December 20, 2018

>>> [Please standby for captions]

>>> Good afternoon.

This is Kevin Hancock.

This is the third Thursday webinar for community health choices, December 20th, 2018.

Today we are going to focus on the southeast implementation, the implementation in the Philadelphia area that's happening 10 days away.

We believe that we are ready but we are going to go through some enrollment related activity and communication activity that's been taking place and provide an opportunity for you to be able to ask some of the questions that you may have about how the implementation is going and what will be next.

Before we begin, however, we want to make sure that you have a chance to know how you would need to submit questions.

So what you need to do is as on the screen in front of you, you type your question or your comments in that box that should be on the right-hand side of your screen and you will be able to use that and that question will be transmitted to us, printed out and then we'll read it and go through with the answers if we need some sort of follow up.

If you wouldn't mind, please submit your questions that way and if we have any clarifying questions we'll ask over the phone and if you wouldn't mind resubmitting that would be great as well.

So we are going to be covering updates for southeast implementation focusing on enrollment and plan selection, participant and out reach and provider education out reach, readiness review, launch oversight and then a quick update on nursing home transition.

So starting with the southeast implementation, so as with the southwest implementation we want to make sure that everybody knows that our essential

priorities are making sure there's no interruption in participant services and provider payment.

We believe this was something that was achieved successfully in the southwest, although there were certainly hiccups and we are looking forward to incorporating lessons learned in the southeast so we minimize the hiccups that we saw in the southwest.

So we are trying to make sure there's no risk of participation interruption of service and no interruption of provider payment as well.

A lot of that has been addressed through earlier training with providers in the provider community, better understanding the tools used through the process and incorporating lessons learned to make sure that providers know what they need to do to ensure on going payment.

So all of that is incredibly important to maintain a stable system as we go through this fairly dramatic change in the way that we are managing long term services in the Medicaid system in Pennsylvania and we look forward to your feedback through the implementation period and through the continuity and care period to make sure if there's any risk of either interruption of participation services or provider payments you'll let us know as quickly as possible so we can address the issues and be able to move on.

So with the southeast implementation we have focused heavily on enrollment and plan selection, participation provider out reach.

There's been out performed by the department.

We focused heavily on readiness review and adequate necessities to make sure that they are ready on day one to take on the services and manage the services at a minimum in the way they were managed in the prior system and we have a reporting system in place to maintain launch oversight to make sure, again, there's no interruption of participation services and provider payments.

All these focuses have been part of our on going discussion with all of our stakeholders and participants and a lot of what we are talking about should be no surprise to anybody on the phone today.

Or at least hopefully not.

So first we'll talk about plan selection.

These slides show the distribution by managed care population.

There's about 49% of the total distribution of population, Pennsylvania health and wellness has 25% and UBMC has 25% as well.

The distribution of popular includes people eligible but not in need of long term service supports, those receiving long-term care in the community, individuals receiving their long-term care in the community but not dually eligible, individuals who are dually eligible receiving their long-term care in nursing facilities and those not dually eligible but receiving long term care in nursing facilities as well.

The amerihealth has 49% of the distribution.

Pennsylvania health and wellness has 25% and UPMC has 25% as well.

This slide shows how the selections were assigned.

Approximately 40% of the individuals actively selected a managed care organization to be their plan.

And then -- boy, I can't do math in my head.

59 to 60% were automatically selected.

If you remember when we read these numbers off for the southwest these should sound familiar.

We were expecting a higher auto assignment rate in the southeast but as it turns out we are on track to surpass the advanced plan selection that we saw in the southwest which as I had previously stated is a national record.

40% doesn't sound like a high percentage but with this type of the program there tends to be a high auto assignment rate because a large portion of the individuals in the program are dually eligible and the primary payer is Medicare so they may not be paying attention as much to their Medicaid coverage.

We are pleased with the advanced selection percentages we have and we are looking forward to be able to exam how this advanced plan selection was accomplished and see if we might even be able to beat this percentage as we enter into the third phase.

So this is actually a pretty good number.

Even though we have a high auto assignment rate for a managed long term care program we have set a national record.

So we are very happy about that as well.

We beat that record that we set last year.

This shows the distribution by plan selection method for the managed care organizations.

All three of the managed care organizations received an even distribution for the process and had more people select than through the advanced plan selection process.

So in addition to the on going enrollment activities and just to be very clear, individuals can continue to change their managed care organization until December 21st, they -- and that change will be effective on January 1st, 2019, we look for opportunities to continue to communicate with participants.

Some examples are on that screen here.

We have independent -- the independent enrollment broker has mailed to our recipients post enrollment packets and that did identify which managed care organization the participate selected or was assigned to.

