Costs Step 3b\)](#)
 - ✗ [b. Provider Summary Costs](#)
 - ✗ [c. Other Costs](#)
 - ✗ [d. Eligible Direct Charges](#)
- ✗ [4. Summary Revenue](#)
- ✗ [5. Verify](#)
- ✗ [6. Print Certification - Quarterly Summary Invoice \(QSI\)](#)
- ✗ [7. Attach Signed and Notarized QSI](#)

RMIS Information [RMIS Information Website \(TX_HHSC\)](#) **MAC Information** [MAC Information Website \(TX_HHSC\)](#)

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Dashboard
Participant List
MAC Financial Submission
Manage

Open Quarter: April - June 2011

Warning: Auto-save functionality has been temporarily disabled. Please save your work often to avoid losing data.

Open Quarter: April - June 2011 [Change Quarter](#)
(Training Status: Full Access)

[FitNotes Orders](#)

[Export to Excel](#)
[Download list of Participants](#)
[Print](#)
[Reference Materials](#)

3a. Provider Specific Costs

[Save and Return to Main Menu](#)
[Save](#)
[Return to Main Menu](#)
Per Page: 20 | 10 | 100 | 500 | All
Showing: 1 - 20 of 20 | First | Previous | Next | Last

Job Category	External ID	Last Name ↑	First Name	Employment Type	Title	Employee Salaries (A)	Employee Benefits (B)	Contracted Staff Costs (C)	TOTAL Expenditures (D) A + B + C
Early Intervention Specialist (EIS)		[Redacted]	Lynn	Full Time	EIS				
Early Intervention Specialist (EIS)		[Redacted]	Jennie	Full Time	EIS				
Early Intervention Specialist (EIS)		[Redacted]	Niva	Full Time	EIS				
Early Intervention Specialist (EIS)		[Redacted]	Margaret	Full Time	EIS				
Early Intervention Specialist (EIS)		[Redacted]	Suzanne	Full Time	EIS				
Director - Program		[Redacted]	Sheila	Full Time	Program Director				
Occupational Therapist - Licensed (OT)		[Redacted]	Shannon	Full Time	OT				
Early Intervention Specialist (EIS)		[Redacted]	Karen	Full Time	EIS				

[Save and Return to Main Menu](#)
[Save](#)
[Return to Main Menu](#)
Per Page: 20 | 10 | 100 | 500 | All
Showing: 1 - 20 of 20 | First | Previous | Next | Last

RMIS Information

[RMIS Information Website \(TX - HHS/C\)](#)

MAC Information

[MAC Information Website \(TX - HHS/C\)](#)

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Dashboard
Participant List
MAC Financial Submission
Manage

Open Quarter: April - June 2011

Open Quarter: April - June 2011 ▼ Change Quarter
(Training status: [full access](#))

[Download list of Participants](#)
 [Print](#)
 [Reference Materials](#)

3a. Provider Specific Costs -- Detailed Explanations

Please provide explanations below

Save
 Cancel

Required edit checks, please enter explanation			
Category	Issue	Calculation	Explanation
Summary	Salary and contracted staff compensation have been entered for same provider (Lynn Berryman -- Early Intervention Specialist (EIS))	'Employee Salaries': 654654, 'Contracted Staff Costs': 6 Edit	<input style="width: 100%; height: 20px;" type="text"/>
Summary	Salary and contracted staff compensation have been entered for same provider (Jennie Boulden -- Early Intervention Specialist (EIS))	'Employee Salaries': 54, 'Contracted Staff Costs': 6 Edit	<input style="width: 100%; height: 20px;" type="text"/>
Summary	Salary and contracted staff compensation have been entered for same provider (Karen Mezell -- Early Intervention Specialist (EIS))	'Employee Salaries': 654, 'Contracted Staff Costs': 46 Edit	<input style="width: 100%; height: 20px;" type="text"/>

Save
 Cancel

RMETS Information

[RMETS Information Website \(TX - HHSC\)](#)

MAC Information

[MAC Information Website \(TX - HHSC\)](#)

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Open Quarter: April - June 2011

Your Financial Data is Not Verified for the Quarter: April - June 2011

Open Quarter: April - June 2011 [Change Quarter](#) (Training status: [full access](#))

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Web Financial Steps

- 1. [MAC Provider Data](#)
- 2. [General and Statistical Information](#)
- 3. **Expense Data**
 - a. [Provider Specific Costs](#)
 - i. [Detailed Explanations for Cost Report Edits](#)
 - b. [Provider Summary Costs](#)
 - i. [Detailed Explanations for Cost Report Edits](#)
 - c. [Other Costs](#)
 - d. [Eligible Direct Charges](#)
- 4. [Summary Revenue](#)
- 5. [Verify](#)
- 6. [Print Certification - Quarterly Summary Invoice \(QSI\)](#)
- 7. [Attach Signed and Notarized QSI](#)

RMIS Information [RMIS Information Website \(TX - HHSC\)](#) **MAC Information** [MAC Information Website \(TX - HHSC\)](#)

Slide 17

Open Quarter: April - June 2011

Open Quarter: April - June 2011 (Timing status: 02_051533)

[Export to Excel](#) | [Download Data to Desktop](#) | [Print](#) | [Refresh Metadata](#)

