OLTL Third Thursday Webinar 04 18 19

- 
- Good afternoon, everybody. My name is Kevin Hancock, I'm the deputy secretary for the department of human services office of long-term living. Today is the April 18th, 2019 third Thursday webinar. It will focus on monitoring report updates and those will be provided by Joe, who is the office of long term living chief of staff. Before that update on community health choices activities in the southwest and southwest. We will discuss provider workshop registration, activities about the EDV implementation and we will go in detail with the report. So as we did with each of the prior to phased roll out the third phase will have provider workshops. We are going to have those workshops scheduled a little bit earlier than we did last year. In the southeast we had the workshops scheduled in early and mid June 2018 for the southeast roll out. We made the decision because we're implementing three zones in 2018 that we will begin in mid-May and we will have provider sessions in mid May, late May and early June to allow for as much opportunity for providers in managed care organizations to develop a relationship and have time to have questions answered if providers are planning to enroll in community health choices with one or all three of the managed care organizations. So we'll also provide us more of a chance to understand the continuity of care period and what they need to do to be able to adjust to this new model of service for long-term services and supports. So as you see on this slide, Lehigh capital zone. The provider sessions will be scheduled May 13th through May 16th. In addition to the three provider sessions we'll be having scheduled in the zone we are having a separate transportation session. We had a transportation session in the southeast in the November time frame. We found it to be very effective as a way to establish communication with all of the necessary and relevant stakeholders for transportation and also to make the connections that are needed to be able to establish a successful transportation launch. If you remember transportation was a particular challenge in the southwest launch and we're looking forward to finding ways to identify problems and work around those problems before the implementation date. And the reality is for this final phase that transportation will be a challenge. Probably much more of a challenge than even was in the southwest because of the rural nature of the three zones involved. The northwest zones will be on May 20th through the 23rd and they will be occurring in the Erie area as well as lock haven state college, et cetera, et cetera. Northeast June 4th through June 7th and that's the Straton area as well as hazel town, et cetera, et cetera and bloomsburg university. We are very grateful to the entities that have provided space for us to have these sessions and we look forward to as many providers attending as possible to learn about community health choices, the particular areas

focused on, we would have the break out sessions focusing on service coordination, physical health services, nursing facility services and long-term community services and supports. So in addition to all of the ramp up activities we have with community health choices, this especially for phase three we will be implementing electronic visit verification as well. The office of long term living, executive assistant and project for EVV is with us today, Kristen and she will provide an update for how this project is progressing.

>> So I wanted to provide you with an update on the timeline going forward so you know what to expect and when different communications will be coming out to you. So by early May we plan to release the technical specifications and the DHS addendum which will really outline the business rules and technical guidance that providers will need when implementing electronic visit verification if you have your own system. As you recall or may recall, we are doing an open system within Pennsylvania. So if you have your own system you are more welcome to use that system but it will need to communicate with the state system which is SAN data if you are within the fee for service system with OBRA or act waivers or provider with ODP waivers or need to communicate with to CHC MCO system if you are participating or will be participating in CHC. So those technical specifications are really going to give you guidance to look at your system and determine if any technical changes need to be made. In mid to late August we anticipate that our state vendor will start their training for any providers planning to use the state system. That training will continue for six weeks through the fall and we're considering this our go live or soft launch period where as providers are trained the system will be live and you will be able to begin training other staff at your office and use the system as soon as you've been trained rather than wait and lose some of that knowledge. So after we finish the training and soft launch process in September and October that fall is really going to give us time to analyze and look at how providers are doing throughout the fall. We will not have any type of impact to claims and payments throughout the fall. This is really a learning period and the state as well as SAN data will be able to reach out throughout the fall in October, November and December if any technical assistance is needed. Just as a reminder, the waiver services included in EVV will be participated directed community support which is our services my way variation of personal assistant services and respite that occurs in the home. Any home health services will not be included at this time although they will be required from the 21st century cures act by 2023. We will not be implementing those at this time. So as I mentioned before, our state vendor, SAN data will offer provider training to those who choose to use the SAN data system. The model that we're using for that training is a train the trainer model. The expectation would be that agencies designate two staff to attend these

trainings. You have an option of in person, online, self-guided or live and you must complete this training in order to gain access to the SAN data EDD system. So it's very important that you monitor our releases for training service which at the bottom of the page you can see the website. That is where all of the updates are going to come through and you'll want to be sure that you keep an eye out for when those trainings are scheduled over the summer.

