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Note: Due to a technical difficulty captioning services started at 10:30 a.m.

DATE: March 7, 2019

EVENT: Managed Long-Term Services and Supports Meeting

>> SPEAKER: To remodel their business and coordination and maintain more of of a provision on long term services.

Is 3 with the first the transition between the manage the care organization were managed very well in my opinion. Both entities worked hard to make sure that the transition was as smooth as possible for the participants we didn't see many change. We the department provided flex guilt.

I'm not going to name names. I'm sure you know who they are. They are one of the largest service entities. To their great credit they gave a lot of notice. There is time to manage that transition. It affects all 3 of the managed care they have the largest amount of people receiving long-term care. They have worked through and provided a plan for transition. The way they are planning to manage it is using public service coordinators if they have any capacity to pick up any of those cases or have uncertain service coordinators as well.

The advantage to this transition given close to 3 months it is manageable to be perfectly honest.

That being said we will monitor it every step of the way to make sure that people have real choice which is on agreement it is part of of the continuity of case at the level that it was approved for community health choices. I appreciate the question.

>> SPEAKER: do you see others in the next few months that will not provide.

>> MALE: So we have not heard of any other large or small service coordination at this point. They are going to be changing their business models. That being said it is going to happen. Mostly it will happen at the end of the continuity period or there after and what would happen in the southwest. The managed care organizations will have the responsibility to be able to present a transition plan. The transition in the southwest were managed effectively had they were enacted. We would expect that the same approach even a much more robust approach would be implemented in the southeast based on the lesson plans they had.

Most of this is about communication and making sure the participants know what is happening and where to get their questions answers. It is to support the participant and navigate through long-term care services.

We have the expectation that that will continue regardless who is providing who or what entity is providing service coordination and we have the spectation that all other requirements in the agreement are met by the managed care organization. The managed care will have to continuously demonstrate to us that they are managing the transition effectively. Thank you.

I am counting on you to provide feedback on that [laughing] thank you for the concern. I will turn it over to Randy.

it should be here so everybody can see.

>> Randy: Good morning, everyone I'm Randy from the office of long term living. I have oversight of the 3MCOs. The last meeting we presented a lot of data with our kinder and some with the operation report. There were questions more intense

data with that. So we are able to pull some of that together and I will walk through some of that today.

There was a session about service denials and breaking that down to a stranger level in regards to what we are seeing. So the UPMC we provided the breakdown by the southwest by farmy denials. Breakdown by physical health and by as you can see their denial in regards to taking a look at. When we look at this I have percentages for pharmacy denials for the year Ameri health denied 53,. UPMC about 40%. Primary reasons for a lot of times these were medications or prescriptions covered under other insurance that they improperly filled so they were denied based on that. Some of them were prior authorityization issues. Some were clause of the class of the drug. That's why we see the number of denials that we do under the pharmacy related services.

Anybody they want toe add to that? Does that cover what we know?

>> **MALE:** Pharmacy denial is a denial of a specific drug for a specific member or is it general they need 5 drugs they are denied 5 drugs? Is it >> **Randy:** It is a specific drug.

>> **MALE:** There are only 108 requests for drugs from UPMC. Only 15 people were denied a request for a drug? A specific drug that's what the number represents?

>> **Randy:** The top chart is the pharmacy one. It shows the total for the year is 1400 and 65 denials. They denied about 40%. If you multiply that out they probably saw over 3500 requests come in close to 4000 requests come in.

On the physical health side as you can see throughout the year, they had over 1300 denial. UPMC over 500. Again the same reason a lot of time is that they were not billing the primary insurer first which is why it generates a denial. Some were because they were duplicate invoices. Some the individual was not with that plan. There is some denials based on that. Any other reason you can think of on the pharmacy side form Larry. We had some over the counter with form Larry. All 3 of the plans know they have to match what f O ormularies were. We have worked with our pharmacy team to work with pharmacy teams at all three of the MCOs so that is done so there are not formulary issues.

>> MALE: Are these denied claims or denied requests for authorization or are they actually claim denials? If

>> Randy: These are actually denials that came in based on claims. Not on prior authorization. Not everything is prior authorized.

>> MALE: When you say physical health not billing primary first, is that Medicare? It how is that coordination between work? If

>> Randy: It is usually they didn't bill Medicare first they build the MCO first.

>> MALE: That is just an error on the part of the provider?

>> Randy: Yes. What they were told and what providers are told they would have to bill Medicare as the primary. If there were any co-payments or additional payments the MCO would be build as secondary.

>> MALE: That could be part D. Some of the drugs railroad under part B and D. Big farmy pays attention to.

>> Randy: On home and community base there is a small amount that occurred. We talked about the regions with that the plans had a work through process to get their denial notices done properly and do internal training and make sure they were done appropriately. So you can see the numbers are based on the fact that UPMC had the okay from the department to start setting out denial notices. We did that fairly quickly.

>> FEMALE: I have a question on the pharmacy drug denial square

>> > Randy: Go ahead.

>> FEMALE: When a double of a drug is made, do the MCOs offer an alternative generic or something that may do the same thing as the drug they denied? Are this alternatives offered to the consumers in this case or participants? Snooped and eye: That would be one of the requirements. If this was a brand drug and there was an alternative again I remember I can drug that would be some of the denials based on that. It is at the claims level. Prior authorization claims.

>> FEMALE: Okay. And how quick can like a plan say, okay, we can't offer you the whatever the drug was, but we can offer you the generic and how long does it take the plan to make sure the participant is still getting the script that they actually need?

>> Randy: Pharmacy?

>> FEMALE: Yeah. Like how quickly are problems like that being resolved? Do we know?

>> MALE: They would generally contact the health plan and reach resolution on the spot. Typically not -- what the physician prescribe [inaudible]

>> MALE: There are a huge number of form Larry changes that occur any year. My tip for any provider are that the pro active changes show up at the pharmacy and have a denial especially if it is a drug you need. It can take a while if there is a change, a decision -- if it is not form Larry you can look at a substitute. You need a substitution and it can take 4 or 5 weeks. The only tip I have there from experience is consumers look to look at form Larrys relative to their medication and plans around reach out in advance.

>> FEMALE: How are consumers supposed to know that ahead of time? Because a lot of times you don't until you get to the pharmacy.

>> MALE: That's true, Tonya. It is something you and your doctor should talk about. Sometimes you don't know that until you get to the pharmacy.

>> FEMALE: A lot of times doctors don't know.

>> FEMALE: I can help answer a couple of these questions. Within the contract we have a 24 hour turn around time. Something was submitted and the subscriber it is within 24 hours. To answer your question for the point of sale there is a 5 day temporary supply that is allowed to be supplied so somebody is not going without a prescription.

>> FEMALE: Okay.

>> MALE: In home and community based service side there is an increase in denial. Most of that period of time was continuity period. So is there going to be any further break out of the denial? So looking at 3 sets of variables. One would be are the denials at the point of -- are they additions, increases, new care plans or are they renewed care plans? It the second set would be by service type. For modifications et cetera. Then thirdly of course my question around age. Any difference between under 60 and over 60. Going forward it might be good to have a sense of what those variables might be.

>> MALE: That is the next step for the breakdown for the age breakdown which we would expect. We will be presenting that data. We are compiling it for a new program we will present it.

>> MALE: If we go to the next slide it will ABC all of your questions in regards to seeing any increase.

The next slide talks about the 2019 several denials January is the last data we have. As you can see, on the pharmacy we have it listed out -- we changed the report. We collect the denial information on 5 different areas now. Pharmacy is the first one. Physical health, home and community based services, dental and home or vehicle mok and pest eradication. We are seeing some increase in regards to service in the southwest. That is the first block.

The second chart is the southeast service denials, pharmacy, physical health and dental are the biggest ones. Most of the denials that we have occurring in the southeast are for -- no changes in reduction in those plans. Those would be for new participants and for participants that are requesting additional services above what they already have on their care plan. So I know that see this will be a lot more activity in February and March and those numbers are much higher. We just don't have them fully formulated. It will be much higher in the home and community based area now. You will see some market increase in that also.

And looking at these probably 95% or more are past service related. The rest are usually home mods related as far as the service reductions or the denials of services.

So it is primarily on the home and community based services side.

age I do not have. We will work on that.

>> FEMALE: [inaudible]

Are they going back to you guys?

they have to have a denial from the MCO to know to appeal 3 memory are up in the air with their home modifications 6

>> MALE: You are saying it the southwest

>> FEMALE: They are not hearing they are not knowing. What are we going to do.

>> SPEAKER: what they get denial what is happening ask --

>> FEMALE: If there is no denial you have no course of action and people don't know the course of action they are --

>> MALE: We would argue that no denial. It might be be clarified in the agreement. If it is a period of time where the determination is not made without reason, then that might be considered to be a denial. Good point.

male sometimes the MCOs -- the pharmacy is the same thing we weren't getting the assessments or the bids that we were requiring. That is part of the issue some of the times.

