

**INTERAGENCY AGREEMENT BETWEEN
THE OHIO DEPARTMENT OF MEDICAID AND
THE OHIO DEPARTMENT OF HEALTH**

A-1819-04-0113

RECITALS

This Interagency Agreement is entered into by the Ohio Department of Medicaid (ODM) and the Ohio Department of Health (ODH).

ARTICLE I. PURPOSE

- A. The purpose of this Agreement is to continue the general terms and conditions for the interactions between ODM and ODH to take the place of multiple agreements that have been used in the past to detail these interactions. This Agreement will include detailed attachments that will contain specific information regarding each program that is administered on behalf of ODM by ODH, or funded by ODM. There are seven attachments to this Agreement, including a definitions attachment, identified as Attachment G.
- B. Each attachment will be independent of the others and may be amended without impacting any of the other attachments. Attachments may be added or deleted if needed throughout the term of this Agreement without impacting any of the remaining attachments.
- C. The language contained in this document shall be applied to all attachments, unless otherwise specified within the attachment.

ARTICLE II. EFFECTIVE DATE OF THE AGREEMENT

- A. This Agreement is in effect from July 1, 2017 through June 30, 2019, unless this Agreement is suspended or terminated pursuant to the provisions of this Agreement prior to the termination date. This Agreement may be renewed upon satisfactory performance by both parties, upon appropriation of funds, and by mutual agreement by the parties.
- B. **Termination.**
 - 1. This Agreement may be terminated at the convenience of either party without cause upon 30 calendar days' written notice of termination to the other party. Notice of termination shall be sent or otherwise delivered to the persons signing this Agreement.
 - 2. This Agreement may be terminated immediately in the event there is a loss of funding, disapproval by a federal administrative agency, or upon discovery of non-compliance with any federal or state law, rule, or regulation. In the event of termination pursuant to this Section, a notice specifying the reason for termination shall be sent as soon as possible after the termination to the non-terminating party.
 - 3. Notwithstanding Paragraph 1 above, this Agreement may not be terminated at the convenience of either party if the performance under this Agreement is compelled by state or federal statute or executive order.

ARTICLE III. COMPENSATION

- A. Specific compensation shall be addressed in each attachment; however, ODM will encumber the funds as they become available and will notify ODH of any change in the encumbrances if they arise.
- B. This Agreement is subject to ORC 126.07. Availability of funds is contingent on appropriations made by the Ohio General Assembly or by funding sources external to the State of Ohio, such as federal funding. If the Ohio General Assembly or the external funding source fails at any time to continue funding ODM for the payments due under each individual Attachment, each individual Attachment will be terminated as of the date funding expires without further obligation of ODM.

ARTICLE IV. BUSINESS ASSOCIATE REQUIREMENTS UNDER HIPAA

- A. The definitions contained in this Section are derived from federal law. Should there be any conflict between the meanings assigned in this Agreement and the meanings defined in applicable federal law (even in the event of future amendments to law that create such conflict), the definitions found in federal law will prevail.
1. **General Definitions.** The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information and Use.
 2. **Specific Definitions.**
 - a. HIPAA means the Health Insurance Portability and Accountability Act of 1996, the American Recovery and Reinvestment Act of 2009 (ARRA) and any other applicable federal statute or regulation.
 - b. HIPAA Rules shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.
 - c. Covered Entity means a health plan, a health care clearinghouse, or health care provider under 45 CFR 160.103.
 - d. Business Associate means a person or entity that, on behalf of the Covered Entity, maintains, performs, or assists in the performance of a function or activity that involves the use or disclosure of "Protected Health Information" under 45 CFR 160.103.
 - e. Protected Health Information (PHI) means individually identifiable information including but not limited to the past, present or future physical or mental health or condition of an individual, provision of health care to an individual, or the past, present or future payment for health care provided to an individual, as more fully defined under 45 CFR Part 164 and any amendments thereto, received or sent on behalf of the Department.
- B. ODH acknowledges that ODM is a Covered Entity under HIPAA. ODH further acknowledges that it is a Business Associate of ODM, and, in carrying out the work described in this Agreement, agrees to comply with all of the following provisions:
1. **Permitted Uses and Disclosures.** ODH will not use or disclose PHI except as provided in this Agreement or as otherwise required under HIPAA regulations or other applicable law.
 2. **Safeguards.** ODH will implement sufficient safeguards, and comply with Subpart C of 45 CFR Part 164 pertaining to electronic PHI to prevent the use or disclosure of PHI other than as provided for under this Agreement. Safeguards will be implemented for all paper and electronic PHI created, received, maintained, or transmitted on behalf of ODM.
 3. **Reporting of Disclosures.** ODH agrees to promptly report to ODM any inappropriate use or disclosure of PHI that is not in accordance with this Agreement or applicable law, including breaches of unsecured protected health information as required at 45 CFR 164.410 and any security incident the ODH has knowledge of or reasonably should have knowledge of under the circumstances.
 4. **Mitigation Procedures.** ODH agrees to coordinate with ODM to determine specific actions that will be required of the Business Associates for mitigation, to the extent practical, of the breach. These actions will include notification to the appropriate individuals, entities, or other authorities. Notification or communication to any media outlet must be approved, in writing, by ODM prior to any such communication being released. ODH will report all of its mitigation activity to ODM and shall preserve all relevant records and evidence.

5. **Incidental Costs.** ODH shall bear the sole expense of all costs to mitigate any harmful effect, of any breaches or security incidents of which ODH has knowledge which are directly caused by the use or disclosure of protected health information by ODH in violation of the terms of this Agreement. These costs will include, but are not limited to, the cost of investigation, remediation and assistance to the affected individuals, entities or other authorities.
6. **Agents and Subcontractors.** ODH, in compliance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2) as applicable, will ensure that all its agents and subcontractors that create, receive, maintain, or transmit PHI from or on behalf of ODH and/or ODM agree to have, in a written agreement, the same restrictions, conditions, and requirements that apply to ODH with respect to the use or disclosure of PHI.
7. **Accessibility of Information.** ODH will make available to ODM such information as ODM may require to fulfill its obligations to provide access to, provide a copy of any information or documents with respect to PHI pursuant to HIPAA and regulations promulgated by the United States Department of Health and Human Services, including, but not limited to, 45 CFR 164.524 and 164.528 and any amendments thereto.
8. **Amendment of Information.** ODH shall make any amendment(s) to PHI as directed by, or agreed to, by ODM pursuant to 45 CFR 164.526, or take other steps as necessary to satisfy ODM's obligations under 45 CFR 164.526. In the event that ODH receives a request for amendment directly from the individual, agent, or subcontractor, ODH will notify ODM prior to making any such amendment(s). ODH's authority to amend information is explicitly limited to information created by ODH.
9. **Accounting for Disclosure.** ODH shall maintain and make available to ODM or individuals requesting the information as appropriate, records of all disclosures of PHI in a Designated Record Set as necessary to satisfy ODM's obligations under 45 CFR 164.528. For every disclosure the record will include, at a minimum, the name of the individual who is the subject of the disclosure, the date of the disclosure, reason for the disclosure if any, and the name and address of the recipient to which the protected health information was disclosed.
10. **Obligations of Department.** When ODH is to carry out an obligation of ODM under Subpart E of 45 CFR 164, ODH agrees to comply with all applicable requirements of Subpart E that would apply to ODM in the performance of such obligation.
11. **Access to Books and Records.** ODH shall make available to ODM and to the Secretary of the U.S. Department of Health and Human Services any and all internal practices, documentation, books, and records related to the use and disclosure of PHI received from ODM, or created or received on behalf of ODM. Such access is for the purposes of determining compliance with the HIPAA Rules.
12. **Material Breach.** In the event of material breach of ODH's obligations under this Article, ODM may immediately terminate this Agreement as set forth in ARTICLE II, Section B. Termination of this Agreement will not affect any provision of this Agreement, which, by its wording or its nature, is intended to remain effective and to continue to operate after termination.
13. **Return or Destruction of Information.** Upon termination of this Agreement and at the request of ODM, ODH will return to ODM or destroy all PHI in ODH's possession stemming from this Agreement as soon as possible but no later than 90 days, and will not keep copies of the PHI except as may be requested by ODM or required by law, or as otherwise allowed for under this Agreement. If ODH, its agent(s), or subcontractor(s) destroy any PHI, then ODH will provide to ODM documentation evidencing such destruction. Any PHI retained by ODH will continue to be extended the same protections set forth in this Section, HIPAA regulations and this Agreement for as long as it is maintained.
14. **Survival.** These provisions shall survive the termination of this Agreement.

ARTICLE V. GENERAL PROVISIONS

- A. **Entirety of Agreement.** All terms and conditions of this Agreement are embodied herein. No other terms and conditions will be considered a part of this Agreement unless expressly agreed upon in writing and signed by both parties.
- B. **Amendments.** This Agreement may be modified or amended provided that any such modification or amendment is in writing and is signed by the directors of the parties. It is agreed, however, that any amendments to laws, rules, or regulations cited herein will result in the correlative modification of this Agreement, without the necessity for executing written amendments.
- C. **Partial Invalidity.** This Agreement shall be governed, construed, and enforced in accordance with the laws of the State of Ohio. Should any portion of this Agreement be unenforceable by operation of statute or by administrative or judicial decision, the operation of the balance of this Agreement is not affected thereby provided, however, the absence of the illegal provision does not render the performance of the remainder of the Agreement impossible. Should the removal of such an unenforceable provision render the intended performance under this Agreement difficult or nonsensical, but not impossible, the parties shall negotiate, in good faith, replacement provision(s) in keeping with the objectives of this Agreement and the budgetary and statutory constraints of the parties.
- D. **Audit Exceptions.**
1. ODM shall be responsible for receiving, replying to, and arranging compliance with any audit exception(s) found as a result of any state or federal audit of this Agreement as it pertains to federal or ODM funding of the Agreement. ODM shall promptly notify ODH of any adverse findings which allegedly are the fault of ODH. Upon receipt of notification by ODM, ODH shall fully cooperate with ODM and timely prepare and send to ODM its written response to the audit exception(s).
 2. ODH shall be liable for any audit exception(s) that result(s) solely from its acts or omissions in the performance of this Agreement. ODM shall be liable for any audit exception(s) that result(s) solely from its acts or omissions in the performance of this Agreement. In the event that any audit exception(s) result(s) from the acts or omissions of both ODM and ODH, the financial liability for the audit exception(s) shall be shared by the parties in proportion to their relative fault. In the event of a dispute concerning the allocation of financial liability for audit exceptions, the parties agree that the dispute shall be referred to the Office of the Governor for a final, binding determination allocating financial liability.
 3. For the purpose of this section, the term "audit exception" shall include federal disallowance and deferrals.
- E. **Liability Requirements (other than audit).** To the extent allowable by law, ODH agrees to be responsible for any liability, suits, losses, judgments, damages, or other demands brought as a result of its actions or omissions in the performance of this Agreement. ODM agrees to be responsible for any liability, suits, losses, judgments, damages or other demands brought as a result of its negligent actions or omissions in performance of this Agreement.
- F. **Resolution of Disputes.** The parties agree that the directors of ODM and ODH shall resolve any disputes between the parties concerning responsibilities under, or performance of, any of the terms of this Agreement. In the event the directors cannot agree to an appropriate resolution to a dispute, they shall be referred to the Office of the Governor for a final, binding determination resolving the dispute.
- G. **Confidentiality of Information.**
1. The parties agree that they shall not use any information, systems, or records made available to either party for any purpose other than to fulfill the obligations specified herein. The parties specifically agree to be bound by the same standards of confidentiality that apply to the employees of both ODM and ODH and the State of Ohio. The terms of this Section shall be included in any subcontracts executed by either party for work under this Agreement. The parties specifically agree to comply with state and federal confidentiality laws and regulations applicable to the programs under

which this Agreement is funded. The parties are responsible for obtaining copies of all applicable rules governing confidentiality and for assuring compliance with the rules by employees and contractors of both ODM and ODH. The parties agree to current and ongoing compliance with Title 42, Section 1320d through 1320d-8 of the United States Code (USC) and the implementing regulations found at Title 45, Sections 164.402(e) and 164.504(e) of the Code of Federal Regulations (CFR) regarding disclosure of protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

2. The parties agree and acknowledge that the information provided by one or both parties may be considered confidential or proprietary under the laws of the State of Ohio or under federal law. If either party to this Agreement, as public entities, receives a public records request for information related to this document, the party receiving the request will promptly notify the other party of the request. If the notified party believes there is information that is confidential or proprietary and should not be released, the receiving party will provide a reasonable period of time for the other party to seek to have the confidential or proprietary information withheld from the document prior to releasing the information.
- H. **Records Retention.** All records relating to costs, work performed, and supporting documentation for invoices submitted to ODM by ODH along with copies of all materials produced under or pertaining to this Agreement shall be retained and made available by ODH for audit by the State of Ohio (including, but not limited to, ODM, the Auditor of the State of Ohio, the Inspector General, or any duly authorized law enforcement officials) and agencies of the United States Government for a minimum of three years after final payment under this Agreement. If an audit is initiated during this time period, ODH shall retain such records until the audit is concluded and all issues resolved or three years after final payment, whichever is longer. If applicable, ODH must meet the requirements of federal OMB Omni-Circular 2 CFR Part 200, Subparts D and F.
- I. **Ethics.** ODH certifies that by executing this Agreement, it has reviewed, knows and understands the State of Ohio's ethics and conflict of interest laws. ODH further agrees that it will not engage in any action(s) inconsistent with Ohio ethics laws or any Executive Orders.
- J. **Fair Labor Standards and Employment Practices.**
1. ODH certifies that it is in compliance with all applicable federal and state laws, rules, and regulations governing fair labor and employment practices.
 2. In carrying out this Agreement, ODH will not discriminate against any employee or applicant for employment because of race, color, religion, gender, national origin, military status, disability, age, genetic information, or sexual orientation, in making any of the following employment decisions: hiring, layoff, termination, transfer, promotion, demotion, rate of compensation, and eligibility for in-service training programs.
 3. ODH agrees to post notices affirming compliance with all applicable federal and state non-discrimination laws in conspicuous places accessible to all employees and applicants for employment.
 4. ODH will incorporate the foregoing requirements of this Section in all of its subgrants or subcontracts for any of the work prescribed herein.
- K. **MBE/EDGE.** Pursuant to the Governor's Executive Order 2008-13S, ODH agrees to purchase goods and services under this Agreement from certified Minority Business Enterprise (MBE) and Encouraging Diversity, Growth, and Equity (EDGE) vendors whenever possible. Likewise, ODH agrees to require any of its subgrantees or subcontractors to purchase goods and services from certified MBE and EDGE vendors whenever possible.
- L. **Certification of Compliance.** ODH certifies that it is in compliance with all other applicable federal and state laws, regulations, and rules and will require the same certification from its subgrantees or subcontractors.

- M. **Counterpart.** This Agreement may be executed in one, or more than one counterpart, and each executed counterpart shall be considered an original, provided that such counterpart is delivered to the other party by facsimile, mail courier or electronic mail, all of which together shall constitute one and the same agreement.

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AND
THE OHIO DEPARTMENT OF HEALTH**

A-1819-04-0113

SIGNATURE PAGE

IN WITNESS WHEREOF, THE PARTIES HAVE EXECUTED THIS AGREEMENT AS OF THE DATE OF THE SIGNATURE OF THE DIRECTOR OF THE OHIO DEPARTMENT OF MEDICAID.

APPROVED BY:

Ohio Department of Health

Ohio Department of Medicaid



Lance Himes, Director

Barbara R. Sears, Director

246 North High Street
Columbus, Ohio 43215

50 West Town Street
Columbus, Ohio 43215

1-2-18

1/3/18

Date

Date

ATTACHMENT A – MATERNAL AND CHILD HEALTH

INTERAGENCY AGREEMENT BETWEEN THE OHIO DEPARTMENT OF MEDICAID AND THE OHIO DEPARTMENT OF HEALTH

A-1819-04-0113A

RECITALS

The ODM Agreement Manager for purposes of this Attachment A only is Icilda Dickerson, Chief, Bureau of Long Term Care Services and Supports, Ohio Department of Medicaid, 50 West Town Street, Columbus, Ohio 43215; 614-752-3578; Icilda.dickerson@medicaid.ohio.gov

The ODH Agreement Manager for purposes of this Attachment A only is Shancie Jenkins, Chief, Office of Health Improvement and Wellness, Ohio Department of Health, 246 North High Street, Columbus, Ohio 43215; 614-644-7848; Shancie.Jenkins@odh.ohio.gov.

ARTICLE I. PURPOSE

The purpose of this Attachment A is to coordinate health services and conduct outreach, program eligibility, and payment for services for Ohio citizens, as defined and specified in 42 USC 701, *et seq.*, and 7 CFR Part 246.

- A. This Attachment A is entered into to implement the provisions of the following:
1. Under ORC 3701.027, ODH is the designated state agency for implementation of the Title V Maternal and Child Health Services Block Grant, 42 USC 701, *et seq.*, as amended, and has established the Office of Health Improvement and Wellness for this purpose and for the purpose of ensuring the provision of maternal and child health programs at the state and local level.
 2. Under 42 USC 705(a)(5)(F), ODH must execute interagency coordination agreements with other state-level agencies involved in the State's maternal and child health programs.
 3. Under 42 USC 1396a(a)(5) and ORC 5162.03, ODM is the designated state agency for implementation of Title XIX and Title XXI programs and must execute an interagency agreement with the state Title V agency as required by 42 USC 1396a(a)(11).
 4. Under ORC 5162.03, ODM has statutory authority to provide reimbursement to approved service providers for the health care expenses of eligible women and children in accord with requirements of the federal Title XIX and Title XXI programs.
 5. Under ORC 3701.132, ODH is the designated state agency for implementation of the Special Supplemental Nutrition Program for Women, Infants and Children (the WIC Program) enacted by amendments to the Child Nutrition Act of 1966, 42 USC 1786, *et seq.*, as amended.
 6. Under 7 CFR 246.4(a)(8), ODH desires to execute interagency coordination agreements for the purpose of coordinating WIC program operations with other state-level agencies involved in the State's health and human services programs.
 7. Under 7 CFR 246.26(h)(3), the WIC program is required to execute written agreements with other public organizations which administer health and human services programs that serve persons categorically eligible for the WIC program.

8. ODH has established the Bureau of Maternal and Child Health (BMCH) services for the purpose of ensuring the provision of Home Visiting services to eligible infants and toddlers and their families at the state and local level.
9. Under 34 CFR Part 303, 303.120, ODH is required to develop interagency agreements with other public health organizations administering programs and services that serve infants and toddlers eligible for Part C services and their families. These agreements define roles and responsibilities within the state's Part C system, including assignment of financial responsibility and methods for dispute resolution.
10. Under ORC 5162.135, provide ODH approved staff with access to the ODM QDSS warehouse. ODH staff will be required to take QDSS training prior to accessing the data and agree to work with ODM to pull data from QDSS.

B. The implementation of this Attachment A shall be guided by the following objectives:

1. To support the accomplishment of the objectives of the State Maternal and Child Health Services Block Grant, Coordinated School Health Program, HIV Prevention, Physical Activity, Nutrition and Tobacco, Youth Risk Behavior Surveillance System (YRBS), Reproductive Health and Wellness Program (including Title X) and other programs administered by ODH.
2. To increase public awareness of the need for personal health care services for women, children, and adolescents under 21 years of age.
3. To conduct outreach to ensure that eligible women, children, and adolescents under 21 years of age receive access to health care coverage and receive needed health services and to ensure that ODH and ODM serve their common population.
4. To make available health services statewide that meet the requirements of the Title V Maternal and Child Health Services block grant, WIC, Home Visiting Services, Ryan White Part B, and Title XIX Medicaid programs.
5. To coordinate the exchange of information and referral between local Maternal and Child Health Program (MCHP), WIC, Reproductive Health and Wellness Program (RHWP) and Home Visiting programs; ODH's Offices of Health Policy and local health departments; Ohio HIV Drug Assistance Program (OHDAP); and Ohio Medicaid programs for the purposes of outreach, eligibility determination, and verification of outcome of referral.
6. To maximize the efficient use of federal and state funds for the provision of health services to women and men of reproductive age, children, and adolescents under 21 years of age.
7. To participate actively in the planning and implementation of services for women of reproductive age; pregnant, postpartum, and breastfeeding women; and infants, children, and adolescents under 21 years of age, including Children with Special Health Care Needs (CSHCN).
8. To share the goal of interdepartmental cooperation in coordinating and implementing interagency systems for serving women of reproductive age; pregnant, postpartum, and breastfeeding women; and infants, children, and adolescents under 21 years of age, including CSHCN.
9. To improve, expand, and maximize the efficiency and effectiveness of existing resources and services for women and men of reproductive age, pregnant, postpartum and breastfeeding women; and infants, children, and adolescents under 21 years of age. Each party intends to continue its present services while moving toward a more integrated service delivery system. The respective philosophies of the parties mutually will build and support an interagency, cooperative system which provides a continuum of services for pregnant, postpartum, and breastfeeding women; and infants, children, and adolescents under 21 years of age, including CSHCN.
10. To clarify issues, define problems and propose alternatives related to promoting a statewide system of coordinated and comprehensive health services to eligible women and men of reproductive age;

pregnant, postpartum, and breastfeeding women; and infants, children, and adolescents under 21 years of age, including CSHCN.

11. To increase public awareness of the need for health care coverage; to encourage HIV testing; to provide developmental screenings to include vision, hearing and lead poisoning; and to provide nutritional assessment and education, and food supplementation to nutritionally at-risk pregnant, postpartum, and breastfeeding women; and infants, children, adolescents under 21 years of age.
12. To maximize the efficient use of federal and state funds, including federal financial participation and Medicaid Administrative Match, for the provision of services to women and men of reproductive age; pregnant, postpartum, and breastfeeding women; and infants, children, and adolescents under 21 years of age, including but not limited to CSHCN.
13. To coordinate the exchange of information between the parties as required by law for the purposes of, including but not limited to, comprehensive health status screening, evaluation and assessment, health services assurance, and health policy development, and data as needed including but not limited to WIC data.