>> Thank you. So we look forward to any questions that anybody wants to submit about EVV and we'll also be providing an update for the EVV May 2nd if I'm not mistaken. So with that I'm going to turn it over to Joe to give us an update on CHC monitoring reports.

>> Thank you, Kevin. Thank you as a refresher, I know that we presented these reports in the past, we have a couple of categories that our managed organizations need to submit to us, operations reports or ops reports and quality management utilization management, QMUM reports that we receive on a regular basis from the managed care organizations. So what we've been presenting is results from our QMUM 7 denial log services home and community based services. It's a monthly report that identifies the denials of medical necessity, terminations, reductions and changes for covered services. So as you can see, we have our four quarters from 2018 and then the month of January 2019 and this is broken down by each one of our managed care organizations. The chart on the side shows you the total number per MCO. We did have a bit of an up tick third quarter of 2018 for UPMC running through January of 2019. This slide shows you a break down just of 2019. As you can see we had a total number of denials for the month for the southeast region of two. This part of QMUM-7 illustrates prior authorization files for physical health services. So, again, we have the 2018 calendar year broken down by quarter and includes January 2019 for each one of the MCOs you see a break down in the chart on the right of the slide. So total number of prior authorization denials included by MCO by quarter and then by January 2019. As you can see, this is, again, prior authorization denials so this would be prepayment. This could be that the claim itself was covered by Medicare or there may have been missing documentation or something like that that would cause a prior authorization denial. This is the break down specifically for the southeast for the month of January. Again, we had a total of two for UPMC. This slide illustrates the January. The claims are higher because the prior authorization requests are higher. This is specifically for the southwest and includes quarters one through four of 2018 and then January 2019. This slide is specific to the southeast for the month of January 2019. As you can see pharmacy prior authorization denials were much higher for Amerihealth keystone and UPMC and PHW had 17. This slide includes dental prior authorization denial. So we're

starting to incorporate some dental measures. This is for the southwest and it's specifically for January 2019. As you can see in the black on the right, there was one total denial. This slide covers the prior authorization denials for the southeast. You can see for January 2019 the block on the right shows you that there were 380 for Amerihealth keystone, PHW 162 and UPMC 125. Again, these are prior authorization denials prior to claims processing. This portion of QMUM-7 addressing home modification authorization denials. This slide is specific to the southwest for the month of January 2019 and as you can see there was one authorization denial in the southwest for UPMC. This slide is specific to the southeast for January 2019. And we had no reported prior authorization or authorization denials for home modifications in the southeast for January 2019. So the next reports are operations report or ops report three. That's the department of health complaints and grievances. The purpose of this quarterly report is to illustrate the number and status of participant complaints and grievances reported by the community health choices MCOs to the department of health. And then OPS 4 is complaints and grievance detail and the purpose of this quarterly report is an itemization by reason for the participant filing a complaint or a grievance. So this slide is broken down by complaints per 10,000 for the southwest. So this is complaints and grievances for the southwest for 10,000 participants for all four quarters of 2018 and as you can see you have a total chart on the right side of the slide that shows your break down by MCO how many complaints and grievances per 10,000 for 2018 are there. So we had an up tick in quarter three it looks like UMPC. An up tick for PHW in quarter four. This is grievances per 10,000 in the southeast for each one of the four quarters of 2018. Again, you have total box on the right for reference. This slide represents the percent of complaints for the participant. This is for the southwest zone. As you can see there is a footnote for the first quarter of 2018, Amerihealth did not have any complaints for that quarter. So you can see that that applies to quarter one, quarter three and quarter four. Again, this shows the number of complaints in favor of the participant specifically for the southwest zone. You can see that PHW has higher percentages than the other two plans. This slide breaks down the percent of grievances if they were the participant for the southwest. As you can see, we did have an uptick for UPMC in quarter three of 2018. So this slide is a little bit more busy. It illustrates the long-term services and supports grievances per 10,000 by category. So this is a break down by DME, durable medical equipment for nursing facility clinically eligible, non-medical transportation, personal assistance services, other long-term services and supports. So there's multiple categories and it's broken down by quarters. You can see the table on the right-hand side to give you totals as point of reference. So you can see that UPMC for quarter four did have the highest number of grievances while PHW had the highest number of grievances for quarter four. So monitoring