>> MALE: The one thing I would agree based on what Randy is saying the process has been problematic since there was a home modification process. The reality is, if anybody who works for the contactor knows that sometimes it is tough to get -- sometimes the question proposed may the be appropriate for the structure itself. Sometimes it takes a loaning time. So there is a requirement in this process that there is good communication between the interestties involve. Sometimes that doesn't always happen. There are problems. There were fee for service. I can give you examples of those clusters that had a list [inaudible]

6 months. 6 months to 12 months. What we expect in health choices is better. That is unacceptable. We want it to work better for people. And that has been the subject of the program. Part of the way we can make it work better is toe look at the tith. Sometimes they take a long time. Probably a lot more home modifications

Mill male my question is related to the denials on dental care which a number of the folks in the roam have part time access dental Kate. Keystone first there is a few there and UPMC we have been kind of curious why those numbers are so much -- can be so much different than the southwest? It is it the roll out? Is it the network? I'm thinking the southeast is a concentrated area we should have more providers. The southwest it tends to be more spread out and rural.

>> MALE: Do any the MCOs have folks here to speak about dental? It

>> MALE: The population in the southwest is larger. That's one reason why there is more denials. When you talk about provider networks and dental service Medicaid program so there might be a proportional number of more providers available providing dental service in a certain geographic area. But it is often not proportional. Dental has been a tough, tough issue.

When it comes to service denial UPMC they are not prepared to do this today. They should problemly -- why there are any dental dials.

>> MALE: We are close to 80,000 in the southwest and 131,000 in the southeast. So [I object audible]

>> FEMALE: In regards to dental it is done by line item. There are 10 items we may denly 5 out of the 10. That's why the numbers seem to be higher.

>> MALE: That was one of the things that we changed on the report. Initially we had if there were 15 items and we denied one we considered the whole authorization denied. We broke it down by line item. If somebody came in and they needed 15 teeth pulled it was only approved for 5 of the teeth to be pulled then we would count it differently. That's why the numbers -- this is not -- these 407 is not 407 prior authorizations. It may have a 100 people that have 4 or 5 line items denied and 10 or 15 approved.

[inaudible]

>> **FEMALE:** That would cost me out of pocket [off microphone]

Which is half of my income per month. Called my provider. Can't do it.

[off microphone]

>> **FEMALE:** I have a couple on the phone. Has OLTL looked end had the southwest denial wondering why denials are so high relative to UPMC who has the highest number.

>> **MALE:** Did they say what category they are looking at?

>> **FEMALE:** They did not.

>> **MALE:** We can break this out further to get codes for denial. We can do that are to the next meeting.

>> **FEMALE:** How many pharmacy and physical health denials are for Medicaid participants versus dual eligible?

>> **MALE:** We can break that out.

>> **MALE:** I would say pharmacy. I think with Brandy and team on the denial we have some tools that our provider network uses in areas like radiology so we don't have very many radiology denials where previously from our experience it was a lot higher until we had changes.

>> **MALE:** I would find it useful to always see the people the providers are serving and the percentage of requests that are denials. If you take dental 86 denials, they could have had 10,000 requests for dental and 1% denial rate.

The relative number is important. They are not as meaningful as the size of the population served and the percentage denial for requests. I think that would be helpful in all denial data that we review.

>> **MALE:** I do know on dental for January 2019, Keystone first denied 29% of the cases they looked at. 37%, and UPMC8%.

So they are fairly low percentage wise

>> The next slide quickly it is the southeast claims data that has come in. As you can see we listed the total claims that each of them have received. Total claims received. Physical health plan nursing facility and we listed the number of claims that were paid out. And then the number of claims that were denied. So that gives you a breakdown of the claims as you can see a high percentage are being paid or in process to be paid. Denials reasons they gave the answer given billing. Inappropriate meaning meaning they should have build primary insurance first. Medicare usually. So the claims weren't submitted properly. Wrong ID numbers on the claim. Wrong participant information. So those were denied and once corrected we will reprocessed.

Fairly high volume. We are looking 700,000 claims in the southeast.

As you can see on the complaint side it centered around quality service and services not covered for Keystone first. The PCP not participating in the network. PATH services and transportation. UPMC were providers not courteous. Issues with operating and quality of care. They were pretty consistent. On the grievance side it was mainly coverage area coverage for dental, pharmacy or any of those physical health services so that was pretty much wh grievances came in. The first slide is the participant health line call that comes in to OTL. We gave you the percentage of the calls that came in. They are pretty could be cyst he be across all of the MCOs. There were questions about community health choices, questions about plans reviews and when services are going to start. Questions about care from service provider to the new one. So they were pretty consistent. On the next slide we show the participant health line that came in through the MCO. We gave you a list of how many calls there were and what the issues or questions were that the participants had. As you can see most are around enrollment and eligibility and network. Questions about their ID cards and their welcome packets.

Then some questions about pharmacy. So it is pretty consistent across all MCOs where the questions read and where the questions raised.

>> FEMALE: Question on the phone about the claim the status. Is this submitted or claims paid.

>> MALE: The total number is number submitted. There is the next left column is the column that shows everything that has been paid out at this point in time. These a have been processed and paid to the providers.

>> FEMALE: Thank you.

>> MALE: Any other questions? We have finalized the launch indicators. We moved in we will continue to collect the data on the operations report. We will continue to have this type of data as needed. We will take the next step in the breakdown for the next meeting on some of the regions behind of the dimes and things like that. So we will continue to be able to provide that data to you.

>> Theo: What did you do with this?

>> MALE: That is a loaded question, Theo.

>> Theo: You get it, what do you learn from it?

>> MALE: The data does a number of things for us. We are able to measure the quality within the program. We are able to present the data out and get these questions and insight from other stakeholders. Things we need to take a look at. Internally we create processes based on the things we see. If we see anomalies coming in we will dress a dress it. Notice process we are creating some processes internally and taking a look at the denial notices. If we see denials services over a certain percentage or things in home mod that doesn't seem to make sense to us we will request additional information from the plans. That information includes our assessment done on the individual and any other assessment done. It includes the person-centered service plan and any other documentation utilized in making the decision. We will review that internally. We will work with the medical director and Dr. Kelly who is the department's medical director to take a look at

the appropriateness of the dials and conversations with the plans in regards to that.

So we do take a look at that and use it as a tool to drive quality improvement. It is something that I think he will talk more about. It is some of the data that will drive what we want the MCOs to do in the future around quality, around improvement measures. So we utilize a lot of the data to do that also.

>> MALE: Just using it as an example why one of the MCO have car questions. The first question we would have to ask [inaudible] all about their ID cards or something wrong with their ID cards if they are not working. It is pretty straightforward. I think there was a problem in January.

>> MALE: We went back to the MCO and found out the vendor was dropping 0s off the ID cards. They had to be redone and resent to the participants so it generated a lot of phone calls. We know we have seen some increased calls around service coordination with some of the challenges we have had in the southeast. So there's been increased calls on the service coordinating line which is something we don't measure right now we will start measuring it as we go forward. We are getting a lot of concerns and complaints in regards to wait time on card coordinating line. We have been working with the MCO to address that. It is a measure we will put no place going forward. It has been a viable problem that we need to deal with. We do take a look at that data to drive some of that stuff.

>> FEMALE: Follow up question to Theo's question. I hear you talk about the medical review. Things that are not medical, non-medical programs you have [inaudible]

>> MALE: I agree. We realize that a large part of our program -- we still look at some bases and utilize staff to take a look at whether things are appropriate. Especially on the home mod side, was it appropriate assessment of that individual. We do take a look at that.

>> FEMALE: We have a comment from the phone from. We need coverage for root canals,ing capping, replacement of teeth personal amly instead of getting teeth pulls that causes problems with eating, digestion and breaking down of bone structure.

>> MALE: We agree. We appreciate the feedback. We recognize that there are opportunities for improvement with dental services.

>> FEMALE: Any other questions? Well thank you, we are going to move on with the behavioral health update. Patty Clark we have a behavioral MCO. Dr. Mahmood and Dr. Appel, welcome.

>> Patty: Good morning I'm Patty Clark I'm with the office of long term living. I will start off the discussion with behavioral health today.

So before we get started there are a couple of new acronyms that we don't typically have in our presentation. So I wanted to call them out that you will be seeing for behavioral hem DH as the acronym. For behavioral managed care organizations BH MCO. We have 3 of the BH managed care organizations here with us today. You will see the CBH which stands for community behavioral health. CCBH.

Then OMHSS. This is an agency an office with department of human services and they have oversight for the Medicaid program with the behavioral health services.

So our agenda for the behavioral health portion I will talk about the requirements of the CHC MCOs around coordination of behavioral health. Then we have our 3 CHC MCOs with us today. They will talk about the effort that they have under way for behavioral health coordination.

Then we will hear from the 3 behavioral health MCOs. We have representatives from those organizations here. They will talk about how they are working to coordinate with CHC.

