Oregon Aging & Disability Resource Connection

Oregon Medicaid Administrative Claiming (OMAC) Guide

Oregon Department of Human Services
AGING & PEOPLE WITH DISABILITIES

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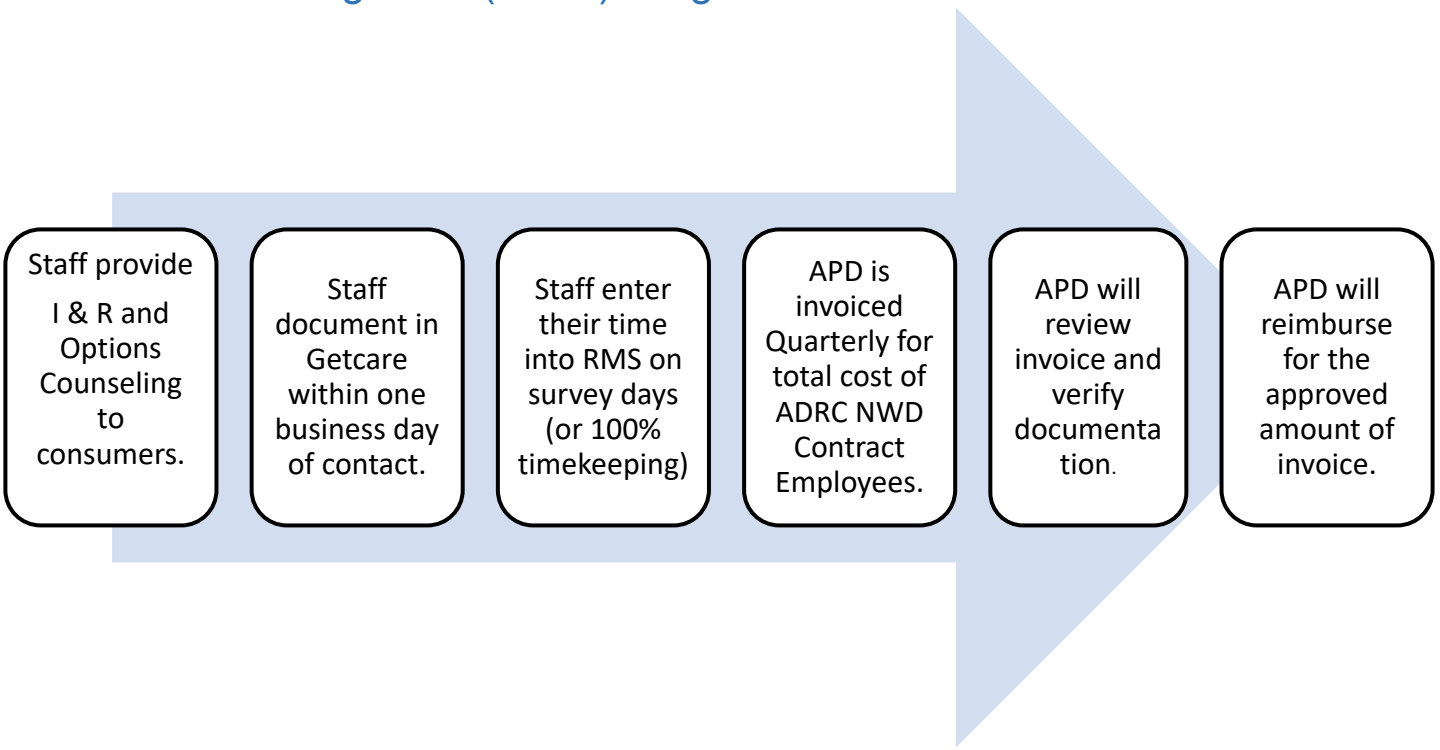
What is Oregon's ADRC Medicaid Administrative Claiming (OMAC)?

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 (NWD) 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. Assistance provided to consumers receiving Medicaid Long term services and supports (LTSS) should be limited to I&R and must be done in coordination with the consumer's Medicaid Case Manager in order to ensure no duplication of services or duplicative federal Medicaid match claiming. These consumers should not be enrolled in Options Counseling. Federal match is also allowable for time spent receiving Medicaid related training, traveling to/from meeting with a consumer, and for time spent on administrative tasks related to the encounter. 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 health and long-term services and support needs. ADRC I&R is performed as set forth by the ADRC consumer-based standards: https://www.oregon.gov/odhs/providers-partners/community-services-supports/adrcdocuments/2015-adrc-consumer-based-standards.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 services and supports needs. ADRC OC is performed as set forth by the ADRC consumer- based standards: https://www.oregon.gov/odhs/providers-partners/community-services-supports/adrcdocuments/2015-adrc-consumer-based-standards.pdf.
To qualify as options counseling, the following steps must be taken:

1. The need for Person-Centered Options Counseling (OC) must be determined, the consumer must be enrolled in OC in the GetCare Caretool, and the minimum required data elements must be recorded.
2. A person-centered assessment must be documented in the GetCare 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 Options Counselor must provide information about public and private sector resources.
5. The Options Counselor must facilitate self-direction.
6. The Options Counselor must encourage future orientation.
7. The Options Counselor must follow-up with the consumer and all follow-ups must be documented in the GetCare 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 GetCare 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 Medicaid LTSS services identified below and who are being provided help with accessing any of the Medicaid services. Assistance provided to consumers receiving Medicaid LTSS should be limited to I&R and must be done in coordination with the consumer's Medicaid Case Manager in order to ensure no duplication of services or duplicative federal Medicaid match claiming. These consumers should not be enrolled in Options Counseling.

