- OLTL Third Thursday Webinar
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- April 19, 2018

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>> SPEAKER: Good afternoon third Thursday webinar.

This CHC update overview.

Just to go over a couple of things, with the functionality here if you want to submit a question you click on the right side of your screen, type your message click send and your question will come to us we'll address it at the end of the presentation. So our 2018 CHC goals for the CHC southwest launch was assuring no participant service interruptions occurred.

Assuring no interruption in provider payment and successful launch of first phase. So um at this point we are coming to the end of month four for the southwest implementation and we've had a very successful launch for the southeast implementation, we are looking at focusing on comprehensive participant communication robust readiness review just as we did for the southwest applying those lessons learned. Provider communication and training and ensuring that it is earlier and more often.

Pre-transition and plan selection for the southeast participants

will occur sooner and they will be additional participant communication and outreach. Incorporation of the southwest implementation and launch lessons learned which we'll touch on in a few minutes. So our southwest population distribution we have reviewed this in past presentations.

73 percent of our population is nursing facility and eligible dual eligible folks.

And with 10 percent being home and community based service duals and 13 percent long-term care duals.

The distribution plan distribution based on selection and enrollment with the 3 MCOs indicated for the southwest that UPMC maintained 54 percent of the population and PHW, Pennsylvania Health & Wellness had 27 percent and AmeriHealth Caritas has 19 percent.

So areas of our current focus we're still wrapping up on some HHA exchange and data integrity issues.

In our past, third Thursday webinars we have discussed some data integrity issues that began with some of the extracts from our service plan information here at DHS that was passed to the MCOs and then passed to their vendor HHA exchange that they used for their authorization process. So we have been very closely monitoring that working with the MCOs and the HHA exchange and the stakeholders are AAAs, service coordinator entities letting us know of any authorizations that they may not be able to see in HHA exchange and then Randy and his team

have been really focused on getting the MCOs to ensure that all of the data is complete and accurate.

At this point, I think we're down to only a couple of cases for resolution so if anyone has any remaining cases please get them submitted to us we'll make sure that they get rectified.

We're also focusing on Medicare and Medicaid participant and provider education.

In the past we've touched on instances where during the open enrollment for Medicare it coincided with our roll out of community HealthChoices. That will occur again for the southeast implementation.

So we have been working with CMS. They have put together a fact sheet for physical health providers and PCPs that are enrolled with Medicare so they understand that CHC is not a Medicare product. And um they are, they're going to assist us in making sure that providers stay informed of what community HealthChoices is.

Our person centered service planning process the MCOs are responsible for developing that person centered plan.

And we're currently working with our stakeholders and consumer advocates in developing a monitoring plan for that.

Each one of the MCOs has policies and procedures related to this and that will be included in our DHS CHC MCO monitoring plan as we move forward. We are reviewing changes in person centered service plans and we do have operations reports that are collected by, from the

MCOs.

That is to ensure that, that the changes are appropriate for our MCO agreements.

Transportation there's been a lot of focus on transportation. We actually did hold a summit that we discussed at our previous third Thursday webinar with all stakeholders and we plan on having a dedicated transportation summit in September in the southeast that will include the MCOs, the MCO transportation brokers and transportation providers. Complaint and grievance processes and notices for home and community based services as folks may be aware there was a Federal guideline that changed the complaint and grievance process we have been focused onen suring that participants understand the process we've had numerous public presentations by our office of legal counsel and we are, ensuring that information is included in participant handbooks available to our consumer advocates and ensuring that we have that information out on our public web site for any participants needing information on that process. The continuity of care period for the southwest will be ending for home and community based long-term services and supports services June 30th.

I think as we discussed in previous sessions our continuity of care period for physical health services mirrored the HealthChoices program of 60 days for physical health services but also for home and community based services, we had an extended continuity of care period so as we

are moving towards the end of this period, managed care organizations are doing outreach to providers and have been ensuring that any changes to provider networks related to continuity of care will be properly communicated and um, folks will be, they will be working with the participants to ensure there's no interruption in service.

So our lessons learned for the south for the southeast implementation we know that we needed to communicate earlier and more frequently. There were certain items that we didn't pay as much attention to, one would be transportation and another NHT services. We wanted to make sure that providers were trained earlier so we're applying that to the southeast. And um, just as with the southwest as we get through our first month of southeast implementation we'll be doing that same exercise and applying that to the implementation for the rest of the State. So any lessons learned from this southeast, will also account for in any communication or policies in the future.

So southeast implementation we touched on so far our southwest lessons learned. We needed earlier stakeholder engagement opportunities. We needed earlier inperson provider communicate sessions which we are doing in June in the southeast.