3b. Provider Summary Costs

Job Category	Total Employees	Total Contractors	Employee Salaries	Employee Benefits	Contracted Staff Costs	TOTAL Expenditures
			(A)	(B)	(C)	(D) A + B + C
Director - Program	0	0	0	0	0	\$0
Early Intervention Specialist (EIS)	0	0	0	0	0	\$0
Nurse - Registered (RN)	0	0	0	0	0	\$0
Public Outreach/Child Find Staff	0	0	0	0	0	\$0
Team Leader	0	0	0	0	0	\$0
Translator/Interpreter	0	0	0	0	0	\$0
Director	0	0	0	0	0	\$0
Occupational Therapist - Licensed (OT)	0	0	0	0	0	\$0
Physical Therapist - Licensed (PT)	0	0	0	0	0	\$0
Speech Language Pathologist - Licensed (SLP)	0	0	0	0	0	\$0
TOTAL	0	0	\$0	\$0	\$0	\$0

RMTS Information [RMTS Information System \(ITS\) - en@fb.com](#) | **MAC Information** [MAC Information System \(ITS\) - en@fb.com](#)


Welcome, [\(Logout\)](#)

[Dashboard](#)
[Participant List](#)
[MAC Financial Submission](#)
[Manage](#)

Open Quarter: April - June 2011

Open Quarter: April - June 2011 (Training status: [full access](#))

[Download list of Participants](#)
[Print](#)
[Reference Materials](#)

3b. Provider Summary Costs -- Detailed Explanations

⚠ Please provide explanations below

Required edit checks, please enter explanation			
Category	Issue	Calculation	Explanation
Dietitian	The number of employees entered on the financial schedule varies by 15% from the number of employees entered on the participant list.	Total on Participant List 1, Total entered on Financials 400 Edit	<input style="width: 95%;" type="text"/>
Director - Program	The number of employees entered on the financial schedule varies by 15% from the number of employees entered on the participant list.	Total on Participant List 1, Total entered on Financials 54 Edit	<input style="width: 95%;" type="text"/>
Translator/Interpreter	The number of employees entered on the financial schedule varies by 15% from the number of employees entered on the participant list.	Total on Participant List 1, Total entered on Financials 650 Edit	<input style="width: 95%;" type="text"/>

RMETS Information

[RMETS Information Website \(TX - HHSC\)](#)

MAC Information

[MAC Information Website \(TX - HHSC\)](#)

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Open Quarter: April - June 2011

 Your Financial Data is Not Verified for the Quarter: April - June 2011

Open Quarter: April - June 2011 (Training status: [full access](#))

 [Download list of Participants](#)  [Print](#)  [Reference Materials](#)

Web Financial Steps

-  1. [MAC Provider Data](#)
-  2. [General and Statistical Information](#)
- 3. Expense Data
 -  a. Provider Specific Costs
 -  i. [Detailed Explanations for Cost Report Edits](#)
 -  b. [Provider Summary Costs](#)
 -  i. [Detailed Explanations for Cost Report Edits](#)
 -  c. [Other Costs](#)
 -  d. [Eligible Direct Charges](#)
 -  4. [Summary Revenue](#)
 -  5. [Verify](#)
 -  6. [Print Certification - Quarterly Summary Invoice \(QSI\)](#)
 -  7. [Attach Signed and Notarized QSI](#)

RMIS Information
 [RMIS Information Website \(TX - HHSC\)](#)

MAC Information
 [MAC Information Website \(TX - HHSC\)](#)


Welcome, [\(Logout\)](#)

Dashboard
Participant List
MAC Financial Submission
Manage

Open Quarter: April - June 2011

Open Quarter: April - June 2011 Change Quarter
(Training status: [full access](#))

Export to Excel
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Print
Reference Materials

3c. Other Costs

Save and Return to Main Menu
Save
Return to Main Menu

MAC Staff Category	Salary & Benefits	Travel & Training	Materials & Supplies	Equipment & Operating Costs	TOTAL Expenditures
	(A)	(B)	(C)	(D)	(E) A + B + C + D
Time Study Participant Staff		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Direct Support Staff (Not-Time Studied)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Unstudied Staff	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
General Administrative Staff	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
TOTAL	\$0	\$0	\$0	\$0	\$0

Save and Return to Main Menu
Save
Return to Main Menu

RMTS Information

[RMTS Information Website \(TX - HHSC\)](#)

MAC Information

[MAC Information Website \(TX - HHSC\)](#)

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Open Quarter: April - June 2011

Your Financial Data is Not Verified for the Quarter: April - June 2011

Open Quarter: April - June 2011 [Change Quarter](#) (Training status: [bill or egress](#))

[Download List of Participants](#) [Print](#) [Refresh Menu](#)

Web Financial Steps

- 1. [MAC Provider Data](#)
- 2. [General and Statistical Information](#)
- 3. **Expense Data**
 - a. [Provider Specific Costs](#)
 - I. [Detailed Explanations for Cost Report Edits](#)
 - b. [Provider Summary Costs](#)
 - I. [Detailed Explanations for Cost Report Edits](#)
 - c. [Other Costs](#)
 - d. [Eligible Direct Charges](#)
 - 4. [Summary Revenue](#)
 - 5. [Verify](#)
 - 6. [Print Certification - Quarterly Summary Invoice \(QSI\)](#)
 - 7. [Attach Signed and Notarized QSI](#)

