- August 16, 2018 Third Thursday Webinar

>> [Please standby for realtime captions]

>>> We are very sorry about the delay for this presentation.

Because we are starting a half an hour late we are going to extend this call to 3:30.

As everybody knows, we have focused this webinar specifically on service coordination and we have some guests panelists here who are going to be working with us to help answer some questions about their experience with the launch of the southwest for CHC and how it related to service coordination.

Now we are working to get the presentation up and on your screen and bear with us for just a moment.

Once again, we apologize for the delay.

As always for the people on the phone, you will be muted when you're on the call.

You can use the panel that is to your right to be able to submit questions to us so the questions will be submitted -- apologize again.

Those questions will be submitted -- or printed out and submitted to us and we'll go through them when we are ready.

Bear with us for another moment as we bring up the PowerPoint presentation.

Can anything else go wrong?

I shouldn't say that.

Great.

So before we begin I'm going to ask the panelists in the room here to introduce yourself and which agency you work for and then we'll go through some structured questions and have a discussion about the service coordination experience in the southwest.

>> Hi.

I'm Randy Noland.

>> Bailey Kerry, vice president of business development.

>> I'm Tiffany judge, director of service coordination from pa health manager.

>> I'm Tammy Rhodes.

>> Kayla, the director of programs.

>> Paul Kent, director of the care connections.

>> Leslie.

>> Jen, office of long term living.

>> Thank you, everybody.

In addition to the panelists on the phone, we will have an individual from service coordination unlimited joining as well.

When she's able to join we'll ask her to introduce herself as well.

So very quickly an update for community health choices. As all of you know, we have worked with managed care organization since the launch of community health choices in the southwest which was January 1st, 2018.

We have focused on a lot of different areas with the delivery of services.

We ended the continuity period on June 30th, 2018 and we have seen a relativity stable transition from continuity of care to direct management.

Where we have focused is first the developments of appropriate service denials for participants and the secondary is person service planning. Just as a quick update, service denials are used to notify participants if there's a change in their service plan that may in any way be viewed by the participant as adverse action or something negative happens to their services.

They are getting less services than they want or the number of service hours they are receiving is less than they think they need to meet their activities of daily living.

So if that occurs there's a denial notice that provides to the participants their appeal rights.

That denial notice has to convey to participants the reason for the difference between their expectation for services and the reason why the services were assessed the way they were.

We've been working with the managed care organization to communicate better.

We had a training on July 19th that was offered by our office of legal counsel.

The MCO staff were involved in a workshop working on how to do a better job of crafting those denial notices.

In the meantime, the office of long term living will be reviewing all denial notices submitted by managed care organizations before they are sent to participants because we want to make sure they are meeting the standard that the agreement requires.

So with this training and with the office of long term living review we believe that we'll be able to have the denial notices presented in a way that will be quicker and comprehensible for participants as they assess their level of services and we'll provide them with enough information to be able to manage an appeals process so that they will be able to be fully informed with the reasons for the denial so they can craft an argument that depends their position on why services should be developed the way that they are.

So next step we'll continue to review these denial notices indefinitely.

We'll ask the managed care organizations not to mail those denials until such a time as when those -- until the denial notices reflect the need for participants.

So in addition to the denial notice training we are also working with the managed care organization to do a better job of representing service persons and person centered service planning. As we were discussed previously on previous third Thursday webinars the corner stone is person centered service planning. I've said this many times and I will say it again, this was also one of our coordinates for our service labors. This is not new.

We have required a managed care organization to meet requirements for persons in service planning and that not only includes the managed care organizations but the service care coordinators they are working with as well.

They are working with service care coordinators and offers training and making sure that the service plans present the goals of participants if they are receiving long term care in the community, making sure that participants have an opportunity to sign the service plans and making sure that the service plans have enough information so participants understand why they were developed the way they were.

So the participants are completely transparent and --

for participants to really clearly understand the way they services are being presented.

In addition, we will be working with the managed care organizations with a validation process.

We'll be sampling those service plans to make sure that they are meeting the standard of person service planning.

At this point I'd like to take the opportunity for our service coordination unlimited person introduce themselves.

We believe your phone is unmuted.

Diane, introduce yourself and the agency you work for.

>> I'm Diane Peggy from service coordination unlimited.

We serve all of western Pennsylvania.

>> So Diane will be participating with the other agencies on our discussion for service coordination in the southwest.

Getting back to updates we will be going live in the southeast on January 1st, 2019 and that has been our focus for implementation.

As you see here on this -- on your screen, the population of individuals transitioning into community health choices in the Philadelphia area is 129,943.

That's from 2015 data.

That represents a much larger population compared to what we saw in the southwest, roughly 50,000 more people.

Most of those people are living in Philadelphia city and Philadelphia county.

As you see, similar to the southwest, the vast majority of those individuals are dually eligible for Medicare and Medicaid, 89%.

The difference in this population are the number of individuals who are receiving long-term care and receiving long-term care in the community.

If you look at your lower right-hand corner, 36% of this total population is receiving its long-term care in a community.

That is very different from the southwest.

In the southwest the split between individuals receiving long-term care in a community and long-term care in nursing facilities was roughly even.

In the southeast many, many more people receiving long-term care are receiving long-term care in a community.

That's really driven by the Philadelphia area.

We believe that that will represent a different role specifically for service coordinators in the southeast as well.

There will be an emphasis for service coordination as there is right now with service labors and we move forward with community health choices.

Everybody in long-term care will have a service coordinator.

It's just is that the role of the service coordinator is much more intensive for home and community-based services because of the array and difference of services that are involved and also because of the fact with nursing facilities, nursing facilities are much more directly engaged in the entire system of care for participants if they are receiving long-term care in a facility.

For the southeast implementation we will be focusing on some key areas, the first of which is our OBRA assessments.

The lesson learned from the southwest is to do everything earlier and we have taken that lesson on with the southeast.

Specifically with OBRA assessments and the waiver.

They must be in a different level of eligibility compared to other types of home and community based labors.

They must be intensive care facility, other related condition eligible which is different from the rest of our home and community based waivers or with nursing facilities which requires individuals to be nursing facility clinically eligible.

Everybody in the OBRA waivers in the southwest will be going through a level of care assessment and at this point that level of care assessment will determine if they are or are not nursing facility clinically eligible, if they are a nursing facility clinically eligible they will be going into community health choices, if not they will stay in the OBRA waiver.

At this .99% -- at this point 99% of the assessments have been completed.

That's a congratulations to them.

Actually I think we have four that are remaining.

This time last year we did not finish these OBRA assessments until November.

The fact that we are effectively completed in August is a major accomplishment here.

It's a lot of work with a lot of participants going through this assessment.

Once again, congratulations to the entities who are responsible for completing them so early.

In addition, we have and continue to be involved in provider out reach and education.

We did have -- as we had mentioned previously, education and out reach sessions in the southeast, we had nine separate sessions, five in Philadelphia and four in suburban counties.

Those sessions were all well attended.

We believe that that was a good jump on making sure that the managed care organizations and the providers would be able to develop a relationship early and to continue that relationship to lead to network contracting.

At this point we have received information from the managed care organizations on network development and they are ahead of schedule.

So we are very pleased with where they are with network development at this point.

In addition, we are working with our state coordinators in the south we are for population identification.

