- May 17, 2018

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>> CAPTIONER: Hello [standi [stand **>> Kevin:** as well as planned implementation in the southeast and later on the office of long term living and Brian will be providing detailed description of the operational before we begin we will give you some housekeeping look at your attendee interface you should be able to see a way to be able to participate via the webinar directly. In the center of the screen is the go to webinar viewer. That's where you will be able to see the presentation. If you notice in the upper right-hand corner is the control panel. That's where you can ask questions and select the audio mode.

If the control panel is closed you will see a slim red control panel you will listen via your compute. If you prefer to join by phone click the telephone number and the dial in information will be displaced this will place you in listen only mode. You may submit questions in the interface any time during the presentation.

And you may send your questions through and we will most likely respond to them in the intermittent periods. Marie and Brian will be able to answer questions about their presentation at the end as well.

Attendee control panel will collapse when not in use. If you want to click it. A quick update on community HealthChoices. Starting with 2018 for the southwest we have stated this a number of times it is assuring that there would be no interruption in participant services and also assuring that there would be no interruption in provider payments. At this point we vow that we have met this objective even with some periodic -- even with some periodic issues especially with regard to provider payment.

We have been able to address those. We are at the point where there are still issuing occurring. They are at an individual provider level. We are working, if necessary, it is usually resolved between the providers and managed care organizations directly. That's certainly what we want. It is also possible that we might have to be involved to address some of those issues. We have been able to work through them.

With regard to participant service interruptions 4 and a half months into the program the volume of participant interruptions recognizededd is actually lower than what we would have expect today see in the future service program. We are very happy about that. With limited interruption in participant services that have been addressed university as well as the ability to be able to address provider payment issues. We are viewing the launch of the southwest as a success. We are happy to state that.

That doesn't mean we don't have lessons learned. We definitely do for the southeast implementation that is a major focus for the project and the program going forward. And we look forward to using that experience to be able to improve the implementation for the southeast.

Just some points about the southeast. We are preparing for the January 1, 2019 launch. That will involve comprehensive participant communication and that comprehensive participant communication will be beginning in July with the mailing of an initial touch employ error flyer that will provide participants with notification that this is going to be coming their way. It is involving a robust review readiness process to make sure the 3 managed care are meeting adequacy. We will be having provider communication sessions starting in June in Philadelphia and the 4 suburban counties in the southeast. We will also have our traditional pre-transition and plan activities for participants starting in August. Then we will be incorporating all of our southwest implementation and launch lessons learned throughout the southeast. We are expecting -- we are certainly not resting on our laurels when it comes to the implementation of the southwest. We know that we have

a lot we can incorporate to improve the implementation of the southeast.

We know the complexity and size of the population in the southeast is different from what we experience in the southwest. So with that being the case we must be -- we must be certain that we'll have to make changes to be able to make a difference and to make sure that we have even an improved experience in the southeast, better than the southwest.

A couple of other updates about the southwest. This shows the population distribution by the population categories in the program. It is roughly 80,000 people in the southwest have been enrolled. The largest portion of which are the community duals or the duly eligible individuals, individuals that are duly eligible for Medicare and Medicaid that are not in need of long term service and support.

The split between individuals who are in need of long term services and support between the community and in nursing facilities is about even. In the southwest we expect that to be different in the southeast. They have a very broad home and community-based population in the southeast. So that will be a significant difference.

The next shows the distribution by managed care organization. UPMC community health choices has 54%. More than 50% of the population in the south west. Pennsylvania health and wellness 27%. Amerihealthcare less.

To highlight what we learned from participants and providers, the southwest implementation we apologize for the typo the southwest implementation which began on January 1, 2018, we noted that there were 80,000 participants listed here. So we did receive a lot of feedback. They are incorporated in a lot of lessons learned.

Some of the participants feedback we received related to transportation services. That is something that is on an ongoing issue to be perfectly honest for home and community based services and for nursing facility services we are learning about ways to improve the transportation system. Non-medical transportation which is a waiver service that is now available to the en fire home and community-based services population. It is also available for non-nursing home facility residents. The managed care are responsible for providing this transportation in both settings. But there has been some challenges with regards to

communication, coordination and there's been some experience gained through the use of the brokers that all 3 of the MCOos are using. In addition participants have provided a lot of feedback with regard to losing their existing service coordinators and also there's been a lot of questions -- these are

specific examples. Of course the feedback has been broader from participants there's been a lot of discussion about what is an eligible home modification as well as access to DME services we received a lot of feedback. One of the common questions is what will happen to the service coordinator relationship after the continuity of care period ends? Just to touch on this, we have talked about this in third Thursday webinars. It is a function of managed care organization administrative care services we consider the service coordinator. -- all 3 managed care are using a hybrid approach which means they are using in-house or staff to be able to provide the service coordinator role as well as using the existing service coordinators as subcontractors to provide a service coordinator role. All 3 plan to continue that hybrid model after the con nowty of care is over. This is an important question because we recognize the importance of the service coordinator relationship with

participants and at the end of the con nowty of care there may be a transition. We want to make sure it is managed correctly if such a transition does occur.