RMTS Information

[RMTS Information Website \(TX - HHSC\)](#)

MAC Information

[MAC Information Website \(TX - HHSC\)](#)


Welcome, (Logout)

Dashboard
Participant List
MAC Financial Submission
Manage

Open Quarter: April - June 2011

Open Quarter: April - June 2011
(Training status: [full access](#))

[Export to Excel](#)
[Download list of Participants](#)
[Print](#)
[Reference Materials](#)

3d. Eligible Direct Charges

Functional Category	Job Category	Last Name	First Name	External ID	Employment Type	Title	Salaries	Benefits	Hours worked in claim period	Hourly Rate	# of Hours to Direct Charge	Subtotal	Travel	Training	Operating Cost	Total Direct Charges
							(A)	(B)	(C)	(D) = [(A)+(B)]/(C)	(E)	(F) = (D)*(E)	(G)	(H)	(I)	(J) = (F)+(G)+(H)+(I)
No records entered																

RMTS Information

[RMTS Information Website \(TX - HHSC\)](#)

MAC Information

[MAC Information Website \(TX - HHSC\)](#)

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Dashboard Participant List **MAC Financial Submission** Manage

Open Quarter: April - June 2011

Your Financial Data is Not Verified for the Quarter: April - June 2011

Open Quarter: April - June 2011 [Change Quarter] (Training status: full access)

Download list of Participants Print Reference Materials

Web Financial Steps

- 1. **MAC Provider Data**
- 2. **General and Statistical Information**
- 3. **Expense Data**
 - a. **Provider Specific Costs**
 - I. [Detailed Explanations for Cost Report Edits](#)
 - b. **Provider Summary Costs**
 - I. [Detailed Explanations for Cost Report Edits](#)
 - c. **Other Costs**
 - d. **Eligible Direct Charges**
- 4. **Summary Revenue**
- 5. **Verify**
- 6. **Print Certification - Quarterly Summary Invoice (QSI)**
- 7. **Attach Signed and Notarized QSI**

RMTS Information [RMTS Information Website \(TX - HHSID\)](#) MAC Information [MAC Information Website \(TX - HHSID\)](#)

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The screenshot displays the 'MAC Financial Submission' page for the 'Open Quarter: October - December 2010'. The interface includes a navigation bar with 'Dashboard', 'Participant List', and 'MAC Financial Submission' tabs. A 'Welcome' message and a '(Logout)' link are visible in the top right corner. Below the navigation bar, the 'Open Quarter' is set to 'October - December 2010', and the training status is 'Full Access'. There are links for 'Download List of Participants', 'Print', and 'Reference Materials'. The main section is titled '4. Summary Revenue' and includes a warning: 'Round to the nearest dollar. Please do NOT return this worksheet with the Quarterly Invoice.' Below this are 'Save and Return to Main Menu', 'Save', and 'Return to Main Menu' buttons.

Unrecognized Revenue

MAC Revenue	Revenue
Donation To Public Agency	_____
Federal Emergency Assistance Reimbursement	_____
Federal IV-E Reimbursement	_____
Local Government Funds	_____
Medicaid Admin Reimbursement	_____
Other State Funds	_____
TOTAL	\$0

Recognized Revenue

MAC Revenue	Unstudied/Unallowable Revenue (A)	General Admin Revenue (B)	Total Recognized Revenue (C) = (A)+(B)
Donations To Contractors	_____	_____	_____
Federal Grants + Match	_____	_____	_____
Fees	_____	_____	_____
Insurance	_____	_____	_____
Medicaid Fees + Match	_____	_____	_____
Medicare	_____	_____	_____
Other Revenue	_____	_____	_____
TOTAL	\$0	\$0	\$0

Below the tables are 'Save and Return to Main Menu', 'Save', and 'Return to Main Menu' buttons. At the bottom, there are links for 'RMTS Information' and 'MAC Information', and a footer with contact information for the Fairbanks LLC Client Information Center.

Open Quarter: April - June 2011

Your Financial Data is Not Verified for the Quarter: April - June 2011

Open Quarter: April - June 2011 [Change Quarter](#) (Training status: [full access](#))

[Download list of Participants](#) [Print](#) [Reference Materials](#)

Web Financial Steps

- 1. [MAC Provider Data](#)
- 2. [General and Statistical Information](#)
- 3. [Expense Data](#)
 - a. [Provider Specific Costs](#)
 - i. [Detailed Explanations for Cost Report Edits](#)
 - b. [Provider Summary Costs](#)
 - i. [Detailed Explanations for Cost Report Edits](#)
 - c. [Other Costs](#)
 - d. [Eligible Direct Charges](#)
 - 4. [Summary Revenue](#)
 - 5. [Verify](#)
 - 6. [Print Certification - Quarterly Summary Invoice \(QSI\)](#)
 - 7. [Attach Signed and Notarized QSI](#)

[RMTS Information](#) [MAC Information](#)
[RMTS Information Website \(TX - HHSC\)](#) [MAC Information Website \(TX - HHSC\)](#)


WELCOME | Logout

Dashboard | Navigation List | APC Financial Information | Reports

Open Quarter: April - June 2011

Open Quarter: April - June 2011
 Closed Quarter
 (Showing Month: [All Months](#))

[Home](#) | [Reports](#) | [Help](#) | [Feedback](#)

5. Verify

[Return to Main Menu](#)