That post enrollment package said to make sure that that is a clear you choice for those 55 and over and nursing facility eligible and there was a community health choices brochure explaining the program.

So the packets have been mailed at the beginning of December.

Everybody should have these post enrollment packets and they still have until tomorrow to make a plan change for it to be effective on January 1st, 2019.

So if you have anybody who is thinking about making a change and they want it to be effective on January 1st, 2019, they have until tomorrow to do so.

But to be very clear about that program, people can make a plan change at any time.

It just -- if it's after December 21st, it won't be effective until some future date.

So, for example, if a person makes a plan change on December 26th, it will be effective on February 1st.

If a person makes a plan change on January 4th it will be effective on February 1st.

If someone makes a plan change on February 21st it will be effective April 1st.

So people can make plan changes any time but there's a lag of three to six weeks for when that plan change will be effective.

Plan change at any time but if they want that plan change to be effective on January 1st they have until tomorrow.

That's the message we are trying to convey.

So in addition to this on going enrollment activity we've had some great partnerships with stakeholders including the Pennsylvania law project working with our service coordination population for additional training and out reach.

We have been working with our service coordinators, we the department have been working with our service coordinators to encourage them to educate their participants on this change and what this change will mean to them.

The help law project or PHLP has been willing to engage in that communication and that strategy to make sure that it's very clear about the December 21st date and its meaning as well as what the program offers to participants and what they need to do to make sure that they are comfortable as they go through this change.

Service coordinators are a key entity in communicating what this change will mean to them as we go through this transition.

We encourage service coordinators to take every means possible to communicate to your participants about this change and hopefully you'll still have time to be able to communicate about the December 21st date.

We have asked all service coordinators to meet with participants in person.

That in-person meeting is something we call meaningful contact.

The meaningful contact allows service coordinators to convey information about community health choices including the enroll. Process and so far we've had 17,00 meaningful contacts which is half of the population in the southeast.

Great number.

We are far exceeding what we did in the southwest when it came to this type of out reach, although we really wish it was 100% and not 50%.

So we encourage service coordinators to continue that effort if they still can.

There's no reason why you can't continue your out reach participants even after the 21st date throughout the continuity period.

With our partner ageing well we conducted participant sessions throughout the Philadelphia area.

Those 72 sessions had 4,500 registered participants and were presented in English, Russian, mandarin, Chinese, Spanish.

We presented a few in a couple other languages with translators present because they were willing to do so.

An example was Korean.

We -- it's noted here we are a little bit closer to 17,000 meaningful contacts for service coordinators and we continue online -- efforts for participant education.

Unfortunately the online participant training will not be available for the southeast implementation.

The online training will be available for the third phase.

We were hoping it would be available throughout the southeast implementation but unfortunately because of some technical snags it was not developed in time.

We will continue population out reach indefinitely to make sure that participants understand what community health choices means to them and have them have an opportunity to have their questions answered.

That population out reach will include training and training will be for CHC audiences as well as key stakeholders who represent those audiences and it will

provide information and over view of CHC as well as ways that community champions or stake holders can answer questions to their constituents about what the program is about or about the program and what it means to thundershower participants.

Additional out reach includes working with community organizations, city and state officials, healthcare advocates, et cetera, all to make sure that those individuals can work with your constituents, answer questions about CHC and point people in the right direction if people have more questions about how community health choices is working for them.

We are also looking for opportunities for public relations, efforts for community health choices.

We've already had a couple of different radio segments that related to community health choices and a development of a short CHC video that was sent to Penn D.O.T for them to run in all of the department of motor vehicle sites.

This particular method has been particularly effective.

We've had a lot of comments on that video and it seems that a lot of people pay attention to videos when they are waiting in line for the short periods of time that they have to wait in line in the department of motor vehicles.

So we are very grateful to our partners for Penn D.O.T to be able to do that.

I mentioned that we are doing a round table with community organizations and community leaders.

We've had one round table with a latino focus on the 5th and African immigrant focus on December 18th.

We look for opportunities to do this more in the third phase.

We are excited about this opportunity because it gives us a chance to interact with community champions and community leaders and answer their questions and fortify them with information so they themselves can go back to their constituents and answer related questions.

Some of the feedback we've received so far is there are a lot of opportunities for these community champions and community groups to work on translation of

materials and also opportunities for increased training with participants and providers, most specifically the service coordinators on how the program works and also the benefits of the program itself.

We continue to focus on participant protections, the key participant protections we are trying to achieve is making sure there's no risk of interruption of participant services as well as no interruption on provider payments.

We will have the participant help line available for people that is 1-800-757-5042.

That's staffed with individuals that work for the department of human services and is available for people to reach out to the department to talk about any concerns they may have on how community health choices is working for them.