We have received a significant amount of provider feedback as well. It provides some of the provider feedback we received. The first is communications with the managed care organization. That has the most significant impact has resulted in delays of payment. Most of the communication challenges there have been some training communication changes that occurred early on in the implementation in the southwest. They have been largely addressed. Some of the communication challenges are technical in nature. They required a little bit more long term solution.

The MCo and providers have been working through those issues we see some significant improvement it is an organize we will focus on and it is an area that will be lesson learned for the southeast.

We already mentioned non-medical transportation and how the MCOos are handling it differently. Billing has always been -- always is an issue when it comes to a change like this and there has been some technical assistance required to particular providers to know how to bill the MCos themselves. New referrals this is specific to a lot of different providers how new the new referral process works and what this means is how are providers in network going to know that they are going to be providing services to individuals in need of long term services and supports.

Important question and it is also an important point of communication between the MCo and providers.

So we did want to high light some of the claims experience by type of service. The most common reason for claim denial. The first here is duplicate claims. That is actually pretty common in the fee for service system as well. So this number 1 reason is not that

surprising. It happens a lot of. A lot of automated billing results in duplicated claims. There is also sometimes providers are -- submit bills on multiple times.

It something that happens all the time in fee for service. Service provide to subscriber effective date is an eligibility related reason. Sometimes it is not correct and sometimes we find that our eligibility system has to be corrected and that has actually happened a lot as well.

It's been as much as -- not more than we expected with community health choices there have been a lot of specific eligibility cases that have affected claims, payments that had to be worked through with our eligibility process. It is mostly specific to Medicare, long-term care eligibility. Denied claim disallow which means it wasn't an eligible service then you can go through the rest of the season. Home and community based service so that standard waiver services that are received in the community those are common designs. None of those are that surprising for us especially the eligibility issues they happen frequently in the fee for service program.

Skilled nursing facility the common denial reason duplicate claims. Inappropriate coding for contact agreement might be an area where some additional technical assistance may have been required. Working with nursing facility knowing how sophisticated they are at billing it's been often the case it happened to be a point of education on the nursing facility side or managed care side. So there's been a lot of work in this area as well.

Then we have a number of eligibility claim denials that are very common. Then last of the claims had to experience the physical health denials duplicate claims are on the list but they are third. Medicare is an impact. So those type of claims Medicaid is the primary payer for those type of claims. We do need Medicare information to process the Medicaid claims in many cases. That has been a common reason for denial. The code not payable for provider specialty.

So continuity of care just to high light the continuity of care point we are getting close to the con nowty of care for the southwest. We wanted to provide some updates on how the MCos are planning to approach it. First with UPMC, UPMC, this is specific to service coordinator we will high light home and community based providers as well. The reason why we have talked about this is we have received a lot of concerns from stakeholder whether provider and participants what will happen to the service provider. All 3 did provide us an update. First UPMC will be offering long term contracts to 9 external service coordinators and that impacts 2101 participants. This is also current that they will be evaluating all other service coordination entities to determine whether or not those service coordinates will also be part of a long term relationship with the managed care organization.

So at this point UPMC is not planning to make any changes but they will be offering some contracts with some service coordinators. Pennsylvania health and we willness will providing -- will not be immediately terminating contracts with service coordination entities at the end of the con nowty of care period it will be part of a longer evaluation

process. Just so you know we require that the managed care organizations provide us with 90 day notice if they are planning to terminate any provider relationship. We include it in the continuity of care notice. We have not received such notifications. Ameicare will not be terminating any service coordinators at this time. They will go through an evaluation. They are all taking the same approach for service coordination. It will be on an ongoing evaluation process and it will largely depend on the relationship between the managed care organizations and the service coordinators.

For physical health providers and home and community based providers we have not received any notification at this point from the managed care organizations. Remember we have a 90 day notice that there will be any termination of any provider relationships. After the end of the continuity of care period it locks as the provider system will remain stable. Current areas of focus for the implementation of the southwest we are focusing pretty heavily on behavioral health coordination. We had a meeting on May 9 between CHC-MCO and our partners in the office of mental health and substance abuse services. We want to encourage the use of behavioral health in nursing home facility. It was an opportunity to answer questions or to have questions be raised about how coordination can improve and how service offerings could be made for resident population.

Resident population and individuals are all new to managed care care. We want to encourage the use of behavioral healthcare and we are looking forward to increase in outization. The up tick is not what we had expected. We are hoping it will progressively increase.