Position	Salary & Benefits	Time Code	Direct Charge Offset	Subtotal of Expenses Due to Allocation	GA Allow	Total of Expenses	Accepted Revenue	GA Accepted Revenue (Estimated)	Net Expenses	Payable Expenses	Net Financial	Leads
	(N)	(B)	(C)	(M)(B)(C)	(D)	(E) + (F)(G)(H)(I)(J)	(K)	(L)	(M) + (N)(O)	(P)	(Q) - (R)(S)	(T)
Time Study Participant Staff	\$17,823	\$95	\$ 189	\$16,539	\$257	\$17,576	\$0	\$7,852	\$11,724	\$11,724	\$257	\$26
Direct Support Staff Time (Obligated)	\$654	\$714	\$0	\$1,368	\$28	\$1,396	\$0	\$409	\$987	\$987	\$148	\$2
Included Staff	\$55	\$764	\$0	\$819	\$3	\$822	\$1,355	\$274	\$548			
Change Appropriation Staff	\$13	\$723	\$0	\$736			\$0,000					
Direct Charge *	\$55	\$1,514				\$1,112				\$1,140	\$1,112	
TOTAL	\$19,662	\$2,472	\$1,188	\$17,134	\$318	\$18,361	\$1,355	\$8,530	\$12,822	\$12,822	\$1,458	\$28

* Direct Charge for accepted: Commission Percentage
 ** Net Financial Commission Percentage (CP%) is 7.52%
 *** Reported Commission Percentage (CP%) is 5.23%

SA Allocation	Salary & Benefits	Percentage
Time Study Participant Staff	\$17,823	26.52%
Direct Support Staff Time Obligated	\$654	2.32%
Included Staff	\$87	0.39%
TOTAL	\$18,564	100.00%

APR Allocation	Net Financial	Financial	TOTAL
	(S) + (T)(U)(V)	(W) + (X)(Y)(Z)	(A) + (B)(C)
Time Study Participant Staff	\$110	\$20	\$130
Direct Support Staff Time Obligated	\$70	\$2	\$72
Direct Charge **	\$205	\$5	\$210
TOTAL	\$385	\$27	\$412

Commission % is calculated by multiplying state-wide average time study results by user Center's Standard Operating Procedure (SOP) Rate (APR) + 2.00%
** Verify that the information entered is correct. If incorrect this information will no longer be able to provide changes. For changes we needed you may contact the Team Health and Human Services Commission at: HSC, Contact: hsc@fairbanks.ak.gov or (907) 451-1300.

[Verify Commission Reports to Main Menu](#)
 [Return to Main Menu](#)

[Help Information](#)
 [APC Information](#)
 Email: help@fairbanks.ak.gov
 Email: apc@fairbanks.ak.gov

For questions: please contact Fairbanks, LLC Client Services Center (907) 474-2224 or cs@fairbanks.ak.gov
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The screenshot displays the Fairbanks MAC Financial Submission interface. At the top, the Fairbanks logo is on the left, and a user greeting with a 'Logout' link is on the right. A navigation bar contains 'Dashboard', 'Participant List', 'MAC Financial Submission', and 'Manage'. The main heading is 'Open Quarter: April - June 2011'. A red notification box states: 'Your Financial Data was Verified for the Quarter: April - June 2011. Verified by Ian Doughty on 05/09/2011 at 02:46 PM Central Time.' Below this, a dropdown menu shows 'Open Quarter: April - June 2011' and a 'Change Quarter' button. A '(Training status: full access)' link is also present. Action links include 'Download list of Participants', 'Print', and 'Reference Materials'. The 'Web Financial Steps' section lists seven items: 1. MAC Provider Data (view), 2. General and Statistical Information (view), 3. Expense Data (with sub-items a. Provider Specific Costs, b. Provider Summary Costs (view), i. Detailed Explanations for Cost Report Edits (view), c. Other Costs (view), d. Eligible Direct Charges (view)), 4. Summary Revenue (view), 5. Verify (view), 6. Print Certification - Quarterly Summary Invoice (OSI) (marked with a red X), and 7. Attach Signed and Notarized OSI (marked with a red X). A verification timestamp 'Verified by Ian Doughty on 05/09/2011 02:46 PM Central Time' is shown. At the bottom, there are links for 'RMTS Information' and 'MAC Information', both pointing to a website. A footer contains contact information for Fairbanks LLC and a copyright notice.

