# CCT Monthly Roundtable | MINUTES

**Meeting Hours:** 2:00 PM – 4:00 PM Date: **9/14/2016**
2:00 PM – 3:00 PM CCT
3:00 PM – 4:00 PM CCA ALW

**Conference Phone Line**
*Line Phone Number: (877) 929-7616
*Participant Code: 6918960

**Standing Updates:** **[2:00 – 2:10 pm]**

**Review of Minutes/Action Items**

- **Karli Holkko (DHCS)** No questions, comments or edits, there was one action item from the previous Roundtable meeting. As a reminder, roundtable Meetings are now being recorded, which enables us to capture more conversation and provide you with more detailed minutes. We encourage everyone to refer to the minutes as they are a valuable tool to keep everyone up to date.
- **Action Item 1:** We had a discussion about the Final Transition Care Plan (FTCP) and the information that we're requiring for the community physician. We did a little re-organizing, on the FTCP. We always requested information about the physician but it was in a different location, we moved this field down to the bottom of the form. Now, along with the appointment date you can list the physician information, contact information, name, date, etc. The updated form has been posted to our website.

**Forms Submission**

- **Karli Holkko (DHCS)**
- Be sure to use the updated forms now available on the CCT website.
- Please submit the Enrollee Information Forms (EIF) directly to the CCT email in-box, do not attach them to the TAR. If an EIF is attached to a TAR, the TAR will not be processed until the EIF has been forwarded to the CCT email inbox and information has been logged into the CCT database. It will save us both time and resources if you submit the EIF as directed. This also enables project staff to verify if an individual is already working with another LO so you can be alerted and stop working with that individual.
- The Assessment tool, which is not posted on the web site, is sent out with every update, the current revision date of the CCT Assessment Tool is June 1, 2016.

**Housing/811**

- **Urshella Starr (DHCS)**
- We have a NOFA for 811 that went out on March 16 for LA County, we are still awaiting applications. In our first round of 811, we spent about 1/3 of the

money which is about $3 million, and we have about $7 million left. We're still taking applications.

- As an overall update, we currently have about 60 individuals who have been able to utilize 811 housing and we have a total of nine projects. We still have a few openings available in LA and in Northern California.

**Topics:** **[2:10 – 3:00 pm]**

**1. Important CCT Milestone**

- **Karli Holkko (DHCS)** We've hit a very significant milestone in the CCT Program, we're happy to announce that since implementing the program originally back in January 2007, we have transitioned over 3000 individuals back to the community. So thank you to all of you! You guys have been an integral part in making that happen!

**2. Additional Hours Within the 100 Hour TAR**

- **Karli Holkko (DHCS)** If you have exceeded the 100 TAR within the original pre-transition TAR, and would like to request additional hours, please update the original TAR with appropriate justification as to why additional hours are needed. Please do not submit a new TAR. We like to keep track on the original TAR with the original attachments and notes.
- Effective immediately, if you submit a new TAR it will be returned back with a request to submit the request for additional hours on the original TAR.

**3. Household Set Up TARS**

- **Karli Holkko (DHCS)** We have updated the way in which we want you to submit Household Setup TARS for approval. Just a little bit of background, last year we released guidance on the new process for submitting household setup TARS. We had initiated soft caps per housing type and this new process was intended to provide a standard framework for approving household setup TARs to reduce the amount of time for our nurses to process multiple household setup TARs. Under our previous guidance letter, which was #15-005, household setup costs were pre-authorized up to the applicable household setup cost threshold through a single TAR.
- Unfortunately, what we didn't anticipate is that this would not allow for the LOs to bill against the TAR multiple times. Once the claim was submitted and that one unit was used, LOs were no longer able to bill against that TAR. So as a temporary fix, we asked LOs to submit the home setup TAR with ten units. This still did not fix the problem, and we continue to have some significant billing issues.
- We have decided to go back to the previous method of submitting household setup TARs. So upon approval for the 100-hour TAR for transition coordination services, CCT LOs may submit TARs utilizing service code T2038 with modifier HT, for allowable household setup costs.

You can submit multiple TARs but the total maximum amount of the services remains at $7500.

