Oregon Aging & Disability Resource Connection

Oregon Medicaid Administrative Claiming (OMAC) Guide

Last updated: 6/10/2019

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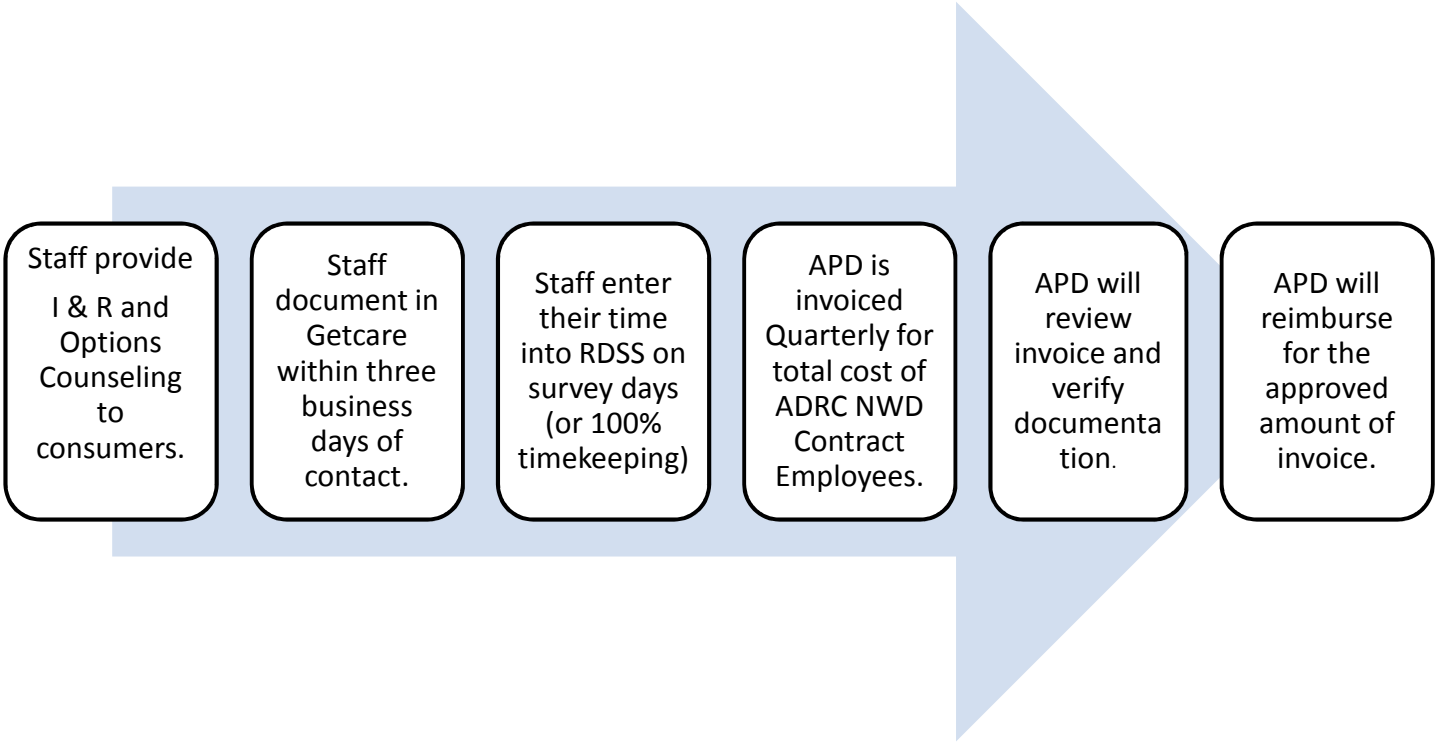
What is Oregon's ADRC Medicaid Administrative Claiming (OMAC)?

Title XIX of the Social Security Act (the Act) authorizes federal grants to states for a proportion of expenditures for medical assistance under an approved Medicaid state plan, and for expenditures necessary for administration of the state plan. This joint federal-state financing of expenditures is described in section 1903(a) of the Act, which sets forth the rates of federal financing for diverse types of expenditures.

Under section 1903(a)(7) of the Act, federal payment is available at a rate of 50 percent for amounts expended by a state "as found necessary by the Secretary for the proper and efficient administration of the state plan," per 42 Code of Federal Regulations (CFR) 433.15(b)(7). The Secretary is the final arbiter of which administrative activities are eligible for funding.

Claims for Medicaid administrative Federal Financial Participation (FFP) must come directly from the single state Medicaid Agency. In addition, the state must ensure that permissible, non-federal funding sources are used to match federal dollars.

ADRC – No Wrong Door Program Flow



Qualifying activities for OMAC

Federal matching funds under Medicaid are available for the cost of administrative activities that directly support efforts to identify and enroll potential eligible consumers into Medicaid and that directly support the provision of medical services covered under the state Medicaid plan. Time spent discussing Medicaid is claimable, even if it is determined the consumer is currently ineligible.

Federal match is allowable for ADRC Information and Referral and Options Counseling activities related to the Medicaid services detailed below specifically. This includes time spent traveling to/from meeting with a consumer and on administrative tasks related to the encounter. Qualifying activities can only be claimed once during a calendar month. Federal match cannot be claimed for time spent on activities outside the realm of these Medicaid services.

