Third Thursday Webinar 1/18/2018

- January >> We will be beginning in just a moment. We had some technical difficulties. We want to make sure this is working. I'm going through the housekeeping slide again quickly. This shows a screen shot of the attendee interface. It's what you see on your desktop. In the center is the go to webinar viewer where you'll see the presentation. In the right-hand corner is the control panel where you can ask questions. If the control panel closed you will see a slim red rectangle. You will be listening to the presentation by your computer speaker system by default. If you prefer to join by phone, press the telephone button and the dial in information will be displayed. This will place you in the listen only mode regardless of how you are dialing in. You may submit questions by text in the control panel. You may send your questions at any time during the presentation.

  We print them out and read them as we go through presentation. The control panel will collapse automatically when not in use. To keep it open click the view menu. We're going to jump into the agenda. Starting with introductions. I'm Kevin hoon cook. With me is -- knoll land , the leadry view and Edward sherry deputy chief council.

  >> Hellen, [indiscernible]

  .

  >> We appreciate the aten does joining us today especially our guest speakers today.

  Starting with the agenda we will go through updates and participation as well. We'll provide an update and then hellen will provide information on the complaint process and focus on how this process works. And what was changed in this process relating to the managed care final role. This is new for community health choices and the process has changed. So for people familiar with how this works under the health choices program, hellen and Ed will go flaw in careful detail. So starting with the first is continue to focus on the southwest launch and two object tiffs we'll continue to maintain throughout the launch to ensure there is no participant service interruptions and also there is no interruption in provider payment. We've said consistently these are our two objectives in community health choices and we want to make sure that continues to be emphasized. Right now our launch took place on January 1. We're in our third week with some hiccups we were anticipating

  although we did have some surprises we've had to address. We continue to address issues. We'll go through them in more detail. So far the launch is going OK. So far so good. We are cautiously optimistic.

  We continue to be vigilant monitoring the launch as it goes forward. Our goal is for a successful launch. Also to capture as many lessons learned as possible we can incorporate in our southeast launch. And where we're planning to focus and incorporate lessons learned is a comprehensive communication process. And there will be a heavy focus on education of participants, especially about the relationship between Medicare and Medicaid coverage.

We learned through the southwest we need to be much more comprehensive when it comes to differentiating between Medicaid and Medicare services. For participants and also for providers. We will continue to have a robust review process. And one objective is to start earlier. Because of finalization we were not always able to start but we did learn that the earlier we start with this review and provider recruitment and communication, the more they will have time to be adjusted to this new service model. This relates to proud

provide communication and training to make sure the mco's are offering training to providers as early as possible to be able to assure they are red do I go in this new service model on day one. Also we will be starting the pretransition process in the southeast earlier. We started it in late September for the southwest. We recognized if we start earlier, it will provide more opportunity for additional reminders, communication with participants. That's a lesson learned. And the rollup is to incorporate as many of the southwest implementation and launch lessons learned as possible. I keep going in the wrong direction. Focus will relate to future service labors. We will continue the focus on employment for office of long term living part parts pants. We've added waiver services in our fee service waivers and the services are also available for community health choices and we will continue to look for opportunities to recruit employment service providers and encourage

participants to engage these service -Ts. If they want to work, we want them to have every opportunity to work, participants enrolled in our program have this goal. We want to make employment services available for participants and don't want participants to feel they have barriers that make it difficult for them to be able to work. We are going to continue to focus on oltl organization alignment. We are operating two systems. We need to support both. But the long term goal is to focus our organization design on managed care programs. Last but certainly not least and this is a primary goal as well, don't focus on community based long term services and support. We will continue to support transition in that program and transition will include both Medicaid services and non-Medicaid services. The transition is pretty comprehensive and we hope to continue to build on that. We'll focus on housing support and relationships. In and outside of community health choices and continue

to focus on community partnerships to be table to emphasize the opportunity to receive long term services for the community. Obviously critical importance nursing facilities in our system and we want to reflect how our long term services support system reflect participants and services in the community. Continuing with communication updates, we have completed the m -- they have completed their mailing to participants. Those mailings were completed on January 12. And we have enacted our launch in the southwest on January 1.Nd we did have v a managed long term services support on January 3. Up coming events and activities, we will have on January 24, the advisory committee meeting on January 25 and next meeting on February 7. In all these sessions we will focus heavily on launch related activities and continue the provide updates. So we're going to provide updates on the launch status itself. As long as I continue to go in the right direction. The keyboard does not seem to be

working. First we're going to talk about the population. The southwest population was roughly 85,000 individuals and this slide provides a break down of enrollment. You can see

the numbers of individuals auto assigned. For the people who can't see the frame, we will make sure it's available in a reported webinar. As you see the break down -- and I'll go to the next slide that shows percentages which may be more helpful shows how people were enrolled in the program. For those individuals who were auto assigned, those were people who were not part of an aligned goal special needs plan, 12% were assigned to uc mc. 19% were assigned to healthcare plus.

