Contact Center Operations

July 7th, 2021

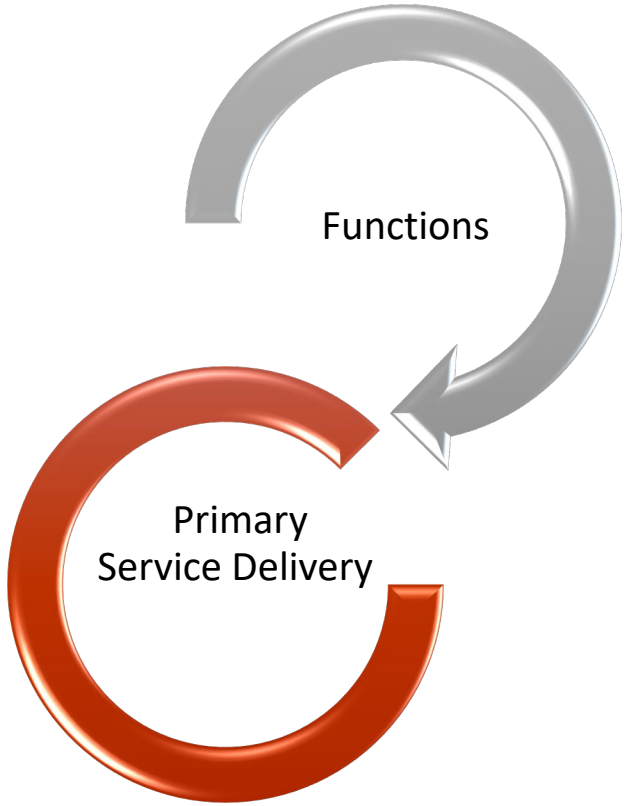
Community HealthChoices | AmeriHealth Caritas Pennsylvania

Delivering the Next Generation of Health Care

Contact Center

The Contact Center serves as one of our main customer interfaces that manages customer interactions.

- Contact Center Functions for Participants Services
  - Inbound/outbound calls
  - Correspondence from the Participants to CHC-MCO
  - Self- Service Options
    - Member Portal/ Website /Mobile App
- Primary Service Delivery for Participant Services
  - Verify Eligibility
  - Facilitate PCP changes
  - Search for a Participating Provider
  - Explain CHC-MCO Plan Benefits
  - Assist with Transportation Coordination
  - Initiate Dissatisfactions/ Formal Complaints and Grievances
  - Provide Service Coordinator (SC)Contact information and Notification for SC Call Back Requested by Participant



Call Volume and Top Call Drivers

Call Volume
January-May 2021

- Keystone First CHC (KFCHC)- 53,414
- AmeriHealth Caritas of Pennsylvania (ACP CHC)-26,676

Average CHC Daily Call Volume

- High-End- 1,000
- Low-End - 550

CHC Top Call Drivers

- Benefit Info – Medical- 30,277
- Member eligibility Verification -19,080
- Service Coordination – 17,097
- PCP Changes – 11,115
- Demographic Changes- 10,650

Different Grievances Review Types and Action Steps

- **Grievance**: A request to have a CHC-MCO or utilization review entity reconsider a decision concerning the Medical Necessity and appropriateness of a Covered Service. A Grievance may be filed regarding a CHC-MCO's decision to:
  1) Deny, in whole or in part, payment for a service or item
  2) Deny or issue a limited authorization of a requested service or item, including a determination based on the type or level of service or item
  3) Reduce, suspend, or terminate a previously authorized service or item
  4) Deny the requested service or item but approve an alternative service or item
  5) Deny a request for a Benefit Level Exception (BLE) This term does not include a Complaint.

- **Expedited Grievance**: A review of a Participant's Grievance within **48** hours. May require a Letter of Medical Necessity from the Participant's doctor. The CHC-MCO will determine if the Participant's life, physical or mental health or ability to attain, maintain, or regain maximum function would be placed in jeopardy by following the regular Grievance process. A review of a Participant's Grievance within either 48 hours of receiving the Provider certification or 72 hours of receiving the Participant's request for an expedited review, whichever is shorter unless the time frame for deciding the expedited Grievance has been extended by up to 14 days at the request of the Participant.

