

- I wanted to provide a quick update on the CHC waiver renewal. It's an while since we provided an update. Some background, a little PL decide to submit the CHC waiver renewal in October 2019 for an effective date of January 1, 2020. We did this to align with the calendar year. To align with our koip time frame as well as the rate development time frame.

We did receive CMS approval for the koip waiver renewal. That renewal is effective January 1, 2020. We did send out a list serve email to all our stakeholders on information where to find the updated waiver. So that is located on our DHS health choices page. And to recap of changes included in the waiver, we revised the residential rehabilitation services definition. But modifying the number of hours as a day unit from a minimum of 12 hours to a minimum of 8 hours.

We also modified the qualifications for service coordinators and service coordinator supervisors. Another substantial change we made to the waiver is revising the service definition for all our employment services, which include job finding, job coaching, employment skills development, screer assessment, and benefits counseling.

We revised the service definitions to add language that addressed the closure of order of selection with OVR. And we added language to indicate that when OVR services are considered not to be available, if OVR has not made an eligibility determination within 120 days.

This language is also consistent with the office of developmental programs language that was added to their employment service definitions as well.

That's the update for the CHC waiver renewal. If you have questions, send those in using the chat function. And I will turn it back over to Kristin [inaudible] to give update on electronic visit verification.

>> SPEAKER: Thank you. A minder is the [inaudible] mandated the states implement EVZ for Medicaid services considered personal care services by January 1 of 2020 -- sorry, of 2019. And we have to implement EVV for home health services by January 1 of 2023. Providers made a significant amount of progress throughout the last fall and worked hard to implement EVV. Based on systematic issues we encountered, particularly with the EVVing a regator part of the system contracted with sand data and CNC. We were given an exception and that was granted around December.

And that allows to extend the timeline and we have a soft launch period for the first six months of 2020. We expect providers to use EVV. If they have not already as soon as possible use EVV for personal care services visits just as an additional reminder in office of long-term living programs, those personal care services exist of personal assistant services, [inaudible] licensed settings, and goods and supports.

Throughout the first quarter of 2020, so through March 31, all providers must complete system integration activity. This activity is specifically for providers of the chosen to have used their own system, either they are using they are choosing not to use the DH S system offered by the department and they are choosing not to use the HHS system [inaudible]

Those providers you must complete your system integration activities to send your EVV data to the MCO or the DHSing a regator by March 31, 2020. If you are not able to make that deadline, we ask you please submit an extension form to the RA box listed on the screen by February 1. It helps us know what difficulties you are having to better assist you no in completing the implementation process.

And we also want to track the date by which you think you can meet that environment. And as of July 1, 2020, for personal care services that are 134EU9ed to promise. This is through the fee for sfs system. If you are in CHC, you are submitting your claims to the MCO and they proceed with a similar process. And the service is submitted to promise will deny if they do not have an EVV visit that matches that claim. And as I said, MCOs will proceed with a similar process as of July 1, 2020.

With that, I think that concludes our topics for today. We do have our typical CHC resource page here in case you need any contact information or links to the different things we discussed today. And we'll wait a little bit for questions.

We did receive a couple questions. The first question is when do the mment C O receive payments for their participants? The MCOs are paid on a monthly cap daytive rate. They'll begin receiving payments for January. The month of January in February. So the cap daytive payments to the MCO for each participant is paid on a month delay. That will begin in February.

And then we have another question here, can we have a provider number to call PA health and wellness? I'll go back to our resource page here. If you go to health choices.PA.gov and go to koip and look at the provider seniorses, on that page is a document that lists all the contact information for all three of the MCOs. I

encourage you to go there to find the appropriate contact information for health and wellness.

With that, we'll hold for a few more questions.

We did receive another question. Is there a timeframe when the MCOs will send 1099s to providers? Assuming you are already active in CHC in south or southeast and you are requesting a 1099 for 2019, you have to reach out to the MCO on a timeframe when they plan to send those out.