Then finally OLTL Dr. Appel will talk about some performance measures that we have in the CHC program around behavioral health.

So a few things to point out to start off with is when we are talking about behavioral health services we are talking about those services that treat both mental health and/or substance abuse diagnosis. Recall participants that are eventually enrolled in CHC will be covered by the managed care organizations for their behavioral care services this is a change for those folks in the aging waiver or were living in a nursing facility. Prior to CHC if you were in the aging waiver or nursing facility your behavioral health services were carved out of managed care. They were provided on a fee for service basis. So for those folks it is knew for them to be engaged with the behavioral health MCOs. Another thing the way the MCO are organized we have 3 of them we operate statewide. However on I behavior oral health side those MC, Os are regionally based. They don't -- the MCOs do not serve every county in the state. Some of them only serve certain counties and regions

now we will move on to what is required in terms of behave oral he will hath. We have a few things written into the agreement that the MCOs sign with the department and these are specific to behavioral health.

When the service coordinator at the MCO develops the service plan, they include in that service plan any conditions or diagnosis that the person may have. This will include any known behavioral health diagnoses. Any services, any behavioral health services a person is receiving, how their behavioral health needs will be managed, and then how the CHCMCO they are enrolled with will work with the behavioral health MCO in order to coordinate services.

The CHCMCO we have a few services in the waiver if somebody is in a CHC home and community based waiver. And if these services are not covered by other sources, for example through the behavioral health MCO or Medicare or other sources, individuals in the waiver can get counseling shall, behavioral therapy or cognitive rehabilitation services. We realize they are offered to folks that do not have mental health diagnosis. They may have a brain injury or something else going on. But I'm just calling them out here because we consider these therapeutic and counseling services.

All of the MCOs have written agreements with the MCOs and these agreements describe how the MCOs will interact with each other and how they will work together to coordinate services these agreements include how the staff will coordinate and which staff will be involved from each of the respective MCOs. How the MCOs will exchange enrollment and health related information. How releases will be exchanged. There is clinical information for each of the participants in the program and releases are needed for that information to be shared with the different MCOs so the participant signs a release. How cross training will occur from one MCO to another so the CHCMCO is familiar with how the MCO operates and vice versa. How payment disputes will be resolved. So if service or treatment is provided and there is a question on who is going to be paying for it, the MCOs need to be able to resolve those issues. And finally, there are some inter agency teams that have

been established since the HC started and the agreements layout who is going to participate in the teams and how those meetings will occur.

So each are required to have at least one behavioral health coordinator. This is a behavioral health professional that monitors the requirement of the MCO in terms of behavioral health and makes sure that the MCO is meeting those requirements. Though coordinate with the behavioral health MCO as well. They could engage directly with participants if a participant is having an issue with gaining behavioral health services the coordinator will help them to work out any issues they may have they lock to coordinate between the primary provider and behavioral coordinator.

Where the primary provider is writing a prescription for medication but the treatment services are on there needs to be coordination between the 2.

Finally this behavioral health coordinator coordinates the behavioral health services with any other health services that the participant may have.

Eye few more things to mention they have orientation programs for new participants and there is a requirement that that orientation program include information about how folks are to game behavioral health services if they need them.

Each MCO has a participant help line and the staff on that help line need to be trained in accessing behavioral health services so that if a participant calls CHCMCO and they need to obtain behavioral health services or they are having a problem with the services, the staff person on the help line needs to know how to refer that person and where to send them so they can have their problem resolved or so that they can gain behavioral health services.

Then finally the MCOs have both the participant advisory and a health education advisory committee and as a requirement that behavioral health providers be part of those committees so that behavioral health is discussed and considered in those issues.

Any questions about that information?

>> MALE: I have one question. How does the implementation of the care coordination requirements between the CHC and MCOs vary for members who -- are not eligible for Medicare versus those that are dual eligible and they have primary through --

>> Patty: That might be something that we could have the plans answer when they present their information.

Any other questions for me? Okay.

So next up we will hear from each of the CHCMCOs. They will talk about what they have been doing for the past year or so around behavioral health how they have been working with the BHMCOs and what they have done doing. First we have Jen Rogers from Amerihealth.

>> Jen: Good morning I'm Jen Rogers. I'm here today on behalf of our BH coordinator many of you know. So I thought it would be advantageous to walk through the referral process and start with some things that we have been doing in the southwest and also in preparation for the launch of the southeast. That is training, training and more training. Service coordinator whether they are internal or external to the CHCMCOs have been grateful for the training that we have been able to provide about the process.

I was in meetings earlier this week. It is evident that service coordinators they don't want to feel like they are going it alone. They don't want to feel like they are navigating alone on the service coordination side. Participants don't want to feel that way either.

So I think there is a requirement in the agreement helps us and gives us opportunities they can ask people that was more difficult previously.

So our part is identification. The thing I want to identify or emphasize here is participants have to consent. And that is also a completely different training process.

We need to be careful of privacy, of course. And service coordinators need to know what details need to be documented on a consent project before we start facilitating and advocating and helping people through a process. Right?

So we have to ensure there is a signed consent before we are making referrals on behalf of participants.

If participants do dire services our coordination team is out reaching to the participants. We are operating as a grassroots level where the CH coordinator is supporting the service coordinator in helping to navigate services and connecting them with the appropriate managed care organization. The appropriate provider based on the county of residence.

So our coordinator discussed the with the participant what are available services and providers they have to choose from for their services. If the participant selects that provider, then we are facilitating a connection between the participant and the providers.

For follow up we do coordinated outreach to the participant or their representative and/or the service coordinator to ensure that services and supports that were identified Id are being followed through and incorporated into the person-centered planning plan as necessary.

On going communication between Ameri health and the coordinator they meet with them on a regular discuss to provide [inaudible] that is a critical component so that we are both in the loop of what is going on respectively and with the [inaudible]

For nursing facility folks it is a little bit different. I wanted to outline it for you today. So the identification consent process is still the same. We are training our nursing facility based service coordinators on the consent management process. And helping them outreach to participants and/or representatives to ensure we have consent to connect people with CH services.

So there is collaboration includes the social work team at the nursing facilities. They are in need of training on what is available to participants that could potentially help them with their need and what is available under the services.

So we have been doing outreach and education to nursing facilities as Patty indicated this is a new a Val service for participants that are currently residing in nursing facilities.

So, again, the practice is the same if a participant is consenting to having their services coordinated with the VH coordinator they are out reaching to the VH managed care organization that are -- based on county or where the participant is residing.

One thing we recognize is someone looking to discharge, then that's a communication between our VH coordinator and VHMCO to ensure continuity of service providers. It is possible we have had it done. I think that benefits participants. Then upon discharge they can continue receiving the services and supports they require that were identified in the nursing facility. They can continue after discharge.

Again our follow up. We have the VH coordinator out reaching to the participants and their representatives to ensure that services and supports acid tide as being met through the VH provider. The on going communication piece touch point to ensure that the staff on both sides the providers or [inaudible are in the know about services, supports, new initiatives and things of that nature.

Any questions?

>> **FEMALE:** Did you have anything specific about Medicare, treatment of individuals Medicare eligible? Is it

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>> **FEMALE:** Sure. We have to ensure that the CHC program is the payer of last resort. And once that is exhausted through the Medicare benefit or not available we would be working with the VHMCO to coordinate care if necessary.

>> **MALE:** For the participant making sure [inaudible]

There is a third party possible sources of coverage for any health choices plan. Open to the ideas [inaudible] I was just wondering to make sure it is kept in line

>> **FEMALE:** Thanks, Jen.

>> **SPEAKER:** Heather: Representing PA health and wellness.

I am going to start off talking about our joint operation committees that are conducted with each VHMCO. One meeting is conducted in person per quarter and the standard agenda items typically include operationallizing some of the pieces of CHC, talking about our data exchanges, our pharmacy and therapeutic committee updates. We have a pharmacy and therapeutic committee in which the VHMCO psychiatrists are part of and report out any find beings during the JOC that come out of that committee. We also discuss any clinical initiatives.

An update on data exchanges. Exchanging data with 3 out of the 4 southwest MCOs. We are working through operationallizing the data exchange with community behavioral health in the southeast.

One of our greatest challenges is that each has a different interpretation of what data can be shared. So over the last 3 months there has been an increase in willingness to share more actionable data so that they are willing to give us more specific data that we can use for some of our initiatives.

One clinical initiative that we are working on is strengthening care coordination. The goal of this initiative is to receive timely and actionable data. After an inpatient discharge a complete medication reconciliation post discharge. Intervention that we are using is notification of inpatient admission and receipt of discharge information on the day of or following day of discharge. The care management team or service coordinator will outreach 2 days before discharge.

We are piloting this with Magellian. They are giving us a daily inpatient admission and discharge file. The others are slowly coming on board working through getting these inpatient notification files from the others as well.

