

**MEDICAID ADMINISTRATIVE CLAIMING  
PARTICIPANT GUIDE**



**TEXAS HEALTH AND HUMAN SERVICES COMMISSION**

**Effective October 1, 2011**

## **Table of Contents**

Section One - Introduction

Section Two - Medicaid Administrative Claiming Overview

- A. Participation Requirements
- B. Public Entity's Roles and Responsibilities
  - 1. RMTS Coordinator/Contact
  - 2. MAC Financial Coordinator/Contact
  - 3. Documentation and Record Keeping
  - 4. State and Federal Audits
  - 5. Training
- C. Elements of a Claim
  - 1. Time Study
  - 2. Provider Cost Data
    - a. MAC Category
    - b. Cost Category
  - 3. Provider Revenue Data
    - a. Recognized Revenues
    - b. Unrecognized Revenues
  - 4. Medicaid Eligibility Percentage
  - 5. Federal Financial Participation Rate
  - 6. Direct Charge
- D. Claim Calculation and Submission
  - 1. Calculating the Claim
  - 2. Claim Submission Timeline
  - 3. State of Texas Automated Information Reporting System (STAIRS)
  - 4. Quarterly Summary Invoice (QSI)
  - 5. Accepted Uses of MAC Reimbursements
- E. HHSC and Public Entity's Responsibilities
  - 1. MAC Claim Desk Review
  - 2. The Desk Review Process Utilizing STAIRS Data
  - 3. STAIRS Edits/Audits

Section Five - Appendices

- Appendix A – RMTS Coordinator/Contact Roles & Responsibility
- Appendix B – MAC Financial Coordinator/Contact Roles & Responsibility
- Appendix C–Intergovernmental Cooperation & Business Associate Agreement
- Appendix D – Record Keeping, Documentation, and Audit Checklist
- Appendix E – Program Services
- Appendix F – Acronyms
- Appendix G – MAC Financial Definitions and Terms
- Appendix H – Rules and Statutes

## **Section One - 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), and 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.

### **Mental Health and Mental Retardation Program**

Texas has operated the MAC project since 1995. HHSC has partnered with local Mental Health Mental Retardation authorities (MHMR) throughout Texas to implement MAC for providers of MHMR services. The purpose of this partnership is to assist HHSC in providing effective and timely access to care for Medicaid recipients, more appropriate utilization of Medicaid covered services, and to promote activities that reduce the risk of poor health outcomes for the state's most vulnerable populations. MHMR 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. 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.

## **Section Two - 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 such as the Children's Health Insurance Program Reauthorization Act (CHIPRA) Services. 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.

### **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. The agreement includes a description of general terms, responsibilities, Medicaid administration, fiscal provisions, and amendments. Refer to the HHSC Acute Care MAC website or the link listed below For the most current version:

Intergovernmental Cooperation Agreement & Business Associate Agreement  
<http://www.hhsc.state.tx.us/rad/mac/mac-contracting.shtml>

Texas (Payee) Identification Number Application  
<http://www.window.state.tx.us/taxinfo/taxforms/ap-152.pdf>

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

Vendor Information Form  
<http://hhsc-online.hhsc.state.tx.us/AdminOps/Svcs/Cpp/forms/Cpp0430.doc>

### **B. Public Entity's Roles and Responsibilities**

Each public entity must designate an individual (an employee of public entity) as the Primary 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 Function**

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, provide

required training to selected time study participants, and ensure their availability to answer questions from sampled staff.

## **2. MAC Financial Coordinator/Contact Functions**

The MAC Financial Coordinator/Contact's function is to attend the required training provided by HHSC or its designee, understand the purpose of the RMTS and the PL, provide oversight and monitoring, 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.

## **3. 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.

## **4. 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.

## **5. Training**

Annual training is mandatory for all RMTS and MAC Coordinator/Contacts. Training sessions are conducted by the HHSC. Until such time that the RMTS and MAC Coordinators/Contact complete the mandatory training they will be given view-only access to the web-based system, upon meeting the training requirements. 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.

- 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.

## C. MAC Financial - Claiming Reimbursement

The claim submitted to the state for reimbursement has several elements: allowable Medicaid administrative time, provider cost data, revenue data, Medicaid Eligibility Percentage, Federal Financial Participation (FFP), and direct charge.

