

Cathy Cooper
Authorized Signature

Number: SPD-AR-10-097
Issue Date: 10/20/2010

Topic: Other

Due Date:

Subject: Transfer AAA OTM (Money Follows The Person Grant) Diversion and Transition Specialist Time Capture

Applies to (check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Health Services |
| <input type="checkbox"/> Children, Adults and Families | <input type="checkbox"/> Seniors and People with Disabilities |
| <input type="checkbox"/> County DD Program Managers | <input checked="" type="checkbox"/> Other (please specify): "Transfer AAA" Directors / staff, and SPD Central Office staff. |

Action Required:

Beginning July 1, 2010, SPD allocated staff resources to the Type B Transfer AAA's to transition eligible individuals from institutional settings to community placements under the On The Move (Money Follows The Person) grant.

Transfer AAA staff who provide assistance to eligible persons under this grant should begin reporting their time expended on OTM (Money Follows the Person) grant activities separately from other daily activities.

Multnomah ADS, NWSDS, and Oregon Cascades West SDS staff who provide transition assistance under this grant will continue to use the Random Day Sampling System (RDSS) to track staff time as usual, but should begin using the new RDSS code #10 (see page 7 of the attached revised definitions) at the next survey date, October 29, 2010, and for all subsequent survey dates.

Lane County uses an internal 100% time and effort system to track staff time. Staff from Lane AAA who provide transition assistance under this grant should begin tracking effort expended for this grant on a daily basis as soon as possible or, at the latest, by November 1, 2010.

Billings to SPD should reflect the appropriate staff time expended in support of this grant as soon as apportioning statistics are available. For Lane ADS, this will be November, 2010 dates of service forward.

Reason for Action: OTM (Money Follows the Person Grant) funds must be tracked separately from Medicaid, SNAP and other programs. Thus, SPD is asking participating Transfer AAA staff to track any time used to provide transition assistance to clients eligible for the OTM program separately from this date forward.

Field/Stakeholder review: Yes No

If yes, reviewed by:

If you have any questions about this action request, contact:

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Oregon Random-Day Sampling System Codes for use by SPD-Transfer Area Agencies on Aging

10/20/10 Update

(Activity Definitions and Notes in Italics)

- **Eligibility/Re-Eligibility Determination (check all that apply for each 15-minute segment)**

Securing information needed to make decisions on eligibility for the programs administered by SPD. This category includes gathering recipient information, intake, data coding eligibility forms and all other activities related to eligibility determinations.

- **1. Medicaid Program Eligibility**
 - Generic financial eligibility;
 - Presumptive Medicaid eligibility determination activities; and
 - CA/PS Assessments for persons who are not categorically eligible (not aged, blind, or disabled) with incomes between 100-300% of SSI (\$674 - \$2,022 for 2010).

 - **2. Food Stamp Program**

 - **3. Non-Medicaid State Programs**
 - **3A. Oregon Project Independence (OPI)**
 - **3B. Other**

 - **4. Older Americans Act (OAA)**

Example: Family Caregiver Program eligibility

 - **5. Other Programs**

Examples: County-funded Programs, Energy Assistance, Emergency Funds, Housing and Urban Development, etc.

 - **6. Medicare Modernization Act, Part D**

Examples: one-on-one choice counseling, and working with providers regarding Medicare prescription drug coverage. Includes staff training related to this program)
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- **Administrative Activities
(Not Eligibility/Re-Eligibility Determination)**

7. Outreach – (Check all that apply for each 15-minute segment)

Methods to inform or persuade recipients or potential recipients to enter into care through one of the DHS-administered programs below. Outreach primarily includes active discussion of the benefits offered by the various programs administered by DHS, using prepared materials as appropriate.

7A. Medicaid

CMS will allow charges for active discussion of Medicaid programs (as Medicaid Administration), regardless of the audience members' current Medicaid status.

- For current Medicaid recipients who have additional unmet needs, outreach often includes information and discussion regarding further utilization of Medicaid.
- For potential recipients, outreach may include discussions aimed at overcoming barriers to submitting an initial application for Medicaid at a local AAA or SPD office (Medicaid outreach does not include intake, application, or eligibility processes).

Medicaid Outreach ends upon:

- Referral of current recipients (those who need an updated evaluation and assessment) to local AAA or SPD office case managers or screeners; or
- Referral of selected potential recipients to local AAA or SPD office screeners and intake workers for possible referral to Medicaid or other programs for eligibility determinations.

7B. Food Stamps

7C. OAA

7D. MMA

7E. Other

(Examples: OPI, local programs; for APS, go to code 15).