This is really going to help us at the CHCMCO to be able to reach out our participants in realtime versus getting a monthly feed that the patient discharged 3 weeks ago. We really want to reach that member at minimum -- at maximum 2 days post discharge.

Our second clinical initiative is medication adherence. The goal of this initiative is to [inaudible] the intervention is to identify participants with prescription refill lapses, long acting psychotropic meds. They will outreach them regarding education on the importance of medication adherence. They will outreach the

prescriber in our network to discuss adherence. We are still working through some additional interventions that we can employ. We are piloting this and hoping to get this moving next quarter.

A collaborative meeting that has been established is CHC partnership meeting. This was to promote coordination and collaboration the CHC, MCO, nurse and home and community based providers. We had our most meeting hosted in January. The next meeting will be posted by P H.W. at the end of the month. This meeting was slated to be a quarterly meeting, however, we believe it will be transitioning to a bimonthly meeting moving forward.

Some of our on going cooperation. Clinical consultation. Clinical consultations are occurring on a regular basis for shared memberships. Topics are what services are available thousand LCSS and I would say the majority of our collaborations are regarding discharge planning for folks returning to a nursing facility.

So in those instances when we are notified that a participant is in an inpatient psych hospitalization we will work with the facility discharge planner, the service coordinator and really any of the other folks that are part of that participant's care to make sure that they are able to transition timely back to their nursing facility depending on the reason for the administration can be not as easy as one had anticipated.

So we're able to work through some of those issues if we have all of the players at the table to move things forward.

And then like I mentioned we have our pharmacy and therapeutic committee where the recommendations -- participate in the quarterly meeting. Training opportunities where we partner on training opportunities for providers on what behavioral health services are and how to access. We have trainings for our service coordination team on what services are available and how to access those as well.

We really want our service coordinators to be the main point of entry for the participants that they have. And so training is key to that.

>> **Patty:** Any questions for Heatherrer? It

>> **FEMALE:** It has been difficult to understand what BH services are covered under Medicare versus Medicaid. Is there a chart for participants and others to help with this understanding? I

>> **MALE:** To my knowledge there is no such chart but that is a fantastic suggestion. We will have to work with Medicare and Medicare advantage partners to be able to help what would be the services covered under the Medicare program and then we can ask our partners at OMHSAS to delineate what would be covered first by Medicare and Medicaid and what would be incurred by Medicaid alone.

>> **FEMALE:** I have seen a chart that CNS put out. They list the Medicare services it is a chart that states can use. They can populate it with the Medicaid services so everything is on one chart. I don't recall if behavioral health services were on that Medicare services were on there. It would be great that have that in up with document.

>> **MALE:** Quick question from the consumer's point of view, we need behavioral health services could be depression it could be drug related. Whatever it is. There are probably 700 categories. Who is the person you go to, the service coordinator who then routes you to the appropriate behavioral health specialist? It would be pretty hard for a coordinator do that. What is the intake process to get a person who need behavioral health to the right person or agency or provider?

>> **FEMALE:** If the participant is connected to a service coordinator the service coordinator is able to work with for your basic, standard type services. Participant needs a referral for outpatient therapist. Participant needs a psychiatrist to manage their meds. The service coordinators are able to tap in and are trained on how to do that. It is a more complex behavioral health need is identified the service cord mater will loop back with their behavioral health coordinator at their plan who will, in turn, connect the planned to discuss what plan of care or what type of services may be best for that participant.

>> FEMALE: I think when the behavioral health MCOs come up and speak they may be able to add to that about the outreach to participants and making sure the participants know where to go when they need services.

We could have one more CHMCO. Dave is here to talk about what they are doing.

[off microphone]

&j

>> SPEAKER: So the second part of your question, my understanding is and I think some of the folks I have heard from the BIMCO side of things may be talking about this when they come up to speak, the nursing facility and the behavioral managed care organizations are working toward as a new region of CHC is up and running they are working towards working together more closely.

It's been a little bit of a learning curve because the nursing facilities were accustomed to having them work with them to set up services. Having a new entity there to support the participant with those services.

But prior to CHC behavioral health services in a nursing facility. Nursing facility either provided them or arranged for them to be provided and paid for under fee for service.

So they did have -- they had a role in coordination and accessing services for the participants. Now they have the BHMCO to help the nursing facility with that role.

>> MALE: Are you asking about the specialized services [inaudible]

The process itself will remain as it is now. If they meet the criteria assessment will be done. It will be monitored through one of the 3 program offices OMSAS, or long term living. The MCO will have the determination that the individual may require specialized services. The CHMCO will work to identify those services on a care plan. If it is a covered service they will be assigned to coordinating service. If it is not covered special but specialized service they are responsible for working with the nursing facility to provide that. So that responsibility shifts. The up front process doesn't change at all.

>> FEMALE: [off microphone]

>> SPEAKER: Good morning I'm the director of CHC with community health choices. I just wanted to highlight some of the main areas of coordination we have S our service coordinator in the community as well as in nursing facilities are the primary points of contact for the person. The question for UPMC's perspective if somebody is connected with the service coordinator that is the first point of access we want them to contact the service coordinator. They are trained and in connection with our behavioral health coordinator they use [inaudible] a depression screening tool and what services they may need. For individuals that are not receiving waiver services, telephonic is the point of contact. They use telephone screen and health assessment to identify needs for individuals.

And we're unique in UPMC. We have 2 behavioral coordinators for each zone. We have 2 in pit berg and 2 in the south east region that is serve as liaisons to the are have us MCOs they are assigned to a behavioral health MCO. They are very familiar with their processes and intake and they are in communication with them on a daily basis as it relates to participants. Our behavioral coordinator have regular meeting was the behavioral health MCO. We meet with each of them on at least a monthly basis. Most of them we meet with on a weekly basis. But we are in contact with them on a much more freak interest basis. So somebody having an admission we get that communication when the person is in that setting. We are talking right there and then how we might be able to support that individual post that admission. We have calls more than those scheduled weekly calls.

We also have been successful in implementing a monthly data exchange with each of the behavioral MCO. They are a little bit different depending on what level we exchange with those behavioral MCOs. On a consistent basis we are able to send out a membership file that they identify claims utilization for those individuals for shared membership and we focus a lot of our attention following up on individuals who had inpatient as well as those who have had case management services and connect our service coordinators or care monitors with those case managers through the behavioral MCOs. What we found in the southwest is about 20% of our membership has utilized over the year that we have looked at 2017 data had utilized a behavioral health service. That ranges dramatically depending on which county. We had a low of 11% and high of 23%. Some of that is depending on the resources available within those counties you see that saturation of services.

But in general we look at it across the board. 20% of our membership had a connection to the behavioral health system in 2017.

And as you would expect, the highest utilization was outpatient going to see outpatient providers that is where you want to see it and where you expect to see a lot of that utilization.

To put some numbers in the southwest we are locking with the 4 behavioral health MCO. The number -- 1100 referrals to our behavioral health coordinators. And 20% of those are for individuals -- 20% of the individuals are in long term nursing facility. So long-term care nursing facility. We have seen a fairly high relative percentage of referral for individuals in nursing homes. I think an important note in the southwest as well as the number of connections to our behavioral health coordinators has gone up dramatically since the continuity of care and some of the changes to coordination.

During the continuity of care period we trained the entities on services. We are finding that a lot of them are not coming to us with referrals. Then when UPMC

service coordinators started coming and having those discussions with the participants we have seen a dramatic increase in the number of referrals that have come through for behavioral health services. As we have continued that the number keeps increasing month over month. In the south east there are 3 behavioral health MCOs 3 have experience in the southwest which makes implementation easier. We had set up those mechanisms. We are able to incorporate those discussions seamlessly into the southeast. We have seen again we expect a relatively slow up tick during the continuity of care period. We have seen for the month of January [inaudible] and the 1100 as well as 77 don't directly coordinate to referral for behavioral health utilization you would see. This is a voluntary benefit. We connect with a

lot of individuals. We provide them with information and help them understand what services may be available to them. And the best providers and services for them. Often times individuals may not necessarily want services at the time. In some instances particularly for mobile mental health services or peer support services in some portions of the state those services have waiting lists or we are working on identifying and expanding provider base with the MCO so that we can address those needs.

Any questions?

[off microphone]

>> **MALE:** Are you talking about the E-mail services or personal assistant services?

>> **MALE:** [I have an aide. I am not getting paid.

>> **MALE:** If [off microphone]

>> MALE: They say call the MCO. They call UPMC and nobody answers the phone. No information at all.

>> MALE: If you provide specifics. It sounds like a PCL or direct authorized.

We have been working with participants as well as workers to resolve it directly, to resolve any of those issues if you have specifics. I know there were some questions early on individuals getting reauthorized within PPL so that the workers get reauthorized. There were some questions about that. We have been able to work through those but they have come up specifically.

>> MALE: The department or MCO [off microphone.

>> MALE: They say go to the coordinator. They say go to the MCO. It is all confused. It is not fixed. Everything changes.