QUARTERLY SUMMARY INVOICE FOR MEDICAID ADMINISTRATION		
AGENCY:		
CONTRACT NUMBER:	329-11-0001-00001	
PERIOD OF SERVICE:	Q3-2010	
CLAIM TYPE:	ORIGINAL	
COST CATEGORIES	COST POOL #1	COST POOL #2
(A) Total Federal Share (enhanced)	\$ 51.00	\$ 0.00
(B) Total Federal Share (non-enhanced)	\$ 1,211.00	\$ 0.00
(C) Total Direct Charge	\$ 0.00	\$ 0.00
(D) Total to be reimbursed by Federal Government		\$ 1,262.00
(E) 3% retention (Contract Sec. II, A, Medicaid Adm) Multiply Line D times 0.03		\$ -94.10
Total Federal Government (FFP) to be reimbursed Line D minus Line E		\$ 1,217.90
This statement is of expenditures that the undersigned certifies are allocable and allowable to the State Medicaid program under Title XIX of the Social Security Act, and in accordance with all procedures, instructions and guidance issued by the single state agency and in effect during the year ended ____ 2010 ____.		
<p>INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED HEREIN MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.</p> <p>CERTIFICATION STATEMENT BY OFFICER OF THE PROVIDER</p>		
HEREBY CERTIFY that:		
<ol style="list-style-type: none"> I certify that the information provided on this invoice is true and correct, and that the funds/ Contributions necessary to match federal expenditure for administrative activities have been provided pursuant to the requirements of 45 CFR parts 74 and 95. I certify that I will adhere to the terms and conditions established in the Medicaid Administrative Claiming Guide. 		
Signature - Officer of Provider (Agency)		Date
Print Name: _____		
Title: _____ Contact number: _____		
Notary Stamp		
STATE OF TEXAS:		
This instrument was acknowledged before me on the _____ day of _____ 20____.		
by _____ (Printed Name of Officer of Provider)		
Notary Public in and for the State of Texas (signature)		
Notary's Name (printed):		NOTARY SEAL
Notary's Commission Expires:		(Ink Stamp Only)

The screenshot displays the Fairbanks MAC Financial Submission web application. At the top left is the Fairbanks logo (FB FAIRBANKS). At the top right, it says "Welcome, [username] (Logout)". Below the logo is a navigation bar with tabs for "Dashboard", "Participant List", "MAC Financial Submission", and "Manage". The main content area shows "Open Quarter: April - June 2011" with a "Change Quarter" link. Below this are links for "Download a List of Participants", "Print", and "Reference Materials". The primary section is titled "7. Attach Signed and Notarized QSI" and includes instructions: "Scan and upload the completed QSI to the Fairbanks System. The QSI will no longer be accepted by mail. If you have any questions, please contact the MAC Unit by e-mail at MAC@hhs.state.tx.us, or by phone: 512-491-1802." There is a "File:" label followed by a "Browse..." button. Below the file selection are "Save and Return to Main Menu" and "Cancel" buttons. At the bottom, there are two columns: "RMTS Information" with a link to "RMTS Information Website (TX - HHS)" and "MAC Information" with a link to "MAC Information Website (TX - HHS)". The footer contains contact information for Fairbanks LLC and a copyright notice for Fairbanks LLC © 2010.

FAIRBANKS LLC Welcome, [User] (Logout)

Dashboard Participant List **MAC Financial Submission** Manage

Open Quarter: April - June 2011

Your Financial Data was Completed and Submitted for the Quarter: April - June 2011.
Completed and Submitted by [User] on [Date] at [Time] Central Time.

Open Quarter: April - June 2011 [Change Quarter](#) (Training status: [full access](#))

[Download list of Participants](#) [Print](#) [Reference Materials](#)

Web Financial Steps

1. MAC Provider Data [view](#)
2. General and Statistical Information [view](#)
3. Expense Data
 - a. Provider Specific Costs
 - b. Provider Summary Costs [view](#)
 - i. Detailed Explanations for Cost Report Edits [view](#)
 - c. Other Costs [view](#)
 - d. Eligible Direct Charges [view](#)
4. Summary Revenue [view](#)
5. Verify [view](#)

Verified by Ian Doughty on 05/09/2011 02:46 PM Central Time
6. Print Certification - Quarterly Summary Invoice (QSI) [view](#)
7. Attach Signed and Notarized QSI [view](#)

Completed by Ian Doughty on 05/09/2011 03:03 PM Central Time

RMITS Information [RMITS Information Website \(TX - HHSC\)](#) **MAC Information** [MAC Information Website \(TX - HHSC\)](#)

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8. Quarterly Summary Invoice

The Quarterly Summary Invoice (QSI) for Medicaid Administration is the statement of expenditures that the undersigned certifies are allocable and allowable to the State Medicaid program under Title XIX of the Social Security Act, and is in accordance with all procedures, instructions and guidance issued by HHSC. The QSI for each public entity may be found in each public entity's section of this guide.

9. Accepted Uses for MAC Reimbursements

As stated in the Intergovernmental Cooperation Agreement, the public entity agrees to spend the federal match dollars generated from Medicaid administrative activities for health-related services and the enhancement of the entity's Medicaid program. It is recommended by HHSC that the funds are used for allowable MAC activities in order to increase services to Medicaid or prospective Medicaid clients. Reinvesting reimbursed funds in eligibility determination, outreach, provider relations and other MAC claimable activities will contribute to the enhancement of the Medicaid program within each public entity's domain.

SECTION FIVE - APPENDICES

Appendix A – Random Moment Time Study (RMTS) Guide

Refer to the HHSC Acute Care Website for information on the RMTS.

Appendix B – Skilled Professional Medical Personnel (SPMP) Classification

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 Health Care Financing Administration (HCFA.CMS). 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.

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 cannot 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 a 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 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 includes 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.

Appendix C – Forms

Texas (Payee) Identification Number Application Instructions

Please note: All Agencies participating in the MAC program must fill out the Texas (Payee) Identification Number Application; however it can be filled out one of two ways. Please see instructions below:

If you already have a Texas (payee) identification number, please fill in the number along with the mail code you are currently using. This will ensure that we set you up in our system with the correct information and you get your payments in an expeditious manner.