ARTICLE II. RESPONSIBILITIES OF ODM

A. ODM agrees to:

1. Require County Departments of Job and Family Services (CDJFS) staff to identify participants potentially eligible for the WIC and Maternal and Child Health programs and to refer them to the appropriate program. Attention shall be given to the timely referral of children with or at risk for developmental delays or disabilities in order to promote their access to primary and preventive health care.
2. Make available to ODH's Office of Health Improvement and Wellness (OHIW) and HIV Care Services Program staff the appropriate online application/recipient eligibility subsystem.
3. Provide technical assistance to ODH's OHIW for Medicaid eligibility and the Healthchek and Pregnancy Related Services (PRS) , as requested, particularly when changes are proposed or occur, or when relevant audit findings reveal interpretation or practice conflicts.
4. Provide ODH with information necessary to maintain accurate information about ODM programs for use by ODH Helpline employees.
5. Keep an up-to-date listing of the names and addresses of CDJFS Healthchek and PRS Coordinators on the ODM website.
6. Initiate, as appropriate, information sharing sessions that will inform ODH on proposed federal and state regulations, policy, forms and OAC rule changes, such as changes related to the Application for Health Coverage & Help Paying Costs ODM07216, Healthchek and PRS. ODM will participate in the information sessions facilitated by ODH.
7. Allow ODM contracted Managed Care providers to verify recipient's current Medicaid status through their connection to the Medicaid Information Technology System (MITS) for assisting with determining WIC and Maternal and Child Health Program eligibility.

B. In accordance with CFDA requirements, ODM will monitor the activities of ODH to ensure its compliance with program and administrative requirements. In this role, ODM may:

1. Perform fiscal or compliance reviews to determine accuracy and appropriateness of Intrastate Transfer Vouchers (ISTVs), making adjustments to ISTVs in accordance with any resulting review findings.
2. Notify ODH staff in writing of the results of any programmatic, fiscal and/or compliance reviews.

3. Request a Corrective Action Plan (CAP) for monitoring review findings and determine if ODH takes appropriate and timely corrective action.
4. Consider whether ODH's CAP meets the requirements necessary to correct finding(s).

ARTICLE III. RESPONSIBILITIES OF ODH

A. ODH agrees to:

1. Require ODH's Maternal and Child Health Program (MCHP), Home Visiting and WIC programs to identify and refer to CDJFS those women, infants, and children served who are potentially eligible for services under the Ohio Medicaid program and assist them in applying for Medicaid using the Application for Health Coverage & Help Paying Costs by original, copy or facsimile, or providing the applicant with the website for applying online at: <http://medicaid.ohio.gov/forohioans/GetCoverage.aspx>. The Children with Medical Handicaps Program (CMH) and Home Visiting shall identify and refer to CDJFS those children with handicapping conditions who may be eligible for services under the Ohio Medicaid programs and assist them in applying for Medicaid, using the Application for Health Coverage & Help Paying Costs by original, copy or facsimile. The Ohio Partnership to Improve Oral Health (OPTIONS) referral coordinators shall identify and refer to CDJFS those individuals who apply for services who are potentially eligible for Medicaid. Ryan White case managers shall identify and refer to CDJFS those individuals who apply for services who are potentially eligible for Medicaid.
2. Keep all local MCHP, WIC, RHWP, and Home Visiting caseworkers and Child Care Health Consultants (CCHCs) informed of Medicaid eligibility guidelines by publishing fact sheets approved by ODM and providing contact numbers for additional information. ODH shall also promote increased use of Medicaid by local health departments, public health agencies, and other agencies serving women and men of reproductive age and children. Prior to use, ODH will seek ODM approval of the fact sheets utilized to ensure that they accurately reflect recent revisions in the Healthchek rule.
3. Provide ODM, Bureau of Policy and Health Plan Services (BPHPS) at least annually with updated lists of local WIC and OHIW programs, project directors, county Home Visiting project directors, OPTIONS referral coordinators, CMH field nurse consultants, and CCHCs with addresses and phone numbers.
4. Require local MCHP, Home Visiting, and WIC programs to have information regarding Healthy Start, PRS, and Healthchek Services, and the ODH Helpline and Ohio Medicaid Consumer Hotline telephone numbers available for clients, including the address and telephone number of the CDJFS. Each entity that distributes or accepts the Application for Health Coverage & Help Paying Costs (ODM 07216) shall prominently post the Healthchek Poster in a conspicuous place for their consumers to view in accordance with ORC 5164.26.
5. Operate the ODH Helpline, using the information provided by ODM about ODM programs, referring to ODM unresolved ODH Helpline questions needing ODM follow-up.
6. Require that CMH program providers and safety net primary care providers placed by ODH's Primary Care unit are Title XIX and Title XXI providers.
7. Provide ODM's BPHPS with electronically transmitted information about policies governing the OHIW programs (e.g., WIC, MCHP, RHWP, Home Visiting services) on a regular basis.
8. Ensure that the CMH program shall not be payer for services eligible for payments by Medicaid programs to ensure the CMH does not supplement/supplant payments made by Title XIX ODM programs, in accordance with ORC 3701.023(F).
9. Notify ODM of any significant reimbursement policy and/or program change which will impact Medicaid claims payment or coverage.

10. Initiate, as appropriate, information sharing sessions that will inform ODM on proposed federal and state regulations, policy, forms and OAC rule changes, such as changes related to the Application for Health Coverage & Help Paying Costs, and maternal and child health programs for consumers eligible for Healthchek and PRS. ODH will participate in the information sessions facilitated by ODM.
11. Provide a listing of dates and places of meetings related to the Maternal and Child Health Grant, Home Visiting, WIC, CMH and any other children and pregnant women related meetings on a bi-monthly basis to the ODM Agreement Manager. This must be done in order to arrange for attendance by ODM staff to encourage a more collaborative atmosphere between the two agencies.
12. Grant secure access in ODH's Ohio Public Health Data Warehouse to specific individuals at ODM for access to all data fields contained in the attached files. The information will be used to link ODM eligibility and claims data to vital statistics birth records for: 1) producing the Children's Health Insurance Program (CHIP) low birth weight measure (percent of live births weighing less than 2,500 grams) according to the national methodology which requires use of the vital statistics data; 2) identifying women with a high risk pregnancy or women who are at risk for a poor pregnancy or poor birth outcome due to a prior poor birth outcome or preterm birth, and/or complex medical condition; 3) the Ohio Department of Mental Health and Addition Services' Maternal Opiate Medical Supports project; and 4) tracking/trending Medicaid infant mortality, as well as preterm births across time and counties, identified in Exhibit A to this Attachment.
13. Allow ODM's contractor, the External Quality Review Organization (EQRO), to use the vital statistics data to perform the linkage between the birth certificate and Medicaid identifiers in Medicaid claims and eligibility data. In addition, ODM will share individual-level information to identify mothers who are at high risk due to a prior poor birth outcome or preterm birth, and/or complex medical condition (including flags to indicate the type of risk) with the Medicaid managed care plans (MCPs) that are contracted with ODM to provide services to Medicaid consumers. The Medicaid MCPs will only receive data for consumers currently enrolled in the MCP. Medicaid MCPs must implement mechanisms to target women with a high risk pregnancy or women who are at risk for a poor pregnancy or poor birth outcome due to a prior poor birth outcome or preterm birth, and/or complex medical condition or social/behavioral risk factors to offer enhanced prenatal care services for those women who are pregnant, as well as inter-conception care strategies for those who are not pregnant.
14. Provide ODM staff electronic access to obtain death certificate data upon approval by ODH.
15. Order and distribute metabolic formula for individuals enrolled in Medicaid. This Agreement does not apply if an individual is enrolled in a MCP, resides in a nursing or intermediate care facility or is on a Home and Community Based Services Waiver. ODH will do the following:
 - a. Receive orders from the Metabolic Service Teams and/or ODM and place the order;
 - b. Respond to formula backorders from the manufacturer, order formula in a timely manner, have the formula drop shipped to the recipient's residence (or other requested point of delivery – place of employment, school, etc.);
 - c. Negotiate volume pricing with manufacturers of metabolic formula;
 - d. Bill Medicaid at the same rate ODH acquires the metabolic formula;
 - e. Provide Medicaid a list of metabolic formulas on the ODH approved formulary list twice per year; and
 - f. Provide ODM with a current list of Metabolic Service Teams.

ARTICLE IV. RESPONSIBILITIES OF BOTH PARTIES

- A. Both parties shall assist their respective local agencies in carrying out the provisions of this Agreement by providing training and technical assistance and promoting improved health services for women and men of reproductive age and children. Both parties will issue a cover letter co-signed by the respective Agreement

Managers to their respective local agencies announcing that this Agreement is signed and the location where the Agreement can be found.

- B. Both parties shall coordinate outreach, education, and program promotion by exchanging program literature explaining operation of the Medicaid, OHIW, and Maternal, Child and Family Health (MCFH) programs at state and local levels (including the jointly developed “Wellness Guide” and other developmental materials); having reciprocal training and/or speaking engagements as necessary for state, regional, and local staff; developing joint outreach, public relations programs, and/or promotional materials for programs administered by ODH and/or ODM (including, at a minimum, Home Visiting and Medicaid eligibility outreach efforts); and participating in training and program orientation for the ODH Helpline staff as needed.
- C. Both parties, for purposes of meeting the goals contained in Section B of this ARTICLE IV, shall require their respective local agencies to provide their program participants’ current eligibility status.
- D. ODH and ODM program staff shall continue to explore common issues and participate as needed in meetings for joint planning. These common issues include, but are not limited to, development of plans and strategies to enroll all potentially eligible Ohioans in Medicaid; development of services in communities lacking comprehensive maternal and child health services; analysis of Health Professional Shortage Areas; recruitment and retention of providers; development of joint studies; development of common data elements for program evaluation; and development of procedures to ensure, as possible, that payments under the Medicaid and CMH programs are not duplicated, or that duplicate payments are identified and recovered. ODM and ODH are also committed to communicating upcoming actions that may affect the other in order to avoid unintended consequences.
- E. Representatives of ODH and ODM shall meet upon request of either of the parties to review implementation of this Agreement.
- F. Both parties shall maintain representatives on committees, task forces, or ad hoc work groups of their respective departments for the purpose of ensuring coordination of services, eliminating duplication and maximizing resources between the two departments as the opportunity arises. Examples include, but are not limited to, the CMH Medical Advisory Committee’s subcommittees, Adolescent Health Advisory Group, Home Visiting Consortium, Ryan White Part B Advisory Group, and Medicaid Outreach Advisory Group.

ARTICLE V. AMOUNT OF AGREEMENT

- A. ODM agrees to reimburse ODH, upon proper invoicing and preparation of annual ISTVs for actual expenditures incurred and paid for performance of the responsibilities outlined in ARTICLES III and IV. The amount to be reimbursed shall not exceed Fifty Thousand and 00/100 Dollars (\$50,000.00) for State Fiscal Year (SFY) 2018, and Fifty Thousand and 00/100 Dollars (\$50,000.00) for SFY 2019, for a total not to exceed One Hundred Thousand and 00/100 Dollars (\$100,000.00) for the Agreement period. All invoices shall indicate only the federal share of the cost of services provided. The state match shall be provided by ODH. The total federal pass-through shall not exceed Fifty Thousand and 00/100 Dollars (\$50,000.00) for SFY 2018, and Fifty Thousand and 00/100 Dollars (\$50,000.00) for SFY 2019, for a total not to exceed One Hundred Thousand and 00/100 (\$100,000.00) for the Agreement period. The parties agree that no further reimbursement will be sought hereunder this Agreement.
- B. On an annual basis, ODH will submit one ISTV to ODM in the amount of Fifty Thousand and 00/100 Dollars (\$50,000.00).

ATTACHMENT B - ENVIRONMENTAL LEAD ASSESSMENT AND LEAD ABATEMENT

INTERAGENCY AGREEMENT BETWEEN THE OHIO DEPARTMENT OF MEDICAID AND THE OHIO DEPARTMENT OF HEALTH

A-1819-04-0113B

RECITALS

The ODM Agreement Manager for purposes of this Attachment B to the Agreement is Icilda Dickerson, Chief, Bureau of Long Term Services and Supports, Ohio Department of Medicaid, 50 West Town Street, Columbus, Ohio 43215; 614-752-3578; Icilda.dickerson@medicaid.ohio.gov

The ODH Agreement Manager for purposes of this Attachment B to the Agreement is Pam Blais, Environmental Supervisor, Healthy Homes and Lead Poisoning Prevention Program, Office of Health Assurance and Licensing, Ohio Department of Health, 246 North High Street, Columbus, Ohio 43215; 614-728-3105; Pam.blais@odh.ohio.gov

ARTICLE I. PURPOSE

The purpose of this Attachment B is to define the relationship and responsibilities between the parties for performing environmental lead risk assessments in the homes and supplemental addresses of Medicaid eligible children identified as having elevated blood lead levels. This Agreement is entered into in order to implement the provisions of federal and state law.

ARTICLE II. RESPONSIBILITIES OF ODM

- A. ODM is designated as the single state agency for the administration of the Medicaid program under Title XIX of the Social Security Act.
- B. In accordance with federal and state regulations governing Ohio's early and periodic screening, diagnostic and treatment (EPSDT) program, hereinafter referred to as Healthchek services for promotional purposes (Title 42, Parts 400 and 441 of the Code of Federal Regulations (CFR), and Section 5164.26 of the Ohio Revised Code (ORC) mandating the application of preventive measures for the reduction of disease in children) ODM shall perform the following functions:
 1. Inform all Healthchek providers (to include all managed care providers (MCPs)) who use private clinical laboratories, of their responsibilities to report the items mandated by rule 3701-30-05(A) through (E) of the Ohio Administrative Code (OAC) to an approved clinical laboratory.
 2. Maintain communication with and provide training to, at least on an annual basis, the eighty-eight (88) County Departments of Job and Family Services (CDJFS) to inform them of the provisions of this Agreement and their responsibilities in assuring that follow-up treatment, in the form of public health lead investigations to identify lead hazards for lead content, is conducted for all Healthchek eligible individuals identified as having lead poisoning.
 3. Instruct all CDJFS directors and Healthchek Coordinators, upon notification of a child being investigated or having a high blood lead level, to coordinate with the ODH Bureau of Environmental Health and Radiation Protection to ensure the completion of all public lead investigations by performing the following activities:
 - a. Assist in providing education to families by informing them of upcoming public health lead investigations and their purpose;

- b. Provide services to those families needing assistance with relocating to a lead-safe environment; and
 - c. Provide a quarterly report to ODH listing the child's name, Medicaid number, permanent address, and temporary relocation address for children who have been relocated as a result of the Healthchek coordinator's efforts.
 4. Keep an up-to-date listing of the names and addresses of CDJFS Healthchek Coordinators on the ODM website.
 5. ODM agrees that for the purposes of reviewing and evaluating the child lead poisoning prevention program, the Secretary of Health and Human Services and the Comptroller General shall have access to any books, accounts, records, correspondence, or other documents relating to the child lead poisoning prevention program that are in the custody or control of ODM, except as limited by law.
- C. ODH and ODM shall meet at least annually to evaluate the effectiveness of the program and communicate to each other any need for changes to enhance the objectives of the preventive services being provided pursuant to this Attachment B.
- D. In accordance with Catalog of Federal Domestic Assistance (CFDA) requirements, ODM will monitor the activities of ODH to ensure its compliance with program and administrative requirements. ODM will perform the following functions in its monitoring capacity:
 1. ODM may perform fiscal or compliance reviews to determine accuracy and appropriateness of Interstate Transfer Vouchers (ISTVs) and may make adjustments to ISTVs in accordance with any resulting review findings.
 2. ODM may request a corrective action plan (CAP) for monitoring review findings and shall determine if ODH takes appropriate and timely corrective action.
 3. ODM shall consider whether ODH's CAP meets the requirements necessary to correct finding(s).

ARTICLE III. RESPONSIBILITIES OF ODH

- A. Pursuant to ORC 3742.35, ODH has the authority to conduct public health lead investigations for the identification of lead hazards in the environment where a case of suspected lead poisoning has been reported. This Attachment B is specific to the responsibility of ODH to conduct public health lead investigations involving Medicaid eligible children.
- B. In accordance with established standards contained in OAC 3701-30-07, ODH has the authority to initiate contact with the parent or guardian of a child with a blood lead level greater than or equal to five (5) micrograms per deciliter ($\mu\text{g}/\text{dl}$) and less than or equal to ten (10) $\mu\text{g}/\text{dl}$ and to administer a questionnaire to assess potential lead hazards in a residential unit, child care facility or school where the child spends a considerable amount of time. Information obtained through the questionnaire may trigger a public health lead risk assessment if a sibling has lead poisoning; a previous blood lead level greater than or equal to five (5) $\mu\text{g}/\text{dl}$ has been reported for another child living at the property; or the parents/guardians indicate the property has chipping, peeling, and/or deteriorated paint surfaces. Follow-up may include a public health lead risk assessment and/or case management services. As a condition for reimbursement, the child must be eligible for Medicaid on the date the questionnaire was completed.
- C. To initiate public health lead risk assessments for those Medicaid eligible children identified by a clinical laboratory as having elevated blood lead levels greater than ten (10) $\mu\text{g}/\text{dl}$, ODH shall:
 1. Receive, from ODH approved clinical laboratories, reports of all blood lead levels analyzed.
 2. Coordinate with delegated local boards of health and Healthchek Coordinators the conducting of public health lead risk assessments after a blood lead level greater than or equal to ten (10) $\mu\text{g}/\text{dl}$ has been determined and Medicaid eligibility verified by the Ohio Department of Medicaid.

3. Conduct a public health lead risk assessment of the primary residential unit as determined appropriate and complete a written report for each child/family listed. As a condition for reimbursement, the child must be eligible for Medicaid on one or more days of the public health lead risk assessment.
4. Upon the identification of probable lead hazards, provide a lead hazard control order as required in ORC 3742.37 to the owner of the structure for the control of identified lead hazards.
5. Upon the failure or refusal of the owner of the structure to comply with a lead hazard control order, a second order shall be issued, as required by Section 3742.40 of the ORC, prohibiting the owner/manager from using the structure as a residential unit until the structure passes a clearance examination on receipt of the order. If a second order to vacate is issued for a residential unit, the Healthchek Coordinator can assist with relocating to a lead-safe environment.
6. Upon failure to pass a clearance examination, a written recommendation will be made to the Healthchek Coordinator at the appropriate CDJFS that the family will be relocated to housing free of immediate lead-based paint hazards.

D. Information and Reports:

1. ODH shall send to ODM or its agents and/or the United States Department of Health and Human Services or its agents, an annual statistical report including a listing of families ODH recommended to the Healthchek Coordinator for relocation to lead safe housing; and
2. ODH shall advise, collaborate and coordinate with ODM any changes in the definition of lead poisoning, and any other changes which affect methods of screening, diagnosis and treatment of undue lead absorption and which may have an impact on the way the Healthchek services are delivered to the eligible population in Ohio.

E. ODH and ODM shall meet at least annually to evaluate the effectiveness of the program to which this Attachment B is related and communicate to each other any need for changes to enhance the objectives of the preventive services being provided as a result of this Attachment.

F. None of the services or functions of ODH as provided in this Attachment B shall be delegated by ODH to any government or private agency except as stated in ARTICLE III of this Attachment.

G. ODH is a vendor for federal reporting purposes and must list the CFDA numbers at the agency level.

H. The ODH Healthy Housing and Lead Poisoning Surveillance System (HHLPSS) can track lead and other heavy metal testing for patients, the subsequent case management and investigation services provided, as well as some limited measures of the home environment. HHLPSS is also used to generate lists of billable events to send to Medicaid for reimbursement. However, ODM requires all requests for reimbursement be submitted as individual claims. Therefore, the Ohio Healthy Homes and Lead Poisoning Prevention Program and all contractors are unable to submit claims for reimbursement. In order to resolve this issue, ODH shall:

1. Monitor data transfers weekly from HHLPSS to ImpactSIIS.
2. Write an annual report on the data matching process that takes place at ODH. This report will also include Medicaid lead testing rate statistics and a calculation of the lead specific Healthcare Effectiveness Data and Information Set (HEDIS) measure.
3. Continue to improve patient, address and provider de-duplication routines within the import process so that all new records are matched appropriately upon import into HHLPSS
4. Continue development of the patient linkage function to allow users to easily link patients within the system to track familial and group relationships.

5. Manage the statewide lead data system. This requires four full time ODH employees paid at 100% of their time - Customer Service Assistant 2, Data Entry Operator 2, Researcher 3 and Epidemiology Investigator 2- dedicated to receiving, managing, and analyzing blood lead results. Medicaid children make up a majority of the lead tested population (67%). Medicaid children are more likely to have elevated results that require additional data management.
6. Initiate development to add the ability to electronically submit individual claims to Medicaid for reimbursement.
7. Initiate development to add the ability to obtain Medicaid IDs, Case #s, demographics, and claims from Impact SIIS to improve completeness of records in HHLPSS
8. Continue development of the ability to import all necessary fields of heavy metal testing data reported in HL7 2.5.1 files.
9. Perform maintenance of the HHLPSS system by identifying and fixing software coding errors.

Reimbursement for HLPSS activities shall be allocated as listed in ARTICLE IV.A.4., below.