Another question, what action should a nursing facility take when [off microphone] is overlapping. And typically there shouldn't be an overlap, so if you don't mind sending that information to us at the CHCRA account on the screen. Or I'll reach out to you directly.

We have an EVV question. When can providers expect to receive further guidelines on EVV? So in regards to additional compliance expectations or thresholds or anything, we'll be outlining additional policies in a bulletin. It will be a joint bulletin between the LOL LOL and office or developmental programs. That's still being finalized but will be released here in the following months.

We received an additional EVV question and I'll we'll need more clarification on this. The question was in regards to when using thing a regator, can it be backdated to January 1? So if you are referring to when you complete integration with your EVV system and begin sending data to thing a regator, you absolutely can send data back to January 1. That would be extremely helpful for us to have more data to ionize. If you have data starting January 1 for EVV visits and you become active with thing a regator on January 29, you are more than welcome to send that information retro actively back to January 1. If that's not what you meant about that question, if you can send me additional clarification, that would be great.

We received a question regarding where exactly the information for the 1915 they have C waiver can be found on the website. On the screen right now, there is a website, the Community HealthChoices website and it's w wrks w.health choices.pa.gov. Go to that website and click on supporting documents, you'll be able to find the approved 1915-C waiver that's effective January 1, 2020.

We have two questions here regarding eligibility and the use of HAA exchange. The first question is is everything in CHC expleated in HAA exchange, including forms, et cetera. You have to work for the MCO on their expectation for what system you

are using for which processes. For critical incidents, you do need to use the EIM system through department of human services it's the same system for fees for services.

And MC have different ebbing peck peckation for different systems based on the process and you have to follow up individually

And can we check a resident eligibility in promise? Or do we have to use the MCO system? Promise is the source of truth for a participant's eligibility. You'll also want to use promise or EVS for that process. But if it is not lining up with the eligibility information in the [off microphone] system you want to make sure you work out those variations with the MCO.

We had another question here, how does that affect answer little rare providers that do not provide home care? If you are referring to the EVV implementation, the [off microphone] equipment providers do not need to implement EVV if they are not also providing a home care services like personal assistant services.

I do have a question here regarding difficulties participant is experiencing with their provider through public partnership and the EVV system. And I'll reach out to you directly to try and troubleshoot that solution.

This question here, should our agency pay our caregivers according to HAA's time? HAA is rounding the time is caregiver is clocking in and out. The use of EVV for being and visit verification is separate from your responsibility to pay your worker for the time they have worked. You'll need to establish a process to make sure your workers are paid for the time they worked. Outside the adjustments made in HAA exchange.

Another EVV question. If a caregiver forgets to clock in or out through EVV and the program confirms the time manually, is that appropriate? Or how should they confirm clocking in or out manually?

This happens frequently especially when you're workers are getting used to the EVV system. You want establish a agency policy what you need to do. We are not dictating what you need to do to establish that. But you have to establish a documentation process whenever you have to manually correct or enter a visit. We are leaving that up to the agencies because everyone's EVV system operates differently. Everyone's business practice is a little different. And that's up to you and how it best fits in your business process with what you want to development.

With that, we'll wait for a few more questions.

Another question regarding EVV visits. If there are visits completed that do not have a matching esm.have V visit, will providers be be paid? For example, if there's a technical issue and caregivers cannot clock in, is there a number of exceptions? In this scenario, you want to develop a process whenever this happens to manually enter that visit as soon as HAA exchange becomes available. It will be expected that there is a visit matching that claim. But if there is a circumstance where it can not be concerned in live time, you can go back and manually enter it whenever you regain access to the system or you regain access to a device.