### 1. Time Study

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. A time study should be a reasonable representation of staff activity during the specified time study period.

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 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.

**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. 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 Non-Medical/Non-Medicaid related Training
- Medical/Medicaid related Training
- Referral, Coordination, and Monitoring Non-Medicaid Services
- Referral, Coordination, and Monitoring Medicaid Services
- General Administration
- Not Paid/Not Worked
- Non-Medical/Medicaid Provider Relations
- Medicaid Provider Relations

## **2. Provider Cost Data**

Cost included in the MAC claim shall be in accordance with the provisions of Office of Management and Budget (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.

Providers have an option of reporting expenditures for the MAC program either on a detailed basis (Provider Specific Cost) or on a summary basis (Provider Summary Costs).

### **a. MAC Staff Category**

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

### **Time Study Participant Staff**

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

### **Direct Support Staff**

Direct Support Staff are personnel who directly support time studied personnel and who do not qualify as general administrative personnel. In accordance with 42 CFR § 432.50, Direct support means the provision of clerical services, which are directly necessary to the completion of the professional medical responsibilities and functions of skilled professional medical personnel (SPMP). 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 the skilled professional medical personnel's responsibilities, the skilled professional medical personnel must be immediately responsible for 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 public entity has the burden of providing evidence to demonstrate the existence of the immediate and direct connection between the duties of the clerical support personnel and SPMP (i.e., evidence about specific work assignments initiated by the SPMP in an SPMP role).

### **Unstudied Staff (Cost Pool 3)**

Unstudied Staff are personnel who were not time studied and who provide services that are not medically related and do not provide general administrative services for the whole public entity are also included. Additionally, this cost pool would include staff whose staff costs are predominately supported by a federal grant. Costs 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.

Professional and contracted staff not time studied are included in the Unstudied Staff section. Professional services rendered by persons who are members of a particular profession or possess a special skill, and who are not officers or employees of the local authority, are allowable as referenced in the (OMB) Circular A-87.

Enter salaries and benefits for personnel who did not time study or are not included in the “Time Study Participant Staff” and “Direct Support Staff” as Unstudied Personnel section. This also does not include those personnel to be included in the General Administrative Staff section identified below.

#### **General Administration Staff (Cost Pool 4)**

General Administration Staff are personnel who do not time study and general administrative personnel (e.g., CEO/ED, Personnel, Business Office, Management Information System [MIS], etc.) are entered in this MAC Category. These personnel support the local agency as a whole, so their costs are allocated across all the appropriate cost areas. This MAC Category includes staff that provide general administration to the whole public entity and were not time studied, as well as costs which cannot be allocated in a more accurate fashion will be allocated to Cost Pool 4. This category also includes any overhead costs such as county or entity indirect costs and other “operating costs” that have not been entered in the Time Study, Direct Support Staff and the Unstudied Staff.

#### **b. Cost Category**

HHSC has established the following cost categories to account for all cost of the local agency.

##### **Employee Salaries**

Salaries are wages for individuals employed by you and for whom you are required to make FICA contributions. Salaries include overtime, cash bonuses, and any cash incentives paid from which payroll taxes are (or should be) deducted.

##### **Employee Benefits**

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

Workers' compensation costs refer to expenses associated with employee on-the-job injuries. Costs must be reported with amounts accrued for premiums, modifiers, and surcharges. Costs must be reported net of any refunds and discounts actually received or settlements paid during the same cost-reporting period. The premiums are accrued, while the refunds, discounts, or settlements are reported on a cash basis. Litigation expenses related to workers' compensation lawsuits are not allowable costs. Costs related to self-insurance are allowable on a claims-paid basis and are to be reported on a cash basis. Self-insurance is a means whereby a provider undertakes the risk to protect itself against anticipated liabilities by providing funds in an amount equivalent to liquidate those liabilities. Self-insurance can also be described as being uninsured. Contributions to self-insurance funds that do not represent payments based on current liabilities are unallowable costs.