For those individuals who select aid plan 29% were selected upsc, 9% selected Pennsylvania health and wellness and 2% selected healthcare. For those people who were enrolled in aligned special needs plan, 11% were part of the upmc. And the break down had 52% of participants enrolled in upmc. 27% enrolled in Pennsylvania health and wellness and 21% primary healthcare plus. Upmc has a presence in the southwest. So these percentage numbers were not surprising. Throughout this launch, we will continue to focus on our launch indicators and the focus is maintaining continuity of services and Peyton Manning. We will have frequent meetings with managed care organizations and I'll fill in more detail later slides. I don't know how we're communicating to the managed care organizations on a daily and sometimes hourly basis.

We are focused on gathering process measures and performance measures related to the mpo's for continuity to continue. We're going to focus heavily on no risk of participant interruption of services or provider payment. We continue to look for public opportunities to be able to communicate how we're doing with the launch and that will include the advisory committee. Local meetings and opportunities to continue to talk about the launch to our website as well as through communication services etc. and also the webinar. When we focus -- I apologize again. When we focus on these indicators, these are the we've seen the slides.

We focus on service continuity, service continuity so they can use their existing coordinators. We'll focus on plan transfer and we'll also focus heavily on making sure there is no interruption in provider participation. These are the main collected indicators. And I apologize again. The launch indicators and these are the launch indicators we'll be collecting. We were hoping my binow to present some of this data.

We recognize we did receive the first week from the managed care organizations and from some other sources for the weekending January 5. When we look add @ data, there was not enough data to present how things are going. The next webinar we'll have a more complete set of data.

We'll focus on weekly new enrollments and plan transfersment and this is related to transfers specifically and the reason why we focus on this is because they may present risk of interrupt interruption of service and we want to make sure that doesn't happen.

We'll talk about service disruptions, complaints, volumes of calls to our participant line and the hot line, any weekly appeals and hearings appeals and we don't expect a lot of data for hearings for some time. But we'll continue to provide updates on these through the next

several webinars. I was told my voice is breaking up and I will do better to -- I think that may not be something that I can help.

I am speaking into the phone. I will continue to focus on speaking in the phone and hopefully that will improve the sound quality for the people on the phone. Also focusing on assessments, need screenings and assessments, claims submissions by provider type, disputes and provider calls. I mentioned earlier we have daily calls, sometimes hourly depend tongue issues. And they -- and they have been able -- having these daily calls helps us to address issues as quickly as possible. And all three of the cm's have been responsible to issues. Issues have emerged so we had to address issues and these daily calls are necessary to get the status on how they are being solved. We have daily calls within department of human services and department of aging to talk about emergent issues we are hearing otherwise that may be coming through other sources. Weekly calls with participants and that has been helpful for to us hear of issues and focus heavily on key concerns participants

are raising.

An example of an issue raised on these calls relates specifically to the Medicare and Medicaid services and some confusion with providers on how those services are to be paid for and some of the confusion that participants are experiencing in the provider community we're hoping to address as quickly as possible. We have calls with providers home and community based providers and nursing facilities. They've been able to address emergent issues and work with us for solutions to issues as well. We have weekly calls with the aging network. The reason why we have calls with the aging network they are not only for individuals in need of long term services bit also with our dual eligible population and they've been able to help us identify issues that need to be addressed there as well. We continue to offer a help line as well as calls being received by the independent enrollment broker.

The participant help line the call volumes we'll touch on later. But they've been steady but not -- they've been very manageable. Most of the calls related to questions about their I.D. cards or benefit. Many of the calls we were able to transfer them back to their individual mpo to have questions answers.

We're keeping it open indefinitely and increasing staff to make sure that if there is any risk in spikes in calls, we can manage them as quickly as possible. The independent enrollment broker calls have been steady and we have not seen a spike since launch of southwest. Give you a couple of quick updates. I'm going to turn it over the Randy to provide updates on call volume.

>> Every day we have daily huddles with the three mco's and they are required to provide information on participants on the call lines and what issues they are finding. Since the beginning of the month, am eri health has gotten 1800 calls and upmc10000 calls. On the proI had veer side her health 800, p and wellness 700 and upmc over 2,000. We're tracking those calls. Usual think participants are asking about their I.D. cards. About switching pcp's

or who their pcp is. Eligibility questions on providers and things like that. And then just general questions about what their benefits are. On the provider side, a lot of questions surrounding eligibility issues, enrollment issues, benefit issues and then the last couple of days plain issues as they are billing through the system. Each of them have been doing outbound calls to determine if they have a service coordinator and had any service interruption. There has been very few days of service interruption. By

the end of this week they will at least had a first attempt phone call to all participants. Next week they will finish one second attempt phone calls for those they didn't reach. They are reaching 35-38% of all their participants on these calls and fielding a lot of phone calls coming back in. They are reaching out the everybody in their network.