- The TAR must be submitted for one unit and the dollar amount requested must be included in the miscellaneous TAR section or included as an attachment in the TAR. We want LOs to submit appropriate documentation to their assigned state nurse to review and justify the request for funds. This may include, but is not limited to, receipts, purchase orders, written justification of items to be purchased, photographs, diagrams, written statement of medical necessity from physicians, etc.
- Just to clarify, you can submit receipts for dollars already spent or you can submit a justification to the nurse for what you intend to spend. For example, you can submit a TAR for $2500 with justification on what you intend to spend the money on. For example, $1000 for furniture, $1000 for rent, $500 for deposit. The nurse can pre-authorize this amount. However, what you bill to Xerox must be the exact dollars spent. We're hoping that this new process will cut down on billing issues and still create a little bit of flexibility for LOs that are purchasing household set up items.
- This is effective immediately, any new TAR you're submitting as of tonight or tomorrow needs to be submitted in this way with one unit and a total dollar amount within the notes or within the documentation.
- **Doug Micetich (SVILC)** The nurses are aware that as of September 14, this change is in place? They're not going to ask us to go back to September 13, or anything earlier to make the changes?
- **Karli Holkko (DHCS)** Yes, the nurses are aware. It's been something we've been talking about internally.
- **Gregory Cascante (AHHI)** You said when we request a dollar amount in advance, let's say $1000, and then we make a purchase, you said to be sure to bill for exactly what you spend. You're not saying bill for the amount we originally requested because it might be less or more, right? You said, be sure that the amount you're billing is the exact amount and that you have back up documentation for it?
- **Karli Holkko (DHCS)** Yes, that's correct. So the billing amount could be less. It can't be more, because we wouldn't have authorized it but it could be less because you're giving the nurses an estimate that we can approve. If you are pre-authorizing a certain dollar amount then what you actually bill to Xerox needs to be the exact dollar amount spent.
- We want to try to be flexible and not create any cash flow issues that still work within the constraints of the TAR billing systems.
- **Tina Campbell (Access TLC)** If we submit a TAR for a certain amount and we find that we didn't spend that much, should we adjust the TAR down to the accurate amount we did spend, just so we don't use up parts of the $7,500 that we didn't actually get to use?
- **Karli Holkko (DHCS)** We can see the claims within the TAR on how much was actually spent. It is a conversation you'll want to have with your nurse

if you pre-authorized an amount you weren't able to spend and now you're needing to go up to the $,7500.

- **Tina Campbell (Access TLC)** Okay, can I ask a candid question on what you just said? When you say when nurses look at the TARs and see what they think was spent, they're not taking into consideration what claims haven't actually processed. Are they aware of that, that what you see against the TAR isn't what the true number is?
- **Karli Holkko (DHCS)** That is true, there is a lag time in the system in what we see on our end versus what has already been billed. We don't see it in our system until it's paid. If you bill something and it hasn't been paid, we will not see that on our end. It's something that you'd want to make sure the nurse is aware of, but likely we're going to want to see the true dollar amount of what was paid.
- **Eduardo Medel (ILRC-SB)** I have a question regarding a TAR for household setup that's already been approved for the ten units and $5000. What will we have to do now, since it's already been approved, will we have to make adjustments to that TAR submitting the documentation to that TAR now or is that already grandfathered into the system?
- **Karli Holkko (DHCS)** Yes, that TAR would essentially be grandfathered in. This is only applicable for new TARs that you're submitting.
- **Gregory (AHHI)** Karli, I have one more question if I may? We're in an odd position because we're both a home health agency and we're operating as a CCT and as a CCA. So the question is this. The functions that we perform as the CCA that overlap with the functions of a CCT. My question is how do we differentiate when we're wearing the CCT hat from the CCA hat because we're being told, make sure you don't double bill. That makes sense. We agree with that. But if we're performing the function, can we charge it toward the CCT instead of the CCA side?
- **Karli Holkko (DHCS)** The way we always explain it, is when a person is transitioning into the Assisted Living Waiver, anything you will bill to CCT has to do with that original transition. When checking in to see did the move go smoothly, how are they adjusting to the facility, did they need any home set up, were there any modifications that still needed to be completed? Those are activities are typical CCT functions.
- **Joseph Billingsley (DHCS)** I'm going to add in, there needs to be clear and separate duties. When you're working with an individual before they transition to the Assisted Living Waiver, when they're still in the skilled nursing facility, that's going to be the CCT work.
- Following that, any ongoing case management, is the function of the CCA. We wouldn't allow you to bill CCT for just typical case management. That function is going to be for the CCA. The only exceptions would be if there is a justifiable thing that needs to be modified in the ALW facility. There are times when we'll use CCT funding to allow for modifications or setup in ALW.

