- January 17, 2019
- Third Thursday Webinar

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>> Good afternoon, everybody. I'm Kevin Hancock and I'm the Deputy Secretary for the office of long term living.

This is the webinar for January 17, 2019. We'll go through housekeeping. This slide on your screen shows how you'll be able to submit questions to us. You type your questions in the box that is in on the right hand of your screen and what we do is the questions are printed out for us. We'll reread the questions and then we'll go through the answers.

If we don't have the answers, we'll get back to you. But we do encourage you to submit questions if you have questions and we also encourage you to submit comments or suggestions or anything that you want us to pay attention to as we launch. We appreciate your participation. Today we're talking about the implementation of providing an update. We'll go into detail about launch indicate yoornz how we're overseeing the launch in the southeast zone and launch communications. Randy Nolan, who is the director of integration and managed care operations for community health choices and works with the managed care organizations will be providing that update and then later in the presentation we'll be providing a quality update as well. That quality update will be provided in detail by the medical director. We'll jump into the implementation update. We implemented the southeast on January 1, 2019 and this follows a

significant amount of provider and participant communication. It's meant to make sure there are no potential issues or risks of ibt eruption of participant service ors no risks or issues relating to interruption of provider payment. Two sides of same coin. Focusing on launch we're focusing on interruption of service and provider payments. If any of that occurs, then we'll work very quickly with the NCOs to put in corrective actions to it continues. So lists -- the goals we have for this launch and

for 2019 are to make sure that throughout the continuity of care period which for home and community based services are is 180 days or six months. We'll have no interruption of participant services or provider payments. We'll monitor any systemic issues that are identified that could be corrected or may need to be representing a program change for community HealthChoices as we launch into phase three for the remainder of the state.

In addition, we'll also be doing ongoing monitoring for the southwest and we'll begin to focus on some of our key goals which include housing, employment and nursing home transition. All three are important community HealthChoices and we look forward to -- we look forward to input and feedback not only from the MCOs with you also the stakeholder community as to how that can be better communicated. Right now the southwest, the Pittsburgh area was the first launch, launched in January 1, 2018. N.S.A. steady state operations. We're monitoring the program in the southwest as an existing program, loss of opportunities for improvements, loss of opportunities for improved services for participants and we're excited about all of the ideas we continue to receive. We look forward to continuing to monitor any of those activities. But really the focus for today's webinar will be the southeast implementation. Phase three will be a focus just as an fyi, it

involves the Harrisburg, York and Lancaster area, the Scranton Will can hes Barre area, Erie and all the places in the Pennsylvania T in between. It's a large implementation and will involve more people that the southeast. It's the largest in population, the largest by far in geography with a large and diverse provider community and participant population.

This will be different from the southeast in many ways because population concentration in the Philadelphia area. It will certainly be different in the southwest because -- primarily because of the buildup and also the fact that the southwest has a pretty significant population of people who are enrolled in dual special needs plans. There's a different component and it will be very different because of the size of the population, the composition of the population and also the geographic disbursement of the population. This phase three is very large. Where did we land for plan selection. As you see on the screen, the plan that had the most enrollments of keystone first known as amerihealth. They received 52% of the enrollment, PA health and witnessness had 24% and UPMC had 24. Keystone first was the most enrollment with the auto assignment and planned section and plan changes. These are the final numbers of the launch of community HealthChoices. We'll

provide updates on the existing enrollment going forward but this is where we are right now after the launch efforts in 2018. This shows the distribution by the way that they selected a plan and also by the individual populations themselves. Those individuals who are auto assigned, that represented 60% of the total population.

Which is exactly the same percentage we had in the southwest. We were hoping that it could be a little bit better. Actually initially we thought it would not be as successful but it ended up being the same. We're hoping that the final phase will be even better than what we're seeing right now. Auto assignment at 40% and MLTSS or managed long term services rollout usually has a high auto assignment rate. But we're receiving a signal. Hopefully is still seeing the screen. We're receiving technical difficulties. We're have a Phi that. But we'll continue forward and assume that you are able to see us continue to move through the slides. Individuals selected by mail or fax were 14%. Those by phone were 18%. And by web were 8%. So it ended up being 40% of people who actively selected a plan before January 1. As a remainder, people can always change their managed care organization at any time with community health case choices and the effective dates will

be roughly, although the dates vary from month to month depending on the enrollment dating rules. In the first half the month it will be effective the first of following month and the second half of the month it's effective the first of the month after that. People can change their plans at any time. We're hoping that people have -- if they have questions about the managed care organizations they reach out to the managed care organizations and if they are not received, they'll enact a change. So this shows the grand total distribution by individual numbers themselves, by plan and by population category. We had -- the distribution ended up being 132,000 743. The duals had roughly 89%. The home and community based duals are those dully eligible for Medicare and Medicaid and receiving the long-term care in the community were 33,363 that's a significant portion of the population, most larger than other parts of the state. The home and community based nonduals were

15,158. The nursing facility duals were 11,956 and nonduals were 1l409. with the total of 132, 743. As it turns out we're finding that the southeast will be a smaller population than the remaining phase that includes Lehigh capital, northwest and northeast. So now we move on to launch indicators. Randy is going to provide an update on where we're at with launch indicaters. We focus on pre-launch when I comes to monitoring April data collection and measurements. This slide which you may have seen before when we launched the south, the southwest where where we

continue to focus on launch measurement activities and with that rate I'm going to turn it over to Randy to start going through the launch indicators themselves.