- **External Grievance**: The Participant or Participant's representative, which may include the Participant's Provider, with proof of the Participant's written authorization for a representative to be involved and/or act on the Participant's behalf, may file a request with the CHC-MCO for an external review of a Grievance decision by a certified review entity (CRE) appointed by DOH.

- **DHS State Fair Hearing**: A hearing conducted by the Department's Bureau of Hearings and Appeals (BHA) or a Department designee.

Type of Review	Timeline	Action Steps
Grievance	▪ A Participant must file a Grievance within sixty (60) days from the date the Participant receives written notice of decision. ▪ If it is a change, reduction, or termination of service notice, the Participant must file within 15 days from the date on the notice to continue receiving the service or service level. ▪ The CHC- MCO must send a written notice of the Grievance decision within 30 days from the date CHC-MCO received the Grievance unless the timeframe for the deciding the Grievance has been extended by up to 14 days at the request of the Participant	▪ The Customer Service Representative (CSR) will begin the Grievance process by asking the Participant or authorized caller several questions to enable us to document Grievance ▪ The CSR will then document the request on a Service Form and submit the request to the Appeals queue for handling.
Expedited Grievance	• A process for reviewing and resolving Grievances within either 48 hours of receiving the Provider certification or 72 hours of receiving the Participant's request for an expedited review, whichever is shorter, unless the time frame for deciding the expedited Grievance has been extended by up to 14 days at the request of the Participant	▪ CSR will explain to the Participant when a Grievance can be expedited ▪ If it is a change, reduction or termination, of service, the CSR will then Document in the SF "The Participant was informed that the provider must submit a letter of Medical Necessity." and submit Service Form to Appeals Queue for handling.

External Grievance	▪ The External Grievance can only be used after the Internal Grievance Procedure is exhausted.
	▪ Must be filed within 15 days of the date of the Grievance determination letter
		▪ The CSR will ask the Participant the following questions to begin the external Grievance Process:
		  ▪ Who is the Grievance Coordinator listed on your letter?
		  ▪ When did you file your initial Grievance?
		▪ The CSR will then generate Service Form and submit to the Appeals Queue with original Service Form number.

DHS State Fair Hearing	▪ The Participant or the Participant's representative may request a Fair Hearing within one hundred and twenty (120) days from the mail date on the written notice of the CHC-MCO's first level Complaint decision or Grievance decision.	▪ The CSR will inform the Participant that they must file a State Fair Hearing directly through the Department of Human Services/OLTL. ▪ Furthermore, the CSR will advise the Participant they may file by phone, fax or mail and that the postmark date on the letter must be within 15 days of the date on the reduction notice letter

What happens once the Service Form is submitted to the Appeals Queue?

- Grievance request received by the Contact Center are sent to the Appeals team via a Service Form created in the EXP system.
- Appeals Intake Supervisor/Team Lead assigns the Service Forms to Intake Associates every morning
- EXP queue is reviewed several times a day for any expedited Grievance request.
- Intake Associate reviews the request, uploads the Grievance request and denial letter to JIVA, sends an acknowledgement letter to the Participant, assigns the Grievance to a Grievance Coordinator and alerts the LTSS team that a Grievance was filed.
- Acknowledgement letter is sent to the Participant within 3 business days.
- Grievance Coordinator follows departmental guidelines to reach out to the Participant to gather documents for review and schedules the committee meeting within 5 days of the Grievance Coordinator being assigned the Grievance.
- Committee Meeting is held with the Participant/Participant Rep, Facilitator, Medical Doctor, Employee Voter and Non-Employee Voter either via telephone or video conference.
- Decision letter is sent within 5 days of the committee meeting and the LTSS team is notified of the decision.

Questions?

Coverage by AmeriHealth First.