Information and Referral (I&R)

ADRC Information and Referral is a service that provides consumers with information, referrals to, or assistance with accessing services available to help address their long-term care needs. ADRC I&R is performed as set forth by the ADRC consumer-based standards: https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/ADRCDocuments/ADRC%20Consumer%20Based%20Standards%20for%202015.pdf.

Options Counseling (OC)

ADRC Options Counseling is a service that includes person-centered planning and short-term support to help address a consumer's long-term care needs. ADRC OC is performed as set forth by the ADRC consumer-based standards: https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/ADRCDocuments/ADRC%20Consumer%20Based%20Standards%20for%202015.pdf.

To qualify as options counseling, the following steps must be taken:

1. The need for Person-Centered Options Counseling must be determined, the consumer must be enrolled in OC in the Caretool, and the minimum required data elements must be recorded.
2. A person-centered assessment must be documented in the Caretool. Ideally the assessment occurs in person with the consumer. It must include goals, needs, values and preferences, etc.
3. There must be a documented action plan and progress notes reflecting outcomes.
4. The OC must provide information about public and private sector resources.
5. The OC must facilitate self-direction.
6. The OC must encourage future orientation.
7. The OC must follow-up with the consumer and all follow-ups must be documented in the Caretool.
8. Once action plan goals have been met or the consumers' needs have been addressed, outcomes should be documented and there should be a disenrollment in the Caretool.

Qualifying consumers for OMAC

i. Individuals not already receiving Medicaid services and who are eligible or potentially eligible for one or more of the Medicaid services identified below.
ii. Individuals already receiving any of the Medicaid services identified below and who are being provided help with accessing any of the Medicaid services.

Consumer screening protocol

i. ADRC staff should screen to identify if the consumer is already receiving Medicaid or Medicaid LTSS services.

ii. Staff are encouraged to search for consumers in Oregon Access, if staff are authorized to use this system, to determine if the consumer is receiving Medicaid/Medicaid LTSS. If staff do not have access to Oregon Access, staff are encouraged to ask questions such as:

    a. Do you have someone who helps you at home with your daily living activities? If so, do you pay for that care, or does the State help you with payment?

b. Does the State help you with your Medicare premiums?

c. Do you have health insurance through the State?

iii. Consumers receiving Medicaid but not receiving Medicaid LTSS services:

a. Should be directed to their local office eligibility worker for assistance regarding their Medicaid benefits. These referrals back to their eligibility worker are eligible to be claimable for federal match. Please note: consumers receiving SNAP benefits *only* do not need to be referred back to their eligibility worker, and can be assisted directly by ADRC staff.

b. May receive information and referral (I&R). Qualifying activities are claimable for federal match.

c. May receive options counseling. Qualifying activities are claimable for federal match.

iv. Consumers receiving Medicaid LTSS services, as defined below under Medicaid long-term services and supports, K plan services:

a. Should be directed to their Medicaid case manager for assistance. These referrals back to their case manager are eligible to be claimable for federal match.

b. May receive Information and Referral (I&R) if requested or referred to the ADRC by the Medicaid Case Manager. In these instances, qualifying activities performed by the ADRC staff person are claimable for federal match, provided they are not also being claimed for by the Medicaid case manager.

c. Should not be enrolled in Options Counseling. They should be referred to their Medicaid case manager to have their needs addressed. These referrals back to their case manager are eligible to be claimable for federal match.

Medicaid services that qualify for OMAC

a. **Medicaid services - Physical health**: Doctor visits, preventive services, testing, treatment for most major diseases, emergency ambulance and 24-hour emergency care, family planning services, and pregnancy and newborn care.

b. **Medicaid services - Behavioral health**: Mental health and counseling, and help with addiction to tobacco, alcohol and drugs.
c. **Medicaid services - Dental health**: **Medicaid services -** Cleanings and preventive treatments, dental check-ups and x-rays, fillings, tooth removal, 24-hour emergency care.
d. **Medicaid services - Prescriptions**: OHP with Limited Drug only includes drugs not covered by Medicare Part D.
e. **Medicaid services - Eye care:** Medical care; glasses to treat a qualifying medical condition such as aphakia or keratoconus, or after cataract surgery.
f. **Medicaid services - Vision care**: Exams and glasses (only for pregnant women and children under age 21).
g. **Medicaid services – Ancillary services:** OHP can pay for hearing aids, medical equipment, home health care, skilled therapy, hospital care, Medicare premiums, co-pays, and deductibles, and transportation to health care appointments.
h. **Medicaid services - Personal Care Services:** Assistance with Activities of Daily Living for people residing in their own home. Limited to 20 hours per month.
i. Medicaid services - Home Health Services.
j. Medicaid services - **Nursing Facility Services**
k. **Medicaid long-term services and supports** - **K Plan Services:** LTSS services including: Adult Day Health, Adult Foster Homes, Assisted Living, Community Nursing, Home Modifications, In-Home Services, Home Delivered Meals, Non-medical Transportation, Residential Care, Technology and Adaptive Equipment, Specialized Medical Equipment and Supplies, Skills Training (STEPS), Transition Services (Nursing Facility to Community)
l. Medicaid long-term services and supports - Waiver services: Case management and transition services (community-based to in-home)
m. Medicaid long-term services and supports - **PACE (Program for All-inclusive Care for the Elderly) Services**
n. Medicaid long-term services and supports - **Independent Choices program**

Note: Supplemental Nutrition Assistance Program (SNAP) and Adult Protective Services (APS) are not qualifying OMAC services because they are not Medicaid services.