We are enhancing our communication materials regarding the Medicare and CHC.

We have created and continue to create more education and communication on continuity of care. We have actually created

additional reports on enrollment and plan transfer scenarios to ensure that we've accurately identified any of those eligibility anomalies that we encountered at the onset of the southwest implementation.

We also have started our OBRA reassessments earlier. Those are currently under way. And we have a due date in May, of course if any one is having difficulty completing them please communicate that to the department and we'll work with you. More communication on the LIFE program as an enrollment alternative. There is more information during the implementation as well as the end of continuity of care for LIFE participants and those folks that may be eligible for the LIFE program, that will be going out to make sure that folks that are eligible for either CHC or LIFE have all of the information that they need to decide which program works best for them.

We are also talking about earlier data clean up in HCSIS and SAMS systems. We did I think under estimate the amount of data clean up that we needed to -- that needed to occur specifically in our SAMS system, so we are actually working on that now. I had an opportunity to speak to folks this morning that work with SAMS and did make sure that they knew that they would be seeing communication blasts shortly from the department about clean up of data elements in SAMS for the service plans. The idea is we want to make sure that our data is as true and accurate and complete as possible. When we send the extracts to the MCOs that just makes sure that the participants complete

service plan information gets transferred appropriately so we don't impact our participants.

We're -- we are going to have an earlier pre-transition period so folks will be able to review and make their selections sooner.

There is actually more provider information on our independent enrollment broker web site now. At the onset of the southwest we didn't have MCO network provider network information out there it is now out there, so that will really benefit our southeast participants when they are trying to make their MCO selections.

And of course, we are expanding our provider training on Medicare versus CHC I did touch on that. Medicare is actually assisting us with that with the creation of their fact sheet.

So for the southeast implementation we're focusing on those OBRA assessments. Those notifications have been sent to the participants and the assessments are under way. Participant communications planning,

um, we had received feedback from some of our participants I believe actually originated under our -- the participant driven model one of our participants suggested having an online participant training session just like we have for our providers. In essence they wanted to be able to watch it online, learn more about CHC and watch it with their direct care worker.

So we're currently in the process of developing that. And clearly, working with our sub-MAAC and our consumer advocates to ensure that we

have touched on everything that folks think we need to include so everybody is understanding about CHC and what they need to do.

The initial touch point flier will be mailed in mid July and I touched on our provider outreach and education. The southeast kick off communication was sent. The beginning of April it was sent.

Randy's group has had their southeast implementation kick off, with the managed care organizations and our internal program offices. And our provider events are scheduled for June, June 4th through the eighth in Philadelphia those will occur at Temple. The other sessions June 18 through 21 we're still finalizing our locations. As soon as those locations are final you will see a communication through the Listserv and a link to registration for those sessions.

Just like our southwest implementation these sessions will include a morning session that goes over overview information of community HealthChoices but the break out sessions in the afternoon will then be dedicated to the different provider types so um they will be a session for hospital a associations and and hospitals and their association and physical health providers. They will be one for the behavioral health providers. One for the service coordinators and AAAs.

One for nursing facilities and one for home and community based providers. Each one of those sessions will also include some additional information about transportation and we recognize that we needed to add a little bit more education about the transportation

benefits and how they will be managed through this CHC program.

The population identification so we're in the process of running and rerunning the numbers and statistics on the demographics for the southeast population.

And as you can see this number is a little bit, quite a bit bigger than the southwest we had about 79,000 for southwest. And for the southeast we're looking at approximately 130,000. Again good number of these folks are nursing facility ineligible duals and, then we have a good population that are home and community based duals.

By county your break down is -- we have a large number in Philadelphia County. And I want to stop there just a minute to touch on something that we don't have included in the slide and that is in the southwest we had a greater penetration of managed care model for Medicare so we had folks that were kind of familiar with that Medicare model because they used a MED advantage plan or DSNP plan for their Medicare benefits.

In the southeast, we have much less of that. We have a good number of folks using the traditional fee for service model for their Medicare benefits.

So we just need to keep that in mind as we move forward in educating people how -- how the delivery will occur and any differences that they might have. And it also adds to the complexity of coordinating with their PCPs under Medicare. So that's where we're greatly appreciative

to CMS and assisting us in educating the Medicare providers. So for communications we have just a reminder to folks we have ongoing public communication through our MLTSS sub-MAAC the consumer sub-MAAC the LTSS sub-MAAC the big MAAC.

[Laughter]

I thought that was -- fun. Third Thursday webinars of course.