report for complaints and grievances. There's a break down here by category. So by health plan in the southwest the majority of the top reason -- excuse me, the top reasons for nonlong-term services and grievance categories ranged from pharmacy, you know, dental and dentures, there were some physical health grievance categories and it does vary by plan so you can see that there were also some additional reasons for non-LTSS complaint categories including MCO administration. So if you look at this across Amerihealth the majority are for out patient, personal service dental, personal assistance services and dentures. Their top nonlong-term service and complaint categories are for non-physical health service or other physical health issues, MCO administration, MCO service. For PHW the top complaints were courteous provider office service, courteous service by MCO. Finally for UPMC their top grievances were home health, other physical pharmacy, dental including denials of dental services other than braces and dentures and their top non-LTSS complaint categories, MCO administration, courteous off service, non-covered physical health, MCO courteous service and quality of clinical eight care. So OPS-008 covers missed services. So this is all services that were delivered for participants who utilize home health skilled care, personal assistant services and also identifies non-delivered or late trips for non-emergency and non-medical transportation services. It could be for various reasons but captures all of the services that weren't delivered that were anticipated to be delivered. So this first chart shows you missed services for home health. And includes the zone of the southwest. It covers January 2019 in comparison to the quarter of 2018. You can see that missed services did range by MCO with UPMC having lower numbers for instances where hours that an agency couldn't staff the home health services. Again, this is a break down for the southeast. This is instances where the percentage of hours that agencies could not staff for whatever reasons they might be with keystone first having 0%. This slide gives you a break down of the percent of hours that a participant refused services. This is in the southwest. This would be missed services due to a participant refusing the service at that scheduled time. This is again for the southeast. This slide illustrates number of hours the participant had unplanned hospitalization. So for the southwest zone any instances where the scheduled home health services were missed or not able to be rendered due to participant having an unplanned hospitalization and this shows last quarter of 2018 and first month of 2019. Here is instances where a missed shift occurred where the participant had an unplanned hospitalization in the southeast. You can see that PHW had a higher percentage there in the southeast. Now moving onto transportations, these are missed services in the southwest. So missed trips by percentage last quarter of 2018 and first month of 2019 by MCO. And again for the southwest you can see PHW did not have any reported for January 2019 in the southeast. Late trip. This is the percentage of trips

that were identified as being late. For the southwest last quarter of 2018 and first month of 2019. And, again, you can see that Amerihealth had a higher percentage during quarter four, UPMC having a higher percentage in the first month of 2019. Here's percentage of trips late in the southeast. UPMC looked to have the lion's share of that. And number of trips that the participant refused. So these are missed shifts. So transportation that's scheduled and was not provided due to participant refusal of the transportation at the time of arrival. So you have a break down for the southwest, quarter 2018, quarter four of 2018 and first month of 2019 in both instances PHW had zero occurrences, UPMC having the largest number during 2019. Here is participant trips refused in the southeast. Again, PHW having zero and UPMC having a percentage of trips missed due to participant refusal. So now we move into person centered service plan changes. Operations report 21, the purpose of this monthly report is identifying changes to persons centered service plans including increases and decreases. So these changes will include both increases and decreases. So for the southwest this is the percent of plan changes with an increase. This is southwest zone by MCO. And you can see that Amerihealth had the majority of the increases for the southwest for 2018 and first quarter -- first month of 2019. Here's percent of plans with a decrease for the southwest. And you can see that UPMC has a majority of those -- well, these percentages are quite low so across the board there were minimal decreases for the southwest zone in person centered service plans. And here is percent of the plan changes decreased due to an MCO decision or to reduce the services following reassessment. So a reassessment had been conducted and then the MCO decided to reduce services. This is specifically for the southwest zone and this shows extremely low numbers for southwest of any reduction following a reassessment. Again, number of personal assistant hours reduced due to an MCO decision following a reassessment and as you can see we actually have some negative numbers on this slide. So there's a negative number of cases.

>> The negative represents the reduction.