Documentation requirements

Documentation in Oregon's ADRC GetCare software system and labor time tracking in the Random Daily Sampling Survey (RDSS) system (or 100% timekeeping if pre-approved) are required in order to obtain reimbursement for activities funded by the No Wrong Door (NWD) contract, even for activities claimed that are not OMAC reimbursable. The instructions below detail the minimum documentation requirements in GetCare.

Minimum requirements for Information and Referral (I&R)

For each qualifying I&R activity, you must:

1. Record minimum data requirements for the consumer based on call type.

2. Attach qualifying referral(s) and document unmet needs.

3. In FollowUp/Notes, choose an answer for "Do you want to follow up?"

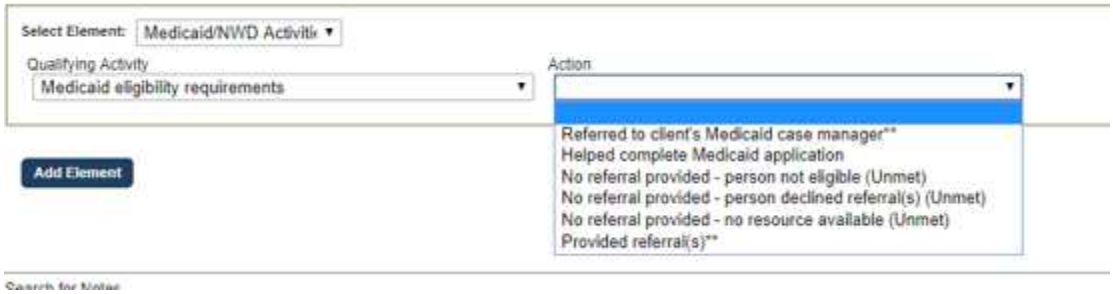
4. Narrate the I&R contact as usual. You do not need to add extra narration for Medicaid activities.

5. Select Add Element: Medicaid/NWD Activities.

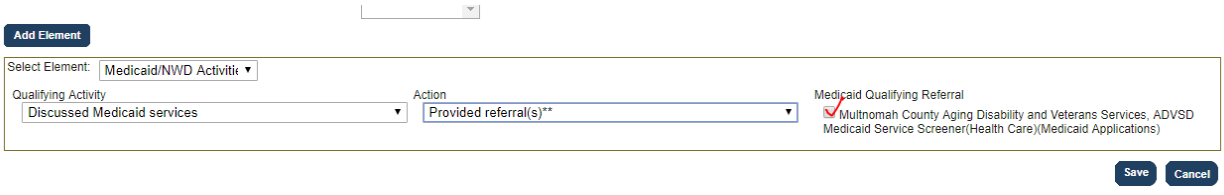
6. Select the activity/topic discussed with the consumer from the dropdown (add additional elements for each qualifying activity). Note:

You can only claim a qualifying activity once during each calendar month. You should still provide assistance and record your work in GetCare but only record the specific qualifying Medicaid activity one time during each calendar month.

7. Select an Action.



8. If you select “Provided referral(s)” or “Referred to client’s Medicaid case manager”, select one of the saved referrals from the list on the right. The referral selected must be an allowable Medicaid referral and must correspond to the allowable Medicaid topic discussed. Do not select referrals that are not allowable for Medicaid administrative claiming.



9. Select “add additional element” and repeat step three to record each additional qualifying activity discussed during the call.

Minimum requirements for Options Counseling (OC)

For Caretool activities, you must:

1. Make sure there is an active enrollment and complete minimum data requirements.

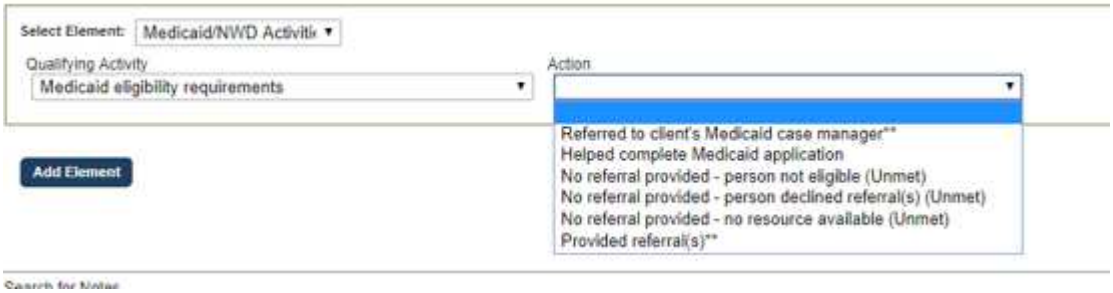
2. Complete and save any Referrals for Medicaid related activities and document any Unmet Needs.