We continue to field calls from the southwest and we will continue to do that indefinitely.

We are looking for opportunities to be able to manage calls and questions from the southeast as well if there are concerns that are being raised.

So what happens with continuity of care which is the next great step in this implementation?

Continuity of care for individuals in the community starts on January 1st and will continue all the way to the end of June.

That is for individuals receiving their long-term care in the community, regardless of whether they are dual eligible or not dually eligible.

What continuity of care means in a nutshell is if a participant had a service plan in place and was receiving services those will stay in tact with no changes unless there's needed changes based on emergent event throughout that 6-month time period.

The managed care organizations are required to contract with all of the providers that are on the service plans if those providers are willing and qualified to be able to provide the services.

They will continue to keep their providers and service coordinators throughout that time period.

If participants are receiving services of certain levels, those service levels will be maintained on a service plan as well.

So the continuity of care period for individuals receiving their long-term care in the community will be for six months and participants should expect no changes.

During that time period the managed care organizations and service coordinators will work with participants to get ready to transition to the period after the continuity of care period expires which will give them a new service plan that the managed care plan has developed and will be overseeing.

In addition to this 180 time period participants who receive their long-term care in nursing facilities and they are receiving those services there you the Medicaid care on the implementation date of the southeast, they will be able to stay in that facility indefinitely as long as that facility remains a Medicaid enrolled facility.

Even if that facility elects to not contract with the managed care organization the managed care organization will be required to do an out of network contract with that facility and participants will be never be in a position they have to move.

That's straightforward.

There will be geographic sessions.

They were well attended and we had a lot of engagement with participants and we look forward to the impact of those sessions as we go forward with the full implementation for the southeast.

We continue to work with other providers including hospitals and health systems and we look for opportunities to present to any provider group that invites us to present on community health choices.

So if you know any provider groups that want a presentation let us know and we'll be happy to do that.

Certainly last but not least we had a transportation summit that occurred just before Thanksgiving on November 16th immediately after the weather event that caused some challenges in transportation so that was fresh in everybody's mind.

The transportation summit was meant to address opportunities for improved community in the southeast and to address some of the key issues and challenges that were faced in transportation in the southwest.

A lot of connections were made in that transportation summit and we believe at this point that it helped facilitate communication.

We do believe the transportation will be an opportunity for improvement compared to the southwest.

In the southeast, the southeast does have SEPA.

They have been a great partner with community health choices in establishing a transportation system that supports this population and we look forward to working with SEPA as well as other transportation providers in the southeast region to make sure that participants are receiving the rides they need to receive.

This was a problem area in the southwest.

We are trying to get ahead of it as much as we possibly can in the southeast and to adjust where we need to adjust in a very complicated service whether there may be some confusion on who is providing what and we look forward to any feedback you may provide on transportation as we go forward with southeast implementation.

I forgot that we have this second slide.

Long story short, transportation summit is something we thought was effective in establishing communication.

It involved representatives from Penn D.O.T, the transportation brokers, transportation providers, SEPTA as well as various other stakeholders, Philadelphia corporation for ageing was there.

With that I'm going to turn it over to Randy to give us an update on readiness review.

>> Hello, everyone.

In the southeast went through a couple different processes.

The first one was to gather all the policies and procedures from the MCOs and review them internally through the monitoring team and other subject matter experts in the department.

All three MCOs submitted 100% of their policies and procedures.

They have been reviewed and approved.

On a policy and procedure front they have done fairly well.

So as you see from this slide, it was the first bullet.

The biggest thing that we are working on right now with readiness review is network adequacy.

DHS works closely and meets weekly with the department of health who has oversight responsibilities for monitoring networks.

We tried a couple of emphasis as we've gone through this.

The first one on physical health providers, PCPs specialists, that all have good networks.

The second emphasis has been on LLTS providers.

We continue to make that an emphasis as we close out the final two weeks here.

At this point in time all three plans are doing well with getting enrollment of home health agencies, SCEs.

They continue to bring them on board to work with them through the continuity of care period.

So we continue working on refining some of the services under LTS to ensure they have enough providers for it.

The next area we focused on was hospitals.

We have all three MCOs have a majority of the hospitals contracted with.

There are some hospitals that will not contract with certain MCOs but the rest of them are continuing to work through those contracts.

They have agreements in place.

They have verbal agreements in place.

If they are not effectively contracted with by January 1 all MCOs know they have to pay those individual hospitals as out of network providers so they are continuing to work for that piece of it.

The next page and the last page we worked on making sure that they had adequate coverage is nursing facilities.

All three of the MCOs have been able to bring in probably about 60% of the nursing facilities at this point.