In that session our partners provided an extensive overview of behavioral health services we hope now that the nursing facilities have a good handle. Just to be clear we are planning to have a similar discussion in the near future or aging waiver recipient and key stakeholders. We are hoping to cloud the area agencies on aging as well as other key stakeholders that work with this population so that they will have a good understanding what behavioral health services are available as well through the behavioral health services.

Transportation continues to be a focus. We had had several meetings this past week. And we're hoping that some of the hiccups we have had with non-medical transportation and transportation coordination will be addressed and improved. We're also working with transportation and thinking about reI am abling the way we could do outreach for transportation as we move forward with implementation in the southeast. So that is a segway into the south east implementation which is our new focus.

We will continue to focus heavily on the end of the con nowty of care for the southwest. We will continue to focus heavily in the southwest on the impact on service plans for participants. But while we're doing that from on an ongoing long term perspective we have to shift focus on community health choices to the southeast implementation which will be January 2019.

So the southeast we will be focusing on making sure that individuals that are in the OBRA program are appropriately assessed so they will stay in the ABRA or will be transitioning to

community health choices people in the OBRA program must be nursing facility clinically eligible. If they are nursing facility clinically eligible they will be transferred into community health choices we will do some communication plans that includes a mailing effort including the initial touch flyer as well as the participant outreach and education sessions which will be occurring in the late August-september-october time frames to talk about implementation and what participants need to do to select the managed care organizations. There will be provider outreach and education including some provider outreach sessions that will occur in June in Philadelphia as well as bucks, Montgomery, Chester and Delaware county and population identification. What we moan here making sure that our

outreach efforts are not missing definitions that are difficult to roach. That is true in the Philadelphia area. When we talk about populations that we're taking into considering special requirements clouding language requirements.

So we will be as mentioned we would have the southeast provider sum its and these provider sum its will be occurring in Philadelphia county from June 4 through 8. If you are not registered please do so. That will be occurring at Temple university and that will provide an overview of community health choices as well as key break out sessions that will focus on physical health services, home and community based services and service coordination and transportation embedded throughout all of the presentations.

And for the remaining 4 counties in the third week of June we will have sessions at different sites in the vidcon advertise. In Chester county we will be at West Chester university in Delaware at Delaware county community college. We will be at Montgomery community college. For Bucks County Bucks County community college. We are very grateful to the community colleges to allowing us to use their space to provide those sessions.

>> Comparing it to the southwest that is approximately 50% larger. And just to be very clear the home and community based dual and non-dual is larger. The largest of course is in Philadelphia 87,000. 87.6. That is larger than the entire population in the southwest. Then the remaining counties have a breakdown that ranges between 5 to 12,000.

Total 127,726. So communication continues to be a focus. We have touched on this. We will continue to have our monthly. Next will be on May 30. We are actually having 2 in May because of the June provider sessions overlap. So we have our next may 30 and we will be focus on the con nowty of care for home and community-based sessions in that session as well as update on service coordination credentialing. The consumer sub Maac. We will be having an in person south in the southwest. I am very excited about that. The consumer sub MAAC is going on the road we will be from 1 to 3 in the assistance office to be able to answer questions for participants who wish to come in person. We are looking forward to that very much. The next is the LTSS sub MAAC. The next in June we will provide updates as well as fee for service home and community based activities. The MAAC will be on Thursday. The next will be on coordination for community and home-based choices. We look

forward to your questions and suggestions for topics. Actually we would encourage you if you have suggestions for future topics to send them to us. We will make sure that they are on our agenda in the very near future. Also we continue to have stakeholder outreach which includes MCo advisory committees, local advisory groups, sub MAAC groups, Thursday web senators and updates from the CAC website.

>> Resources this is our standard slide you can find this on line as well. We always encourage providers and participants to send us list serve to receive the updates and to continue to go out to the community choices websites to be able to access a lot of our information including frequently asked questions which continue to grow. So we have a lot of frequently asks questioned and we have a lot of questions that are frequently asked. We encourage you to go through that and learn about that as well. We also have an MLTSS which has a transcript session as well as previous agendas and presentations. We will continue to have our E-mail available to answer your questions as well as our LTL provider line and participant line. The information is noticed at the bottom. That is foreign rolled individuals if they wish to have information answered as well as make a plan change if that is something they want to do. With that we will jump into a few questions quickly before

we jump

>> Marie and Brian's presentation. Can the northeast provide the southeast to provide logistics. Great question. Rephrase can northeast service coordinator attend the southeast sessions. We last year with the southwest actually sold out. We ran out of space. We had to cut off enrollment. We are not there in and out we might be there. We want the southeast providers and service coordinators to attend those sessions first. But it is possible that if there is space available that other service coordination entities in the northeast or elsewhere should consider joining us. Thank you very much for that question. Next question when DHS gets a 90 day notice are the fees -- that the fees are being eliminated how quickly the contracted be notified to increase their capacity? I'm not sure what they mean by increasing their capacity. But I think what that means when will they be notified they will be eliminated. It is my recommendation that you ask them the MCo directly.