If you do not have a Texas (payee) identification number, please fill out the form in its entirety so we may forward it on to the Comptroller's Office to obtain an individual number for your entity and set you up for direct deposit.

SAMPLE – For a copy of this form, refer to the Texas Comptroller website at <http://www.window.state.tx.us/taxinfo/taxforms/>

TEXAS APPLICATION FOR PAYEE IDENTIFICATION NUMBER



SUSAN COMBS • TEXAS COMPTROLLER OF PUBLIC ACCOUNTS
Claims Division
Austin, Texas 78774-0100

WHO MUST SUBMIT THIS APPLICATION -

This application must be submitted by every person (sole owner, individual recipient, partnership, corporation or other organization) who intends to bill agencies of the state government for goods, services provided, refunds, public assistance, etc. The Payee Identification Number (PIN) will be required on all maintenance submitted by state agencies. The use of this number on all billings will reduce the time required to process billings to the State of Texas.

NOTE: *To expedite processing of this application, please return the completed application to the state agency with which you are conducting business. It is not necessary for the payee to sign or complete this form. The state agency representative may complete the form for the payee.*

FOR ASSISTANCE -

For assistance in completing this application, please call the State Comptroller's Office at 1-800-531-5441, extension 3-3660, toll free nationwide. The Austin number is 512-463-3660.

NOTICE TO STATE AGENCIES -

When this form is used to set up additional mail codes, Sections I, II and V must be completed. State agencies may refer to the Texas Payee Information System Guide for additional information.

GENERAL INSTRUCTIONS -

- Please write only in white areas. (Shaded areas are for state agency use only.)
- Do not use dashes when entering Social Security, Federal Employer's Identification (FEI) or Comptroller's assigned numbers.
- Disclosure of your Social Security Number is required. This disclosure requirement has been adopted under the Federal Privacy Act of 1974 (5 U.S.C.A. sec. 552a(note)(West 1977), the Tax Reform Act of 1976 (42 U.S.C.A. sec. 405(c)(2)(C) (West 1992), and TEX. GOVT. CODE ANN. sec. 403.055 (Vernon Supp. 1992). Your Social Security Number will be used to help the Comptroller of Public Accounts administer the state's tax laws and for other purposes. See Op Tex. Att'y Gen. No. H-1255(1978).

SPECIFIC INSTRUCTIONS -

SECTION I - PAYEE IDENTIFICATION NUMBER

Enter a nine-digit Federal Employer's Identification (FEI) Number issued by the Internal Revenue Service if the business is a partnership or corporation, etc. Enter a nine-digit Social Security Number or the nine-digit Federal Employer's Identification (FEI) Number issued by the Internal Revenue Service if a sole owner. Enter the nine-digit Social Security Number if an individual recipient. The comptroller's assigned number is a number issued by the Texas Comptroller's Office for specialized usage. Please enter only ONE of these numbers and check the type of number entered. If known, enter the Texas Taxpayer Number in item 3.

SECTION II - PAYEE INFORMATION

Items 4 through 9 - Enter the complete name and mailing address where you want payments to be received. Names of individuals must be entered first name first. Each line cannot exceed 50 characters including spaces. If the name is more than 50 characters, continue the name in item 5 and begin the address in item 6. Item 9 - Enter the city, state and ZIP code.

SECTION III - OWNERSHIP CODES

Item 11 - Check the box next to the appropriate ownership code and enter additional information as requested. Please check only one box in this section. The Secretary of State's Office may be contacted at 512-463-5555 for information regarding Texas charter or file numbers.

SECTION IV - PAYMENT ASSIGNMENT

Item 12 - Use when one payee is assigning payment to another payee. When setting up an assignment payment, fill out this section completely and include the assignment agreement between the assignee and the assignor.

SECTION V - COMMENTS AND IDENTIFICATION

Item 13 - Enter any additional information that may be helpful in processing this application. Items 14 and 15 are for identification purposes. Always complete the identification section, including comments and authorized signature.