8. Initial Screening – (Check all that apply for each 15-minute segment)

- Activities to screen persons for appropriate referral to a worker for an eligibility decision in the programs listed below.

8A. Medicaid

8B. Food Stamps

8C. OAA

8D. MMA

8E. Other

(Examples: OPI, local programs; for APS, go to code 15)

9. Medicaid Program - Enter Prime Number: _____
(not case number)

(A prime number is required for activities directly related to specific Medicaid clients, such as **9B** SPMP, **9D**, OHP, and **9F** Case Management activities.

This does not apply to activities such as Outreach, Intake Screening, MMIS input, PASRR, or Medicaid Administration).

Allowable administrative activities as those that “are necessary for the proper and efficient administration of the Medicaid State Plan (or waiver) services”. CMS allows federal financial participation (FFP) to be claimed against salary or other compensation, fringe benefits, travel, per diem, services and supplies and training at rates determined on the basis of the individual’s position. The FFP claims include an appropriate proportion of general administrative charges, consistent with SPD policy and OMB A-87 principles.

The following administrative activity categories of MMIS, SPMP, PASRR, OHP, Administration, and Medicaid Case Management are available for activities related to Medicaid State Plan or waived services provided to Medicaid-enrolled clients:

□ **9A. Medicaid Management Information System (MMIS)**

Data coding, data entry and other activities that initiate payment or update the accuracy of the Medicaid payment system for managed care enrollment and provider enrollment (example: entering providers into the MMIS system). Making program management decisions on specific suspended claims are allowed, as are program management decisions on specific claims entered into MMIS that have suspended (note: code prior authorizations for services, entry of pay-ins on SFMU, and generic claim research as general Medicaid Administration (Code **9E**)).

Use only the time spent on the screens, forms, or systems listed below to charge the enhanced MMIS match rate:

Managed Care Enrollment and Exemption

- PHP Enrollment Screen
- 415H Medical Resources Form

Provider Enrollment –

- Oregon ACCESS HCW Enrollment and authorization
- Provider Enrollment Screens: PRV8 (Review)
- SDS 736 –Provider Enrollment
- 7262H-Direct Deposit Enrollment

Prior Authorization and Payment – Data entry functions related to processing Home Care Worker (HCW) vouchers, payments, and adjustments. Data entry and suspense resolution related to Community Based Care (CBC) authorizations, payments, and adjustments. Data entry and functions related to processing claims through the DHS claims systems.

- CEP Payment System Screens: HINQ, AATH, HATH, APAY, HPAY, HFIQ
- SDS 598B - Agreement, Authorization and Provider Invoice (computer generated only)
- CBC Payment System Screens: SMRQ, SMRF, SERF, SEFP, SEFS, SNRS, RATZ, SADD, FNAR, SBEG, DISB, SCFD, SMSG, SCFS, SCFP, PESM, PUTL, MRAT
- SDS 512 – Community Based Care Provider Payment Authorization and Invoice (computer generated only)
- Form SDS 599A – Agency Provider Invoice – In Home Services

Medical Payment Processing - Data entry and functions related to processing claims through DMAP and the AFS/SPD claims/payment systems.

- Form DHS 437 – Authorization for Cash Payment
- DMAP 405T – Medical Transportation Order (payment directly to provider)
- DMAP 409 – Medical Transportation Screening/Input document (payment to client or attendant)
- MMIS POC-Nursing Facility Payment Plan of Care

□ **9B. Skilled Professional Medical Personnel (SPMP)**

(You must be authorized to use this code. You, or the SPMP you support, as well as the services provided, must meet the following criteria:

- i) The expenditures are for activities directly related to the administration of the Medicaid program, including medical assessment, and as such do not include expenditures for direct medical care.
- ii) The SPMP have professional education and training in the field of medical care or appropriate medical practice. “Professional education and training” means the completion of a 2-year or longer program leading to an academic degree or certificate in a medically related profession. SPMP possess a medical license, certificate, or other document issued by a recognized National or State medical licensure or certifying organization or a degree in a medical field issued by a college or university certified by a professional medical organization. (Note: Experience in the administration, direction, or implementation of the Medicaid

program is not considered the equivalent of professional training in a field of medical care);

- iii) The SPMP are in positions that have duties and responsibilities that require the use of professional medical knowledge and skills;
- iv) A State-documented employer-employee relationship exists between the Medicaid agency and the SPMP and directly supporting staff; and
- v) Any direct support staff (such as secretarial, stenographic and copying as well as file and records clerks) perform duties that are directly necessary for the completion of the professional medical responsibilities and functions of the SPMP medical staff. The SPMP staff must directly supervise the supporting staff and the performance of the supporting staff's work.