Consumer screening protocol

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

ii. Staff are encouraged to search for consumers in Oregon Access and the ONE system if staff are authorized to use these systems, to determine if the consumer is receiving Medicaid/Medicaid LTSS. If

staff do not have access to Oregon Access or the ONE system, 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?

d. If you have health insurance, who is it through or who manages it?

iii. Consumers receiving Medicaid but not receiving Medicaid LTSS

a. Should be directed to their local office eligibility worker for assistance regarding their Medicaid health benefits. These referrals back to their eligibility worker after Medicaid related Information and Referral (I&R) is done are eligible to be claimable for federal match. Simple inter-agency transfers are not eligible to be claimable for federal match.

i. 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. Medicaid eligible individuals seeking assistance with LTSS related issues may be enrolled in OC. Qualifying activities are claimable for federal match.

c. Individuals solely receiving Medicare Savings Programs may also be enrolled in OC. Qualifying activities are claimable for federal match.

d. May receive Medicaid related Information and Referral (I&R). Qualifying activities are claimable for federal match.

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

iv. Consumers receiving Medicaid LTSS, 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 after Medicaid related Information and Referral (I&R) is done are

eligible to be claimable for federal match. Simple inter-agency transfers are not eligible to be claimable for federal match.

b. May receive Medicaid related 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

Note: Assistance provided to consumers receiving Medicaid LTSS should be limited to I&R and must be done in coordination with the consumer's Medicaid Case Manager in order to ensure no duplication of services or duplicative federal Medicaid match claiming. These consumers should not be enrolled in Options Counseling.

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 substance use or addiction to tobacco, alcohol, drugs or gambling.
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 270 hours per year.
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, Employee Resource Connect, Transition Services (State Hospital or Nursing Facility to home or community based care)
l. **Medicaid long-term services and supports - Waiver services:** Case management and transition services (Acute care hospital or community-based care 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.

Consumer criteria/Medicaid claimable activities

Consumer criteria	**FUNDING SOURCES** (Note: Federal funds cannot be used for OMAC federal match)

Medicaid claimable activities	**Oregon Medicaid Administrative Claiming (OMAC)**		**ADRC/NWD General Fund (GF)**		**Rehab Act** *Applies to CILs only*	
	I&R RMS code: 5.G.5	**OC** RMS code: 5.G.6	**I&R** RMS code: 5.G.2	**OC** RMS code: 5.G.3	**I&R** RMS code: 5.G.2	**OC** RMS code: 5.G.3
No public benefits and spent time doing any of the following: • Discussed Medicaid coverage options and/or Medicaid eligibility, requirements and/or when referring a consumer to apply for Medicaid. • Discussed Medicaid services and/or provided referrals to Medicaid service providers. • Discussed Medicaid long-term services and supports and/or provided referrals to Medicaid LTSS service providers.	✓	✓	✓	✓		

• Provided Medicaid application completion assistance.						
Receiving OHP (Medicaid) and spent time doing any of the following: • Discussed Medicaid coverage options and/or Medicaid eligibility, requirements and/or when referring a consumer to apply for Medicaid. • Discussed Medicaid services and/or provided referrals to Medicaid service providers. • Discussed Medicaid long term services and supports, and/or provided Medicaid	✓	✓	✓	✓		

application completion assistance.						
Receiving Medicaid LTSS • Should be directed to their Medicaid case manager for assistance. These referrals back to their case manager after Medicaid related Information and Referral (I&R) is done are eligible to be claimable for federal match. Simple inter-agency transfers are not eligible to be claimable for federal match. • 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*	✓ *For referrals to Medicaid CM and/or if in coordination with Medicaid CM*	**N/A**	✓ *For referrals to Medicaid CM and/or if in coordination with Medicaid CM*	**N/A**	✓	

claimable for federal match. • **Should not be enrolled in Options Counseling.** They should be referred to their Medicaid case manager to have their needs addressed. *These referrals, including the time on the call with the individual and the calls to the case manager, if necessary, are eligible to be claimable for federal match.*						
Other Medicaid claimable activities: • Travel to/from meeting with a consumer if Medicaid was discussed. • Medicaid related administrative tasks. • Medicaid related training.	✓	✓	✓	✓		

Examples of qualifying activities

Examples included in this section are borrowed from the No Wrong Door System reference document for Medicaid Administrative Claiming Guidance, developed by the Administration for Community Living (ACL).

Information and referral (I&R) and options counseling (OC) activities related to Medicaid outreach

Activities that inform Medicaid eligible or potentially Medicaid eligible individual about Medicaid, how to access Medicaid and medically related services and the importance of accessing these services. Such activities include bringing a Medicaid potentially eligible individual into the Medicaid system for the purpose of determining eligibility which may, but not necessarily, include certified application counselors. Both written and oral methods may be used.

Examples include:

- Engaging in a conversation with individuals and families about preferences, strengths, needs, and available resources to determine initial interest in and potential eligibility for Medicaid.
- Interactions with individuals to learn information about them relating to potential Medicaid eligibility (specifically their functional capacity and/or limitations and their finances), but not including financial or medical related counseling.
- Informing individuals or their representatives about their potential eligibility for Medicaid programs, including their rights and responsibilities and the benefits and services offered under different Medicaid LTSS programs.
- Time spent on the telephone, in-person, or via a website obtaining information to fill out a Medicaid pre-screen.
- Time spent contacting additional individuals, such as physicians or other family members, to complete or verify information included on a Medicaid pre-screen or assisting in Medicaid application processes.
- Time spent traveling to and from a Medicaid pre-screen that is conducted in person.
- Time spent conducting administrative activities necessary to complete a Medicaid prescreen, such as:

    - Identifying correct contact information
    - Entering data into an electronic system
    - Answering questions about the purpose and nature of the screen
    - Providing results of the screen and making appropriate referrals
    - Setting up translation or signing services
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective Medicaid applicants.
- Discussing the pros and cons of applying for Medicaid relative to an individual's preferences, support system, resources, needs and any other factor the individual wants to address.

Information and referral (I&R) and options counseling (OC) activities related to referral, coordination and monitoring of Medicaid services

Making referrals for, coordinating, and/or monitoring the delivery of health related/medical services <u>when an individual is not receiving Medicaid case management</u>.