What that means is we are trying to work with community-based organizations to reach hard to reach populations because of language or other types of potential community barriers.

That's been effective and we are looking forward to -- or we are focusing on this because we want to make sure that all populations know what they need to do next for community health choices service for plan selection and we are hoping that all populations receive all information in the mode they need to receive it to be able to be informed on what they need to do next to be able to make this choice for a managed care organization.

In addition, readiness review is in full flight. Randy, do you want to give a quick update?

>> We are working with all three at the point.

The new tool is out there.

They are starting to drop their policies and procedures for internal review.

A number of their policies, probably about 40% will be the same as they were in the southwest.

We'll just attest that there's been no changes.

The hope is that we will have the policies and procedures all by the end of the month to finalize them by the end of September.

So policy wise, procedure wise, they are doing pretty good with that.

Again, like said earlier, the biggest challenge is getting a network set up.

There are contracts out to network provider, nursing facilities, home and community based providers, physical providers going through the signing and credentialing process.

They are submitting their networks to us on a weekly basis and between the office of long term living and the department of health we are monitoring their progress.

So everything is going well at this point.

>> Thank you, Randy.

Participant communication.

Right now we are in full flight for participant communication.

I have a slide later on that goes through each of the steps.

Right now focusing on participant communication and makingmaking sure they get the information they need and selecting the best organization that meeting -- meets their needs and preferences. We did mail out an awareness flier on July 23rd to all southeast participants moving into community health choices and the next mailing that was sent to them are on ageing well event.

Ageing well is an entity that is overseeing in person participant communication in the southeast area.

More than 70 sessions in the five counties in the southeast and those sessions will be providing detailed information about what is community health choices and what participants need to do to be able to make a planned selection.

That mailing started on August 8th and was completed by the end of last week.

It also included a schedule for where those events will be taking place and it encouraged individuals to be able to attend in person to have their questions answered about how this change will be effecting them.

In addition to the ageing well presenters representatives from the appraise program will also be on site to answer questions about Medicare and representatives of the life program will also be there in person to answer questions

about the life program itself and to provide information about local life offerings in that area.

If you remember, the life program is the enrollment alternative for community health choices.

In addition, the pretransition notice will start going out next week on August 20th.

Those pre-transition notices are the normal notice for participants to know that they will be moving into community health choices as a mandatory managed care program and will provide appeal rights if the participants believe they are not part of the appropriate population going into community health choices.

Those pre-transition notices will also let participants know they will be receiving an enrollment packets and they will start being mailed the first week of September and throughout September and those enrollment packets will provide a lot of information for participants to be able to compare managed care organizations, provide information on how the participants can view the website or enroll on the website for the independent broker and they have call and contact information so participants would be able to reach out to the independent enrollment broker and ask questions about benefits as well as networks for the managed care organization.

In addition the nursing facilities will be training their participants in their programs and those service coordinations of nursing facilities will be asked to review a training that's currently on the department of human service website and do some out reach with their participants to let them know this change is going to be to be way.

So they will both be involved in the participant communication and out reach as well.

So service coordination role in CHC, which is the focus of today's presentation.

The reason why we elected -- the department and our partners elected to focus on this as a third Thursday webinar is because we received a lot of questions during the southwest implementation from service coordinators not really understanding what the role will be in the change.

We have asked this panel to join us so that southeast service coordinators or any service coordinators will have an opportunity to ask other service coordinators who

participated in the southwest launch directly about the experience and have an open conversation about what the experience was like and suggestions for what service coordinators should do to be able to prepare themselves for this change.

We are really grateful for our participating service coordinators to be able to be involved in the type of a discussion and talk about their experiences and to be able to provide tips to the service coordinatrs in the southeast and elsewhere how to be successful in this transition.

We believe the more prepared service coordinators are the more likely it is that they will be able to have a positive experience in the southeast launch as well as the launch for the rest of the state.

We are focusing on service coordination here specifically because really especially with long-term care and long-term care in the community the service coordinator is the quarterback for the management of service plans.

They are one of the most important roles in this entire system and especially for homing community based long term care they are the gateway for community health choices.

So the role essentially is important for the program and that's why we are focusing so strongly on it.

So before we go into the individual questions, I wanted to provide some key requirements.

For those service couped --

coordinatrs on the phone some slides will seem familiar from the five sessions in June.

These are the requirements relevant to service coordination in the CHC or the community health choices agreement.

So what are the objectives of the service coordination in CHC?

First, responsible for managing the comprehensive needs assessment process.

What that means is they will be available for working with participants and using training tools and other information to be able to identify participant needs.

That's comprehensive needs assessment includes a formal tool which is called the NRI cool, NRA tool as well as other tools to gather information that will help inform a participant's person centered service plan.

So they will be talking to participants and caregivers, other providers, et cetera and they will work with participants to develop that service plan through this needs assessment process.

This happens today -- to be clear this happens today.

One of the biggest changes are the tools that service coordination will be using as well as different software.

I know this is spontaneous.

Is there anything anybody participating would like to add about the comprehensive process in your experience right now?

>> This is Bailey Kerry.

I think just one important note is that it is required and needs to be done all the time and any questions direct to the managed care organization. It's quite simple.

It's a new tool and it's something that everyone has to go through training on but once you do it will be second nature just like doing a CMI.

It's nothing too, too scary.

I suggest not to delay doing those assessments because they are absolutely necessary going forward.

>> Great.

Okay.

In addition to the comprehensive needs assessments service coordinators today are responsible for making sure participants are receiving the services they need that have been identified on the service plan. Those services are going to be developed through the person centered planning process and they will include all long-term services and support of course but they will also --

the person centered service plans will also be tracking other types of services as will the managed care organization and that includes physical health services like primary care physicians and hospital stay, et cetera and behavioral health services as well as in some services Medicare services the participants are receiving.

So service coordinators will be involved in monitoring those types of services to make sure the services are being received in a comprehensive way.

Last but not least is the coordination of the participants long term services and supports with all other services they are receiving.

That includes Medicare, behavioral health and Medicaid physical health services as well.

What we are trying to achieve with community health choices as we have said on many occasions is a coordinated model of care.

We are getting a note on our screen.

I'm not sure if everybody else can see it.

It's a little concerning.

We'll just continue and hope for the best and deal with the technical difficulties.

We are a little concerned.

We do want coordination for all different services to be something that's achieved by the program health itself as managed by the service coordinators.

So we are coordinated model of care and the person needs to take that into consideration.

So we are going to continue.

We hope we do not have loss of connection but we are going to continue and hopefully the people on the phone are able to see that we did change slides.

So we did do a comparison between what was different between the fee for service service and community health choices.

The answer to that in general is really not much.

All of these requirements --

what is different will be the tools that are used in the process but the person centered planning possess was a requirement in our waivers and it is a requirement in community health choices as well.

One fundamental difference between community health choices and the fee for service waivers for service coordination is in the fee for service waivers it was a billable service and in community health service it's an administrative function of the managed care organization and the managed care organization may have a different relationship that will help to fund the service.

There may be a different type of payment arrangement.

I hear it's common for a payment for the managed care organization that covers the cost of all the services.

Anybody want to highlight anything about that without a whole lot of detail because it might be something that's evolving?

Okay.

Thanks.