>> Folks, good afternoon, we made a number of changes in how we did launch indicators from the southwest that we're doing in the southeast. The southwest we had a lot more launch indicators that lasted approximately two months, some of them a little bit longer. The reason we did them so long in the southwest is it was a brand new program. First time we brought up a zone. Plus we did not have a lot of operational reports in effects. So we're changing a little bit about how we're moving forward with launch indicaticators in the southeast. Basically we have launch indicators to look at service continuity, service coordination, provider participation and information transfers. So we're going to report on some of the launch indicators here. Our first launch indicator that we have is a indicator of the weekly brand new enrollments in the CHC. These are individuals not effective January 1 but have been effective the weeks afterwards. As you can see,

keystone first picked up a total of 98 in this first week. This reporting is for the first week ending January 4. On our next webinar in February, we'll have the complete launch indicators done is we'll report everything out. Keystone, like I said picked up 98. PAL from we will nal -- PA health and wellness and UPMC. The second indicator that we're tracking is plant transfers within the southeast zone. These are transfers from one of three MCOs to another. As you can see, keystone first had four and 61 transfers into the plan and 117 transferred out. 53 of those went to PHW, 64 went to UPMC. They gained an anded diddationel 344 participants in the first week. PA health and wellness had 113 transfer out and 243 transfer out. Most of those went out to Keystone first and they ended up with a net loss of 130 participants in that first week. UPMC had -- they ended up with a net loss of 214 participants. a lot of this is because people did not make a plan selection

prior to the date in December to do that and when implementation came up they decided they were auto enrolled so they wanted to pick another plan and most picked keystone first. We see transfers. Usually within the first month we see numbers like this going through. Launch indicator 6 is the critical incident report that the MCOs have to report to us. We break it down between service interruption, neglect and abuse. As you can see, very light reporting for the first week. Two incidents for keystone first, one for Pennsylvania health and wellness and one for UPMC and the break down out of 10,000 participants what the rate is. It's 1% or less across the board of having any critical incidences within the first week. The other part of the launch indicator seven is any participants that had complaints or grievances. None have come in for any of MCOs in the first week. Again, being

brand new implementation we would expect that we'll start seeing numbers in the next

couple of reports. But we're not hearing a lot of grievances and complaints at this point in time. Launch indicator 8 is weekly calls that come in to the office of long-term livings participant line. We run a participant line. The MCOs run a line. We have one internally that participants can call. As you can see, the call volume has been low coming in to LLTL. It's been a lot higher going out to the MCOs and we'll see that on another indicator. We can receive 42 calls from keystone first participants, 26 from Pennsylvania health and wellness and 20 from UPMC. a total of 88 calls between the three MCOs. It's been fairly light calling in to the office itself. We have another participant line that we contract out with. We have an outside entity that tieks over flow of calls. Through the first month of implementation. At this point in time, they've had 502 total calls come.

In 398 referred, a lot of them directly to the MCO or they may have been referred back to the I EB for enrollment questions. Still a fairly low number of calls including the population. Launch indicator 17 talks about the weekly calls that have come in from the provider hotline in the office of long-term living. Again, light numbers, 9, 8, 6. Very few calls have come in from providers. Most of the calls are going directly to the MCOs. Launch indicator four we track the payment related issues with PPL for direct care workers. At this point in time there's been very limited issues that have gone through PPL. As you can see there's one for keystone first and seven for Pennsylvania health and wellness and eight for UPMC. a lot of that centered around making sure the authorizations are correct in the system to payments can go out to direct care workers. And then launch indicator 26 of the calls coming in to the MCO participant care lines or hotlines. In

that first week, keystone first has fielded over 4400 calls. PA health and wellness over 2700 and UPMC is 1300. One of requirements we have is they answer 80% of the calls within 30 seconds. They are not meeting that within the first week. There was an overabundance of calls, maybe a higher call volume than expected.

In previous weeks they've changed their staffing patterns and they have -- they are addressing the issues and meeting the 85% or above threshold. The last line there is the number of calls abandoned. People who called in and hung up no matter what the time was. You can see the percentage. Again, their agreement states that it has to be 5% or below. So, keystone first is right at the 5.1 level, UPMC is 4.8. They're rates -- their rate have gone down in subsequent weeks. We'll present the numbers in February. We'll present every week following this. We'll present the week of data that ended the 11th, 18th and 25th. We'll be able to show you that on

February's call. There are a couple of launch indicators that we're collecting data on that we're still working through the data. We didn't have clean data from the first week. One launch indicator is in regards to claims that are submitted to the MCOs and how they are handling those and we'll

report on that next month. And then the second indicator that we don't have here is one that is in regards to outreach or outbound calls that the MCOs are required to do to every participant to ensure that they understand the services and make sure they don't have any missed services during the implementation. We're working on those two launch indicators also. All the launch indicators except the one that collects data on missed services will be for the duration of one month. The one missed services may take six weeks until it's final. The launch indicators will be gone after a month. The information we're collecting here are also -- is also part of information we're collecting on operations reports that the MCOs have to submit monthly or quarterly. We created the launch indicators to take a good weekly snapshot during the first month of implementation. We'll continue to work and collect the data on operations reports because it's something we still