>> Some of the issues we're seeing for launch status, I.D. cards have been one of the mco's had challenges in issuing I.D. cards and they went out late. At this point all should be received by participants. If they are not we recommend participants reach out the their mco's. They should be in your hands by now. There has been an issue with card presentation oh providers. If the I.D. card have I primary care physician, that's not their medicare primary care physician, that's been a point of confusion in the primary care office. This was a requirement to have the physician on the card. We are waiving that agreement with the managed care organization for people who are dually eligible so there won't be any confusion with the Medicare providers. And we're working through the confusion and recognizing this is an area of opportunity for additional education on the difference between Medicare and Medicaid services. Eligibility records on an individual basis have been an

area where we've had to focus and make some updates and changes to eligibility records. An example was a system error where individuals who had a Medicare enrollment date that was in the future they had Medicare enrollment march 1, 2018. This system was incorrectly enrolling them in community health choices. They should not be enrolled in community health choices until they are eligible for Medicare. So this system error has been initially addressed. And this should no longer be an issue for participants. We have other eligibility issues we're working through on an individual basis. Provided claims testing continues to be an issue.

We've received a lot of questions and when we go through questions we'll highlight those issues because a lot of the questions are raising the issues. Service coordination setup continues to be an issue. That's where service coordinators may not be able to see participants on their list and that is being corrected as we speak but on an ongoing basis as well and as they emerge. We continue to work through issues with transportation. Transportation will be a focus in the next and we'll talk about how the program is meant to be providing services and each of the managed care organizations will be providing an update on how they provide the service. This is additional resource information we always have available. And this is the mco contact information. This information is on our website, our community health choices website and will be available as part of the webinar. Our next webinar is on February 15. With that I think I'm going to toggle over to the complaints and

hearings. Presentation and I'm going to turn it over the hellen who are l walk us through the new program. Immediately after her presentation we'll go through the questions.

Focus on the complaints, grieve Vances first and then go through operational questions as well.

>> Hello. I'd like to begin with when a participant can file a complaint or grievance. If a participant is unhappy about something a provider has done , the participant can file a complaint. A participant can file a complaint for a grievance. The most important thing is what is a complaint? A complaint is a dispute or objection regarding a participating healthcare provider or the coverage operation or management of a caco. That is a very broad definition. Just a few examples of a complaint. A participant is unhappy with the care the participant is receiving. The participant can't receive a service or item the participant wants because it's not a covered service or item or the participant has not received services that the chcmco has approved for the participant. These are just examples. The definition is very broad. A grievance definition is not so broad. A grievance is a request to have a chcmco or utilization review entity reconsider a decision concerning the

medical necessity and appropriateness of a covered service. Examples of when a participant can file a grievance include a chmco denies the service a participant requested because it is not medically necessary. Decreases a service a participant has been receiving because the amount of the service the participant has been receiving is not medically necessary or they approve a service different from the service requested because the service requested is not medically necessary. If a participant files a complaint and it should be a grievance, the c hcmco is responsible for reclassifying it and the same is true if a participant files a grievance and it should have been a complaint. Depending on the subject of the complaint a complaint either has one or two levels of chmco review.

All complaints are subject to what is called a first level of review. All Greiviss have only one level of chcmco review. And for anybody familiar with the department's other managed care products, that is a big change in the past in the past they could have two levels of review. Now they can only have one. Complaint add grievances can be filed orally or in write. If in writing the complaint or grievance can be mailed or faxed to the chcmco. A participant can write a letter or use a complaint or grievance request form when filing a complaint. The complaint grievance request form will be sent to the participant if the participant receives a notice from the chcmco telling the participant the chcmco's decision. And the way the complaint grievance can be filed applies to all grievances and applies to both levels of complaints. A complaint or grievance can be filed by a participant , the participant's representative or provider. If filed by a representative or provider,

the participant must provide written consent for the representative or provider to be involved or act on the participant's behalf. Anybody can be a participant's representative. It can be the neighbor, best friend, anybody the participant chooses as long as written consent provided. The time frame for filing a first level complaint are important. If it not filed timely it can't be heard. If the complaint is a result of the decision by the chcmco , the complaint must be filed within 60 days of the date the participant received written notice of

the decision. In the next slide I'll go over which times the participant receives written notice of a decision. If it is a complaint as a result of the failure of the chcmco to provide a service or item in a timely manner, the complaint must be filed within 60 days from the date the services should have been ro provided. And the time frame by which services must be provided are included in the participant handbook. If it is a complaint

as a result of a failure of the chcmco to decide a complaint or grievance within the time frame for deciding complaint or grievance, the complaint must be filed within 60 days of the date the participant receives notice of the chcmco's failure to timely decide the complaint or grievance. There is no time limit for filing all other complaints. A participant can file a complaint after receiving notice of the following decision. A denial because the Social Security or item is not a covered or the participant. A denial of payment after a service or item has been delivered and a denial of a participant's request for financial liability including cost sharing, copayment, premiums, deductibles, coinsurance and other participants financial liables. The notice will explain what a participant can do if the participant disagrees with the chcmco's decision. A complaint must be reviewed by a first level complaint review committee. On that committee is one or more chcmco's staff. The chcmco