>> I agree it's evolving.

The one thing I can tell you from personal experience done with the service coordinatrs is they enjoy not having the billable unit.

It seemed to be a pretty administrative task tracking that time and that was a bit of a breath of fresh air.

>> So that's what I've heard.

I've actually heard that this is a little bit more of a flexible model and reflects more with what service coordination is supposed to be, more flexible.

When you do it by unit you are constrained by those units so it can be a net plus.

But it's risk based too.

We have more flexibility but the model is always a risk-based approach.

So something to keep in mind.

These are questions we encourage service coordinatorrs to have when they develop those relationships.

As stated, in general the general requirements are not that much different.

This is probably one of the most significant requirement changes.

As I try to advance the slides, there we are.

Apologize again.

So we have already noted this the general requirements are fundamentally the same between CHC and the fee for service waivers.

We did highlight in bold another difference between the two.

Just to be clear, the reason they are similar is because we built a lot of the requirements very much on what we thought worked well in the fee for service waiver.

So that's the reason why there's a lot of similarities.

We also note here that we included the language that is service coordinators are responsible for ensuring the health, welfare and safety of participants on an on going basis.

So service coordinators are responsible for this and that's a requirement in the CHC agreement.

Service coordinators in many cases took on that responsibility as part of their role as a fee for service provider.

We just have it an a requirement related to the MCO and the role of the service coordinator in the CHC program. It's a requirement.

It may have been an implied requirement but now it's part of the agreement.

In addition, some additional differences, we require service coordinators and the CHC to explore other options of care through the person centered planning process.

That would include coverage of services that may be available under Medicare or other private insurance or other types of community-based resources.

Many service coordinators actually did this already.

It's part of their standard operations.

We have put it in the agreement.

That's the reason we are highlighting it.

In addition we are requiring the service coordinators to coordinate with other individuals in other entites in the physical and behavioral health as well.

Many did this already but now it's a formal requirement in CHC.

Just to get back to the reasoning we want CHC to be coordinated models of care because we believe it provides better outcomes to participants as well as a better system of care and it's a little bit more of what we are trying to achieve with service integration between Medicare and Medicare and behavioral health services.

In addition service coordinators are responsible for a broader array of services in partnership with other roles in the CHC MCOs.

That includes housing coordinator and the service coordinations will be working with that housing coordinator to address housing-related questions including transition services and looking for opportunities to manntain stable housing. In addition they are working with nursing facilities.

That's new.

Nursing facilities have always -- have independently managed the service planning process for participants and now they have a partner with service coordinators working with the managed care organizations.

Anything that anybody here with the panel or Diane on the phone would like to highlight that you see is the difference between the fee for service system and managed care?

>> I think one of the things is the availability to think more broadly and it was mentioned a minute whole.

Being able to look for wholistically and having the managed care organization behind you.

If you need to speak to someone with a clinical background you have is that in the MCO.

It's more of a team approach and being seen more broad as how you look at it.

>> Great.

>> I also think that the coordinating of discharges has been easier because we are able to work directly with the hospital discharge coordinators.

We worked with them on some level, not as much as we are now.

Some of the MCOs have transition teams placed within the hospital and nursing facilities that we can access to ensure that we have all of the services that the participants needs to have a successful discharge.

>> Great.

>> I think our staff is also being recognized as more part of that team than we had.

You know, we were sort of a separate entity or seen as a separate entity before but now we are seen more as part of that team.

So it's helpful.

>> Yeah.

I agree.

I also am recognized now.

Before it was a struggle sometimes to reach out to the doctor's offices and healthcare providers.

They are more readily giving us information and sharing information back and forth.

>> Great.

>> Absolutely.

>> So the continuity of care is relevant for service coordinators the way that it's relevant for home and community based providers.

To refresh everyone's memory, for home and community based services there's 180 day continuity of care period.

What that means is for that 180 day period all services on a person's service plan that was approved on the date of the services will be in place for that entire 180 day period.

In addition, participants may keep their existing providers for 180 days.

That means the home and community based providers on their service plan will be able to maintain the same services throughout the continuity of care period.

Service coordinators who were providing services will be the same service coordinators participants will use during that entire continuity of care period as well.

Once the continuity of care period is over the role of service coordination is going to convert to an administrative function.

So the role will be object --

absorbed by the three and they will have to develop a separate contract and relationship to continue operating with them to provide these types of services.

So the relationship will be different.

That's relevant to service coordinators compared to other types of providers in the home and community based system because it's a direct relationship with the managed care organizations from the department's perspective service coordination is a direct function of the managed care organization.

We are no longer talking about service coordination agencies we are talking about the CHC MCOs and they have to look at themselves as being that way as well.

That's a change at the end of the continuity of care period.

When we talk about an administrative function, you are absorbed by the managed care organization. There's no difference between the service coordinator role and the role of the managed care organization itself.

So we don't really look at service coordination agencies as an independent entity anymore.

You are a part and parcel of the delivery model that the managed care organizations are offering.

That is really different from the fee for service system because you are treated as a separate service provider and sort of a link in the chain for the fee for service system.

Now you're part of the wholistic system.

So highlighting staffing requirements, many people have seen these before.

These are the formal requirements in the agreements and the managed care organizations have adopted different approaches to the way they are delivering.

For service coordinatorerses themselves -- coordinatrs themselves they must have a nursing degree, work in psychology or other related feeds with three years of experience.

Service coordinators hired to the CHC implementation date may have qualifications and standards and proved and approved by the departments.

That means that the CHC MCOs can offer a different model.

Folks in the room can correct me if I'm wrong, two of the three man anded -- managed care adopted this wholstically and another offered a different approach.

Is that correct?

Was that your experience?

That's our understanding.

>> We have an understanding that two of the three have a hybrid approach.

>> Same for us too.

>> Okay.

That is news to me and that's the reason you would know that further ahead than we do.

Randy's team is probably Aware of who those entities are.

In addition, service coordinator supervisors must be a registered nurse or a Pennsylvania licensed health professional with three years relevant experience and if they were hired prior to the implementation date -- once again the managed care organizations are in a position where they can propose a different model or they have the opportunity to obtain a license within the start of the first year of community health services.

So two different options. It's not just two of the three are offering a hybrid model as well.

>> And taking it internally.

Some of them are doing the supervision inside.

>> Okay.

Great.

Is there anything that anybody would like to add to this at this point?

>> I would add to to -- to make sure to have a conversation with the MCOs.

If they are going to be doing this technical supervisor role your supervisor role may change somewhat.

Each of the MCOs look at it differently.

That's what we've seen.

>> This is Tammy.

Hours is the exact same.

We are in the -- ours is the exact same.

We are in the same type of conversations about whether it's external, internally and how you want to structure it internally.

Having a supervisor has been a benefit because of the fact that it allowed you to streamline the communication with the MCOs.

So we are in the same conversations as well.

>> Great.

Diane, was there anything that you wanted to add?

>> No, I agree with what they are saying. That's the same kind of discussions we are having as well.

>> Thank you.

So this is kind of the high level flow of person centered service planning that service coordinators oversee.

It starts with a comprehensive needs assessment that has to happen within five days of when the person is enrolled.

The next is the person centered service plan.

That person centered service plan not only involves the assessment but involves the engagement of a person centered planning team to determine the needs and preferences of participants.