They are finalizing contracts with some of the larger entities or organizations out there including the manner of care, genesis, catholic health.

So they have bringing them on board hopefully in the next week or so that would take the nursing facility adequacy up quite a bit.

The other issue is they are working with all the county homes.

They will probably not have contracts assigned until mid-January as it goes through the signing process at the county but they are agreeable to come on board.

So adequacy is good.

The one benefit we have is nursing facilities will not bill until February 1st so that gives some time to get everything finalized and into play.

So we are working through that piece of it.

As part of monitoring we did do site visits at all three MCOs.

We look a look at their call centers, planning process, their goal planning process, all three monitoring visits went very well.

So we continue with that.

The MCOs are providing a lot of training to providers including they did two three-day train the trainer sessions.

They have done claims testing with nursing facilities and providers that requested it, providing on the HHA exchange and how to work with that and the MCOs so they are providing a lot of on going training for the providers out there.

Technical issues here with the keyboard.

Part of what we are doing as we move into implementation or launch, we have daily meetings with the MCOs.

We began this last week.

We had two with them last week, two this week.

Next week we'll be doing the dailies on Wednesday, Thursday and Friday.

And then we'll have one on the 31st and then we'll start on the 2nd on a daily basis at least for January and probably through February.

The purpose of the daily meetings with them is to identify any issues, problems, concerns both on the participant side, provider side, claims billing side, any issues with PPL or the IAB or any other issues in general with the program that we can work through that meeting with them.

The issues or problems or concerned identified through the daily meetings in the morning with them are then talked about at an executive daily meeting so the department itself is aware of everything that is going on and can work on making resolutions.

So those daily meetings are going on at this point in time.

We continue to have weekly meetings with the MCOs to go over stuff and then we also have weekly meetings with a number of stakeholder groups and participant and participant advocates.

We have a transportation stakeholder meeting.

We meet with the MCOs and other health and human based providers on a weekly basis to talk about issues going on.

And then we have on going meetings with the different associations that include nursing facility associations to talk about things that are going on.

So through launch we'll continue to do this.

The other thing that we have in launch before we move onto nursing home transition is we have what we call launch indicator reports.

There are five of those that we have in place that will measure things like call volume, it will measure the MCOs are required to have a contact with every participant and it measures their attempts to make those contracts, whether there's any disruption of services according to the participants.

So we are monitoring that.

We are monitoring claims through the launch indicators.

These are reports that are due on a weekly basis.

Four of the five will be used during the month of January.

One of them will take about six weeks that we'll collect the data on.

These are short reports just to give us a flavor of how launch is going on a number of different fronts.

Once we are complete with the launch indicators we do have operations reports that will gather that same data that are on going reports that the MCOs are doing right now so we'll transition into those.

That's what we are doing with implementation.

We feel at this point that we are comfortable moving forward and that we have a provider network in place to do this.

The MCOs do understand that if they don't have providers in place they will be paying out of network providers so we are working through all that process.

So I think we are in pretty good shape right now.

>> At this point Amy high to provide some update on nursing home transition.

I think before we begin we are going to go through some of our questions because they are directly relevant to Randy's and my presentation.

First was an enrollment question.

Are there community Medicaid recipients in a nursing facility that will be auto enrolled rather than having the ability to select a plan?

All nursing home residents had the opportunity to actively select a managed care organization.

There are some cases where those individuals were auto assigned however.

They did have the opportunity to actively select a plan and they may make a plan change at any time just like any other enrollee for community health choices.

Next question, will billable activities follow the same guideline or will which MCM make that decision and share it for the continuity of care period?

So the billable activities will follow the same guidelines that occurred prior to the implementation of community health choices.

Service coordination will be an administrative function of the managed care organization but during the continuity care period at least as evidenced by the southwest they treated it similar to a service.

So it's likely -- specific with a managed care organization to understand what they are expecting but it is basically going to follow what you would have experienced in the service system.

Next question.

Hoping to address nursing home transition and home modification ins the process that were not completed by January 1st, 2019.

One of the managed care organizations told this individual they are waiting for direction from the state.

We do have the direction for home modifications in place and I'll turn it over quickly to Randy for an update.

>> Home modifications -- we'll be getting some information out.

If it came in from the state, approved by the state, the work is being done or approved to state assuming the state will maintain responsibility over those home mods.

If it came in and we have not viewed it yet or gained all the information for that new home mod, those will be turned over to the MCOs beginning January 1st.

So if it's in process, if the work is in process, if it's been approved to be in process, LTL will continue to cover it.

>> The next question, do we have a sense as to what portion of the service authorizations are loaded in HHA exchange at this point?

This transition was much more successful than what we experienced in the south, southwest.

