Department of Health Care Services (DHCS)
Annual Medi-Cal Tribal and Designee Meeting
February 26, 2014- Questions and Responses as of 5/23/14

Eligibility

1. Eligibility workers in San Diego county are still using non-MAGI methodology for patients that are not going to Covered California to enroll in Medi-Cal, it is our understanding they should apply the MAGI methodology to determine Medi-Cal eligibility, is this correct?

   DHCS Response: Yes, eligibility workers are supposed to be using MAGI to determine Medi-Cal eligibility. DHCS followed up on this issue and confirmed that county eligibility workers are now applying MAGI correctly in San Diego County. No further follow-up is needed at this time.

2. In regards to a new aid code X6 under Covered California, is this a new aid code? The description says, "American Indian/Alaska Native (AI/AN) CSR only, with no income test", what is this? Should this be an aid code for our clients?

   DHCS Response: The X6 Aid Code is for AI/AN's enrolled in a Covered CA health plan. It denotes that the member has Cost Sharing Reductions (CSR) and that there is no income test for eligibility determinations. The individual applied for Covered CA without any subsidies but still receives CSR because they are AI/AN. This aid code should not be assigned for Medi-Cal members, but may be assigned to AI/AN individual participating in a Covered CA health plan. To the extent that your program is contracted to see Covered CA beneficiaries you may see the X6 aid code assigned to those members. To see a full description of all the Affordable Care Act (ACA) aid codes please visit: http://www.dhcs.ca.gov/services/medi-cal/Documents/Eligibility%20and%20Enrollment%20Workgroup/AidCodesandStatuswMap.pdf

3. Can beneficiaries enroll in both the Commodities program and the CalFresh program?

   DHCS Response: Food Distribution Program on Indian Reservations (FDPIR) provides U.S. Department of Agriculture (USDA) foods to low-income households living on Indian reservations and to American Indian households residing in approved areas near reservations. Many households participate in FDPIR as an alternative to the Supplemental Nutrition Assistance Program (SNAP), because they do not have easy access to SNAP offices or authorized food stores. The SNAP program is known as CalFresh in California.

   FDPIR programs are administered locally by either a Tribal Organizations or an agency of a State government. Households are certified based on income standards set by the Federal government and must be recertified at least every 12 months. Per federal guidelines households **may not** participate in FDPIR and SNAP (CalFresh) in the same month. Further information of the FDPIR can be found at: http://www.fns.usda.gov/sites/default/files/pfs-fdpir.pdf.

4. How would the county know if the beneficiary is enrolled in Cal Fresh?

   DHCS Response: All CalFresh beneficiary information is contained in the Statewide Automated Welfare Systems (SAWS). The counties have access to the SAWS and can look up beneficiary information.

5. Why did DHCS only use CalFresh for express lane eligibility and not the FDPIR program?

   DHCS Response: The Express Lane Enrollment (ELE) Project is based on federal guidance designed to help streamline Medi-Cal enrollment for newly eligible adults. For this particular project, the targeted populations are approximately 600,000 adults (ages 19-64) and 150,000 children (under age 19) currently enrolled in CalFresh, but who are not Medi-Cal beneficiaries. ELE allows CalFresh enrollees to affirm (opt in) they want Medi-Cal without having to submit a Medi-Cal application.

   The Centers for Medicare and Medicaid Services (CMS) issued State Health Official (SHO) letter regarding using SNAP as MAGI enrollment strategy in May 2013. DHCS followed the CMS guidance to develop the ELE project described in response to question 2 above. A copy of the SHO letter can be viewed at: *http://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Express_Lane/ExpressLane-Letter2.pdf*

Medi-Cal Denial Letter for Purchased/Referred Care (PRC)

6. Is there a document available from Covered California that can be used as proof of ineligibility/denial for Medi-Cal?

   DHCS Response: Per the Federal Indian Health Services-California Area Office, the use of the Covered CA letter would be considered a local policy issue, but that the letter could be considered sufficient proof of Medi-Cal denial for PRC provided the issue date is current.

Mental Health Services

7. Will Associate Social Workers (ASWs) be covered under mental health coverage? What is the availability of billing Associate Social Workers (ASWs) under the mental health component of managed care? Currently we cannot bill for ASWs and would like more information on this.