That person centered service plan results in the care management plan that will focus on physical health services or an LTSS service that looking at long term services supports and requirements.

What is truly different here is the direct relationship between the person service planning process and a par --

participants physical services.

Such as dialysis, for example, or if a person is a diabetic, and it's direct connection tot long-term services and support.

Our fee for service system this doesn't exist as well as we would have liked or all.

There's a lot more transparency in this system. That's what we hope.

Would you all agree at this point?

>> Yeah.

>> Yeah.

>> Yes.

>> Great.

Noting that nursing home transition is also a role of the man aged care.

Service coordinatrs may be working with nursing home transition actors which may be internal or external entities or entities that subcontracted to the managed care organization as they help transition a participant from facility based care to community based care.

So service coordinators have to be involved because they are involved in identifying the reports that is needed to make that transition as successful as possible.

I don't know how many folks in the room have been involved in nursing home transition activities.

They continue in community health choices and I would imagine that transition process is working largely the same.

Anything that anybody would like to highlight about your experience with nursing home transition?

>> This is Tammy.

We've done nursing home transitions for years.

Getting approval to continue to work with them is key because you want to make sure.

We did successfully help transition out several people with at least one of the MCOs.

So it's just having that constant communication with them.

>> Given the area use of ageing have done this for a long type -- time and they continue to work on nursing home transition.

The one issue is the issue we dealt with back in January and February.

That is if you started a transition before the role out working with both the department as well was the MCO on exactly how that is going to work and making sure you have that list and you -- as much as you can get people to transition before and not have that carrying over the lot today is probably helpful.

If you can't, making sure the MCO knows that really right off the bat that you have that issue, you have people in process.

>> Thank you, Paul.

I would add that it is up to the department to make sure that we're providing better guidance to individualing -- individuals.

Nursing home transition is a service we want to highlight since one of our main goals is for participants to receive their care in the community if that's what they want.

We will definitely own better communication.

Okay.

We also mentioned a little bit earlier coordination with non-Medicaid services that includes Medicare services as well as other types of services that participants may be receiving including community-based services and in some cases services that are not funded by the state Medicaid program at all such as the options.

It's possible that individuals who are community duals may not be enrolled in long term care but enrolled in the 150 program or options program.

We want to make sure those services are offered as part of the care coordination model that community health choices is offering.

Monitoring is something that will involve the departments, service coordinators and other entities that are directly related to community health choices.

The office of long term living will be monitoring service plan changes and we'll be working with the managed care organizations and their service coordinators when it comes to the review of these service plan changes and we'll look forward to service coordinators with the managed care organizations providing some content behind why they are taking place the way they are.

We are going to provide those report to assure reports to participants to ensure they are El Faro -- to ensure they are getting their services as well as for health and safety.

The role of service coordinators is to provide the information and make sure the participants understand the components.

The role of the service coordinatr in in -- in this process is to make sure they are communicating to participants on the out comes of the person centered planning process and making sure that there's full transparency for the participants on what the service plans are and why they are the way they are and why they are designed the way they are and providing participants with some information on their rights as well.

So a lot of lessons learned when it comes to the southwest implementation, all of which we've high lighted many times before, doing everything earlier.

We've learned a lot about how service coordination has to be involved in these different steps.

Here are some highlights on the role of service coordination based on lessons learned in the southwest.

First early training for external service coordinators on both continuity of care and the role of the service coordination in CHC.

That's the responsibility of the managed care organization and we do believe that the training for service coordinators was much later than it should have been in a roll out for CHC.

We are looking forward to the managed care organization and their partner service coordinators to engage in that training much earlier and hopefully way before the launch date for the southeast.

In addition, making sure that there's a great communication system in place with this CHC MCOs.

This was a pain point earlier on.

We believe that it's been stabilized and improved.

With this experience we believe that there really is no good reason for a lack of communication between service coordinators and the managed care organization.

A lot of the mechanisms that were causing interruption in communication should have been addressed and cleaned up.

Third is data clean up and standardization.

One of the most significant issues we had with the launch of the southwest was data integrity, especially from the case management systems in SAMS.

We are way ahead now with data clean up for the southeast and we believe we will have a much more successful transition for that data in the southeast compared to the southwest.

We want to make sure that we have opportunities to have service coordinators involved in those data clean up efforts and also to have an opportunity to develop and validate data some of the information we saw in the southwest will not occur in the southeast.

Since data was one of the biggest issues is there anything that anybody in the room wants to highlight about that experience?

Many of the people in the room were very involved in conversations with the department and the MCOs and addressing those data clean up efforts and we are very grateful for your contribution. It was a challenge and we believe we have worked through that challenge but it was difficult.

>> Instead of focusing on pain points maybe focus on things you can do to ensure that you know what your case load is post the implementation of CHC.

So in December it's a really good idea to print out maybe your case loads from SAMS so you know which participants were assigned to each service coordinator and after you're reviewing the systems post implementation you can make sure that no participants fell through the cracks and that everybody is accounted for and assigned to a service coordinator.

>> I would add to that touching base with all of your participants close to the end of the year, make sure and remind them that this is happening, that you're there for them if they need anything after the first of the year you will be there. One of the things the department focused on is gas and getting information about gas and touch base after the first of the year to make sure the participants didn't have gaps if care.

One of the things that happened immediately this the southwest was the MCOs comes to us and asking us to touch base with participants and report back.

Expect that.

>> That was a requirement that the departments imposed on the CHC MCOs.

That's something we will report back on.

>> Is there other things you will be asking for from the MCOs?

>> We talked about launch indicatorrs on this call before and we have evaluated the ones we used were not meaningful and helpful.

We are scaling back and focusing on the risks in interruption of services and risk to provider payment.

So they will actually be more focused and more manageable.

>> Yes, we cut down the launch indicators from 15 or five or six.

We wanted them more focused and we have a lot of operations report that will collect that same data.

Our launch indicators will be there just for the month of January to give us a quick snapshot.

They will be submitted on a weekly basis.

Once January is done they will be done and the other information will be reported on other reports.

>> So in addition to data clean ups some system set up issues are focused for earlier implementation between service coordinatrs and the MCOs.

User account set up and record change with the managed care organizations.

All this is something that we want built into the process earlier and to communicate to the MCOs.

Also opportunities for augmented training with external and interim service coordinators on the person centered planning process.

We are beating this because of what we saw with the southwest.

We believe this is something that should have been an easier transition between the fee for service system and the managed care service for community health choices.

Person centered service planning as always been a part of our programs.

We think it should be -- this should be low hanging fruit.

The fact that it wasn't was a surprise to us. We believe that it should be something that is part of the system now and we are actually going to continue to advocate that service coordinators and even in the fee for services should be paying more attention to person centered service planning requirements because it's your job.

So we do have some structured questions and we've already started to receive questions from the audience.

We are going to start with the structured questions for the panel.

This is a free form conversation.

Feel free, and Diane on the phone as well, answer them as you see fit and then we'll jump to the questions from the audienceaudience.

How did you prepare yourself for the transition to the community health choices?

That is for anybody.

>> We built a series of trainings and we really used the RP that you put out from the state standpoint and what those requirements were to build training for the service coordinators.

We did training to help people understand how this was going to be different working with the MCOs.