3. Add a Progress Note and narrate as usual. You do not need to add extra narration for Medicaid activities.

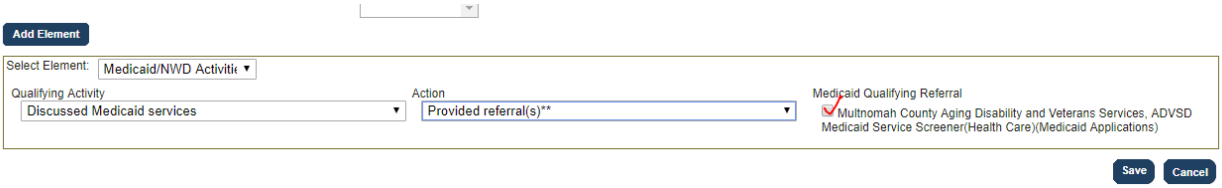
4. Add Element “Medicaid/NWD Activities”.

5. Select the activity/topic discussed with the consumer from the dropdown (add additional elements for each qualifying activity). Note: You can only claim a qualifying activity once during each calendar month. You should still provide assistance and record your work in GetCare but only record the specific qualifying Medicaid activity one time during each calendar month.

6. In the second dropdown, select an Action.



7. If you select “Provided referral(s)” or “Referred to client’s Medicaid case manager”, select one of the saved referrals from the list on the right. The referral selected must be an allowable Medicaid referral and must correspond to the allowable Medicaid topic discussed. Do not select referrals that are not allowable for Medicaid administrative claiming.



8. Select “Add Element” and repeat step three to record each additional qualifying activity discussed during the encounter.

9. Add other Elements to complete the Progress Note as usual.

10. Save and Sign.

Medicaid qualifying activity options

Discussed Medicaid coverage options and/or Medicaid eligibility requirements: Select this option when you’ve discussed Medicaid coverage options and/or eligibility requirements with a consumer who is not already receiving Medicaid but may be eligible. Also select this option when referring a consumer to apply for Medicaid.

Discussed Medicaid services: Select this option when a consumer has received a referral to apply for Medicaid, is in the process of applying for Medicaid, or is already receiving Medicaid. Select this option when discussing Medicaid services and providing referrals to Medicaid service providers to help address consumer needs once they receive Medicaid. Do not select this option when referring a consumer to apply for Medicaid.

Discussed Medicaid long-term services and supports: Select this option when a consumer has received a referral to apply for Medicaid, is in the process of applying for Medicaid, or is already receiving Medicaid.

Select this option when discussing Medicaid long-term services and supports (LTSS) and providing referrals to Medicaid LTSS service providers to help address consumer needs once they receive Medicaid. See consumer screening protocol section iv above for consumers already receiving Medicaid LTSS. Do not select this option when referring a consumer to apply for Medicaid.

Provided Medicaid application completion assistance: Select this option when helping a consumer complete a Medicaid application. This includes entering screening information into a software system that populates the data into an electronic application. Do not select this option when referring a consumer to apply for Medicaid.

Documentation scenarios

Scenario 1: Consumer contacts ADRC inquiring about health insurance options. ADRC staff discusses eligibility requirements and asks consumer questions to help determine if the person may be eligible for Medicaid. Staff thinks consumer is eligible for Medicaid based on conversation and offers a referral to apply. Consumer accepts referral. Staff also provides referrals for the Supplemental Nutrition Assistance Program (SNAP) and the Oregon Project Independence (OPI) program.

Document the following:

- Qualifying activity: Discussed Medicaid coverage options and/or Medicaid eligibility requirements
- Qualifying action: Provided referral(s)
- Qualifying referral: Select the recorded referral to the Medicaid office
    - Note: Do not select the other referrals made because they are not allowable for Medicaid administrative claiming.

Scenario 2: Consumer contacts ADRC inquiring about health insurance options. ADRC staff discusses eligibility requirements and asks consumer questions to help determine if the person may be eligible for Medicaid. Staff thinks consumer is eligible for Medicaid LTSS based on conversation and

offers a referral to apply. Consumer accepts referral. Staff also provide referral(s) to Medicaid LTSS service providers to help address consumer needs once they receive Medicaid. Additionally, staff provided a referral to the Supplemental Nutrition Assistance Program (SNAP).

Document the following:

- Qualifying activity: Discussed Medicaid coverage options and/or Medicaid eligibility requirements
- Qualifying action: Provided referral(s)
- Qualifying referral: Select the recorded referral to the Medicaid office

AND

- Qualifying activity: Discussed Medicaid long-term services and supports
- Qualifying action: Provided referral(s)
- Qualifying referral: Select the recorded referral(s) for the Medicaid LTSS providers referred to.
    - Note: Do not select any referrals made that are not allowable for Medicaid administrative claiming. In this instance, SNAP.

Scenario 3: Consumer contacts ADRC because they need help finding Medicaid service providers to help address a medical need. Consumer is already receiving Medicaid but not Medicaid LTSS. ADRC staff provides referrals to Medicaid service providers.

Document the following:

- Qualifying activity: Discussed Medicaid services
- Qualifying action: Provided referral(s)
- Qualifying referral: Select the recorded referral(s) for the Medicaid service providers referred to.
    - Note: Do not select any referrals made that are not allowable for Medicaid administrative claiming.

Scenario 4: ADRC staff receives referral from hospital for consumer who may be eligible for Medicaid. ADRC staff enters consumer information into

GetCare as an I&R contact and records referral to Medicaid office. Staff also creates an eligibility screening in OACCESS for the consumer (begins data entry for the Medicaid application).