We do have a couple scenarios here in regard to issues with providers rendering services but it not being appropriately reflected with the MCO and whether or not providers will be paid. So those types of scenarios, you have to work with the MCO to resolve these discrepancy. A prompt verification system is the source of truth for eligibility before you render services. So you should check that before you render services to the participant. But if you are having discrepancies with timing in a given month or any time of discrepancy with the eligibility verification system, you need to work with the MC ovums to make sure that's resolved with their system.

We received another question regarding EVV, can [inaudible] being used if it's used on the client's cell phone? Telephony (sounds like) typically operates through a land line phone because it does not collect any sort of location information. And location is a requirement for EVV in the 21st [inaudible] act. If you are going to use telephony, you'll either need to use a fixed -- some type of a fixed telephone service or a land line phone, so a fixed voip service, for instance. Or a land line telephone. If you are going to use a cell phone, you'll also have to have a fixed verification device accompanying that to capture the location. These are not offered with all EVV systems. But we are aware there are EVV systems in Pennsylvania that offer a fixed verification device to use it with a cell phone. And that device generates a code that establishes that that clock? Associated with a fixed location at that time.

Another question here. Are providers required to bill through HAA exchange if they are not currently ready for EVV info? Regardless of your status with EVV implementation, you still need to follow the managed care organization billing process. And most of the managed care organizations do expect you to bill through H.a A exchange. I know sometimes there are some exexceptions to that depend option the systems you opted to use. But you need to follow their processes for billing regardless of your E.have V implementation status.

When did OLTL [off microphone] final CHC agreement? That's pending. So we'll be able to give you a better date in the near future on when that's going to get posted.

We have another one here. If we do not have an authorization from an MCO, even though they have a current service authorization form from when the participant was in fee for service in 2019, how long are they expected to provide services without that authorization? We are in the continuity of care period.

If there are any issues right now receiving the appropriate authorizations from the MCOs, you should continue to provide the same level of services on that authorization form. While also working with a managed care organization to make sure those issues are resolved.

For phase 3 participants.

Who should we contact if there's an issue with authorizations from the MCOs entered into HAA exchange in we are receiving conflicting information from the MCO and HAA telling us to contact the other person. It seems the information is added but the provider cannot see updates in HAA exchange on our side.

The MCO should be the one to resolve that because HAA exchange is their subcontractor. That being said, I do want to point out on the slide that is on the screen right now, there are a couple of ways for you to contact the office of long-term living if you cannot resolve your issues with HAA exchange. Specifically for providers, you can contact us through the OLTL provider line. Or you can send your issue through the RA box via email. And that's RA [see screen for address]

The MCO is the one if you are having difficulty with the HAA exchange, they should be the one you are contacting and if you are not getting your issue resolved, please contact OLTL.

Do the MCOs have different codes for the same codes to register in EVV? MCO did not include plans of care yet in HAA exchange, what codes do we use? Because all EVV systems work differently. I can't speak specifically to how the managed care system set up the system and what codes they are using if different services. And you need to reach out to the MCO and speak to them what the expectation after the informs you are entering when you use EVV. MCO and HAA exchange have quite a few different trainings for you to learn about the systems. And reach out to them to access those trainings. And receive clarification.

Do MCOs have direct 1-800 numbers for communication? You will contact the MCO through their customer service line. And they then will transfer to the appropriate SC to resolve your issue.

Another question we received is, what's the difference between long-term care goals and home and community based duals in the chaptered we presented earlier?

So long-term care biles or non-duals in for that matter are people who reside in the nursing facility.

Duals are eligible for Medicare and Medicaid and [inaudible] and services -based duals are enrolled in our waiver program and eligible for Medicare and Medicaid.

For those participants affect bid the data upload issue MRX codes and eligibility dropped in EVV access to result [off microphone] OLTL authorize payment for services provide while the eligibility issue is straightened out. If you can please send us those individual cases, we are handling any type of eligible anomalies on a case-by-case basis. If you can make sure we have those specific cases to ensure they get resolved, that's how we're handling them one at a time.

