

MEDICAID SELF-ASSESSMENT CHECKLIST

General Provision Standards:

Standard	Documentation Evidence	Self Assessment	Checklist	
			YES	NO
I-A.1. The Board adheres to Federal and State Medicaid laws, rules and regulations in accordance with the Peer Certification Standards of the Ohio Association of County Behavioral Health Authorities.	Assurance Statement	Does the Board have an assurance statement on file?	I-A.1.	
I-A.2. Consumers have freedom of choice in selecting a service provider.	Consumer Satisfaction Surveys/ Consumer feedback Review of Consumer Satisfaction on file at the Board office Any complaints filed by consumers requesting to seek services Assurance Statement	Were there any consumer complaints regarding selecting a service provider?	I-A.2-1	
		Were any consumers denied their option of selecting a service provider?	I-A.2-2	
		Does the Board have an assurance statement on file?	I-A.2-3	
I-A.3. The Board complies with applicable federal and state law in taking no action that might limit the amount, duration, or scope of services provided.	Assurance Statement	Does the Board have an assurance statement on file?	I-A.3.	

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<p>I-A.4. The Board adheres to the requirements of the “Guidelines and Operating Principles for Residency Determinations in MACSIS among CMH ADAS and ADAMH Boards”, as evidenced by a policy.</p>	Policy	Does the Board’s policy incorporate MACSIS residency guidelines?	I-A.4.	
<p>I-A.5. Board enrolls Medicaid eligible consumers for all residents of the Board service area into MACSIS when a complete and accurate “New Member enrollment/ UCI request” form is received.</p> <p>Clarifier: All Medicaid eligible consumers shall be enrolled and a UCI communicated to the provider within 5-10 business days.</p>	Enrollment Data	Did the board enroll Medicaid-eligible consumers for all residents of the Board service area into MACSIS when a complete and accurate New Member enrollment UCI request form was received?	I-A.5-1	
		Did the Board forward UCI information to the provider within 5-10 business days once a complete and accurate New Member enrollment UCI request form was received?	I-A.5-2	
<p>I-A.6. The Board complies with the federal requirements within the Deficit Reduction Act of 2005, including apprising staff of prompt reporting requirements for suspected fraud, the means to report and afforded the reporter under the law.</p> <p>Clarifier: This standard applies to all Boards who receive or make annual payments of at least \$5,000,000 under Ohio’s Medicaid Plan.</p>	Policy Signed Acknowledgement Educational Materials	Has the Board established written policies for all employees that provide detailed information about the Federal False Claims Act, and other state and federal laws?	I-A.6-1	
		Has the Board provided education to its employees regarding False Claims Recovery Under the Deficit Reduction Act of 2005, and rights of employees to be protected under the act as whistleblowers?	I-A.6-2	
		Has employees of the Board signed and acknowledged that they have received education about the False Claims Reduction Act of 2005?	I-A.6-3	

Contracting Standards:

Standard	Documentation Evidence	Self Assessment	Checklist	
			YES	NO
<p>I-B.1. The Board utilizes only the ODMH and ODADAS issued standardized Medicaid provider payment agreement as written for all Medicaid services.</p> <p style="text-align: right;">Critical</p>	Copy of agreement on file from ODMH and/or ODADAS	Does the Board have copies of the Standardized Medicaid Provider Payment Agreements on file?	I-B.1.	
<p>I-B.2. All Reimbursed Medicaid services are provided by agencies certified by an Ohio Department of Mental Health (ODMH) or Ohio Department of Alcohol and Drug Addiction Services (ODADAS) certified agency.</p>	List of all Service Providers that are reimbursed through Medicaid within the Board's Service Area	Does the Board retain copies of agencies' certifications on file for each provider?	I-B.2-1	
	Copies of Service Providers, State Department Certifications	Are the certification copies current?	I-B.2-2	
<p>I-B.3.Board adheres to 42 CFR 431.51 "Free Choice of Providers" assuring that a Medicaid contract is issued to any requesting agency within the Board service area that is ODMH or ODADAS certified, as evidenced by a policy.</p> <p>Clarifier Boards are required to pay a Medicaid claim from a provider from any county, but must issue contracts to any requesting certified agency within their Board service area</p>	Policy	Does the Board have a policy assuring that a Medicaid Contract would be issued to any requesting agency within the Boards service area that is ODMH or ODADAS Certified?	I-B.3	
<p>I-B.4. Board has current copy of ODJFS Medicaid Standardized provider agreements on file for all certified Medicaid providers within the Board's service area.</p>	ODJFS Medicaid Standardized Provider Agreements for each Certified Medicaid Provider within the Board's Service Area	Are there current copies of all ODJFS Medicaid Standardized Provider Agreements for each Certified Medicaid Provider within the Board's Service Area?	I-B.4.	

Standard	Documentation Evidence	Self Assessment	Checklist	
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I-B.5. The Board has a current ODMH and or ODADAS Board/ State Department Medicaid agreement on file.	Board/ State Department Medicaid Agreement	Is there a current copy of the Board/ State Department(s) Medicaid Agreement?	I-B.5.	