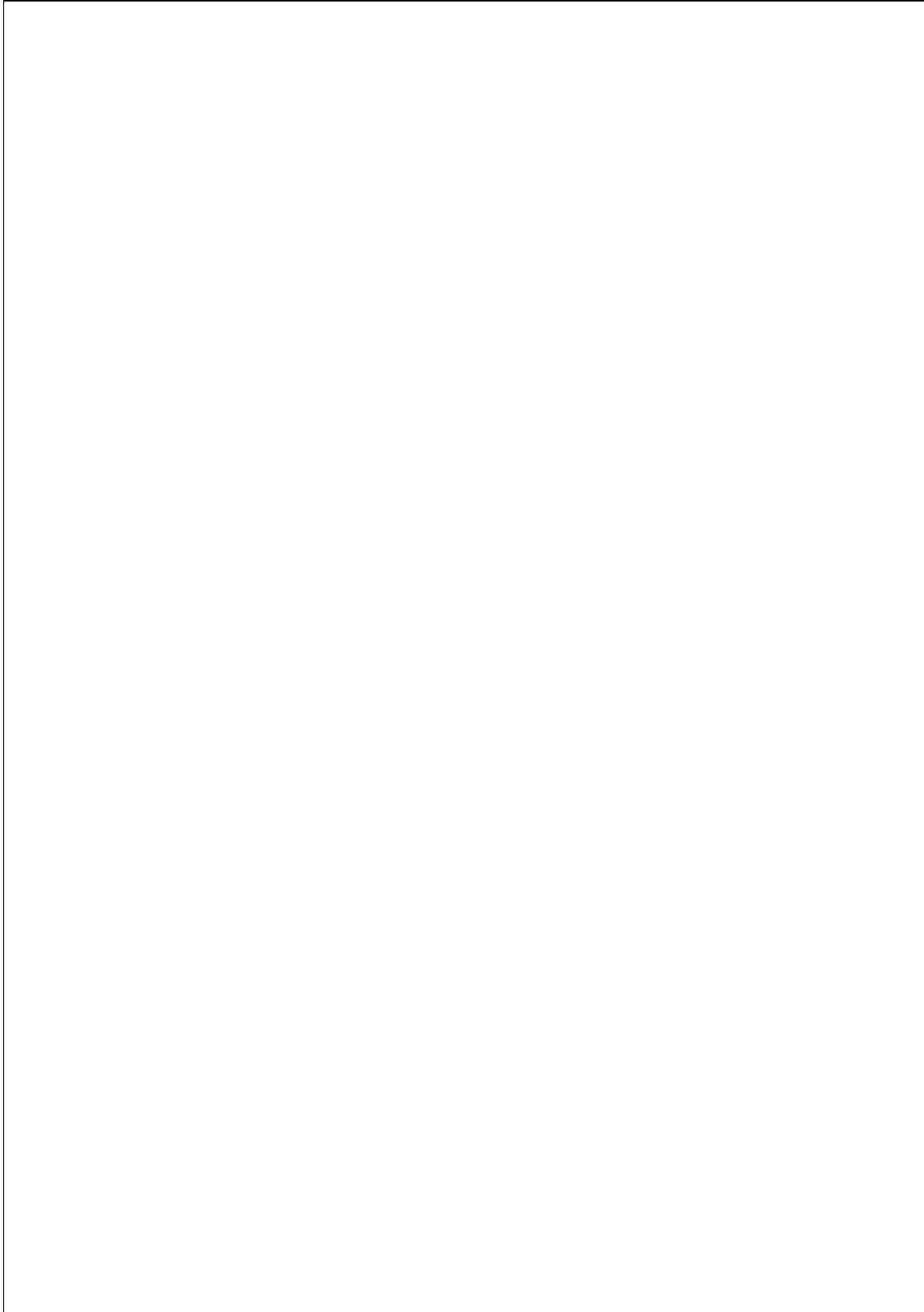
Under Ch. 559, Government Code, you are entitled to review, request, and correct information we have on file about you, with limited exceptions in accordance with Ch. 552, Government Code. To request information for review or to request error correction, contact us at the address or toll-free number listed on this form.

Form AP-152 (Back)(Rev.1-07/9)

SAMPLE - Vendor Direct Deposit Form

The vendor direct deposit authorization form may found at the website below. The form below has been included as a visual aid for the purpose of the guide.

<http://www.window.state.tx.us/taxinfo/taxforms/74-176.pdf>



Appendix D - Record Keeping, Documentation and Audit 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 _____.

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

- A completed MAC claim.

B. The following materials are on file for each employee who is being claimed as a Skilled Professional Medical Personnel.

- The class specifications or job description.
- A duty statement, if the job description is too generic to describe the individual's actual job responsibilities.
- 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.
- A table of organization showing the relationship of SPMPs to their direct supporting clerical staff.

Appendix E – Program Services

LHD Services

LHDs utilize funds to improve or strengthen local public health infrastructure by evaluating the effectiveness of providing essential public health services. The majority of services provided by LHDs include education and outreach to the community regarding prevention of disease and other priority public health concerns; surveillance and monitoring of the community's health through disease reporting and investigation; mobilization of community groups to develop plans for addressing the community's public health concerns; and development of local policies to safeguard and protect the community's health and safety.

Refer to the local LHD or DSHS website for a list of program 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/EPSTD 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 mental 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 - Acronyms

The following is a list of acronyms that are commonly used by HHSC.

CFR	Code of Federal Regulation
CMS	Centers for Medicare and Medicaid Services
ECI	Early Childhood Intervention
DADS	Department of Aging and Disability Services
DARS	Department of Rehabilitative Services
DSHS	Department of State Health Services
FFP	Federal Financial Participation
FMAP	Federal Medical Assistance Participation
FFY	Federal Fiscal Year (October 1 through September 30)
HCAT #	Health and Human Services Contract Administration Tracking Number
HHSC	Health and Human Services Commission
ISD	Independent School District
LHD	Local Health Department/District
MAC	Medicaid Administrative Claiming
MER	Medicaid Eligibility Rate
MHMR	Mental Health Mental Retardation
OIG	Office of Inspector General
OMB	Office of Management and Budget
PIN	Payee Identification Number
PL	Participant List
QSI	Quarterly Summary Invoice
RMTS	Random Moment Time Study
SPMP	Skilled Professional Medical Personnel
STAIRS	State of Texas Automated Information Reporting System
TAC	Texas Administrative Code
TEA	Texas Education Agency

Appendix G – MAC Financial Definitions and Terms

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

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

Participant List – A participant list is a list of public entity employees who are eligible to participate in a time study.

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

Direct Support Staff are public entity employees who directly support staff who provide direct services to entity clients/recipients.