We received a question, whether providers should still access the DHS bulletin board system? Since all providers in Community HealthChoices are all still MA or medical assistants-enrolled providers, you should still maintain access to the bulletin board system to be aware of any changes or information as a MA provider.

That includes quick tips and any upcoming MA bulletins that come out and get distributed and that thing. But for being for a CHC participant, you'll be communicationed cod specifically with the CMOs and you need to be aware of any requirements by that MCO and the provider agreement with you signed with them.

Next question. Are you aware that [inaudible] is enrolling residents in the southwest to keep them instead of Ameri health and this is causing billing issues?

We know there's some issues causing periodic issues in the planned code. If you are having those issues, send those to us but we are resolving them on a case-by-case basis.

We received a question we need more clay for case on. What's the resolution timeline for MCOs and who do we contact if it's not been resolved for several months? To better answer you question, we need to understand, are you referring

to [inaudible] resolution, other types of provider dispute resolutions? We need a little bit more detail in order to answer that question. So if you could please submit that.

How do MCOs pay [inaudible] days for submitted -- for days submitted to PA nursing facility assessment on a quarterly basis like payments for Medicaid day one, et cetera. So any questions regarding billing will need to go to the individual MCO. And if you're not able to resolve your issue, then you can submit either to our provider line or to our RA email box.

Additional question, discharge days -- discharge dates listed in the exchange prevent claims from being released to MCOs. Who is the best person to be contacted to remove discharge dates listed in the exchange? If it's related to HAA exchange and you contacted them and you can't get your issue resolved, please go to the individual MCO.

To get the issue resolved. If you are not able to get resolution at that point, please come to OLTL as the provider line or through our RA box.

Someone asked a question about the exception form for providers if they need additional time integrating their EVV system with the egg regulator or the EVV exchange. And that form is on the EVV website and search for EVV, you'll find that website and the link for the actual form is titled E-have VGFE provider request.

This is a good [inaudible] exception provider request.

Where do we submit over 180 day claims when we receive a PA162 form? And the resident has not yet selected a CHC map? There's a couple questions that I have back on that. If the participant is not eligible for CHC is still covered by pay for service, then you are going to be submitting that to our OLTL provider operations. As you would in the past. If they are you would use EVS, then to determine if they are CHC or are assigned to a plan. Go by the date of service. If that 180 days is during the fee for service eligibility period, then you need to send that to us at OLTL. If you have further questions on that, you can contact us through the OLTL provider line.

Or you can send it through the RA box. And it will get to the OLTL provider line.

Another question on claims here. This provider is providing clarification on the previous question. Do we have to send claims through HAA exchange for payment? Or can we only use HAA exchange to send visit data for EVV and continue to

submit claims via a clearinghouse? Once again, any type of billing process or questions related to being you have, you need to speak to each of the MC os as they all have their own billing and expectation and requirements.

Which direction can be provided with retroterminations for eligibility? We would need to see those specific cases. If you could send that directly to us. Or we can follow up directly with you. You can also email that question with details to the RA box PACHC at.pa.gov.

How do providers get electronic payments from each MCO? So again, you would need to work with each individual MCO to set up your 835 transactions. So specifically work with each provider area in each one of the MC ovums to get that set up for you.

Where and when will a provider see an actual written plan of care? Prior listed daily activities to be completed to each visit. We are aware HAA exchange is structured a bit differently under the fee for service system. So those type of details for service provision, we want to work with the service coordinator to make sure you understand any questions related to this type, [off microphone] frequency or duration of the services.

How long from the date we bill do the MC ouch Os to to pay the claim before we process it. Directly from our CHC agreement, there are timeliness standards. Each one of our MC ovums must adjudicate provider claims consistent with requirements we laid out in that gree. Adjudication timeliness standards claim 90% of claims must be adjudicated within 30 days of receipt. And 100% of claims must bed a Jude dated within 45 days of receipt.