Payment Standards:

Standard	Documentation Evidence	Self Assessment	Checklist	
			YES	NO
I-C.1. Medicaid Claims are always paid at 100% (match +FFP) of the Medicaid approved rate prior to seeking reimbursement for FFP. The Remittance Advice (RA) will be utilized as the source for payment amount. Critical	Remittance Advice Cost Information for providers CPE	Does the Remittance Advice show that 100% of the Medicaid Claim has been paid (match + FFP)?	I-C.1.	
I-C.2. The Board uses only non-federal (public) funds to pay 100% of a Medicaid Claim prior to seeking reimbursement for FFP. Clarifier The requirement in 42 CFR 433.51(C) is that “the public funds are not Federal funds or are Federal funds authorized by Federal law to be used to match other Federal Funds. Donations from private agencies are also not considered proper match Critical	Assurance Statement Fiscal Documentation CPE	Does the Board have Fiscal documentation to support the standard?	I-C.2-1	
		Does the Board have a Medicaid Assurance Statement on file?	I-C.2-2	
		For all Medicaid match, did the board use only non-federal (public) funds or federal funds that were authorized by Federal law to be used to match other Federal Funds?	I-C.2-3	
I-C.3. Payment for covered Medicaid services are made within 30 days of the receipt of a remittance advice which complies with the submission specifications stipulated in rule 5101:3-1-19.3 of the Ohio Administrative Code (OAC).	Documentation of Reimbursed Claims and Remittance Advice (NOTE- Sometimes remittance advice and payment occurs at the same time)	In comparing the total # of Reimbursed Claims against the Remittance Advice, is payment for covered Medicaid services made within 30 days?	I-C.3.	

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<p>Clarifier Resubmission of claims is paid utilizing the same process as initial submissions.</p> <p>Payment period is calculated by the time the Board sends the claim to the County Auditor, not by when the County Auditor issues the check.</p> <p style="text-align: right;">Critical</p>				
<p>I-C.4. Board pays the provider no more than the approved rate up to the Medicaid ceiling for Medicaid services, less any third party payments.</p>	<p>Approved Rate Sheet</p> <p>Remittance Advice</p>	<p>Has the Board paid the provider no more than the approved rate up to the Medicaid ceiling for Medicaid services?</p>	<p>I-C.4.</p>	
<p>I-C.5. The Board pays Medicaid claims for all residents of the Board's service district whether these services are provided by contract agencies within the Board service area, or in another Board service area.</p>	<p>Documented Evidence of Payment</p> <p>MACSIS generated report of Medicaid Claims by Provider</p> <p>Procedures designed to show how the Board pays Medicaid claims for all residents of the Board's service district</p>	<p>Did the Board pay Medicaid claims for all residents of the Board's service district?</p>	<p>I-C.5.</p>	
<p>I-C.6. All Medicaid claims are processed through the Multi-Agency Community Services Information System (MACSIS). (Medicaid/Medicare crossover claims are the exception).</p>	<p>Board claims data to determine which Board/State funded providers are not using MACSIS</p>	<p>Are all Medicaid Providers utilizing MACSIS?</p>	<p>I-C.6.</p>	

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I-C.7. Board has a procedure to work the Medicaid RETRO eligibility, Held, and mismatched reports to assure that the correct source of payment is used, and prompt payment occurs for Medicaid eligible services.	Policies and Procedures	Does the Board have a procedure for Medicaid RETRO eligibility?	I-C.7-1	
		Does the Board have a procedure for Held reports?	I-C.7-2	
		Does the Board have a procedure for Mismatched reports?	I-C.7-3	
I-C.8 The Board uses the state issued modified Certified Public Expenditure (CPE) process to demonstrate the source of funds used to pay for Medicaid covered behavioral health services delivered by providers or alcohol	CPE Screenshot Shadow Report	Is there evidence where the Board has certified the Board's last quarter public expenditures?	I-C.8.	

Monitoring and Auditing Standards:

Standard	Documentation Evidence	Self Assessment	Checklist	
			YES	NO
I-D.1. The Board ensures that all contracted CMH/AOD agencies have an independent audit in accordance with ODMH/ODADAS Financial and Compliance Audit Guidelines, and Auditor of State rules pursuant to ORC 117.20. The Board ensures that a Circular A-133 audit is completed as required.	Records of Contracted CMH/AOD agencies' independent audits Records of Circular A-133 audits	Can the Board document that each provider of Medicaid Services completed an independent audit, within required timeline?	I-D.1-1	
		Can the Board document that a Circular A-133 audit was completed as required?	I-D.1-2	

<p>I-D.2. The Board retains all records relating to costs, and supporting documentation for invoices submitted to ODJFS by ODMH or ODADAS for a minimum of 6 years after final payment or if an audit has been started records shall be retained until the audit is complete past the six year time period</p>	<p>Cost Records Policies and Procedures</p>	<p>Does the Board retain records relating to costs, and supporting documentation for invoices submitted to ODJFS by ODMH or ODADAS?</p>	I-D.2-1	
		<p>Are records maintained for a minimum of 6 years after final payment?</p>	I-D.2-2	
		<p>Does the Board have a policy regarding the maintenance and storage of Medicaid records?</p>	I-D.2-3	
		<p>Does the policy include a requirement that all cost data will be maintained for a minimum of six years?</p>	I-D.2-4	

The Ohio Association of

COUNTY
BEHAVIORAL
HEALTH
AUTHORITIES



MEDICAID ASSURANCE STATEMENT

As reflected in the Medicaid Self-Assessment Checklist completed on _____, The
_____ (BOARD) adheres to Federal and State Medicaid
laws, rules and regulations in accordance with the Certification Standards of The Ohio
Association of County Behavioral Health Authorities.

Signed:

Executive Director

Date