SPD Operations Committee Meeting
Thursday, August 11, 2011
1:00 – 3:00 pm

Attendees:

Angela Munkers
Brenda Reed (Teleconferenced)
Carol Mauser
Dale Marande
Gene Sundet
Jeanette Wilson
Joe Easton
Marci Howard
Phil Deas
Trina Lee
Vicki Davis

Guests/Presenters:

Brooke Emery
Caryn Whatley
Chris Avery
Jennifer DeJong
Jenny Cokeley
Joanne Scheidler
Selina Hickman

Scribe:

Janet Morse

Absent:

Jenny Sneddon
Melinda Compton
Karen Gulliver
Nancy Sargent-Johnson

Announcements:

Meg Killgorecathcart, Information Systems & Provider Pay Manager, is retiring effective October 1st.

TOPIC:	Action/Task Decision Log:	Responsible Person(s):	Due Date:
541 Form Revisions (Selina Hickman, Joanne Schiedler) (Referral# OPS 091)	The committee gave their approval for the revisions to the form.		

At the last OPS meeting, Selina and Joanne agreed to follow up on the requirement to show the liability calculation when sending the SDS 0541. A draft form was revised and sent to the committee for approval. Listed below are some of the revisions made:

- On the backside of the form, there is a 'drop down' menu with choices, a) assisted living facility, b) residential care facility, or adult foster home. It notes to see attached SDS 450 which shows the liability calculation. It now shows the liability plus the room and board.
- 1st paragraph, more of an explanation about the need to pay the liability.
- **In-Home care** – Added "see attached Pay-in Calculation Worksheet" and "You have a pay-in *(liability)* that must be paid…."
- OARs have been added throughout the form.
- "Note/Comments" section has been added.
- **Nursing facility services** – A 'drop down' menu to choose *with* or *without* a liability.

The committee gave their approval for the revisions to the form with a potential effective date of November 1, 2011.

TOPIC:	Action/Task Decision Log:	Responsible Person(s):	Due Date:
CQIT Update – Field Lean Leaders (Catherine Seminary)	None at this time.		

Catherine reported eight new LEAN leaders will be hired to provide support throughout SPD and Field Services. The goal is to have the new LEAN leaders hired and trained by September 6th.

TOPIC:	Action/Task Decision Log:	Responsible Person(s):	Due Date:
Change in QA Process (Dale Marande, Chris Avery)	None at this time.		

As a requirement of the 1915c Waiver, the Quality Assurance Review Team is responsible for completing a statistically valid review of all waivered cases in SPD/AAA offices. The Fall of 2011 will bring some changes designed to improve the process, which follows:

- Pull statistical data per area, using CMS approved formula.

- Complete electronic review of case, including financial and CAPS. *New:* The quality assurance process will now include an in depth review of service related costs. This includes appropriateness of in-home hours assigned, facility add-on's and payment levels.
- Conduct an in office file review to ensure that required forms are appropriately completed and filed per current policy.
- Conduct home visits for approximately 50% of the cases reviewed. The visits are to verify the accuracy of the current CAPS assessment. (It was suggested to change the word 'verify' to '*validate'.)*
- Invite case managers to participate in the review process. *New:* The Quality Assurance Team selects the client. Client visits with a CM will be chosen based on the presence of questionable service eligibility and/or payment levels.
- Send the area manager detailed client and statistical reports for distribution within three weeks of completing the area review.
- Require a corrective action plan to be in place from the local area within 60 days of receipt of the reports. *New:* Case managers will now have 45 days to complete the new assessment, rather than 30 days.
- *New:* Schedule a second visit to the area approximately two weeks following receipt of the corrective action plan.
- *New:* Provide, upon completion of the second visit, a final report to In-Home Services, Field Services, and Federal Reporting.

As a requirement, the statewide review process will be completed within two years. Notification of area reviews will be sent to the field approximately 30 days in advance. All communication will be sent to District Managers/Executive Directors.

TOPIC:	Action/Task Decision Log:	Responsible Person(s):	Due Date:
OIG Referrals (Jenny Cokeley)	Send feedback re: the draft PT to Jenny.	All members	8-19-11

Jenny distributed a draft policy transmittal re: Referrals to the Office of Inspector General Exclusion Program for Terminated HCWs. The department is responsible to refer any action taken by SPD to limit, deny, or revoke a homecare worker's participation in the Medicaid program to the U.S. Department of Health & Human Services Office of Inspector General (OIG) in accordance with 42 CFR 1002.3(b) & (c), within twenty (20) working days from the date the information is received. If placed on the OIG's exclusion program, the individual will be prevented from receiving payments made by any Federal health care program, including Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or

indirectly by the United States.