>> So the reduction is a total of hours across all of the plans that were reduced due to an MCO reassessment. So that is quarters three, four and January 2019. So slide 44 we are look at the number of participants with a reduction to their services based on MCO following reassessment. As you can see, the total number of participants with reductions to their plans in the southwest majority of them are UPMC. Keep in mind UPMC does have a large market share in the southwest. It looks like there were all encompassing 20 in the third quarter of 2018 and January of 2019. So is this slide illustrates the reduction of services due to MCO decision following reassessment. This is the average number of hours. So, again, the

southwest you can see that the hours reduced were approximately 111 and 131 for UPMC. And with that, I think we're going to open it up for questions.

>> We haven't had any questions submitted at this point. We are going to wait a few minutes to see if any questions come in.

>> So there may be a technical difficulty. We believe that we're going to be getting questions coming through but it's going to take a few minutes for those questions to come through. Once the technical difficulties are resolved we'll be right back with you with answers to the questions that are submitted. While we're waiting for questions to come through we just wanted to let you know that we will not be having a third Thursday webinar in the month of May because as you see on this slide here, third Thursday is actually occurring when we have a transportation summit. So we will not be having a third Thursday in the month of May. We'll resume the third Thursday webinars in the month of June. We are still waiting for questions so bear with us for a few minutes. I'm sorry to say that we're still trying to resolve our technical difficulties. We are still hoping for the questions to come through in a few minutes so bear with us. Thank you.

>> Thank you for your patience. Can providers join organized care without having a 59 ID number. If it is a Medicaid provider they must go through the Medicaid provider enrollment process before the contracting process. So the answer to that likely is no.

>> Response, we seem to be in a catch 22, we are a provider organization that's a collective of psychologists and behavioral specialists and provide services to the system and BHRS. We submitted provider type 59. We sent this application by every way we were told and we were still denied and told we could not correct anything et cetera, et cetera. So we have an e-mail address for this individual and we'll reach out to this individual to see where we may be able to help. Next question, will the state's EVV system allow use of the EVV system for OLTL, ODP and other services such as prior to pay, triple pay options and others.

>> So the state's EVV system at this point is only including the services mandated under the 21st century cares act. So it will include the ODP and OLTL services included under that. If you have other services that you provide that you would like to use electronic verification service for you can speak with the vendor you're interested in or the SAN data vendor and talk to them about options for you to expand this system to accommodate more services that you provide that you may want provide EVV for but we are only providing the state system for services mandated under the care's act at this time.

>> Recording home modifications where you were tracking denials, how many were authorized and completed or billed in the southwest and the southeast?

>> That detail is something that we are working closely with the MCOs on gathering. We should have that compiled and be able to start reporting on that in July at that MLTS meeting.

>> Question did not see a slide around behavioral health services. Is this because there's no providers offering BSD or cognitive rehab? So cognitive rehabilitation services, as much ass associated with that type of rehabilitation are not tracked as behavioral health services but home and community based waiver services. Traditional behavioral health services for grievance and appeals or complaints is not tracked as part of community health services because it's offered by the behavioral health organization. So we do not track those as part of the reporting we've been provided. We can certainly ask our partners at the office of mental health and substance abuse services to provide that information on a future date. Do the 2020 zones mimic the zones in place for the health choices program? Yes, they do. They are identical, the northwest, the northeast and high capital zones are also potentials. Did LLCL look at these reduction in hours and what did they find? These are a large number, averaging four per day. We are looking at as many of these service reductions and service class reductions and also percentages and yes we are reviewing with the managed care organization so we can apply for this reduction in careful detail. How will incident reports be required to be submitted? So there is an enterprise instant management system that's used by provideers and a managed care organization to report reportable incidents that will be used. Is there anything you would like to add?

>> Not at this time.

>> For these upcoming provider workshops can intake coordinators from home health agencies attend? Absolutely, yes. You would be recommended to attend the all day sessions. Home health agencies could benefit from attending both, the home and community based provider afternoon system as well as the physical health provider afternoon session. You'll have your choice of sessions that you attend to receive valuable information. Is Philadelphia considered in the northeast zone? No, it's the southeast zone and has already been implemented. So when this -- when this was implemented in the southwest medical transportation providers were told that all transportation -- nursing facility resident and non-nursing facility resident was to go through the brokers. When it began in the out east medical transportation providers were reissued the old bulletin that a nursing facility resident non-emergency transformation is the responsibility of the nursing facility.