We do not have a requirement for when providers need to be provided or will be notified by the managed care organizations that will be MCo specific. We encourage you to reach out to the managed care organizations to ask that question if it is something that they plan to do. After the continuity of care period did any of the Mco say any positions would be eliminated. We did not receive any specific -- we should receive the notification the 90 day notifications we have not received any such notification at this point. Next question when the CHC is implemented in the southeast will they require a prior authorization on claims during the con nowty of care period? It is possible that you will have to have a prior authorization requirement.

The MCo will be able to provide answers in much more detail I would encourage to you attend the provider services to ask that question to them directly. It depends on claim type. The answer too that is probably yes. But we would encourage you to reach out to them directly to have that question answered that is a great question.

The next question do fingerprint check node to be obtained the same as child abuse checks with current CHC. The person answering this question we will get back to you on this. I actually think I need to research that question just to be sure. Thank you. The next question in the southwest what is the percentage receiving mental health and behavioral health services across the board? We NOAA cross the state -- that is a great question, across the state 35% of the community duals are receiving behavioral health services. There is very limited outization for community health for nursing facilities and individuals in the aging waiver. That is a really great question. For the southwest the percentage receiving behavioral health services how much is it increasing? Not much. How much were they receiving at the baseline for the community duals 35%. So we're going to be monitoring this it is a great question we will be monitoring this to see from the baseline how much it

will be increasing. But at this point for the aging waiver population for nursing facility it is not that significant. Next question on slide 4 I seem to ask this every time I thought you said you would make this change can you include the total numbers as well as percentage of enrollment. The reason why we didn't include this to the person who is asking the question is that we had -- it is approximately 80,000. We prefer to give the percentage at this point they are Ray more accurate pre-fiction of the distribution. In the next presentation that will be standardized. The percentage is more accurate. That's why we include percentage instead of several numbers. Going forward we will be including total numbers as well.

Next question I will try to get through those quickly so Brian and Marie have time talk about the way you receive with the managed care. If it needs to be a real inhibitor of participants or an understanding how to do outreach with the participants I would strongly encourage you to bring this to the department and we'll start talk about the MCO and see if the scope of information on the referrals can be changed.

Next question if a provider is contracting with a particular MCO will that provider need to contract again with them in the southeast that is a great question. The answer to the question will be depending on what the MCo wants to do with their contracting. It is possible that they filled out their contracts to be done or specific. That is a question I would encourage you to ask directly to the managed care organizations in many cases they decide to do a statewide network. But I would think the managed care organizations should answer that question it is more about their contracting with their providers. Next question the first bullet on Page 14 did you mean 9 service coordination entities and not for 2102 people. Hopefully I'm not people giving a headache as I go back to that slide. It says 9. We did determine it is 10. The actual number is 10. On the slide when we developed the slide it is 9. Great catch. It is 10. Thank you for the question.

Same question. Thank you very much. Have the MCos determined the education request for MCE we heard master or licensed social work. They have an opportunity to be able to present a proposal on otherwise. At this point we have had lots of discussions with the MCo but I think that the service coordination requirements are something that we are

talking to the MCos about. So the questionly receive an E-mail to the Chester county provider summit. We will keep your E-mail and respond back to you. Jen, do you know that actually? If they will be receiving a confirmation? Previously when they did the registration they did receive a confirmation. I'm not sure if that is true for the southeast. We will confirm that as well.

What is the percentage of the 87,000 do you think in the southeast will be behavioral health. Constitution or therapy. Another great question for the population we know that the aging waiver population and nursing facility population in the southeast is certainly higher in the Philadelphia area. So if you are talking about individuals that do not have access and behavioral care it could be as much as 25 or 30%. But that is an estimate at this point which means I have to guess. It's a questionville to drill down more closely.