Examples include:

- Making referrals for and coordinating the delivery of Medicaid services (includes acute, primary, mental health and LTSS).
- Providing follow-up contact to ensure that the individual received the coordination of Medicaid services identified as needed and available.
- Informing or arranging for Medicaid transportation that assist an individual to access Medicaid services, or for interpreter services to access Medicaid services or NWD Medicaid activities.
- Gathering any information that may be required in advance of referrals, evaluations and treatment for Medicaid LTSS.
- Assisting individuals to move from one location to another to assure continuity of care.

Information and referral (I&R) and options counseling (OC) activities related to facilitating Medicaid functional and financial eligibility

Assisting an individual or family in gathering information and/or referring them to the appropriate local Medicaid agency for a Medicaid application as

well as assisting an individual to maintain Medicaid eligibility. Medicare supplemental insurance, Medicare Advantage, or other insurance are not considered Medicaid related activities unless the request is related to a Medicaid application activity. Both written and oral methods may be used.

Examples include:

- Verifying an individual's current Medicaid eligibility status.
- Assisting individuals or families in gathering information related to the Medicaid application and eligibility determination for an individual, including resource information, medical information and third-party liability (TPL) information, as a prelude to submitting a formal Medicaid application.
- Collecting additional functional data or medical information needed to inform functional eligibility determination.
- Assisting individuals, for whom a disability determination is needed, in gathering information related for Medicaid eligibility and the disability determination process.
- Assisting individuals under the age of 65 with a diagnosis of a mental illness in gathering documentation on the primary driver of need.
- Providing necessary Medicaid forms, assisting the individual in completing Medicaid forms and packaging all Medicaid forms in preparation for the Medicaid eligibility determination.
- Time spent referring an individual or family to the local assistance office to make application for Medicaid benefits; including time spent setting up an appointment for the individual or family with the local assistance office.

Medicaid related training activities

Coordinating, conducting, or participating in training and seminars regarding Medicaid related LTSS, health care services, and other supports that may assist an individual to remain in the community, return to the community, or otherwise enhance the person’s quality of life.

Examples include:

- Participating in Medicaid related training which enhances the quality of screening, one-on-one person-centered counseling or other components of the Medicaid eligibility processes.
- Training in application assistance for the Medicaid program or training to qualify as a certified application counselor for the Medicaid program.
- Participating in, coordinating, or presenting Medicaid related training designed to address the specific administrative and reporting requirements associated with Medicaid program services for providers and NWD System personnel.

Documentation requirements

Documentation in Oregon's ADRC GetCare software system and labor time tracking in the Random Moment Sampling (RMS) 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.

OMAC documentation requirements for Information and Referral (I&R)

For each qualifying I&R activity, you must:

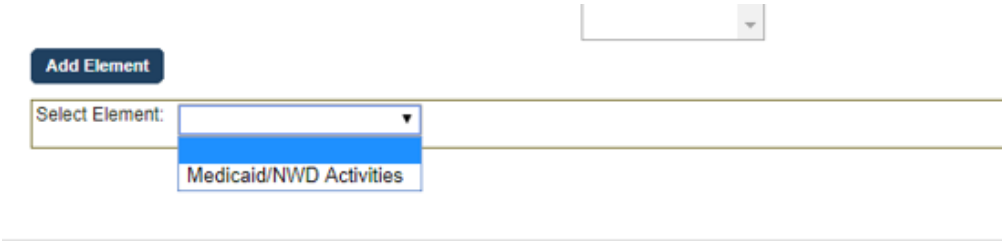
1. Record minimum data requirements for the consumer based on call type.

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

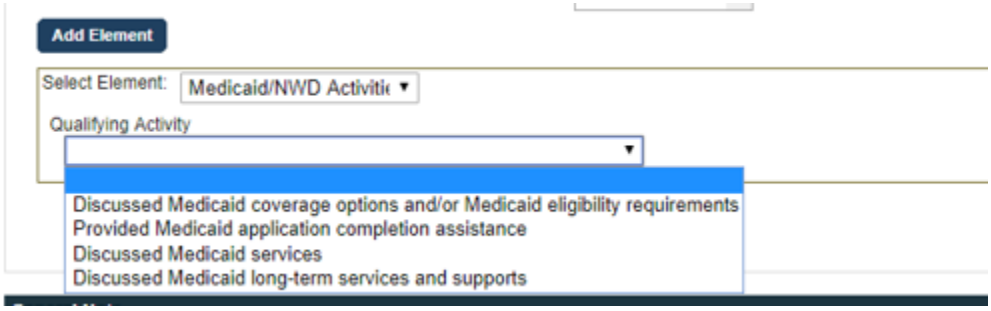
3. In FollowUp/Notes, choose an answer for "Do you want to follow up?"

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

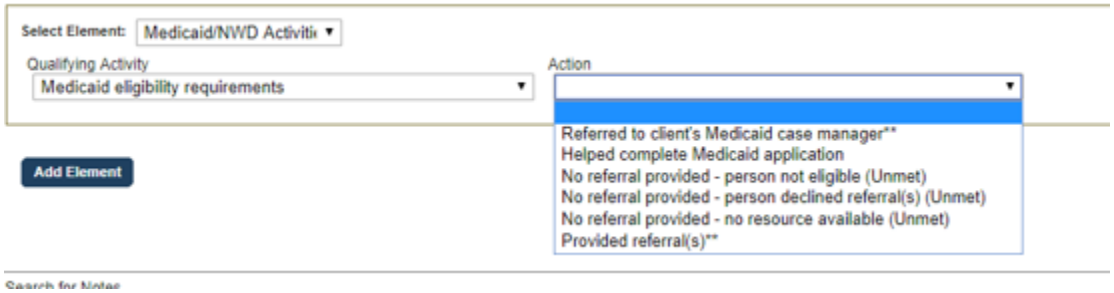
5. Select Add Element: Medicaid/NWD Activities.



