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  >>CART Provider: Calling in 213-929-4232, access code code 832-648-652. Unable to join. I will stand by and try again.

  >> Been involved and engaged in helping us provide the messaging across the board. I would also say careful planning for program and design and implementation has been another contributing factor. Before we implemented the program we took a full year to design it and the process was a very carefully managed project and that procurement process took an additional year. We didn't implement community health choices until almost three years after joining it. We have have had stakeholder input and the continued feedback we received from stakeholders has underwritten the success of community health choices in a very Broadway. Some of the most important stakeholders but this is not an exhaustive list but most important stakeholders I want to particularly thank include those participants of future, those past and current participants. MLTS. As well the larger MAC itself. Very important stakeholders the Pennsylvania health law project and community legal services have helped us with outreach with participants as well as with education with larger stakeholders on what are the considerations for community health choices.

  Participant advocacy groups including adapt, carry and the Pennsylvania health access network all were very important when it came to messaging and the specific design of the program. Healthcare foundations including the Jewish healthcare foundation and the southeast funders were very instrumental in not only getting the messaging out but also helping us to validate some of the concepts in the program. The long-term care provider community and our associatings including the nursing facility association leading age pH CA and the county nursing home association as well as the home Pennsylvania home care association RCPA, hands, and so many others and all other providers were instrumental in the design of the program and making sure that the managed care organizations themselves were ready for this implementation. As well as so many individual consumer advocates all involved in program design as well as program implementation.

Some other contributing factors included the communications and outreach efforts by many stakeholders and most especially by the aging well, centers for independent living and minute know group all our stakeholders were involved in communication were particularly helpful in reaching special populations the AAA SIL's and Mendoza group. The commitment to success by the three managed care organizations UPMC, Pennsylvania health and wellness have worked tirelessly to make sure they were ready to take over the administration and oversight of the long-term care system and Pennsylvania's Medicaid program on day one for each of the phases and they continue to work tirelessly to be able to make sure the successes continue to occur making sure their systems, their teams and provider networks are ready to be able to manage the services for participants on day one and throughout the life of community health choices. Support from the general spli and legislative supports. Department of human services department of aging and health . Teams working together from all agencies from our office of income maintenance office of medical assistance programs, office of mental health and substance abuse purposes. The department of aging working with the area on aging and helping us design the program and the managed care team at the department of health all working together to make sure the community health was once again ready to go on day one for each of the phases. Tireless work of many of our contractors and consultants. Most specifically delatitude consult being KPMG and many others have worked together to make sure our systems were ready as well as our processes were ready on day one once again to be able it take care of this program and also most specifically with the greatest degree of gratitude the tireless work at the office of long-term living. Regardless of the role of the office of long-term living I've had people work 12 to 14 hours a day to make sure the implementation was successful and they will have my endless gratitude for the hard work they did either in standing up the program or working to make sure all the existing programs continue to operate at a high functioning and successful level. And now I want to just take a few seconds to celebrate the success of community health choices and immediately afterwards we will move forward to continuing to improve the quality services of the Pennsylvania medicine indicated long-term system and we don't have an opportunity often to be able to talk about such a broad success as we've had community health choices that has been an achievement for so many. At this point we have to own it. We pulled it off. We pulled off a reform of the long-term care system in Pennsylvania that we believe will be a movement towards true improvement. With that being said the work is certainly not done. We have much to do to improve the quality and the service offerings to work on provider access and look for better opportunities for integration with Medicare, behavioral health services and physical health services and long-term services and supports. We want to make on our balancing numbers

look pretty good but we want to work on efforts to offer opportunities for long-term care in the community, to reflect participant preferences we want to improve quality and accountability. We want to continue to work through program innovation and last but not least certainly for the long-term care system because in reality and as we all know as costs continue to increase and as the program growth continues to progress at a very rapid rate we do have to take into consideration that the growth as it is right now is unsustainable so we have to look for opportunities for efficiency and effectiveness and bend the cost curve for the Medicaid long-term care system.