Couple more questions quickly and then I am going to hand it over to Marie and Brian. So when is the sub MAAC meeting at the Allegheny county assistance office? It is my understanding it is may 23. I will verify that right now. It is may 23. Thank you very much. How much enrollment in the life has changed with the southwest? So the enrollment we have not seen -- great question. We have not seen the life enrollment change with the implementation of the southwest. It is holding steady and that is something that has been a focus for us as well. We appreciate the question very much. The life program will be the enrollment alternative to community health choices it is a wonderful program for people who are interested in pursuing a truly integrated model for Medicare services, Medicaid services and behavioral health services across the board. Unlike community health choices which is a coordinated model the life program is a fully integrated model which means it is a

one-top shop. We haven't seen as much enrollment in the program as we would have liked in the southwest. We are looking for opportunities to get the message out about the program's offerings one of which we will do some directed outreach to eligible recipients in the southwest towards the end of the continuity of care period to let them know this is available to them. Thank you very much for the question. We do very much want the life program to thrive with community health choices it is a wonderful program. Next question have any of the MCos entered no contract with home care companies? The answer is yes part of their network if you moan the southwest. If you mean the southwest I can't answer that. We have not received reports from the MCos and when we receive our first report in why you. Next question how will nursing home residents be able to participant in meetings? If they mean -- great question. We have had nursing home facility residents participate in

in person meeting. It is possible that the nursing facilities may help their residents to access these meetings. That is a point of discussion with the nursing facility as well as the managed care organizations. Last question I'm going to be able to answer if the consumer is enrolled in the MCo would like switch to an mco is that possible? Participants are able to make a change to a managed care organization at any time. The effect of that change

depends on when during the month they make the change. They can make a change at any time. If they make a changed in the first half of the month that change will be effective the first of the following. That will be affected the first of the month after that. For example if they make a change today that change will not be effective until July 1. With that I'm going to switch over to Marie and Brian and Marie and Brian are going to provide us a thorough review of the operational process relating to complaints

>> Marie: Thanks, condition. As Kevin had indicated we are with the bureau of quality assurance and program analytics we wanted to provide you with an overview of the internal process that's in place for MCo service complaints, grievances and fair hearing process that's in place again to ensure that participant complaints, are being addressed and processed accordingly and in a timely manner. The areas we would like to cover today is going over a little bit on the differences between what is a complaint, what is a grievance, what is a fair hearing what is a standard or expedited fair hearing, an explanation of the process a little bit about the data analysis and then we will answer any questions that you may have on our processes.

so on this slide this goes over the definition that's can be found on page 270. These are verbatim what we consider a complaint. A complaint is a dispute or organization regarding a healthcare provider or the coverage operations or management that a CHC-MCc which has not been resolved which has been filed with the CHM-Mco or with the Department of Health or insurance department. A grievance is a request to have the MCO reconsider a decision concerning the medical necessity and appropriateness of a covered service.

Then below that I have listed that how a grievance may be filed regarding the decision it could be denied in whole or pardon. Denied in, request the request but approve an alternative. Request a request for benefit limit exception.

Our third definition is a fair hearing now where fair hearings are concerned they are broken down into a standard fair hearing and expedited fair hearing. For a standard fair hearing the participants or the participant's request can request a fair hearing in 120 days from the written notice that they received from their MCo regarding the first level complaint decision or a grievance decision.

The bureau of hearing and a peeps will issue an adjudication within 90 days of the date that the participant has filed the first level complaint not including the number of days that would be before the participant requested the fair hearing.

For an expedited fair hearing the participant or the participant's rep may foil a request for an expedited fair hearing with the department in writing or orally. And before they do that the participant must exhaust the complaint or grievance process prior to feel the expedited fair hearing. They will conduct an extradited fair hearing and provide the department with a signed written certification from the participant provider that the participant's life, physical

or mental health or ability to attainment or remain maximum function if they didn't follow the process.

It is pretty much a breakdown of what I just discussed, it is the process that is internal from start to finish. So as you look at this chart what is not included is a little bit of before that first box CHC MCO a participant is getting a service or item. At some point the provider or MCO it is something you are unhappy with. All of this information is contained in section 8 of the agreement for complaint and grievances. Some reasons that you may not be unhappy would be you're you be happy with the care you are getting. You cannot get the service or item you want because it is not covered or you have not gotten services that your MCO has actually approved. At that point we would file a complaint. If your MCO would deny, decrease or prove a service or item different than the service or item you requested because they feel it is not medically necessary, you would get a notice that would tell you that's what they have decided. At that point you would foil a grievance

. The grievance is when you tell your MCO you disagree with the decision that they denied, decreased or did not approve a service or item.

In either of these cases, the participant would follow the process in their MCO participant handbook. This is section 8 which discusses the complaint and grievance process. It is the last section in the handbook. If you did not get a copy of the participant handbook reach out to your MCO and request a copy. The handbook is a great explanation on the differences between complaints and grievances. It is a great resource on a step by step process of complaints and grievances how it is important to work with the MCO first. The handbook will further breakdown a complaint into first and second level complaints. This is again discussed in more detail in the handbook. At this point I won't be drilling down specifically to that.

In regards to filing a complaint or filing a grievance, you have the ability at any time -- you're able to continue getting your services. If you have been getting services that are being reduced, changed or denied and you file your complaint or grievance, whether you are filing that verbally or faxing it into the office or you are hand delivering it into the office, as long as you do that within 10 days the date that the notice that you received the notice from your MCO that indicated that the service or item was being reduced, changed or denied, your services will continue until a decision is actually made. So that is very important to understand that your services would not be cut.