Document the following:

- Qualifying activity: Discussed Medicaid coverage options and/or Medicaid eligibility requirements
- Qualifying action: Provided referral(s)
- Qualifying referral: Select the recorded referral to the Medicaid office

AND

- Qualifying activity: Provided Medicaid application completion assistance
- Qualifying action: Helped complete Medicaid application

Scenario 5: Consumer contacts ADRC inquiring about health insurance options. ADRC staff discusses eligibility requirements and asks consumer questions to help determine if the person may be eligible for Medicaid. Staff thinks consumer is eligible for Medicaid based on conversation and offers a referral to apply. Consumer refuses referral.

Document the following:

- Qualifying activity: Discussed Medicaid coverage options and/or Medicaid eligibility requirements
- Qualifying action: No referral(s) provided – person declined referral(s)

Scenario 6: Consumer contacts ADRC inquiring about health insurance options. ADRC staff discusses eligibility requirements and asks consumer questions to help determine if the person may be eligible for Medicaid. Staff determines consumer is not eligible for Medicaid based on conversation and offers referrals to other services.

Document the following:

- Qualifying activity: Discussed Medicaid coverage options and/or Medicaid eligibility requirements

- Qualifying action: No referral(s) provided – person not eligible

Scenario 7: Consumer contacts ADRC because they need help finding Medicaid service providers to help address a medical need. Consumer is already receiving Medicaid LTSS and has a Medicaid Case Manager. ADRC staff directs the consumer to their Case Manager for assistance.

Document the following:

- Qualifying activity: Discussed Medicaid long-term services and supports
- Qualifying action: Referred to client's Medicaid case manager
- Qualifying referral: Select the recorded referral for the Medicaid office.

Note: See consumer screening protocol iv above for more information on this scenario.

Minimum required data elements for Information and Referral (I&R)

Required field	Utility/Description
Caller Type	Identifies senior consumer, agency, community gatekeeper, etc.
Method of Contact	Identifies contact by phone, email, in person visit, TTY, etc.
Referral Source	e.g. ADRC website, radio, AAA, library, friend, etc.
Caller info	If caller is not calling for self, record name, phone of caller
Anonymous Caller call frequency	Whether an anonymous caller has called more than once this FY
Consumer Phone	Allows for follow-up, emergency intervention

Date of Birth/Age	Informs identity and eligibility
County and Zip Code	Allows localized referrals
Gender	Federal data requirement NAPIS
Race and Ethnicity	Federal data requirement NAPIS
Veteran Status	Informs referral process
Functional Impairment	Self-identified: Alzheimer's/Dementia, Physical disability, TBI, ID/DD, etc., informs referral process
Need	Stated reason for call
Referred Programs	Referrals from resource database
Unmet Needs	Needs for which no appropriate referral found
Call Outcome	Information, Referral, Assistance
Referral Type	Medicaid, Options Counseling, Other public, Non-public
Call Notes	Narrative of call

Minimum required data elements for Options Counseling (OC)

Required field	Utility/Description
Name (Last, First, Middle)	Informs identity
Internal ID (Prime Number or Unique Identifier if not in OA)	Assists with knowing if client is already in OA on other services

Options Counselor/CM	Tells us who is working with this client
Address (Street, City and Zip)	Allows localized referrals and place to send info
Phone number	Allows for follow-up, emergency intervention, etc.
Date of birth	Informs identity and eligibility
County	Allows localized referrals, helps with tracking needs and referrals/services by county
Gender	Male, female, etc. – federal data requirement? NAPIS
Race	Federal data requirement NAPIS
Ethnicity	Federal data requirement NAPIS
Urban/Rural	Federal data requirement NAPIS
Veteran Status	Allows OC to help client or family connect with other benefits they may be eligible for
Functionally Impaired	Self-identified: Alzheimer's/Dementia, Physical disability, TBI, ID/DD, etc.
Person Centered Assessment	Gets to client goals, needs, preferences, community supports, etc.
Service Enrollment (make sure client is properly enrolled)	Service Enrollment is used to track which services a client is receiving, for what amount of time, and their status with each service.
Progress Notes (see table below)	Progress Notes section is used for options counselors to add notes to a client file.
Action Plan. May be a	Identifies consumer's goals, how they will be achieved

simple next step	step by step, who is going to help them, and timelines
Options Counseling Progress Notes	
Encounter Date	Date of client contact
Note/Narration (entered no later than 3 business days after contact)	This is a note describing encounter with client or encounter on behalf of client. See Caretool Help section in GetCare: *Narration Standards for ADRC Staff*
Progress Note Element: **Medicaid**	Select this element if encounter is eligible for OMAC (we are taking this one out of the progress notes elements)
Progress Note Element: **Method of Contact**	This tells us whether the encounter is a home visit, a phone call, a visit to nursing home, email, etc.
Progress Note Element: **Schedule Follow-up**	System way to help track follow-up schedule
Progress Note Element: ***Significant Event**	This is not required, but it is encouraged that staff use this element option. For remarkable events like falls, hospitalizations, loss of housing, etc. Selecting an applicable event from the dropdown list will enable ability to tract and report significant events.
Progress Note Element: **Unit (0.25=15 minutes, 0.5=30 minutes 1.0=1 hour)**	This is for NAPIS reporting and to help us look at the social return on investment by tracking how much time is spent with clients or on behalf of clients.