##### **Contracted Staff Cost**

Contracted Staff performing any Direct Services (DS) or Medicaid Administrative Claiming(MAC) activities, must participate in the RMTS. The Contracted Staff cost reported under this section are personnel performing DS and MAC that have participated in RMTS. Contracted staff are individuals for whom the provider is not responsible for the payment of payroll taxes (such as FICA, FUTA, and TUCA). Contracted staff refers to those persons performing functions routinely performed by employees. Contracted staff does not include consultants; however, includes temporaries, substitutes, and contract labor.

## **Other Costs**

### **Travel and Training**

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

Costs incurred by employees and officers for travel, including costs of lodging, other subsistence, and incidental expenses, shall be considered reasonable and allowable only to the extent such costs do not exceed charges normally allowed by the governmental unit in its regular operations as the result of the governmental unit's written travel policy. In the absence of an acceptable, written governmental unit policy regarding travel costs, the rates and amounts established under subchapter I of Chapter 57, Title 5, United States Code ("Travel and Subsistence Expenses; Mileage Allowances"), or by the Administrator of General Services, or by the President (or his or her designee) pursuant to any provisions of such subchapter shall apply to travel under Federal awards (48 CFR 31.205-46(a)).

### **Materials & Supplies**

This includes cost incurred for materials, supplies, and fabricated parts necessary to carry out the governmental entities services. 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. Where federally donated or furnished materials are used in performing the Federal award, such materials will be used without charge.

### **Equipment & Operating Cost**

Equipment is an article of nonexpendable, tangible personal property having a useful life of more than one year and an acquisition cost which equals or exceeds the lesser of the capitalization level established by the governmental unit for financial statement purposes, or \$5000. Equipment is not limited to research, medical, scientific or other technical activities. Examples include office equipment and furnishings, modular offices, telephone networks, information technology equipment and systems, air conditioning equipment, reproduction and printing equipment, and motor vehicles.

### **3. Provider Revenue Data**

There are two types of revenue sources for the purpose of the Medicaid Administrative Claim. Some revenues are not recognized by the federal Medicaid agency as revenue that can be used to offset costs, but rather are designated as the matching funds necessary to draw down the federal support. These funds are designated as Unrecognized Revenues. In determining the share of the costs for which it is willing to pay, the federal government generally expects a local agency to utilize its own income to offset costs, lowering the amount in which the federal government is responsible to participate. These revenues are referred to as Recognized Revenues.

#### **a. Unrecognized Revenues**

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. 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. Enter the following MAC revenue categories:

##### **Donations to Public Agencies**

All donations to public (legislatively mandated) agencies are placed in this item.

##### **Federal Emergency Management Assistance Reimbursement (Title IV-A)**

These are Federal Emergency Management Assistance funds and grants to States for aid and services to needy families with children and for child welfare services.

##### **Local Government Funds**

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

##### **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. This section is utilized to verify MAC match requirements as stated in CFR 433.51 and full reporting.

##### **Other State Funds**

These are General Revenue and grants from state funds from all state agencies.

#### **b. Recognized Revenues**

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

##### **Donations to Contractor**

This category is used only by private agencies.

##### **Federal Grants + Match**

It is important to identify which funding sources are federal and which are state. A federal grant may pass through one or more state agencies, but it is still federal money. 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 local agency preparing the claim. Inputting and adding the match must be done separately for each grant. Placing these funds into the correct cost pool requires determining what expenditures the grant covers. If the grant funds the entire salary of a time study personnel, then at least the portion of the grant pertaining to the expenses of that personnel must be placed in General Administration Staff (Cost Pool #4) in order to allocate to all the cost pools, just as those expenditures are allocated. If the grant covers only specific direct service activities of a time study personnel, and/or specifically excludes such activities, then the grant receipts for the personnel may be placed in the Unstudied / Unallowed Revenue (Cost Pool #3).

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

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

### **Fees**

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

### **Insurance**

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

### **Medicaid Fees + Match**

This section includes all Title XIX reimbursement and, where required, the State Matching Funds. To calculate the matching funds, divide the receipts by the Federal Participation Rate to get the total of reimbursements and match. All Medicaid funds are placed in the Unstudied / Unallowed Revenue (Cost Pool #3), as they are earned by direct service activities.

### **Medicare**

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

### **Other Revenue**

All revenue sources not previously mentioned are generally placed in the Unstudied / Unallowed Revenue (Cost Pool #3), although some are specifically assigned to General Administration Staff (Cost Pool #4).