And we continue to receive data from our stakeholders. We, from the MCO participant advisory committees, which are under development right now. Local individualsry groups, again the sub-MAAC, the third Thursday webinars, CHC web site. We are continuing to review data collected how things are going, and any issues that we may need to address or improve communications on the go forward.

So some resources for you.

Here's your CHC MCO contact information. AmeriHealth Caritas, Pennsylvania Health & Wellness, UPMC community HealthChoices I will take this moment to to illustrate that in the southeast, AmeriHealth Caritas is using their keystone first name. So that is just something that we're going can to be -- you'll see included AmeriHealth Caritas/keystone. So that you'll understand that is one in the same but that's their business name in the southeast.

Resource information we have our CHC Listserv if you're not signed up to receive our regular communications this link will take you to a place where you can enter your email address and sign up for that.

The community HealthChoices web site is listed here. That is where you'll find all of those fact sheets that I talked about the provider narrated sessions. We also have our community HealthChoices MCO agreement posted out there. So if you are interested in seeing the a agreement between DHS and the MCOs and the requirements of the MCOs you may want to check the agreement out.

The MLTSS sub-MAAC web site is listed here you'll have access to previous meeting minutes and presentations at this site. You can email comments or questions to us through the RA box.

RA-PWCHC@pa.gov.

We our provider line is listed here, participant line and independent enrollment broker.

So now onto the questions.

>> SPEAKER: This is Randy before I go do the questions, couple things we said earlier about the launch in itself, was being successful yes we consider it successful. There have been issues concerns that have come up we have handled and worked through with the MCOs or with PPL or HHA to resolve. There have been no more issues that came up we only moved into the CHC we're not dealing with on a fee for service side. They just kind of, have come up and seem to have a little bit more life to them because we're moving through CHC it's more of a public profile program. Far as addressing the issues helping

to make it success I want to thank the participants an their families but certainly all the providers the advocates out there, the different associations that helped out with us that have been involved with all of the meetings provided us questions suggestions what to do. This is a success not just from the department but everyone involved with the program.

I want to say that thank you for that.

And if up any questions I have some here I'll go over send them in.

Other thing I would like to say to you, we seem to be going over some of the last stuff the last couple third Thursdays if you have suggestions for other presentations that you would like to see or other programs that you would like to talk to us on a third Thursday, go ahead send those suggestions also and we'll work them in.

All right question wise, couple of these questions I already send out emails once I'm back online they will come out to you, question home mod provided not yet been paid by two of the MCOs how do we resolve this situation? I did send you an email asking you for specifics on cases.

So once you send those to me I'll be able to work with the MCOs get your responses back.

What about the people that are not duals. Chart only addressed duals. Our dual population, non-dual population is about 6 percent of our over all population.

In the southeast population we have HCBS dual population, HCBS

non-dual population, same with long-term care. And the southwest, um, we have listed 3 percent of the HCBS population is non-duals. And about 1 percent of the long-term care population is non-duals. So it comes out to about 4 percent on these charts. Our estimate at about 6 percent of our over all population in the state are non-duals. So that's kind of how that population fits in.

In December we were told information was coming to contact MAXIMUS we filed a paper MA application when will that information be provided? I will go back and check with Jeanie Parisi who overseas the MAXIMUS contract see if that information has been provided and if it's been done we'll make sure we get it out on the web site. Also one will aging well begin completing the options process, I'm assuming options process you are talking about the level of care determination. The level of care we're working with aging well right now to -- to start the implementation of that.

I know that in July, we'll be starting to of the use of the new tool which will be the FED tool, to determine whether a person FCE or versus NFI, but as far as full process we are working through the processes right now with aging well, to put that stuff in into place.

And we'll keep you updated, I'll have an update on that whole process with aging well at the next third Thursday, hopefully we're through that process we will be able to do that.

All right we still updated issues missing participants and extra

participants and participants with incorrect information I did send an email out -- um, in regards to that. Asking you to provide me some more information.

I'm assuming you're meaning missing participants in HHA if you send me information who it is, I will make sure that it gets corrected.

How are participants authorizing exchange of personal data?

Um, it would be the same way as it was in the fee for service program, they would have to sign medical releases. They sign off on their care plan. They you know, would be the ones the participant is the one who a approves all exchange of information if it's information going from one MCO to another, they would sign off on that.

So it's all participant driven.