   DHCS Response: Yes, ASWs are included as providers of mental health service effective January 1, 2014. State Plan Amendment (SPA) 14-012, adding Licensed Marriage and Family Therapists (MFT) & Registered Interns as Mental Health Providers was approved by CMS on May 2, 2014. SPA 14-012 allows ASW's to provide services under the supervision of a licensed mental health professional, in accordance with the requirements of applicable state laws.

Reconciliation of Claims

8. Is there a requirement to complete 2013 data prior to submitting the retro-reconciliation?

   DHCS Response: Reconciliations are based on the clinics' Fiscal Year end. For example, a normal reconciliation is required for the period 1/1/13-12/31/13. However, Code 2 claims prior to 1/1/13 will be included in the retro-reconciliation.

9. What is the timeframe for submission of the retro-active reconciliation?

   DHCS Response: Providers were given 150 days to submit the retro-reconciliation. The due date is June 1, 2014.

10. What is the timeframe for a normal reconciliation? Where is the citation for this requirement?

    DHCS Response: Providers have 3 years to submit reconciliation forms as required by Welfare and Institutions Code, Section 14170. To view a webinar on the reconciliation process for IHS/MOA providers please visit: http://www.dhcs.ca.gov/services/rural/Pages/PRHMeetingsandWebinars.aspx

11. Where does a clinic send a request for a code 2 rate adjustment?

    DHCS Response: Providers can submit the request for a Code 2 to the DHCS Audits and Investigations Division (A&I) clinic mailbox at: clinics@dhcs.ca.gov

12. With the rural expansion of managed care, under what circumstances is a Code 2-Medicare Crossover billed?

    DHCS Response: Currently, all Medi-Cal beneficiaries are not enrolled in managed care; Code 2-Medicare Crossover claims are required for beneficiaries with Medicare coverage who are not enrolled in a Medi-Cal managed care plan.

13. What payment data is required for the reconciliation?

    DHCS Response: A&I will provide payment data free of charge for the retroactive reconciliation of Code 2-Medicare Crossover claims only. The payment data provided will identify all billing codes for paid claims and will be summarized monthly. Payment data for reconciliation outside of the retroactive period is available through Xerox; however, there is a charge to the provider for the reports when ordered through Xerox.

14. Is Code 18-Managed Care Differential Rate the code required for Medicare patients enrolled in a managed care plan and not a Code 2-Medicare Crossover?

    DHCS Response: Yes, Code 18 must be billed for all Medi-Cal Managed Care Plan beneficiaries; Code 2 is billed for Medicare patients not enrolled in a Medi-Cal managed care plan.

Substance Use Disorder Services (SUDS)

15. Why are Certified Substance Abuse Counselors not included as billable providers?

    DHCS Response: Agencies that are certified as Drug Medi-Cal Providers are able to employ and bill for the services of Certified AOD (Alcohol and Other Drug) Counselors. Certified AOD counselors are not reimbursable providers in IHS/MOA facilities that are not certified Drug Medi-Cal providers.

16. In regards to Drug Medi-Cal, we were told that the county has to verify there are no other programs available in the county before an Indian Health Program clinic can enroll as a Drug Medi-Cal provider. Is this correct?

DHCS Response: No it is not. If a county refuses to contract with an Indian Health Program there may be an option for that program to contract directly with the State Department of Health Care Services Drug Medi-Cal Program. Please contact Robert Maus of the Substance Use Disorder Prevention, Treatment and Recovery Services Division at (916) 323-1074 for information on how to contract with DHCS for Drug Medi-Cal Services or to discuss any issues regarding contracting with your local county.

17. Why can't out of state youth residential treatment center (YRTC) services be available for adults?

    DHCS Response: Public Law 102-573 Sec 704, as codified in Title 25 U.S.C 1665c is a federal law that directs the Indian Health Service to develop and implement a program that provides treatment for Indian youth who are alcohol and substance users/abusers. The eleven IHS funded YRTCs accept youth ages 12-18. As a result of the expanded services to Medi-Cal eligible adults, the Department of Health Care Services is seeking an 1115 Waiver for Drug Medi-Cal Substance Use Disorders (SUD) . The overall purpose of the waiver is to create an organized delivery system of SUD services, including residential treatment. DHCS is committed to actively engaging its partners and stakeholders to ensure the best possible planning, delivery and monitoring of MH/SUD services. Please email questions, comments, or concerns to: MHSUDStakeholderinput@dhcs.ca.gov For additional information regarding SUD stakeholder information please go to: http://www.dhcs.ca.gov/Pages/DHCSBusinessPlanforMentalHealthandSubstanceUseDisorderServices.aspx

18. When the pending Substance Use Disorder State Plan Amendment is approved, is the reimbursement in addition to our Indian Health Service/MOA rate?