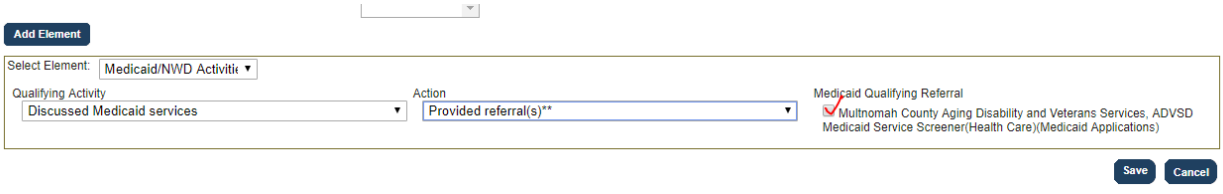
6. Select the activity/topic discussed with the consumer from the dropdown (add additional elements for each qualifying activity).



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. Make sure to save referral(s) prior to selecting qualifying activities. The referral selected must be an allowable Medicaid referral and must correspond to the allowable Medicaid topic discussed. Refrain from selecting 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.

OMAC documentation requirements for Options Counseling (OC)

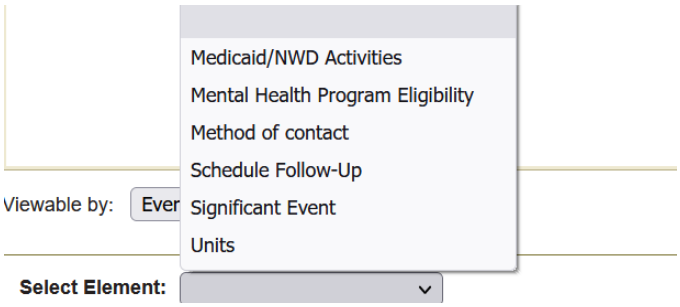
For GetCare Caretool activities, you must:

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

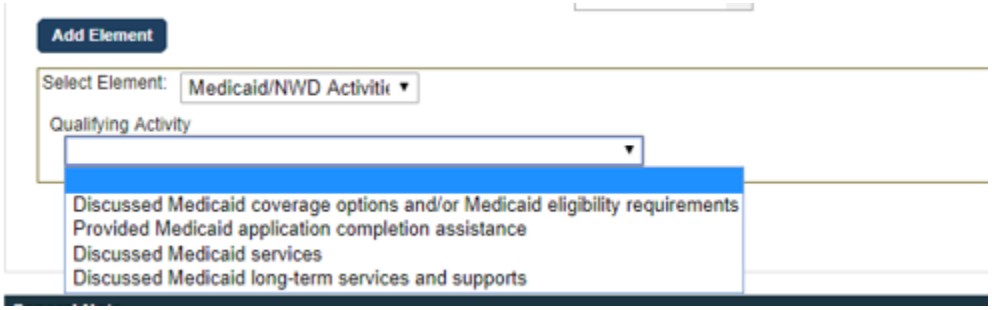
2. Complete and save any Referrals for Medicaid related activities and document any Unmet Needs.

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

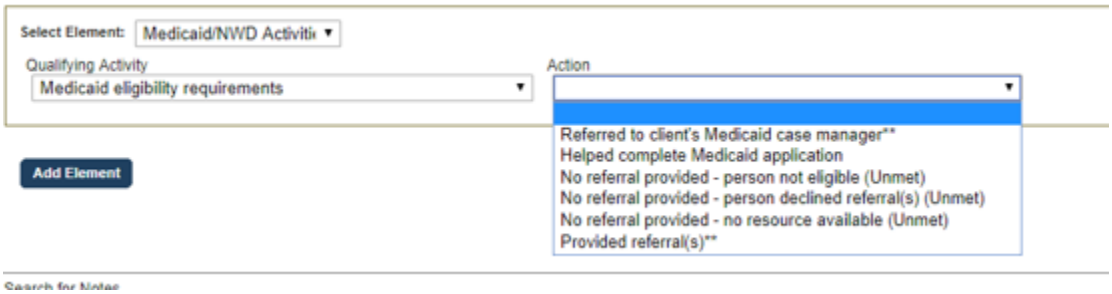
4. Add Element “Medicaid/NWD Activities”.



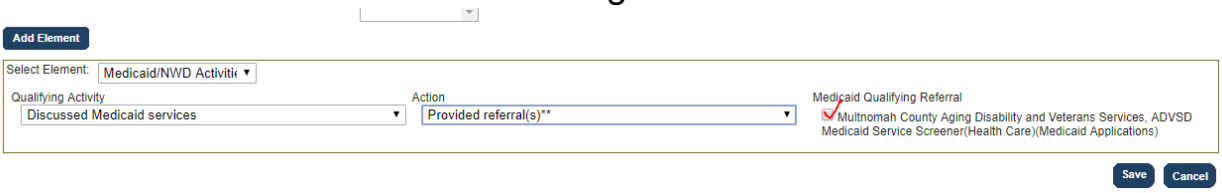
5. Select the activity/topic discussed with the consumer from the dropdown (add additional elements for each qualifying activity).



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. Make sure to save referral(s) prior to selecting qualifying activities. The referral selected must be an allowable Medicaid referral and must correspond to the allowable Medicaid topic discussed. Refrain from selecting 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. Select **“**Discussed Medicaid coverage options and/or Medicaid eligibility requirements” 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. Select **“**Discussed Medicaid coverage options and/or Medicaid eligibility requirements” 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 application registration or assist in applying for benefits in the ONE system 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 above for more information on this scenario.