Now locking more closely at the chart, that is a preview what is going on prior to it coming no our office. Once the participant submits a complaint or grievance to the MCO, the MCO would let you know that they received the comment or grievance. They would explain to you the review process that is in place and they would mail you a notice within 30 days or less that they got your complaint or grievance telling you of the decisions and what you can do if you don't like the decision that they have made. So at that point if you do not like the decision that the MCO made, you have the option. Your options are to have an external complaint review done. You can have an external grievance review, fair hearing. You could ask for both an external complaint review and fair hearing. My focus will be when you

request a fair hearing. Again the other items described in the participant handbook in more detail going over the process as well as the time line.

So if you do not like the MCO decision and you requested a fair hearing. You request the fair hearing from the department of human services within 120 days from the date on the notice from the MCO telling you the complaint or grievance. So for instance -- let me read you some examples. Denial of a service item it is not a covered service. It is a payment to a provider. It could be because your MCO failure to decide your complaint within 30 days or less. So at that point you would fill out a fair hearing request form which would have been provided to you in the letter you received from your MCO. Or you could write a letter. If you write a letter there are a few items that need to be in that letter for us to be able to do the research that we need to do and help you out. Again that information can be found in section 8 of the complaint and grievances section of the participant handbook. Some of the items we're going to need are situations like your name, date of

birth your telephone number where we can reach you during the day and whether or not you want the fair hearing to be in person or by telephone.

At that point the department of human services the bureau of quality assurance and program analytics appeal unit takes the information you have and will send it in the format you provided to us in hard copy and will coordinate with the bureau of hearing and appeals on that request. At that point the bureau of hearing and appeals will send you a letter on the date of your fair hearing. The fair hearing will be decided 90 days from when you filed your complaint or grievance. And the department of human services will send you your decision in writing and tell you what to do if you don't like the decision that they have made. Once again, as I indicated earlier, at any time any of the services or items that you are receiving that are reduced or changed or denied you can ask for a fair hearing. As long as that request is postmarked or hand delivered 10 days from the date on the notice that the MCO told you that they were dennying it your service or items will continue until

the final decision is made. Now on this next slide Brian is going to go over some of the data analysis that our unit complaints as complaints and grove answers come in.

>> Brian: Hi, good afternoon everyone. Thank you for joining us. Just real quick in regards to the qualified data analysis, we have a couple of things just to let you know that one of the roles as far as our bureau is keeping track as far as when the complaints and grievances are brought to our attention. Two of the ways we are going at it is through -- one of the ways is through an opps department a Department of Health complaint. We are keeping track of another opps report. Both of those reports are where you want to be conducting analysis as far as to help identify the potential trends, as far as the managed care organizations and there is a larger volume of a particular type of denial of services which is resulting in eye type of complaint or grievance of those changes in the participant services.

What we're planning to do is an in depth analysis as far as identify as far as any trends which we need to make sure it is brought to the attention of all OLTLs and staff to see if there are any additional issues behind that as far as one of the MC organizations why they maybe denying a service or why there are specific complaints or grievances in regards to the services that are being delivered. And also why the changes in those services.

Another way in which we are also keeping track as far as the overall the complaints, grievances and fair hearings is also one of our first priorities is making sure the internal hearing process is going smoothly. We will cope track as Marie indicated once we are aware of a participant's appeal of an MCO to be working with the bureau of hearings and appeals and stay on top of that in regards to the actual processing of the appeal as well as making sure that the outcome as far as tracking what the outcome decision is, if the appeal will be found in favor of the department or in favor of the participant. In regards to more or less -- reassuring when the fair hearing is being processed it is being done timely in regards to that.

Just to let you know they will report on the identified trends to the CHC-MCO monitoring teams if we do identify any potential red flags or concerns in regards to the processing of the complaints or grievances as well asization to the overall fair hearings process.

Our next slide is a quick on line resources which we want to make -- remind everyone that there are some good resources available on line. The first one of course is the 2018 final CHC agreement information. As referred to in exhibit G grievance and fair hearing processes that does begin on page 270. The link will take you directly to that document to the agreement. Then on page 270 it will take you right to exhibit good.

where you can learn more information, detailed information in regards to the complaint, grievance and fair hearing process overall. Just to let you know that the participants should also as Marie indicated refer to the hand book in section 8 which deals with the complaints and grievances provided by their MCO.

Lastly we have also available on line is the fair hearings and appeals. There was a presentation given by our general council on the previous Thursday webinar on January 18. This one definitely is a great source because it provides a very in depth overview of the grievance complaints and fair hearings process as a whole. At the time I believe we have some time here in regards to questions. I believe Marie has a couple.