Assign miscellaneous revenues, which are one-time, unusual or not readily identifiable and were placed in a miscellaneous account to General Administration Staff (Cost Pool #4). This includes Interest Income, Other Business Income, and Fundraising Income not specifically designated for a specific Unstudied Cost Pool activity and any other purely administrative

income.

Place revenues for vocational production, from clients, families or other sources covering residential costs and grants from private foundations in the Unstudied / Unallowed Revenue (Cost Pool #3).

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#### 4. 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 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).

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

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.

#### 5. 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 such as CHIRPA. The results of the time study are multiplied by the administrative costs at either 50% or 75% FFP.

#### 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 3c. Other Cost. The adjustment will be reflected on Step 5. Verify section of the STAIRS system.

## **D. Claim Calculation and Submission**

### **1. 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 (CHIRPA))	equals
Subtotal	Plus
Direct Charge @ 50% FFP	equals
The amount of federal request	

### **2. 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.

### **3. 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. Public entities participating in MAC will utilize STAIRS to complete their MAC claims. Once the 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.

### **4. 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 will be generated by the STAIRS system. Prior to signing and uploading into the STAIRS system, please ensure the following:

The proper employee of the local authority is responsible for signing the Quarterly Summary Invoice (QSI) which certifies that the following items are true and correct:

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

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

## **5. 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.

## **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.

### **3. STAIRS Edits/Audits**

HHSC has developed financial reporting system edits that prompt the provider to include additional information or an explanation of the variance on the cost reported. The edits/audits may vary each quarter. The provider is required to respond to the edits in order for HHSC to conduct an appropriate desk review of the MAC claim.

## **APPENDICIES**

### **Appendix A – 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, 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.

#### **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.

### **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.

#### 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.

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.

## **Appendix B – MAC Financial Coordinator/Contact**

### **Functions**

The MAC Financial Coordinator/Contact's function is to attend the 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.

### **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.

### **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.

## Appendix C – Forms

### 1. Intergovernmental Cooperation Agreement

STATE OF TEXAS

§

COUNTY OF TRAVIS

§

INTERAGENCY COOPERATION CONTRACT

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

\_\_\_\_\_ Early Childhood Intervention hereafter referenced as ECI 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 Medicaid Administrative Claiming (MAC) Guide hereafter referenced as “the MAC Guide” and appendices as issued by HHSC. Allowable activities under Medicaid administration are described in detail in the MAC Guide. Attachment A – Business Associate Agreement is attached hereto and incorporated herein for all purposes.

The ECI 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 ECI agrees to perform or coordinate its subcontractors' performance of Medicaid administrative activities on behalf of 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 MAC Guide.

The ECI agrees to submit its quarterly participation data using the HHSC standardized Time Study (TS)/MAC Financial system. All financial expenditure data must be submitted to HHSC via the TS/MAC Financial system in adherence with the MAC timeframes outlined in the MAC Guide. The ECI agrees to provide support for any expenditures information included in the quarterly claims data it submits to HHSC, or its designee, in the manner and timeframes described in the MAC Guide.

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

The ECI agrees to spend the federal match dollars generated from Medicaid administrative activities for health-related services for clients.

The ECI 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 the ECI.

#### II. GENERAL RESPONSIBILITY

HHSC recognizes the unique relationship that the ECI, and the affiliated entities operating under contract or memorandum of understanding with the ECI, has with its Medicaid eligible clients. HHSC further recognizes the expertise of the ECI in identifying and assessing the health care needs of Medicaid eligible clients it serves and in planning, coordinating, and monitoring the delivery of preventive and treatment services to meet their needs. In order to take advantage of this expertise and relationship and to promote the proper and efficient administration of the Texas Medicaid Program, HHSC has entered into this agreement with the ECI.

HHSC and the ECI enter into this agreement with full recognition of its relationship to any other agreements that HHSC may have developed for services to Medicaid eligible clients living in Texas and which are currently included in the Texas Medicaid Program.

### **III. BASIS FOR CALCULATING REIMBURSABLE COSTS**

HHSC agrees to pass through to the ECI no less than ninety-five percent (95%) of the 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. 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.