>> MALE: Understand

>> MALE: I can't go nowhere because I can't drive. We are not getting paid. They are working not getting paid. That is not fair.

>> MALE: We agree.

>> MALE: That is not fair at all.

>> MALE: Seriously we have been able to -- when we have had specific cases there is usually cases using your example cases when personal assistant services workers are not getting paid when individuals who are providing personal assistants they are in the consumer employer model they are not getting paid, if we know the specifics about the individual case we can usually figure out what is going wrong. Sometimes it is a time sheet issue.

>> MALE: When they get signed in UPMC took them and now they are confused. They don't know who they got or what is going on now this is going on. If it wasn't broken, why fix it.

>> MALE: I'm going to respond to that. I would argue that the system -- the fragmentation of the system was broken. So we are looking to improve the service model for community health choices. We have seen improvement in the south

west. We are going to hope we can address the duration. But we believe the service model will improve community healths choices.

>> FEMALE: My name is Shirley. I just wanted to piggyback on what lewis said. My question is, we are wondering if the authorization for personal assistant services are being handled differently now that the MCOs have taken over this part of the state. The reason I ask that is because personally [inaudible]? January my attendant didn't get paid for a couple of days. First I called to inquire about the PPL service coordinator. I was told that there was not an authorization for those couple of days they would send an authorization over. The issue was resolved once they did that.

My question is if this has not happened before, if the authorization is being handled differently are they placing the hours differently? Why is there all of a sudden missing hours sent. My attendants [inaudible]

And nothing is changed yet we are still having problems with the change. and now being told that if it happens again just call back if my authorization is for hours it should pay out. It is an authorization issue not a time sheet issue or anything like that. So I'm concerned not only for myself, I know a little bit more, but also for friends of mine who I know don't even know who their MCOs are and changes. So it is not being respected. What can we expect? Is it

>> MALE: What has changed in the system with the MCO is services in the foe for services have to be pre-authorized. Services in the fee for service system had to be pre-authorized as well. They were in different software. Fundamentally what changed in community health choices is the software being used by the 3 managed care organizations it is my understanding that one of the 3MCOs did have some issues with regard to data integrity on prior authorization and has since been corrected. That may have caused delays for the authorization of services.

That being said this should have been no interruption of delivery of services because of the con nowty of care.

So just to be clear did you have any interruption in your services? It

>> FEMALE: My attendant was paid. I didn't know that they weren't paid. I had PPL so my attendant worked through PPL. My attendant performed service. I didn't know they weren't getting paid for it.

It took 3 weeks to get fixed.

>> MALE: But she was paid. Right?

>> FEMALE: It was paid out once I was able to get to the MCO, get somebody on the phone who understood what I was talking about and then have it paid. It wasn't rectified right away. You also had the problem of the MCO actually understanding what is going on. You call the participant hotline for some of these places,ing some of them don't even know, I don't want to specifically name MCOs. But they don't even know who you are supposed to be directed to. It was a 3 week hold up.

The same thing happened with my chair. I was do you live eligible. So I had authorization for Medicaid to pay as first payer. Before the MCO took over med okayed had the secondary portion. They were schedule today deliver my chair and I was called and told that they couldn't because they were waiting on authorization through the MCO.

I don't know what the turn around time is supposed to be, but it took 2 and a half weeks for the authorization to come through.

And when somebody takes your chair away they take your life away. You can't work, you can't do that. So I don't understand it is not a thing that is being followed.

>> MALE: I really appreciate your willingness to talk about your experience. We might reach out specifically about your problem with the chair.

it is reality [inaudible] it is a integrity issue.

>> FEMALE: My time sheet is paid all of the time. I work. When I called even my MCO was able to tell me it is an authorization issue.

>> MALE: It shouldn't take as long as it did for you. We apologize.

>> FEMALE: Thank you very much. My question for future reference if this is an organization issue for hours especially chair, are the authorizations being looked at on a weekly basis or are they being handled differently now?

>> MALE: The authorization should be looked at on a daily basis, in the only the MCO and also PPL.

>> FEMALE: Is this something -- is this the way it was being handled before? It

>> MALE: I would say -- I'm going to be honest with you in the managed care model you have more individuals involved than in the fee for services.

>> FEMALE: If you are born into this, it is messed up. Is some something -- it seems like [up audible]

>> MALE: I am not going to ever promise in any system of healthcare it will be.

>> FEMALE: Primary care issue. If this is what we are dealing with before continuity of care I'm wondering, my concern is what happens when changes are really -- this affects people's life and every day.

>> MALE: I agree.

>> FEMALE: It affects my ability to have my job and everything.

So I am concerned about it impacting me again and if it happens again.

>> MALE: We believe that there is no question that there have been a few hiccups. The southeast had fewer south west. Will that being said you are right about continuity of care there should be no change in your services at all through

the 6 month time period. You will go through an assessments and determine whether or not your service levels need to be increased or decreased depending on your need. All of that is true. The only thing I can say is without any hesitation the fee for service system prior to the I am implementation of community health choice when it came to authorization and payment, we are trying to put more infrastructure in place to have more partners to be able to address those issue when's they arrive. The fee for service system the service coordinators didn't have the resources they need to support participants and advocate. Now they have more support with the managed care organization to be treat and manage the services for the whole person. Rolling

this back from be life oral health services there was very little integration or communication between the long term services and supports and support services in the system.

So community health choices is a coordinated model. The coordinated model is meant to help people and a half fate a very complex process. With regards to long-term care, physical health services and behavioral health services that community never really took place in the fee for services. We're going to contradict it with community health choices. I think that was the focus and point of what the 3 managed care organizations and Patty were trying to discuss and what we are trying to approve here.

>> Theo: I am feeling her pain. I believe there has to be something in a more efficient way if someone is without a wheelchair or causes someone to have someone with durable medical equipment that we must be able to go past red tape and get that person that equipment. There has to be something we can do to make that happen.

>> MALE:

>> MALE: I can agree. You some out no not had to wait 2 weeks. Gail gave you her card. We want to know more about the case and talk with the managed care organization involved. Thank you for not naming them. Thank you for not naming them.

We would like to use your experience as a way to learn and make sure we are improving the system. You shouldn't have had to wait that long.

>> **FEMALE:** Thank you.

>> **MALE:** Thank you.

>> **FEMALE:** Thanks very much, David. So now what we are going to do is we are going to turn things over to office of mental health and substance abuses service the deputy is going to start it off. They will hear from the behavioral health managed care organization to hear what they are doing. [off microphone]

>> **FEMALE:** Many of our people need both counseling and all of the resources.

One handles the other.

>> **MALE:** We couldn't agree more. We believe that.

>> **FEMALE:**

>> **FEMALE:** Not everybody is going to be able to call especially if they have mental health issues or brain injuries. They don't know what to go to they are lost.

>> **MALE:** What I have to say to that in the prior model there was very little coordination. At least in this system we have a lot of infrastructure in place to be able to coordinate those services. We agree there is a direct connection between a person's need for home modification and their ability to be able to access other services. We agree with that. Recognizing the 2 have to have some relationship to each other is the whole basis of the model of community health choices is a coordinated model. It is taking no consideration behavioral health needs and their long-term care needs which include -- we agree with you completely. That's what this is trying to do better coordination of services.

>> **FEMALE:** People are being pushed to the side. She has a big mouth I have a big mouth. Many consumers do not do that. They are lost in the system.

I get many phone calls and I don't even work for you guys.

I'm trying to explain it. I had to fight with the insurances. I'm still waiting on a door that's closed. I have to wait for somebody to open it to get out of my house and get to the doctor. What about those that control them throughout the day or they need counselling because they are going through so much.

>> MALE: If they need counseling they should get counseling. If they need transportation to get prescriptions they should have that available. If they need modification to have access to the community and outside world, those modifications should be -- appropriate home modifications.

>> FEMALE: That is 3 months later. Male male I'm going to say again I wish it was simple. But the problem is with home modification there is a lot of back and forth that is required to make sure that you do the right thing. I wish I could say it was simple. I have been in this business for a long time.

>> FEMALE: Good afternoon, everyone. I think we are into afternoon. 12:01. We are which one do I push? Got it.

So I'm the deputy secretary for the office of mental health and substance abuse services. As Patty said, we are one of offices within DH, the department of human services it is like office of long term living and Kevin Hancock. This is my first meeting with you guys. I really am happy to be here and I am happy to really listen to the conversation and the discussion really want to reiterate the commitment on the part of SMSAS. Kelly who is our person with OMSAS who works with Randy and Patty on the inclusion now of behavioral health for as Patty said for individuals in nursing homes and individuals that are part of the paver. We have always worked with individuals that are duly eligible. So the 2 new populations are people in nursing homes and people receiving services through the abling waiver.

So we want to make sure that people understand and clearly understand that behavioral health system can be difficult at times to navigate and so we are trying to really make sure folks understand that the service coordinators the nursing homes, the waiver providers. But also most importantly the individuals who need those services.

