Policy Transmittal
Aging and People with Disabilities

DHS | Oregon Department of Human Services

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Authorized signature

Number: APD-PT-18-034
Issue date: 8/6/2018

Topic: Other

Due date:

Transmitting (*check the box that best applies*):

☐ New policy ☐ Policy change ☒ Policy clarification ☐ Executive letter
☐ Administrative Rule ☐ Manual update ☐ Other:

Applies to (*check all that apply*):

☐ All DHS employees
☒ Area Agencies on Aging: Types A and B
☐ Aging and People with Disabilities
☐ Self Sufficiency Programs
☐ County DD program managers
☐ ODDS Children's Residential Services
☐ Child Welfare Programs
☐ County Mental Health Directors
☐ Health Services
☐ Office of Developmental Disabilities Services (ODDS)
☐ ODDS Children's Intensive In Home Services
☐ Stabilization and Crisis Unit (SACU)
☒ Other (*please specify*): Centers for Independent Living Directors

Policy/rule title:	Oregon Medicaid Administrative Claiming (OMAC) policy clarifications for allowable Aging and Disability Resource Connection (ADRC) services		
Policy/rule number(s):		**Release number:**	
Effective date:	Upon release	**Expiration date:**	
References:			
Web address:			

Discussion/interpretation:

This policy transmittal clarifies activities that are allowable for Medicaid administrative claiming for approved Aging and Disability Resource Connection (ADRC) services and the documentation requirements for these activities.

Implementation/transition instructions:

Training/communication plan:

Local/branch action required: Yes

Central office action required:

Field/stakeholder review: ☒ Yes ☐ No

If yes, reviewed by: Oregon Medicaid Administative Claiming (OMAC) Quality Assurance Workgroup

Filing instructions:

If you have any questions about this policy, contact:

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Oregon Medicaid Administrative Claiming (OMAC)
Guidance for approved ADRC services

Qualifying consumers

i. Individuals not already on Medicaid services and who are being provided information, referral, or assistance in learning about or applying 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 information, referral, or assistance 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.
    a. Consumers receiving Medicaid but not receiving Medicaid LTSS services:
        i. Should be directed to their local office eligibility worker for assistance regarding their Medicaid benefits.
        ii. May receive information and referral (I&R). Qualifying activities are claimable for federal match.
        iii. May receive options counseling. Qualifying activities are claimable for federal match.
    b. Consumers receiving Medicaid LTSS services, as defined below under Medicaid services, section ii.c, K plan services:
        i. Should be directed to their Medicaid case manager for assistance.
        ii. May receive information and referral (I&R) if requested 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.
        iii. Should not be enrolled in options counseling. They should be referred to their Medicaid case manager to have their needs addressed.

Qualifying activities

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. Federal match cannot be claimed for time spent on activities outside the realm of these Medicaid services.

Medicaid services include:

i. Medicaid
   a. **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. **Behavioral health**: Mental health and counseling, and help with addiction to tobacco, alcohol and drugs.
   c. **Dental health**: Cleanings and preventive treatments, dental check-ups and x-rays, fillings, tooth removal, 24-hour emergency care.
   d. **Prescriptions**: OHP with Limited Drug only includes drugs not covered by Medicare Part D.
   e. **Eye care:** Medical care; glasses to treat a qualifying medical condition such as aphakia or keratoconus, or after cataract surgery.
   f. **Vision care**: Exams and glasses (only for pregnant women and children under age 21).
   g. **Other needs:** 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.

ii. State Plan services
   a. **Personal Care Services:** Assistance with Activities of Daily Living for people residing in their own home. Limited to 20 hours per month.
   b. Home Health Services.

c. **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)
d. **Nursing Facility Services**
e. **PACE (Program for All-inclusive Care for the Elderly) Services**
f. **Waiver services:** Case management and transition services (community-based to in-home)

Qualifying activities for consumers receiving Medicaid or Medicaid LTSS services

Consumers receiving Medicaid services

Consumers already receiving Medicaid but not receiving Medicaid LTSS may receive ADRC information and referral and options counseling (OC) services. Qualifying activities are eligible to be claimed for federal match. These consumers should be directed to their local office eligibility worker for assistance with their Medicaid benefits. These referrals are eligible to be claimable for federal match.

Consumers receiving Medicaid LTSS services

Consumers already receiving Medicaid LTSS should be directed to their Medicaid case manager for assistance. If the Medicaid case manager requests, information, referral, and assistance activities related to the Medicaid services identified above may be provided by ADRC staff. In these instances, those activities performed by ADRC staff are eligible to be claimed for federal match provided they are not also being claimed for by the Medicaid case manager. These consumers should not be enrolled in options counseling. They should be referred to their Medicaid case manager to have their needs addressed. These referrals are eligible to be claimed for federal match.

Documentation requirements

Documentation in Oregon's ADRC software system (referred to as GetCare or RTZ) and labor time tracking in RDSS 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.

RDSS labor time tracking requirements

RDSS labor time tracking requirements are detailed in the No Wrong Door – Oregon Medicaid Administrative Claiming (OMAC) Guide.

GetCare (RTZ) Minimum data entry requirements

Minimum data entry requirements in Getcare (RTZ) for information and referral and options counseling activities are detailed in the No Wrong Door – Oregon Medicaid Administrative Claiming (OMAC) Guide.

For information and referral (I&R) activities, you must:

1. Record minimum data requirements for the consumer based on call type;
2. Attach qualifying referral(s);
3. Select referral to Medicaid as the call outcome option; and
4. Narrate in follow-up/notes how the discussion and referral(s) provided relate to identifying and enrolling the potential eligible consumer into Medicaid or how it directly supports the provision of medical services covered under the state Medicaid plan (see narration examples below). If no qualifying referrals were provided, you must narrate that referrals were offered and declined by the consumer, that referrals were not offered because it was determined the consumer was not eligible for Medicaid, or that no qualifying referrals were found.

For options counseling (OC) activities, you must:

1. Record minimum data requirements for the consumer;
2. Attach qualifying referral(s);
3. Narrate in progress notes how the discussion and referral(s) provided relate to identifying and enrolling the potential eligible consumer into Medicaid or how it directly supports the provision of medical services covered under the state Medicaid plan (see narration examples below). If no qualifying referrals were provided, you must narrate that referrals were offered and declined by the consumer, that referrals were not offered because it was determined the consumer was not eligible for Medicaid, or that no qualifying referrals were found; and
4. In progress notes, add a new element: Medicaid and click the box next to Medicaid eligibility/programs discussed.

Narration requirements in GetCare (RTZ)

For information and referral (I&R) and options counseling (OC) activities, the specific qualifying action and outcome must be documented as part of your written narration. You must state the action that occurred that directly supports efforts to identify and enroll potential eligible consumers into Medicaid or that directly supports the provision of medical services covered under the state Medicaid plan.

Narration action examples:

- Discussed Medicaid _____ program/service benefits and eligibility requirements with consumer.
- Explained eligibility requirements for Medicaid _____ program/service with consumer.

Narration outcome examples:

- Offered referral to Medicaid _____ program/service but consumer declined because they do not want to pursue Medicaid at this time.
- Provided referral to Medicaid _____ program/service.
- Assisted consumer with application process for Medicaid _____ program/service.
- No referrals were provided to Medicaid programs because consumer is not currently eligible.

* The qualifying Medicaid program/service discussed or referred to must be named as part of your narration.