- There could be an identified need for some kind of habilitation in addition too, or separate from what services are provided by the facility, then it could be something that could be potentially billed to CCT.

**4. CCT LO Participation in ADRC Meetings.**

- **Karli Holkko (DHCS)** We really would like to encourage all of our CCT LOs to participate in ADRC meeting at a local level. ADRC stands for Aging Disability Resource Connection, for those of you who are not familiar with the acronym.
- Since transition of service is under the ADRC umbrella your participation in these meetings could be extremely valuable.

**5. Provider Contracts**

- **Karli Holkko (DHCS)** We introduced this topic at the last Roundtable, and I just wanted to give you a further update. We have updated our CCT Provider Contracts, and are currently having them reviewed by our legal division. Once they're approved, we'll be sending out to you for review and comment. We will be allowing a two-week review period.
- We hope to have the updated draft out by the end of next week and as we mentioned during the last Roundtable Meeting, CCT LOs that have not performed a transition and/or invoiced in over a 1 year, or have been de-activated as a Medi-Cal Provider will be required to justify to us why we should enter into a new contract with your organization. Contract justifications must also be a detailed plan on how the organization will transition new members and fulfill program and administrative requirements included in the 2014-2016 CCT LO contracts.
- We'll have some further information out to everyone about that soon, but just wanted to give an update today.
- **Nichole Kessel (DHCS)** I just wanted to reiterate the face that we're making very few changes to the contact Scope of Work. The review time frames should really give everybody enough time for your review. You have your current contract's Scope of Work, go over it and you'll notice that the changes that' we've made are very few and there shouldn't be any concern as far as with new requirements or additional work that we're asking you to do. We're also including parts from the Policy Letters that we issued between the contract period, so there should be no surprises and if you do have any questions, please don't hesitate to ask.
- **Thomas Gregory (CIL-Berkeley)** The prior contract that's going to expire soon, had a clause that said in the future, we'll be issuing policy letters. Please consider those policy letters as being incorporated into this contract. If the new contract has similar language how will, will it incorporate policy letters that have been issued prior to the execution of the new contract?
- **Karli Holkko (DHCS)** Yes, that's correct. It will still include policy letters that were executed within the prior contract period.

- **Joseph Billingsley (DHCS)** So basically-this is Joseph, In the new contract, we are updating a lot of it. Many of the changes being made are to update the language to reflect new requirements we identified through policy letters, and then it'll also include the same language moving forward that we may, moving through the program and the next contract term, incorporate new policy through policy letters.

**6**. **Capacity and Consent**

- **Karli Holkko (DHCS)** We recently received guidance from our Legal Division, regarding Capacity and Consent. Essentially, unless a court of law has determined an individual is no longer capable of providing informed consent for him or herself, we will assume that he or she has the capacity to do so. A medical diagnosis is not considered a statement of capacity, so when you are working with a potential CCT participant, the transition coordinators must first determine if the resident has a legally obligated decision maker. The information of who is responsible for making healthcare and treatment decisions on the individual's behalf should be included in the individuals' records at the skilled nursing facility. As a reminder, neither the facility nor the CCT LO staff may act as a legal decision maker.
- If the individual does not have a legal representative and has not been determined incapable of providing informed consent for him or herself by a court order of law, we will accept the individual's signature on the program forms. Please note that if any other individual is signing for the program participant, that individual must be legally authorized to do so. Finally, we're finalizing guidance on this so you will have something in writing and we hope to have this to you by the end of next week.
- **Julie (HHCM)** We have a client who gave consent with his eyes because all he can do is blink, and we had people sign as a witness, that yes, he gave consent that said yes, he wanted to be in the program, is that ok?
- **(Mary DHCS)** I will check with legal and find out what we need to do for his case and what we can do about witness signatures.
- **Gregory (AHHI)** So as long as there's not court ruling that says this person is incapable, the person is therefore capable.
- **Joseph Billingsley (DHCS)** Unless they have a designated legal representative. You have to do your due diligence, when your reviewing the medical records and the history to see if they have a legal representative. And if they do, you need to work with that person.
- If the Durable Power of Attorney (DPOA) and physician determine they're at the point where they longer have a capacity to make those decisions, then you'd work with the designated power of attorney. Or, if they have a conservator, you'll meet with them. But if you have an individual that doesn't have legal representation and hasn't been declared incompetent by the courts, then that's the only signature that you need. In that instance, you need to demonstrate that the setting they're transitioning into is appropriate and the care that they need will be there for them.