Random Daily Sampling Survey (RDSS) labor time tracking requirements

Labor time tracking is required in order to be eligible to receive Medicaid match for claimed activities. The approved system for time tracking is the random daily sampling (RDSS) system. Random sampling of time spent on job duties in a day is conducted approximately once per month and results are used to calculate the reimbursement rate for one quarter of the year. Agency managers are notified in advance of the survey date and staff are notified on the day before the sampling.

Agencies may request permission to complete 100% time tracking instead of using RDSS. If approved, staff is required to track their work time each day, broken down in 15 minute increments with each 15 minute period coded using the appropriate RDSS codes. A 100% timetracking template with a built-in drop down menu with RDSS codes is available for download here: https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/ADRCDocuments/Timekeeping-Template.xlsx

RDSS codes for approved ADRC activities

The following RDSS codes should be used when documenting time spent on qualifying ADRC claimable activities:

- 6B: NWD Information and Referral
- 6C: NWD Person-Centered Options Counseling

Qualifying travel, training, and general administration activities being claimed for Medicaid match need to be coded using 6B and 6C, not the RDSS general codes.

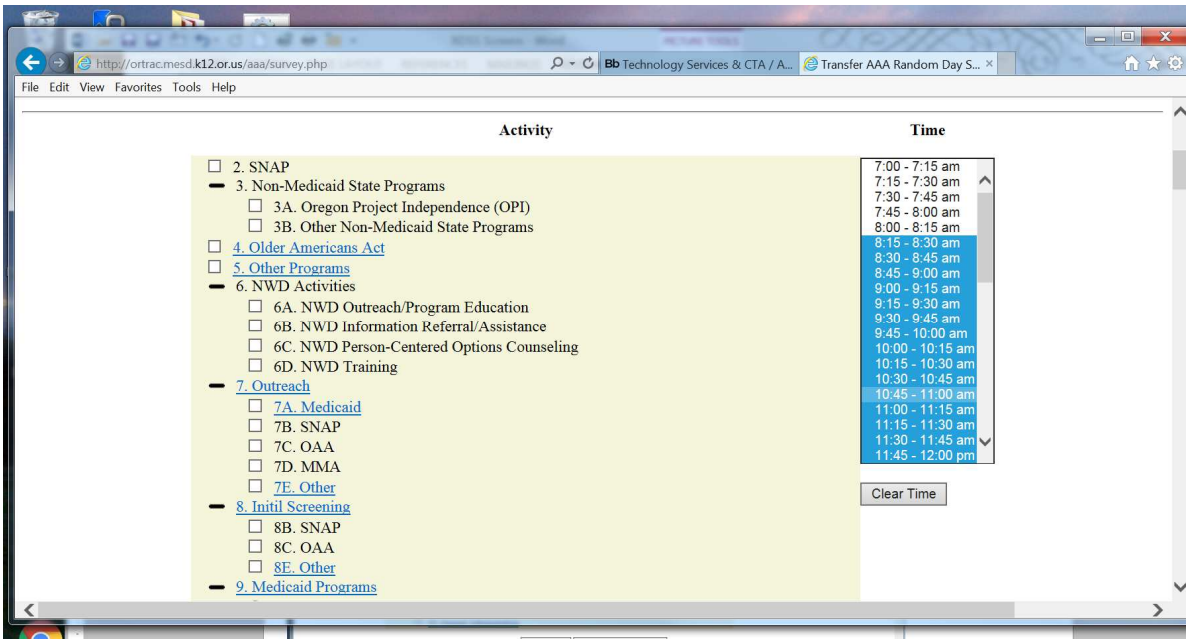
When entering activities into RDSS or when doing 100% time tracking, **you must document how you spent your time for the whole day by using ALL of the RDSS codes, not just the RDSS codes for allowable ADRC activities.** The list of all codes is available on the RDSS website and can also be downloaded from the Oregon Medicaid Administrative Claiming

section of the ADRC page here: https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/Pages/ADRC.aspx

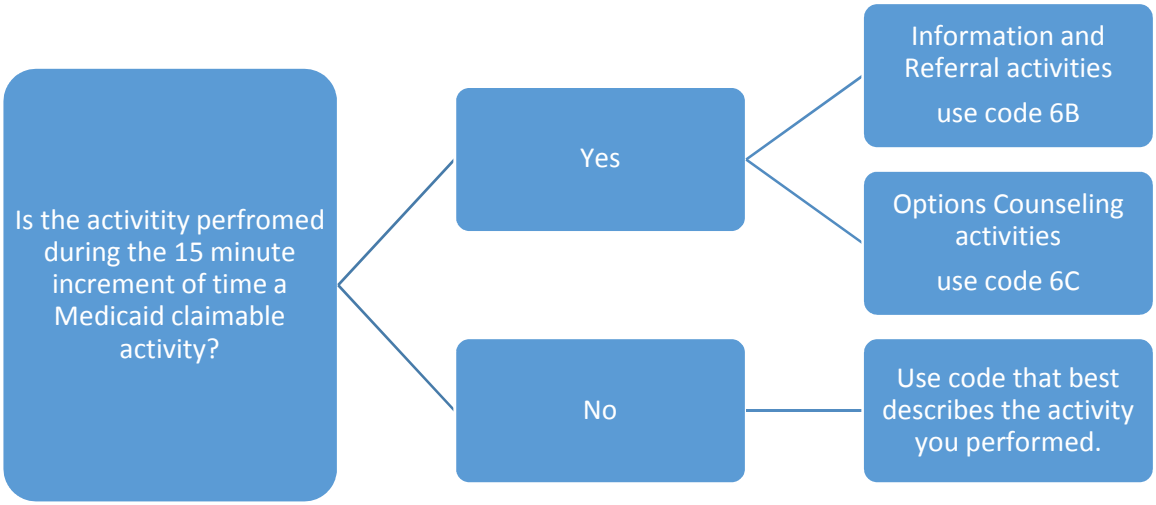
Using the Random Daily Sampling Survey (RDSS) System

