

# **TEXAS**

## **Health and Human Services Commission**



## **Medicaid Administrative Claiming**

**March 30, 2012**

## MEDICAID ADMINISTRATIVE CLAIMING GUIDE

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## **SECTION ONE IMPLEMENTING MEDICAID ADMINISTRATIVE CLAIMING (MAC)**

### Overview

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

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

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

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

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

### Health and Human Services Commission Required Participation Documents

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

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

### Public Entities' Responsibilities for Participation in MAC

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

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

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

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

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

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

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

**SECTION TWO  
MEDICAID ADMINISTRATIVE CLAIMING**

Overview

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

The Elements of the Claim

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

*Allowable Medicaid Administrative Time*

Time Study Activities/Codes

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

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

The time study activity code indicators are:

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

		which the costs are limited to the proportion if Medicaid eligible's served.
	R	Reallocated – refers to those general administrative activities which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under Code 15, General Administration.

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

*Cost Pool Construction*

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

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

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

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

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

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

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

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

### *Cost Pool Construction*

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

### *Medicaid Percentage*

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

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

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

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

= Medicaid Percentage for the quarter

### *Federal Financial Participation (FFP) Rate*

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

### *Revenue Offset*

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

Examples include:

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

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

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

Insurance receipts

Fees paid by or on behalf of clients for direct service

Donations to Public Entity are only used by private entities

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

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

Examples include:

Medicaid Administrative Reimbursement is the reimbursement received for this claim process

Other State Funds are General Revenue and grants from state funds

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

Donations to Public Agencies are legislatively mandated donations received

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

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

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

### *Direct Charge*

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

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

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

Calculating the Claim

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

- Participant staff costs multiplied by
- Percent of time claimable to Medicaid administration multiplied by
- Medicaid percentage (the percentage of Medicaid eligible's in the service population) plus
- Direct Charge plus
- Allocated General Administrative costs Subtotal equals multiplied by
- Percent of FFP (50% for some costs and 75% for other costs) equals

The amount of federal request

#### Financial Data

As stated in the ICA the public entity agrees to spend the federal match dollars generated from Medicaid administrative activities for health-related services for clients. The financial data to be included in the calculation of the MAC claim are to be based on actual expenditures incurred during the quarter. These costs must be obtained from actual detailed expenditure reports generated by the provider's financial accounting system. Claims may not be based on quarterly budgets.

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

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

#### Direct Costs

- Compensation of employees and Contractor and Direct Clerical Support Costs
- Cost of materials acquired, consumed, or expended
- Equipment
- Travel and training expenses incurred
- Other Operating Costs

#### Indirect Costs

Indirect costs included in the claim are computed by multiplying the costs by the public entity's approved unrestricted indirect cost rate. These indirect rates are developed by the entity's state cognizant agency and are updated annually. The methodology used by the respective state cognizant agency to develop the indirect rates has been approved by the cognizant federal agency, as required by the CMS guide. Indirect costs are included in the claim as reallocated costs. If an approved indirect cost rate is not available for a participating entity from its cognizant agency, the participating public entity's indirect cost rate will be capped at ten percent (10%).

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

### Allocated Costs

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

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

### Unallowable Costs

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

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

### Claim Certification

Public Entities will only be reimbursed the federal share of any MAC claims billed. The Chief Financial Officer (CFO), Chief Executive Officer (CEO), Executive Director (ED) or other individual designated by the public entity as the financial contact will be required to certify the accuracy of the submitted claim and the availability of matching funds necessary. The certification statement will be included as part of the invoice and will meet the requirements of 45 CFR parts 74 and 95.

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

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

#### Overview

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

#### Building and Maintaining a Supporting Documentation File

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

#### State and Federal Audits/Reviews

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

## **SECTION FOUR PARTICIPATING ENTITIES**

### **Early Childhood Intervention Program**

#### Overview

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

#### MAC Financial Claiming Elements

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

##### *Allowable Medicaid Administrative Time*

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

##### *Cost Pool Construction*

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

##### *Medicaid Percentage*

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

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

*Federal Financial Participation (FFP) Rate*

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

*Revenue Offset*

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

*Direct Charge*

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

## **Local Health Departments**

### **Overview**

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

### **MAC Financial Claiming Elements**

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

#### *Allowable Medicaid Administrative Time*

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

#### *Cost Pool Construction*

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

#### *Medicaid Percentage*

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

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

#### *Federal Financial Participation (FFP) Rate*

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

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

#### *Revenue Offset*

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

#### *Direct Charge*

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

## **Mental Health and Mental Retardation**

### **Overview**

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

### **MAC Financial Claiming Elements**

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

#### *Allowable Medicaid Administrative Time*

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

#### *Cost Pool Construction*

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

#### *Medicaid Percentage*

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

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

#### *Federal Financial Participation (FFP) Rate*

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

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

#### *Revenue Offset*

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

#### *Direct Charge*

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