CCA Monthly Roundtable | MINUTES

Meeting Hours: 2:00 PM – 4:00 PM Date: **1/17/2017**
2:00 PM – 3:00 PM CCT
3:00 PM – 4:00 PM CCA ALW

Conference Phone Line – **PLEASE NOTE NEW NUMBER**
*Line Phone Number: (800) 369-3310
*Participant Code: 42823

Standing Updates: **[3:00 – 3:10 pm]**

- Review of Minutes/Action Items
  - No edits to the meeting minutes.
  - The action item I have from our last meeting is clarification on waiver billing when the individual is receiving hospice services. The answer to this is that it depends on the individual's eligibility. If the individual's Medi-Cal eligibility is restricted to hospice services only then the provider will not be paid for providing waiver services as this is seen as a potential duplicate of services. You can determine this by checking the individual's Medi-Cal eligibility.
- ALW inbox / enrollment statistics
  - We are finishing review of October applications and have about 23 left to go for October. Moving on to November, we have 218. We are working through applications as quickly as possible.
  - We would like to review some of the most frequent errors we are seeing when processing applications. **Please be sure to share these notes with your staff.**
    - Please do not send a move in request if there's still an aid code or share of cost issue, as we will not be able to process it, and we will need to send it back. Please check eligibility prior to sending in the move in date.
    - Resubmitted applications may also need updated documents. Please make sure any document that is re-submitted is current.
    - Cases will not be held open if we have to return an application because the individual has lost eligibility, so be sure to check eligibility month to month. We will also return applications for any individual enrolled in Cal MediConnect. Cal MediConnect enrollment is now voluntary and an applicant may not have realized that they chose to enroll in Cal MediConnect. Please be sure and check for this with every applicant residing in a Coordinated Care Initiative (CCI) county.
  - Assessment / IR Inbox submission standards
    - We discovered an IT issue recently that affected the delivery of some of our secure emails. That issue has been resolved, however if your

emails were affected by this issue, we will honor the original submission date.

- If you are checking for status updates, given our review timeframe, we ask that you don't submit anything that is less than 60 days. If you have submitted an application, please don't e-mail us until after 60 days have passed because if it has been less than 60 days, we will not be checking status.

Gregory Cascante (Archangel) What is the current review timeframe for ALW applications?

Karli Holkko (DHCS) We are hovering around the three-month review timeframe, assuming that you submit a complete application to us, and we're able move it forward for review. We are trying to hire people and get them on board, it's just not happening very quickly for us, this leaves us very severely understaffed. Our current staff of nurses are doing a wonderful job of reviewing applications as quickly as possible.

Stephanie (Blossom Ridge) I'll submit an application, then get a request to send additional documentation. I send the additional documentation, then two or three months later, I get an email saying it's past 90 days and I need to resubmit everything again. This is happening quite often. So is it because of the shortage of staff, or do I need to resubmit the whole package again whenever I'm being requested to send additional documentation?

Karli Holkko (DHCS) During the screening of applications, we are not able to accept any application that missing documentation. If an application is returned, you will need to resubmit a complete package again. When you are resubmitting an application, keep in mind that the assessment tool and ISP need to be signed within the past 90 days. By the time we return the package and you send it back for screening, the assessment and ISP still needs to be current the as of the day it is resubmitted.

(Unidentified Individual) If we assess an individual for CCT and identify that ALW is the best option, do we need to do another assessment before we submit an application for ALW?

Karli Holkko (DHCS) I think it depends on the timeframe. Even though both program's use the same assessment tool, it's two different programs. It is best to do another assessment due to the timing of the two activities. Just because you are an agency working both CCT and ALW, it is best to do a different assessment.

Topics: **[3:10 – 4:00 pm]**

1. ALW Daily Rates / Monthly SSI Rate
   - The ALW daily-tiered rates have increased as of January 1, 2017. Unfortunately, we experienced a delay when we requested the system change to increase the rates and the new rates have yet to be implemented. However, once the new rates have been implemented, Xerox will reprocess all of the claims that were underpaid. For now, when facilities submit claims, Xerox will still pay the old rate until the system update has been made. When communicating with your facilities, let them know that yes, the rates have

increased, but until the system change takes place, they will still be paid at the old rate.