Scenario 8: Consumer is referred to Options Counseling after speaking with I&R team. I&R discussed Medicaid LTSS as an option, however consumer would like to explore other options prior to applying. OC staff have meeting with consumer and complete Person-Centered Assessment to determine needs. Consumer and OC determine that Medicaid is an appropriate referral and OC assists consumer in starting an 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

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

Required field	Utility/Description
Caller Type	Identifies Agency, Caregiver, Community Gatekeeper, Consumer with a disability, Family Member/Friend, Other, Senior Consumer, and Veteran
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 *If Anonymous – record caller phone number
Consumer Name	Consumer name or Anonymous if consumer refuses.
Consumer Phone	Allows for follow-up, emergency intervention
Date of Birth/Age	Informs identity and eligibility
County and Zip Code	Allows localized referrals
Language	Informs communication needs
Interpreter	Informs communication needs

Gender	Federal data requirement NAPIS
Race and Ethnicity	Federal data requirement NAPIS
Veteran Status	Informs referral process
Disability Questions	State REALD requirement
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
Element	Qualifying Medicaid Activity

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
Language	Informs communication needs
Interpreter	Informs communication needs
Gender	Male, female, etc. – federal data requirement? NAPIS
Race/Ethnicity	Federal data requirement NAPIS
Income	Informs eligibility
Lives with	Informs about supports
Housing Type	Type of housing – rent or own home, community-based care setting.
Urban/Rural	Federal data requirement NAPIS
Veteran Status	Allows OC to help client or family connect with other benefits they may be eligible for
Disability Questions	State REALD Requirement
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 simple next step)	Identifies consumer's goals, how they will be achieved step by step, who is going to help them, and timelines.
PCOC Exit Interview	Follow-up assessment completed 90 days after Person Centered assessment, used to collect consumer satisfaction and Return on Investment (ROI) survey data.
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 GetCare 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: **Enrollment**	Used to link a progress note directly to an enrollment(s). Progress notes should be linked to any active enrollment. For general notes, this element can be removed in order to save the note.
Progress Note Element:	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

***Significant Event**	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 Moment Sampling (RMS) labor time tracking requirements

Labor time tracking is required to be eligible to receive Medicaid match for claimed activities. The approved system for time tracking is the Random Moment Sampling (RMS) survey system. Random sampling of time spent on job duties is conducted throughout the month to capture work performed at a moment in time. Results are used to calculate the reimbursement rate per month and invoices based on that information are sent out quarterly. Staff have two business days from the date and time of the survey to complete it but are encouraged to complete them as soon as possible. It generally takes staff 3 minutes to complete a sampling survey. Having the consumer identifier ready when the survey begins may help save additional time.

Primary Branch Coordinators and Back-up Branch Coordinators have access to survey scheduling in advance of survey dates and staff are notified via email at the time of sampling. A Primary Branch Coordinator cannot be a survey participant. A Back-up Branch Coordinator may be a survey participant. Primary and Back-up Branch Coordinators MAY NOT give advanced notice to participants per federal guidelines. It is important for every office to have an Agency Branch Coordinator and Back-up Branch Coordinator to ensure surveys are not missed. Branch Coordinators can complete surveys for participants that are not doing case specific activities.

Agencies may request permission to complete 100% time tracking instead of using RMS. If approved, staff are required to track their work time each day, broken down in 15-minute increments with each 15-minute period coded using the appropriate RMS codes. A 100% time tracking template

with a built-in drop down menu with RMS codes is available for download here: https://www.oregon.gov/odhs/providers-partners/community-services-supports/adrcdocuments/timekeeping-template.xlsx.

RMS codes for approved ADRC activities

The following RMS codes should be used when documenting time spent on qualifying ADRC/NWD Medicaid claimable activities:

- 5.G.5. Information, Referral & Assistance Medicaid claimable
- 5.G.6. Person Centered Options Counseling Medicaid claimable

You must complete the "case identifier" field in RMS by including the GetCare ID for the corresponding Medicaid allowable activity documented in GetCare. **Qualifying travel, training, and general administration activities being claimed for Medicaid match need to be coded using 5.G.5. and 5.G.6, no other RMS general codes.**

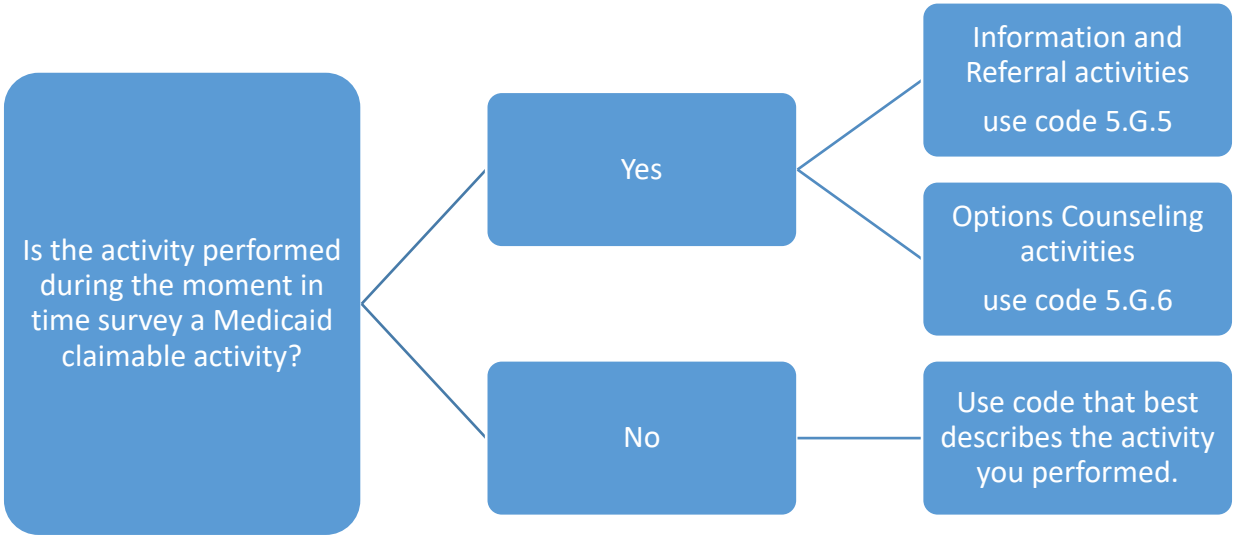
When entering activities into RMS, or when doing 100% time tracking, **you must document how you spent your time by using ALL of the RMS codes as appropriate, not just the RMS codes for allowable ADRC/NWD activities.** The list of all codes is available on the RMS website and can also be downloaded from the Community Services and Supports Unit (CSSU), ADRC training page here: https://www.oregon.gov/odhs/providers-partners/community-services-supports/adrcdocuments/timekeeping-template.xlsx.