- **(Unknown woman)** I just want to clarify. With the DPOA, they still have decision-making capacity and they've listed that they want their DPOA only to act on their behalf when they can't make decision on their own. Then do we still have to go by the DPOA, if they are still able to make their own decisions?
- **Karli Holkko (DHCS)** No, thanks for clarifying. In the case where they do have an DPOA, we do review the documentation very clearly, because it will designate within the documentation when the DPOA is in effect.
- **Tita (SVILC)** We had a patient with enough smarts to make decisions regarding his medical plan and everything. But he was a quadriplegic, and he was not able to move his fingers, so he had to depend on his girlfriend to make the signature. If a person is commutatively smart and intelligent and is able to make decisions, but physically unable to put his signature, what does he need to do?
- **Karli Holkko (DHCS)** We'll bounce this one off our legal division again just for clarification for individuals who physically cannot sign and don't have a legal representative, what is the course of action?
- **Joseph Billingsley (DHCS)** Yes, we'll double check on that specifically, but again, if somebody's able to indicate consent, be it winking or however they are doing it, it shouldn't come down to the fact of whether they have the physical capacity to make a signature to indicate that decision. We will be clarifying what the correct process should be there.

**7. Open Discussion**

- **Karli Holkko (DHCS)** Okay, we have 18 minutes so we can go to the open discussion portion for questions regarding any of the topics that we discussed today. Any burning questions? Now is your time.
- **Doug Micetich (SVILC)** Karli, I have a question regarding vehicle modification. We have a client that has a vehicle that's already been modified, but they went into long term care and wants to move back to the community, now their vehicle is in disrepair. Can CCT make repairs to his car?
- **Karli Holkko (DHCS)** No Doug. I'm sorry, it can't. Actually I asked this question to CMS and CCT can pay for modifications but not maintenance.
- **Joseph Billingsley (DHCS)** While you are thinking of some questions, I just have one more update I wanted to let you know about. We had talked about our next home and community based advisory workgroup that we were going to be initiating, that begins the second series of that workgroup in January. We're going to be sending out information probably next month to request application for participation. We're trying to build the workgroup so we'll be sure to send that out to everyone. If you're interested in participating please let us know, and send us back the one-page application.
- **Joseph Billingsley (DHCS)** The purpose of this work group is to work towards sustaining institutional transitions. We will be looking at what we do within our waivers and looking at what works well within the CCT

program. We're looking for stakeholder input on how we'll continue to build up our waiver networks and partnerships with managed care, to ensure that we continue to have sustained capacity for institutional transition work that we already started through CCT. We encourage interest on your side as participating CCT lead organizations.

- We are looking for a number of different stakeholders to be representatives. And even those that aren't participating as actual workgroup members, we still strongly encourage your participation as members of the public during the meetings because you are doing the work. There's great opportunity there for you to be able to be aware of what's going on and also to provide your input.
- **Nichole (DHCS)** I was wondering if you would be able to maybe share a little bit about what we heard about national interest in continuing MFP, and the confusion that remains because of the fiscal extension.
- **Karli Holkko (DHCS)** Yes, thanks Nichole. As some of you have probably seen, there is a lot of advocacy and support to extend the MFP Program. Some of that information states that the program is ending September 30th of 2016, so probably a little bit of confusion there. Technically, the program does end September 30, 2016 but the Affordable Care Act allowed grant activities to continue until September 30, 2020.
- What we decided to do in California is to perform transitions through December 31, 2018 which will allow the provision of post-transition services until December 30, 2019.
- There is a lot of interest out there right now to extend MFP. I think the language is circulating CMS's desk right now, but nothing official as of yet, whether or not the program will get extended. There continues to be a lot of advocacy out there to reach out to Congress to let them know to extend the program. You're more than welcome to lend your voice to that as well.

**Action Items:**

- Guidance Letter on Capacity and Consent
- Clarification on how to document consent when the individual is physically unable to sign

Please forward your CCT questions to: California.CommunityTransitions@dhcs.ca.gov