- The Monthly SSI rates have also increased. For 2017, for those with SSI income of $1,158.37, the amount payable to the facility for room and board is $1,026.37. This accounts for a minimum personal and incidental needs allowance of $132. For those with income of $1,178.37 or greater, the amount payable for room and board is $1,046.37. This accounts for a minimum personal and incidental needs allowance of $132. It is very important that each ALW participant keeps a minimum of $132 per month to cover their personal and incidental needs. This information is on our web site also.
  Elizabeth Mason (RICV) The $132.00 doesn't kick in until the person is at the rate of the $1,158.00 a month, or does that kick in at the minimum SSI level? I thought it was for any facility like a hospital.
  Karli Holkko (DHCS) It's my understanding that the minimum SSI level for an individual in a board and care facility, which is officially known as the non-medical out of home care rate, is $1,158.37. That's what the individual should be getting if they're living in a board and care facility. If they are receiving less, then that's a conversation with the Social Security Administration. However, to answer your question, the SSI recipient is entitled to keeping at least $132.00 of the $1,158.37.
  Lauren Kinsel (Senior Care Solutions) I recently ran into an issue where a person had called for their mom, who is on a cash assistance program for immigrants, but doesn't qualify for SSI through the Federal Program. Is that going to work the same as far as getting the bump up in her income for assisted living? I've never run into this before. She is getting somewhere around $900.00.
  Karli Holkko (DHCS) It is my understanding that the Social Security Administration might be able to augment her current income with Supplemental Security Income (SSI) so that combined she will receive the minimum non-medical home care rate of $1,158.37. They might authorize it based on her disability, her age or her ADL limitations. Again, that's a conversation with the Social Security Administration, of course.
  Karen Hess (Jewish Family Services) When is the day increase for the tiers effective? Is this only for clients whose tier increase was submitted after January 1st?
  Karli Holkko (DHCS) It is effective January 1st, and it is for any participant on the program. Each of the tier rates have increased.

2. Quarterly Status Reports
   - Your most recent Quarterly Status Report is due today. Please be sure and submit this report as soon as possible. Receipt of the quarterly reports on a timely basis helps us research any pending cases you may have and ensure that our records match. It also helps us determine any disenrollment we may have missed which is very important given the capacity of our waiver. As a reminder we do not research any cases for CCAs who have not submitted their most recent quarterly status report.

Patty Watson-Wood (Huntington Hospital Senior Care Network) I'm working on ours, we many need until tomorrow morning, is that possible?
Karli Holkko (DHCS) Yes, that's fine. I neglected to send out a reminder to you so we can be flexible on that date. This is just a reminder that it is that time again, please get them in as soon as possible.

3. Waiver Totals
    - Our total enrollment is currently at 3,590. As we have stated before, we are tracking this number very carefully and will continue to update you as this number increases. We are also continuing to research what our options are for expanding capacity.
      Bill Mathis (ABCSS) When you get to that 3,700 mark that means you'll not be enrolling anyone else?
      Karli Holkko (DHCS) Yes, potentially. We are looking at what flexibilities we have. Obviously, we don't want to risk any program integrity or federal financial participation. It may hit a point for a certain period of time that we won't be taking any more participants so we don't risk the integrity of the program, but we are really hoping not to get there. That's why we keep begging for you to submit your disenrollments and your quarterly status reports. We use these reports to help track total waiver enrollment.
      Carol Heap (EO) Are you also asking to open the waiver to new counties?
      Karli Holkko (DHCS) Yes, we are going to be expanding to San Francisco County.
      Debbie Brooke (NorCal) The original waiver has five phases of counties to be brought into the waiver. The last phase that was scheduled came in 2013 which were Placer and Shasta Counties. Are they still coming on board, or are they on indefinite hold, we get a lot of inquiries form Placer County.
      Karli Holkko (DHCS) We don't have any immediate plans to expand to Placer or Shasta, it's something we can look at in the future. There are budget implications to expanding to other counties so it gets a little challenging to get approval.