Using the Random Moment Sampling (RMS) Survey System

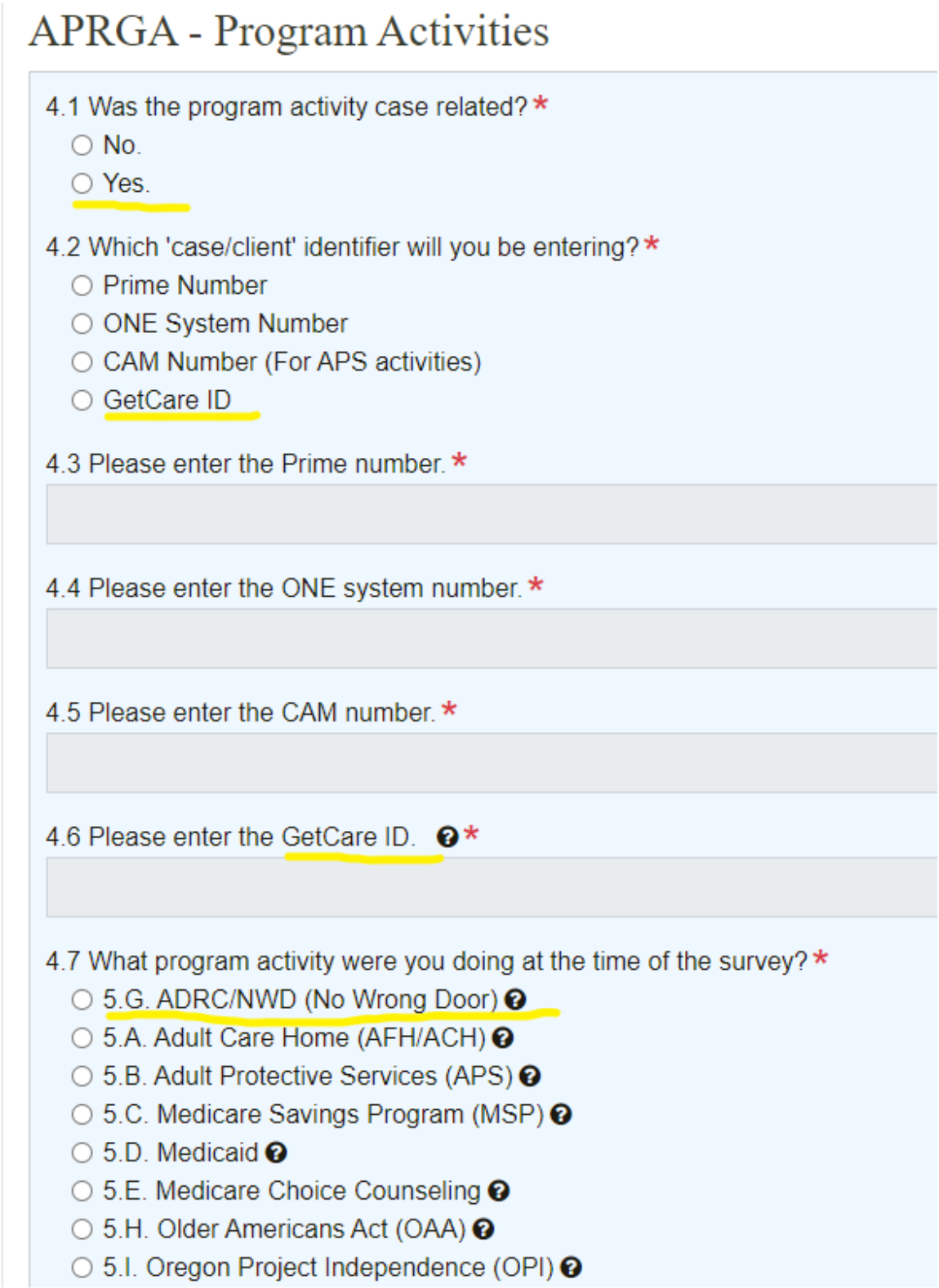
- To get an employee started in RMS they must already have Citrix access and a P#. Send email to: RMSS@dhsoha.state.or.us with the following information and indicate if they are one of the designated ADRC/NWD OMAC participants:
    - Employee Name
    - ADRC/NWD OMAC participation (Yes/No)
    - P#
    - Employee email address

    - Brand name if applicable
- Once you receive your RMS survey notification e-mail instructing you that you have a survey to take, follow the directions in the email to access RMS. By clicking on the link you will be prompted to log into Citrix to access your survey.
- After making selections, click on the Next button in the bottom right-hand corner of the screen. If there is no “next” button in the bottom righthand corner, click Save in the top right corner to complete the survey.

Decision tree for claimable activities



Sample RMS Screens



APRGA - Program Activities

4.1 Was the program activity case related? *
- No.
- Yes.

4.2 Which 'case/client' identifier will you be entering? *
- Prime Number
- ONE System Number
- CAM Number (For APS activities)
- GetCare ID