continue to monitor. As far as communication as we go through implementation we have daily calls or huddles we call them with all three of MCOs. They each get a half hour every morning where we talk about issues, concerns participant related, provider related. Any either issues with the authorization and PPL making sure direct care workers are paid and any other issues they may have that need to be discussed. We have that half hour meeting. We also have in the afternoon then have a meeting scheduled we did an internal executive call based on the morning calls to discuss any outstanding issues that need bye dressed. We continue to have weekly participant and participant advocate calls. We have calls with different groups of advocates. We have calls with providers, nursing facility associations. We have a transportation weekly call with transportation providers. Internally the monitoring teams have a weekly meeting with all three of the MCOs. Separately

they have an hour where they meet. Plus they have a weekly meeting where they talk about strictly related participant issues and resolve those. We continue with that communication so we're addressing and identifying issues ea they come up. We have calls with the nursing facility associations, aging network and home and community based providers. Again, here is some information. Our participate papt hotline. You can see 800-757-5042. That's our office of long term living hotline. We track the calls coming in every day. The calls are sent to the appropriate area and all of the calls every day are sent to the MCO so they can fog-up with the participants to resolve issues they may have. And the information for the

independent enrollment broker is 844-824-3655. Their TTY line is 833-254-0690. They can call the independent enrollment broker if they have questions or haven't received the post enrollment packet or have questions. They can also go on the

web site at enrollchc.com to enroll in one of CHC MCOs or to change their plan. As far as launch communications they are required by the agreement to have contact and mail enrollment packet within five days of enrollment. That includes a welcome letter, I.D. cards, information on how to get their participant handbook and then other forms including risk assessment forms, provider change forms and other forms that are relevant to the MCO. So they provide that information. Then the behavior health MCOs are mailing out packets within ten days of enrollment which includes information about behavioral health services. Participants are getting packet from the MCOs. What we'll do is move through. That's the update on launch. At this point the implementation in the southeast is going fairly smoothly. We deal with issues every day but we're not seeing the volume of concerns like we were last year. Traftion issues are -- transportation issues are

working out pretty well. Things moving in southeast at this point in time. We have a long time to go and a lot of work to do.

We continue to work with the MCOs, participants and everybody on a daily basis. One of the things we do is a lot of quality updates. I'll turn it over to talk about some of the quality programming being done.

>> Before we begin we'll go through the questions we received and jump into quality. First question relates to the credentialing and enrollment process that has been provided to go through.

What are the plans to streamline this process and how many individuals in the Philadelphia region are currently receiving behavioral health consultation. On the second question it's a little early. We haven't captured any utilization except for health plans processed. It's a great question that we're happy to answer in some future dates. with regard to the first question we're looking at the process for credentialing and more than willing to take suggestions on how it could be streamlined wemp talked about the credentialing process. There's regulations in place through MCQA and legal ramifications so it can be tedious at times.

>> Thank you, Randy. Second question, we are having difficulty in getting timely discharges and authorizations processed by the manage care organization when a client switches MCOs. Can they process be expedited to enter the authorizations right away and HHA exchange which is the 3R50EUor authorization software used

by all three managed organizations so that services can continue seamlessly and as quickly as possible.

This is very good feedback we'll take back. We believe it could be expedited.

>> His an ongoing conversation about the portion of this. This is a major lesson and issue we had in the southwest. They've been told that this stuff has to be done as quickly as possible. That they have to close out their authorization so the accepting MCO can put the authorizations in the system so we continue to work with them to do that. If you have specific issues with a participant that you are not seeing that switch happening and a quick manner you can let us know. You can reach out to the MCOs and we'll make sure we get it figured out for you.

>> One of three managed care organizations, the person who wrote this question stating one of three managed care organizations is cutting participant services. If the person gets an example of any case we're happy to investigate it. This is a violation of continuity and care period. It would not be allowed. It might be a mistake. We would be happy to investigate and work with the managed care to get it corrected. It's a violation of the agreement and it's something you need to bring to the department's attention.

If we bring back to the participant line we can show where this person can call in and communicate this. Please call 800-757-5042. Next question Red Sox providers experiencing difficulty with one of the three -- navinet. We encounter an error. My recommendation would be to reach out the MCO. I won't name the MCO in the presentation but that MCO should correct this for you. Next question, hope you address a few issues today. Number one, when the three MCO's delay in sending packets and limited communication. They instructed postponing visits until after January 30. This is delaying assessments or new waiver participant as proved in late 2018. The question of the assessment after 1 lsh 1 as well as those who are ineligible and became eligible after 1 lsh 1. This is after -- 1/1. This is good feedback. We want to make sure they are not delaying assessments for individuals treated as new enrollees.

>> There's criterion agreement of the amount of time they have to go out and provide information to the individuals and schedule the NRI assessments. They need to be meeting them and can't be putting it for a month. If there's specific issues, please let us know and we'll reinforcement that with them.

>> Thank you. Next comment, awaiting participate pans to be loaded in the exchange and systems. I assume this applies to multiple MCOs. We have data gaps

with participant information. We had similar issues last year primarily relating to the source data. They are working through it much more quickly this year than last year. We're expecting that most of the issues if not all will be addressed by the next two weeks.

>> They are continuing to add horsations in. Keep looking for them. If you are not seeing something reach out and ask them why it's not there.

>> And if they are unresponsive reach out to us on the provider line which I think we have on here as well. Do we have a provider line?

>> I don't think we put the provider line on here.

>> 800-932-0939 for anyone who would need any provider issues resolved.

>> Thank you, Daniel.

>> Their services are being interrupted. How would you address.