And start early as you've highlighted to prepare folks.

We didn't wait on training coming from the MCO and we encourage others to do the same to get training.

>> Great.

Anything else?

>> This is Tammy --

>> This is Diane.

Sorry.

>> Go ahead, Diane.

>> Thank you.

We also encourage staff not to -- to try not to schedule vacation time right at implementation.

Even staff that were not directly involved with it because we knew we were going to need everybody's efforts, you know, just making sure that everybody was accounted for and that everything was as smooth as possible.

>> Good point.

>> They expect to be in the office around Christmas and new year's.

That's a really good point, Diane.

>> Was there a holiday last year?

>> Didn't seem like it.

>> There was supposed to be.

>> True.

>> This is Tammy.

Also talking to your staff with the training and in advance is not something you need to panic about.

It's happening.

Talking about how we are going to transition, what the plans are and not to panic and just to go with what is happening.

To be flexible, to understand that it's going to change.

We did business as usual.

We flowed with the changes as they came down.

We didn't make changes immediately, it was do business as usual and as we get information and we were communicated to we changed as we moved forward in the process.

The other thing we did was we appointed supervisors pretty early in the process for each of the MCO for communication reasons. It was easier to have one point person get receiving communication and then filtering that down to the staff because it just streamlined everything and kept things calm as we made some changes.

>> On the management perspective, I think it boils down to some really simple steps.

Number one, attend the training offered by the MCOs.

Have your staff in the office during the holiday season.

Follow the updates from the department.

On the administrative side and also on the billing perspective, register with HH exchange soon rather than later and go through the testing before implementation starts so you're agency is ready to bill from the beginning and you have no delays.

If there are delays it's only because you didn't set up with HH exchange soon enough.

They have a cut off time.

I think it's a month early before the roll out they cut off signing up new agencies and testing the system because they were working with the ones who preregistered.

It's important as Tammy said to continue business as usual until the updates start coming and not panic.

That panic filters down to the par -- participants we are trying to help.

As long as you continue with that in mind it should go quite smoothly.

>> The next question, how did you make contact with the CHC-MCOs during the southwest implementation period?

So I would have an expectation that hopefully service coordinates ers -- coordinators have made contact with the MCOs or are in the process of doing so.

I know last year at this time everybody in the room had contact with at least one if not all three.

If you haven't done that this is something you really want to move on very quickly.

If the folks here wouldn't might highlighting the way that you have approached contact with the managed care organization it would be helpful to provide that perspective.

>> This is Tammy.

Make sure that you're at meetings that are made available to you.

Be sure that you introduce yourself, your staff right away when you're at the meetings so the MCOs know who you are, what your agency is.

>> Pay attention to the materials you put out.

You will often provide that information with the contact with the MCO.

It's there.

The other things that the state is doing is putting out the information is how to contact them.

Totally agree, if you haven't already contacted them you need to be doing it.

>> The department releases the general contacts for the MCOs so the service coordination line, the participant help line, several lines for the MCOs.

That's important to follow up with.

After that comes meets and greets.

While you're at the meet and greets you will meet their service coordination directors and management team.

>> Don't be afraid to reach out.

Sometimes we want don't want to ask questions because we don't want to look like we don't know what we are doing.

The best thing you can do is reach out and ask who your point of contact is and they will give you that.

Communication when you're unsure is the best way to handle it.

Don't wait, go to that MCO directly because they will give that information.

>> Diane, anything you wanted to add?

>> A number of our staff also participated in the informational is -- sessions that were offered to the community.

As everybody said, you can't have enough communication with them, communicate too early.

We want them to know us, trust us, understand our background and we want to get to know them as well as their expectations.

So just working together and having as much contact as possible is great.

>> The only other point I would add is the long-term services and support includes all three managed care organizations.

They are always there and they always have their network people there for providers for developing that relationship.

So if you want to meet the managed care organization in person and you haven't yet, you will probably be able to meet them at a public meeting.

Next question, how did you approach service coordination training offered by CHC-MCOs?

I think that you already hit on this.

Did you want to maybe highlight anything more about the training itself other than the fact that you would all like to see it earlier and it should be this year?

>> I would agree.

It came a little later and it came fast and furious.

It was training upon training upon training for a little bit.

So hopefully if they are doing it sooner and spreading it out so that it's a little bit easier to get all of your staff to go to the trainings.

We are still working among doing the training.

So just go to the training, be available for the training.

They are important because they show you what you are going to do next and how to change things.

>> To that point, you have to manage it within this unit billing system.

So one of the things to do is look at this from a fiscal standpoint as well.

Most of the agencies took a hit because people are in training so they are not actually out there able to be in the field.

You need to prepare for that.

>> One additional point is that some of the MCOs if not all three require that your staff who will work with them attend a training to have access to their system.

Make sure that your staff that will be working with the MCOs are able to attend because if they miss they won't be registered.

>> Diane, anything that you want to add?

>> I thought that it was vital that we had multiple staff people attending the various meeting to get information and compare our notes and learn as much as possible about the MCOs, knowing their staff and understanding what the expectations were.

Like Tammy was saying, there's so much information from so many different sources. There were a lot of meetings.

>> Great.

So the next, how did you communicate to participants in your case load about CHC?

As we mentioned earlier, we were asking service coordinators during the implementation period to talk about community health choices and how this change is going to impact your par --

participants.

>> This is Diane.

I think that we did a lot of that especially ahead of time in one on one sessions with participants. We also sent out meetings.

Like I said, we were involved in the public sessions.

We had sessions here for participants, informational meetings.

We answered lots and lots of calls and tried to share information even among other providers.

We were all getting pieces of information and some getting more than others.

We also, you know, found like there was lots of worry among participants and we kind of said that it was sort of like Y2K when everybody thought in the year 2000 that all the lights were going to go dark and everything was just going to implode.

So we tried to be very reassuring with participants and we kept echoing what we were being told by the MCOs, that services were going to continue and providers were going to get paid and -- you know, so we worked hard to be that levelling factor and to continue business as usual knowing that things would work out.

>> The only thing I would add is that teaching them to advocate for themselves on letting them know that they are in the control of the plan because a lot of or participants were calling in asking us who to choose and we taught our staff to we take all three out and say what is most important to you, let's highlight what is most important to you under each plan and then you can decide based on what you know they are able to provide you.

First is them feeling like they are forced to make a choice or not making a choice and being put under one was to go out and meet with them hand make it not so scary.

A lot of my participants tend to be iliterate so the material was over their head.

They were relying on us to make good choices and the right choice and because we were trained through ageing where we couldn't -- like we had to be extremely careful with going over the plan.

What we found to be the most useful is truly sitting them side by side by side and going down through and telling them which each other offers and high lighting what is most important to them and letting them choose tended to work for us.

>> That's a really good point.

Participants need to understand they are in charge of their person centered service plan.

They are also in charge of making the choice for the managed care organization.

We have want the participants to select the managed care organization they want to meet their needs.

Even if they are auto assigned into a plan they can make a change at any time and it will be effective.

They are make a change. That's a really good point.

Thank you, Kayla.

>> I know our agency we did very similar to what everybody has been saying.

Before they got their packets we had all the SDs all the participants to let them know that it's coming, to watch out for it and then when it comes to actually call into their SD and then the SD will go over -- we had -- we've got to train the SDs what to say so they are not scared by it.