staff may not have been involved and may not work for someone involved in the issue the complaint is about. If the complaint involves a clinical issue, the committee must include a licensed physician and the physician must decide the complaint. A chcmco has 30 days to decide a first level complaint and seabed written notice of the decision to the participant. I want to explain that 30 days is not 30 days to decide and then send notice. It's 30 days to decide and the notice must be sent within the 30 days. This time frame can be extended by up to 14 days if requested by the participant. The participant does not agree with the complaint decision f a complaint is about the polling the participant may request the department of human services hearing, request an external complaint review by the department of health or the insurance department or request both a fair hearing and an external review. If a participant is requesting both a fair hearing and external review, those two

things can be requested at the same time. These options apply the which a chcmco decision to deny a service or item because it is not a covered service or item, chcmco's decision to not pay a provider after a service or item has been delivered, chcmco's failure to provide a service or item in a timely manner. Chcmco's failure to decide a complaint or grievance within the specified time frame or chcmco's decision to deny a request to disagree with chcmco's decision that the participant has to pay a provider. For all other complaints , the participant may request a second level complaint review. If the complaint addresses one of these listed topics, second level review can't be requested. Only a fair hearing or external review. And then for all other complaint the participant may request a second level complaint review. Requests for fair hearings must be filed within 120 days of the date on the written notice of the chcmco first level complaint decision. This is a big change.

For those familiar with any other program where you were allowed to file a request for fair hearing, that used to be 30 days to file a request for fair hearing. This has been extended by

another three months. It's now 120 days from the date of the written notice to file a request for a fair hearing. Request for external review by either department of health or insurance department must be filed within 15 days of the date the participant receives the written notice of the chcmco's first level complaint decision. Second level complaint must be filed within 45 days from the date the participant receives the written notice of the chcmco's first level complaint decision. I'll discuss fair hearings and external reviews later. I want to town second level complaint at this point. Second level complaint is filed, the committee that reviews it must include three or more individuals, at least 1/3 of the members of the review committee may not be employees of the chcmco , the

chcmco staff may not have been involved and may not work for someone involved in the issue the complaint is about. If the complaint involves a clinical issue , the committee must include a licensed physician and a licensed physician must decide the complaint. The second level complaint is filed , the chcmco has 45 days to decide a second level complaint. And written notice of the decision to the participant. After a second level complaint decided if the participant is unhappy, after a second level complaint is decided, if the participant is unhappy, the participant may request an external review by either department of health or the department of insurance. Request for external review must be filed with either department within <!16384> days of the date the participant at least written notice of the chcmco's second level complaint decision. As you can see there is only one option for review of all second level complaint decisions. You can only request an external review. If an

external review is requested, the department of health can review the complaint if it involves the way a provider provide care or services. Pennsylvania choice department will restrew complaint if it involves the chcmco's policies and procedures. Department of health and the insurance department will determine the appropriate agency to review the external complaint. The time frame for filing grievances is pretty straight farm all grievances must be filed within 60 days from the date the participant receives written notice of the chcmco's decision about the medical necessity and appropriateness of a covered service. Unlike complaints, all grievances start way written notice of a decision by the chcmco. This will include the reasons for the denial or rejection of services and should explain the reason at a sixth grade reading level and include every reason for the denial of services.

The notices will also explain what a participant can do if the participant disagrees with the chcmco's decision. The grievance review committee must include three or more individuals, at least 1/3 of the members may not be employees of the chcmco, chcmco staff may not have been involved and may not work for someone involved in the issue the grievance is about and the grievance committee must include a licensed physician and the physician must decide the grievance. The time frame for deciding the grievance is the same for the time frame for deciding a first level complaint.

The chcmco has 30 days to decide a grievance and send written notice of the decision to the participant. The time frame can be extended by up to <!0> days if requested by the participant. After a grievance is decided, if a participant is unhappy with the decision , the participant may request a dhs fair hearing, request an external review by the department of

health or request a fair hearing and external review. Request for fair hearing must be filed within 120 days from the date on the written notice of the chcmco's grievance decision. Where for external review must be filed within 15 days of the date the participant at least written notice of the chcmco's grievance decision. The external grievance review is requested , the review Bobby a doctor who does not work for the chcmco. A written decision will be issued within 60 days from the filing of the request for the external grievance review. The external grievance review if the participant is unhappy, the decision

may be appealed to a court of competent jurisdiction. I want to talk briefly about expedited reviews. That's when a chcmco decides a complaint or grievance faster than the normal time frame. The process for expediting review of complaints and grievance is pretty similar. The biggest difference is the two can decide each one. A chcmco must conduct expedited review if a chcmco determines that waiting the usual amount of time to receive a decision about a complaint or grievance could harm the participant's health. Or if the participant provides the chcmco with verification from the participant's provider that explains why waiting the usual amount of time to receive a decision about a complaint or grievance could harm the participants health. The certification from the provider when submitted must include the providers signature and expedited review can be requested for ongoing service or for new services that are denied or not approved as requested. The review committee for an

expedited complaint must include a licensed physician and the physician must decide the complaint.