This any example of participant interruption and services reach out right away. Use that participant line on the screen right now. 800-757-5042. So participants are -- participants are able to change their plans at any time. If they were auto assigned and not happy they can change it. That would be something that we want to make sure it's communicated to participants. We're looking for the person who sent this question to make sure that that is communicated to anyone with whom you are speaking. They can make the plan change at any time. We do not want services to be interrupted, however sork if we have instances of particular cases call us and let us know and we work with the MCOs to get it corrected right away. One of the three MCOs is asking how to scan and upload individual service plans and CMIs and asking how to get proves a-- plans approved in late 2018 and having us reenter through RE I we thought the state was -- the -- this data I'm assuming

was flowing over to the MCOs. a lot of data did flow over. Some of the newer data may not have been put into the system. It could be quite possible that they didn't get the data because it was entered late or not in time. So it might be quite necessary to reenter the data we're sorry to say. Hopefully those cases are rare. But if are particular concerns about service interruption once again, I reach out to the participant help line or the managed care organizations as well. As of today 1 slrks 17, 19 we are having a large number of consumers who don't appear in HHA exchange. They reached out to the MCOs and have not yet herd back. Just to be clear the MCO should be responding to you. We'll provide feedback and make sure

they reach out to you about this. As stated earlier the information gaps that exist and prioritization should be corrected in the near future. We're finding that PA promise is missing selections for some existing clients where

a process should be followed to address this issue. I would love to know more and I'm assuming you need eligibility verification system and it should be listed. So even one example of one case. If this individual is willing to send this to the department, that would be particularly great and we'll actually reach out to you about this to see if you can give us some examples. Next up, what type of urgent calls come in to you?

As far as on the participant hotline we get a variety of calls. People checking in to verify what their plan is, checking in when their services are going to start, some have been checking in on who the SC is. They may not know who it was before hand or they are confused moving to CHC whether it's the same. There's been calls making sure direct care workers get paid and general questions in regard about CHC itself.

>> How is it we're hearing and being told to continue owe to provide services and the authorization will be forthcoming and when I reach out to the NCOs for an update and find out one of participants does not have a care plan so there's no help for this individual. That's related to the previous problem. It's quite possible if it's a recent enrollee or newly eligible individual it's quite noobl they didn't have a care plan shared with the MCOs and it's something that will have to be reentered into the system. It's my strongest encouragement you continue to communicate these cases and ask for their assistance and if they are not responsive ask that they reach out at.

>> 800-932-0939 that is provider help line.

>> Thank you, Daniel. And last, we're being told by the MCOs they are still receiving member information. When do they expect 100% of members will be transferred to the MCOs. At this point 100% of the information has been transferred. The exceptions are what we described earlier. If they were recent enrollees and they weren't entered into and there some examples of this. There's also some examples of cases entered late. That should be addressed in the very fear future. That's all the current questions we have available. We're going to turn it over for a CHC quality update.

>> Good afternoon, thank you. Wanted to take the opportunity to provide an update on the activities that the department has regarding quality related to CHC.

My name is Dr. Larry Apel and I'm the medical director at OLGL. Wanted to discuss several areas today. Really these areas of focus revolve around two basic questions we continually ask. The questions we ask are. . Are we doing the best we can to ensure that our participate participants are receiving good care and the second question we ask is can we raise the bar and improve the care our participants are receiving?

Some of the ways we did that are through the areas of focus we'll touch upon here. One is the DHS quality strategy. Another is the CHC evaluation plan which is an independent evaluation by the Medicaid research center at the University of Pittsburgh, a seven year evaluation plan that offers a wealth of information. We also have CHC quality components and we have some MCO accountability where we ask the MCOs to report on quality measure and performance improvement projects. As far as the quality components go, you can see from this diagram there's a multiple of efforts that simultaneously result in CHC quality programs. These include readiness review has Randy has touched on, monitoring and compliance that Randy's team works very diligently on. Critical incident reports that we're asking the plans and others to report on and three main things that we'll touch on today including performance mesh measure reporting where we ask how they are receiving career

performance improvement projects atouching on ways to improve and raise the bar of care and independent evaluations to ensure that quality care is being provided. As far as the evaluation plan goes, from the Medicaid research center at the University of Pittsburgh, this is a seven-year plan. We did want to share one piece of data they've provided early on here. That is they interviewed 827 participants in late 2017 and then they reinterviewed 54% of these people after the continuity of care period in the southwest. These participates were in the southwest. They interviewed them between July 30 and September 14. In that interview they talked about multiple aspects of their care including the CHC enrollment process, plan selection, coordination, usual source of medical care and transportation. a full report will be following. Be do have this one piece of data already that we did want to share. These participants when asked about their medical care, 80% of them said it

really hadn't changed before CHC and now after the continuity of care period. But 15% said their care was better. 5% said it wasn't as good. And as far as prescription drugs it was basically the same story with 79% saying that their access to prescription drugs had not changed, 15% saying they had better access and 6% saying not as well. So more to come from the CHC -- Medicaid research center

data. As far as performance measures go, we asked the plans to report on several measures of how their participants are doing. Why these measures, we ask about these measures because we feel that these measures are largely important to the participants. These measures stem from nationally based measures called hedis or modified Hedis. We have these things that we're asking the plans to report on how members are doing overall. Now, as far as the key performance measures, these are very important to the participants and they were selected based on the experience

of the participants and also national experience with LTSS plans. We're asking the plans to report on three basic ideas regarding key performance measures. We're asking them to report on physical health measures, behavioral health and long-term services and supports. These are three key areas of focus. Within the physical health measures, we're asking the plans to report on two measures related to hospitalization and ER usage. That's inpatient and AMB. The hope is that certain disease processes can be managed in outpatient settings which will be much less strain on the participant and perhaps much better management. These include you'rerary tract infections, short-term diabetes, upper respiratory to name a few. As far as AMB we're talking about ED utilization and the hope is that the plans will be insented to work with participate paves and service coordinators to ensure that participants are going to providers offices or urgent care centers and

getting prevention of processes that are occurring so that they don't end up in the emergency room. We're also asking the plans to report on all cause readmissions.