ARTICLE IV. AMOUNT OF AWARD/AMOUNT OF SUBGRANT

A. ODM shall reimburse ODH for each public health lead investigation as follows:

1. Reimbursement for each Lead Assessment completed by ODH with a risk assessment shall be One Thousand, Two Hundred Eighty-Nine and 00/100 Dollars (\$1,289.00) per assessment; or
2. Reimbursement for each Lead Assessments completed by ODH without a risk assessment shall be One Hundred Fifty and 00/100 Dollars (\$150.00); or
3. Reimbursement for each Lead Assessment completed by a local health department (LHD) shall be One Thousand, One Hundred Four and 00/100 Dollars (\$1,104.00).
4. Healthy Housing and Lead Poisoning Surveillance System reimbursement shall be as follows:

HHLPSS Reimbursement for SFY 2018: \$154,242

Ongoing Operational Costs (50%)	Total SFY16 Salary/Fringe/Indirect (Dedicated to Medicaid Data (81%))	Medicaid Share (50%)	ODH Share (50%)
Customer Service Assistant 2	\$74,114	\$37,057	\$37,057
Data Entry Operator 2	\$62,315	\$31,157	\$31,157
Researcher 3	\$87,460	\$43,730	\$43,730
Epidemiology Investigator 2	\$84,596	\$42,298	\$42,298
Subtotal	\$308,485	\$154,242	\$154,242

HHLPSS Reimbursement for SFY 2019: \$329,242

Ongoing Operational Costs (50%)	Total SFY17 Salary/Fringe/Indirect (Dedicated to Medicaid Data (81%))	Medicaid Share (50%)	ODH Share (50%)
Customer Service Assistant 2	\$74,114	\$37,057	\$37,057
Data Entry Operator	\$62,315	\$31,157	\$31,157
Researcher 3	\$87,460	\$43,730	\$43,730

Epidemiology Investigator 2	\$84,596	\$42,298	\$42,298
Development Costs (50%)	Total SFY17 Salary/Fringe/Indirect (100% Dedicated to development)	Medicaid Share (50%)	ODH Share (50%)
*IT Development Project	\$350,000	\$175,000	\$175,000
Subtotal	\$658,485	\$329,242	\$329,242

- B. ODM agrees to reimburse ODH up to Eight Hundred Thousand and 00/100 Dollars (\$800,000.00) in State Fiscal Year SFY 2018 and Eight Hundred Thousand and 00/100 Dollars (\$800,000.00) in SFY 2019. It is expressly understood by ODM and ODH that the terms of this Agreement do not allow total compensation in excess of One Million Six Hundred Thousand and 00/100 Dollars (\$1,600,000.00) for the period set forth in this Attachment B.
- C. ODM agrees to reimburse ODH, upon proper invoicing, and preparation of an Intra-State Transfer Voucher and electronic reporting, on a quarterly basis for actual expenditures incurred pursuant to responsibilities outlined in ARTICLE III. The invoices shall include a report in an approved Excel format, which may be submitted prior to hard copy invoices. ODM will verify accuracy of the invoice with the electronic reporting. All reporting must be in an electronic format and will be delivered to ODM in an agreed upon transmission. The electronic reporting format will follow HIPAA guidelines for electronic transmission of protected health information (PHI) and will include the following information:
1. Total number and names of individuals served including case names, recipient numbers, dates when blood samples were collected, the types of lead hazards found, dates of public health lead investigations, addresses where assessments were conducted for each individual in alphabetical sequence by county, and by surname within the county;
 2. Billing date and total amount of dollars claimed;
 3. Name and telephone number of the person responsible for the preparation of the invoice; and
 4. Signature of an authorized representative of ODH.
- D. Payment for any and all services provided pursuant to this Agreement may be contingent upon the availability of federal funds. If the Ohio General Assembly or the federal government disapproves or ceases to continue funding ODM for payments due hereunder, this Agreement is terminated as of the date funding expires without notice or further obligation of ODM. ODM will provide written notice to the party (ies) signing this Agreement as soon as possible.

ARTICLE V. LEAD ABATEMENT PROJECT

- A. A related cooperative arrangement between the parties is the Lead Abatement Project, whose scope and detailed payment methods are outlined in a separate Operating Protocol document. ODH will administer all aspects of the program and ODM will file State Plan Amendments and provide oversight.
- B. Pursuant to that Operating Protocol, ODH will partner with ODM to leverage State Children's Health Insurance Program (SCHIP) funding to pay for lead abatement activities at an amount up \$5,000,000 each year of the State Fiscal Year 2018 to 2019 biennium. Approximately \$4,800,000.00 of the \$5,000,000.00 each year will be used for remediation and associated testing services for homes under lead hazard orders. The remaining \$200,000.00 each year will be used to develop, support, and market a Registry of Lead Safe Housing for non-owner occupied rental housing by leveraging a current resource administered by the Ohio Housing Finance Agency. All funding for the program will be in ODM's budget and ODH will administer contracts for the program and code purchase orders and invoices to ODM accounts.
- C. The funding amounts in ARTICLE IV are for Environmental Lead Investigation components only and do not include funding for the Lead Abatement Project.

ATTACHMENT C – MEDICAID ADMINISTRATIVE CLAIMING
INTERAGENCY SUBGRANT/SUBRECIPIENT AGREEMENT BETWEEN
THE OHIO DEPARTMENT OF MEDICAID AND
THE OHIO DEPARTMENT OF HEALTH

A-1819-04-0113C

RECITALS

The ODM Agreement Manager for purposes of this Attachment C is Christopher Patrone, Medicaid Health Systems Administrator, Ohio Department of Medicaid, 50 West Town Street, Columbus, Ohio 43215; 614-752-3502; christopher.patrone@medicaid.ohio.gov.

The ODH Agreement Manager for purposes of this Attachment C is Kimberly Dick, Medicaid Administrative Claiming Coordinator, 246 North High Street, Columbus, Ohio 43215; 614-644-7236; kimberly.dick@odh.ohio.gov.

ODM hereby awards this Subgrant and ODH hereby accepts this Subgrant and agrees to comply with all the terms and conditions set forth in this Attachment C.

The Subgrant is made pursuant to the Federal Award further identified in Exhibit A hereto.

DEFINITIONS

- A. For purposes of this Attachment C, the terms “auditee,” “auditor,” “audit finding,” “Catalog of Federal Domestic Assistance (CFDA) number,” “Federal award,” “Federal awarding agency,” “Federal program,” “internal control,” “management decision,” “non-profit organization,” “Office of Management and Budget (OMB),” “pass-through entity,” “single audit,” “state,” and “subrecipient” have the same meanings as provided in Title 2 of the Code of Federal Regulations (CFR) Part 200, Subpart A of the OMB Uniform Guidance: Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, hereafter referred to as the “OMB Omni-Circular”.
- B. For purposes of this Attachment C, the terms “equipment,” “HHS,” “HHS awarding agency,” “real property,” “subaward,” “subrecipient,” “supplies,” “suspension,” and “termination” have the same meanings as provided in Title 45, Part 75 of the CFR.

ARTICLE I. PURPOSE

The purpose of this Attachment C is to identify a subrecipient relationship between ODM and ODH with regard to providing, or assisting to provide with ODM, statewide access for eligible individuals who are covered by the Medicaid program as set forth in Title XIX of the Social Security Act or the State Children’s Health Insurance Program (SCHIP) Medicaid expansion as set forth in Title XXI of the Social Security Act. This Attachment provides the mechanism to reimburse ODH bureaus and/or local public health departments (LPHDs) for Medicaid administrative activities provided by them, pursuant to the provisions of 42 CFR 431, Subpart M of the Code of Federal Regulations (CFR). This Attachment C authorizes the transfer of federal funds between ODM and ODH for those Medicaid services under CFDA 93.778, as detailed in Exhibit B, “Ohio Department of Health Medicaid Administrative Claiming Methodology Guide” (the Guide), hereby incorporated by reference, which may be updated from time to time without the need for a formal amendment.

ARTICLE II. RESPONSIBILITIES OF ODM

- A. ODM will act as the single state agency for Ohio’s Medicaid Program as defined in 42 CFR 431.10.
- B. ODM will file Medicaid State Plan amendments related to administrative activities performed by ODH Bureaus and/or local public health departments (LPHDs) with the Centers for Medicare and Medicaid (CMS).

- C. ODM will designate either an individual ODM staff member or a work unit consisting of ODM staff as the single point of accountability for the Medicaid administrative claiming (MAC) program.
- D. ODM will provide information and technical assistance to ODH as needed in order for ODH to properly discharge its responsibilities under ARTICLE III of this Attachment C, providing data to ODH in the format necessary for ODH to develop and submit appropriate claims. In the event it becomes necessary for ODM to cease production and distribution of this data, ODM will notify ODH no less than 90 days prior to the beginning of a new claiming year.
- E. ODM will monitor ODH's performance and compliance with state and federal laws, rules and regulations pertaining to this Attachment C. ODM may request copies of draft and final contracts between ODH and participating LPHDs that pertain to MAC.
- F. ODM will review and approve time study training curricula and other materials. The timing of the approvals will be consistent with the schedules agreed upon by ODM and ODH.
- G. No earlier than eight nor later than ten weeks prior to the beginning of a quarter, ODM will randomly select a particular week from the eligible weeks of the quarter for a time study to be conducted and inform ODH of the week selected.
- H. ODM will review ODH claim monitoring functions by overseeing and monitoring field audits conducted by ODH staff. Oversight monitoring may include the performance of field audits by ODM. Some of these audits may be conducted jointly with ODH.
- I. ODM will be responsible for receiving, replying to, and arranging compliance with any audit by the appropriate state or federal auditor directly related to the provisions of this Attachment C.
- J. Annually, ODM will work with ODH on the selection of LPHDs targeted for oversight reviews and/or audits of the quarterly claims. ODM will perform reviews and/or audits of participating ODH bureaus that will be carried out as stated in the section "Monitoring Procedures" of the Guide.
- K. ODM will review the data used by ODH's MAC Unit (ODH MAC) to calculate the Medicaid Eligibility Rate (MER).
- L. ODM will transfer Medicaid federal financial participation (FFP) funds to ODH within 15 calendar days of its receipt for appropriately adjudicated MAC claims relating to the operation of ODH MAC. ODM will not process or submit for FFP reimbursement any MAC claim that ODH MAC or ODM has determined to have errors. Such claims will be returned to ODH for review and correction.
- M. Pursuant to Ohio Revised Code (ORC) 5162.40(A)(2), ODM may retain five percent (5%) of all FFP dollars generated by this program.
- N. ODM will suspend payment of claims if, after providing 30 days written notice of specific noncompliance findings, ODM reasonably believes ODH and/or the LPHD is/are not in material compliance with the requirements of this Attachment C or with state or federal laws or rules that govern the Medicaid program.
- O. In the event that an ODH bureau and/or an LPHD is unable or unwilling to make an appropriate reimbursement adjustment based on a CMS finding, ODM will recover the reimbursement amount to be made to CMS by adjusting the amount of reimbursement to be made to ODH and/or the LPHD on the next claim submitted by the entity.

ARTICLE III. RESPONSIBILITIES OF ODH

- A. ODH will designate either an individual ODH staff member or a work unit consisting of ODH staff as the single point of accountability for the MAC program.
- B. ODH will comply with all applicable state and federal regulations, rules and laws that govern the Medicaid program as listed in A-1819-04-0113, including ORC 5162.30, and the provisions of the Guide.

- C. ODH will notify and receive approval from ODM of any change in the design and/or operation of the program at least 30 days prior to the implementation of the change.
- D. ODH will maintain all documents and materials related to or created by the administration and operation of the MAC program for a period of three years as stated in 2 CFR 200.333.
- E. ODH will establish and maintain a written contract with every approved LPHD. The contract will include the minimum requirements delineated in Section H of this Article.
- F. ODH will be the primary contact for LPHDs for technical assistance, correspondence, inquiries and response to media requests.
- G. ODH will evaluate and approve or disapprove each LPHD's request to participate in the MAC program.
- H. ODH will ensure that each entity, whether an ODH bureau or LPHD, participating in the MAC program adheres to the following minimum requirements:
1. Identification of a single point of accountability for all communication between ODH and the participating entity. The person or unit must be an employee of the entity and not a contracted entity;
 2. Granting to ODH MAC, ODM and CMS access to all documentation necessary to review and audit administrative claims, including the data used to prepare the claim, i.e. the coding sheets or electronic files that document the time study and the expenditure information for the entity that contains the name, salary and benefits for each person named as performing Medicaid-eligible activities;
 3. Collection of time study data using a method approved by ODH MAC. Data collected must conform to the requirements described in the Guide;
 4. Maintenance of all time study documents and MAC related files for three years in accordance with the Guide and Section D of this Article. If an audit has been started, the records will be retained until the audit is completed and all exceptions are resolved;
 5. Development of time study curriculum submitted to ODH MAC for review and approval before use during time study training sessions;
 6. Submission of a time study training schedule to ODH MAC at least three weeks prior to the training session;
 7. Submission of the number of people eligible for selection in the time study for the upcoming quarter and the names of all participants;
 8. Performance of training of all time study participants and assurance that they participate;
 9. Provision of time study participants with materials to perform the time studies;
 10. Report of the names of all time study participants every quarter with the claim;
 11. Calculation of the percentage of time spent on Medicaid activities;
 12. Preparation and submission of quarterly claims as defined in the Guide to ODH MAC in a format specified by ODH MAC;
 13. Compliance with all applicable state and federal regulations, rules and laws that govern the Medicaid program;
 14. Compliance with all relevant and applicable requirements stated in 2 CFR Part 200;

15. Repayment of any findings or identified overpayments received by ODH within 21 days from the date of discovery. The amount repaid to ODH will be the total overpayment not to exceed the amount paid to the entity. If the entity does not fully repay the finding or overpayment within 21 days, ODH will deduct the remaining amount of the finding from any future payments to the entity;
 16. Conformance to the following guidelines:
 - a. Submission of quarterly claims as directed by ODH MAC including the attestation stated in Section R of this Article;
 - b. Submission of any changes in training materials to ODH MAC for approval at least six weeks prior to their use in a training session; and
 - c. Provision of sufficient, appropriately trained staff to successfully implement the program and comply with the standards of this Attachment C. The entity will identify the staff committed to the project by name, title, and relevant experience. Upon any changes to the staff named, notification must be made to the individual identified in Section A of this Article.
 17. Maintenance of a list of all individuals responsible for administrative claiming for each entity. The list must include the individual's title, phone number, and e-mail address;
 18. Compliance with all applicable provisions of the Guide;
 19. Maintenance of original activity logs and/or appointment books kept by time study participants. The entity will also maintain the payroll records that document the salary, benefits, materials, and supplies of all persons named as performing Medicaid-eligible activities;
 20. Accounting for supply costs according to 2 CFR 200.94. This includes allocating costs to the specific unit using the supplies according to policies developed by ODH MAC;
 21. Maintenance of a list of excluded federal revenue, identified by source; and
 22. Maintenance of claim certification with signature of the entity's treasurer or chief financial officer.
- I. ODH will develop a written resolution process to address complaints by participating LPHDs.
 - J. ODH will terminate the contract with an LPHD with 30 days written notice for not following the terms of the contract. No notice will be required if there is evidence of fraud, misrepresentation or malfeasance.
 - K. ODH will provide ODM with a current list of the individuals responsible for administrative claiming at each ODH bureau and LPHD as specified in Section H, Paragraph 17 of this Article. Any changes to the list will require ODH to submit a new list.
 - L. ODH will review and approve the time study training curriculum and materials of each bureau and LPHD.
 - M. ODH will periodically attend, unannounced, time study training sessions to ensure that the trainers are following the approved curriculum. ODH MAC will attend all time study training sessions up to a maximum of ten training sessions every quarter. If there are more than ten training sessions in a quarter, ODH MAC will randomly select ten training sessions to attend.
 - N. ODH will biannually ensure that time study participants understand the training and have the ability to correctly complete the time study. ODH MAC will interview five percent of all time study participants up to a total of 50 participants, either in person or via telephone. Interview questions will be developed jointly by ODM and ODH MAC staff.
 - O. ODH will biannually perform a review of five percent of the time study participants to ensure that they are following the time study procedures.

- P. ODH will submit any MAC related documents, forms, and materials for ODM review and approval upon request by ODM. The timing of the reviews and approvals will be consistent with the schedules agreed upon by ODM and ODH.
- Q. ODH will calculate the MER for each ODH bureau and/or LPHD as stated in the section “Medicaid Eligibility Rates (MER)” in the Guide.
- R. ODH will check claims for accuracy and reasonableness before submission to ODM for payment in accordance with Level 1 review procedures stated in the section “Monitoring Procedures Conducted by ODH” in the Guide. For each claim submitted to ODM, ODH will attest to the following:
1. The person submitting the claim is the designee of ODH authorized to submit this claim.
 2. The claim only includes expenditures permitted under the Medicaid program, as detailed in Title XIX of the Social Security Act, in compliance with all applicable implementing federal, state, and local statutes, regulations, policies, and under the State Plan in effect during the period of the claim.
 3. The expenditures included in the claim are based on actual recorded expenditures.
 4. The required amount of state and/or local public funds were available and used to match the State’s allowable expenditures included in this claim, and the state and/or local public funds were used in accordance with all applicable federal requirements for the non-federal share of expenditures.
 5. Federal matching funds are not being claimed to match any expenditure under any federal program that was submitted after January 2, 2001, that has not been approved for the period of the claim.
 6. The information in this claim is correct to the best of the designee’s knowledge and belief based on reasonably available information. Also, the designee has notice that this information is to be used for filing a claim with the federal government for federal funds, and that a knowing misrepresentation constitutes violation of the Federal False Claims Act.
- S. ODH will submit claims to ODM in accordance with the following schedule:
1. January through March - Claim submitted by July 15 of the same calendar year;
 2. April through June - Claim submitted by October 15 of the same calendar year;
 3. July through September - Claim submitted by January 15 of the following calendar year; and
 4. October through December - Claim submitted by April 15 of the following calendar year.
- T. ODH will submit appropriate ODH MAC claims for reimbursement of FFP to ODM per agreed upon schedules in a format acceptable to ODM.
- U. ODH will annually review the claims of participating LPHDs as stated in the section "Monitoring Procedures" in the Guide and will consult with ODM on the determination of claims to be reviewed.
- V. In cases where an ODM review of a claim results in the need for a corrective action plan, ODH will ensure that the participating ODH bureau or LPHD preparing the claim submits the plan to ODH MAC for review within 30 days from receipt of written notice, and that the plan is implemented. The plan is to be submitted to ODM within seven days of receipt by ODH MAC.
- W. ODH will implement sanctions and penalties for non-compliance of the CMS-approved ODH MAC plan. Such sanctions and penalties shall also be included in agreements between ODH and LPHDs, or as specified by ODM or CMS, whichever is more restrictive.
- X. If CMS, ODM, ODH, or any LPHD discovers, through any means, that ODH MAC, an ODH bureau, or an LPHD received an overpayment of FFP, ODH will repay ODM the unallowable FFP amount within 40 days of discovery to provide ODM enough time to make repayment to CMS as required by federal statute. The

amount repaid to ODM will be the total overpayment, not to exceed the amount paid to the ODH bureau or LPHD. Should the overpayment exceed the amount paid to the ODH bureau or LPHD, then the remaining balance of the repayment will be shared proportionally by ODH and ODM.

- Y. When a claim is not in compliance with this Attachment C or the methodology defined in the Guide, ODH MAC will require the ODH bureau or LPHD submitting the problem claim to resubmit a corrected claim.

ARTICLE IV. AMOUNT OF AWARD/AMOUNT OF SUBGRANT

- A. The total amount of the federal award is Twenty-Seven Million and 00/100 Dollars (\$27,000,000.00). ODM agrees to transfer up to Thirteen Million Five Hundred Thousand and 00/100 Dollars (\$13,500,000.00) to ODH in State Fiscal Year 2018 and Thirteen Million Five Hundred Thousand and 00/100 Dollars (\$13,500,000.00) in State Fiscal Year 2019.
- B. ODH shall prepare proper invoices and Intra-State Transfer Vouchers (ISTVs) for reimbursement on at least a quarterly basis for actual allowable expenditures incurred and paid pursuant to responsibilities outlined in ARTICLE III. Invoices shall indicate the total program costs, verification of the non-federal match, if applicable, program relationship to the federal grant and administrative costs. The parties agree that no further reimbursement will be sought hereunder.

ARTICLE V. COMPLIANCE WITH FEDERAL REGULATIONS

- A. ODH shall be deemed the subrecipient of the federal grant received by ODM. Any provider, subcontractor, or subgrantee who receives funds from ODH under this Attachment C is also considered a subrecipient of federal funds and must meet the requirements of OMB Omni-Circular, 2 CFR Part 200. ODH is required to conduct monitoring activities consistent with OMB Omni-Circular, 2 CFR Part 200 Subpart D and F for any provider, subcontractor, or subgrantee who receives funds from ODH under this Attachment C.
- B. As a subrecipient of federal funds, ODH hereby specifically acknowledges its obligations relative to the funds provided under this Attachment C pursuant to 45 CFR Part 75, as well as 2 CFR Part 200.104, as applicable to ODH, including but not limited to the following federal rules:
1. **Standards for financial management systems.** ODH and its subgrantee(s) shall comply with the requirements of 45 CFR 75.302, including, but not limited to:
 - a. Fiscal and accounting procedures;
 - b. Accounting records;
 - c. Effective internal control over cash, real and personal property, and other assets;
 - d. Budgetary control to compare actual expenditures or outlays to budgeted amounts;
 - e. Source documentation and cash management; and
 - f. Written procedures to implement the requirements of 45 CFR 75.305.
 2. **Period of Availability of Funds.** Pursuant to 45 CFR 75.309, ODH and its subgrantee(s) may charge to the award only allowable costs resulting from obligations incurred during the funding period specified in the Recitals section of this Attachment C. All obligations incurred under the award must be liquidated no later than 90 calendar days after the end of the funding period unless otherwise specified herein.
 3. **Matching or Cost Sharing.** Matching or cost sharing requirements applicable to the federal program must be satisfied by allowable costs incurred or third party in-kind contributions, as provided in 45 CFR 75.306, and subject to the qualifications, exceptions, and requirements of that section.
 4. **Program Income.** Program income, as defined in 45 CFR 75.300, must be used as specified in this section.