So I don't want to go off on too huge tookant the hour is late. We want to make sure our behavioral care organizations can talk through their processes which will be similar to what you heard from the CHC managed care organization. Again, I am just happy to be here. Kevin and I are very committed to making this work. We want to make sure people are receiving the behavioral health services they need.

I really look to CHC as the opportunity to provide services to folks that may not have been receiving the behavioral health services that they need. So really look at this as an individual. Will we hit bumps and bruises along the way? I believe that's probably true. But to the extent that we want to make sure we're hearing about those and always letting the service coordinator know or your care manager back at the plan when you hit any bump so we can jump on things very quickly.

With that being said we have our 3 behavioral health managed care organizations represented today. They are really the CHC coordinator. You just heard from the behavioral health coordinator for the CHC plans. Now you will hear from the behavioral -- the CHC coordinators within the behavioral health plan. So Magill an is represented. I will ask Joseph from community behavioral health to come up and talk first about the work that is happening within community behavioral health which is really the Philadelphia area.

>> MALE: General question first. Are there going to be targeted outreach efforts to reach out all of the populations that --

>> FEMALE: I think you will hear that. I know that I talk with Kelly regularly and talks with the plans regularly about the outreach effort. There definitely is that. They will talk about that.

>> **MALE:** Good afternoon, everybody. I'm Joe from the Philadelphia department of behavioral health and intellectual disabilities. And community behavioral health.

Thank you all for inviting me to Harrisburg. South Philly boy. For all of my friends in the southwest and Pittsburgh, I just want to et let you know that [inaudible]

>> **FEMALE:** I was going to.

>> **MALE:** So community behavioral health is under the department of behavioral health in the City of Philadelphia. We are the managed care organization for behavioral health services for Medicaid individuals living in Philadelphia.

We are the county as well as the behavioral health managed care organization. Our vision we envision every fill Dell person to get healthcare and quality health services for their well being and self determination.

Our vision as you can see is to educate, strengthen and serve individuals and communities so Philadelphiaal ns can thrive.

We have goals, the 3 goals CDH to help ensure that people get the right services they need, we will manage their care and we will always provide services for the individuals in Philadelphia that need behavioral health challenges. That is substance abuse as well.

I am going to move on because I know it is getting late.

Community behave or and community health choices as we -- it is a new initiative. But it is isn't that new. We worked for 2 years to prepare the network and prepare Philadelphians. We just started in January. But our objective was really clear. We have to educate the provider network that we have over 240 providers in the Philadelphia behavioral health net, would. We have prepared the upcoming bids and with the challenges in happening in Philadelphia the opioid crisis was really

front and center throughout the past years. We tried to get the word out from the providers. They had eye lot in front of them that they were expected to hear.

Community health choices was also on the docket of all of our meetings under the executive director.

So they are a way. Then the other objective is that we coordinate behavioral health services for people that have community health choices now. And with community health choices it is an organizational change that we had to prepare for. That means increase numbers of people on enrollment of CBH. We had 700,000 people approximately in CBH for the City of Philadelphia with community health choices we added 13,013,000. We are looking at more specialized services because of community health choices. We are looking at services such as peer services. I just want to make a comment that when went out and visited nursing homes.

We have been to the English house and I met behind A it was just an extraordinary place. She really pushed for behavioral health services as well as with die Anne the CEO. So thanks so Linda for getting that up. We also look at new providers such as English house and have a network of providers that are already in nursing homes. Procurement for independent practitioners people that have never been in our network before to come into our network so they can treat individuals in nursing homes and in the other facilities throughout the city.

We have coordinated with the 3MCO. Those organizations are new. Keystone first is well known. This is the first time working with the older adult and community health choices division.

We had to educate them on Philadelphia and our provider network the way we do things so we have been working weekly, maybe daily phone calls with each other. So that's been something.

We are partnering with agencies that we have never partnered with before the office of long term living. We have always had some sort of partnership with PCA and carly and it's been very up front and you can have a good conversation.

So we are partnering with agencies we never did before. And of course new roles at CBH for community health choices. As you can see here we have all members of the organization working on community health choices. Our member services department. It is 24/7 operation. They will direct care for everyone even if Medicare is your primary. Our member service tomorrow has a list of Medicare eligible providers in our network. They will set up appointments and get you certified.

Get you services.

so we have been working on 7 goals throughout this whole project. I just want to go through them. We have been collecting a lot of data. We have duly eligible individuals in our network. That was about 58,000 people. Adding the new members to our rolls has increase that had number. We are looking at providers in the network and who is servicing community health population. We did network capacity. We have over 240 providers providing all levels of care. Adults we have providers already working with older adults that will continue working with older adults. We have -- you talk about partial programs we have programs in the city called Cert program that are certified recovery centers.

Those programs also have older adult Cert programs attached to them. We have those services available.

We have procurement.

[off microphone]

>> MALE: This is a peer program.

>> FEMALE: I was approached by somebody in English house I would not do it.

>> **MALE:** I will explain. Peer services is a provider that has people going out that have both behavioral health challenges and physical disabilities. They will go out to people all over the city.

>> **FEMALE:** [off microphone] it

>> **MALE:** Male we are going to work this out.

>> **FEMALE:** ADAPT to let people know about English. You are no longer stuck in there. Now with the new system, people have the opportunity to go out in the public. So you pass along communication on your side too that people are able to transition out.

>> **FEMALE:** [off microphone]

>> **FEMALE:** As soon as they hear nursing home many people shy away from it because they are petrified.

>> **MALE:** English house --

>> **FEMALE:** It is a nursing home. It is a nursing home. Some of the people that are out in the community were there at one time.

>> **MALE:** We have peers that will come out and help people. So we have a whole host of providers.

>> **FEMALE:** One specific assertion. English house is a major part for people with physical disabilities. There should be more than one person.

>> **MALE:** There are providers that will come no our network. So we are really looking forward to that.

We also have a lot of internal team development that is working throughout the whole community health choices. We have clinical care management working with the integrated care tomorrows which is a part of community health choices relating to care. To speak on other things we have been looking at best case practices for

adults especially with the integrated care. We have been researching all of the challenges that are facing older adults these challenges are getting older. Older adults have problems with gambling. Older adults have problems with opioid abuse and hoarding. We have a hoarding task force in the City of Philadelphia. So to finish up we have been trying to reach out and mostly reaching out to nursing homes to get the word out that we have CH is a part of their network now. We have partnered with many nursing homes right now. We are still lock to go partner with more. That is on an ongoing communication and outreach that we are working on.

So the last slide is our web site CDH Philly. Member service line. If you ever have a question about your behavioral health needs, please call the member service line. Somebody will answer that phone. So I want to thank you all again and have a safe trip home.

>> FEMALE: Offer a comment. I would hope if you [off microphone]

>> FEMALE: Now I would like to ask magellan -- wait. I'm sorry. We had a communication we didn't realize CDDH was able to join us. Take it away.

>> FEMALE: This is going to be a report. I do have a handout that I put up there.

So my name is duncan. I am the behavioral health cord nighter at community care behavioral health. I have I have 6 hours to touch on and cover. Prior to that I want to take a quick second to point out the geographic area that community care operates. In the southwest we cover Allegheny county and Blair county out of the 14 counties in that area. In the southeast we cover the Chester county area and then in 2021 it goes live across the rest of the state we will cover 36 counties. I am not going to attempt to try to name all of those.

I primarily wanted to give an update on some of the network activities that we have done in the last 2 years to focus on that work that we have done and then our process for coordination and collaboration.

So prior to CHC going live in the southwest and southeast, we did a survey of our behavioral health provider networks. We asked them a couple of different things. One their experience working with older adults and specialized populations under CHB. Expanding services their training needs among a few other things. We did that in the southeast and southwest prior to going live.

We did geo access analysis that we do for Allegheny, Blair and Chester. All of the standards were met for that. We began working directly with our providers. We primarily did that through our provider meetings so we have regular provider meeting. We presented on CHC at prior to and after the go live date in the southwest and southeast.

A couple of things we did focus on were the 2 new populations the nursing facility population and folks on the aging waiver were new members to us. We pointed out to our providers that this would be a new group that they would potentially be working with. We did focus on the bidirectal nature of the CHC program in the sense that our behavioral health provider would be working with a new group of individuals. But also for them to keep in mind as they working with our folks that they already work with, some that of the individuals will have extra benefits. We need to keep that in mind. Putting together a comprehensive plan to work with their membership.

We did sponsor a training which is older adult peer support training in Allegheny in May. In June of 2018 we did a symposium, day long training that we offered to our providers from the us inning facility CHC partners. We did that in Blair and Allegheny county in an effort to prepare our network and expand their knowledge base.

We have created a section on the community care website where we have put the CHC symposium training. We put it on there with other resources that are provided

that other folks can access. Anybody can go into the website and look at those materials.

We have done trainings with all of the CHC on some level and the AAAs as well. We have gone in and talked about how to coordinate and corroborate with community care and discuss the level of care and treatment out there.