This is to ensure that participants are getting appropriate case when they are in the hospital so they don't have to return. Several disease processes often result in readmission when participants are not able to receive all the appropriate care they should the first time. So we are monitoring all cause readmissions. As far as behavioral health. We're monitoring many aspects and we'll talk about those on a future slide actually two slides down. Two key performance areas we're asking specifically related to behavioral health include adherence to meds with individuals with schizophrenia and those with schizophrenia are they being prescribed anti-psychotic meds. We'll talk about personal assistance services or missed services and nursing home transition. Nursing fashion silt transition. We do have our first data -- preliminary great on the measures and this is from the southwest only and this is data from January

through September of 2018.

This is preliminary. I wouldn't get too focused on the numbers. You can note that on average readmissions are roughly 15% and this is where we note already that we have room to improve substantially. The rest of the data does show there's room to improve on utilization both in the in-patient setting and medication and medication adherence. Now we mentioned that behavioral health is a focus. We wanted to talk about several of the measures that we're asking the plans to report on related to behavioral health. We're asking them not only to report on the measure s for individuals who have schizophrenia, we're asking home it report on anti-deprecedent measures for those with depression, we're asking them to report on follow-up after hospitalization for mental illness and also ED visits for mental illness. Related to substance use disorder we're asking home it report on initiation and engagement and use of opioids of high dosage and concurrent use of

opioids. Those using Percocet and Val you'll, for example, the two combined for severe side effects. As we talked about, we're asking the plans to report on adherence to medications for individuals with schizophrenia. Why behavioral snelt because we've found that a large portion of participants do require some behavioral health focus. I do appreciate the question earlier regarding consultations for behavioral health and that's an excellent suggestion and we work towards monitoring that as well. As far as other measures We're asking the plans to report on, we do ask the plans to also report on LTSS measures because our population certainly does require long term service and supports. The measures include nursing facility transition and long-term services and support involving comprehensive assessments and updates and that's within 90 days of enrollment for reporting purposes for quality and then after the assessment, development of a care plan within 120 days

of enrollment in a plan and updating that and sharing that plan within 30 days of its manufacture and finally reassessment and care plan update after any inpatient discharge. As far as access and availability we find it's very important to assess how many members are receiving an annual dental visit and we're asking the plans to report on the percentage of members that do visit the dentist or dental practitioner over the course of a year. Also as far as care effectiveness, several measures are being asked of the plans to report there including controlling blood pressure, monitoring medications and follow up after ED visits for substance abuse and risk utilization and utilization, mental health utilization and antibiotics for perhaps those member and participants prescribed antibiotics that don't need it or some that do need it and are not receiving it. We also have nursing facility activities underway and we have meetings between the DHS, department of health,

hursing home associations and quality insights. We're trying to develop surveys for visitor and residents and review existing quality measures in the nursing fashion silt to start to begin quality there. Also wanted to touch briefly on performance improvement projects about how to raise the bar of care and in the two areas we've identified and asked the plan to develop on including strengthening care coordination and nursing facility transition. When we talk about coordination, we're talking about coordinating between CHC/MCOs, other insurance plans, nursing facilities arc cute care and behavioral health ipped at thises we don't want them to receive uncoordinated phonecalls we want it all to be as seamless as possible and for participants to receive one coordinated health care plan telling participants what care they are going to receive. Finally as far as nursing facility transition we're asking the plans to make sure that those elements are in

place that need to be in place for participants if they are transitioning out of a nursing fashion silt to the community to have a high chance of success at remaining in the community. So we have multiple tracking measures and have asked the plans to work diligently to develop the performance improvement projects and they began on January 1 in the southwest. Happy to take any questions. We have several next steps and more reports to come. and here is MCO contact information that has been previously been displays.

>> We have questions not all related to quality. Thank you very much for the update. We'll do this on a quarterly basis.

>> As we go forward with steady state of community HealthChoices more of the focus are on quality mesh showers and outcome mesh sheur for the program. Would you please clarify the difference between new newly eligible individuals in nursing facility and nullly eligible individuals receiving long term care in the community. Most of the plan questions we received earlier were for individuals who were newly long term care in the community or new HCDS. Next question, when the CAO cannot resolve the issue what number should the -- or department nursing provider call when there are issues with CAO updates or needs for update or should trigger assist enrollments. My recommendation would be to -- the MCOs can help you here. The MCOs do have different ways that they are able to contact us and they can reach out to the department as well.

>> I mean it's probably the best way to go through unless you go through the county assistance office because they are the ones that control a lot of the information to go and assist when people are found eligible. It's the two ways to go.

>> I think they were asking if the CAO can't resolve an issue. They are the keeper of information. Next question: We have an LPN doing service coordination. Are you seeing any LPNs grandfathered in as an exception to the rule that an SC must be an RN or four year degree. The answer would be depends on the MCOs. All three have a model of service coordination that they are providing. I believe that one of the three MCO as a different approach than the other two, I believe. Two of the three MCOs are following strictly to the requirements of what is in their agreements. I don't know, Randy, if there's anything else you want to add?