Have the MCOs ensuring all needs being met it's part of the person centered planning process it's the responsibility for the service coordination to ensure that participants are get everything that they need in their care plans all services are being delivered. It's responsibility of the MCOs to monitor all that. Participant attend the transportation summit that would probably be a little bit difficult because it was actually held on March 26th basically what we did that the summit we had, all 3 MCOs there, we had, CTS who the transportation broker for UPMC. We have MTMs the transportation broker for AmeriHealth and Pennsylvania Health & Wellness. We had staff from the medical assistance transportation program there, we have staff from

the offices of income maintenance there. We had advocates there from Pennsylvania health health law project and we had some provider transportation provider companies also there.

We talked to a lot of things in that meeting we are in the process of trying correct a lot of the issues that came up with transportation.

Which leads into the next question almost four months in we're still having transportation issues with MTM, um, the seem to understand the nursing home residents we are four months into the CHC we realize there's some transportation issues. But you have to, also realize that, apparently transportation is been an issue for years. Under the fee for service program and we're trying to make corrections to that, this is a new service that is being provided through the MCOs for the nursing facilities it is a major change for those entities. How I'm addressing that is I met with CTS about a week ago. Walked through some of the issues and some of the concerns that I have on the nursing facility side.

I will be reaching out to MTM, today. Um, to also discuss that with them. My next step is I'm going to have two meetings one with CTSUPMC and nursing facility associations and another meeting with MTM, AmeriHealth Pennsylvania Health & Wellness and the nurse facility associations we'll have those meetings and imgoing to require that both of the brokers do a webinar for nursing facilities in the southwest and then, we will follow the same process in the southeast as

we're going through that implementation we'll have that webinar with the southeast providers also. So we're trying to address those issues in that manner.

Many SCs are having billing issues what's what's been done to address it, my first thing is have they contacted the MCOs to discuss the billing issues? If they have, not gotten resolution, um, they can certainly come through the department.

Call in the participant hot line or send me an email and I will work with the MCOs to ensure that we get these, these SCs paid. It could be an issue with the authorization showing up in HHA. So we will certainly work through that and make sure they're paid.

So I mean issue like that, if they have already gondola the MCO not got resolution you can certainly send them to me.

I will give you my email address. So if everybody is ready we'll write this down it is rnolen@pa.gov.

So it is rnol an@p ap.gov let me know the issues. Many people do not have access to the internet. We do realize that, that's why a lot of our material goes out -- all of the materials go through mailings we do a lot of the education in person. We work with the providers in person so they have the information. Um, the internet, is certainly one of the options for people to get information but not the only option.

Will the agenda and locations for the provider events be listed on the web site can you register for them? The answer is yes the augend

canned locations will be on the web site, can you register through that, yes.

We'll be sending more registration information out, we are finalizing the contracts with the venues, once they're finalized we will get the registration information out, hopefully within the next ten days.

You stated the pre-transition period will be earlier in the southeast and southwest, what are the proposed dates for the pre-transition period.

Do you know the dates? Those dates for the pre-transition period, do you know when we letter is going out?

>> SPEAKER: I have a tentative, go to the next question.

>> SPEAKER: We'll come back and answer that in a second.

Is there a time line for the decision on the IEB? Um, I'm not sure exactly what you're asking. If you're asking, in regards to the new RFP, and the announcement of who the new IEB was, there is no time line, and there's still a, number of internal discussions going on in regards to the process.

>> SPEAKER: So pre-transition notices should begin probably about the third week of August.

And they will be running in phases just as they did for the southwest.

So um, so they will be multiple rounds of pre-transition notices beginning the end of August.

>> SPEAKER: Other thing we're doing with time line with the southwest we allowed participants to change their MCO enrollment all the way up until December 29th. With the guarantee they would be in that MCO on January 1st. Um, that caused a lot of issues in regards to making sure that we got authorizations in the system and that the care plans were getting to the appropriate MCOs. And it caused a lot of potential issues the first couple of weeks in January.

For the southeast implementation, we're going to have that cut off period for the ability to transition from one MCO to another is going to be December 20th or 21st, and around that time. So that we can ensure that we're able to move the information appropriately around and to ensure that there's, there's -- a little bit more smoother transition as of January 1, occurs.

Individuals will continue to have the opportunity to change their MCO at any time but as far as the initial start up we're changing the date, making it about a week earlier than we did last year. All right any updates on behavioral health services being covered for individuals? Behavioralth services is part of the package for individuals we are working on trying to open up those services this is a new service for individuals who are either in a nursing facility or who are on aging

waiver which is a large amount of our population.

We are meeting on may ninth with the behavioral health CHC MCOs and nursing home association touses Did you say discuss behavioral health services and how to access them and getting through the system to get those provided we'll be looking at ways to ensure the services are, are more prevalent and, for home and community based individuals the hope is that once the MCOs start the next assessment process, for individuals that they identify those services and we're able to get them LinkedIn those services a lot quicker than what we have.