What's the communication for all areas now and when is the nursing facility responsible to pay? So we've provided clarification bulletin in 2018 that made it clear that since resident transportation is part of the great development for nursing facilities that the nursing facilities were to be responsible for providing that transportation. They would be working with the managed care organization and their brokers if needed for transportation but for nursing facilities it was said to be the responsibility of the nursing facility because it was part of their structured payment. Are there reasons for the refusal of services from the participants? We're assuming yes there are reason codes. It's not something that we have part of the reporting process but it's the information that we can add.

>> And some examples of where a participant would refuse the services they are not feeling well, they have chosen not to go if it was a transportation refusal, maybe the weather was bad and they changed their mind and they didn't what to go or they decided to cancel their appointment, something like that where -- or their schedule had changed and, you know, maybe communication error forgot to change the shift report with that particularly momentum care entity. Something like that would be a reason for participant refusal.

>> That is the questions we have at this point. We're going to wait a few minutes and see if anymore questions do come on. -- do come in.

>> So we did receive a new question. Will constant refusals effect provision of future services? So I'm going to assume -- so if the question relates to the participant refusal of service, no. The answer to that question would be that people have their needs assessed and future services will be crafted to address the needs of the participant. It should not effect the provision of the future services assuming that's what the question relates to. Next question, when the nursing facility resident is a dual eligible is the nursing facility still responsible for non-emergency medical transportation even if the Medicare part B could cover the transportation? We recommend you talking to the Medicare provider about if the participant is covered. In all reality the nurses facility services covered by Medicaid which includes transportation in the rates are the payer of last resort. So if it is responsible for Medicare to cover those services which we cannot confirm or deny depending on the case, Medicare should be paying for their services if that is an eligible benefit. So our question could be possibly yes but I think that a Medicare question would be -- the Medicare entity would be better to answer that question. So we are still waiting for a few more questions and we'll come back to you in just a moment.

>> So very good question, the provider workshops, lock haven is in Clinton county, not in the northwest zone. I wanted to share but wanted to make sure that's correct. Very good point. I believe the reason why lock haven was selected even though it is not in the northwest zone, it is -- it was the closest geographic proximity for providers to be able to attend. So, yes, it is indeed in the northeast zone and northeast providers are certainly welcome to attend that session but we have it for the northwest because of its geographic proximity to a lot of providers. Very good point. Thank you for the clarification. So we're still waiting for a few more minutes, it's a little bit early. We'll wait until 2:30 and if we don't get anymore we will consider ourselves done. If you have anymore questions please feel free to submit them in the next few minutes. Thank you.

>> We have a few more questions. As a medical providers of community health services I need to choose one MCO for -- so the question is, as a new provider do you need to choose one MCO. That's between you and the MCO. From our perspective you can participate in all three. Next question for EVV. I assume part of the EVV technical speculations will be the qualified or verified.

>> So in the technical specifications it will include the distance parameters that we have set up although the distance itself is not -- the distance from any given location is not going to be expected as part of determination to pay or not pay that particular visit. We are collecting that information out of the requirement of the cure but that's your requirement. On the back end agencies and departments will be able to analyze the accuracy and the usefulness of that distance data and the location data but at this time the location itself not being at any given expected location will not have any impact to the provision or payment of services.

>> Next question, the question is specifically to this share payment. We will e-mail the individual who requested the question directly. It's very specific. So we're going to keep the lines open for a few more minutes because of questions that are still coming through.

>> So we did receive another question. Our residents are located in lehigh county and we're looking to open another structure in buck's county. Would this effect billing? It depends on when because if you're represents are located in lehigh county and you're a provider in bucks county I still think it will be okay even if you're still in the fee for service system. But eventually even lehigh county will be part of community health choices. That's literally in eight months. So eventually what will be effecting is the implementation. So at some point in the near future you'll be working with the three managed care organizations but still be able to --

even if your facility is located in buck's county if the residents are part of the fee for service zones it would be still billing for the fee for service.

>> They still need to enroll in that other location.

>> Right. Jill just pointed out you still need to be enrolled in the Medicaid program for the new location. So that's all the questions we have this point. We appreciate your time and attention and look forward to on going conversations. Because of the provider workshops on the screens right now we will not be having a May third Thursday webinar. They will resume in June. We encourage all providers who are going to be part of the implementation for the lehigh capital, northwest or northeast zones to schedule and attend these provider sessions and the registration web page is located on this slide. Health choices.pa.gov/prideers/about/community/index.htm. Thank you and we hope you have a great holiday weekend.