Examples:

- SPMP who make medical judgments or recommendations related to the quality and utilization of Medicaid covered services provided to Medicaid applicants or recipients;
- SPMP who advise and assist case management and medical workers in securing and interpreting essential medical data regarding client eligibility for Medicaid and for Medical Review Team documentation.

□ **9C. Preadmission Screening/Resident Review (PASRR)**

Costs directly allocable to PASRR activities.

PASRR is a system to screen all applicants to, or residents of, nursing facilities:

- To assess whether the individual requires nursing facility services;
- To determine whether the individual may have mental illness or a developmental disability; and
- If either mental illness or developmental disability is confirmed, to determine if the individual requires specialized services.

All other Medicaid activities (such as prior authorization, and determinations regarding individuals with the greatest need when limited beds are available) are tracked under administration or case management.

Examples:

- SPMP preadmission Screening and Annual Resident Review for individuals with mental illness and mental retardation who request admission into a Medicaid-enrolled nursing facility or who are already in such a facility; and
- Data coding of the PASRR screening form.

- **9D. Oregon Health Plan (OHP) Activity**
 Examples: Time spent on Medicaid activities directly related to Oregon Health Plan enrollment or acute medical services coverage, enrolling a client in a health plan, or setting up medical transportation. (not Long-term care).
- **9E. Medicaid Administration**
 Examples: Prior Authorization of Medicaid services; determination of payment amounts; Medicaid data entry on Mainframe or into Oregon ACCESS, including pay-ins on SFMU; policy reviews; screen corrections; batch coding; consultation on Medicaid issues. Includes Medicaid staff training and non-client-specific quality assurance activities.
- **9F. Medicaid Case Management**
 Services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services:

 - Comprehensive assessment and periodic reassessment of individual needs, using the CA/PS tool, to determine the need for medical, educational, social, or other services. *These CA/PS Assessments are for persons who are categorically eligible for Medicaid (aged, blind, or disabled), and: are at or below the SSI level (\$674.00 for 2010); or are eligible under the waiver up to 300% of SSI (\$2,022 for 2010). Activities include:*
 - i. taking client history, identifying the needs of the individual and gathering information from all other sources such as family members, medical providers, social workers, and educators;
 - ii. activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - iii. identification of a course of action to respond to the assessed needs of the eligible individual.
 - Development (and periodic revision) of a specific care plan based on the information collected through the assessment. This includes:
 - i. specification of the goals and actions to address the medical, social, educational, and other services needed by the eligible individual.
 - ii. activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals;

- iii. identifying a course of action to respond to the assessed needs of the eligible individual.
- Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
 - Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to help determine whether the following conditions are met:
 - i. Services are being furnished in accordance with the individual's care plan.
 - ii. Services in the care plan are adequate.
 - iii. There are changes in the needs status of the eligible individual. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

Case Management may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.

10. Money Follows the Person (MFP) Transition Activities

(On The Move Program)

Transition assistance provided to individuals during the one year they are eligible under the MFP (On The Move) Program to facilitate their movement from institutional settings to community placements.

11. Foodstamps

- 11A. Benefit Issuance**
- 11B. Maintenance**
- 11C. Fraud/Overpayments**
- 11D. Quality Control**
- 11E. Administration** (Includes FS-specific staff training)

- Includes Legal/Court Procedures
Note: APS workers should tally time expended directly assisting a Medicaid-eligible clients to access Medicaid services (usually in coordination with a case manager) to code **9E**.

16. Adult Foster Home Licensing: relative, non- relative and limited license (and training directly related to this function).

Licensing and monitoring of adult foster homes; including, conducting reviews of facilities and checking background information on facility owner(s) and staff to ensure the appropriateness for initial licensing or re-licensing.

- **16A. Relative**
- **16B. Non-Relative**

17. Home Care Worker Activities

- **17A. Recruitment**

Examples: sending recruitment packets, doing criminal background checks, conducting orientations.

- **17B. Other**

Examples: Filing, advisory committee activities, monitoring HCW work that is non-client specific.

- Other Activities

- **18. Paid Break**
- **19. Paid Leave (ex: sick leave, vacation time)**
- **20. Non-Paid Leave (ex: lunch)**
- **21. Training** (generic training only; charge all program-specific training to the applicable program area code)
- **22. General Administration**
(ex: filling in this timesheet survey, general meetings, etc.)