The review committee for an expedited grievance is the same as the review committee for a regular grievance. A chcmco must issue a decision with either 48 hours of receiving the provider certification or 72 hours of receiving the request for expedited review whichever is shorter. Participant can request that the time frame for deciding an expedited complaint or grievance can be extended by up to 14 days. We inenvision a request for this would happen when a participant provider isn't available to testify during the normal time frame to decide an expedited review which is 48 hours or 72 hours. It's a tight time frame. But it turns out the that the provider is available the following week. If the participant is unhappy with the decision. They may request a fair hearing. Request an external complaint review by department of health or insurance department or request both a fair hearing and expedited external complaint review. Must be filed within <!0> 20 days from the

date on the written notice of the expedited complaint decision. Request for expedited external review. They must be filed within two business days from the date the participant receives the chcmco's expedited complaint. If a participant is unhappy after an expedited grievance is decided, a participant may request a fair hearing, request an expedited external review by department of health or request a fair hearing and expedited external review. Request for fair hearing must be filed within 120 days and request for expedited external review must be filed within two business days. I want to talk briefly about what happens after a member a participant request a grievance review. The participant must be sent an acknowledgment letter.

The acknowledgment letter includes instructions about the complaint and grievance process. It will also include a description of the complaint or grievance which provides the participant an opportunity confirm that the chcmco correctly understood the complaint agreement. If the complaint or grievance is tried correctly , the participant is supposed to send back the form saying I agree. If not there are instructions and tell us what is wrong. And the participant can send information it has about the complaint or grievance to the chcmco. A participant may attend review. The chcmco will tell the participant the location, date and time of the review in advance. The participant has the option of appearing at the review in person by telephone or video conference if video conferences is available. If the participant does not attend review, the review must be conducted as if the participant was present and it will not affect the decision. The chcmco must

maintain an accurate written record of complaints and grievances which include the name of the participant, on whose behalf the grievance was filed, the date it was received, a description of the reason for the complaint or grievance, date of review or date of the review meeting, date of resolution, what the resolution is and a copy of any documents or records reviewed. Let's turn to fair hearings. Fair hearings are conducted by the department of human services, there is no direct access to a fair hearing.

The complaint or grievance process must be exhausted before a fair hearing is requested. For anyone familiar with the current health choice program, I want to emphasize the exhaust requirements because it is new and it will apply to all managed care programs but right now it's applying to chc. Big change there is no direct access to fair hearing. The participant must participate in the fair hearing. Unlike the complaint and grievance review where the participant does not have to physically participate, they have to participate in a fair hearing.

The participant can participate in person or by telephone. Chcmco will also participate in the fair hearing to rain in explain why the chcmco made the decision or explain what happened. Participant can ask the chcmco for any records, reports and other information the chcmco has about the issue at no cost to the participant prior to the fair hearing. And the participant will have the opportunity to review it. A fair hearing must be decided within 90 days of the date the participant filed the first level complaint or grievance. Not include the number of dates between the date on the written notice of the chcmco's first level complaint or grievance decision and the date the participant requested a fair hearing. Just like there are expedited complaint and grievances, you can request an expedited fair hearing. There is no direct access to an expedited fair hearing. The complaint and grievance process must still be exhausted. Chcmco will conduct an expedited fair hearing

if the participant provide written certification from the provider explaining why waiting the usual amount of time to receive a decision could harm the participant's health F. the participant provider provide testimony at the fair hearing which explains or if the participant provider provide testimony at the fair hearing which explains why using the usual -- the fair hearing must be decided after the request for expedited review. I want to also briefly discuss services.

When a participant is receiving a service.

The services must continue even if they are denied when a participant has already been receiving the services, participants request any leave of grievance review, or file for a fair hearing , the complaint or grievance review or request for a fair hearing is made within <!8192> days of the mail date on the written notice of the chcmco's decision. Questions.

>> We have a few questions, one of which I'm going to answer. These two Kelly probably.

>> I'm going to tread questions. When there is a complaint Greens about the appropriateness about cutting their services there will be no consult with the independent person who specializes with that diagnosis and service. It will be with a doctor without knowledge of the client's issue. In other words if the person way brain injury complains their pt is cut back, there will be no pt consultant. It will be the decision of a medical consultant. I'm not sure I understand the question. But the purpose of a complaint or grievance review is to allow an independent review and not something who is already made a decision review the complaint or grievance.

>> So the next question about the service based on a person's service plan. Some services may not be deemed medically mess but add quality a person's quality of life. This is about difference between services that are long term services in the community that may support the activities of daily living versus some types of medically necessary services that may be related to physical health services which is surgery etc. This is we believe the complaints grievances and fair hearings accommodate both types of services and the services something recognized on a person's service plan the relation to their need for long term services or it would be covered under the complaint or grievance process the person would be otherwise eligible the receive. Really depends on the service an participant just to be clear.

>> Right.

>> Do we have any other questions? If not we'll jump -- how does the chcmco handle anonymous complaint and grievances? I think you can't do an anonymous complaint.