And we are working towards ensuring those services please explain what providers should be doing EVS shows an participant is inactive.

Designation is because the consumer forgot to hand in the recertification paperwork.

CAO tells the case managers that they will back date with no lapse in coverage once the paperwork is in.

Yes you're supposed to check eligibility all the time this is an ongoing issue with recertification one of the thing we've are holding the MCOs to do is assist recertification of individuals to try to avoid any of this lapse in getting the paperwork in and messing up the continuity of enrollment for the individual.

So we are working towards that if you find a participant you look up in ABS they're listed as inactive your best bet is to provide the

provider hot line we'll work through the case see if we can correct that.

You can have the participant contact the CAL, to make sure they get the information, to them. They -- the participants are responsible for making sure they submit their paperwork for redetermination.

I mean there's issues with that usually sometimes mistakes made by the CAO on the dating of stuff.

We will certainly work through that on the individual cases. But, the biggest push is to make sure that the participants and their family get the information back to the CAOs.

What is the difference between CC and LIFE program, what is the LIFE program and how is it funded. Real quick, difference between CHC is a mandatory Medicaid managed care program, that the State is implemented for our population.

The LIFE program and CHC eventually will be statewide. Managed care mandatory manage care go participants the LIFE program is another optional managed care program for participants if you look at the nationally it's known as the PACE program.

In Pennsylvania it's the LIFE program, living independence for the elderly. You can look up their web site. They have multiple sites across the State they are not involved in every county. But part of the similarities between them is the providing all services for participants the LIFE program is a more integrated program that provides all services it is more centered around an enclosed network, centers around an LIFE center with adult day care services

clinical services most of the participants are seeing the physician at the LIFE center getting their service trouse the LIFE center in CHC they have a little bit proper discretion who their providers are more choice of their providers.

But both of them provide, a managed care platform that provides for services for all individuals all required services for individuals. They're just two managed care options that are available.

Funding for the LIFE program, they're actually receiving managed care funds. Both from the State and also from CMS. So they're funded through both current programs similar to community HealthChoices is.

So there is funding in the LIFE program shall they get a capitation fee from the feds and from the State.

Regarding NPI numbers on invoices pertain to W1793 services through type 59 providers I see where home health aides are required to prefer to the MPI, but pass workers provide nonmedical health-care services not home health aid services.

>> SPEAKER: Can you give that to Jill to read over.

Um.

>> SPEAKER: So past services are provided by an atypical what we refer to as a typical provider.

So not -- atypical providers are not required to have an NPI number.

And it is, if we need to if you have some particular examples we can have our provider operations area due some outreach to you. If you

have any questions regarding that but for past services though, no there is not a requirement for an NPI number.

UPMC value code is not working this is say billing question I'll send your information oust to UPMC have them get in touch with you.

Please repeat where the one can find the MCO agreements I'll go back to that web site. Community HealthChoices web site. You know once you go to the web site, look for community HealthChoices our agreements are on there.

What will happen with the fee schedule beginning July? It is my understanding they are to renegotiate rates after six months. I'm not sure what you mean by fee schedule what you're talking about negotiating rates with the MCOs, but that is part of the process of the MCOs will have with their providers if you signed an agreement or contract with them, that is up in July, then you'll renegotiate that contract, um, you might have signed a yearlong contract so your rates would be set in by that contract that you have with the, MCO.

Providers of trappings reluctant to sign contracts with MCOs because of onerous requirements.

I mean the contracts actually signed are not with the MCOs they're signing with one of the brokers.

So I know there's been some concern about the requirements of the brokers as they are, assuring that the individual transportation providers are certified and appropriately contracted with provided

transportation services.

I think, again if you have made, if a transportation provider has major issues with what one of the brokers is requiring, um, we can certainly have further discussion with them about that.

Can you identify the transportation benefit for both nonemergency medical transportation and nonmedical transportation -- this either are seems to have a limit on a number of trips there is certain limitations some of it depends whether you're in a individual NFCE or NFI dual. Transportation for NFI well duals is benefit of the MCO maybe limitations on it. As far as the -- nonemergency medical transportation and nonmedical transport that will depend upon the care plan of the individual. Did should be in there, what the transportation needs are. Who is providing the transportation what the frequency is. That should be part of the person centered planning care process. We have been waiting for months on the decision for a home mod, are the MCOs held the response standard the pretty much held to the staple standard that the department had, a lot it is based on the information you need to provide back and forth.

Again, if you have outstanding cases um, all I can look into that and I will -- I will send an email out to the individual to see if there's more specific information they have.