They help them walk through it.

If they don't call them the SD was, hey, did you get your enrollment package and they would say yes or no and then walk them through the steps.

It's similar.

>> Just keep your coordinators educated and updated on the information that is coming in to the participants as well as like what you're receiving with the training.

We ran into a lot of agencies that weren't keeping their service coordinators up to date on the changes in the CHC and the coordinators are key.

They help them with the information and reviewing it and not panicking.

>> Absolutely.

Okay.

So moving onto your experiences, what do you see is the most significant challenge with the CHC transition and how did you handle it?

>> Let me throw out one.

I don't know if this was significant or not.

People have to think about the exclusivity issue.

Beyond continuity they require that the service coordinator be exclusive to a particular MCO.

You have to think about that within your staff, how you are going to realign your staff to work with three different MCOs and have that staff also have cross coverage in case somebody is out.

40 you are you going to manage that and talking with the MCOs about that.

I think that's an important consideration that we are not used to doing under the traditional waiver.

>> To add to that same topic, we had staff working with all of the MCOs to start and actually what we found was that it's confusing for the coordinators to work under all of the MCOs.

So it is much better and easier for your staff if you have a particular MCO that you assign them to.

Now there is communication you need to have with the participants because some of the case loads needed to change because of the fact that we were moving them to different MCOs and having them working directly under that MCO.

So it's communicating about changes to the case loads and having your staff working under one actually turns out better because they are only focusing on what do I need to learn for this MCO.

>> We had the same experience.

>> We did do.

We started out with multiple case loads and moved them around because their systems are different.

Their requirements are mostly the same but just doing their service plans and everything is all different.

It's easier to have them all separated.

>> We felt the participants would not get as good service because the coordinators would have to learn all three systems and the differences between.

So we wanted to be sure they got the best service.

It was challenging because at a time when people needed their trusted adviserers, the service coordinators they worked with for a long time we had to shift some of those relationships.

So it was a big learning curve for everybody I think.

>> I think the other thing that I would see as significant for us too is the -- we are used to different timelines for things getting approved and we were used to different communication pools and we had to adjust to learning and waiting sometimes for different things to happen where as before it might have happened sooner and it was learning to do that and it was also learning to communicate this doesn't have to happen right now but this does have to happen right now and learning to escalate what is an emergency and what is not an emergency.

In our world everything is an emergency because we wanted it to happen yesterday.

In the true MCO world there are emergencies that have to happen now that should be communicated now and urgent and then things that aren't urgent that can wait a little bit and learning the difference between the two so your staff is not INT --

inundatng them.

>> Another challenge that we saw was the implementation of trigger assessments in the middle of flu and pneumonia season.

We had a lot of hospitalizations that we had to do a whole complete NRI.

With the training delayed we did not have training on the NRI.

So it was difficult with clarification on which form we should use.

I think that's a lesson learned for the southeast.

That the MCOs have also identified and are moving forward with that earlier training so you have the tool at least available to you to complete those trigger assessments.

>> Anybody else have any challenges you want to highlight?

>> This is Diane.

There was one other thing that came to mind as other people were talking.

Requests for SAFs from PAF agencies.

Because that process is different and they need certain -- they're accustomed to getting certain information that's on the SAF and need that information in order to staff the case, so that was a little bit of a hiccup for us because some agencies didn't want to provide service until they had that in their hands.

>> How did you address it, Diane?

>> I sent the SAF to be honest.

It wasn't supposed to do it.

I wasn't really supposed to do it but I didn't want anyone to go without service.

We just let the agencies know that we had to get -- we still had to get approval through the managed care company but in order for them to have the other information from that that they needed.

You know, we went ahead and gave them the information they needed.

>> So what we did, we took a preauthorization form that a doctor's office would use and I created a proauthorization form that educated the MCO on what they currently had, what we were requesting the change to be, how it would effect it and at the bottom it said this is just to let you know what we are requesting, this is not permission to bill.

We sent that because if we sent the FAS we assumed that was us taking the risk of being held accountable to pay the provider if the MCO said no.

So we did the preauthorization form so the provider would know that it was coming but know that we had no responsibility fiscally for what was being done.

>> That's a great idea.

>> I think that's a gap.

That's definitely a gap that was happening.

>> That's a great idea.

That could be implemented elsewhere I would think.

I wish I had thought of it.

>> So I have to say that this issue doesn't surprise me actually.

So how did the -- I'm sure you've had communication with the MCOs to try to improve this.

Have they been responsive to you and maybe looking for a different process of adopting like what Kayla was describing?

>> We are discussing that.

>> Just getting in their systems where you can actually make the request.

On January 1st we weren't there yet.

It was really difficult.

Being in their systems really addresses it.

>> Being in their system?

>> Yeah.

>> Yeah, that makes a huge help.

The other thing is in HHA I believe -- so some notes were put in the MCO systems that were not translating into I believe it's HHA.

So there was some information that agencies needed and didn't have access to and it might have been in there but they weren't able to see it.

I think that's being addressed now as well.

>> Those are some of the bumps in the road.

>> Absolutely.

>> The next question, what is the most important lesson learned for your agency from this process?

>> Communication is key.

>> Communication.

>> Flexibility.

>> Communication with the MCOs, communication with?

>> Across the board.

Just have to be good communicating as a team.

>> You need to communicate with the MCOs, keep up with the updates with the department and make sure that gets down to staff and the people who have their feet on the ground working with the participants and then also communication with the participants so they are not scared because this can be scary for them.

Communication easing everything.

When everyone has the knowledge of what is going on, no one is here to do any harm.

I think this whole system is to help actually.

The only issue is a few bumps we are hitting along the way but it's smoothing out quite well already.

>> We knew there would be bumps because you can't start something this massive and not have some hurdles to cross.

We did the same thing and just trying to also -- the communication is the biggest thing.

But encouraging staff to just hang in there and we understand, we know that it's hard right now, we are going to continue.

The six-month continuity of care period, very, very helpful.

I was so thankful that the region 2 roll out was postponed to January because we really needed that time.

>> Same here.

>> What would you consider to be your most positive change with regard to community health choices?

It can be organizationally or personally?

>> I think it's the continued care.

Being able to talk to the doctors and to the hospital and have them actually listen when we say these Friday discharges are not the best thing to do, can we look at a Thursday or a Monday.

>> That was a problem and such an obvious thing to correct.

I'm happy to hear that managed care is helping them.

>> They support it more.

They will block a discharge if we call them and say we have serious concerns, they have no plan of action at home.

The MCO will get involved with their hospital people or whatever they have to.

It's been nice.

>> Yeah, I completely agree.

Along with that I think it's been beneficial that we have access to all of the different services that the MCO offers.

If we identify that a participant is having a problem the tool was the first services.

They are having a decline in their health, we'll give them more PSA hours.

Now that we have access to that whole team we can get to the root of the problem.

It may not be they need more services but they need to get to the doctor.

There's also services that we are able to offer understood you are community -- under community health choices especially for the under 60 population has been a welcome change.

>> Absolutely.

For those who didn't want to switch over to independence waiver it's opened up a lot of services to them and it's opened up services like community integration and some of the meals and pest IR -- IR --

pest.