5. **Real Property.** If ODH is authorized to use Subgrant funds for the acquisition of real property, title, use, and disposition of the real property shall be governed by the provisions of 45 CFR 75.318.
 6. **Equipment.** Title, use, management (including record keeping, internal control, and maintenance), and disposition of equipment acquired by ODH or its subgrantee(s) with Subgrant funds, shall be governed by the provisions of 45 CFR 75.320.
 7. **Supplies.** Title and disposition of supplies acquired by ODH or its subgrantee(s) with Subgrant funds shall be governed by the provisions of 45 CFR 75.321.
- C. Subject to the threshold requirements of 45 CFR 75.501 and 2 CFR 200.501, ODH must have an entity-wide single audit. ODH must send one copy of every audit report to ODM, Audit Performance Section at 50 West Town Street, Columbus, Ohio 43215, within two weeks of ODH's receipt of any such audit report.
- D. Responsibilities of ODH as an auditee under 2 CFR 200.508 that include, but are not limited to:
1. Proper identification of federal awards received;
 2. Maintenance of required internal controls;
 3. Compliance with all state and federal laws, and regulations, and with all provisions of contracts, grant agreements, or subgrant agreements that pertain to each of its federal programs;
 4. Procuring or otherwise arranging for the audit required by this Article in accordance with 2 CFR 200.509, and ensuring it is properly performed and submitted when due in accordance with 2 CFR 200.512;
 5. Preparation of appropriate financial statements, including the schedule of expenditures of Federal awards in accordance with 2 CFR 200.510;
 6. Promptly follow up and take corrective action on audit findings, including preparation of a summary schedule of prior audit findings and a corrective action plan in accordance with 2 CFR 200.511; and
 7. Provide the auditor with access to personnel, accounts, books, records, supporting documentation, and other information as needed for the auditor to perform the audit required by this Article.
- E. **Subawards.**
1. **Subgrants.** Any subgrants by ODH will be made in accordance with 45 CFR 75.352.
 2. **Debarment and Suspension.** As provided in 45 CFR 75.212, ODH and its subgrantees must not make any award or permit any award at any tier to any party that is debarred or suspended or is otherwise excluded from or ineligible for participation in federal assistance programs.
 3. **Procurement.** While ODH and its subgrantees may use their own procurement procedures, the procedures must conform to all applicable federal laws, including 45 CFR 75.327 through 45 CFR 75.335. In the event of conflict between federal, state, and local requirements, the most restrictive must be used.
 4. **Monitoring.** ODH must manage and monitor the routine operations of Subgrant supported activities, including each project, program, subaward, and function supported by the Subgrant, to ensure compliance with all applicable federal requirements, including 45 CFR 75.342.
- F. **Duties as Pass-through Entity.** In the event that ODH subgrants federal funds received under this Attachment C to a government or non-profit organization, ODH, as a pass-through entity, must follow the procedures and requirements specified in 2 CFR 200.331, and must perform duties including, but not limited to:

1. Inform each subrecipient of the proper identification of the federal awards received pursuant to 2 CFR 200.331(a)(1). When some of this information is not available, ODH will provide the best information available to describe the federal award.
 2. Advise subrecipients of requirements imposed on them by federal laws, regulations, and the provisions of contracts or subgrant agreements as well as any supplemental requirements imposed by the ODM and any subsequent pass-through entity.
 3. Monitor the activities of subrecipients as necessary to ensure that federal awards are used for authorized purposes in compliance with all applicable federal and state laws and regulations, and the provisions of contracts or subgrant agreements and that all performance goals are achieved.
 4. Ensure that subrecipients expending Seven Hundred Fifty Thousand and 00/100 Dollars (\$750,000.00) or more in federal awards during the subrecipient's fiscal year have met the audit requirements of this Agreement for that fiscal year. One copy of every audit report must be sent to ODM, Audit Performance Section at 50 West Town Street, Columbus, Ohio 43215, within two weeks of the subrecipient's receipt of any such audit report.
 5. Determine whether subrecipients spent federal assistance funds provided in accordance with applicable laws and regulations;
 6. Issue a management decision on audit findings within six months after receipt of the subrecipient's audit report and ensure that the subrecipient takes appropriate and timely corrective action.
 7. Consider whether subrecipient audits necessitate adjustment of the pass-through entity's own records.
 8. Require each subrecipient to permit ODM, any other state or government entity, and federal and state auditors to have access to the records and financial statements as necessary for the pass-through entity to comply with this Section.
 9. Ensure that any subgrant agreement includes the approved indirect cost rate negotiated between the subrecipient and the federal government, or other indirect cost rate information as required.
- G. ODH agrees to comply with the applicable financial and administrative requirements set forth by the awarding agency.

IDENTIFICATION OF FEDERAL AWARD

Pursuant to 2 CFR 200.331 Requirements for pass-through entities, ODM hereby informs the SUBGRANTEE:

- (a) This Agreement is clearly identified to SUBGRANTEE as a subaward and includes the following information at the time of the subaward. This information represents the best information available to ODM at the current time. If, at any time, SUBGRANTEE or ODM has access to any additional information, that information must be made available to ODM, and shall require a formal amendment to this Agreement.
- (1) Federal Award Identification.
- (i) Subrecipient name (which must match name registered in DUNS): Ohio Department of Health
 - (ii) Subrecipient's DUNS number: 808847933
 - (iii) Federal Award Number (FAIN): 1705OH05ADM, 1805OH5ADM, 1905OH05ADM
 - (iv) Federal Award Date (date of award to ODM by the Federal agency): 10/1/2016, 10/1/2017, 10/1/2018
 - (v) Subaward Period of Performance Start and End Date: July 1, 2017 to June 30, 2019
 - (vi) Amount of Federal Funds Obligated by this action by ODM to SUBGRANTEE: \$27,000,000
 - (vii) Total Amount of Federal Funds Obligated to SUBGRANTEE by ODM including the current obligation: \$27,000,000
 - (ix) Federal award project description, as required to be responsive to the Federal Funding Accountability Act: Provide the mechanism to reimburse Ohio Department of Health bureaus and/or local public health departments (LPHDs) for Medicaid administrative activities provided by them, pursuant to the provisions of 42 CFR 431, Subpart M.
 - (x) The Federal awarding agency is the U.S. Department of Health and Human Services, the pass-through entity is ODM, and the awarding official of ODM is Barbara R. Sears, Director, the Ohio Department of Medicaid, 50 West Town Street, Columbus, Ohio 43215.
 - (xi) Dollar amount made available under each Federal award and the CFDA number at the time of disbursement: \$27,000,000, CFDA 93.778
 - (xii) This Agreement is not for Research and Development purposes.
 - (xiii) Indirect cost rate for the Federal award (including if the de minimis rate is charged per 2 CFR 200.414: 29.55%



Ohio Department of Health

**Medicaid Administrative Claiming
(MAC)**

Methodology Guide

November 2017

TABLE OF CONTENTS

<u>PART I: CLAIM CALCULATION METHODOLOGY</u>	3
<u>INTRODUCTION</u>	4
<u>Medicaid Administrative Claiming in Public Health Agencies</u>	4
<u>Administrative Structure for the Management of the Program</u>	4
<u>Ohio Department of Medicaid (ODM)</u>	4
<u>Ohio Department of Health (ODH)</u>	5
<u>Ohio Department of Health Claiming Units</u>	5
<u>Local Public Health Departments (LPHDs)</u>	5
<u>CALCULATION OF THE ADMINISTRATIVE CLAIM</u>	6
<u>Personnel</u>	6
<u>Time Study</u>	6
<u>Determination of Actual Expenditures</u>	6
<u>Collection of the Actual Expenditure Data</u>	6
<u>Financial Expenditure Form Requirements</u>	7
<u>Allocation of Expenditures for Salaries and Fringe Benefits of Personnel</u>	8
<u>Indirect Cost Rates</u>	8
<u>Personal Services Contracts</u>	8
<u>Other Costs</u>	8
<u>Exclusion of Federal Revenue</u>	8
<u>Exclusion of Provider-Related Donations and Health Care-Related Taxes</u>	9
<u>Claim Certification</u>	9
<u>Medicaid Eligibility Rates (MER)</u>	9
<u>ODH Medicaid Eligibility Rate</u>	9
<u>Local Public Health Department Medicaid Eligibility Rate</u>	10
<u>Monitoring Procedures</u>	11
<u>Monitoring Procedures Conducted by Local Public Health Departments</u>	11
<u>Monitoring Procedures Conducted by ODH</u>	12
<u>Monitoring Procedures Conducted by ODM</u>	13
<u>Quality Assurance Activities</u>	15
<u>CLAIM CALCULATION EXAMPLE</u>	16
<u>TABLE A: Map of Reimbursement Type to Activity Code</u> ..	17
<u>Gross Claim Calculation</u>	17
<u>TABLE B: Claim Calculation</u>	17
<u>TABLE C: Calculation of Claimable Percentages for Allocation of Type R Codes</u>	18
<u>Annual Claim Reconciliation</u>	18
<u>Periodicity</u>	18
<u>Part II TIME STUDY METHODOLOGY</u>	20
<u>Overview</u>	21
<u>Implementation Plan</u>	21
<u>Time Study Approach</u>	21
<u>Time Study Week and Time Study Participants</u>	21
<u>Time Study Activity Definition</u>	22
<u>Time Study Instrument</u>	24
<u>Time Study Training</u>	24
<u>Time Study Monitoring</u>	25
<u>ATTACHMENT A: CLAIM AND INSTRUCTIONS</u>	26
<u>ATTACHMENT B: MER METHODOLOGY AND FFP BY ACTIVITY CODE</u>	36
<u>ATTACHMENT C: MEDICAID ADMINISTRATIVE CLAIMING PROGRAM ACTIVITY CODES</u>	38

PART I: CLAIM CALCULATION METHODOLOGY

INTRODUCTION

Medicaid Administrative Claiming in Public Health Agencies

The Ohio Department of Health (ODH) and Ohio Department of Medicaid (ODM) share a focus on improving access to health care for low income Ohioans. The most vulnerable of Ohio's citizens experience difficulty in accessing needed health care because of a lack of health insurance, poverty, limited transportation, language barriers, and job instability resulting in inconsistent health care coverage.

Through Medicaid Administrative Claiming (MAC) state and local public health departments can be reimbursed in part for activities that assist low income Ohioans in enrolling in Medicaid and accessing Medicaid-covered services. Medicaid-covered medical, dental, and mental health services contribute to the elimination of disparities and can improve the overall health of the high risk population. Both are fundamental goals of public health.

Administrative Structure for the Management of the Program

The administrative structure for the management of the Medicaid Administrative Claiming (MAC) program for the Ohio Department of Health (ODH) involves two state agencies and up to 136 local public health departments. The public health activities which are reimbursable under Medicaid Administrative Claiming are performed by staff within the Ohio Department of Health and at local public health departments. As a result, parts of the management of this program lie with each of the governmental entities. Each entity has specific responsibilities that will be further delineated in interagency agreements and contracts. Those responsibilities include the following:

Ohio Department of Medicaid (ODM)

ODM, as the Single State Agency for administering the Title XIX Medicaid Program in Ohio, has ultimate responsibility to the Centers for Medicare & Medicaid Services (CMS) to ensure the program is in compliance with Federal Medicaid regulations. In this role, ODM has final oversight responsibility for all aspects of the program. ODM is the point of contact with CMS for all communications, including claiming, federal audits, state plan amendments, and CMS approval of modifications to this methodology. ODM reviews and approves administrative claims and draws down Federal Financial Participation (FFP) from CMS. ODM establishes reviews and monitoring protocols.

ODM, through an Interagency Agreement, delegates day-to-day administration of the MAC program to ODH and retains an oversight responsibility which is two-fold. ODM monitors ODH in its claiming of activities conducted by state agency staff in the Bureaus. ODM also oversees ODH in its processing and monitoring of claims from local public health departments. ODM reserves the right to withhold payment of claims if ODH or any claiming unit fails to comply with the approved methodology, or other state or federal regulations.

Ohio Department of Health (ODH)

The ODH MAC Unit is assigned the day-to-day responsibility for the administration of the ODH Medicaid Administrative Claiming program. The MAC Unit functions in two distinct capacities. It oversees and monitors the claiming units within ODH, as well as provides oversight and monitoring of the claims and MAC operations of the local public health departments. ODH will request 50% reimbursement for the operational costs of the ODH MAC Unit. ODH will sign a certification statement every quarter to assure 100% of costs of the MAC Unit are MAC related. The reimbursement will be for salary, fringe, federally-approved indirect cost, travel, and training expenses.

ODH will develop a rollout plan for all claiming units that ensures timely implementation of the MAC process. The ODH MAC philosophy is to invest considerable attention to training, technical assistance and oversight from the initiation of claiming entities through the submission of claims (invoices). At the orientation meeting with a potential claiming unit, ODH provides the Implementation Plan format which has been approved by ODM. The Implementation Plan then is completed by the claiming unit and approved by ODH prior to their participation.

The ODH MAC Unit reviews quarterly claims and submits them to ODM. The Unit ensures the expenditure of adequate and appropriate matching funds; reviews and monitors claims in accordance with protocols developed by ODH and approved by ODM, and directs the time studies. The MAC Unit conducts training and technical assistance for claiming units at ODH and local public health departments to ensure the proper use of the Activity Codes, ensure the accurate preparation of claims, and proper maintenance of files. The Unit also reviews and approves all claiming unit Implementation Plans prior to their participation in MAC.

Ohio Department of Health Claiming Units

ODH is organized into three programmatic divisions, each with multiple bureaus. ODH's claiming units are either a bureau in total, or one or more programs within a bureau. Examples of ODH bureaus include, but are not limited to: Bureau for Children with Medical Handicaps, Bureau of Child and Family Health Services, Bureau of Early Intervention Services. Each ODH claiming unit that proposes to participate in MAC is required to complete an Implementation Plan for review and approval by the ODH MAC Unit. Each approved claiming unit must participate in the quarterly time study.

Local Public Health Departments (LPHDs)

Local public health departments operate independently from the Ohio Department of Health. LPHDs will be performing MAC activities at their sites and in other settings with the exception that Medicaid Outreach code (Code 3) can not be used in the home setting.

A local public health department can have one or more claiming units within the department. Multiple claiming units are needed when organizationally there are separate program areas that have unique age and gender specific populations to be served. The LPHDs are responsible for conducting the quarterly time studies, collecting and compiling time study and financial data, preparing the quarterly claims, and maintaining files. Each

LPHD is the point of contact for ODM and ODH for reviews, monitoring and claim questions. Each LPHD that proposes to participate in MAC is required to complete an Implementation Plan for review and approval by the ODH MAC Unit. The interagency agreement between ODH and each LPHD will include an approved Implementation Plan for each claiming unit. All interagency agreements between ODH and local public health departments must contain language specified in the Interagency Agreement between ODH and ODM.

CALCULATION OF THE ADMINISTRATIVE CLAIM

Four Components of a claim

This Medicaid Administrative Claiming methodology is based on four key components:

- The Personnel who perform the administrative functions;
- The time study which documents the proportion of personnel time spent on administrative activities;
- The use of actual expenditures; and
- The calculation of the Medicaid Eligibility Rate.

These four components are the building blocks for the claim calculation.

Personnel

Medicaid administrative claims are based on staff activity and actual expenditures related to staff that perform allowable MAC activities. Each ODH and local public health department claiming unit completes an Implementation Plan that identifies staff to be claimed. The rosters of participating staff are updated on a quarterly basis by each claiming unit.

Time Study

Each MAC participant to be claimed must time study for the entire time study week. This is not a sampling or random moment approach. A time allocation methodology (time study) is applied to determine the appropriate percentage of personnel time dedicated to Medicaid administrative activities during the claiming period. Time studies are performed once each quarter for a seven consecutive day period. The time study captures information to distinguish allowable administrative costs from non-allowable costs. See Part II for an explanation of the time study methodology.

Determination of Actual Expenditures

Collection of the Actual Expenditure Data

Financial information is collected from all participating entities each quarter. The financial data used to calculate the claim is based upon actual detailed expenditures obtained directly from the participating entity's financial accounting system. The types of expenditures are: salaries; fringe benefits; indirect cost; personal service contracts; supplies; and others.

Each financial accounting system from which the expenditure data are obtained must adhere to Generally Accepted Accounting Principles (GAAP) and the following five principles apply to the preparation of the claim:

- The methodology and calculated financial data are fully consistent with the requirements of OMB Circular A-87 and adhere to Medicaid principles of reimbursement as stated in CMS Publication 15-1.
- The financial information is classified in a format that facilitates the application of the time study results. The appropriate MER is applied for each MAC code.
- The process minimizes the time spent by financial personnel to meet the reporting requirements while maintaining assurance of the accuracy of the data.
- Reporting is on a cash basis.

All supporting documentation will be made available by the claiming entity for audit by the State of Ohio (including ODM, ODH, the Auditor of the State of Ohio, the Inspector General of Ohio, or any duly authorized law enforcement officials) and by agencies of the United States Government. All supporting documentation is retained by the claiming entity for three years from the last quarter of the federal fiscal year of reimbursement. ODH will adhere to the federal regulation 45CFR Subtitle A § 92.42 which states: "If any pending litigation involving the records has been started before the expiration of the three year period, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular 3-year period, whichever is later."

Because MAC represents a claim for federal reimbursement, any federal revenue directly or indirectly related to the Medicaid administrative functions and positions is offset to avoid potential duplicate claiming. Each claiming entity must maintain documentation to show the proper offset of federal revenues has been applied. All sources of funds must be included in order to assure any funds directly or indirectly related to federal funds are listed and not included in the claim.

Financial Expenditure Form Requirements

ODH supplies financial reporting schedules (forms) and training materials to all participating claiming units to facilitate the collection of their quarterly expenditures. Each claiming unit submits financial expenditure forms to ODH as part of the review and approval process. The forms are used to report the following information:

- The name of the agency or bureau, and the claiming unit;
- The name and phone number of the person completing the form;
- The quarter for which the expenditures are being reported;
- The actual expenditures listed by type; and
- All sources of funds, including the availability of matching funds.

All claims will be submitted in a format specified by ODH and reviewed and pre-approved by ODM (see Attachment A). As ODH improves or updates the format

ODM will review and approve prior to use. Any substantive change will be sent from ODM to CMS for review.

Allocation of Expenditures for Salaries and Fringe Benefits of Personnel

Actual salaries and fringe benefits of personnel performing allowable Medicaid administrative activities are obtained from payroll records for the claiming period. All personnel costs are allocated to the Medicaid Administrative Claim based on the appropriate quarterly time study results.

Indirect Cost Rates

Indirect Costs are only included in the claim calculation for claiming entities that have a federally-approved indirect cost rate. Each rate is examined to determine if it is a restricted or unrestricted rate. The rate will be applied in compliance to the federally-approved indirect cost agreement. Otherwise, indirect costs are not allowable. Each claim must clearly identify the federally-approved indirect cost rate. Indirect Costs will be reported separately.

Personal Services Contracts

ODH and local public health department expenditures related to the performance of MAC activities by contract personnel are also obtained from the agency's financial system. All staff employed under a contract to be claimed will time study. All contract costs are allocated to the Medicaid Administrative Claim based on the appropriate quarterly time study results.

Other Costs

All Other Costs (e.g., travel, materials and supplies) are obtained from the agency's financial system. All Other Costs are allocated to the Medicaid Administrative Claim based on the appropriate quarterly time study results. Indirect Costs are not included as Other Costs.

Exclusion of Federal Revenue

Because the Medicaid Administrative Claiming program represents a claim for federal reimbursement, any federal revenues directly or indirectly related to the Medicaid administrative functions and positions are excluded to avoid potential duplicate claiming for federally funded positions. Federal funds that the Ohio Department of Health awards to the local public health departments and expenditures from those funds also are excluded. Only expenses supported by appropriate state and local funding sources are included for reimbursement in the claim calculation. The following are examples of funds that must be excluded:

1. All federal funds, and any state/local matching funds as required by a federal grant;

2. All state expenditures which have been previously matched by the federal government (including Medicaid funds for medical assistance).
3. State funds, which are required to be specifically targeted or earmarked for the delivery of non-MAC activities, must be used for the purpose for which they are targeted or earmarked and cannot be used to match other expenditures. For example, state funds that are earmarked for health care for uninsured pregnant women and children may not be used for match in MAC. These funds would be considered unallowable as matching for MAC activities.
4. Insurance and other fees collected from non-governmental sources for non-MAC activities must be offset against claims for Medicaid funds.

The ODH MAC claims must strictly adhere to the OMB Circular A-87, Attachment A, Part C, Item 4.

Exclusion of Provider-Related Donations and Health Care-Related Taxes

Any provider-related donations and health care-related tax revenues are not allowed as revenue sources for any local public health department's Medicaid Administrative Claim. (42CFR §433.54)

Claim Certification

The accuracy of the submitted financial information and availability of sufficient state and local revenue to meet federal match requirement guidelines as outlined in 42 CFR 433.51 is certified by the controller, chief financial officer (or an appropriate designee) of each participating agency.