PHW Resolutions Call Center Operations

Call Center Operations

- PHW has one toll-free number (1-844-626-6813) for participants/providers statewide.
- Assistance is provided for all inquiries such as:
  - Schedule COVID vaccinations
  - Update demographic information (address, contact information)
  - Request a new participant ID Card
  - Update PCP or find a provider
  - Answer eligibility, benefits and services questions
  - Identify local community resource information
  - Schedule transportation
  - Support with complaint, grievance or appeal
  - Sign up for participant and care giver portal accounts
  - Speak to service coordinator

Call Center Trends

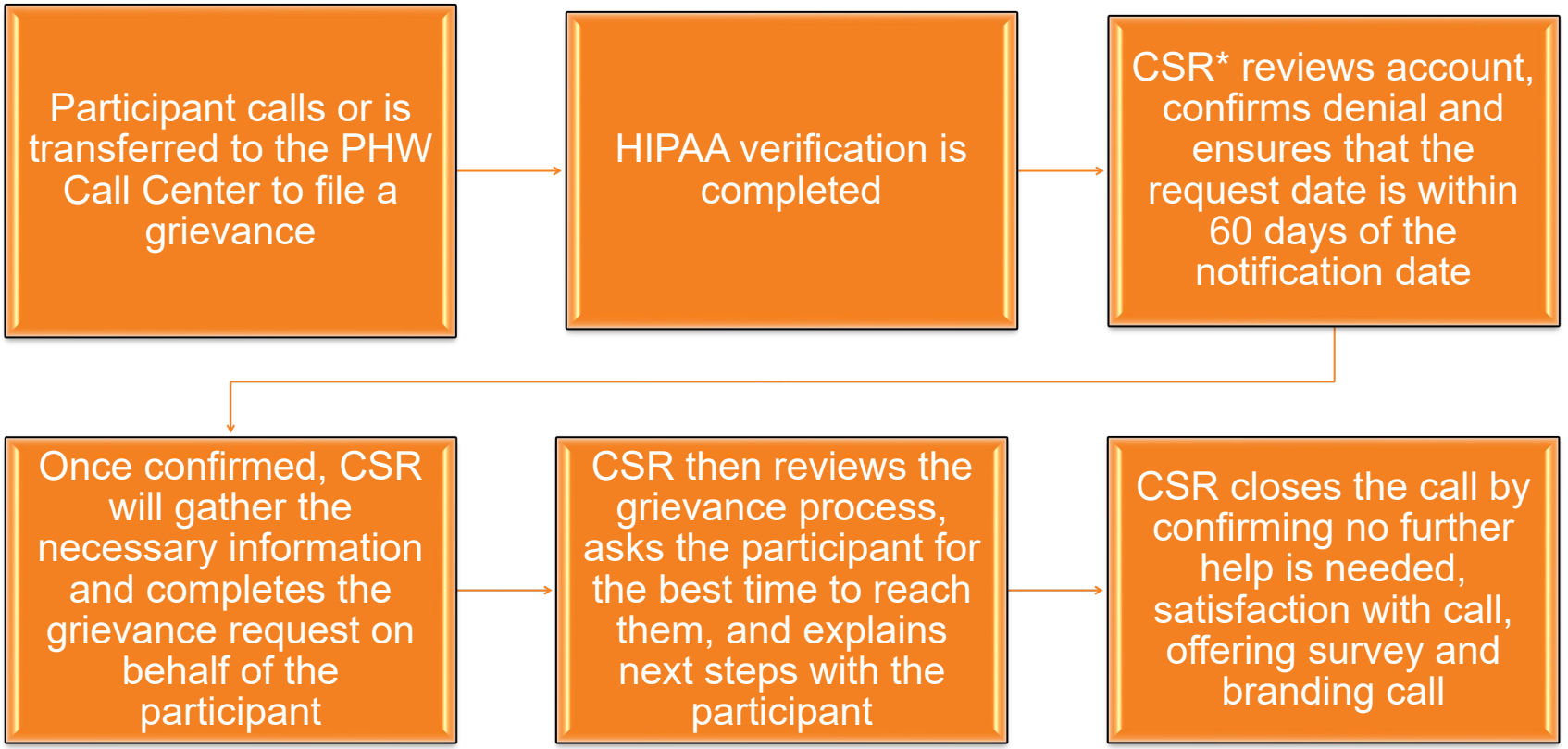
Top Participant Call Topics

Call Topic	% of Total
Benefits and Eligibility for a Member	39%
Pharmacy and Dental	16%
Order ID cards	11%