Also be in the MCOs we are able to complete our paperwork immediately so that process is smoothing out.

>> We agree with that.

It's nice to have a team that you can contact in regards to a particular person instead of not knowing who to contact.

You have a specific MCO with a case load that handles that particular person, maybe team members to help for different services.

>> Great.

So I think we had a number of questions from the audience on what you've been talking about.

I'll read them and then we'll go through them and then we'll have a conversation as well.

So is any of the entities still providing service coordination services for the MCO without a contract?

So I guess a different way of asking that same question is are you still working with managed care organizations without a contract?

I think that's the question.

>> So I think what they did was they gave us an extension on the contract that we had during the continuity of care while we continued to work with them on what would happen after that period of time.

>> So that's --

>> Yes.

>> Yes.

>> Great.

>> To add to that, I think MCOs to make it really clear were saying continuity of care continues until either we have a long-term contract or continue those discussions. That's it.

It does have a six-month time frame but doesn't technically end until the MCO says it does.

>> So this question is a challenge.

Would anybody be able to provide a comparison between how you submit the needs assessment, which is now the CMI and the individual service plan in the CHC system verses what you would have done in the fee for service waivers?

Anybody want to give that one a try?

>> I think there's a lot of encouragement to get the assessments done electronically in the home.

I think that that would be my biggest compare/contrast.

That there's some service organizations that felt more comfortable doing things on paper and coming back and entering it into the computer.

The MCOs are looking for realtime documentation.

To be honest the documenting in the field is saving some time.

We experience some connectivity issues and for those instances we have downloadable forms that we can put on our laptops and upload them back into the system when we get back into the office.

I believe Tiffany made a point before that you'll get used tot new assessment form.

Once you start to use it you'll get more used to it.

>> Great news.

Very technically oriented.

We have seen that many times before.

So the next question, this is an individual that I could actually answer this question.

This individual is in the southwest and they have not had a person centered service plan at the present and why is that.

One of the reasons could be that they plan to continue the service plan as well.

The requirement and -- the question is they have not had a comprehensive needs assessment, their service plan approved will stay in tact indefinitely.

So it could be possible that they were prioritized not to need any changes to their service plan and they -- they will eventually have to have a person centered service plan but I guess it wasn't needed because they didn't see anything to change to their existing service plan.

Anybody have anything to add?

That would be my Athought.

What do contacts do you have through the HMO?

Are you working with the dual special needs plans that may be either be aligned with the CHC-MCOs or not aligned with those MCOs?

Are you working with dual special needs plans in other words, the Medicare coverage?

>> Well, where they are aligned there is some coordination of those services.

That would be the main thing, they would be aligned.

>> That's interesting.

We do have the expectation that the CHC-MCOs still coordinate care with the non-aligned dual special needs plans as well.

We will continue to have that alignment because we want Medicare and Medicaid to be coordinated regardless of where they are aligned or not.

We just know that it's easier in an aligned dual special needs.

>> My expectation is the MCOs are doing that themselves on the clinical side. That's my expectation.

>> That makes sense.

Next question, very -- not a surprising question.

Service coordination is new.

When does the NCI home care tool need to be completed for residents living in nursing facilities?

When a -- does a nursing home resident expect to hear from their service coordinators?

>> It's the same five days.

It would be five days.

Service coordinaors have to make contact within that five-daytime period.

Randy say they may not be using the NRI tool.

They will be using a different tool.

There will be contact with the nursing facilities to make sure there's a coordinated care.

Anybody here doing any nursing facility coordination at this point?

I didn't think so.

>> The MCOs are keeping that in house.

>> Different case loads.

Just what we've seen so far is that the nursing facilities are still largely managing the cases in their facilities and they are working with the MCOs and any service coordinators for anything.

That's my thought.

It might be helpful to give an example of how to provide a seemless example.

Maybe like if they need a therapist where they are hospitalized or need a new medical specialist.

Would anybody provide an example for how you would approach coordinating care in those types of service need situations?

>> This is Diane.

One of our service coordinators just made the referral and set up the team meeting so that the person could get the behavioral health services they needed.

They were instructed by the MCO to arrange it so that's what we did.

>> I would say it doesn't change much.

I mean, you're normally doing that now.

If they request something we go out and we find it and help them get it.

I know the MCO is more of a team approach now.

You were doing it alone before.

You would reach out to the MCO, educate them on what is being asked and then the team would develop a plan together.

>> Great.

Any other examples?

>> I just would mention that the coordination with behavioral health resources is new in CHC for those over the age of 60.

I encourage you to get to know those local resources in the area and utilize them because it's a benefit to the participant.

>> Good advice.

Thank you.

I think Paul this is a question for you.

You said that the supervisor you may know now may change.

Do you mind elaborating on what that means?

I think that means is that the managed care organization is assuming a lot of the supervisory role in terms of the approval of care.

>> Before CAC the service coordinator goes to their supervisor when they have a question for approval and that kind of thing.

Under CHC a lot of that communication goes to the supervisor who is an employee of the MCO.

So they are coordinating directly with that superviser.

We are finding that the supervisor with the MCO is expecting the service coordinator to make more decisions on their own.

There's not as much as a task by task approval process required.

It's more of a global process and that supervisr is at the MCO going to do it rather than the supervisor in their agency.

Ly I -- I will say the three MCOs do this a little differently.

>> Anybody have anything to add?

What is your case load per service coordinator for community based services?

>> So I think it's by MCO and it's kind of -- I mean, they are saying a maximum of 75 on a case load. It fluctuates per the MCO.

>> Same for us.

>> So this is a little bit more of an awkward question.

We get these here sometimes.

Do you have any -- is there an issue where the MCOs are recruiting your staff as a service coordinator?

>> Yes, we have had staff go to the MCO.

>> You mean the --

>> Yeah.

>> But I don't know. This is Diane.

I don't know that think are necessarily recruiting our staff specifically but they are out there on, you know, linkedin and monster and different websites.

I don't think they say this person works at X, Y, Z and I'm going to get them.

They are recruiting and as they come across people with qualifications they reach out.

>> I would say our experience has been kind of a hybrid of that.

That's -- I have not seen them intentionally see them go after staff in a blanketed way but they go after individuals they have identified.

Which you expect them to do.

>> It's an event.

>> Yes, it is.

>> So next question, do any of you provide services through an organized healthcare delivery system?

Would you be able to talk about your experience offering it in CHC?

>> I think it's been different with each MCO.

I think in one case we were asked to continue to do what we had been doing for non-medical transportation.

We continued to pay the non-medical transportation and then the MCO was going to reimburse us for paying that.

That was one instance.

>> We were able to get it approved faster if we were willing to front some money and be reimbursed by the MCO.

In our case we did it for people who needed it for health and safety reasons.

We approached the MCO and offered to pay if they did a promise to pay back.

That made it easier during the transition to get mods faster.

>> So I know they are heavily involved as well.

Diane, do you offer OCDS service?

>> Yes, we had offered that.

I would say that that's something to -- that we could improve on in the future because there was -- initially there was some kind of back and forth about what if the home aud started before CHC but extends after.

We were not real sure what was going to happen with reimbursement on that.

So there was some uncertainty.

I think that people experienced some delays as a result.

So I would say that's something that could be improved on.

>> And then clarity on what is a conflict and what isn't and how to make this work.