Medicaid Eligibility Rates (MER)

Methodology for Calculating MER

Some of the Medicaid administrative activities performed by the Ohio Department of Health and the local public health departments benefits both Medicaid and non-Medicaid individuals and populations. Therefore, the costs associated with these activities must be allocated accordingly. This ensures that only the costs related to Medicaid administrative activities for Medicaid eligible individuals are claimed to Medicaid. Medicaid eligible are individuals who have a current Medicaid card. This allocation of costs involves the development of the proportional Medicaid share, also referred to as the Medicaid Eligibility Rate (MER), Medicaid discount, or Medicaid percentage (See Attachment B: MER Methodology and FFP by Activity Code).

ODH Medicaid Eligibility Rates

The population based methodology is specific to the ages and gender of the population of Medicaid eligible served by the claiming unit as described in their

Implementation Plan (e.g., pregnant women; children under age 18; all ages/genders). The specific age ranges and gender(s) of the population served by the claiming unit must be described. The claiming unit's Implementation Plan must clearly state that the population served is limited to that particular demographic. If the claiming unit conducts a variety of programs that collectively serve all ages and genders, then the whole state population must be used in the calculation.

The MER is calculated by dividing the number of Medicaid eligible individuals in the age range and/or gender served by the claiming unit (numerator) by the total number of individuals in the state in that age range or gender (denominator).

Number of Medicaid eligible individuals in the age range and/or gender residing in the state
Number of individuals in the age range and/or gender residing in the state

The number of Medicaid eligible individuals in the age range and/or gender is provided by the Ohio Department of Medicaid from their Medicaid eligibility data for the time period. The number for the state population in the age range and/or gender is determined by the Ohio Department of Development for the most recent time period. ODH calculates the MER each year in May and distributes the relevant rate to each ODH claiming unit for the July 1st to June 30th fiscal year.

Local Public Health Department Medicaid Eligibility Rate

The population based methodology is used for local public health departments. The population based methodology is specific to the ages and/or gender of the population of Medicaid eligible served by the program as described in the Implementation Plan for the claiming unit (e.g., pregnant women, children under age 18, all ages/genders). The claiming unit's Implementation Plan must clearly state that the population served is limited to a particular demographic. The specific range of ages and/or gender(s) of the population served by the claiming unit must be described. If the claiming unit conducts a variety of programs that collectively serve all ages and genders, then the whole county population must be used in the calculation. Of the participating local public health departments, ODH anticipates approximately 90% will have claiming units whose programs collectively serve the full range of ages and/or genders. Those local public health departments will use the countywide Medicaid eligibility rate.

The MER is calculated by dividing the number of Medicaid eligible individuals in the age range and/or gender in the county served by the claiming unit (numerator) by the total number of individuals in the county in that age range or gender (denominator).

Number of Medicaid eligible individuals in the age range and/or gender in the county
Number of individuals in the age range and/or gender in the county

The number of Medicaid eligible individuals in the age range and/or gender is provided by the Ohio Department of Medicaid from their Medicaid eligibility data for the time period. The number for the state population in the age range and/or gender is determined by the Ohio Department of Development for the most recent time period. ODH calculates the MER each year in May and distributes the relevant rate to each ODH claiming unit for the July 1st to June 30th fiscal year.

Monitoring Procedures

Monitoring Procedures Conducted by Local Public Health Departments

MAC associated staff at the local public health departments will review MAC invoices and documents to ensure that submissions to ODH are appropriate and reasonable. In addition, the chief financial officer at the local public health department will attest by signature to the accuracy of the claim invoices submitted to ODH. For each claim submitted to ODM, the local public health department as well as ODH's chief financial officer on behalf of their respective agency will attest to the following:

1. I am the designee of the State Department of Health authorized to submit this claim.
2. This claim only includes expenditures under the Medicaid program under Title XIX of the Social Security Act (the Act), that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies, and the state plan approved by the Secretary and in effect during the period of the claim under Title XIX of the Act for the Medicaid Program.
3. The expenditures included in this claim are based on actual recorded expenditures.
4. The required amount of state and/or local public funds were available and used to match the state's allowable expenditures included in this claim, and such state and/or local public funds were in accordance with all applicable federal requirements for the non-federal share match of expenditures.
5. Federal matching funds are not being claimed to match any expenditure under any Federal program that was submitted after January 2, 2001, and that has not been approved by the Secretary effective for the period of the claim.
6. The information above and in this claim is correct to the best of my knowledge and belief based on reasonably available information. Also, I have notice that this information is to be used for filing a claim with the Federal Government for federal funds, and the knowing misrepresentation constitutes violation of the Federal False Claims Act.

Monitoring Procedures Conducted by ODH

The Ohio Department of Health conducts reviews of all MAC program claims to assure their accuracy and to determine that appropriate documentation exists to support the claims. This oversight includes, but is not limited to, reviews of documentation to assure that the accuracy, sampling, and completeness of time studies, as well as the documentation necessary to justify that the claimed expenditures comply with state and federal requirements of the program.

The ODH MAC Unit will review all claims submitted by the ODH claiming units and the local public health departments. There are three levels of review and monitoring of claims. ODH will review all claims for levels 1 and 2. For level 3 ODH will review a sampling of claims.

Level 1 is a technical review in which the mechanics of the claim, such as mathematical computations, the use of the proper MER, and presence of all required information are checked. This level of review is conducted on all claims prior to submission to ODM. The mathematical accuracy of 100% of each quarter's claims will be performed before submission to ODM for reimbursement.

Level 2 is a desk review of all claims. The data for any particular claim are compared to past claim data to look for patterns that seem out of the normal range. There are also internal comparisons of activities reported and cost data to identify any combinations of time spent on a given activity and the costs of that activity that seem out of an acceptable range.

Level 2 reviews will include a review of the following potential risk factors:

Time study results with outliers of percentage of code usage weighted by the following order:

- Non-Discounted
- Discounted
- Reallocated;

History of errors or problems;

Claims with individuals included in the claiming plan that use code 16 (Time Not Documented); and

Number of claiming units

Level 3 is a full field review. At least 5% of the claiming units will be reviewed. Until ODH can establish a protocol of review based on historical claims data, ODH will perform a full field review of enough claiming entities to cover 50% of the claimed amounts submitted each quarter. ODH's initial review will be a minimum of one claim and a maximum of five claims. If the initial review uncovers significant and/or systemic problems additional review may be performed.

The number selected for a full field review will also be influenced by the risk factors associated with the:

- Inaccuracies detected during the mathematical accuracy check performed on all claims as identified in Level 1 review.
- Risk factors outlined in Level 2 review.

ODH will perform an initial limited review of the remaining claiming entities based on a random sample to cover 20% of the claimed amounts per quarter, up to the maximum of seven. If the initial review uncovers significant and/or systemic problems, additional reviews may be performed.

The claiming unit maintains the data used to prepare the claim, which includes the coding sheets or electronic files that document the time study and the expenditure information from each claiming unit. The field monitoring includes review of time study results, Implementation Plan compliance, claiming unit functions, and invoices.

If the field monitoring results in the identification of an invoice overpayment, ODH will require reimbursement from the claiming unit in the amount of the overpayment. Additional steps may be required such as additional training, procedure changes, and internal audits.

The claiming agency (ODH or the local public health department) will maintain the original time study logs. The claiming agency will maintain the payroll records that document the salary and benefits of all persons designated as performing Medicaid administrative activities. Only staffs that participated in the quarterly time study training and participated in the quarterly time study are included in the claim. ODH and individual local public health departments are responsible for maintaining and storing their own documentation and records.

Monitoring Procedures Conducted by ODM

ODM performs reviews and monitoring on claims submitted by ODH claiming units and reviews monitoring and oversight activities performed by ODH of the local public health departments. ODH is the entity that has direct monitoring and oversight responsibility for claims submitted by local public health departments. ODH is also a claiming entity with responsibility for submitting accurate claims to ODM for reimbursement.

ODM has direct monitoring and oversight responsibility of claims submitted by ODH claiming units. ODH has direct monitoring and review responsibility of the claims submitted by the local public health departments participating in MAC.

ODM will verify the mathematical accuracy of all claims submitted by ODH claiming units as well as eight of the claims submitted by the local public health departments. Quarterly, ODM in its monitoring and oversight capacity will perform a complete review and evaluation of a selected claim submitted by an ODH claiming unit. During the first two quarters of claim submission following CMS approval of the MAC methodology, this complete review and evaluation will include two submitted claims representing the value

of at least 60% of all claims. These reviews will include a thorough examination of expenditure reporting.

Also, ODM will select one additional ODH claiming entity not previously selected from which to review in detail one claim component from the list below of ODH's claim:

- Indirect Cost Rate
- Training
- Payroll
- Invoice/Expenditures
- Time Study
- Revenue
- Third Party Liability

As historic claiming data is collected, ODM will review claims submitted by ODH claiming units based on variations between periods and other claiming entities. ODM will gather data to highlight trends and variations between periods and across the claiming entity population. Should ODM discover significant and consistent problems with submitted claims it may request that ODM's auditing entity, the Office of Research, Assessment, and Accountability conduct an audit.

Before ODH begins their review of claims submitted by local public health departments, ODM will review ODH's review methodology for adequacy. ODM will select for its own review the results of ODH's review of claims submitted by local public health departments.

ODM will select 5% of the reviews performed by ODH (at least one review per quarter). If the calculation produces more than 10 reviews ODM will limit its initial review to 10 reviews. If the initial review uncovers significant and/or systemic problems additional review may be performed.

ODM will not process or submit for FFP reimbursement, any MAC claim that has been determined by the ODH MAC Unit or ODM to have errors. Such claims will be returned to ODH for review and correction.

A chart starting on the next page summarizes the monitoring activities to be carried out by each organization.

Oversight and Monitoring of the ODH MAC Program		
Local Public Health Departments	Ohio Department of Health	Ohio Department of Medicaid
Staff will review materials to ensure appropriateness and responsibility.	All claims reviewed for math accuracy.	All claims from ODH units and a sample of up to 8 LPHD claims reviewed for math accuracy.
Financial officer will attest to accuracy of claim invoice.	All claims reviewed through two levels: <ol style="list-style-type: none"> 1. Technical review 2. Desk review including comparisons to past claims. 	Complete review and evaluation of one claim from ODH unit. During first 2 quarters of MAC plan approval, 2 claims representing 60% of claimed amount will be reviewed.
	At least 5% of claiming units (up to 5 claims) will receive a level 3 review which is a full field review. Early in the MAC program 50% of claimed amounts will be reviewed.	One additional ODH unit claim will have one claim component reviewed intensely.
	Of the claims not previously reviewed, claims equaling 20% of claimed amount (up to 7 claims) will be selected for review.	Will review 5% up to 10 of the reviews conducted by ODH of LPHD claims.
		ODM has option to request that ODM auditing office, ORAA, audit claims if severe problems exist.

Quality Assurance Activities

Local public health departments and ODH claiming units must submit to the ODH MAC Unit a quality assurance plan as part of the Implementation Plan to ensure accuracy of the data. The responsibilities of each claiming unit for claim development includes, but is not limited to:

1. Establishing guidelines for audit files and archiving claiming plans, signed original time studies, MAC claims, and applicable documentation.
2. Participating with the ODH MAC Unit in MAC reviews and monitoring.
3. Establishing and operating a quality assurance system for assessing compliance with MAC policies and procedures through desk reviews, onsite reviews, and technical assistance.

4. Excluding from the claim the costs associated with a staff member that did not complete their time study. For example, if a staff member did not fully complete the time study form for the day or cannot produce their time study log, then the associated costs would be labeled as Code 16: Time Not Documented.

CLAIM CALCULATION EXAMPLE

In general, the claim is calculated by activity code, administrative category, and reimbursement type. The total claim is simply the sum of these calculations across all allowable activity codes. The claim associated with any particular activity is based on the following factors:

- Gross reported costs; and
- Percentage of time distribution for that activity, as determined by the time study; and
- Application of reimbursement level factors:
 - ✓ Application of Medicaid Eligibility Rate for Activity Codes;
 - ✓ Reconciliation of those activities that are non-allowable; and
 - ✓ Allocation of allowable general administration off as described in code 15.

There are four reimbursement types:

1. **Non-Discounted (Type ND)** activities are MAC activities that are 100% Medicaid applicable and reimbursable. Medicaid eligibility percentages are not applied to these activities.
2. **Discounted (Type D)** activities are administrative activities that are only reimbursable for the Medicaid eligible for the claiming unit. The costs associated with these activities will be reduced according to the Medicaid Eligibility Rate percentage in the claims calculation.
3. **Unallowable (Type U)** activities are unallowable activities under the Medicaid Administrative claim, but these activities account for the balance of the participants' time. These activities are unallowable regardless of whether or not the population served includes Medicaid eligible individuals. As required in OMB A-87, the full spectrum of activities performed by the participants is measured in order to accurately account for all of the study participants' time.
4. **Reallocated (Type R)** applies to the activity code for general allocable administrative activities. Time allocated to this activity is reallocated across the other activities, including those that are unallowable. None of the reallocated time can be reimbursed at enhanced rates.

The gross amount of each reimbursement type (i.e., ND, D, and R) has the appropriate FFP rate applied to determine the amount of reimbursement.

Table A presents the Activity Codes and the appropriate reimbursement type for each code.

TABLE A: Map of Reimbursement Type to Activity Code

Reimbursement Type	Activity codes to which this calculation applies
ND	3 and 5
D	7, 9,11 , 13
U	1, 2, 4, 6, 8, 10, 12, 14 and 16
R	15

Gross Claim Calculation

Table B is an example of calculations for Activity Codes 1, 3, 7 and 15 for the Personnel category of expenses. The grand total of expenses for Salary and Fringe Benefits is assumed to be \$1000 for each category.

TABLE B: Claim Calculation

Activity Code	Gross Cost	Time Study %	Rate Factor	Size of MAC Activities	FFP	Claim
1 (Direct Care)	\$1000	40%	0% Unallowable	\$ 0	0%	\$0
3 (Medicaid Outreach)	\$1000	10%	100% (no discount)	\$100	50%	\$50
7 (Referral, Coordination)	\$1000	25%	20% (MER)	\$50	50%	\$25
15 (General Admin)	\$1000	25%	20% (step 2)	\$50	50%	\$25
Total		100%	-	\$200		\$100

- Type ND:** The example uses Activity Code 3 to demonstrate the calculation applicable for any Type ND code (codes 3 and 5). These codes are not impacted by the Medicaid Eligibility Rate so the gross claim is simply the product of allocated time study percentage times the gross MAC expenditures. (10% x 100% x \$1000 = \$100)
- Type D:** The example uses Activity Code 7 to demonstrate the calculation applicable for any Type D activity code (codes 7, 9, 11 and 13). These codes must be reduced by the Medicaid Eligibility Rate. The example uses a Medicaid Eligibility Rate of 20%. Thus, the gross claim for Activity 7 is equivalent to the product of the reallocated time study percentage times the Medicaid rate times the gross MAC expenditures for Activity Code 7 (20% x 25% x \$1000 = \$50).

- **Type U:** The example uses Activity Code 1 to demonstrate the calculation applicable for any Type U activity code (codes 1, 2, 4, 6, 8, 10, 12, 14, and 16). These codes are unallowable and are not reimbursed. Thus, the gross claim equals \$0.
- **Type R:** The example uses Activity Code 15 to demonstrate the calculation applicable to the only Type R Activity Code. Time allocated to this code is partially allowable, based upon the sum of the claimable percentage of time attributable to all of the other activity codes, as a percentage of the total time spent on all other activity codes (except 15). The claimable percentage of time equals the time study percentage multiplied by the reimbursement rate for that activity (e.g., 100% for ND and 20% for Type D). The example assumes the entire claim is built from the activities used here as examples, so the calculation of the gross claim distribution for Activity Code 15 would be as follows:

Table C: Calculation of Claimable Percentages for Allocation of Type R Codes

Activity Code	Time Study %	Rate Factor	Claimable %
1 (Direct Care)	40%	0% Unallowable	0%
3 (Medicaid Outreach)	10%	100% (no discount)	10%
7 (Referral, Coordination)	25%	20% (MER)	5%
SUM	75%	15% / 75% = 20%	15%

The allocation rate factor for Activity Code 15 is equal to:
(Sum of Claimable % for Other Activities) divided by (Sum of total time spent on other activities) **15% / 75% = 20%**

Annual Claim Reconciliation

All claiming agencies have financial audits either by local, state, or federal auditors. When a financial audit is conducted on the claiming agency, all filed administrative claims must be reconciled to the audited financial findings. The adjustments, both negative and positive, must be reported on a separate special schedule. Adjustments resulting in underpayments can be reimbursed by CMS up to two years from the last quarter of the federal fiscal year the claim was submitted to CMS for reimbursement. Adjustments resulting from overpayments to ODH and Local public health departments have no time restrictions regarding repayment to CMS. The adjustment will be processed on the next available claim after adjustments are communicated.

Periodicity

ODH and LPHDs submit claims quarterly. The claim is initially due to ODM per the chart below. The claims are submitted through the Ohio Department of Health to the Ohio Department of Medicaid. The quarterly claim submission to ODM is due per the following schedule:

Schedule for the Claims Submission	
Quarter	Claim Submission Due Date to ODM
January-March	July 15
April-June	October 15
July-September	January 15
October- December	April 15

All claims are submitted by ODH to ODM no later than 15 months after the actual expenditures. ODM will submit a claim within two years of the last month of the quarter which is being claimed. Reimbursement for a claim is made to the LPHD by ODH following receipt of federal funds from ODM.

PART II TIME STUDY METHODOLOGY

Overview

This section describes the methodology used to calculate the amount of time dedicated to the performance of Medicaid Administrative functions by claiming units at the Ohio Department of Health and local public health departments for allocating the costs related to Medicaid reimbursable activities and functions. This methodology is applied each quarter for purposes of supporting the calculation of the Medicaid Administrative claim amounts for the Ohio Department of Health and local public health departments.

The following is intended to provide a general overview of the basic principles and approach for the methodology.

Implementation Plan

The Implementation Plan completed by each claiming unit at ODH and local public health departments is used as an application and aids in organizing each administrative claiming unit. The Implementation Plan provides support for the MAC reimbursement. The Implementation Plan identifies the types of staff (by job title) who participate in the time study and the MAC activities they perform. The Implementation Plan must be completed and approved by the ODH MAC Unit prior to the start of a quarter for which a claim is submitted. It provides all involved parties with a common document and ensures consistency in the claiming process. Implementation Plans submitted by local public health departments are approved by the ODH MAC Unit. ODM reviews and approves Implementation Plans submitted by ODH claiming units. Any revisions to the Implementation Plan must be approved prior to the quarter for which the claim is to be submitted.

Time Study Approach

The time study is used to allocate the fair share of staff costs to Medicaid administration. Time study participants include staff whose job functions include activities that can be reimbursed under Medicaid administration. Job functions, rather than job title, determine an individual's inclusion in the administrative time study. Staff must participate in the time study each quarter in order to claim reimbursement for that quarter.

If administrative staffs have job functions that encompass activities reimbursable under Medicaid administration, then they must do the time study.

Time Study Week and Time Study Participants

A workweek (seven consecutive days Sunday through Saturday) per quarter is randomly selected by ODM. All time study participants will use the same workweek as the observation period for determining how time is allocated. A seven day, self-administered time study tool is used to document the activities during the randomly selected week.

To determine the universe of weeks eligible for time study, the weeks of the quarter are reviewed for full weeks. The Ohio Department of Medicaid or its designee then makes a random selection of the time study week. This selection process is documented and maintained on file. The Time Study is conducted four times a year, in the following quarters: January – March, April – June, July – September, and October – December.

During the time study week, each participant codes and documents all of his or her work related activities for each day of the seven-day study week, in compliance with OMB A-87 guidelines requiring capture of 100% of the individual's time including the use of code 16 (Time Not Documented). Time study participants code their daily activities to a prescribed set of Activity Codes in 15-minute increments.

Each participant is required to complete the study instrument daily. The study instrument is submitted to the participant's supervisor or claiming unit time study coordinator. The supervisor or claiming unit coordinator signs and dates the study instrument to attest to the date the forms were received from the participant. If during their review of the time study the supervisor or claiming unit coordinator determines any part of the time study to not have documented time, they will change such time to Code 16 (Time Not Documented). All forms must be signed in ink by the participant and supervisor. All electronic entries are to be completed by the end of the third week following the time study period and all hard copy forms are dated and signed by the participant and supervisor to the date completed. If the time study form is completed later than date of the activity, then the entire day is coded to Code 16 (Time Not Documented).

All time study participants will provide a brief description of the activity and corresponding Activity Code on the study instrument for each of the seven days of the study week. The written descriptions on the study instrument should be brief, but need to clearly reflect the activity that was performed.

Time Study Activity Definition

Many different sources were used to support the development of detailed definitions for Medicaid Administrative functions. The sources include administrative function definitions in the 42 CFR Part 441, Subpart B, and HCFA/CMS approved and/or reviewed Medicaid administrative claiming materials employed in several other states.

The Activity Code descriptions for Ohio are listed, starting on the next page.

The following are the Activity Code descriptions for Ohio:

Activity Code	Activity Description
1	Direct Patient Care
2	Non-Medicaid Other Programs and Social Services Activities
3	Medicaid Outreach
4	Non-Medicaid Outreach
5	Facilitating Medicaid Eligibility Determinations
6	Facilitating Eligibility for Non-Medicaid Programs
7	Referral, Coordination and Monitoring of Medicaid Services
8	Referral, Coordination and Monitoring of Non-Medicaid Services
9	Transportation and Translation for Medicaid Services
10	Transportation and Translation for Non-Medicaid Services
11	Program Planning, Development and Interagency Coordination of Medical Services
12	Program Planning, Development and Interagency Coordination of Non- Medical Services
13	Medical Related Provider Relations
14	Non-Medical Provider Relations
15	General Administration
16	Time Not Documented

Detailed definitions of the MAC activities can be found in Attachment C: Medicaid Administrative Claiming Activity Codes.