- To get an employee started in RDSS send email to: Tatia.A.Halleman@state.or.us with the following information:
  - Employee Name
  - Employee Job Title
  - Supervisors Name
  - Location of office
- Once you have your login info, Go to: www.mesd.k12.or.us,
- Click on the AAA Random Day Survey System Link or MAC Medicaid Administrative Claiming link.
- Click on the Survey Log in – Transfer AAA/RDSS Survey Login.
  - Staff who provided their names to APD are loaded into the system. Use First Name, Last Name and your Agency/District name to log-in. Examples: Washington and Clackamas are listed and Jackson-Josephine is for RVCOG.
- To take the RDSS web-based survey, enter the dominate activity for each 15-minute period. Or keep a paper or other type of log of activities, then the RDSS web-based survey can be completed later (up to 5 working days after the survey date).
  - You can either click on the activity and enter the time spent on the activity or select multiple time periods (that equal the time spent of the activity) and then select the activity.
    - If you select multiple times you only can select the activity once versus multiple times during the day.

Sample RDSS Screen



Decision tree for claimable activities



Additional ADRC OMAC resources

- ADRC OMAC resources page: https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/Pages/ADRC-OMAC.aspx
- ADRC OMAC FAQ: https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/AAABusinessTraining/ADRC-OMAC-Webinar-FAQ-2018-08-08.pdf

- 100% time tracking worksheet: https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/ADRCDocuments/Timekeeping-Template.xlsx
- ADRC training calendar: https://www.oregon.gov/DHS/SENIORS-DISABILITIES/SUA/Pages/Training%20Calendar.aspx

OMAC program management and oversight

Reimbursement Methodology

Invoice Reimbursement will be based upon actual expenses and actual time entry into RDSS with the GetCare as backup documentation. RDSS quarterly reports on time captured for NWD Medicaid Administrative Claiming Activities.

The reimbursement methodology will be based on the following formula: (Approved time spent in 6B & 6C/Total time-(Codes 18-22) = % of Reimbursement).

We will average the last 6 monthly RDSS percentages to calculate the Quarterly Reimbursement Percentage.

AAA	Date	6B & 6C NWD	Total from Detail She	Allowed NWD %	Non Allowed NWD%	All other
	8/15/2017	**380**	**1,620**	19.59%	0.00%	80.41%
	9/19/2017	**420**	**3,255**	11.62%	0.00%	88.38%
	9/27/2017	**510**	**3,225**	13.71%	0.00%	86.29%
			-			
Rolling Quarter (last 6 surveys)						
			8,100	**14.97%**	**0.00%**	**85.03%**
2017-19 Year 1 Totals						

*In this example 14.97 % of the ADRC-NWD Quarterly cost is eligible for Federal Match. Each AAA can ask for total cost reimbursement by asking for additional general funds if there are general funds left on contract.

Invoicing

AAA/CIL will submit a quarterly invoice to the State Unit on Aging, tatia.a.halleman@state.or.us.

ADRC - NWD Quarterly Invoice

AAA:		**Contract #:**
Quarter:		

Quarterly Site Expenditures	**Total Costs Per Category**
Salaries:	
Employee Benefits:	
Direct Supplies	
Direct Rent/Utilities	
Telephone/Travel	
Indirect Rate/other Indirect cost	
Total	**$0.00**

* If claiming indirect cost the indirect charts needs to be filled out.

ADRC -NWD/Medicaid Minutes		=	0.00%
Total Minutes			

** State will fill out at end of each Quarter and send percentage to you.

Total ADRC-NWD Medicaid Eligible Costs		
State Match Share		50%
Requested federal share		50%
If total cost of invoice does not qualify for federal match, you can request the difference between Total Cost and Total ADRC-NWD Medicaid Eligible Costs. This will reduce available Federal Match Funds.		
Amount requested in State (General Funds)	$0.00	
Total= Total Cost- Total ADRC-NWD Medicaid Eligible Costs		

All costs included in this invoice:
- comply with OMB Circular A-122 Cost Principles for Non-Profit Organizations.
- have not been claimed under other federal grants.
- include only actual expenditures.

Certified by:
Printed Name
Signature:
Date

Certified by APD: Printed Name
Signature
Date

Note: Agencies will not receive match dollars beyond the Not to Exceed (NTE) amount within their respective contracts. The NTE amount will be based on 50% General Fund and 50 % Federal Funds but actual cost distribution can vary based on actual expenditures. The General Fund allocation will have a set amount. Each AAA will need to provide a GetCare report showing documentation that supports the time logged into RDSS on each survey date. If the GetCare documentation does not support the time entered into RDSS they AAA will only be reimbursed for the General Funds of the invoice.