That means 100% of all claims must b adjudicated within 90 days of receipt. If you are having difficulties with a particular MCO and you are not able to resolve it, you can submit to our provider hotline. But there are timeliness standards for adjudication of clean claims. I say clean claimst because there's there's additional information required or there's maybe third party information that needs to be submitted, then that can take longer for a claim to adjudicate. But in general, 90% of claims must be paid within 30 days. 100% must be within 45.

There's a request for the link to the DHAEV Vice President website. Go to DHS.pa.gov. And backslash providers. Backslash billing. Hyphen info. Backslash pages. Backslash EVV. I know that's a long link to read but if you also go to DHS.pa.gov, you can use the search function and search for EVV or electronic [inaudible] verification to get to the same link.

Should we be concerned if a client comes up in EVF as not having waiver services yet they were with an MCO prior to January? We would like to see that specific case to be able to answer that question correctly. I mean, it's entirely possible that an individual was with a managed care organization under the heel programs and transitioned to the program in January if they were a phase 3 participant in one of those three zones of the state. If you could send us that specific case information, and we can research it for you.

A question on EVR? What's the purpose on EVV if claims can be submitted to MC ovums directly? EVV is separate from claims. It is a technology used to support claims. Increased program irregularity and claims processing. So we have been required by the 21st century act, which is a federal mandate to implement electronic visit verification. And this data must be collected for all services previously mentioned. Not only do you have to submit your claims as standard process. But you'll also have to use electronic visit verification in order to provide additional documentation to support those claims.

Is it possible for all -- sorry, is it possible to submit all resident [off microphone] nursing facility to the eligibility verification system in promise as a batch? And yes, it is. We absolutely encourage you to submit batch files to the EVVF system. It will greatly increase the efficiency for your office process. Go to heel.pa.gov and look at the provides errors under CHC faction, there's an extensive fact sheet. I think it's close to 20 pages at this point about the eligibility verification system and the different way you can use it.

We'll hold on for a few more minutes for any additional questions.

So in regards to difficulties in participants being reflected appropriately in HAA exchange, this individual said they did send an email to the RA box we have on the screen, if you have done that, that email is passed on to the appropriate MCO to assist in resolving that as well as the LOL LOL who works with that MCO. And you should be seeing resolution on that here shortly.

Another question regarding a participant's service plan. Do we communicate with the service coordinator or the the client had certain level of service provide or the January 1, 2020, or do MCO have service coordinators provided to the client? They do. And for the most part unless a service coordinator chose to no longer participant in CHC or the participant switched their coordinator it's most likely the same service coordinator they had before CHC.

And MCOs all receive files with the past service plan so they had all that information reflected.? Had the history of that participant in their level of service. If it's not being reflected, though, you want to work with the MCO to identify who their service coordinator is to assist in this process and make sure those discrepancies are resolved.

We received the question whether the questions and answered are shared after the webinar, we'll reach out directly to individuals who have case-by-case questions or we will respond to them if they submit the detailed questions to our resource account. But the webinar itself is recorded and shared online as well as the transcript. So if you want to look back and re-listen to anything discussed today, the link for those will be posted to the Community HealthChoices website in the near future.

For -- there's a question here regarding eligibility. So the eligibility system to submit a batch file, you'll want to go to the eligibility verification system. And there should be instructions there on how to complete that batch process.

And you will find information on all of the EVF methods, including the batch on our handout that Kristin referenced before. So under on our Community HealthChoices website, we have the fact sheets there. One of them is entitled eligibility verification system and membership cards. And like Kristin stated. It's in excess of 20 pages with detailed responses, EVF response examples based on different case scenarios. M so you'll be able to find at the top of that document information on how to establish a batch connectivity.

Okay. Seeing we have no additional questions, we want to thank everyone for all of your participation, thank you very much for the questions you submitted today. And we will look forward to having future discussions next month at our next third Thursday webinar.

Good afternoon, everyone.

[end of webinar]