Time Study Instrument

The time study instrument approved by ODM is designed to capture the full complement of activities and functions performed by the time study participants during the course of the randomly selected week, including Medicaid administrative activities, Medicaid direct service activities and non-Medicaid administrative activities. The time study participants are required to account for all of their time during the course of the study week to reduce the possibility of over or under estimating time spent on administrative related or other activities. All overtime is to be approved by the supervisor. The time study instrument is designed to be functional for the participants while still capturing the necessary level of detail required to appropriately allocate costs. The time study instruments are compiled electronically, either by computer readable form, web-based, or other electronic method.

The time study instrument is self-administered and captures participant activities in 15-minute increments for each day of the seven day study period. Activities are recorded into one of 16 Activity Codes, which include allowable MAC activities and non-allowable MAC activities. Collectively, the categories of activities identified in the time study document account for the diverse range of activities performed by ODH and local public health department staff.

Upon completion of the time study period, all time study documents are accounted for and maintained by ODH and the local public health departments, as required for audit purposes. Activity data recorded in the time study document are used in the allocation of activities by personnel category and later used in the calculation of the claim amount.

Time Study Training

Training of time study coordinators and time study participants is key to the successful implementation of Medicaid administrative claiming. Initial training of the time study coordinators and time study participants is conducted for each participating agency by the ODH MAC Unit. Subsequent quarterly trainings are conducted using a train-the-trainer format. The ODH MAC Unit trains the time study coordinators, who in turn train the time study participants. The MAC Unit contacts trainers quarterly on a statewide or regional basis, depending on the number and location of participating agencies. Training focuses on the time study procedures and the proper use of the Activity Codes. All time study coordinators use a uniform set of training materials.

Each claiming unit is responsible for training all of its time study participants prior to the time study period. All time study participants will be informed of the time study week no earlier than three weeks prior to the time study period. On-site comprehensive training for new participants will occur no earlier than three weeks prior to the time study period. Participants who have previous comprehensive training will be provided updates and a review of MAC. Each claiming unit maintains documentation of its training schedules, attendance, and materials used.

Attendance at the quarterly training is mandatory for new time study participants who are employed at the time of the training. Otherwise, their time study results are not included

in the compilation of the time study instruments. Costs for new staff that do not attend the training and/or do not participate in the time study are unallowable.

Time Study Monitoring

The ODH MAC Unit monitors the time study process to ensure its accuracy and validity. The monitoring functions include, but are not limited to the following:

1. Randomly sample training attendance rosters to verify attendance by time study participants;
2. Periodically attending, unannounced time study training sessions for claiming units to ensure that the trainers are following the approved curriculum;
3. Randomly interviewing trainers for competence, consistency in training and understanding of Activity Codes, and time study procedures;
4. Ensuring that time study participants understand the training and are correctly completing the time study (e.g., by randomly analyzing individual time study documentation and interviewing time study participants);
5. Reviewing and analyzing time study results for the first two quarters of participation by each claiming unit, and subsequently conduct random reviews of selected time study results for the following:
 - i. Completeness of time study documentation (including supervisor's signature);
 - ii. Reasonableness of individual results (e.g., coding appears appropriate for type of staff; identify outliers);
 - iii. Verification of participants' attendance at training;
 - iv. Verification that the number of positions participating as specified in the Implementation Plan is consistent with actual participants in the time study.
6. Performing trend analysis of time study with prior quarters (e.g., results by claiming unit).

ODH MAC Unit provides technical assistance to address any issues identified during monitoring process.

ATTACHMENT A: CLAIM AND INSTRUCTIONS

MEDICAID ADMINISTRATIVE CLAIMING (MAC) ACTIVITIES
CLAIM WORKSHEET

Claiming Entity	<input type="text"/>	Claiming Date:	<input type="text" value="3/30/2007"/>
Claiming Unit	<input type="text"/>	Preparer:	<input type="text"/>
Claiming Number	<input type="text"/>	Phone Number:	<input type="text"/>
Period of Services	<input type="text"/>		
Tax Identification Number	<input type="text"/>		

SOURCE DESCRIPTION	SALARY AND FRINGE	TRAVEL AND TRAINING	OTHER COSTS	PERSONAL SERVICE CONTRACTS	INDIRECT COST	TOTALS
FEDERAL GRANTS & MATCH	\$500	\$0	\$0	\$0	\$0	\$500
MAC MATCH	\$500	\$0	\$0	\$0	\$0	\$500
GRAND TOTAL	\$1,000	\$0	\$0	\$0	\$0	\$1,000

TIME STUDY ACTIVITIES

		MER%	TIME STUDY %	FFP
DIRECT PATIENT CARE	1	0.00%	40.00%	0%
NON-MEDICAID OTHER PROGRAM AND SOCIAL SERVICE ACTIVITIES	2	0.00%	0.00%	0%
MEDICAID OUT REACH (NOT DISCOUNTED)	3	100.00%	10.00%	50%
NON - MEDICAID OUTREACH	4	0.00%	0.00%	0%
FACILITATING MEDICAID ELIGIBILITY DETERMINATIONS (NOT DISCOUNTED)	5	100.00%	0.00%	50%
FACILITATING ELIGIBILITY FOR NON-MEDICAID PROGRAMS	6	0.00%	0.00%	0%
REFERRAL, COORDINATION & MONITORING OF MEDICAID COVERED SERVICES	7	20.00%	25.00%	50%
REFERRAL, COORDINATION & MONITORING OF NON-MEDICAID SERVICES	8	0.00%	0.00%	0%
TRANSPORTATION AND TRANSLATION FOR MEDICAID SERVICES	9	20.00%	0.00%	50%
TRANSPORTATION AND TRANSLATION FOR NON-MEDICAID SERVICES	10	0.00%	0.00%	0%
PROGRAM PLANNING, DEVELOPMENT & INTERAGENCY COORDINATION OF MEDICAL SERVICES	11	20.00%	0.00%	50%
PROGRAM PLANNING, DEVELOPMENT & INTERAGENCY COORDINATION OF NON-MEDICAL SERVICE	12	0.00%	0.00%	0%
MEDICAL RELATED PROVIDER RELATIONS	13	20.00%	0.00%	50%
NON-MEDICAL RELATED PROVIDER RELATIONS	14	0.00%	0.00%	0%
GENERAL ADMINISTRATION	15	20.00%	25.00%	50%
TIME NOT DOCUMENTED	16	0.00%	0.00%	0%
TOTAL TIME			100.00%	

REALLOCATION DENOMINATOR 75.00%

QUARTER CLAIM \$ 100

PRIOR PERIOD ADJUSTMENT \$ -

Level of MAC Activities			%	COMPARISON %
COMPOSITE RATES	20.00%	10.00%	MAC % of time	35%
EXPENDITURES	1,000	1,000	NON-MAC time	40%
CALCULATION	200	100	Reallocated % of time	25%
			Total %	100%

TOTAL CLAIM \$ 100

I hereby certify the following:

- I am the designee of the State Department of Health authorized to submit this claim.
- This claim only includes expenditures under the Medicaid program under Title XIX of the Social Security Act (the Act), that are allowable in accordance with applicable implementing federal, state, and local statutes, regulations, policies, and the state plan approved by the Secretary and in effect during the period of the claim under Title XIX of the Act for the Medicaid Program.

LOCAL CLAIM PREPARATION March 30, 2007

Supporting Documents:

Prior to preparing an invoice five items are needed. They are:

- **The unit's MAC Implementation Plan.** Within this plan includes a listing of MAC Personnel. The plan should also include a table of organization (T.O.) to help document the relationships between all personnel.
- **The quarter's Medical Eligibility Rate (MER)** should be for the quarter you are preparing the invoice. ODH will calculate and distribute the MER annually.
- **The quarter's payroll data** from appropriate local reports. Actual payroll expenditures are to be used. Use standard local reporting methods when generating this information. The costs for each person must be separated by each source of funds.
- **The quarter's time-study results** for the claiming unit.
- **The quarter's list of trained time-study personnel** for the claiming unit.

Review of Supporting Documents:

Upon receipt of the above items the first step is to compare the MAC Implementation Plan's personnel to the time-study results and the sources of funding.

- Any position not in the plan cannot be included in the claim and their time study results are removed.
- If a position is in the plan but did not go to the time-study training and/or participate in the time study, then their time-study results should be coded to MAC code 16 (Time Not Documented). Their costs end up being backed out via the time study results.
- If a position is in the plan but was vacant or on disability leave during the training and/or time study week, the costs are to remain. Their costs end up being allocated upon the appropriate time study results.
- If a position is in the plan, but is on leave during the time study week, their costs are to remain, and they should use code 15 (General Administration). If the leave is predetermined by a contractual agreement (i.e., school nurses agreeing to work 9 months a year and being paid over 12 months for a summer leave), the costs are to remain and their costs end up being allocated upon the average of the previous three time-study periods.

- If a position is funded 100% with federal funds and related match revenue, then the costs are not included and their time study results are removed.
- Positions are approved in the plan, *not* people. Compare names to titles. If a person changed positions the make sure the time-study results and costs are associated with the correct position.

Opening the invoice:

The invoice is to be sent by the Department of Health. An e-mail with an Excel file called “Local Claim Template” and a sample will be sent to. Save both in your computer in a separate folder.

Naming of Claim File:

To generate an invoice for a claiming unit, go directly to the “Local Claim Template”, open it and immediately do a “File Save As” in another folder. In order to have consistent file names the naming sequence is for the January to March, 2008 quarter for Buckeye County Health Department’s Division of RNs Claim. The lower case “y” represents year and the lower case “q” represents the quarter, followed by the “Claiming Agency” name, a dash (-), “Claiming Unit” name. **Quarter numbers are on the calendar basis.** The file name for the quarter mentioned above would be: y08q1 Buckeye County Health Department – Division of RNs.

Invoice Overview:

Information can **only** be entered in “White Cells”. All others are locked.

Current worksheets of the claim are as follows:

- **Claim** – this is the main worksheet. All other worksheets are either linked to or provide supporting information to this worksheet. Detailed instructions are outlined later.
- **Revenue Descriptions** – this worksheet breaks information into revenue categories. Detailed instructions are outlined later.
- **Payroll** – use this tab to import all local payroll supporting information.
- **Non-Payroll** – use this tab to import all local non-payroll supporting information.
- **Time Study % Summary** – use these tabs to import time-study results. “Copy and Paste” the results into the appropriate worksheet. If the review of supporting documents results in changes of category assignments then supporting data must

be updated. For example, if the time study results include a person that did not attend training then their data must be removed from the time study.

- **Checklist** – this is a checklist of all the items that should be retained in a file in case of an audit.

Claim Worksheet

Header Section:

The **Header Section**, along the top of the **Invoice Worksheet** provides information to help identify the specific **Invoice**. The **Header Section** includes:

- **Claiming Entity** – enter the name of the **agency** making the claim.
- **Claiming Unit** – enter the name of the **claiming unit**.
- **Period of Services** – claiming is completed quarterly. Enter the quarter of the claim as follows: January through March, 2008.
- **Claiming Number** – assign invoice number as the name of the file (e.g. y08q1 Buckeye County Health Department – Division of RNs).
- **Tax Identification Number** – enter the claiming agency's **Federal Tax ID number**.
- **Claiming Date** – enter the date that the invoice was prepared.
- **Preparer** – enter the name of the person preparing the claim.
- **Phone Number** - enter the phone number of the person preparing the claim. (Please include area code)

Source Description Section:

This is where the **Actual Costs Total** is entered. Costs are to be segregated by MAC Match and Related Match. The determination of revenue classifications is determined by the MAC Revenue Qualifier Questionnaire in the Implementation Plan.

The line items listed below are to be completed, all others are calculated. Round all figures to the nearest whole dollar.

- **Salary and Fringe** – actual costs for this category are to be entered. The supporting documentation of the actual costs is to be detailed in the Payroll Worksheet.
- **Travel and Training** - actual costs for this category are to be entered. The supporting documentation of the actual costs is to be detailed in the Non-Payroll Worksheet.
- **Other Costs** – actual costs for this category are to be entered. The supporting documentation of the actual costs is to be detailed in the Non-Payroll Worksheet. This category includes all costs that are not included in other line items. It is required that an itemized listing of the **Other Costs** be provided in the **Non-Payroll Worksheet**. **Other Costs** listed must be completely allocable to the specific claiming unit staff. **Supply Costs**, at a broader level (e.g. bureau, division or program area level) can not be included.
- **Personal Service Contracts** – actual costs for this category are to be entered. The supporting documentation of the actual costs is to be detailed in the Non-Payroll Worksheet. Contracts and invoices must clearly distinguish MAC reimbursable activities along with all other activities. All contracts with or on behalf of personnel must time study. Include any supporting documentation of cost in the Non-Payroll worksheet.
- **Indirect Cost**: actual costs for this category are to be entered. The supporting documentation of the actual costs is to be detailed in the Non-Payroll Worksheet. Complete this only if a federally approved indirect cost rate already exists. The Indirect Cost rate must also be explained in the MAC Implementation Plan. A copy of the approval notice, along with the approved rate, is the source document. Apply the rate to the Salary and Fringe figures.

Time Study Activities and MER % Section:

MER % Column: enter the discounted MER rate in MAC Activity Code 7. All other rates populate automatically. The MER is supplied by ODH annually.

Time Study %: the time study results for the quarter are to be entered in their appropriate column. **Special Note**: for percentages under 1%, enter zero, prior to the decimal point. For example: if you are entering one quarter of one percent (1/4 of 1%) you would enter 0.25.

After entering the percentages, double check that the time study results total 100%. There could be a rounding error. The rounding error is generally under 0.01%, so the total percentage could then d to only 99.99%. If the total is under 100%, then add the difference to Code 2 (Non-Mac) activities to eliminate the possibility of gaining reimbursement. If the total is over 100%, then the difference is subtracted from a MAC activity code that would gain the most reimbursement.

**ATTACHMENT B: MER METHODOLOGY AND FFP BY
ACTIVITY CODE**

MER Methodology and FFP by Activity Code

Code	Activity Description	FFP	MER Methodology
1	Direct Patient Care	0%	Not Claimable
2	Non-Medicaid Other Program and Social Service Activities	0%	Not Claimable
3	Medicaid Outreach (not Discounted)	50%	100% claimable without applying a Medicaid Eligibility Rate discount
4	Non-Medicaid Outreach	0%	Not Claimable
5	Facilitating Medicaid Eligibility Determinations	50%	100% Claimable without applying a Medicaid Eligibility Rate discount
6	Facilitating Eligibility for Non-Medicaid Programs	0%	Not Claimable
7	Referral, Coordination & Monitoring of Medicaid Services	50%	Population Based
8	Referral, Coordination & Monitoring of Non-Medicaid Services	0%	Not Claimable
9	Transportation & Translation for Medicaid Services	50%	Population Based
10	Transportation & Translation for Non-Medicaid Services	0%	Not Claimable
11	Program Planning, Development & Interagency Coordination of Medical Services	50%	Population Based
12	Program Planning, Development & Interagency Coordination of Non-Medical Services	0%	Not Claimable
13	Medical Related Provider Relations	50%	Population Based
14	Non-Medical Provider Relations	0%	Not Claimable
15	General Administration		Reallocated to other codes using approved methodology
16	Time Not Documented	0%	Not Claimable

**ATTACHMENT C: MEDICAID ADMINISTRATIVE
CLAIMING PROGRAM ACTIVITY CODES**

**OHIO DEPARTMENT OF HEALTH
MEDICAID ADMINISTRATIVE CLAIMING PROGRAM
ACTIVITY CODES**

CODE 1: DIRECT PATIENT CARE

Medicaid Rate: U

All staff may use this code.

Providing client care, treatment and/or counseling services to an individual in order to correct or ameliorate a specific condition. Includes the provision of direct services reimbursed through Medicaid, as well as direct services that are not reimbursed by Medicaid. Any activities as billable Targeted Case Management should be included in this code. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Direct clinical/treatment services including scheduling, collecting medical history, performing assessment/medical exams, and patient education that is part of a routine office visit;
- Developing treatment plan;
- Providing transportation to medical/dental/mental health services;
- Health screenings and diagnostic evaluations (e.g., orthopedic evaluation, vision screen, and audiological testing services);
- Screening and treating communicable diseases (e.g., STDs, HIV, TB);
- Counseling/therapy services;
- Skills training for medical/dental/mental health services;
- Administering first aid, emergency care, medication, or immunizations;
- Preparing for and cleaning up after screening or medical procedures;
- Submitting billing documents for patient care;
- Performing specialty clinic examinations;
- Performing pregnancy tests;
- Developmental assessments;

- Providing smoking cessation and/or breastfeeding education for pregnant women;
and
- Participating in chart reviews that include Medicaid-covered services to ensure compliance with medical documentation and forms requirements.

**CODE 2: NON-MEDICAID OTHER PROGRAM AND SOCIAL SERVICE
ACTIVITIES**
Medicaid Rate: U

All staff may use this code.

This code should be used when performing any activities that are not health related, such as education, employment, job training, social services and other activities or services as well as non-Medicaid health related activities. Includes activities unrelated to the administration of the Medicaid program. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Developing funding proposals for non-Medicaid services;
- Activities related to immunization requirements for school attendance;
- Conducting any public health environmental investigation and education/case management for a child with an elevated blood lead level >9 micrograms/deciliter;
- Providing written lead hazard orders for reduction or abatement of lead hazards;
- Providing orders prohibiting use of a structure as a residence upon failure of a lead clearance examination;
- Providing lead poisoning prevention educational services to parents and guardians of lead poisoned children;
- Teaching first aid or CPR classes;
- Teaching individuals and their family members ways to improve or maintain their health status (e.g., nutrition, physical activity, weight reduction);
- Purchasing food, clothing or other supplies for a client;
- Investigating communicable diseases;
- Administering contracts for Medicaid and non-Medicaid services;
- Providing ODM with information about policies governing the WIC program;
- Sharing information with ODM on the evaluation of the Help Me Grow Helpline;
- Developing curriculum and training materials on child development for the Help Me Grow program;

- Meeting with child care providers to review state and county policies and procedures;
- Providing non-medical/dental/mental health technical assistance and monitoring of local programs; and
- Preparing for and attending court appearances and any court-related activity.

CODE 3: MEDICAID OUTREACH
Medicaid Rate: ND

All staff may use this code. **This code can not be used in the home setting.**

A campaign, program or ongoing activity targeted to 1) bringing potential eligibles into the Medicaid system for the purpose of determining eligibility or 2) bringing Medicaid eligible individuals into specific Medicaid services. Activities may include informing Medicaid eligible or potentially eligible individuals, agencies, and community groups about the range of health services covered by the Medicaid program including preventive or remedial health care services offered by the Medicaid program that may benefit them. Oral or written informing methods may be used. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Use this code when conducting outreach campaigns directed to the entire population to encourage potentially Medicaid eligible individuals to apply for Medicaid and outreach campaigns directed toward bringing Medicaid eligible individuals into Medicaid covered services, such as Healthchek, Medicaid prenatal care, a Medicaid medical home, etc.

A health education program or campaign may be allowable as a Medicaid outreach activity, if it is targeted specifically to Medicaid services and for Medicaid eligible individuals, such as an educational campaign on immunization addressed to parents of Medicaid eligible children. Health education programs or campaigns or component parts of health education programs or campaigns that are general in nature such as oral hygiene education programs, car passenger safety, or antismoking programs should be code 4.

Report under this code only that portion of time spent in activities that specifically address Medicaid outreach. Report the non-Medicaid portion of these outreach campaigns for Code 4 (for example, general health education programs such as car passenger safety, lice control, etc).

Examples of activities reported under this code include:

- Providing information to the general population about the Medicaid program to encourage potential Medicaid eligibles to apply for Medicaid;
- Identifying Medicaid eligible pregnant women who are medically-at risk and referring them to seek services through the Medicaid system;
- Providing information to individuals, families, agencies and community groups about Medicaid covered services for the purpose of bringing Medicaid eligibles into Medicaid health care services;
- Providing and presenting materials to explain Medicaid services that are available to Medicaid eligible individuals, such as prenatal health care, or lead testing services for Medicaid eligible children; and

- Informing families with children about the availability of Medicaid services, such as Healthchek, and how to enroll in Medicaid.

CODE 4: NON-MEDICAID OUTREACH
Medicaid Rate: U

All staff may use this code.

Use when informing individuals about social, educational, legal or other services not covered by Medicaid and how to access them. Also use when conducting general health education programs addressed to the general population. Oral or written methods may be used. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Conducting outreach activities that inform individuals about non-Medicaid health programs and services (e.g., car passenger safety);
- Providing immunization information to the general public;
- Conducting general health education programs or campaigns addressed to the general population (e.g., dental hygiene, antismoking, alcohol reduction, victim assistance and domestic violence);
- Scheduling and promoting activities that educate individuals about the benefits of healthy lifestyles and practices;
- Conducting public health education campaigns on the non-Medicaid aspects of Help Me Grow;
- Providing information about child care resources;
- Activities related to immunization programs required by state law and the associated outreach campaigns; and
- Conducting outreach campaigns that encourage persons to access social, educational, legal or other services not covered by Medicaid such as clothing, food, child care, TANF, food stamps, WIC, Head Start, legal aid, housing, jobs, etc.

CODE 5: FACILITATING MEDICAID ELIGIBILITY DETERMINATIONS
Medicaid Rate: ND

All staff may use this code.

Use this code when assisting an individual in becoming eligible for Medicaid. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

This activity does **not** include the actual Medicaid eligibility determination.