We do not have a percentage readily available but what happened in the southwest was not repeated in the southeast.

So we are expecting them to be more visual and more readily available.

This was definitely a lesson learned.

Have all nursing facilities signed their contracts with the managed care organizations?

No and they are working to have that enrollment.

The managed care organizations have the requirements to develop an out of network relationship with the nursing facilities.

If the participants are enrolled in community health choices on day one and receiving their services in the Medicaid enrolled nursing facility.

Please advice how the UMR reviews and visits will change as it relates to the Medicaid fee for service days of service.

>> At this point in time field operations is not going to change.

They are going to continue to review the MDS because it's part of the rate setting process that we utilize at the department.

So they will continue to review the MDS.

They are still responsible for PASRs and those issues related to the PSAR process and they will be doing financials and in the southeast they will be closing financials all the way -- they will do financials until we close 12/31/18.

So it may take a year to a year and a half to close all the financials up to 12/31/18.

A lot of processes they will be doing will be similar so what they are doing right now.

>> Thank you, Randy.

Is the CAC number 833-745-1416 still operation?

The answer is yes for interim participant questions.

If yes what issues should be called into that number?

High level questions and general guidance on where to call.

It's meant to be an introduction call center line.

Question, if there's an interruption in service who should be notified?

First the service coordinator for all participants and also the managed care organization should be contacted as well.

Those are the first lines that should receive these types of inquiries.

If they are not successful call the participant health line in the office of long term living if you are not making any headway.

Have all participants been assigned even if auto assigned?

The answer so that is yes.

They still have a chance to make a change for it to be effective on January 1st, 2019.

How do they change after 12/21?

Call the independent enrollment broker they can mail in a change or use the website to be able to make a plan change.

If it's after December 21st, all the way up until the middle of January that will be effective on February 1st.

We've had hundreds of nursing facilities participate in the provider session.

What are the key pieces of info nursing home residents need to manage care organization, et cetera, et cetera.

So the key pieces of information nursing facility residents will need after CHC goes live will be their identification card.

That identification card will be mailed to them the fist week of January.

That is in add DILGS to the access card.

Does anybody have anything else they would like to add?

>> The other thing they will get is they will get information from the service coordinator from their MCO who will come and visit them.

If there's issues related to the MCO they will continue to coordinate their needs and services with the staff at the nursing facility who will also work with the service coordinators or the MCOs.

It will be a coordinated effort between the nursing facilities and the MCOs to ensure all the care needs that the individual are met.

>> Thank you, Randy.

It was suggested that we present to the Pennsylvania psychological association.

That's great.

We would love the opportunity to present to your association on community health choices.

Next question, how will -- I'm not completely sure.

How will going to brokage impact?

At this point we can't really say.

We are in the beginning of the procurement process and some of that is still to be determined.

More information to come on that.

With that we are going to turn it over to Amy high who is going to present an update on nursing home transitions.

Amy high.

>> Good afternoon.

I'm just going to provide an update on the work we have been doing on the nursing home transition process for individuals that are receiving their long-term services and supports in the nursing facility that wish to transfer to home and community-based services.

We have been working across offices to develop a new process that will allow county assistance to expedite financial eligibility determinations for individuals transitioning from receiving services in a nursing facility to home and community-based services.

The anticipated effective date of this updated process is scheduled to be in effect February 19th.

This process will require that waiver applications are processed two weeks -- I'm sorry.

The county office is notified two weeks prior to nursing facility discharge which will allow the county assistance office to actually determine financial eligibility prior to the individual returning to the community.

This process will allow participants to make an informed choice on the services that they are receiving in the community and also promote a safe discharge plan.

This will be a coordinated effort among several entities including service coordinators, nursing facilities, the independent broker and the county assistance office.

The managed care organizations and service coordinators will be responsible to make referrals to the independent enrollment broker to determine functional eligibility for participants interested in receiving home and community-based services.

They will notify the independent enrollment broker of the pending discharge state and ensure that the nursing facility issues the MA103 upon discharge for the process to work.

The independent enrollment broker will issue the 1768 to the county assistance office in advance of the discharge to determine the financial eligibility and, again, the county assistance office then will be available to process those financial eligibility determinations two weeks in advance of discharge so the individual knows whether or not they are eligible for those services.

Just some important information to know for this process, an individual must be enrolled and open with medical assistance for the expedited determination to occur.

Not all medical assistance categories will be eligible for home community based services.

So it will also allow a participant that may not be eligible for home and community-based services to make informed choice of their discharge plan.

Also, again, with the coordination of this process the -- it is very important for the county assistance office to have that two-week window in order to process it timely.

We will be issuing detailed instructions to each individual entity and instructions over the next several weeks as we prepare for the implementation.