The rate of reimbursement for allowable administrative activities performed by personnel other than Skilled Professional Medical Personnel (SPMP) shall be 50 percent of such costs. The rate of reimbursement for activities qualifying under regulations applying to SPMP and their direct supporting clerical staff shall be 75 percent of such costs for activities identified as "enhanced" or 50 percent for activities identified as "non-enhanced." Categories of costs eligible for 75 percent reimbursement include the following items only: compensation and applicable fringe benefits, travel and training of SPMP and their direct supporting clerical staff.

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 ECI and this Agreement will be amended to reflect the applicable changes in federal regulations.

HHSC agrees to include the ECI 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 MAC Guide.

HHSC agrees to reimburse claims for Medicaid administration from the ECI only if the ECI 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 staff to act as liaison with the ECI for issues concerning this agreement.

### **IV. LAWS AND REGULATIONS GOVERNING CIVIL RIGHTS**

(a) ECI agrees to comply with state and federal anti-discrimination laws, including without limitation:

- (1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*);
- (2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);
- (3) Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq.*);
- (4) Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);
- (5) Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);
- (6) Food Stamp Act of 1977 (7 U.S.C. §200 *et seq.*); and
- (7) The HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

ECI agrees to comply with all amendments to the above-referenced laws, and all requirements imposed by the regulations issued pursuant to these laws. These laws provide in part that no persons in the United States may, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service or other benefits provided by Federal or State funding, or otherwise be subjected to discrimination.

(b) ECI agrees to comply with Title VI of the Civil Rights Act of 1964, and its implementing regulations at 45 C.F.R. Part 80 or 7 C.F.R. Part 15, prohibiting a contractor from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of clients in its

programs, benefits, or activities on the basis of national origin. Applicable state and federal civil rights laws require contractors to provide alternative methods for ensuring access to services for applicants and recipients who cannot express themselves fluently in English. ECI agrees to ensure that its policies do not have the effect of excluding or limiting the participation of persons in its programs, benefits, and activities on the basis of national origin. ECI also agrees to take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities.

(c) ECI agrees to comply with Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16. These provide in part that any organization that participates in programs funded by direct financial assistance from the United States Department of Agriculture or the United States Department of Health and Human Services shall not, in providing services, discriminate against a program beneficiary or prospective program beneficiary on the basis of religion or religious belief.

(d) Upon request, ECI will provide HHSC Civil Rights Office with copies of all of the ECI'S civil rights policies and procedures.

(e) ECI must notify HHSC's Civil Rights Office of any civil rights complaints received relating to its performance under this Agreement. This notice must be delivered no more than ten (10) calendar days after receipt of a complaint. Notice provided pursuant to this section must be directed to:

HHSC Civil Rights Office  
701 W. 51<sup>st</sup> Street, Mail Code W206  
Austin, Texas 78751  
Phone Toll Free: (888) 388-6332  
Phone: (512) 438-4313  
TTY Toll Free: (877) 432-7232  
Fax: (512) 438-5885.

## **V. TERM OF AGREEMENT**

This agreement is to begin upon execution and shall continue until terminated by either HHSC or the ECI.

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

## **VI. 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 ECI 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: \_\_\_\_\_

Billy Millwee

Associate Commissioner for Medicaid & CHIP

Date: \_\_\_\_\_

**PERFORMING AGENCY**

EARLY CHILDHOOD INTERVENTION

By: \_\_\_\_\_

Executive Director/CEO

Date: \_\_\_\_\_

sample

## 2. Business Associate Agreement

HHSC

STATE OF TEXAS  
COUNTY OF TRAVIS

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

## 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 (SPMP).

- 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

### Medicaid Covered Services

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

- Physicians' services
- Hospital review
- Clinic services for children under 21
- Limited maternity care clinics
- Lab and X-ray services
- Home health care
- THSteps/EPSTDT screens and services
- Medically needed oral surgery and dentistry for adults (not routine dentistry)
- Pharmacy services (prescription drugs)
- Rehabilitative mental health and mental retardation services (provided by the Texas Department of Mental Health and Mental Retardation and its contract agencies, including local mental health and 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
TIN	Texas Identification Number

## Appendix G – MAC Financial Definitions and Terms

**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** 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](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](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](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](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](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](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](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](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](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](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](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)  
[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)