Examples of activities reported under this code include:

- Explaining Medicaid eligibility rules and the eligibility process to prospective applicants;
- Making referrals to local Department of Job and Family Services (DJFS) in order to encourage individuals who are potentially eligible to apply for Medicaid or Healthy Start;
- Assisting an applicant to fill out a Medicaid eligibility application;
- Accompanying individual to local DJFS office to apply for Medicaid;
- Assisting an individual to provide third party resource information at Medicaid eligibility intake;
- Gathering information related to the Medicaid application and eligibility determination (or re-determination) from an individual, including resource information and third party liability (TPL) information, in preparation for submitting a formal Medicaid application; and
- Providing or packaging necessary Medicaid forms needed for the Medicaid eligibility determination.

CODE 6: FACILITATING ELIGIBILITY FOR NON-MEDICAID PROGRAMS
Medicaid Rate: U

All staff may use this code.

Use when assisting an individual to become eligible for non-Medicaid programs, such as food stamps, SSI, TANF, WIC, Section 8 housing, etc. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Informing individuals about programs such as cash assistance, food stamps, WIC, day care, legal aid, and other social and educational programs and referring them to the appropriate agency to make an application;
- Explaining eligibility rules and the eligibility process for non-Medicaid programs, such as food stamps, TANF, WIC, SSI, etc., to prospective applicants;
- Assisting an individual to complete an application for a non-Medicaid program such as food stamps, TANF, WIC, SSI, etc.;
- Gathering information related to the application and eligibility determination for non-Medicaid programs from a client; and
- Providing necessary forms and packaging all forms in preparation for the non-Medicaid eligibility determination.

**CODE 7: REFERRAL, COORDINATION AND MONITORING OF
MEDICAID SERVICES
Medicaid Rate: D**

All staff may use this code.

For Medicaid eligible providers: Use Code 1 when conducting any screening, referral, coordination and monitoring that are part of a routine office visit or Targeted Case Management visit and reimbursed as part of the Medicaid program and Targeted Case Management. Activities that are part of direct services or an extension of medical services are not claimable as an administrative activity.

Use when performing referral, coordination, and monitoring activities that facilitate access to and coordination of Medicaid covered services. Includes identifying the need for and types of medical care an individual needs, making referrals to Medicaid providers, and doing follow up or monitoring to assess individual's progress. This includes consultation with other providers to access Medicaid services for a client. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Gathering information that may be required in advance of- medical/dental/mental health referrals;
- Monitoring the implementation of the plan of care, e.g., appointments with referral specialists are completed, test results are forwarded to treating physician;
- Identifying and referring individuals who may be in need of Medicaid family planning services;
- Referring and/or coordinating scheduled medical or physical examinations and necessary medical/dental/mental health evaluations;
- Referring and/or scheduling Healthchek screens, interperiodic screens and appropriate immunizations;
- Arranging for any diagnostic or treatment services, which may be required as the result of a condition identified during the child's Healthchek screen;
- Working with children, their families, other staff and providers to identify, arrange for, and coordinate services covered under Medicaid that may be required as the result of screens, evaluations or examinations;
- Referring individuals for necessary medical health, dental, mental health or substance abuse services covered by Medicaid;

- Assisting families of medically fragile children to establish a “medical home” and to access other necessary medical/dental/mental health services;
- Providing follow-up contact to ensure that an individual has received the prescribed medical dental/mental health service and to provide feedback whether further medical services is required;
- Providing follow-along activities that ensure high-risk populations (e.g., substance abusing pregnant women or new mothers, frail elderly, individuals with tuberculosis, etc.) achieve positive health outcomes;
- Participating in case conferences or multi-disciplinary teams to review an individual’s health-related needs and plans and to coordinate medical and health-related care and services;
- Participating in consultation to individuals to assist them in understanding and identifying health problems or conditions and in recognizing the value of preventive and remedial health care when this activity is not an integral part or an extension of a medical service;
- Assessing, the need for and adequacy of medical care services, including related consultation with individuals and medical providers, when not part of a medical visit or other Medicaid billable service;
- Reviewing the results of medical/dental/mental health assessments and evaluations needed to coordinate and sequence services and to facilitate referrals that meet the client’s needs, when not part of a medical visit or other Medicaid billable service;
- Facilitating the exchange of relevant and timely information among providers and family members regarding the individual’s complex medical/dental/mental health problem, when not part of a medical visit or other Medicaid billable service;
- Consulting with other medical specialists, about the necessity for adequacy and sequencing of care or treatment of specific conditions;
- Consulting with the client to improve the client’s understanding of complex medical issues and how they relate to the coordination of services;
- Monitoring of individual medication management and service authorization for medical care covered by Medicaid when the provider is not billing Medicaid for these services;
- Monitoring the interdisciplinary care plan for medical services when the provider is not billing Medicaid for these services;

- Linking women to ongoing contraceptive care; and
- Assessing the necessity for and adequacy of medical care and services provided, as in quality improvement activities such as:
 - quality assurance reviews
 - peer reviews
 - special studies
 - standards of practice
 - best practices

CODE 8: REFERRAL, COORDINATION AND MONITORING OF NON-MEDICAID SERVICES

Medicaid Rate: U

All staff may use this code.

Use when performing referrals, coordinating, and/or monitoring the delivery of social, educational, legal, or other services not covered by Medicaid. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Making referrals for and coordinating access to social and educational services such as child care, employment, job training, clothing assistance, and housing;
- Making referrals for, coordinating and monitoring the delivery of school and/or community based health screens (vision, hearing, scoliosis);
- Gathering information from individuals to determine the kinds of social services that may be needed;
- Providing information to another provider about non-Medicaid services being provided to an individual; and
- Providing follow up to ensure whether individuals received social services such as housing, income assistance, domestic violence services, after school services, and child care.

CODE 9: TRANSPORTATION AND TRANSLATION FOR MEDICAID SERVICES
Medicaid Rate: D

All staff may use this code.

Use when assisting an individual to access services covered by Medicaid through arranging or scheduling (by car, taxi, van bus, etc., but not an ambulance) to a Medicaid covered service or accompanying the individual to a Medicaid service. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Translation services furnished by a direct patient care provider (e.g., speech therapist, nurse, physician) during a direct patient care visit should be reported to Code 1.

Use when arranging, obtaining or providing translation services for the purpose of accessing Medicaid services. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Non-Medicaid transportation and translation services should be reported under Code 10.

Examples of activities reported under this code include:

- Scheduling and/or arranging recipient transportation to Medicaid covered services as the result of an evaluation or examination;
- Accompanying a Medicaid eligible individual to a medical appointment that is Medicaid covered service;
- Arranging for or providing translation services (oral and/or signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid; and
- Developing translation materials that assist individuals to access and understand necessary care or treatment covered by Medicaid.

CODE 10: TRANSPORTATION AND TRANSLATION FOR NON-MEDICAID SERVICES
Medicaid Rate: U

All staff may use this code.

Use when assisting an individual to access services not covered by Medicaid through arranging, scheduling or providing transportation, accompanying the individual to a non-Medicaid service, and obtaining translation services so the individual can access a non-Medicaid service.

Translation services furnished by a direct patient care provider (e.g., speech therapist, nurse, physician) during a direct patient care visit should be reported to Code 1.

Use when assisting an individual to access non-Medicaid services through arranging, obtaining or providing translation services. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Scheduling or arranging transportation to social, vocational, and/or educational programs;
- Scheduling weekly bus transportation for seniors to the senior center;
- Arranging transportation for a pregnant woman to WIC appointments;
- Arranging for or providing translation services (oral and/or signing services) that assist the individual to access and understand social, educational, and vocational services; and
- Developing translation materials that assist individuals to access and understand social, educational, and vocational services.

**CODE 11: PROGRAM PLANNING, DEVELOPMENT AND INTERAGENCY
COORDINATION OF MEDICAL SERVICES**
Medicaid Rate: D

All staff, whose job descriptions or duty statements include responsibilities for program planning, policy development, and interagency coordination, may use this code.

Planning and development of services, programs and resources that relate to Medicaid covered medical/dental/mental health services, such as the development of policy, procedures and protocols for the delivery and coordination of care to individuals. Use this code for collaborative activities that involve planning and resource development with other agencies, which will improve the availability and quality of medical/dental/mental health services and the cost-effectiveness of the health care delivery system. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Working with other agencies providing Medicaid services to improve the coordination and delivery of services, to expand their access to specific populations of Medicaid eligible, and to improve collaboration around the early identification of medical/dental/mental health problems;
- Assessing the capacity of the agency and its providers to deliver accessible Medicaid covered medical/dental/mental health assessment, treatment and care services to Medicaid eligible and identifying potential barriers and needs;
- Assessing the capacity of providers to deliver Medicaid covered health assessment, preventive health services and medical care;
- Reducing overlaps and duplication in Medicaid services, and closing gaps in the availability of services, especially for children;
- Planning programs and services to meet the identified needs of high-risk populations of Medicaid eligible served by the agency and its providers;
- Interagency coordination to improve the delivery of Medicaid services;
- Collecting and analyzing Medicaid data related to population group or geographic areas, including data gathered from chart reviews, in order to improve service coordination and delivery;
- Conducting needs assessments related to medical/dental/mental health services including Medicaid services within a community, such as identifying the need for and working with local providers to expand prenatal and obstetric services to Medicaid eligible individuals or ensuring that residents in a

community where a Medicaid provider(s) is closing or leaving have ongoing access to medical care;

- Developing plans for expansion of Medicaid-covered services;
- Coordinating efforts to improve access to Medicaid covered medical/dental/mental health services to specific populations or geographic areas that are under-served;
- Interpreting and using medical statistical data from Medicaid claims data and other health services data system to forecast services utilization, and close gaps in medical services;
- Participating in interagency coordination efforts where medical expertise is needed to identify barriers to care and patient management issues around specific medical conditions;
- Participating in interagency coordination with other medical providers, to improve the medical aspects of Medicaid services, or to plan or monitor the delivery of Medicaid-covered medical services; and
- Developing strategies with other medical providers and other health care agencies to improve access to care and service utilization for high risk, high cost populations with complex medical needs;

**CODE 12: PROGRAM PLANNING, DEVELOPMENT AND
INTERAGENCY COORDINATION OF NON-MEDICAL
SERVICES**

Medicaid Rate: U

All staff may use this code.

Use when performing activities associated with the development of strategies to improve the coordination and delivery of non-medical services, including educational, social, vocational, and other services and when performing collaborative activities with other agencies. Includes paperwork, clerical activities, related staff travel or training.

Examples of activities reported under this code include:

- Identifying gaps or duplication of other non-medical services (e.g., social, vocational, and educational programs) and developing strategies to improve the coordination;
- Evaluating the need for non-medical services in relation to specific populations or geographic areas;
- Analyzing non-medical data related to a specific program, population or geographic area of these services;
- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services;
- Planning, developing, conducting and/or attending training that promotes community collaboration and developing non-medical services in the community;
- Developing interagency policies and procedures for non-medical programs and services;
- Participating in community planning efforts to close gaps in social services such as housing, childcare, and after school programs;
- Attending interagency meetings to develop strategies for increasing non-medical programs or services such as early child care and education programs;
- Writing proposals for non-medical care services such as smoking cessation and domestic violence;
- Conducting external relations (e.g., site visits to police departments, domestic violence services, nutrition programs);

- Coordinating with interagency committees to identify, promote and develop non-medical services; and
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services.

CODE 13: MEDICAL RELATED PROVIDER RELATIONS
Medicaid Rate: D

All staff may use this code.

Use this code when performing activities to secure and maintain the pool of eligible Medicaid (medical/dental/mental health) providers. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Recruiting new medical/dental/mental health providers into the Medicaid Program;
- Providing information and technical support to providers on medical policy and regulations;
- Developing medical service/provider directories for those who provide services to targeted population groups e.g., Healthchek children, pregnant women;
- Providing technical assistance and support to providers;
- Working with medical resources, such as managed care plans, to locate and develop health services referral relationships;
- Monitoring effectiveness of programs providing Medicaid-covered services, including client satisfaction surveys for medical/dental/mental health services; and
- Developing future referral capacity with specialty medical care providers by discussing medical health programs, including client needs and service delivery requirements.

CODE 14: NON-MEDICAL PROVIDER RELATIONS
Medicaid Rate: U

All staff may use this code.

Use when performing activities related to securing and maintaining non-health related providers. Includes paperwork, clerical activities, staff travel or training directly related to performing these activities.

Examples of activities reported under this code include:

- Recruiting non-medical providers, (e.g., child care, domestic violence, food pantry);
- Recruiting with outside agencies regarding social and education programs, for example agencies that assist with childcare and housing assistance;
- Providing technical assistance and support to new non-medical staff, including orientation;
- Developing staff directories; and
- Developing non-medical referral sources.

CODE 15: GENERAL ADMINISTRATION

Medicaid Rate: R

All staff may use this code.

Performing general administrative activities (i.e., those that are not specific to any identified function or that relate to multiple functions of the agency) and paid time off. This coding is used by program staff that is not included in the federally approved indirect cost rate.

Examples of activities reported under this code include:

- Attending or facilitating general agency or unit staff meetings or board meetings;
- Developing and monitoring agency or program budgets;
- Providing general supervision of staff and employee performance reviews;
- Processing payroll/personnel-related documents;
- Maintaining inventories and ordering supplies;
- Reviewing or writing agency, departmental or unit policies and procedures;
- Conducting health promotion activities for staff;
- Providing or attending training;
- Providing or attending general in-services or training, including new employee orientation or supervision or computer training;
- Paid breaks;
- Paid jury duty;
- Vacation, sick leave, holiday time, compensatory time; and
- Filing out MAC time study.

CODE 16: TIME NOT DOCUMENTED
Medicaid Rate: U

All staff may use this code. The time study participant's supervisor can use this code if there is time not documented.

- Use to document the time staff identified to participate in the time study either do not complete the time study or cannot produce their time study log.

ATTACHMENT D – IMMUNIZATION VACCINES FOR CHILDREN

INTERAGENCY AGREEMENT BETWEEN THE OHIO DEPARTMENT OF MEDICAID AND THE OHIO DEPARTMENT OF HEALTH

A-1819-04-0113D

RECITALS

The ODM Agreement Manager for purposes of this Attachment D only is Icilda Dickerson, Chief, Bureau of Long Term Care Services and Supports, Ohio Department of Medicaid, 50 West Town Street, Columbus, Ohio 43215, 614-752-3578, icilda.dickerson@medicaid.ohio.gov.

The ODH Agreement Manager for purposes of this Attachment D only is John Joseph, Manager, Immunization Program, Ohio Department of Health, 246 North High Street, Columbus, Ohio 43215, 614-466-2273, john.joseph@odh.ohio.gov.

ARTICLE I. PURPOSE

The purpose of this Attachment D is to maintain and enhance the statewide automated Immunization Information System (Impact/SIIS) including the Vaccines For Children Program (VFC) through a collaborative exchange of electronic data from ODM to ODH.

ARTICLE II. RESPONSIBILITIES OF ODM

ODM, pursuant to federal regulation, is responsible for the administration of the Medicaid program and the collection of Medicaid data in the State of Ohio. ODM shall retain final authority for the administrative decisions related to Medicaid Information Technology System (MITS) data. ODM shall cooperate with ODH to plan, implement, monitor, and evaluate the provision of services under this Attachment D.

1. ODM will provide electronic claim line data to ODH in an electronic format at intervals agreeable to ODM and ODH to update data in Impact/SIIS.
2. ODM will provide points of contact to ODH for notification activities included in ARTICLE III.

ARTICLE III. RESPONSIBILITIES OF ODH

ODH will:

1. Maintain an electronic interface between Impact/SIIS and the Blood Lead Tracking programs operated by ODH.
2. Award and implement a contract for education, enrollment, electronic reporting support, and training, and for logging and reporting on those activities. Create and implement strategies to increase Medicaid provider resources and benefits from Impact/SIIS.
3. Mail computer-generated reminder letters to parents/guardians of Medicaid children informing them of immunizations that are due, based on the information in the Impact/SIIS database.
4. Maintain ongoing operational education, enrollment, reporting and training to include Help Desk and site visits.
5. Manage and implement the VFC program in Ohio through the Ohio Department of Health, Bureau of Infectious Diseases, Immunization Program.
6. Notify VFC-enrolled Medicaid providers of vaccines designated as "free" under the federal VFC program. These vaccines are covered in accordance with the Section 5160-4-12 of the Ohio Administrative Code (OAC), provided that funding and vaccines are available through the federal VFC program.

7. Notify ODM of approved VFC vaccines and forward information about necessary changes to OAC Section 5160-4-12. ODH will communicate with ODM regarding the effective coverage date of a new VFC vaccine, ordering time frames, and shipping arrival dates on all new vaccine codes to be added to the OAC Section 5160-4-12.
8. Notify ODM of all potential VFC vaccine supply shortages that may affect Medicaid providers as soon as possible and prior to ODH release of this information to the public. ODH will work with ODM to communicate a plan of action to Medicaid providers.
9. Comply with the Centers for Disease Control and Prevention (CDC) VFC Operations Guide. Inform ODM of decisions regarding interpretation of this guide as it relates to Medicaid providers. ODH will communicate any appropriate standards and vaccine delivery news that CDC forwards to ODH. ODH will enter into agreements with VFC providers and assure that VFC policies are followed by enrolled providers.
10. Promote the use of Impact/SIIS by all Medicaid providers in order to effectively account for all VFC-supplied vaccines and improve the timeliness of vaccines administered on-time.
11. Provide ODM (upon request) with a list of providers who have enrolled in the VFC program. This listing can include all demographic information such as name, address, phone number, and National Provider Identifier (NPI) number.
12. Inform ODM of suspected vaccine fraud or abuse among Medicaid-enrolled VFC providers according to the ODH VFC Fraud and Abuse Policy. ODM will provide a point of contact to ODH for this purpose.
13. Assist ODM and the Medicaid managed care providers (MCPs) to identify VFC process improvements, communications and plans for enhanced use of the VFC program by Medicaid providers contracted with each of the Medicaid MCPs.
14. Obtain points of contact from ODM for notification activities in this Article.
15. Import immunization data per ARTICLE II into Impact/SIIS.

ARTICLE IV. AMOUNT OF AGREEMENT

1. ODM agrees to reimburse ODH up to One Hundred Sixty-One Thousand, Nine Hundred Seventy-Eight and 00/100 Dollars (\$161,978.00) in State Fiscal Year (SFY) 2018, and One Hundred Sixty-Seven Thousand, Twenty-Four and 00/100 Dollars (\$167,024.00) in SFY 2019. It is expressly understood by ODM and ODH that the terms of this Attachment D do not allow total compensation in excess of Three Hundred Twenty-Nine Thousand, Two and 00/100 Dollars (\$329,002.00) in federal financial participation (FFP) for the period set forth in this Attachment D. All obligations under this Attachment D are subject to the requirements of ORC 126.07.
2. ODH shall prepare proper invoices and Intra-State Transfer Vouchers (ISTVs) for reimbursement on a monthly basis for actual allowable expenditures incurred and paid pursuant to responsibilities outlined in ARTICLE III. The parties agree that no further reimbursement will be sought hereunder.
3. Detailed budgetary data for the term of the interagency agreement follows:

ImpactSIIS Reimbursement for SFY 2018:

Resource/ARTICLE III Deliverable(s)	Total Cost	Medicaid Share (50%)	ODH Share (50%)
Epidemiology Investigation Supervisor (ImpactSIIS Manager; oversight of ARTICLE III Deliverables 1 through 4, 15)	\$171,239	\$85,619	\$85,620
Administrative Professional (Deliverables 3, 4 and 5)	\$91,538	\$45,769	\$45,769

Resource/ARTICLE III Deliverable(s)	Total Cost	Medicaid Share (50%)	ODH Share (50%)
Epidemiology Investigator 3 (50% Time; Deliverables 1,3,4,15)	\$61,179	\$30,590	\$30,589
Subtotal	\$323,956	\$161,978	\$161,978

ImpactSIIS Reimbursement for SFY 2019:

Resource/ARTICLE III Deliverable(s)	Total Cost	Medicaid Share (50%)	ODH Share (50%)
Epidemiology Investigation Supervisor (ImpactSIIS Manager; oversight of ARTICLE III Deliverables 1 through 4, 15)	\$174,866	\$87,433	\$87,433
Administrative Professional (Deliverables 3, 4 and 5)	\$94,185	\$47,093	\$47,092
Epidemiology Investigator 3 (50% Time; Deliverables 1,3,4,15)	\$64,997	\$32,498	\$32,499
Subtotal	\$334,048	\$167,024	\$167,024

ATTACHMENT E – SMOKING CESSATION PROGRAM

INTERAGENCY AGREEMENT BETWEEN THE OHIO DEPARTMENT OF MEDICAID AND THE OHIO DEPARTMENT OF HEALTH

A-1819-04-0113E

RECITALS

The ODM Agreement Manager for purposes of this Attachment E only is Christopher Patrone, Bureau of Long Term Care Services and Supports, Ohio Department of Medicaid, 50 West Town Street, Columbus, Ohio 43215; 614-752-3502; christopher.patrone@medicaid.ohio.gov

The ODH Agreement Manager for purposes of this Attachment E only is Mandy Burkett, Chief, Tobacco and Indoor Environments Section, Bureau of Environmental Health, Ohio Department of Health, 246 North High Street, Columbus, Ohio 43215, 614-644-7553; mandy.burkett@odh.ohio.gov

ARTICLE I. PURPOSE

The purpose of this Attachment E is to reimburse ODH the cost of operating the Ohio Tobacco Quit Line to the extent it complies with the State Medicaid Letter (SDL #11-007) dated June 24, 2011, 1903(a)(7) of the Social Security Act, 42 CFR 433.15(b)(7) and 2 CFR Part 200, Subpart E.