>> So the department is going to be providing guidance on home modifications in the near future as well.

We recognize that there was a particular problem in the transition because it's a service that will extend -- or often extend over the January 1st date.

>> And for those who have providers that could be MA approved to continue your providers to do that and get that MAID number and help them through the process early, especially if you're helping with OACDS for homely delivered meals.

They could get them themselves approved and that can ease billing issues in the future.

>> Just a reminder, the department of -- I don't have to remind the department.

We remind them of the requirements and it's a service that may be offered by the -- we had permission to be able to offer certain types of services request service coordinators.

We are a CMS that will use it as a conflict and allow us to continue OACDS services in its existing model throughout the con continue knew -- continuity and care period.

Other wise way have to enroll.

We have the authority from CMS to have some exception and those exceptions usually are if there's no other entity in a given service area that can provide those same services.

We may be able to continue the OACDS model if there's no other option.

So we do have examples oh of --

of that as well.

Are service coordination entities getting new participants after the continuity of care period?

So have you received referrals for new participants?

>> We have recently received some new referrals.

In the beginning we did not.

If we had someone that we were working with prior to the January date, we did get those participants once the MCO implementation started or CHC but after that there was a very big period of time where we did not receive any new participants.

>> We had the same thing.

>> People were grandfathered in.

They visited with our agencies prior to CHC implementation.

>> I would just add to that, or they're not providing the technical supervisory function as the department is requiring.

They are providing HR type of function and coaching and developing and that kind of thing but the MCO supervisor is taking on the actual official supervisor roll.

>> Clinical, yes.

>> Right.

>> So how are you managing or experiences participants changing from one of the MCOs to another of the MCOs?

This has been a pain point especially in exchange and I'm sure that's why it's being asked.

>> Probably the biggest difference is because of alignment.

If they change but then want to keep their agency they can't keep that service coordinator.

They have to move.

That would be the primary difference as I see it.

>> I think in the beginning --

I think this has gotten better but in the beginning we didn't know when they switched to a different MCO because not communicated to us. We weren't sure and we would find out when we went to do billing or whatever.

I think it's gotten better.

>> You have to figure out what works inside of your agency for tracking that.

I don't think that who works in my agency is going to necessarily work with C3 or management.

I think that as managers of your agency you have to decide what works best for your agency, your consumers, your staff and really communicating that.

Like we sat down with our staff and said this is an issue, how do we fix it.

We let them come up with what worked internally and then we approached the MCO exTER --

externally about what benefitted us and how to transition them easier too.

>> Our agency being in contact with both of the MCOs.

One has to end date it.

We have had experiences where they switched and we assumed our name was attached to it and it wasn't.

It was corrected, it was a simple fix.

We had to be in constant communication.

Don't assume anything.

Make sure that you're following the participants in all steps.

>> You make a great point.

The MCOs have been pretty receptive.

If they know that we are getting a participant they keep it with our agency because we are familiar and they feel it helps with continuity.

>> Coming back to Tammy's point earlier, one of the challenges was who we thought was our participant with the MCO. That was a real challenge throughout continuity trying to make it match up.

>> They had enrollment files that were valid but there was data integrity.

We talked about that earlier.

We believe that we are ahead of that but the problem in the southwest is if files that transition from the legacy system to the new system had problems and those problems created a lot of disconnects and the case loads participant information.

The it was -- it was a lot of work to get cleaned up.

Is that all the questions that we have so far?

>> Specifically, yes for the service coordination entity.

>> Since we have about 15 minutes I'm going to run through some of the other questions we received in general about CHC.

Feel free anybody in the room for chiming in.

First, how was 150 to be administers under CHC?

It's not directly administered by the CHC-MCOs but there's a requirement.

If they are a dual and enrolled in the 150 program the CHC and MCO will be coordinating the role between.

Questions -- important question, is there a way to get copy os of the July 23rd mailing, the awareness flier as well as the invitations for the ageing well sessions or any of the other mailings going out to par --

participants?

Go to the health choices website and go to the CHC page, all mailings are available to you as well as a lot of other very important information that relates to the community health choices program.

So go to the healthchoices.pa.GOV website, go to the participant information for community health choices and you'll be able to find all that information available there on the website.

Question, will your out reach include the life information and then the question is whether there will be a side by side comparison between the life program and other types of programs.

So all of our out reach information will have come inclusion of a life program and we'll be including life specific information in our preenrollment and post enrollment packages as well.

The answer to that would be yes.

There may not necessarily be a side by side comparison but we are hoping there will be as much information as possible for people to know that life is an enrollment option for them and to make an informed choice between life and community health choices if they are in need of long-term care.

Next question, is there clarity on electronic verification?

We have heard it's been postponed.

So to postponement was actually at the federal level for when it needs to be implemented.

It was postponed for a year.

The original implementation date required by our federal partners was January 2nd, 2019, --

January 1st, 2019, and that was postponed to January 1st, 2020.

There will be changes announced much more publicly in the future about electronic verification.

So the question, will there ever be limitations or restrictions placed on members when it comes to changing MCOs?

I think the answer would be always no.

We will never restrict when participants will change their managed care organizations.

It's been a practice since 1998.

It was built in community health choices as well.

The answer to that would be no.

>> There's a couple of additional questions that came in.

>> Great.

>> What is the ratio for MCO to coordinators?

>> That's contractual.

>> That's great.

What we would encourage that individual to do, especially the individual who asked the question is to reach out to the MCO and ask that question directly.

I don't think that we'll have any problems in doing that.

Next question, how do you handle a situation where an FEE is no longer in business and they already have services in place for the service providers contracted with the MCO?

It's the MCOs responsibility to make sure that the participant has access to a service coordinator but to make sure those services that are on their service plan are being delivered so the immediate response will be they will be resigning.

The participant will have a choice of service coordinator but that participant will be reassigned a service coordinator and that service coordinator will be available to make sure those services are delivered.

Anybody have anything to add to that?

That's a requirement.

Great question.

Do the service coordination agencies speaking today have local offices in each of the regions of the state where the services will be delivered?

>> Yes.

>> Yes.

>> Yes.

>> Yes.

>> So all four say yes.

So you actually have a pretty broad answer for all four of you.

>> Yes.

>> These two questions are for me.

If you have not received any contracts from the MCOs should you be concerned at the point?

My answer would be to reach out to the MCOs right away.

If you're a service provider an existexistingexisting person.

>> Can I ask which system that information needs to be?

>> The client information system.

>> Right.

>> Anymore questions?

>> No.

>> So we are out of questions at this point.

We really appreciate the patience of the folks on the phone as well as the people in the room.

We had earlier technical difficulties.

It ended up working out okay.

We did end up for the starting 40 minutes late.

Thank you for those who stuck with us.

For the people on the phone who are service coordinators in the southeast, we really strongly encourage you to open up communication with managed care organizations as quickly as possible and to make sure that you continue to look for continues to learn as much as you can as you begin to transition into this new model of care.

We want you to be successful in that transition and we cannot thank enough the people in the room today as well as Diane on the phone for answering those questions and being part after this dialogue.

We look forward to continued dialogue with this group in the future to continue to help improve the program.

With that we thank everybody for participating and we wish you a great rest of the summer and we'll talk again in the third Thursday webinar in September.

Thank you.