So that is my update.

>> Thank you, Amy.

I think we have a few new questions.

Can the IEB enroll in a CHC and select managed care organizations for people who need LPS.

That's not true.

Anybody can make a planned selection if they are dually eligible and need long-term service support.

If they are not dually eligible and need support or if they are dually eligible and do not need service support to make a selection.

Maxamus covers them all and they will be able to provide that support.

You can see the number to call on the next slide.

Or you can visit enrollCHC.com.

Can a nursing home provider obtain a list of which MCO the residents are assigned?

They will be able to see that in the eligibility verification system which they should already been checking to verify Medicaid eligibility.

The eligibility verification system will identify only Medicaid eligibility but also the managed care organization in which the participant is assigned.

What will happen if a nursing facility participants are not credentialed with the organization prior to the date?

That's a question that you want to is if you're provide -- that's a question you want to ask the managed care organizations directly.

Regarding the transportation summit, any transcripts that can be shared for those of us not in attendance?

We can share the presentations available.

There was no transcript though.

It was not that kind of a meeting.

It was a public meeting but we didn't have a transcriptionist available.

We can certainly make the presentations available and we have your e-mail address and we'll do that.

What will SCs will doing after 7/1/19 if the MCOs are taking over care plans?

As we have mentioned previously, service coordinators are an administrative function of the managed care organizations.

If they continue a subcontractor relationship with the managed care organizations those service coordinators will be managed and continuing to manage the care plans that are administrated by the managed care organization.

The answer, you'll be working for the MCOs, either directly or through a subcontractor relationship.

That's what service coordinators will be doing.

All three managed care organizations currently offer a hybrid model where they have some in house coordinators and use external entities as well.

How will waiting for approval be handled if not approved prior to 1/1/2019?

So how will increases that are currently waiting for approval from LLTL be handled?

Randy is going to answer that question.

>> If it's increases in services it will be turned over with the care plans to the MCOs beginning January 1st and the MCOs will have to monitor and review any of the authorizations there and make decisions on whether the services is appropriate or not and whether they will make the increases.

>> Thank you, Randy.

So is there a number where individuals can be refer today a systemless enrollment?

I just red that number but I'll read it again.

That number is 1-844-824-3655.

The hearing impairment line is 1-833-254-0690 and the website is enrollCHC.com.

Thank you very much for the question.

What will happen to participants ineligible and need something cleared at the county assistance office on 1/1/19?

Not sure I completely understand the question.

I think I'm going to assume what will happen if individuals are still going through the eligibility process and are not determined to be eligible until after 1/1/19.

I'll answer the question that way.

That answer would be that they would be newly enrolled in community health choices, not eligible for the six month continuity of care period and the managed care organizations will be managing their care plan.

They will be new to CHC and they will be responsible for the systems they are providing.

How long will service coordinators have access to SAMS?

That is a question that you would want to answer through your managed care organizations.

Your managed care organizations may have different types of relationships with the historical case management systems and they want their service coordinators to use other resources to look at care plans after January 1st.

So if you're a service coordination entity please reach out to your managed care organization to have them answer that question for you.

This individual had a report of someone that changed their managed care organization but it shows February.

Thank you for the question.

Just to be very clear.

If they made their plan change prior to December 21st, that change will be effective regardless of what you see on the enroll CHC website.

It has a banner that shows that information but there's been some confusion in this regard and we are being very clear if a person made a plan change prior to December 21st or on December 21st that plan change will be effective on January 1st.

Thank you again for the question.

Do new referrals go to maxamus or who receives new referrals?

I'm assuming that is for individuals -- it looks like you're looking for home care service referrals.

After January 1st new referrals for clients will be going through the managed care organization.

The managed care organizations will be managing the referral process.

Question, what happens to a provider who is not yet contracted with -- I'm assuming not yet contracted with a managed care organization.

Continue to reach out to the managed care organization.

If you go to the [inaudible]

it will show the information on where.

>> If you have issues with that call in through the department's provider hotline and we will help resolve those issues with the managed care organization.

>> If you're talking about referrals for [inaudible]

I just want to clarify.

They should go through the independent enrollment.

>> Thank you.

Next question, how about out reach to social workers?

It was suggested that we do out reach to the national association of social workers.

I love that idea and I'll do that.

Thank you for that suggestion.

We will do that as soon as possible.

Next question, nursing home transition with a February date should be 2019 on the slide.

I think that is what they are suggesting.

There was an issue with the slide and we'll make sure that that is corrected.

Thank you very much for the correction.

Our next question regarding the transportation summit, are there any transcripts, et cetera?

I think that we answered this question.

The answer to that will be that we will do not have a transcript.