    DHCS Response: No, it is an alternative method of reimbursement and is not in addition to the IHS/MOA rate.

Tribal Advisory Process

19. Until a formal consultation process is in place, can you or will you provide our comments to Centers for Medicare and Medicaid Services (CMS)? Also can DHCS provide to Indian health clinics what is sent to CMS?

    DHCS Response: Please note that the cover letter for each SPA and Waiver proposal addresses the tribal and designees of Indian health programs advisory process and reports on comments received. DHCS does not routinely submit copies of the questions or responses unless requested by CMS. CMS is invited and present at all DHCS quarterly webinars and the annual meeting. In the event CMS inquires about feedback received, they are promptly directed to the DHCS Indian Health Program website where comments on proposals are posted. You may view that site at: http://www.dhcs.ca.gov/services/rural/Pages/Tribal_Notifications.aspx

    Additionally, Welfare and Institution Code Section 14100.3 requires DHCS to post all submitted state plan amendments (SPAs), federal waiver applications, requests for new waivers, waiver amendments (renewals or extensions) within ten business days from the date the department submits them to CMS.

The DHCS State Plan as well as approved, pending, or withdrawn SPAs can be viewed at: http://www.dhcs.ca.gov/formsandpubs/laws/pages/californistateplan.aspx

Information regarding waiver submissions can be accessed at: http://www.dhcs.ca.gov/services/medi-cal/Pages/MediCalWaivers.aspx and at: http://www.dhcs.ca.gov/provgovpart/pages/waiverrenewal.aspx

20. In regards to Tribal Notices, can you give us a heads-up on what is going to be sent out? We get the Tribal notices all at one time and do not have time to review and provide comments.

    DHCS Response: The Primary, Rural, and Indian Health Division (PRIHD) often does not get the tribal/designee notices from DHCS Divisions until the day the notices are scheduled to be sent out. PRIHD does release all notices on a flow basis and does not hold the release until the deadline. PRIHD will see if there is a way to get information on anticipated notices out prior sending the tribal/designee notice.

21. When we submit comments on Tribal Notices, we never know that you received our comments; can you send a confirmation that they were received?

    DHCS Response: Thank you for bringing this to DHCS attention. Every effort will be made to acknowledge the receipt of written comments.

Medi-Cal Managed Care

*Note that subsequent to this meeting. DHCS is convening a series of webinars designed to facilitate discussion and resolution of Managed Care issues between the plans and clinic contractors. For additional information on the webinars please visit: http://www.dhcs.ca.gov/services/Pages/PostImpManagedCareExp.aspx

Access to Acute and Specialty Care

22. We are using a Letter of Agreement (LOA) for some patients; however, it takes three weeks or longer and we have not been successful yet in that process.

    Response: Plans will complete a LOA or a Single Case Agreement on a case by case basis. Should additional assistance be needed please contact the Medi-Cal Managed Care Ombudsman by telephone at 1-888-452-8609 or by secure email to: MMCDOmbudsmanoffice@dhcs.ca.gov; Website: http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx or The Department of Managed Health Care Help Center can be reached by telephone at 1-888-466-2219; Website: http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_complaint.aspx

Contracting, Rates, and Communication Issues

23. Partnership Health Plan (PHP) suggested we sign a contract with Beacon, which is optional as an Indian Health Service/Memorandum of Agreement 638 Clinic (IHS/MOA). The IHS/MOA supersedes the authority of contracted plans; can we continue to bill the state as we did previously? PHP stated a definitive answer is needed from the state.

    Response: Rules differ depending on who you see; American Indian/Alaska Natives (AI/ANs) or non-AI/AN patients. If services are to AI/AN patients only, no contract is

required. However, if non-AIAN/ patients are served a contract is required.