We co-sponsored the eighth annual aging conference in Pittsburgh. We promoted that in the south west region for our providers to a end it. We have done some consultation with local nurse being facilities that have specialized behavioral health unit. We met with lake Erie college of osteopathic medicine. It sports geriatric care. We met with them to pick their brain about some ideas and suggestions they may have.

So in addition to the work we have done with our behavioral provider network we have also done outreach with nursing facilities and the home and community based providers. We did telephone outreach to the nursing facilities that are numbers in Blair, Allegheny and Chester county. So we called them all up and offered to meet with them individually in person. We met with about 15 of them in total.

We also partnered with Pennsylvania healthcare association and Pennsylvania healthcare to set up a letter on our behalf. Including a survey in there and offered to meet with them in person if they wanted to more n depth talk about how the system worked and treatment options that are out there.

We have hired a geriatric nurse practitioner to help with supplemental service development that we are working on. Heather mentioned that we had hosted a quarterly south west partners meeting that included all of the behave oral health MCOs and organizations, us inning facility providers and home and community based providers. We did that in January. We have another one at the end of the month. In an effort to target those 2 groups in particular, nursing facility and home and community behavers to make sure everyone is aware of the services available out there.

Direct work we have done individually with members, we would like to take the approach of a couple of different things. We really en can encourage behavioral health is important. We tried to make our processes for coordination simple, easy, timely. We have also encourage behavioral health screening and referral.

Towards that end, prior to CHC going live, we did set up a coordination collaboration line to be a single point of contact. We have a short phone tree. You can call in. It will directly talk to somebody. If they can't help you then they will transfer you to someone to work with you.

We have a physician line available any doctor or medical staff if they would like to talk to one of our doctors can call in.

A couple of the quick things, coordinator position. We have weekly operational and clinical meetings we have contact with them daily. We are currently working on some supplemental program development so that in recognition [inaudible] in the spirit of one of the 4 or 5 goals of the CHC program was to spur innovation and development. We are trying to do that.

We are working on data exchanges in CHC so we have 2 of them that data exchanges that we are working on. A third one as well.

Some aboutive efforts so far. Any questions?

>> FEMALE: Sorry.

>> FEMALE: Hi there. I just have a question about network surveys. You mentioned about getting geo access analysis. Does that factor in things like whether a provider -- by public transit whether they are ADA acceptable or [inaudible] or how comprehensive is that analysis? It

>> MALE: I will be honest with you. I'm not an expert on all of the mechanisms. They do the geo access. I know it is a requirement of the health choices program that we do that on a yearly basis. I would have to get back to you on the exact details how that operates. I don't know it down to that level that you are asking. I can find that out though.

>> FEMALE: Thank you.

>> FEMALE: In general the geo access standards are time and distance to the provider. We can dig down to some of those more specific questions as well.

>> FEMALE: Thank you.

>> MALE: Know that you are MCO operates in the southwest and you have got a year now. 2 new populations that were part of community health choices were the aging waiver that supported individuals and people and disabilities. How would you characterize your experience in evolving and providing services to those 3 new populations in the southwest? It

male sure. One of the things I will say is the behavioral health up take in those 2 populations has been low. Over the year a steady but gradual increase. But it has been low. One of the things we learned is a lot more education and outreach is needed. Still is needed especially with the nursing facility and the home and community based. I think that was one of the things.

>> MALE: Provider education is going to be one of your objectives to talk about the services?

>> MALE: Absolutely.

>> FEMALE: Okay. We will d thank you very much, Duncan. Now we will ask Melanie to come up from Magellan and give their overview as well.

>> FEMALE: [off microphone] just to point out the reason there is a lot of that discussion is the behavioral health MCOs they have not served those aids have. That's why their focus with CHC [it inaudible] prior to CHC if you were enrolled in the independence waiver or attendant care or com care we were being suffered by the behavioral health MCO. As you transition from those previous waivers into CHC your behavioral health services are not changing. That's why there is not as much discussion about those folks and more the discussion is about aging waiver and the nursing facility. I just wanted to point that out. I know there is a sensitivity around

nursing facilities. It is not something that a lot of folks -- that's the reason for this discussion today.

>> FEMALE: That's not true. People with physical disabilities have not been served by behavioral health. That is our problem. Speech impaired are not. That's why we have been so upset. We have not been served. We will get psychotropic drugs but nothing else. It is difficult to get treatment for addiction because of your physical disability. They don't think -- everything is related to that and that's the reason why you are how you are. That is a huge. We are upset in the disability community. We have not been served at all.

>> MALE: In response to that, we a degree. The reality is --

>> FEMALE: Not for lack of trying either.

>> MALE: That's right. On your side, I have to say on our side it is not lack of trying either. The whole point of this coordinated model is to make this better. Even in the area where people would have been involved in the health choices program and behavioral health choices program there have been low utilization with the physical disability population. That is one of our goals. We are counting on you to help us with this to make it better.

It is an opportunity.

>> FEMALE: We would like to. Everybody talking and talking about people with physical disabilities. Again, we are invisible even though we are pretty visible.

>> MALE: I am going to add to what you are saying, Nancy it is not just people with physical disability. It is people with disabilities. I think Lynn's team is committed to addressing that gap and MCOs are as well.

>> FEMALE: [off microphone]

>> FEMALE: That's good feedback. We really appreciate that. We will take that back. Joe will work that. Nothing is going to happen at the facility. Everybody will happen in the community. But it is a messaging I go this.

We don't want to put the two together. I absolutely understand that.

>> FEMALE: That's very good feedback. That's why we have these meetings. Absolutely. Joe, right?

>> FEMALE: [up audible]

>> FEMALE: I want to reiterate it what Kevin just said and our commitment and our behavioral health managed care organizations as well as our county. The behavioral health choices program is driven by the county. It is county run. Except in 2 instances where OMSAS does. We are absolutely committed. For me to sit here and hear that, that is very disturbing for me that that has been the experience. We will figure this out and make sure folks are getting the services that they need.

I can very confidently say the same that the BMCO will do the outreach that is need today make sure we are engaging folks.

>> MALE: [off microphone]

>> FEMALE: That's because you hear the name of the nursing home.

[inaudible]

>> MALE: I think you have made your point clear about the services we access. One of the things I will have to say our program covers people in nursing facilities as well as in the community. We have often heard concerns raised about access to behalf oral services. We have to say that people in nursing facilities don't have the

same level of access to behavioral services. Lynn's team is committed to addressing that gap for that population as well as for folks living in the community.

>> **FEMALE:** This may be a topic for another day. The issue of for people with attendant care there have been circling in recent years issues with people needing inpatient substance abuse treatment and not being able to access inpatient services because they needed a chair. I think that we need to look at the system because I had to help someone within the last 3 years find a facility in Illinois to help him with his substance abuse issue because he couldn't take an attendant into a facility. The facility would not provide his care.

So this is another topic for maybe another day. But substance abuse is something that needs to be looked at.

>> **MALE:** That's true. Was this for in patient or outpatient?

>> **FEMALE:** We needed inpatient rehab for his substance abuse program. I couldn't find him anywhere to go kept for Illinois. And he ended up declining that support because he would be away from everyone he knew.

That's happened to me I guess my 18 years, that has happened to us about 5 times where we have had people that couldn't access in patient.

>> **FEMALE:** Was that individual with Medicaid?

>> **FEMALE:** Yes.

>> **MALE:** They were on waivers.

>> **FEMALE:** Yep. The issue is that has been explained to me that the entreatment facility they are accustomed to providing attendant care to individuals move a substance abuse issue. That is not something that they do. They didn't want to do it. We find people needing substance abuse treatment that can only get outpatient

services and that is often difficult maybe the environment they are in is amplifying the addiction.

So at some point we need to look at that system and come up with a coordinated plan to address it.

>> FEMALE: Thank you. Again, that is really good feedback. Okay.

>> FEMALE: My name is Monica I'm the health manager at magellan. I have Melanie who is our health choices manager. She is the MCO for bucks, cambria, Lehigh and north Hampton. Rolling out in January 2020. I know there's been a lot of discussion about coordination that's been going on. So I won't go into all of that detail. We coordinate very closely with all of the 3MCO. There is weekly contact. Monthly meetings and sometimes they are in person. Sometimes they are involving our county partners. There is a lot of collaboration that occurs. That is to collaborate on our clinical work flows to enhance our processes and also to enhance our data sharing processes which will help drive initiatives and coordination going forward.

We also collaborate with the county partners and community partners in trying to continue to educate about community health choices. As I mentioned before I have joint meetings. So we have been participating in individual member reviews. Aist ising in locating in network providers and community supports. Coordinating care and community education about CHC and behavioral health support.

So in in some of the work that Melanie does she does a lot of the coordination and outreach efforts. She will speak to some of her efforts in the past couple of years through the years.