>> It's an MCO decision.

When they want to make the decision they discuss it with us because it's a requirement in the agreement of what the educational background is to be. We have discussions with them about that.

>> Thank you. Do you know when the MCOs start assigning new consumers to service coordination entities. They are receiving new participants now. New people are enrolling in community HealthChoices. The answer to that would be -- the question should be posed to the MCOs because it would different for the MCOs. We're receiving authorization and service plans that lay out the frequency and scope of services. Where can we obtain in addition for HHC exchange. The MCOs should be able to provide that information.

>> the MCO should have it. If your service coordinator doesn't have it they should be able to provide it. If you are a service provider the service coordinator should provide it.

>> There's still no clear process for those receiving services and service coordinates and companies are unclear of the process.

>> In reality there's a clear process. It's the same process we were utilizing under fee for service. The service coordinator would work with the MCO and submit to the MCO just like they would have submitted it to the department. We're going to provide the MCOs next week with a list of home mod, is that were in process prior to 1 lsh 1. We'll provide the list and let them know if it was an approved project that they'll continue to monitor, follow through and pay for it. If it's a new project or project just submitted and wasn't fully approved they will be turned over to work on. The process as far as submitting questions to the MCOs and the MCOs come back and ask for back-up documentation. They may ask for bids on the work it's the same process we follow through when fee for service was doing it.

>> Thank you, Randy. Do we know when homecare, did do home care proindividualers have access to the tool. We have provided that in the past. Many home care providers in the southwest ask requested ask S. and we'll provide feedback again. the reason why is past practice that they had did have access in some cases and the primary services offered in our programs as it exists right now is personal assistance services. We'll ask the question and provide the feedback. Next question: There a central system to check which MCO a consumer has chosen. Yes, it's the eligibility verification service or EVS. It's connected to promise and if you have access to that you should be able to access that. The way to access sit available on the web site on the webinar for EVS. You should be able to find it through a search. Next question: A nursing home's work outside -- work with outside labs for our residents and

they don't have a CHC contract. How will that work for continuity of care?

Are they sending labs to a different place for results which may delay care and how will this affect nursing facilities?

It's a great question. We recommend that you have -- pose that question to the managed care organizations. The managed care organizations do have the responsibility to provide continuous care with nursing facilities during the continuity of care indefinitely while the person was enrolled at the time of implementation and the facility remains enrolled in the Medicaid program. That said the relationship with ancillary services such as labs may be different and it's my strong recommendation that nursing facilities reach out to the MCOs.

>> They should be working with the MCOs and let them know there's other providers that they work with and encourage those to enroll with the MCOs so there's a seamless transition. Nch thank you, Randy.

>> Do you have any updates on where they are providing log-in cred ten shales. It's a question they can answer. They should be able to do it now actually but we recommend you reach out to the MCOs and will provide feedback as well. Next question: To participate in a CHC do we need to enroll or be credentials by any company other than the MCOs?

At this point you have to be enrolled in the Medicaid program if you are providing service with the MCOs but the credentialing is managed by the MCOs themselves. Next question, we have a client discharged from a hospital who now has increased needs yet we can't get a response from the SEs or MCOs as far as doing a new assessment and getting authorization. So we can take care of this participant who

is bed bound. So we would love to be able to learn more about this individual case because of the seriousness of it obviously. We're going to reach out to the person who sent this question directly and see if we can get more detail about the participant. Next question. . We have 27 authorizations we've not received from the particular CHC/MCO they've been contacted and we've not received response. We provide feedback and we'll reach out to the individual to see if it's okay we give their name to basically promote them to reach out directly.

You should receive a response. How come one of three MCOs is telling SE consumers they are no longer with our agency and their service coordination agency. The participants of this MCO are stating that they are cutting services before the 180 days. That is not -- they are not allowed to do that based on the agreement. We have to say that service coord 2345EUGS is part -- coordination is part of continuity of care as long as they are willing and qualified to provide the services. We'll reach out to the MCO to provide the feedback. Next question: New referrals -- have new referrals been given to home providers. We're told they are not getting new referrals due to glitches in the system to.

Our knowledge, that is not true. We'll be happy to provide this feedback to the MCOs but they are giving new referrals to new participants in the system. They are giving them. We know this for certain. It might be feedback we provide but we have evidence they've been giving referrals and receiving new participants as part of enrollment for CHC. When will the HHA exchange provide eligibleity information after the implementation is done?

I think -- the answer to that question is it should be something that HHA exchange is able to do now. But I might not answer the question correctly. HHA should be able to provide not eligibility information but prior authorization information. Eligibility information can be accessed -- if you are talking about participant eligibility in an MCO through the eligibility verification system connected to promise. I hope I understood that correctly. If not send another for clarification. We're a skilled nursing facility located in upper buck's. Many resident goes tie local hospital. They are not participating. Do we need authorization to send them to the hospital?

Absolutely ask your MCO that question. They should be able to explain how they want the services connected for participating and non-participating hospitals. If a patient selected a specific agency in December 2018 but the CHC/MCO did the assessment this, is the norm moving forward for 2019 during the transition period?

Any must participant will receive the assessments either by the CHC/MCO or their designated sub contracted agency. That's the way it's going to work. It's true. In this particular case it's likely the assessment was completed before the implementation date so no service plan was developed and that's the way they decided to go forward with the aassumption. So the answer to that question is broadly yes. for new enrollees it would be the MCOs or their designates service coordination agency. Next question, a family has let us know that their relative will have the opportunity to have a meeting with the CHC team to discuss services and supports that this individual currently needs. the individual asking the question is not clear what this meeting entails or how to arrange this type of meeting. Our office is aware of many individuals with unmet needs not enrolled and we want to give the information so they can find out the resources for CHC. They

have to be eligible for Medicaid and in some cases Medicaid long term care to be in the CHC program.