In order to make a referral to the OIG exclusion program, the local office must electronically submit the following information to the OIG Referrals e-mail box within ten (10) working days from the date the homecare worker exhaust the termination appeal process or does not request an appeal:

- OIG Adverse Action Reporting Form (DHS 0335)
- Signed copy of 613 describing the accusations
- Any correspondence mailed by the local office, other than the 613, that details the accusations and outcome of an Administrative Review
- If applicable, the Final Order, signed by an Administrative Law Judge, issued by the Office of Administrative Hearings affirming the Department's termination decision
- Copy of the HCW's signed Provider Enrollment Form

Homecare worker terminations based on the following should be referred to the OIG exclusion program via OPAR:

- Substantiated adult protective service allegations of abuse, neglect, or financial exploitation *(It was suggested to remove "adult protective service".)*
- Fiscal improprieties with the intent to commit Medicaid fraud
- Failure to provide services as required, in conjunction with fiscal improprieties or a substantiated adult protective service allegation of abuse or neglect *(It was suggested to remove "adult protective service".)*

Central Office will notify the local office when a terminated homecare worker does not request a second level Administrative Review (terminations pending appeal) or an Administrative Review based on an immediate termination so the local office can initiate the referral for exclusion. When a terminated homecare worker has exhausted the appeal process and does not request an Administrative Hearing within 30 calendar days of the date of the termination notice, the local office can initiate the referral for exclusion on the 31st day. If a terminated homecare worker requests an Administrative Hearing and the Department's decision to terminate is affirmed, the local office can initiate the referral for exclusion once the Final Order is received. All referrals must be routed to OPAR within ten (10) days of the final action.

Homecare workers investigated by the Medicaid Fraud Unit and who are convicted of Medicaid fraud will be referred to the

OIG exclusion program by the Medicaid Fraud Unit directly.

Any further feedback should be sent to Jenny no later than Friday, August 19th.

TOPIC:	Action/Task Decision Log:	Responsible Person(s):	Due Date:
437s on PMDDT Cases (Elizabeth Willis via Brooke Emery) (Referral# OPS 093)		Dale Marande	

There are a few cases getting R&B and PIF payments issued through 437's on a monthly basis. Some are PMDDT cases in which they have no income (until SSA determines disability and issues payments to them) and have been placed in CBC facilities. They meet criteria in 461-155-0700. Ideally, the desire is these payments go out automatically through the CMS system. This is becoming an additional workload issue since not only the CM's have to routinely create the 437's, then the clerk has to process them. Some years ago, there was a mechanism for the CMS system to do this. Brooke contacted Michael Avery and he stated entering and processing 437s for this activity was the only method. It was suggested if removing the "NCP" c/d on the program 5, the case would initiate the payment needed as it used to. An end date would be required so that ongoing payments would not continue beyond the redetermination. Dale will research the number of cases where this situation happens and report back to the committee his findings.

MISCELLANEOUS ITEMS:

1. **Joe:** All of the staff at Joe's office do not have access to TRACS. It was suggested he contact the Service Desk and provide a list of the staff needing access. There will be training for TRACS on the Learning Center in the near future.
2. **Dale:** Erin Kelly-Seals is on the email distribution list and receives a large amount of SPD transmittals. Because of this, she suggested distributing them once a month similar to CAFs process. Dale offered a suggestion to Tricia Baxter that we continue to generate them, have them posted, and send the field a list of all available transmittals now available since the last distribution with links to the transmittals. He suggested this happen the second Tuesday of each month.

The committee agreed Karen should continue distributing her weekly transmittal summary. Dale will continue to discuss this topic with Tricia.

3. **Dale:** For SMBs and SMFs, for some reason MMIS decided it shouldn't be in buy-in anymore. Some of the clients are receiving letters from the Feds telling them the State of Oregon will no longer be paying for Medicare Part D. The staff in the buy-in unit have worked the list of clients that received a letter, put them back in and there will be no gap in their buy-in.

4. **Dale:** The new MSC 0415H (replaces DHS 0415H) is coming out next month. Representatives from OPAR will be attending the next meeting to review the new form with the committee. The form will be available on online, however, it does not auto-fill because it will not be in ORACCESS.

5. **Carol:** DMAP confirmed that they will be applying the mass exceptions for 10-1-2010 until the HP issue is fixed which will by pass Medicare clients for physical health plan enrollment bypass. This may look different in the future depending on how the CCO concept is put together. At this point in time, staff won't have to manually go in and try figuring out how to update the upcoming exemptions that will end on physical health. Staff need to continue to work all new cases and apply the correct exemption code per the PT.

6. **Gene:** We need to do something with the DD system and our carrying the medical cards. It is a mess. Especially in what really brings it to the forefront is the whole PMDDT thing because they are on the General Fund, the lack of communication from between the county and are staff and the brokerage, the Central Office staff. It's twice the caseload of a normal eligibility worker. She suggested they are county employees and why don't we just give them the eligibility. Let them make their own Medicaid eligibility….have them as HSS3s. Clackamas has about 1400 cases, maybe a little less. Gene would like some input before submitting a referral.

7. **Gene:** A service delivery workgroup has been created to prepare for eligibility automation. The workgroup would like two representatives from SPD on this workgroup. Angela asked Gene to write it up looking at management level for AAA, staff representation, front line, eligibility. Gene will forward the charter to the committee.