Can you show numbers and percentages not just one or the other. I'm assuming you're meaning in our tables we can modify those

in the future to have numbers and percentages in.

Individuals two clients and not in the portal I'll reach out to you.

Or you can email me. And who the clients are, we will look those in

I will work on getting those resolved.

The average of the last four CMI periods will set the drink hold are

rates for nursing facilities.

How long would that rate last?

The CMI continue to establish the minimum rate or will it go away

completely we're still doing the, all the data and paperwork on the CMI

that will continue to go on as it is.

And as far as the rate calculation we provide that to the MCOs.

And that is their responsibility to set up their individual rates when

they contract with the nursing facilities.

Do we need to contact the MCOs to enroll? I asked the content one

by email told they were contact me when the process of enrollment starts

. You have to have two things one you have to be enrolled in medical

assistance if you're not enrolled in medical assistance you have to come

through our provider unit to get enrolled. In the EMA program if

you're not enrolled in the MA program you're looking to be enrolled in

the network you're in the southeast they're concentration has been,

getting things ready for the southwest. They have started the emphasis

on the new southeast network. Of providers so they should be

reaching out to you. If you have not heard from them at this point in

time I would recontact them the numbers are up on the screen right now and just follow-up with them. It was stated that the 3 MC ons were provided to sign contracts with the Medicaid providers one has said unless they have a need with the waiver program they do not need our services.

Um, the stipulations under continuity of care period the MCOs to work with all willing, for any willing provider to provide, this same continuous services to individuals.

So, if you were providing services, to an individual, um, participant, the MCO would have needed to work with you to continue providing those services as long as you were willing provider that the participant wanted to use if there's an issue with that, you can certainly let us know we can look into it.

Provide a short review what is aging well, is that the replacement for MAXIMUS the answer is no, it does not replace MAXIMUS, MAXIMUS is our independent enrollment broker.

Aging well is a consortium of AAAs have come together to contract with the State to provide some of the similar services that the aging network has in the past.

Um, most likely they will be contracting or subcontracting with all of the AAAs to continue to provide the services aging well is being contracted with the provide education and outreach.

Um, the assessments to determine, NFE versus NFI status the pass

level 2 evaluations for those individuals.

So it is just a, entity that will be representing the AAAs in the end the State is going to be contracting with instead of us working with all 52, we'll work with aging well, who then will have the AAAs as part of their network.

FCEs go not see an individualized ISP with one of the MCOs, they complete the NRI, in a gentlemen generic form with past services they're not utilizing the OLTL ISP how is the person centered plan being addressed they may not be using the same forms that OLTL used in fact I'm pretty sure they're not going to. But their person centered plan should address all of the issues surrounding the participants care their needs, who is providing those services, who is involved in providing those services.

So all of that information should be out there and if you're the SC working on the case you should certainly have access to the person centered care plan.

So it is a U the service coordination is an administrative function of the MCOs. They should be working with, if you are an external SC and you're working with the MCOs, you should be part of that person centered planning process.

MCOs have to inform providers procedure to June if they intend to contract long term with them or not? Yes. The MCOs need to give provider's 60 day notice, if they are planning to

contract, or not contract with the individual agency.

So they're -- if they're deciding not to continue working with you, you need a 60 day, need to provide you a 60 day notice if at the end of the continuity care period they're planning not to work with your agency you should be notified may 1st of that occurring.

Or, any time you're notified that it's a 60 day window notification.

Do fully home care companies in the southeast have signed contracts with the MCOs at this time? I -- do not know for sure. But I'm pretty sure they probably don't unless there are companieses that represent the State they may have contracted with the southwest they have to add in the contracts for the southeast.

Delaware County is one transportation provider for waivers, community transit. They're only waiver provider and only provider only provides services for the aging waiver.

So effectively there's no waiver transportation, in Delaware for all other waivers. If community transit fails to enroll with MCOs there will be no nonmedical transportation for any waiver consumer in Delaware County. How would a consumer get to a adult day care where they're supposed to go. It is the responsibility of the MCOs through their brokers to ensure they have an adequate transportation network.

So, I would assume, if there's only one transportation provider in Delaware County, um, the MCOs are going -- the brokers will have to work

with that transportation provider and if for some reason, they cannot come to the agreement on a contract, to provide services, they need to still ensure, adequate transportation services in that county.

Do you know anything about information sessions the MCOs will be holding where position group have patients will be participating in the CHC program need to know what we need to do.

>> SPEAKER: There will be MCO representation at those provider sessions in June.