Will the form will available for all the waivers in CHC?

I'm not sure I completely understand the question.

If it's after CHC and fully implemented the answer to that question would be no.

So the question regarding eligibility, as of yesterday the information is not yet available.

EDFs will not show or verify MCO enrollment until after January 1st.

So starting on new year's day if you look you'll be able to see the managed care organization associated with participants.

If you are a provider or a service coordinator providing services in one of the current fee for service waivers continue providing services at the level you currently are providing on the service plan.

You will get paid.

So you may not know which managed care organization until January 1st but continue providing services as planned.

That is the instruction the department is giving you.

Where can providers which contract of services or service coordination agency or case manager is working with our clients?

Is this on the form?

I'm assuming this relates to home care providers and I think what you really mean is which managed care organization.

The way that you will be able to see that is in the eligibility verification system after January 1st and then you can call the managed care organizations and they should be able to point you to the service coordinators or patch you through to the service coordinators.

The answer is through the eligibility verification system or EVS.

Next question, how do we process nursing home transition participants after 1/1/19 not yet transitioned in the process?

I turn that over to Amy high to answer that question or to Randy.

>> Amy is looking at Randy.

Any participants in the process going into January 1st that will be part of their continuity of care that the MCOs will work with the transition team or entity who is helping that individual and they will be incorporated into their plan of care and before the continuity of care in ensuring that the services are provided.

It will write into the new plan.

>> Thank you, Randy.

As of right now we have no other questions.

We are going to wait a few minutes to see if any other questions are submitted.

>> So we have a few more questions.

At what point in time after the application is submitted, the paper application is an applicant notified to select an CHC MCO?

So if a person is going through the application process they will be working with their nursing facility and the nursing facility should have the information available for them to be able to make a plan selection.

It will be part of the long-term care application process.

They should be eligible -- they should be with their managed care organizations within five days following their enrollment into the program.

>> The nursing facilities will work with the IAB to make sure that planned choice counseling is done with that individual.

So once the MA application is approved they are eligible for long-term services that their managed care will flow at the same time so to try to keep the system from growing.

>> There was a clarification to a prior question.

The individual was asking for participants that were eligible but become ineligible, assuming they didn't go through the recertification process that would have determined if they are eligible.

They have responsibility to be able to work with their participants to help them through the recertification process.

If that's not happening that's something we definitely want to know.

If they become ineligible for the program or for whatever reason they are no longer clinically eligible and they wouldn't be eligible from a long-term care perspective they would lose Medicaid eligibility.

The managed care organizations would have a responsibility to transition them but they would lose Medicaid eligibility.

Assuming that answers the question.

Can we elaborate a little on a bullet point on page 24 about the expedited financial enrollment determination process?

You want to go over this again, Amy?

>> The process?

>> Yeah.

>> The first bullet is when an individual is transitioning from nursing facility to home and community-based services as it is now the 1768 or the financial

eligibility for home and community-based services will determine once they are in the community.

They will have the office process and determine financial eligibility prior to nursing facility discharge.

So the MCO, SC or the service coordinators will notify the independent enrollment broker two weeks prior to discharge and the IEB will notify the county assistance office who will then process the financial eligibility determination for home and community-based services before the person is referred to the community.

>> Just to confirm, prior to 12/21 the billing should go through promise?

That's correct through January 1st.

Any service provided after 12/31 is to be billed through HHA exchange.

The answer is MCO dependent.

So reach out to the managed care organization for the specific billing instructions after January 1st if you're enrolled in a managed care organization.

So reach out to the MCO.

Next question, can we find an answer online to the question above?

I think I have answered that question.

Reach out to your managed care organizations.

Thank you for that question.

With that we are currently out of questions once again.

We will wait a few minutes to see if anymore questions are sent.

>> So we have some new questions.

What should we contact for dual eligibility?

Contact the department.

>> If you can flip to the one slide forward.

The participant line is right there on the screen.

LLTL participant line.

1-800-757-5042.

>> Thank you, Jill.

>> You're welcome.

Has any MCO chosen to not continue contracting in the southwest?

We have not heard of any changes to home care agencies at this point.

They maintain contracts.

>> Or any other provider except the SC providers that you already know about.

>> And the SCs are actually not provider, they are administrative components of the managed care organization.

What will happen if the facility physicians are not credentialed with managed care organizations by the deadline date?

Any assumption is that will be MCO specific so they should reach out to the managed care organization to find out what would happen next.

Next question, did not hear the revised answer to who they should send new referrals?

Those who do not currently have home care services.

We are recommending that you reach out to the managed care organizations which is on the previous slide and the managed care organizations are going to be managing the referral process for all new individuals.