>> Melanie: Okay. So we have done a lot of outreach efforts as well as some of our counterparts. I'm just highlighting some of the big outreach efforts that we have done. I have out reached to over 105 Medicare facilities regarding our county. As part of the outreach we have asked questions what behind of services do you cover, do you know what CHC is, do you have any questions and what provider is in your network so that we can look to expand who we cover and who is in our

network so we can best service this population. We have educated them what services are available to the residence in their if a sill and what services are available if a resident wants to transition out.

We have done in person meetings with some of the nursing facility. This comes from some of our county counterparts. They have gotten data from the state that target large populations we have gone to those nursing facilities directly, met in person, met with the social workers and answered some of their questions and concerns about the new population that they are serving.

Outreach to over 68 service coordination agencies, personal care homes, adult day centers and this is just to educate them on CHC, who we are, who our population is and we wanted to go over what levels of care we provide.

We wanted to educate them on if they see somebody in their home and they feel like they may need behavioral health or may need mental health or drug or alcohol, those are the levels of care and this is how you can access the levels of care for the population that you are serving.

We work in collaboration with our local area on aging agencies our behavioral health providers. PA home care and PA health association to cover some of the individuals at waivers. We wanted to understand their need and how we can integrate services better.

Again, educate them on on what we can offer and how to access it

>> SPEAKER: We have attended all of the sum its that the state held. We have been there to answer questions and meet any members that may have questions or providers.

We have done -- we have been collaborating on training. With our counties we have countered on mental health first aid training an webinar that we are hoping to put up shortly. All of the levels of care that they are eligible for the community health choices population. We are also working on training that just covers some of the warning signs of behavioral health, some questions to ask, what signs and symptoms may be and how to get help and services this is to target care givers, individuals at homes and home health aids. We also surveyed our behavioral health providers prior to CHC coming out in their area and closer to when we started. We sent it out twice. Do they know what CHC is. Can they serve this population and what happens if they have an increase of people who have special needs, are they able to provide services.

And we discuss opportunities to expand our provider network as we said earlier. We have talked to them about peer services. We have talked to them about mobile services and we have talked to them about what providers are in their network already that we may be able to expand our contract with.

So going forward, we have been working on the level of care train willing. We had a general training that we are working on. We had it initially we are cuss numbizizing it for the CHC population that will be on the website with the behavioral health 101 training how to identify behavioral concerns, questions to ask and where to go and identify if there is a need for support. And then the tip sheet will be on the website. We are in the early stages of planning a training and event later this year. Again, this will be in the south east region it will continue to promote education. And we will be collaborating with the CHCMCO to improve care collaboration.

Any questions? It

>> **MALE:** I have a question. Just following up, you were a MCO [inaudible]

>> **FEMALE:** I don't know if you have heard of anything. I think those are the type of things that we bring back an we identify this is a new need that hasn't come up yet but we are willing to collaborate and work on.

>> FEMALE: To add to that, I would also like to introduce Dr. Usman he is the new medical director for OMSAS. He has bimonthly calls with the medical directors. I would ask him to have this conversation with them. It might be something that is a niche service that we have to really talk to you guys about developing. People should not have to go out of Tate to receive substance abuse treatment.

So that is something that we will take back as well.

>> FEMALE: Thank you, Patty, Lynn, behavioral health MCOs. We appreciate the information you provided us today.

As usual, we are running out of time. So Miranda agreed to present next month. Should we go into the MCO scenario? I had 2 questions that came in over the phone mail male maybe something in the audience has a question.

>> FEMALE: A general question, if the Governor's proposed increase for minimum wage to $15 is passed as part of the budget are there any plans to in reimbursements.

>> MALE: The initial legislation starts increasing the might be um wage to $12 an hour and gradual increase associated with that. Personal service rates in the future service that would be translated to community health choices are calculated in community health is which have taken into consideration what wage would be, wage change would mode to be from what it is right now on average which is $11.51 to the $12 an hour. More money has been proposed in the Governor's bun for personal service rates to be able to accommodate the $12. We have to say that the passage of the minimum wage increase and the increase in personal assistant [inaudible] is based on the other.

>> FEMALE: For the southeast, something else just popped up. Made a lower out of me. For the south east as FCEs are having participants change plans from month to month if it is completed in up with plan do we need to do another for the new MCO plan or the a agreement is one required per agreement

>> MALE: That is needs assessment. It requires they enter a home care pool. Managed care organizations will likely do another assessment process when they assume services for participants. It is part of -- not only is it a requirement. It is in

their interest to have a full understanding how the participant's service design has to be accommodate dated. He Y the managed care organization will do another for the participant if they move from one managed care organization to another.

If they are in need of long term service supports, it depends on that need. The managed care organizations can agree with me or disagree with me if they would like.

>> FEMALE: Here is the question for the MCO. Can each share when your first advisory committee meet be will be? Early April? Will the CHCMCO will consider compensation consumer members with a gift card like some of the behavioral MCOs do?

>> MALE: Male this is Ray. I don't know the exact date. We are planning it. We have begun the identification process for participants. If you are interested, please do grab my cell or another team member. We do provide some gift cards for participation.

>> FEMALE: Thank you. Jen? ?

>> Jen: Hi. Community health choices our advisory meeting is scheduled for March 14. We have come up with transportation and I can't remember what else. [inaudible]

>> FEMALE: Thank you.

>> FEMALE: For the south west our next meeting is March 30 in the southeast it will be happen. We are confirming the date. Our meetings are held during the day. We provide transportation. And we also feed lunch to all of our participants in attendance. We can always discuss other opportunities. That's currently what we do.

>> FEMALE: Thank you.

>> MALE: We have come to learn that there may be 2 different care areas [inaudible] 3 month medical. Can we get clarification on that? Since that is being brought up in behavioral health, I was wondering if there was a third for behavioral health.

>> FEMALE: I can speak to the behavioral health. There is a continuity of care period versus nursing facilities. A person in a nursing facility [inaudible]

They continue to participate in the Medicaid program those individuals will be able to stay in that nursing facility indefinitely.

Even if the nursing if a and the MCOs do not come to terms for the contract the MCO will have an out of network contact. People in the nursing facility that they are able to maintain those services.

The second is home and community based services. It is a 6 month continuity of care period. And that covers anybody who is receiving home and community services and any of the prior fee for service waivers or part of the community choice from day 1. For the southeast it would end on June 30.

Now for physical health services this is true in health choices and community health choices continuity of care period is always 60 days. That is the way the programming was designed. So the person is for example was receiving -- 2 examples. If a person was in health choices and they were receiving hospital-based services, they were in a different managed care organization the community health choices would be responsible to main those services during the transition period. Or for however long it would take. Whether it was in network or out of network.

Fee for services in the aging waiver in community health choices that would be the example, the fee for service physical health service that was on going like physical therapy, a service that has multiple services the continuity would continue with that

same provider as long as they were a Medicaid participating provider up to 60 days. During that time the managed care organization would be working with that participant to develop a new application for additional physical therapy services after that 60 days is up.

Does that answer your questions? Just to be clear about the 60 days. That is also on going. That is also on going not only after the continuity of care period after the home and community based services and indefinitely for community health choices. 60 days is the continuity of care period. There is always going to be a continuity of care period in community health choices.

The continuity of care period is 60 days. There is continuity of period. 60 days for physical health. 60 days for home and community-based services. 60 day for nursing facility services for a new enrollee after all of these implementation periods.

>> MALE: The answer is full [inaudible] one more question. The next meeting. We understand that [inaudible] in a short 6 months from now.

>> MALE: I will ask Chris. The subject matter expert. Provide you [inaudible]

He will be very thorough.

>>

>> FEMALE: As of right now we are looking at implementation September 1. The goal is for providers to be trained and be using it as their training while education is fresh in their mind. The goal is by September 1 all providers will be trained.

>> MALE: Thank you. Perhaps in the next meeting more in depth [off microphone]

Compiling the location of service delivery. In the rural area there are issues back and forth.

>> MALE: So when you need mental health services you need at home care and home health are 3 terms. That's what you mean.

>> MALE: They are 2 different things [inaudible]

>> FEMALE: [off microphone]

>> MALE: Thank you.

>> MALE: That is part of the update. For April we will update you. We will spend 15 minutes and answer your question.

>> MALE: Thank you. Appreciate that. [off microphone]

>> MALE: I did have some understanding some of the experiences some of the providers are hearing with prior authorization. I think with that clarity we will lock if this is a systemic issue with the MCOs in the southeast we will get the systemic issues fixed. We have 2 priorities making sure there is no interruption of services and making sure there is no interruption in provider payment. Workers are paycheck to paycheck. I have talked to many direct care workers about their experience. We don't want them to ever have to wait. So we will get it fixed. We will get it fixed.

>> MALE: Thanks.

>> MALE: Thank you.

>> FEMALE: One clarification, Anna from PA Health and Wellness asked that I let you know that the meeting is March 12. That being said I want to thank everyone for your attendance and participation and hope to see you next month April 4, 10:00. Safe travelers.