So each one of the MCOs will have a table set up, they will be there they will be speaking in the morning when we do the overview session. So um, I do encourage you to keep your eye out for the information regarding those sessions. And get registered so you'll have an opportunity to meet face-to-face with each one of the MCOs.

If not, each -- the contact information is up on the screen and the first email address there is for provider communications so um, I would encourage you to do outreach to each one of the MCOs if you want to get that process started prior to June.

>> SPEAKER: All right can agencies attend the may ninth meeting with behavioral health and the nursing services that's an internal meeting for those 3 entities to try to work through the issues regarding behavioral health services my hope is that coming out of that meeting is

that we will then do a larger webinar for behavior health services out there, to include all agencies and nursing facilities want to have that discussion. So the initial meeting on the ninth is an internal meeting with those groups. But the hope is that, after that, we will have some educational webinars available with behavior health and CHC MCOs to walk the agencies through addressing behavioral health services.

What is the role DDP is playing in CHC?

>> SPEAKER: I don't --

>> SPEAKER: I'm not sure, I'm not sure.

I don't know what DDEP is.

>> SPEAKER: Um, is that the -- I don't know.

I'm trying to think.

>> SPEAKER: Send some clarifying question in we will certainly look it up or try to answer that for you.

>> SPEAKER: Hopefully we can Clair that.

Why can't the effective daylight be the first of the month instead of a random day, the billing process is not he's when I this happens. Its the first of the month, all new enrollees that come in on January 1.

When people change plans effective the first of the month, the reason why it can be any other day of the month is when it is a new

participant coming in they're eligible to start CHC services the day after they are approved for services. So they're approved, for medical assistance, they're had approved through services through CHC and services will start the next day someone gets that approval on the fourth of month, we're going to start their services on the fifth of month. We do not want to wait until the first of the next month and leave them for 25 days without services.

So, the reality is, we try to provide services as soon as the person is eligible for them.

>> SPEAKER: So the DDEP is the department of drug and alcohol programs. So we will be coordinating and the centers for excellence are part of the networks under the behavioral health benefit for folks enrolled in CHC. So, each one of the participants when they enroll in CHC whether they had the behavioral health services available to them under the fee for service program in the past, they are all enrolled now in the behavioral health managed care plan to receive their benefits.

>> SPEAKER: All right I appreciate this comment very much. And I will read your first part of it. Do you guys ever sleep?

[laughter]

I did in 2014 I took a nap.

[laughter]

I have not since then.

But Aaron thank you very much for the other follow-up in there, thank you.

Why is there a huge disparity of CHC enrollment rate among 3 MCOs in the southwest region.

Couple reasons for it, the primary one is UPMC had the name recognition the provider network, um, in the southwest.

PHW coming in as a new entity into the State, it has had to work for their market share.

And AmeriHealth is a primarily based in the Philadelphia area, so was -- a little challenging for them to get the name recognition also in the southwest.

So that's, what we saw in the southwest UPMC certainly has the networking. The -- the physicians offices the services out there.

And the presence in the southwest and has for awhile.

So there was a disparity especially around individuals that self-enrolled into one of the MCOs.

The auto enrollment helped balance things out a little better.

And, also looking at the DSNP plans again, UPMC has a strong DSNP plan in the southwest so those individuals that correlated, between the DSNP plan were auto enrolled into the CHC plan that coordinated it.

So it is kind of the, the basis that they are, well-known out in the southwest. What has been sided to use of ADD and participants have input.

There's been a lot of input in the EVV system.

The State has put out -- information, for public comments there was a 30 day public comment window we received hundreds of comments on the EVV system. We continue to work as a state to decide how to implement it.

>> SPEAKER: Currently an RFQ right now out. There's a request for qualifications out, posted out for EVV.

So, we, look forward to any responses we receive from that.

And then, once that is closed, um, there will be further communication from the department of about our approach for EVV.

We do know that it will be an open system, so those folks are using EVV solution, currently, as long as that system can take to ours and provide the information that we request they're able to continue to use that EVV solution.

>> SPEAKER: This next question I'll apologize in advance, last call you discussed the DHS come up with a list of top ten reasons for claim denials for this call. I have not gotten that back from the MCOs I will certainly do that.

But I can tell you from discussion with them, um, some of the, the

major reasons are, duplicate claims, they do not claims were not submitted with the EOB.

So they, they could not verify the appropriate primary payer.

They were billing for services that were not appropriate or on the fee schedule or approved through the CHC program.

There were errors on the billing, wrong numbers, um, on the billing.

I think those are the four major ones that we have seen.

But I will get a full list -- for the next webinar and get that out to you.