ARTICLE II. RESPONSIBILITIES OF ODM

ODM will:

1. Pay the federal and nonfederal shares of Ohio Tobacco Quit Line services provided to Medicaid recipients incurred by ODH.
2. Take steps to make Medicaid providers aware of the Ohio Tobacco Quit Line services that are available to Medicaid recipients.
3. Review and approve ODH claims subject to compliance with applicable federal and state requirements. ODM shall approve and remit payment to ODH within 30 days of the approved invoice date.
4. Provide appropriate claim format to ODH to facilitate submission of claims by ODM to the Centers for Medicare and Medicaid Services (CMS) to facilitate reimbursement of the federal shares to ODM.
5. Ensure all claims for reimbursement meet requirements to assist ODM to administer the Medicaid program.
6. If CMS, ODM, ODH, or other authority, through any means, determines a previously submitted claim resulted in an overpayment of Federal Financial Participation (FFP), ODM will provide notice to ODH and initiate an intra state transfer voucher (ISTV) to collect the unallowable federal and non-federal amount within 60 days of notification.
7. Work with ODH to prepare a plan to reduce tobacco use by Ohioans, with emphasis on reducing the use of tobacco by youth, minority and regional populations, pregnant women, Medicaid recipients, and others who may be disproportionately affected by the use of tobacco as included in Ohio Revised Code 3701.84.

ARTICLE III. RESPONSIBILITIES OF ODH

ODH will:

1. Submit invoices to ODM for the cost incurred by ODH to operate the ODH Tobacco Quit Line as documented by Ohio Sub. S.B. 332 by the 131st General Assembly and subsequent Ohio law and rule.
2. Submit claims to ODM and certify compliance with applicable federal and state requirements.
3. Submit claims in an appropriate format to ODM to facilitate reimbursement of the federal shares to ODM.
4. Certify that all claims submitted for reimbursement are appropriate and are eligible as allowable administrative activities that assist ODM to administer the Medicaid program.
5. If CMS, ODM, ODH, or other authority, through any means, determines a previously submitted claim resulted in an overpayment of FFP, ODH will repay ODM the FFP amount within 60 days of notification.
6. As directed by Ohio Revised Code 3701.84, work with ODM to assist in the preparation of a plan to reduce tobacco use by Ohioans, with emphasis on reducing the use of tobacco by youth, minority and regional populations, pregnant women, Medicaid recipients, and others who may be disproportionately affected by the use of tobacco.

ARTICLE IV. RESPONSIBILITIES OF BOTH PARTIES

Both parties will:

1. Carry out the provisions of this Attachment E by providing training and technical assistance and promoting improved health services related to tobacco cessation activities.
2. Coordinate outreach, education, and program promotion by exchanging program literature explaining operation of the Ohio Tobacco Quit Line.
3. Document program participants' current Medicaid eligibility status.
4. Representatives of ODH and ODM shall meet upon request of either party to review implementation of this Attachment E.

ARTICLE V. AMOUNT OF AGREEMENT

- A. ODM agrees to reimburse ODH up to Four Hundred Fifty Thousand and 00/100 Dollars (\$450,000.00) for State Fiscal Year (SFY) 2018, and Four Hundred Fifty Thousand and 00/100 Dollars (\$450,000.00) for SFY 2019, for a total not to exceed Nine Hundred Thousand and 00/100 Dollars (\$900,000.00) for the Attachment E period. All invoices shall indicate only the federal share of the cost of services provided. The State Match shall be provided by ODH. The parties agree that no further reimbursement will be sought under this Attachment E.
- B. ODH shall prepare proper invoices and Intra-State Transfer Vouchers (ISTVs) for reimbursement on a bi-weekly basis for actual allowable expenditures incurred and paid pursuant to responsibilities outlined in ARTICLES III and IV.

**ATTACHMENT F --
BUREAU FOR CHILDREN WITH MEDICAL HANDICAPS COST SETTLEMENTS**

**INTERAGENCY AGREEMENT
BETWEEN
OHIO DEPARTMENT OF MEDICAID
AND
THE OHIO DEPARTMENT OF HEALTH**

A-1819-04-0113F

RECITALS

The ODM Agreement Manager for purposes of this Attachment F is Christopher Carson, Section Chief, Financial Management, Planning and Rate Setting Section, Ohio Department of Medicaid, 50 West Town Street, Columbus, Ohio 43215, 614-752-5213, christopher.carson@medicaid.ohio.gov.

The ODH Agreement Manager for purposes of this Attachment F is Pat Londergan, Ohio Department of Health, 246 North High Street, Columbus, Ohio 43215, 614-728-7039, pat.londergan@odh.ohio.gov.

ARTICLE I. PURPOSE

This Attachment F will define the relationships and responsibilities between the parties for the conduct of desk reviews, interim settlements, field audits, and final settlements for ODH's Bureau for Children with Medical Handicaps (BCMh). BCMh is established under authority granted by Subchapter V of the Social Security Act (the Act), Title 42, Section 701, *et seq.*, of the United States Code, the Maternal and Child Health Block Grant (Title V) and administered under the authority granted by Sections 3701.021 through 3701.028, inclusive, of the Ohio Revised Code (ORC). This Attachment F is entered into in order to meet the requirements established under Title V and ORC 3701.023 relative to the financial accountability and administration of the BCMh program.

ARTICLE II. RESPONSIBILITIES OF ODM

A. ODM will:

1. Provide cost reporting forms to participating hospitals.
2. As deemed necessary, perform field audits or desk reviews to determine interim settlements and final settlements for cost reporting periods not yet settled for participating Title V hospitals.
3. As deemed necessary, conduct field audits, taking into consideration generally accepted accounting principles and generally accepted auditing standards under Title XIX of the Act (Medicaid). ODM will determine if the providers subject to audit are not in compliance with applicable laws and regulations of the State of Ohio and the Federal government.
4. Acknowledge that Title V and Title XIX audits may occur simultaneously.
5. Process financial transactions with Title V hospitals which result from field audits/desk reviews. ODM shall make interim or final settlements with Title V hospitals on behalf of ODH. ODM will keep ODH fully and timely informed of these financial transactions. In no instance shall ODM attempt to recoup more monies for Title V findings than the amount paid to the hospital by ODH. This amount is in total and shall encompass both inpatient and outpatient services as detailed on the hospital's cost report.
6. Provide Title V hospitals with the opportunity for a hearing in the event that a dispute arises concerning any field audit or desk review findings. If there are both Title XIX audit findings concurrent with Title V findings, ODM may hold one hearing on the combined audit issues. Hearings will be conducted in accordance with the requirements of ORC Chapter 119.

7. In the case of combined Title V and Title XIX hearings, ODM agrees to pay for the portion of the hearing costs attributable to Title XIX field audit and desk review issues. ODH is not liable for Title XIX hearing or audit costs.
8. Maintain records of field audit and desk review findings used as a basis for determining interim and final settlements, hearing results, hearing transcripts, time records, and actual audit cost/desk review information. These records will be made available by ODM for review by ODH.
9. Maintain a process in collaboration with ODH to allow ODM and ODH to complete Title V and XIX cost settlements for providers subject to cost settlement using the scenarios included in Table 1 to this Attachment F, resulting in the following payment structure:
 - a. Participating Title V hospitals receiving Title XIX (ODM) in addition to Title V (ODH) funding are required to file an annual cost report with ODM. Based on this cost report ODM reconciles the information for both Title XIX and Title V to determine if monies are owed to or from the hospital for both programs.
 - i. **Title V hospital reconciliations where ODM makes Title V payments on behalf of ODH.** If the hospital is to receive additional Title V monies, ODH authorizes ODM to make payment on behalf of ODH and ODH agrees to reimburse ODM for the additional Title V funds paid to the hospital by ODM in an amount up to Eighty Thousand and 00/100 Dollars (\$80,000.00).
 - ii. **Title V hospital reconciliations where ODM collects Title V monies on behalf of ODH.** If the hospital is receiving Title XIX monies from ODM and owes Title V monies to ODH, ODH authorizes ODM to net these amounts and collect these amounts. ODM agrees to reimburse ODH for the Title V monies collected by ODM on behalf of ODH in an amount up to One Million and 00/100 Dollars (\$1,000,000).

ARTICLE III. RESPONSIBILITIES OF ODH

A. ODH will:

1. Provide ODM with adequate cost-settlement information as requested by ODM. This information may include charges, days of coverage, payments made by ODH, as well as other data necessary for cost settlement.
2. Prepare and submit invoices and ISTVs to ODM for amounts due to ODH for Title V and Title XIX interim and final settlements resulting from the scenarios contained in Table 1 of this Attachment F.
3. Maintain a process in collaboration with ODM to allow ODM and ODH to complete Title V and Title XIX cost settlements for providers subject to cost settlement using the scenarios and resulting in the payment structure cited in ARTICLE II, Section I, above.

ARTICLE IV. AMOUNT OF AGREEMENT

- A. ODH agrees to reimburse ODM up to Eighty Thousand and 00/100 Dollars (\$80,000.00) in State Fiscal Year (SFY) 2018, and up to Eighty Thousand and 00/100 Dollars (\$80,000.00) in SFY 2019 for a total of One Hundred Sixty Thousand and 00/100 Dollars (\$160,000.00) that may be reimbursed by ODH to ODM for the period set forth in this Attachment F. This amount consists of two primary activities (administration and cost settlements) performed by ODM on behalf of ODH. Reimbursement for administration shall not exceed Twenty Thousand and 00/100 Dollars (\$20,000.00) per state fiscal year and reimbursement for cost settlements shall not exceed Sixty Thousand and 00/100 Dollars (\$60,000.00) per state fiscal year.
- B. ODM agrees to reimburse ODH up to One Million and 00/100 Dollars (\$1,000,000.00) in SFY 2018 and up to One Million and 00/100 Dollars (\$1,000,000.00) in SFY 2019, for a total of Two Million and 00/100 Dollars (\$2,000,000.00) for the Agreement period, for Title V hospital reconciliations where ODM collects Title V monies on behalf of ODH.

- C. It is understood that ODH will not reimburse ODM for those hearing costs arising out of a Title XIX program audit.

Ohio Department of Medicaid & Ohio Department of Health
Title V Hospital Cost Settlement Payment Scenarios (revised 12/11/15)

Scenario	Hospital Settlement Amount (A)			PROCESS
	ODM	ODH	Total	
	A Title XIX	B Title V	A + B	
1	\$4	\$3	\$7	ODM and ODH each should receive payment from the hospital (Title XIX and V funds respectively) = \$7 *ODM normally receives the total settlement amount and deposits the Title V funds directly into the ODH account = \$3 (NO ISTV needed)
2	(\$4)	(\$3)	(\$7)	ODM and ODH each pay the hospital (Title XIX and V funds respectively) *ODH should submit E-mail/memo to ODM confirming that they paid the hospital (check/EFT number, date and amount) = \$3
3	\$0	\$3	\$3	ODM Receives Title V monies from the hospital = \$3 ODM will deposit all funds directly into the ODH account. = \$3
4	\$0	(\$3)	(\$3)	ODH Pays provider for Title V = \$3 No Title XIX funds are involved - ODH should submit E-mail/Memo to ODM confirming that hospital has been paid = \$3
5	(\$4)	\$3	(\$1)	ODM pays the hospital the difference between the program total = \$1 ODH prepares ISTV to collect Title V funds from ODM = \$3
6	\$4	(\$3)	\$1	ODM receives the difference between program total from hospital = \$1 *ODM prepares ISTV to collect the Title V monies from ODH = \$3
7	(\$3)	\$4	\$1	ODM receives the difference between program total from the hospital = \$1 ODM deposits hospital payment into ODH account = \$1 ODH prepares ISTV to collect remaining balance from ODM = \$3
8	\$3	(\$4)	(\$1)	ODH pays the hospital the difference between the program total = \$1 ODM prepares ISTV to collect funds from ODH = \$3

(A) Provider Owes Agency / (Agency Owes Provider)

ATTACHMENT G - DEFINITIONS
INTERAGENCY AGREEMENT
BETWEEN
THE OHIO DEPARTMENT OF MEDICAID
AND
THE OHIO DEPARTMENT OF HEALTH

A-1819-04-0113G

Application for Health Coverage and Help Paying Cost (ODM07216)	The ODM form 07216 is the federally designed single streamlined application that gathers information necessary to determine eligibility for Medicaid or subsidized health coverage through the federal marketplace, and can be used to refer applicants to CFHS, WIC, HMG, and/or BCMH, as needed.
Catalogue of Federal Domestic Assistance (CFDA)	A database of all federal programs available to state and local governments.
The Children with Medical Handicaps Program (CMH)	The Children with Medical Handicaps Program (BCMh) is a health care program in the Ohio Department of Health (ODH). BCMH links families of children with special health care needs to a network of quality providers and helps families obtain payment for the services their children need.
Children with Special Health Care Needs (CSHCN)	Children who have or are at an increased risk for a chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally.
Clearance Review	A step in the rule-making process that allows for public to review and comment on posted draft Ohio Administrative Code rules.
Coordinated School Health Program and Physical Activity, Nutrition, and Tobacco (CSHP- PANT)	The project's major focus is to develop collaboratives to implement best practices in response to the health and education needs of local school communities.
Corrective Action Plan (CAP)	A plan for monitoring compliance review findings of ODH activities by ODM.
County Departments of Job and Family Services (CDJFS)	The Ohio agencies responsible for the day-to-day implementation of state and federal financial and medical assistance, such as Temporary Assistance for Needy Families, Ohio Works First, Medicaid, Expedited Medicaid, Healthy Families, Healthy Start, and Disability Assistance (DA); as well as social services, work programs, food assistance, and services to the elderly.
Disability Assistance	Consists of ODM-based Disability Medical Assistance, and Disability Financial- Assistance programs, acting as a safety net for those not eligible for other services.

Early Childhood Comprehensive Services	An initiative of the US Department of Health and Human Services which provides grants to States and organizations with significant experience developing and implementing statewide strategies to build systems that improve the health of young children.
Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)	The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT services are key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services as described in 42 U.S.C. 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.
Expedited Medicaid	A Medicaid benefit available to pregnant women for prenatal care for 60 days. This benefit does not include hospital coverage.
Federally Qualified Health Centers (FQHC)	A public or private non-profit organization which receives federal grant funding under Section 330 of the U.S. Public Health Service Act to provide comprehensive primary health care and supportive services to all patients regardless of ability to pay. Health centers must serve federally designated Medically Underserved Areas/Populations, and may be funded to serve the community at large or to focus their services on special populations (migrant farm workers, homeless or residents of public housing).
Health Professional Shortage Areas	A federal designation of under serviced (indicating an area) population group or facility that has an inadequate number of providers who cannot be easily accessed within a reasonable travel time or distance. HPSAs may be designated for primary care, mental health or dental health. The designation is a prerequisite for participation in various state and federal recruitment/retention programs.
Healthchek Services	“Healthchek” services is Ohio's brand name for the federally mandated Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services as described in 42 U.S.C. 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.
Healthchek Coordinator	The staff person or primary liaison within the CDJFS who is responsible for the operation of EPSDT/Healthchek services.
Healthchek Screenings, Diagnosis, Treatment poster	The Healthchek Screenings, Diagnosis, Treatment poster explains the services that are available to all Medicaid eligible individuals under the age of 21 years. The poster must be prominently posted in an area where Medicaid applications are distributed or accepted and where it can be seen by the maximum number of consumers.
Health Promotion Consultants	Provides a nurse consultant to work with licensed child care centers and regional resources and referral centers to make health and safety information available to child care providers throughout the state.

Healthy Families	A Medicaid program that provides comprehensive health coverage for income eligible families. Families include parents/caregivers and their dependent children.
Healthy Start	A Medicaid program that provides comprehensive health coverage for income eligible individuals up to age 19, and income eligible pregnant women of any age. Healthy Start Coverage for Pregnant women spans throughout the entire pregnancy and up to 60 days after the baby is born.
Home Visiting	The Home Visiting program provides parenting education for pregnant women and first time mothers. The program helps families with young children connect with resources so the child(ren) can start school healthy and ready to learn.
Individuals with Disabilities Act (IDEA)	Part C of IDEA provides assistance to states to provide early intervention (birth through age 2 years) programs (34 CFR Part 303).
Infants and Toddlers with Disabilities	Defined by IDEA as children from birth through age 2 years.
Intrastate Transfer Voucher (ISTV)	A voucher utilized for intrastate (interagency) transfers of funds.
Maternal and Child Health Program (MCHP)	The Maternal and Child Health Program is an organized community effort to eliminate health disparities, improve birth outcomes and improve the health status of women, infants and children in Ohio.
Maternal and Child Health (MCH) Services block grant	Provides grants under Title V of the Social Security Act, administered by the Maternal and Child Health Bureau of the federal Department of Health and Human Services, to ensure the health of mothers, infants, children, adolescents, and CSHCN.
Medicaid Administrative Match	Reimbursement to government entities for providing administrative activities related to outreach and coordination for those eligible for or receiving Medicaid benefits.
Medicaid Buy-In for Workers with Disabilities (MBIWD)	This is a Medicaid program for individuals aged 16 through 64 who have a disability determination by the Social Security Administration. The program allows Individuals to earn more money, and retain more resources than would be allowed with most other Medicaid categories.
Medicaid Consumer	An individual who has been determined to be eligible for the Ohio Medicaid Program.
Medicaid Managed Care Plan	A Medicaid managed care plan is a health insurance corporation (HIC), as defined in section 1751.01 of the Ohio Revised Code, and is licensed in the state of Ohio, and has entered into a provider agreement with the Ohio Department of Medicaid in the managed care program pursuant to Chapter 5160-26 or 5160-58 of the Ohio Administrative Code.

Medically Underserved Area/Population	A federal designation of under service, indicating an area or population group that has a shortage of personal health services. The designation is based on the Index of Medical Underservice, which considers the ratio of primary medical care physicians per 1,000 population, infant mortality rate, poverty level, and population age 65 or over. The designation is a prerequisite for participation in the Federally Qualified Health Center program.
ODH Helpline (1-800-755-GROW [4769])	A toll-free telephone information and referral service for the use of parents, consumers, professionals, and the general public to access information about health care providers and practitioners who provide health care services through MCH, WIC, and Title XIX and Title XXI programs, and about other relevant health and health-related providers and practitioners.
Ohio Medicaid Consumer Hotline (1-800-324-8680)	A toll-free customer service line for individuals to access information about Medicaid, case specific information, Medicaid application assistance, locate Medicaid health care providers, and enroll in Medicaid Managed Care Plans.
Ohio Medicaid Information Technology System	System designed to process and store Medicaid Claims.
Ohio Works First	Ohio's name for the federal Temporary Assistance for Needy Families (TANF) program, which provides cash assistance through emphasizing employment and self-sufficiency.
OPTIONS	A public-private partnership between the Ohio Dental Association and the Ohio Department of Health. In OPTIONS, dentists willing to donate or discount services for uninsured Ohioans with poor access to dental care, specifically the poor and working poor of all ages, low income seniors, and individuals who are medically or physically challenged, are matched with qualified patients by a referral coordinator.
Oral Health	Emphasizes community-based programs of disease prevention, education and primary dental care to promote and improve the oral health of Ohio citizens.
Pregnancy-Related Services (PRS)	Services available for all pregnant women who receive Medicaid. The services span from the date of identification of pregnancy through sixty days after the end of the pregnancy.
Pregnancy Related Services Coordinator	The staff person or primary liaison within the CDJFS who is responsible for the operation of Pregnancy Related Services.
Primary Care and Rural Health Programs	Supports community-based programs to improve and expand access to comprehensive primary care in urban and rural communities through a network of safety net primary care, mental health, and dental health services.

Patient-Centered Medical Home	Health care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, culturally effective and delivered by a physician who knows the patient and works with the family to develop a partnership of mutual responsibility and trust.
Reproductive Health and Wellness Program (RHWP)	A community-based program that uses a combination of federal, state, and local monies to offer reproductive health services to low income women and men of reproductive age in Ohio. The RHWP is designed to improve the overall health and well-being of women, men, and children by improving health care access, promoting healthy lifestyles and encouraging the establishment of a reproductive life plan.
Rural Health Clinics (RHCs)	Designated clinics in underserved rural areas eligible for funds to increase primary health care.
Temporary Assistance for Needy Families (TANF)	Administered by the Office of Family Assistance of the federal Department of Health and Human Services, TANF offers grants to states for flexible welfare programs.
Title V of the Social Security Act	Maternal and Child Health Services Block Grant.
Title XIX of the Social Security Act	Grants to States for Medical Assistance Programs.
Title XXI of the Social Security Act	State Children's Health Insurance Program.
Women, Infants and Children (WIC)	The Special Supplemental Nutrition Program for Women, Infants and Children which helps income eligible pregnant and breastfeeding women, women who recently had a baby, and infants and children up to the age of five years who are at health risk due to inadequate nutrition by providing supplemental, highly nutritious foods, nutrition and breastfeeding education, and referral to prenatal and pediatric health care, and other maternal and child health and human services programs.
Youth Risk Behavior Surveillance System (YRBS)	Monitors health-risk behavior in young adults, conducted by the Centers for Disease Control and Prevention (CDC), with state and local agencies.

ACRONYMS

ABD	Aged, Blind, and Disabled, an eligible group for Medicaid benefits
AFC	A federal program for the administration of foster care recipients placed in out-of-home arrangements
CFDA	Catalogue of Federal Domestic Assistance
CMS	Centers for Medicare and Medicaid Services, an agency of HHS which administers Medicare, Medicaid, and the State Children's Health Insurance Program

FFP	Federal Financial Participation, a funding mechanism for federal government participation in state program administration costs
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996, providing national standards for protection of health information
LPHD	Local public health department, a city health district or a general health district as defined in Section 3709.01 of the Ohio Revised Code (ORC)
MAC	Medicaid Administrative Claiming, a program to provide methods for claiming federal reimbursement for the costs of Medicaid administrative activities
MER	Medicaid Eligibility Rate
OHIW	Office of Health Improvement and Wellness
PHI	Personal Health Information