>> There shouldn't be an anonymous complaint or grievance. Fits a grievance it would be about a service that was denied or reduced for a participant. So that should not be anonymous. I don't think there is an expectation that a service -- a complaint is anonymous. It needs to be filed by a participant or representative of the participant or participant's provider. And the information that you share during complaint or grievance is not something that should be shared with the public. So there is some anonymity.

>> What we're talking about is the formal process here to resolve disputes that a participant may have with the mco. And because it's formal, it can't be anonymous in that sense. That isn't to say that if the mco received an anonymous complaint or an anonymous commute that the mco wouldn't act upon it and investigate it. That's not saying that. All

we're saying in the context of this formal process, there is not a thing known as an anonymous complaint or grievance.

>> Another question we've been given if the grievance and peel is within 10 days, the continue of service continue during the appeal process f the appeal is denied with l they will retract for the service.

>> No service is discontinued pending appeal.

We don't allow the mco's to retract payment.

>> Will enrollment terminations notices be posted?

>> There are templates for the denial notices. I don't know whether they are being posted on any chcmco website.

>> We can share the templates for the people asking the question. Hopefully you already received a view of the template. If not we'll get it to you.

>> There was a question and I'll read it verbatim, can the ombudsman be involved in the complaint/grievance process. I'm confused by what you mean by involved. If you are saying could they be the representative of the individual in the complaint or grievance, there are rules where a representative or even the provider could present the complaint or grievance on behalf of the participant as long as that was confirmed in writing. If that is what is meant by involved. There is also concern rights associated with this process. I'll call them due process rights for lack of better phraseology. And if they are involved in substamping a fact in that case, they might be involved in that sense. It's difficult to answer that question because we're not sure what is meant by involved.

We hope it gets to what you wanted but we need more clarification what you mean.

>> How do these new roles apply to the care determination waiver program. The person determining no longer clinically eligible, this is not applicable to the process. It is appealable however if a determination -- if this is an eligibility determination and eligibility determinations are appealable.

You receive a notice from the department of humans services once the determination has been made and that notice has how you file an appeal.

>> When would the complaint go to doh. Anyone can call D.C. oh at any time. That will not change. This is regard to the formal complaint process. It would first have to go through the mco's internal review and then it could go to department of health F. you are asking if the question is when would it go to department of health as opposed to insurance department, insurance department -- let me pull the slide I have on it that explains the difference. Bear with me for one minute.

It really depends on the subject of the complaint versus the grievance. And whether it comes down to what is in the purview of the insurance department and when is in the purview of the department of health. If it's a policy question it goes to insurance. If it has to do with care it would go to department of health.

>> At this point I think we are out of complaint, grievances and fair hearings questions. Please keep sending them in and we're going to jump into the question for community health choices. We did receive a number of questions regarding life enrollment in the southwest and its impact on chc. We will provide numbers for enrollment in the next webinar and next support. Just to be clear , the reason why we want didn't want to present life enrollment because we want to see what Tim packet of enrollment was.

We haven't seen it at this point. So we'll present that in the next webinar. We did receive a number of questions with regard to that. That is request for data.

Next question we also received a number of questions relating to processing as well as the hha exchange software. We're going to go you this them as they are noted. We'll not be talking about specific managed care issues. We'll be taking those issues when the managed care organization is identified. We will have them address directly with the providers. So starting with this is a general question.

New service orders diddown not include the choice. Did k this be added to the service order to be received. We'll run this through managed care organization to see if -- the new offensive orders should make clear who the mco is. We'll talk through how this is being presented to the providers and the service coordinators. Next question is there a resolution in place for participant who have seen their Medicare special needs plan changed incorrectly. To be clear, community health choice plan, there is no impact on dual special needs plan enrollment. If there was a change to the dual special needs plan, it has nothing to do with community health choices. Community health choices our object is to coordinate but we have no impact or authority to make any changes to a participant's Medicare coverage.

We have no authority to make changes to a participant's Medicare coverage. If that change occurred, we want to reach out not only to the participant but to the dual special needs plan to research why that would have happened. Next question a participant doctor doesn't call -- does not [indiscernible]

and call the independent mco. What is the participant to do in the meantime? So this is a good question.

The participant should be working with the mco where they are enrolled to find providers in network to provide the services they need. Participant did the right thing if they are once they continue the use their current doctor and the doctor is not participating in the network, they can change their plan. They can change their managed care organization at any time. If they change in the second half of a month, it will not be effective until the first of the

following month. There may be a six week time difference and they'll want to reach out to their current mco to provide providers for services.

>> Another one is still working on our test log and a third one they haven't got the claims gone through but haven't gotten the eop. I sent an email out to all three follow up on where they are with the claim assessing process. Once I get that, I will follow one this individual of where they are at. We had a two hour walk through last Friday with the mco's, a number of nursing facilities oh try to resolve the claims testing issue and hopefully that are l occur in the next week. I'll get an update for this individual and respond back by email.