4. ISP Signature / Submission Timeframes
    - During our conference call last week on the new ISP format, we received a question about the required signature and submission timeframes. As you are aware, we require that the ISP be completed and signed within 10 days of the completed assessment tool. On the call we discussed the challenges with getting an ISP completed and signed within 10 days of completing the assessment tool, particularly if the individual has a power of attorney. This timeframe is a performance measure we have established for our waiver program so it cannot be modified at this time. Therefore, when this timeframe cannot be met, we need to be notified and we can work with you on a case by case basis.
    - We also require that the completed assessment tool be submitted to DHCS within 45 days of the registered nurse signature. Given the acuity and frailty level of the individuals we serve, we built this requirement into the program to

ensure that applications are submitted timely so our nurses have an accurate picture of the applicant's status at the time they review the application.
Lauren Kinsel (SCS) With respect to the performance measure on the ISP, when the waiver is up for renewal in 2019, would you have the opportunity to tweak it to try and change anything based on the feedback from the CCA's?
Karli Holkko (DHCS) Yes, this is something we can look at then or through a future amendment.

5. Billing Issues
    - As most of you are aware by now we have discovered a pretty significant billing issue with service codes G9001 and G9002. When service code G9001 or G9002 is billed for a dually eligible individual, it will deny for payment with RAD code 0012 which means Medi-Cal benefits cannot be paid without proof of payment/description of the denial from Medicare. We are aware of the significant impact of this billing issue and are working hard to resolve it. If any of you are receiving this denial code for service codes other than G9001 or G9002 please let me know immediately. I cannot apologize enough for the inconvenience this is causing, please know that our team is working hard with our CA-MMIS division and Xerox to resolve this issue.
      Carol Heap (EO) Are we going to need to rebill, or are you assuming that they are just going to resolve the issue from their end?
      Karli Holkko (DHCS) Yes, we suggest you keep billing, and once the solution is identified, they will go back and reprocess all of your claims that were previously denied. Just keep submitting those claims so we don't run into any timeliness issues, and they will get reprocessed.
      Kathleen Marek-King (Always Best Care Senior Services) Did this affect facility billing also, or just the CCAs?
      Karli Holkko (DHCS) I'm not aware of the facilities being affected. But if you start to hear that, please let me know. I think we probably would have heard something by now if they were affected, and I haven't heard anything. I only know of these two service codes, which unfortunately are the ones that the CCAs bill.

6. Pended Cases
    - As most of you are aware, enrollments are only pended for 6 months. We start this 6 month period from the date the application was originally submitted. This ensures we can enroll back to the application date for the participants who moved in prior to an application being received by our office or for those who moved in shortly after the application was received by our office. We are aware that due to our review timeframes, you may not be notified that an application has been pended until a few months after the application was submitted. However, it is the responsibility of the CCA to monitor and track this timeframe and notify us of the applicant's current status and if you need the pend date extended. Cases that have been pended for over 6 months without an update from the CCA and a request to extend the pend date with be closed without enrollment and the CCA will not be notified

7. Open Discussion

Gregory Cascante (Archangel) Given what's going on as of January 20th, do you know any more than we do by listening to the news, what's going to happen to Medicare, and going to happen to any of this?

Karli Holkko (DHCS) No, I wish we knew, but no, we don't have any more information than you do. We are operating as status quo.

Michelle Botbyl (JFS) With the ISP dates and the 10 days, is that business days, not including holidays and weekends?

Karli Holkko (DHCS) That is 10 calendar days, but we can make exceptions if need be. Give us a heads up when you submit the application and let us know if you exceeded that ten-day timeframe. It's good information for us when we report our performance measures.

Michelle Botbyl (JFS) When we are re-assessing a person, whose eligibility has lapsed, do we just go ahead and submit the RA anyway? What happens if I find out later they have been terminated, how does that work?

Karli Holkko (DHCS) Yes, go ahead and submit it**.** You need to let them know their eligibility has lapsed and see what you can do to get it reinstated. In most cased, if it's just a paperwork issue or something, the county may be able to reinstate the eligibility retroactive, and there wouldn't be the risk of non-payment to the CCA or the facility. However, if it's an ongoing issue and you can't get the Medi-Cal eligibility back, then they will be dis-enrolled.

Michelle Botbyl (JFS) I was actually referring to health matters, they have the requirements for the program, except their health has improved. I'm seeing improvement and I'm at a loss, before they were tier 1 and now they've improved.

Karli Holkko (DHCS) Interesting, let me take that back to the team to discuss. We can talk about it, and address at the next roundtable.