The next question, tomorrow's deadline is for participants and providers?

Tomorrow's deadline is for participants to have a plan change that would be effective on January 1st, 2019.

It's not a deadline for providers.

Next question, any specifics on home care companies choosing not to continue providing services in the southwest?

We have no such evidence of any home care agency that has elected to not provide services.

If you are a home care association I recommend that you reach out to them and they would probably have more up to date data on home care providers.

At this point we have no knowledge of contracts to be terminated by the managed care organizations.

In the southwest roll out there was an issue with managed care organizations denying pharmacy claims for Medicare part B and supplies, have they corrected this in their system so the same thing does not happen in the southeast?

That's a very good point to raise and very specific.

The person who raised the question, we are grateful for you asking that question.

This has been corrected.

Randy, would you want to provide some more details because you worked on this specifically.

>> All three MCOs have faced this in the southwest.

They have all resolved the issue surrounding payments whether it's Medicare B or D.

They have all resolved those issues.

Their drug -- or pharmacy benefits managers they are utilizing have all resolved those issues so it should not crop up as an issue in the southeast because they addressed this quite quickly as we moved through the southwest.

>> Thank you, Randy.

At this point that's all the questions we have available.

We'll wait a few more minutes to see if we have anymore questions to come through.

>> So we have a few more questions.

The next question, is [inaudible]

nursing transition waiver?

I'm not really sure what that means.

Amy and Jen?

>> For nursing home transition participants.

>> The process is for individuals that are currently receiving their long-term services and supports in a nursing facility that are transitioning to receiving their services through home and community-based services.

So that would apply to anybody going through that process.

>> Thank you, Amy.

Next question, will individuals have access to hixis and sams?

The managed care organizations will.

We recommend that you reach out to the managed care organizations to see how that is going to continue.

Was an update provided on the southwest?

If so I apologize for not hearing it.

We did not provide an update for this southwest because we were focusing on the southeast implementation and we wanted to make sure that we allotted all the time available to southeast implementation.

We will provide on going updates.

The next Thursday third webinar, I'm going to give this an opportunity, we'll will talking about quality data that we've been collecting in the southwest and that information will also be presented in the MLTS as well.

So much more detailed information on southwest on going operation ins the next third Thursday webinar as well as the MLTS.

Next question.

What should be contacted if maxamus declines to help healthy dual individuals enroll?

We already answered this question and we'll show you the slide again.

You call the LLTL participant line 1-800-757-5042.

Who is the IB contacting when the application is in the nursing facility?

Are they asking me for the nursing home resident or the representative such as a social worker?

That depends.

They may be asking for a family member or power of attorney.

It depends on who is the designee for the individual.

Clarifying question regarding the 1768.

How will the service coordination agency submit 1768 forms starting on January 1st?

The ageing waiver was sent in paper and where will this 1768 be available for agencies?

The managed care organizations will be responsible for those types of activities and we encourage you to reach out to the managed care organizations for specific instructions on the possess of how that will be managed.

That's all the questions we have currently.

We'll wait for a few more minutes to see if there's additional questions that can be asked by the audience.

>> So we have a few more questions.

Thank you for your patience.

The MCOs have adequate health network.

Randy will answer that question.

>> Do the MCOs have adequate physical networks including large hospital systems?

>> The MCOs have adequate physical health networks in regards to PCP specialists.

They have the networks for that.

As far as the large hospital systems, two of three MCOs have signed contracts with temple, the third MCO is working with temple to come to a resolution for the issues so they can get their contract signed.

Other large systems, U Penn has contracted with two of the three MCOs.

They will not be contacting with UPMC but UPMC will pay any services through them as an out of network provider.

The rest of the larger facilities have signed contracts with the MCOs and they do have adequate coverage in every county.

>> Thank you, Randy.

What is the criteria MCOs will use when placing referrals with companies?

That's the question that you want to ask the managed care organizations directly.

They may have their own criteria and that would be managed care organization specific.

We'll go back to the slide that shows the managed care organization numbers.

Thank you, Amy.

Next question, given there are so many home care providers thousand will the MCOs present a fair list of providers to consumers?

That's a question you want to answer to the managed care organizations you will be contacts.

That's all the questions we have currently.

We are going to wait maybe just a few more minutes and see if we have anymore questions coming up before we close out.

>> We don't have any questions left.

We appreciate your time so close to the holidays.

We look forward to hearing from you again or having you listen to the future third Thursday webinars that we schedule throughout 2019.

We'll be focusing on southwest and southeast as well as the third phase when you get ready to be fully implemented with the program.

We thank you for your time.

We wish you the very best holiday season and look forward to talking to you again in the near future.

Thank you and have a great holiday.