Top Provider Call Topics

Call Topic	% of Total
Benefits and Eligibility for a Provider	61%
Medical Claims Inquiry for a Provider	35%
View Authorization for a Provider	3%

Grievance Process (during the call)



*CSR = Customer Service Representative

Grievance Process (after the call)

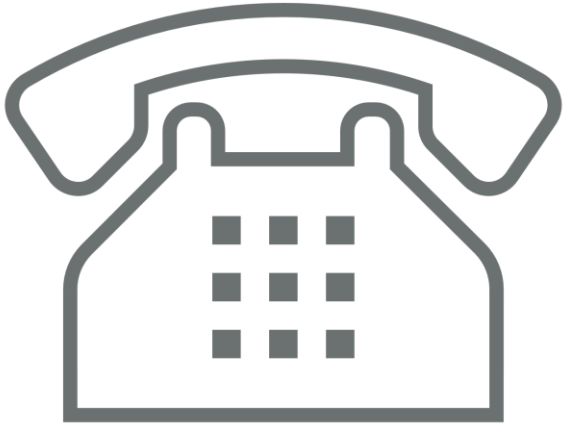
pa health & wellness

Participant will be sent an acknowledgement letter within 1 business day of a valid grievance being filed

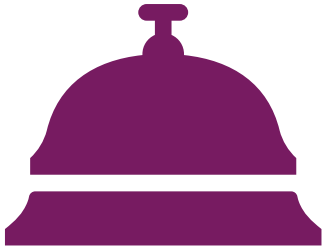
Participant will receive notice of scheduled date and time at least 10 days prior to the grievance hearing

Grievance hearing is held

Once the hearing is held, the participant will receive a decision letter with additional grievance rights within 30 days of the valid grievance being filed



UPMC Community HealthChoices



1-844-833-0523 (TTY: 711)

UPMC LIFE CHANGING MEDICINE

Health Care Concierge Team

The UPMC Community HealthChoices (UPMC CHC) Health Care Concierge team is available 24 hours a day, seven days a week, 365 days a year. We can help participants to:

- Find providers and schedule appointments
- Know what benefits UPMC CHC covers, including what medications are covered
- Understand how UPMC CHC and Medicare work together
- Obtain documents such as the Participant Handbook, Summary of Benefits and ID cards
- Connect with internal and external resources
- File complaints or grievances
- Verify eligibility and enrollment
- Navigate web applications

For dual eligible participants who have Medicare with UPMC Health Plan, we can also answer questions about your Medicare plan.

UPMC LIFE CHANGING MEDICINE

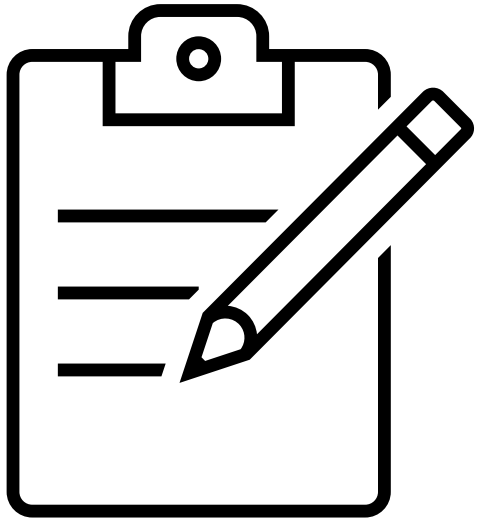
World Class Service

- Overall, the UPMC Health Care Concierge team receives 126,000 calls a month.
- About 12,000 calls are from participants and their representatives related to UPMC CHC.
- Concierges strive for World Class Service on each call, providing one-call resolution by outreaching on the participant's behalf and never leaving the participant with homework.
- We are always seeking to improve the services we provide and encourage all callers to complete the after-call survey to provide feedback.
- Year to date, UPMC CHC has received 28,470 Survey Results achieving 4.8/5 Agent Satisfaction, 98% Agent Helpfulness and 95% First Call Resolution.