If they are not they have to be dually eligible for Medicaid and med cared. You can reach out to the maximus which can be shown on the screen. We'll bring that number back up on the screen. for the independent enrollment broker was at the bottom of the screen it's 844-824-3655. So this person should start there or at the systems office in your area nursing homes work with outside labs. We answered this question. Thank you. a few more questions. We're going to turn it over to Dr. Apel.

>> Sure. Thank you for these questions. First question: Are the behavioral health measures being reported by the behavioral health plans?

And we are asking the CHCMCO plans to report on these themselves in coordination. We've had two meetings for the CHCMCOs combined with the behavioral health plans. One of the goals of CHC program is coordination of care and streamlining care. We want the CHC/MCOs to be well aware of any participant and all of their behavioral health needs. We're asking them to report on the behavioral health measures that we've developed. Next question: Related to the slide on nursing facility quality, are long-term care ombudsman involved in the meetings?

If not, why not and how are residents voices being included?

A good question. We're including residence voices in several ways. We have the Medicaid survey of residents and they ask a large variety of questions and that will help us gather resin put. Two -- resident input. Two we have focused key informant

interviews of residents that Medicaid research center is doing in several facilities and we're asking for that input and finally through the association we're asking for direct resident input as well in any discussion of nursing facility quality measures. Third question. Please elaborate on meaning of annual monitoring of persistent medications. Very good question. Often times participants go to provider's office and they are on several medications that they've been placed on for very long times and these sometimes require monitoring. for example, the statin drugs, the anti-cholesterol medications should river liver function test monitoring and lipid monitoring and triglyceride monitoring at least once a

year and also questions about muscle aches and other side-esques. We're trying to -- side effects and we're trying to ensure that this occurs in addition to combination of medications that could be detrimental. We're asking providers review med lists once a year and make sure they are congruent. There are several questions.

>> Thank you. Next questions more general, what does the department have in place for they had to individuals wishing to apply for services without medical answerrance or the lack of ability to -- assistance or lack of ability to complete the application. Unfortunately the individuals with the least amount of need have the least help. This is a good help. The I EB can help people. Another resource could be the age and disability resource centers depending on the type of support individuals need. We agree that if there's anything more we can do people-to-help people through the process we're open to suggestions on had you to improve the process. Next question: We've been asking for a hard copy of service plan and not have -- have not gotten a clear answer. the agencies do not need to utilize electronic devices for home visits. We provide this feedback for the MCOs. Are unit allocations for service coordination as with the case for future service?

Can't answer that question. We want to refer to the MCOs but at a minimum participants should receive as much service coordination during the continuity of care period as they would have received. After that period is over, it would be for the managed care organization to answer such questions. Next question: CHC members admitted to a nursing facility in a non-CHC county or phase 3 county, who does the nursing facility contact to have the member removed in order to convert back to the Medicaid fee for service?

I believe they could start at the county assistance service. The IEB is 844-824-3655. Either place is a place to start for moving that type of a -- that type of a situation. If a member starts receiving services after 1/1/19 is that considered the continuity of care period?

The answer is no. Eligibility is after January 1 they are new and not eligible for the six months. We have a consumer showing eligible for service in promise but OLTL is telling them they are not eligible. I don't know why we're referring to an ombudsman day for help. We were receiving help and now nothing.

What can we do if promise is not accurate as far as eligibility.

We need look at the case to understand what the problem is. It's quite probable the individual went through a reassessment or has a special eligibility configuration that requires them to go through on a monthly basis. This is a question that we would be happy to answer for this individual. We would also be happy to answer -- if you are willing to send the case to us we'll be able to re vied more detail -- provide more details. We'll reach out directly. Next question: The MCOs have support of coordination departments how are they monitored with new participants coming in who have chosen their support coordination agency?

Is conflict of interest a concern?

Speaking broadly there's no conflict of interest. Service coordination regard was whether it's provided directly or through a sub contractor agency are literally the MCO. There's no difference in our mind. I can't emphasis this enough. If you provide service coordination or fee for service it's not the same. You are an administrative function of the managed care organization. There's no convict of interest. You are the MCO. You are the MCO. Just to be clear. for home modification questions, one of the thing MCOs does not want a service coordination entity to gather bids. They want to submit questions and confirm it was done. So I'm not really sure what the question is for that. It might be a change in process.

If you have particular questions about how the process is working you might want to have a conversation with the MCO itself. But participants are eligible if they are receiving modifications. Our concern is that they are getting what they need. The process and how it's delivered is really a discussion with the home modification entities and the MCOs themselves. Once again, like service coordination, home modifications are a administrative information of managed care organization. Next question: Is there any information on understanding home billing?

At this point we have a few claims submitted for facilities but not many so the answer is very little and if the question relates to how do you bill the managed care organization, you need to reach out to the managed care organization and you want to do that quickly especially if you have an end of the month billing cycle.

There was a CHC communication regarding documentation of missed services and the HHA exchange and portal. Is this document required for medical equipment providers?

I believe preauthorization is required but you have to ask the MCOs themselves.

>> That document that went out is mainly for missed services. If you are providing a DME you are not missing services, you won't have to enter into that.