>> Define what is included in critical incidents. Will the department be monitoring the numbers with critical sciences such as a break in service? The second part of that question the answer is absolutely. We're capturing critical incident sciences is to review root cause of the incident and analysis. It's part of our quality evaluation. To define, I'm going to give examples of what would approximate included. Death, serious injury that results in emergency room visit, hospitalization or death. Hospitalization accept in certain cases such as hospital stays planned in advance. Provider staff misconduct. And abuse which includes the infliction of injury, unreasonable confinement, intimidation.

Mental anguish or sexual abuse of participants. Types of abuse are not limited to physical abuse, psychological abuse, sexual abuse, verbal abuse and neglect. So these are examples, not inclusive definition for people who are asking this question, we did use our critical incident of long term living policy as the framework for that definition. And it's also included in the community health choices agreement.

>> Can you discuss the role of the coordinator for resident already enrolled in ma and have an mco. There seems to be confusion about who is doing what approximate when a person is approved for ma in the facility and enrolled with an mco. What is the rolfer nht? Nht is one of the services that the mco's are going to be providing but work in conjunction with the nursing facilities to provide nht. We are providing the mco's a list of individuals who started the nht process, where they are at in the process and who they are working with.

>>> Add the mco's will continue to work with those voids further and finish the nht process so people can be discharged back to the community.

The role of the nursing facility will be working with the mco as they currently do. The coordinator will provide an additional partner oh try to figure out everything that needs to be done to transition somebody back out of the facility.

>> This is a known issue. Most members are not adhering. We believe a lot of this has been corrected. We know there are cases members may not be adhering. All are working together to have these issues corrected.

>> My facility has not done claim testing. What should I diddown?

>> You can reach out to me or each of the mco's or reach out to your nursing facility association. They were doing claims test with a set number of facility. Once that was done they are going to work with all the facilities oh make sure the claims got processed through. You can reach out through your association, directly to the mco or department.

>> It was noted in a series of webinar last week that where it was stated and restated providers will continue to bill for over wafer claims. To be very clear, it is possible for somebody in the program to be involved in commute health choices but only as a dual eligible. Their fiscal health services will be build through the managed care organization but long term services support is build through that. That is how that will work. It is possible for somebody to be in health choices. Not community health choices but possible for somebody to be in health choices, their physical health services will be health choices or potentially in a service program. But their long term services support would continue to be build through prada. All service coordinators have been asking us and have no idea what to do about this. Hopefully this provides clarification. AnotherH ha exchange issue which is a known issue. When an individual or when a provider is billing for services

only allows a 15 minute increment on the hour. This is a known issue and they are working on a correction right now.

>> It has been corrected. It should be listed out there in 15 minute incremented to bill on.

>> Financial abuse, also consider add Buss. That was not mentioned but it's present on the list of abuse.

>> It is.

>> Fur not included nursing homes that are testing claims, should you move forward with submitting claims or wait until the edit issues are resolved?

>> You are not involved in the testing and you want to test claims before you submit your full cycle in February, reach out to the mco and go ahead and do that and we'll work with you to process them through.

>> It's been known there is an issue for transportation for participant and there is not a list of providers at this point. Public transportation is not yet included.

We encourage to continue to provide transportation prior to the implementation of community health services in the southwest. Transportation issues are being addressed with all three of the mco's.

>> have service codes been changed? One of the mco's have added modifiers that did not exist before. W codes 1793 and adding a modifier r1 and r the. Which what service code is supposed to be in our billing cloud? That I'm not sure. Let me talk with the mcO and see what the issue with that is.

>> for billing related issues they should work with the mco directly to have those questions answered. Reason nts planning to work with providers after the 180 days continuity care period expires? To be very clear nursing home transition for community health choices recipient says requirement for the mco's to provide. They may though however be confusing existing nursing home transition providers to prostride services. Individual providers reach out to one or all three of the mco's and discuss with them directly how they are planning to provide the transition services. It is a requirement.

>> Who offers nht services for individuals not enrolled in the chcmco. For those who have private insurance. In that situation it's not a service covered by ma. It would be the responsibility of the nursing facility to work on nursing home transition with that individual.

>> How soon will the training outreach start in the southeast part of the state?

>> We are working on time frames and time lines when we will start communication in the southeast.

We're looking to do a kickoff probably in early April with a number of dates set where we'll start to send out participant milings, provider mailings.

We're going to hold five oh ten sessions in regards to chc with providers and hopefully session with participants and goal is to start earlier than we did in the south WWE.

We are putting plans in place now to start the communication.

>> So when we bill through promise, as mentioned for 150 and obra you bill the long term services through promise. If the participants being in health choices mco you build the health choice mco. If the 150 participants participate in health choices -- it would be build to the chcmco. [indiscernible]

.

>> The enrolled chc website still active?

>> Yes it is.

>> Only signed up with one mco so do we need to check for authorization through three systems?

>> As far as I know all thee are using the same exchange.

I'm not sure what you mean by they are only signed one one mco. I will follow up with you to get more details.

>> Next question provider stating they do not have provider manuals at this point. We'll mention this to the mco's. The next question --

>> I got an update on that. I just checked when this question came in. The provider manuals are out on their websites. Billing guides for Amir health is on their website. Upmc it on their website. It's chapter h and c hw is being finalized and will soon be out there.