How often would the MCOs reset their rates would it always be a factor of the CMI average? The MCOs will reset the negotiations withen the nursing facilities we did not, we have given them a look at where the CMI rates are at.

And, as part of their negotiations with the nursing facilityies they will determine whether they will renegotiate rates how, what they will base it on.

Why when someone has been assessed for LTC, long-term care is the IEB requesting another assessment to get waiver to go home. Especially when they were very recently assessed for the nursing facility. I'm not really sure.

The question I mean they have been assessed to go into long-term care sometimes if they go back out in the community, um, they have to go from long-term care, MA to community MA.

So, there are certain assessments and financial eligibility that needs to be determined because the guidelines for financial eligibility between long-term care facilityities and community is different.

So that may be, what the IEB is requesting.

But I can certainly follow-up with the individual because I have a, um, a note on my desk to call her any ways we have been playing phone tag I'll follow-up with her.

Where can a list of all the -- SCOs be found.

I'm hoping you meant MCOs.

Which is the list that is right here.

If you mean something different than that let us know.

What is the extent of training which will be provided by the MCOs regarding HHA exchange. One of the lessons learned from the southwest is we did not train the providers well enough, and in advance enough of the use of the HHA system.

And the billing, protocol that needed to be go through we'll be working with the MCOs to start that process a lot sooner. Um, and after the June meetings we're going to be encouraging the MCO toss work with the nursing facilityities to do claims testing they not have to be contracted with the MCO to do claims testing so we'll start that process.

And then we're going to be pushing the MCOs to do provider training and of use for the HHA exchange system as early as October and refreshers

as needeeds we go towards the live date.

Will EVV be required for adult day services?

I'm assuming you mean adult day care service ins and no, that's a service outside of the home so that's not going to be part of the EVV requirement.

>> SPEAKER: Home care or home health.

Can we sign up for the June meetings online, as soon as we get throws finalizes with the contracts weight get those meetings out online . How does reporting and payment work for PANF and disproportionate share in the CHC? This is part of a discussion you'll have to have with the MCOs. We have changed some of the add on payments most of them are wrapped into the rates that, we are paying to the MCOs who in turn will, wrap them into the rates they will pay you. We will do a -- a pretty intense, presentation on that.

At the June meetings. And in the break out session with the nursing facilities. So, you can look forward to that.

DDAP, is the Pennsylvania drug and alcohol. Thank you hopefully we addressed that question limit to the prescription plans contracted with the MCOs.

The MCOs I think are all using they're all using different prescription companies to do the work I'm not sure who they are. That's a question that is best asked directly to the MCOs.

>> SPEAKER: You can go to the MCOs web site so if they are using a PDM, then, it should be listed out there.

And their formularies are out on the web site as well.

>> SPEAKER: Criteria that the MCOs use when deciding not to continue a contract with home care company base upon quality of care, low volume of clients, et cetera.

And then, there's another question let me ask the first one first.

The MCOs and this is dealing with all provider types whether there's FCE or home care agency whether it is a doctor's office, they will be basing their decisions on whether to continue to work with the entity based upon the quality of care, that they're having, the relationships that they have with the, the -- provider.

The client numbers that they have with the provider, a lot of it will be based on that information that they have with that.

And then follow-up question how many providers in the MCOs are planning not contracting with?

At this point in time, the MCOs are evaluating and, looking at the FCE entities there are some that they will not be contracting with after the continuity of care period.

And relation to other provider types whether it's physicians home health or any other LTSS provider type, the MCOs have told me at this time they are not looking to change anything that they will continue to

contract with them at this point.

But it does not preclude them from in the future evaluating the relationship and the services that they provide back and forth with you.

All right someone said the volume -- someone said they called it back again we're good.

>> SPEAKER: Give it a few more minutes to see if there's additional questions before we close out for the day we have very good questions thank you.

While we're waiting just another reinforcement if you have any ideas any areas that you think that we need to improve our communication, and any additional suggestions for fact sheets or, um, subjects that you think we should focus on for provider or participant education please, um, send that to us.

And, um we appreciate any and all suggestions.

>> SPEAKER: We'll leave the line open for two minutes to see if any questions come in we'll wrap it up.

And again you know, I said earlier Jill said if you have any suggestions how to tailor this meeting and topics you want, discussed by the department, let us know we can certainly bring in any entity to talk about whatever topic whether it's, something with HHA or something with the LIFE program.

Whatever, topics you want to talk we'll certainly entertain hosting

those topics.

>> MALE SPEAKER: Based my talk we went through two minutes again guys thank you very much.

Have a nice afternoon and a nice weekend.

[session concluded]