UPMC LIFE CHANGING MEDICINE

Top Call Reasons

- **Benefit Inquiries:** Questions about what benefits are covered, how UPMC CHC and Medicare work together, how to obtain a prior authorization, etc.
- **Pharmacy Inquiries:** Questions about what medications are covered, how to obtain a prior authorization, assistance needed at the pharmacy, etc.
- **Provider Inquiries:** Questions about finding providers that are in-network, scheduling appointments, addressing provider confusion about UPMC CHC as secondary payer, etc.



Additional Service Options

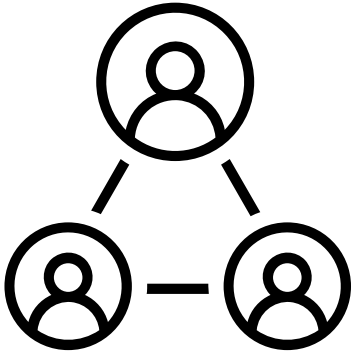
The Health Care Concierge team strives to always have one-call resolution. If an inquiry cannot be addressed by the team, we can seamlessly connect the call to additional resources for resolution. Some of these resources include:

Internal Resources:

- **One HUB Service Coordination Center**
- Care Management
- 24/7 UPMC Nurse Line
- Health Coaching

External Resources:

- Medicare plans
- Independent Enrollment Broker (IEB)
- Medical Assistance Transportation Program (MATP)
- County Assistance Offices



One HUB Service Coordination Center

The One Hub Service Coordination Center is focused on providing high touch, participant-centered customer service.

- One HUB takes calls from Nursing Facility Clinically Eligible (NFCE) and Nursing Facility Ineligible (NFI) participants, as well as caregivers, providers and community partners.
- One HUB receives more than 20,000 calls each month.
- One HUB is open Monday through Friday from 8:00am to 5:00pm, including holidays. After-hours calls on evenings and weekends are answered by the ***UPMC CHC Health Care Concierge team.***
- After-hours urgent needs related to Home and Community Based Services are ***transferred to an on-call Service Coordinator Supervisor.***

Top Call Reasons:

- Requests to speak with service coordinator/telephonic care manager
- Service authorization inquiries
- PPL related inquiries

UPMC LIFE CHANGING MEDICINE

Complaints and Grievances (C&G)

- ***Complaints*** include but are not limited to Claim Denials, Billing Issues, Benefit Limit Exceptions, Customer Service, Quality of Care and General Dissatisfaction.
- ***Grievances*** include medical necessity denials for both pre-service and post-service.

- Complaints and grievances can be filed by phone or in writing. The UPMC CHC Health Care Concierge team can assist participants to file by phone or provide guidance on how to file in writing.
- Service Coordination is always available and willing to support the process and connect participants and their representatives to the Concierge.
- When filing a complaint or grievance by phone, the Concierge will take a verbatim statement from the participant and read it back to ensure it was taken correctly. The Concierge will send the statement to the Complaints and Grievances Department for processing and also let the Department know if the participant would like to attend the hearing.

Complaints and Grievances (C&G)

When a Complaint or Grievance is filed, it is reviewed internally first. If the participant is not satisfied by the decision made internally, he/she can file additional Complaints or Grievances. Throughout the C&G process, the participant will receive letters to let them know that their complaint or grievance was received, when hearings will take place and what decisions are made.

This can be a long process, but the UPMC CHC Health Care Concierge team is here to help! We can be reached at any time to:

- Answer participant questions about the process
- Review the content of letters with the participant
- Explain to the participant what the next steps are at any point in the process