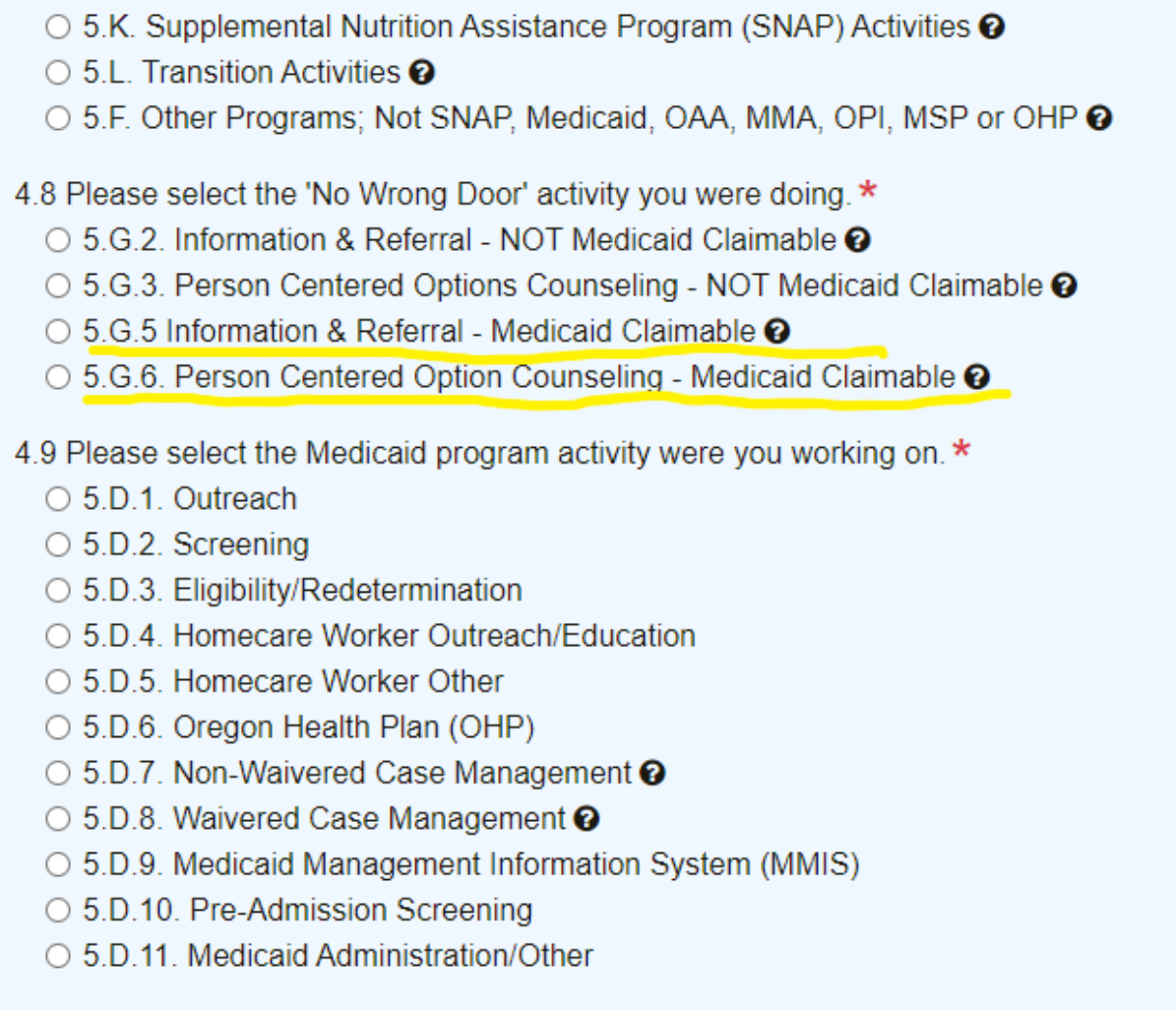
4.3 Please enter the Prime number. *

4.4 Please enter the ONE system number. *

4.5 Please enter the CAM number. *

4.6 Please enter the GetCare ID. *

4.7 What program activity were you doing at the time of the survey? *
- 5.G. ADRC/NWD (No Wrong Door)
- 5.A. Adult Care Home (AFH/ACH)
- 5.B. Adult Protective Services (APS)
- 5.C. Medicare Savings Program (MSP)
- 5.D. Medicaid
- 5.E. Medicare Choice Counseling
- 5.H. Older Americans Act (OAA)
- 5.I. Oregon Project Independence (OPI)



Additional ADRC OMAC resources

ADRC OMAC resources, including an FAQ, RMS training and codes information, 100% time tracking worksheet, and training materials and information are located in the ADRC OMAC section of the training page here: https://www.oregon.gov/odhs/providers-partners/community-services-supports/Pages/training.aspx.

OMAC program management and oversight

Reimbursement Methodology

Invoice reimbursement is based upon actual expenses and actual time entry into RMS, with the GetCare as backup documentation. The last 6 monthly RMS reimbursement percentages are averaged to calculate the Quarterly Reimbursement Percentage. The reimbursement methodology is based on the following formula:

Approved time spent in (5.G.5 + 5.G.6) / (Total time-(Codes 1.A + 1.B + 1.C + 1.D + 2.A + 2.B + 2.C)) = % of reimbursement.

AAA	Date	NWD 5.G.5 & 5.G.6	NWD non 5.G.1, 5.G.2, 5.G.3, 5.G.4	Other	Check Total	Remove 1.A.-2.C.	Adjusted Total	Allowed NWD %
	Mar-22	3.0	3.0	21.0	27.0	(19.0)	8.0	**37.50%**
	Apr-22	1.0	3.0	20.0	24.0	(18.0)	6.0	**16.67%**
	May-22	3.0	2.0	22.0	27.0	(21.0)	6.0	**50.00%**
	Jun-22	1.0	5.0	19.0	25.0	(19.0)	6.0	**16.67%**
AAA	Date	NWD 5.G.5 & 5.G.6	NWD non 5.G.2 & 5.G.3	Other	Check Total	Remove 1.A.-2.C. & 8.A.1-8.A.8	Adjusted Total	Allowed NWD %
	Jul-22	1.0	5.0	19.0	25.0	(19.0)	6.0	**16.67%**
	Aug-22	1.0	4.0	21.0	26.0	(21.0)	5.0	**20.00%**
Rolling 4th Quarter		(Jan-June)						
		2.0	**2.3**	**17.2**	**21.5**	**(16.0)**	**5.5**	**36.81%**
Rolling Quarters		(Last 6 months)						
		1.7	**3.7**	**20.3**	**25.7**	**(19.5)**	**6.2**	**26.25%**

*In this example 25.15 % of the ADRC-NWD Quarterly cost is eligible for Federal Funds (FF) Match.