>> Marie: Yes, thank you. We have a couple of questions that came through. Are the MCO participant hand books available on line? If not how can we access this information? I will need to lock and see. I don't know off the top of my head if the MCOos did post them on line. They did send them out to all participants. I would have to check on this to see if it is available on line.

Second question, how do participants receive this handbook? Your MCO should have received a copy when you signed up with that MCO if you have not received a copy reach

out to them and ask a copy. Again in the meantime I will be looking to see if those are posted on line if they are we will make sure that you are made aware of that.

again the participant handbooks are particular to each MCO. Each of the MCO have their own participant handbook they did follow our guidelines. It is their individual hand book. So no, we do not have any of the MCO ones currently posted on the website. Where can we get a copy of the handbook? Again, if you are a participant your managed care organization would have mailed a participant handbook to you. So if you have not received one you need to reach out to your MCO and request a copy. If we determine that they are posted on line we will make sure that you are made aware of that.

Next question do all hearing requests go to OLTL? How are they submitted E-mail or fax? They do come no the office of long term living as I indicated we will coordinate with the bureau of hearing appeals. We will collect all of the information necessary from the participant. They will submit hard copy. Notice that they receive from the MCO on the MCO decision. At that point we will take that information and give it to the bureau of hearing and appeals so they can review it and begin the process.

Another question are providers allowed to file a complaint or grievance on behalf of the participants? If the participants are allowed to have a representative. I don't have it in front of me the specifics to which the representant what the status has to be. I would have to look at that a little bit further to see if the provider can act as the participant's rep. That's that point. That's all I have at the moment.

>> Brian: I have one more question. The consumer and advocates have access to the results of the quarterly qualified analysis. I double checked with Mr. Hancock we will make that available through the roll date and that will be provided in the future once we start getting more of the data we are able to complete the an as many sustain we will be able to share that information. And the other question we had was how many people have requested fair hearings within the southwest. Marie, have we received any fair hearing requests yesterday.

>> Marie: We haven't received anything to date. We understand that things may come up with continuity of care ends June 30.

>> Kevin: we are expecting because of the continuity of care period we weren't expecting that much grievances after the continuity of care period the MC organizations are taking over hopefully not but we expect there will be more.

>> Brian: The other part of the question, if the process unsuccessful how the hearing felt about the outcomes are they satisfied. How about the grievance. The writer wrote my worries that the consumer will not see these processes as legitimate. They use them because the cards are stacked against them. I believe at this time as far as the overall fair hearings the process is as we stated in place. When they do arrive they will be processed timely and accurately. In regards to the overall current complaints and grievances basically I believe it is my understand from what we have seen so far that the MC organizations are being very

reactive in regards to the grievance and complaints that they have been working with and they have been willing to work with the participants and other parties involved to resolve those in such a capacity that they haven't had a need to have a fair hearing at this time. It is the reason as Marie pointed out we haven't had any in regard to

the MCO services at this time.

>> Marie: I have another question. It is a question. I'm not sure if it might be an explanation. Plans do not automatically mail handbooks. They need to request that they mail a hand book. It was my understanding all plans mailed them. But obviously that is incorrect. If you didn't receive something a member or participant hand book contract your MCO. Another response, UPMC hand book is on line. I can send out -- we will make sure that we send out the link to everyone so you know how to access that

>> Is that the UPMC representative? Okay.

>> Brian: One more.

>> Marie: Another clarification the websites for other UPMC participant documents they do have some resources on line. So we will make sure that rather than try to recite the pink we will make sure we send it out so they have access to information.

Another question please provide examples how nursing facility provider willing departments use this process.

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>> MALE: It is between the participants and managed care. The nursing facility residents can access this process if they have a concern for a service that has been denied or service that has been denied but especially for physical health services for example. The grievance process is not something that has a direct impact between the relationship for nursing facility and their managed care organization.

>> Brian: Thank you, Kevin. Okay.

>> Marie: That's all we have at this point.

>> Brian. . We have one more. Another one I should say.

>> Marie: What do the forms that give the grievance information look like? Are they done in a cognitively accessible format? Are they readable and accessible? The current forms are difficult for many consumers to understand. The forms -- when the MCO makes the decision and they send out a form you will have a hand copy physical form for you to work on. At this point I would have to double check since I have been told that some of the MCO have on line presence I will take it yes they may have the forms on line that would be interactive filling them out on line. But you may have to still print them to submit them.