24. When a MOA provider completes and submits the Medi-Cal Managed Care/ Non-Medical Exemption form for Native Americans that choose not to enroll in a Plan, a faxed response from DHCS is received approving the request; however, the Native American is still showing on the eligibility file as enrolled in the plan the following month. Assistance with this issue was unavailable from Health Care Options

    DHCS Response: DHCS would need samples to identify any issue with the enrollment status of a Native American requesting to disenroll to Fee-For-Service.
    Please send samples in a secure email to MMCD.TPGMC@dhcs.ca.gov

Managed Care and Behavioral Health

25. Where and how can issues with Beacon be addressed?
    - There is language in the contract that states if you bill Beacon you must accept that as full payment and cannot bill the state for the difference.

    DHCS Response: DHCS recommends that the provider contact the contracting plan to discuss these issues, however, as stated previously, rules differ depending on who you see; AI/ANs or non-AI/AN patients. If services are to AI/AN patients only, no contract is required. If non-AI/AN patients are served, a contract is required. The contract should not prohibit an eligible provider from billing for the wrap around payment from the State of California. Plan contact information can be found at:
    http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx

26. How are rates determined and negotiated with the state for county providers?

    DHCS Response: There is an actuarial process; it is a very robust negotiating process with the managed care plans, including county managed care plans. The rates are published in an annual report and are part of the budget process. Rates are published on the DHCS website:
    http://www.dhcs.ca.gov/dataandstats/rreports/Pages/MMCDFinancialReports.aspx

27. We are in a County Organized Health System (COHS) county, who takes the financial risk of treatment, the Clinic or County? Specifically, if a patient is sent to the hospital, would we as a clinic have to pay?

    DHCS Response: The COHS assumes the risk for hospitalized patients.

Provider Types

28. Beacon will not allow billing for Physician Assistant (PA) behavioral health visits.

    DHCS Response: Physician Assistants are supervised by physicians; claims cannot be billed directly for PAs, claims are billed by the physician.

Pharmaceutical/Formulary Issues

29. Providers must deal with different plan formularies.
    - This can be a serious issue for those patients who have been on a particular medication for a long time, but now must switch due to their assigned plan formulary.
    - Certain prescription claims can be denied when prescribed by a primary care provider rather than a specialist.
    - There is confusion about behavioral health medications: do they need prior authorization or a treatment authorization request.

    DHCS Response: Drug formularies are unique to each Plan. Plan Pharmacy Consultants are available to assist providers with questions. Health Plan contact information can be viewed at: http://www.dhcs.ca.gov/services/Pages/PostImpManagedCareExp.aspx

Comments Received

Managed Care-Access to Care
There has been a lot of training and outreach on the managed care rollout, thank you. California Rural Indian Health Board (CRIHB) - what is the availability and accessibility for enrollees to specialty care? We hang our hat on federal law, Medicaid law requires managed care plans must provide providers sufficient in number, type, geographic locations. Tribal health managed care enrollees, federal law requires this. Key health concerns have been raised here, we are doing our due diligence but at the end of the day, federal managed care rules apply, the state must comply. The Health and well-being of patients is our primary concern.

Asset Recovery
At the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG) meeting in Washington DC meeting topics included estate recovery and I want to thank you today for having it on the agenda, we know that what is discussed here today will be taken back to DHCS leadership. Also, regarding tribal funding, we recommend funding be restored and request that this be taken back to DHCS leadership as well. Regarding estate recovery, there appears to be a Secretary exemption available to enable states not to take the assets from beneficiaries or their descendants. Estate recovery is a key barrier to health care. If people believe their family lands will be taken away they will not enroll; therefore, not receive the healthcare needed and healthcare problems are then compounded. DHCS should assist us in identifying ways to achieve an exemption for American Indians in California.

YRTCs
Thank you for the information recently sent on the YRTCs, we know you are listening to us and appreciate it.

Indian Health Medi-Cal Data
In regards to the drop in number of visits for 2012-2013, we thought it was unique to us but we did a study and found that 2012-2013 was a healthier year, we pulled hospital admissions, Emergency Room visits, FQHC and RHC visits, found less demand for services, this could be a possible explanation of the decrease.

Reconciliation of Code 2 (Retro) Crossover Claims
In regards to the Code 2 Reconciliation, we reviewed the numbers, within our clinic we have 30% of Medi-Medi patients, we encourage everyone to look at this closely as the reconciliation amounts to quite a bit of reimbursement for the clinics.

Eligibility Determinations

Shasta County received 1,800 applications for Medi-Cal from Covered California in one weekend, they are being held as there is not enough staff to process these applications. The backlog is causing confusion for everyone, providers, counties, and especially patients.