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

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

Functional knowledge means that the candidate is able to actually perform the activity involved and explain verbally or in writing what they are doing."

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

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

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

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

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

Types of employees

Full-time employees is defined as generally working 38 hours per week and receiving full weekly wages and conditions for working the hours identified in the hiring contract. An employee should receive all wages and conditions under the hiring contract which includes annual leave and long service leave. If an employer-employee relationship exists between a public entity and an individual (regardless of what the relationship is called), then the individual is not an independent contractor.

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

Part-time employee is defined as one who works regularly less than 40 hours per week. Part-time employees are typically not eligible for the same benefits as full-time employees, such as vacation time, sick pay, and unemployment compensation, and may not be eligible for benefits at all. The Fair Labor Standards Act (FLSA) does not define full-time employment or part-time employment. This is a matter generally to be determined by the employer. Whether an employee is considered full-time or part-time does not change the application of the FLSA. Local laws and employer policies should be consulted for applicability to your job.

Casual employees/hourly employees are engaged to work on an hourly or daily basis and are compensated. They generally receive an extra amount on top of the normal rate of pay to compensate for not receiving benefits such as paid sick leave and paid public holidays

Independent Contractor - People such as doctors, dentists, veterinarians, lawyers, accountants, contractors, subcontractors, public stenographers, or auctioneers who are in an independent trade, business, or profession in which they offer their services to the general public are generally independent contractors. However, whether these people are independent contractors or employees depends on the facts in each case. The general rule is that an individual is an independent contractor if the payer has the right to control or direct only the result of the work and not what will be done and how it will be done.

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

Travel Costs are expenses/costs for transportation, lodging, subsistence, and related items incurred by employees who are in travel status on official business of the governmental unit

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

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

Equipment Costs –are expenses/costs incurred for an article of tangible nonexpendable personal property having a useful life of more than one year and an acquisition cost of \$5,000 or more per unit, as defined in 45 CFR Parts 74 and 92.

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

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

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

Appendix H – Rules and Statutes

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

TITLE 42 - PUBLIC HEALTH

- 42 CFR 431.1 Part 431 State Organization and General Administration
http://www.access.gpo.gov/nara/cfr/waisidx_10/42cfr431_10.html
- 42 CFR 431.15 Part 431.15 Methods of administration.
http://edocket.access.gpo.gov/cfr_2010/octqtr/42cfr431.15.htm
- 42 CFR 432.2 Centers for Medicare and Medicaid Services, Department of Health and Human Services, Part 432 State Personnel Administration, Subpart A General Provisions; Sec. 432.2 Definitions
http://edocket.access.gpo.gov/cfr_2010/octqtr/42cfr432.2.htm
- 42 CFR 432.50
(b)(1)(1986) Part 432.50 (b) Rates of FFP. (1) For skilled professional medical personnel and directly supporting staff of the Medicaid agency or of other public agencies (as defined in §432.2), the rate is 75 percent.
http://edocket.access.gpo.gov/cfr_2010/octqtr/42cfr432.50.htm
- 42 CFR 432.50(d)(1)(ii) Part 432.50 (d) Other limitations for FFP rate for skilled professional medical personnel and directly supporting staff
http://edocket.access.gpo.gov/cfr_2010/octqtr/42cfr432.50.htm
- 42 CFR 433.51 Part 433.51 Public funds as the State share of financial participation.
http://edocket.access.gpo.gov/cfr_2010/octqtr/42cfr433.51.htm

TITLE 45--PUBLIC WELFARE AND HUMAN SERVICES

- 45 CFR Part 74 and 95 Part 74 - Uniform administrative requirements for awards and sub-awards to institutions of higher education, hospitals, other nonprofit organizations, and commercial organizations
http://www.access.gpo.gov/nara/cfr/waisidx_08/45cfr74_08.html
Part 95 - General administration--grant programs (public assistance, medical assistance and state children's health insurance programs)
http://www.access.gpo.gov/nara/cfr/waisidx_08/45cfr74_08.html
- Part 95 - General administration--grant programs (public assistance, medical assistance and state children's health insurance programs)
http://www.access.gpo.gov/nara/cfr/waisidx_08/45cfr95_08.html

MEDICAID STATUTE SECTION OF THE SOCIAL SECURITY ACT

Social Security Act section 1903 (a)(2) Sec. 1903 (a)(2). Payment to States - [42 U.S.C. 1396b] (a) From the sums appropriated therefore, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—; (C) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under section 1919(e)(7);
http://www.ssa.gov/OP_Home/ssact/title19/1919.htm#act-1919-g-3-b

Medicaid statute section 1903(a)(7) of the Social Security Sec. 1903 (a)(7). Payment to States - [42 U.S.C. 1396b] subject to section 1919(g)(3)(B), an amount equal to 50 per centum of the remainder of the amounts expended during such quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.
http://www.ssa.gov/OP_Home/ssact/title19/1919.htm#act-1919-g-3-b

OFFICE OF MANAGEMENT AND BUDGET

OMB A-87 Office of Management and Budget
http://www.whitehouse.gov/omb/circulars_a087_2004
http://www.whitehouse.gov/omb/circulars_a087_2004

Texas Administrative Code Texas Department of Information Resources adopted the Guidelines for the Management of Electronic Transactions and Signed Records as a rule
[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac_view=4&ti=1&pt=10&ch=203](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=1&pt=10&ch=203)