>> Question on the demographics of the enrollment. Why were so many individuals assigned to u pmc? In this process the largest number of individuals selecting managed care in the southwest selected upmc. Why wasn't the auto assignment addressing the auto assignment question for upmc. Question do auto assignment for the other two plans because of the heavy plan selection for upmc.

The auto assignment allocated heavy plan selection for upmc. We did.

>> Members requested a change in mco prior to 12 which shall 29 -- 17. How were the changes not in ups. The person just sent this in, I just responded to another email. If you can send me a list of these individuals, I'll check into them.

>> Next question it's noted that two of the three mco's are using software than the other mco and questioning why this was the case. Just to be clear, all three of the managed care organizations are required to use phone care tools for comp hence I have needs assessment. That does not mean that the managed care organization can't August meant the comprehensive needs process with their own selection of information and we're not preventing them from being able to do that. Our requirement is the use of the home care tools. So they should be and will be using that tool.

>> In regards to skilled nursing do our doctors have to be participating with each chcmco in order fair facility to be reimbursed. As long as they are Medicare enrolled they don't have to participate with the chcmco. Those doctors placed on the upo for billing.

>> We're pausing to --

>> I think we'll reach out to this person -- there may be misunderstandening what the requirements are for chc enrollment. The if the doctor is a primary care doctor for the participant and they participate in Medicare, it may not be necessary for them oh enroll in chc. If they are planning to use that doctor in any way for the authorization of services for participants this chcmco, they may need to participate in chcmco. We may not understand question.

We'll reach out as a follow up.

>> This is more of a comment than a question.

We're starting the education and the southwest hasn't even been trained.

>> We continue to reach out and train providers in the southwest. We continue to send communication out.

The mco's are doing different types of training with providers. We are continuing on a daily, weekly basis to provide all the training we can. But we also know from implementation in the southwest that we need to start a little sooner in the southeast to ensure that all providers are trained by the start date of next year.

>> Talked about traveling expense, can we get extra money for transportation. A lot of our employees are asking for money to go shopping, doctors appointment etc. Anything have you service related you should discuss directly with the mco's.

>> Next question is there enough data to let [indiscernible]

theF t performing functional eligibility determination going forward. The managed care -- the independent enrollment broker will be actually contacting agent well to initiate the eligibility determination as the process evolves.

Participants can continue the submit paper allocations to maximus and they will process them.

>> A lot of concerns coming in about hha, what mcS using for all billing, others for parts of billing. I'm going to go back and follow one the mco to see what they are doing with hha. We have daily conversations about that. They are providing us their overview of hha next week. We will continue the work to figure out how they are using it and make sure you are appropriately billing their system or the system they need to you bill through.

>> General question about continuity of payment. Continue services even as the mco's may not be able to load all the participant in the system and can they provide an update before we can expect payment. If a provider is not yet ready to -- is receiving feedback from mco's their claims are being held or not paid, please feel free to let us know that. We'll work with the mco's to make sure that's addressed very quickly. We'll submit to the department so that there is no interruption of provider payment throughout this process.

>> Issues we're having is none of the sga's are sending service to tell us what consumer chose what sgo. We're continuing to work through processing now.

>> How can individuals be able to access services that were not previously available. Service coordinators are saying there is no way to request services that were not previously available but are now. Obviously it is a true statement if a participant is assessed through comprehensive need assessment can the person have a process for a service they couldn't receive in the past through a waiver? They are eligible through that service in community health choices. What is required is that if there is an issue or some other, they would have to go through the assessment process to identify that need.

They are eligible for that service. And service coordinator should work with the managed care organization to identify the process for thousand service eligible for the participant -- [indiscernible]

regardless through the continuity care period, the service will be available during that 180 day period.

>> We have two resident approved for ma services effective January of 18. They were not given the opportunity to select which mco they wanted. It was auto select for them. Will they be able to choose. When they were asked to change they would told they would not be able to change until march of 18.

We thought they could change at any time. They can change at any time. Doe update rules in place. If they make a choice the change the mco between the first and 15th of the month, it will become effective first of the next month. After the <!16384>th of the month, it will become effective first of the proceeding month. If they maketa choice January 20 it will become available march 1.

They should have that ability to make a selection. For some reason they may not have. If you want to send information in about the two specific cases, we can look into them.

>> Thank you. This is our last question. Just in general these questions were really in a launch of southwest. We have a lot of followups with the mco's. It was particularly helpful. Feel free reach out to our mailbox to be able to submit these questions. We'll answer them or somebody in the organization answers those questions. And last question are the chcmcos obligated to provide reimbursement for transportation services.

>> The requirement of community health choices, the community health choices managed care organization provide nonmedical transportation services. Nonmedical transportation and emergency medical transportation. With that we appreciate all of your time and tension and these great questions we received and we look toward to continuing this conversation as we move forward with the southwest. And we also look forward to hearing any emerging issues that you may have and please feel free oh forward them to our mailbox. Thank you and have a great afternoon.