Invoicing

ADRC will return quarterly invoices to Aging and People with Disabilities (APD) staff, Jeremiah Vosler at jeremiah.vosler@odhs.oregon.gov.

ADRC - NWD Quarterly Invoice

A.	**AAA:**			**Contract #:**
	Quarter:			
		***Remaining General Funds (GF):**		**1/6th NTE:**

* The *Remaining GF* value is an estimate and not a guarantee of available funds.

B.	**Quarterly Site Expenditures**	**Total Costs Per Category**		**Description**
	Salaries:	$ -		Cost of direct ADRC- No Wrong Door Employees
	Employee Benefits:	$0.00		
	Direct Supplies:	$0.00		
	Direct Rent/Utilities:	$0.00		
	Telephone/Travel:	$0.00		
	**Indirect Rate/Other Indirect Cost:	$0.00		
	Total Cost:	**$0.00**		
	*****See RMS Info sheet**		**=**	**26.65%**

** If claiming indirect costs, the *Indirect* tab must be filled out.

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

C.		Last Quarter Dates: _____	This Quarter Dates: _____	% difference (+/-)
	# of unique I&R consumers served			
	Total # of I&R contacts			
	Total # of I&R records with Medicaid Element recorded			
	Total # of new options counseling enrollments			
	Total # of options counseling records with Medicaid Element recorded			
	Medicaid match % rate calculated by RMS			
	Describe efforts made to increase number of consumers served:			

D.				
	Total ADRC-NWD Medicaid Eligible Costs	$ -		Must have GF available
	State GF Match Share	$ -		50%
	Requested Federal Funds (FF) 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 GF (May request less here)	$ -		
	Invoice Total = Total GF + Total ADRC-NWD Medicaid Eligible Costs	$ -		

E.	
	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.

F.	
	Certified by:
	Printed Name
	Signature:
	Date

G.	
	Certified by APD:
	Printed Name
	Signature
	Date

Internal Use only

	GF		GF/FF
PCA:	33602	PCA:	30328
Index:	34162	Index:	34162
Obj:	4555	Obj:	4555
Amount:	$ -	Amount:	$ -

Note: Agencies will not receive match dollars beyond the Not to Exceed (NTE) amount within their respective contracts. The NTE amount is based on 50% General Funds and 50% Federal Funds but actual cost distribution can vary based on actual expenditures. Federal Funds match cannot be

claimed once the General Funds have been exhausted. Agency will be paid an amount up to 1/6th of the Agreement not-to-exceed amount per quarter for actual costs per quarter. If actual costs per quarter exceed 1/6th of the agreement NTE amount, excess costs may be rolled over to a subsequent quarter. Please track this for your ADRC and avoid submitting invoices that exceed the 1/6th. Invoices are required to be submitted no later than 45-days after the end of each quarter.

Each ADRC will need to provide documentation showing Medicaid claimable activities recorded in GetCare that supports the Medicaid claimable activities logged into RMS on each survey date. If the GetCare documentation does not support the activities entered into RMS, the ADRC will only be reimbursed for the General Funds of the invoice.

Invoice - Section C: GetCare report instructions are available in the ADRC OMAC section of the CSSU training page here: https://www.oregon.gov/odhs/providers-partners/community-services-supports/Pages/training.aspx

Quality Assurance

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

There are some prepared reports and some 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.

Prepared Missing Data and 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 from Operations>Reporting>Reports:

- **I&R Quality Assurance Report**
- **I&R OMAC/NWD Report**
- **Quality Assurance Report for Caretool Programs**
  (Choose Options Counseling in the ‘Services’ field)
- **OC OMAC/NWD Report**
  (Choose Options Counseling in the ‘Services’ field)

Custom OMAC Quality Assurance Reports for claimable activities

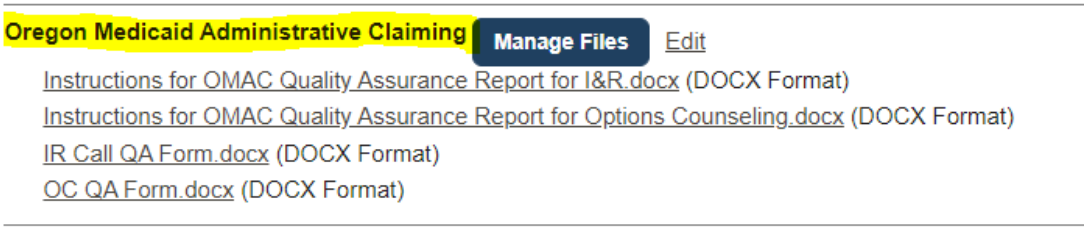
To ensure activities claimed for Medicaid match are appropriate and have been documented correctly, run the following reports. The reports can be accessed in GetCare by following these steps: Select **Operations>Reporting>Custom Export Reports and then select a report type from the dropdown menu on the top right.**

I&R Custom Export Reports:

- **OMAC Quality Assurance for I&R**
  Instructions for this report are located in the GetCare Help Library under Oregon Administrative Claiming>**I&R OMAC Quality Assurance Report Instructions**

Client Custom Export Reports:

- **OMAC Quality Assurance Report for Options Counseling**
  Instructions for this report are located in the GetCare Help Library under Oregon Administrative Claiming>**OMAC Quality Assurance Report for Options Counseling – Instructions**



(Screenshot from GetCare Help Library)

The following quality assurance is recommended:

- Ensure minimum required data elements are recorded for I&R and OC.
- Ensure that the volume of Medicaid claimable activities recorded in GetCare seems reasonable based on what's being reported via RMS (RMS % rate vs # of GetCare Medicaid claimable activities recorded).
- Ensure that Medicaid claimable activities are recorded in GetCare when Medicaid activities are reported during RMS. Use

the GetCare ID reported in RMS to check the GetCare record to confirm the Medicaid claimable activity reported is documented.

- 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.”
    - Confirm the referral recorded is appropriate based on the qualifying activity recorded.
    - 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.

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