Again, I would have to research this a little bit further to determine just any other accessible format. Sometime

>> Kevin: thank you very much Marie and Brian for the very thorough of the operational process associated with grievances and appeals or complaints and grievances. We have a couple other questions from the earlier presentation that's we wanted to answer before we close up since we have 20 more minutes I will give people time to submit for questions. Will it be a conflict of interest for the organization to have a separate department but also provide behavioral health services great question. So conflicts do tend to occur. There will need to be clear separation between the two. But there are existing relationships now that exist between the CHC and MCO organizations. It depends on on the circumstances. I would like to explore that with the provide for they reach out to us directly. We think there is a window that could allow this to occur that is not a commitment it. must be specific to the individual question. We are more than willing

to explore this directly with the individual provider. Next question since transportation benefits are part of the benefit package are you expecting consumers and participants to continue to be he will I think and for benefits as well the answer to that question is yes. The medical assistance transportation program is for non-emergency medical benefits individuals in the Medicaid program with some exceptions are eligible for these services. So the answer so that question is yes. Couple of additional questions we have. With all 3MCO working are we mandated to sign a contract with the exchange. You will be working contractually with the managed care organizations as part of the managed care organization agreement you will be required to use the exchange that is a question that you want to ask the MC organizations directly. With adult waiver programs which adult waiver programs if any are rolling no the community health choices program. The answer to that question would be

for the aging waiver the attendant care waiver, what was the come care waiver it was reprepared. And the attendant care waiver the aging waiver, and the independent waiver with the recipients. The only long term living waiver that will remain in attack is OPRA. Most will be moving into the community health choices as well. This does not affect the waivers that are operated by the by our colleagues in the office of departmental program. Which adult waiver program -- I answered that. Which were the time frames for the meetings in the southeast. So there will be a list serve for those meetings. I think I am going to put them back up on the screen for a second. Bear with me for a couple of seconds as I switch from Marie and Brian's presentation as I switch back to my original presentation. Here it is. Hopefully the people on the screen can see these dates June 4 through 8 and the third week of June, the 18 through the 21. I will leave that up on the screen as I go to the next

question. Referring to southeast care communities -- I'm not sure what it relates to. Signed up for the conference for Delaware community college on 6/19 but did not receive a confirmation that my registration went through. Will we be getting something shortly? Jen hale will provide an update as to whether or not confirmations will be coming from registration. It is likely they will not. I want to make sure that's true. I think we had another

question -- we have another question about complaints and grievances. Question, can the provider -- can the provider foil the complaint grievance on behalf of the participant nursing facility. I'm not sure what that means.

>> **Marie:** That was a question that was earlier.

>> **Kevin:** whether the provider -- now that I'm reading it. I am going to translation can the provider file a complaint on behalf of the participant that is the question. The answer to that would be no. I think it would have to be the provider cannot file as part of the participant. The participants and their care givers or the representatives have to foil. So the answer to that would be no. Just to be perfectly honest the complaint or grievance could be directly related to the services that are provided by the nursing facility. The entity is a contracted entity of the MCO that is a great question. With that I think we are out of questions at this point. We will give you 18 minutes back to your afternoon. Well I am wrong we have 2 new questions.

>> **Marie:** Clarifications amerihealth as well as all MC organizations have information on line

>> Could you please confirm no service coordination agencies have received terminations notices as of today. It was announced that Amerihealth that's a list of 20 agencies that will receive notices. Are they past providers

>> They have a change in direction since what was announced in the sub MAAC. They decided because there might be an opportunity to be able to review and establish a longer term relationship with service coordinator they have decided to take a longer term review with the service coordinators they have been working with in the last several months they made the decision not to go forward with any terminations at this point.

>> **Marie:** Can you explain the termination with no cause?

>> **Kevin:** I'm not sure what the question means. I'm not sure exactly what the individual is asking. I think I'm going to make an assumption will the termination -- when the provider or service coordination entities receive a termination will that have a reason. I can't answer that. That's really going to be something between the managed care organizations and the providers themselves. And my strong recommendation would be for this individual to reach out to their managed care organizations to have them answer that question more directly.

Okay. So next question, is EVV -- when will EVV be implemented? It is January 2019 which is federal requirement. We are working with our partners at CMS to be able to clarify what was provided to us. A lot more to come on that.

The next question will this program create an increased burden for a psychiatrist in the state and what are the planned program if it does. Psychiatrists have been seek to go provide these services. Would you support that if the burden increases. That is a broader question. I wouldn't be able to answer that but I'm open to discussion. It might be thought provoking. Psychologists are not exactly care professionals. I am not expert on behave or health climate. I know there are some services where psychologists are he willth able to bill and provide services I would love to provide that further. I can't provide a definitive answer at this point. It looks like we are now officially out of questions. We appreciate everybody's time this afternoon we appreciate the time for Marie and Brian to talk about the operational process associated with the operational process associated with complaints and grieve answers. We hope you enjoy the rest of your day and thank

you very much and we look forward to your participation in the next third Thursday webinar. Thank you, bye [webinar completed]