Quality Assurance

Contractors shall ensure that all required documentation requirements are being met and that staff are documenting and claiming appropriately.

There are some canned reports and saved custom report filters available in GetCare that can be used to aid in conducting quality assurance for Information and Referral and Options Counseling activities.

The reports can be accessed in GetCare by following these steps: Select Operations>Reporting>Custom Export Reports and then select a report type from the dropdown menu. A link to instructions for pulling these reports is also included below.

ADRC Activity Report

To ensure incremental increases in information and referral (I&R) calls and options counseling (OC) new enrollments as required contractually, run the following report:

- ADRC Activity Report

Missing Data Quality Assurance (QA) reports

To ensure the minimum data requirements have been met for Information and Referral and Options Counseling activities, run the following reports:

- I&R Quality Assurance Report
- Options Counseling Quality Assurance Report

Use the I&R Quality Assurance Report to:

1. Confirm all required data elements have been recorded. Only required data elements appear on these reports. If any fields are blank, this means the minimum data requirements have not been met. Note that the caller fields will be blank if the 'Caller' was also the Consumer (this is okay).

Use the OC Quality Assurance Report to:

1. Confirm all required data elements have been recorded. Only required data elements appear on these reports. If any fields are blank, this means the minimum data requirements have not been met. This report also includes the **required** person-centered assessment and action plan.

OMAC Quality Assurance Reports for claimable activities

To ensure activities claimed for Medicaid match are appropriate and have been documented correctly, run the following reports:

Information and Referral (I&R) reports:

- I&R OMAC/NWD Report
- I&R OMAC Qualifying Activity/Referral Report

Options Counseling (OC) reports:

- OC OMAC/NWD Report
- OC OMAC Qualifying Activity/Referral Report

Use these reports to:

1. Ensure that the volume of recorded qualifying activities seems reasonable based on what's being reported via RDSS.

2. Ensure that the qualifying activity is only claimed for an individual once during the month.
3. Ensure that a qualifying referral is recorded on the call for information and referral or to the Caretool record for options counseling for qualifying activities with a resulting action of “provided referral.”
    a. Confirm the referral recorded is appropriate based on the qualifying activity recorded.
    b. Confirm the referral relates to enrolling the consumer into Medicaid or relates to directly supporting the provision of medical services covered under the state Medicaid plan.

GetCare compared to RDSS

It’s recommended you do a manual review to compare GetCare records against RDSS reporting to ensure all activities reported during the RDSS sampling day match what was recorded in GetCare and that the activities recorded are allowable.

Quality Assurance Tools

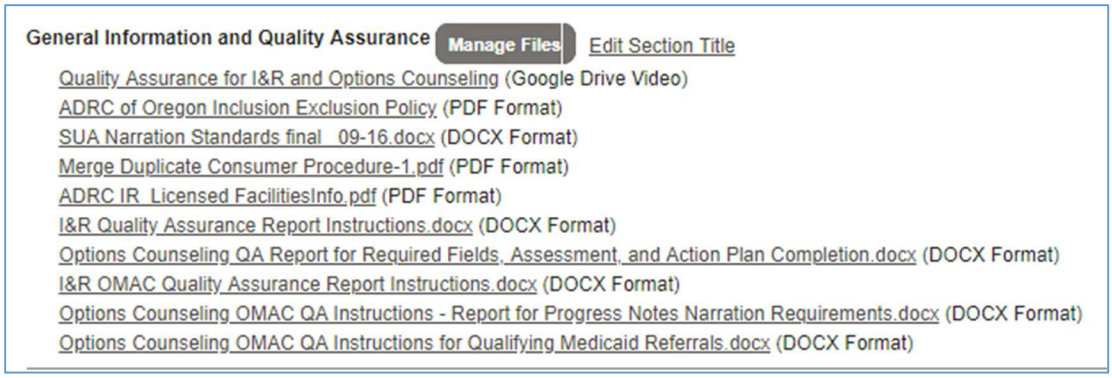
The worksheets below can be used to help support broader ongoing ADRC quality assurance activities. These worksheets are designed to be used to conduct monthly reviews of ADRC data entry practices by individual staff. They are available for download on the Help section of GetCare.

Quality assurance worksheets:

- I&R record scoring form
- OC record scoring form

Instructions for Running Quality Assurance Reports

Instructions for running quality assurance reports are available for download on the Help section of GetCare.


General Information and Quality Assurance
Manage Files
Edit Section Title
Quality Assurance for I&R and Options Counseling (Google Drive Video)
ADRC of Oregon Inclusion Exclusion Policy (PDF Format)
SUA Narration Standards final 09-16.docx (DOCX Format)
Merge Duplicate Consumer Procedure-1.pdf (PDF Format)
ADRC IR Licensed FacilitiesInfo.pdf (PDF Format)
I&R Quality Assurance Report Instructions.docx (DOCX Format)
Options Counseling QA Report for Required Fields, Assessment, and Action Plan Completion.docx (DOCX Format)
I&R OMAC Quality Assurance Report Instructions.docx (DOCX Format)
Options Counseling OMAC QA Instructions - Report for Progress Notes Narration Requirements.docx (DOCX Format)
Options Counseling OMAC QA Instructions for Qualifying Medicaid Referrals.docx (DOCX Format)