>> There was a clarification to an earlier question, hospital was mentioned that was actually out of network because it's not in the region to begin this. Now that I see the clarification I appreciate it very much. This is a very good question.

>> the hospital in question is Lehigh county actually. So it's quite possible that they haven't put together a contract yet.

>> If you notify the MCO that you work with that hospital because you are on the border and you work with that hospital, just notify the MCO, your account manager there that you work with that hospital, and they should reach out to get a contact with them or to pay them as a nonpar at this point in time. In the reality they'll a contract with the next year anyway.

If they know you are utilizing them now they can get a jump on contracting with them.

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>> That's a great suggestion. Tell the MCO you need that hospital -- tell them you work with them and need them to be part of the network. All the MCs you work with. We'll share this particular case. That's a good example of a border hospital. Next question: Are residents in nursing facilities considered -- that are considered dual eligible can they use Medicare or do they have to use CHC. to be clear Medicare is primary as it always was. There's no change. They don't have to make changes to Medicare unless they want to. The firm answer is use Medicare as the way you are using it before. Next question: Comments on nursing homes and upper buck mentions the hospital. I think we answered that question. Now that we understand it it's particularly helpful for us and we make sure we provide that feedback to the MCOs as with with that particular hospital. We have a few residents that have effective dates on

1/4, 19. Who is responsible for and how will be handle the private portion?

That's a very -- I guess it would be -- I am assuming it's for nursing facility services. If they have an eligibility date -- ifs a CHC enrollment date of 1/4 that's one thing fsmg it's Medicaid eligibility 1/4 there's no change in eligibility. It is what it is. The question is who would be responsible would be largely when they were enrolled in the CHC/MCO. I think it would be as you would have handled it in the past. That 1/4 date is unusual though. It could be the application date. It could be worth calling the county systems off to verify the date. Next question: Please consider including an ombudsman in meeting described on slide 36. I think that would be productive.

>> We did.

>> Great. Why are nursing facility residents not invited to the care plan meeting?

They should be invited.

>> That is the nursing facility's responsibility to invite the resident, family and significant anothers to any care plan they have. It's the requirement of the nursing facility. If the service coordinator from the MCO is sitting in, they assure that the person has an invite. That's part of the internal process nursing facilities should be following.

>> I would add that the service coordinator assigned should also be providing that information to the residences as well.

>> It's the responsibility to be able to make sure they are part of planning meeting next question: Are we going to need a prior authorization to send individuals to a hospital?

That would be a question the MCOs would have to answer. I would think it would be largely case by case. Like an elected procedure that might be involved in patient hospital state. Might be something the MCOs must require but reach out all three MCOs to talk about their current procedures for hospital admission.

>> Certainly if there's an emergency dork not hesitate to -- do not hesitate to seek the hospital at all times.

>> Thank you, Dr. Apel.

>> When should a home care implement the EVV system?

It's on August 1, 2019. Any more information you want to share?

>> we should provide more information to providers. You can watch for that coming around March.

>> Thank you, Kristen. Kristen Marman is our subject matter expert on the system. I have attended meetings at different nursing home facilities where residents were not present. When asked why they said they did not need to attend. They are the primary member of the planning team for the service plan. They should be there.

>> They should be invited to this meeting. It's a responsibility of the nursing facility and now the service coordinator for the MCO to make sure they get the invite for the meeting.

>> We'll provide that feedback.

>> Have the MCOs canceled any service contracts in the southwest?

In the southwest there were two of the three managed care organizations provided a list of service coordination where they didn't continue business and we have shared that information about the past. So the answer is yes. So there's a question will there be a webinar on understanding home bill something in I think the MCOs are required to provide that information. So we encourage to you reach you to your MCO to get that information. and they should provide you a billing guide. All three have offered to nursing facilities. That offer is out.

There they do have that information on web sites. You work with them. Next question: Will audits take place or is the MCO responsible for compliance?

MCOs are responsible for compliance. Audits may take place if they are providing services for the F150 program or the OBRA waiver if that continues. It's most likely the MCOs. During the continuity of care period can participants switch from a current SCE or do they have to go back to the MCO?

So if a participant wants to switch they can reach out to the MCO. They have the opportunity to select their service coordinator, the individual service coordinator. the MCOs -- the question for the MCOs on how they handle individual agencies. from the MCOs have handled that differently. If you have any interest in switching from one service coordination entity to another or if you know a participant that would be something where they should talk to the managed care organization. We

have an individual who is currently on a CHC waiver but we are inL Lehigh county that has not transitioned.

What do we do?

If they are a resident of Lehigh county they should not begin. If a provider provieding services to a resident in one of active zones reach out to the MCO. If you are on the service plan and you are an approved provider the MCO has to work with you but you have to reach out to be contracted as well. So if you are a provider asking this question, my recommendation is reach out to the MCO for the participant and with that. That is all the questions we have at this point. We'll wait two minutes for any additional questions but we'll have to cut it off very quickly. We really appreciate the thoughtful questions we've received today and especially appreciate the presentation from Randy Nolan and Dr. Apel and be assured in the near future we'll have updates on CHC related quality activity which is provided by either Dr. Apel or both. We'll be waiting for one more minute. Any more questions?

And we'll close it out if we do not receive any. Thank you all for your attention and for the great questions we received. We'll be doing the third Thursday webinar next month February with additional updates on southeast implementation as well as ongoing operations in the southwest. We'll publish ahead of time any copies we'll adding on as well. Thank you for your time and have a wonderful January.