And with that, that's all really we have to talk about today. We're going to leave ourselves open for a few questions. I want to highlight the 8009320939 for providers who may have issues or questions during implementation. We always encourage you to reach out to your managed care organizations first for billing or other related issues but if you're not going relief from that effort please call our provider line and we'll help on your behalf. We have the OLTL line but the participant line will be once again available and staffed to be able to answer your questions for the program and to research any types of significant issues that are not being resolved through that outreach with the managed care organizations. 800755042. A reminder tomorrow is the last day for planned change to be effective on January 1, 2020. To be able to make a plan change please reach out to the independent enrollment broker at 1844-824-3655 or visit enroll CHC.com and we'll leave the phone lines up for a few minutes to be able to answer any questions that may come through. So we still haven't received any questions but we're going to keep the phone lines open for a few more minutes to see if any additional questions come through.

>> I'll be bringing the questions down shortly. Give me one second I'm printing them out.

>> Thank you.

>> Great we have some good questions here, a lot that printed out.

So broader question relating to contracting. I had a question whether or not any of the managed care organizations have a back long in their contracting. My understanding managed care organizations will be working through any backlogs they may have and they will like will I have to facilitate payment with providers out of network contract if the official contract is not in place.

So here is a larger point, an individual a client inform them that a service koorder call them and said they had to choose a specific MCO or they would lose their waiver. My understanding this is untrue or unethical and it absolutely is. If this individual would like to reach out with the name of the service coordinator we will take action because this is the violation they are not to steer to a particular managed care organization it's not only unethical and untrue it is an absolute violation of our program requirements and that is absolutely inappropriate and to emphasize strongly people cannot be, people who are going through this process can receive information about the managed care organizations but they can't be directed to a managemented care organization by any entity offering that organization. They need to have an opportunity for independent choice. When the are the managed care organizations planning on inputting participants in the HHA system is this going to be done by 1/1/20 or do we have to contact each. I would recommend you reach out to the MCO for that organization but the information has been available. They have the capacity to be ready by 1/1/20 but they may be based on particular type of service. Reach out specifically to ask about their particular schedule.

People in the southwest are having issues with their service coordinator not returning before they speak with a participant and not addressing their needs. This issue mainly has to do with one of the three managed care organizations or actually would of the three managed care organizations so we have this information and we'll provide that feedback to the managed care organizations thank you very much.

Next question, any update on EVV and I will turn this over to Kristin.

>> At this time we have not received any update from the centers for Medicare and Medicaid services regarding our application for the good faith exemption. As soon as we receive a final decision from CMS we will send out an official update through all of the list serves office of long-term left and EDD listserv and provider exception into 2020. All providers should continue to implement EVV as soon as is feasible but so you are aware payment will not be impacted on January 1st of 2020. We will provide the expectations for how that will occur through 2020.

>> Thank you Kristin. Next question will there be a pass through of the 2% increase to personal assistance providers from the managed care organizations. The managed care organizations will be the source for the race for personal assistant services so we recommend providers reach out to their managed care organization contacts to be able to find out what the rates will be but the managed care organizations are aware of what the change to the long-term care fee for service

for personal assistant services was and they were waiting for that information to be able to have a better understanding as to how the personal assistants rates would be set. So I would recommend that provider reach out to the managed care organizations about rates.

What happens if a service provider is not yet under contract with a managed care organization before January 1, 2020. So if they are a home care provider or receiving services for home and community based participants, and they are a Medicaid enrolled provider they will continue to provide services as they did prior to January 1, 2020, they are covered by the 6 month of continuity of care period. For nursing facilities if they are Medicaid enrolled and don't have a contract with the managed care organizations please continue to provide services for your participants. The community of care period is indefinite and they will have responsibility to develop either an in network our out of network relationship with you. If you're a physical health provider and providing services for a participant who is moving from fee for services or community health choices there will be a 60 day continuity of care period. You will be able to continue for 60 days but reach out as quickly as possible to make sure you are providing this physical health services such as dialysis, physical therapy, any service that would be covered under the Medicaid adult benefits package.

So when can phase 3 participants expect their CHC plan cards. Great thank you very much. Managed care organizations I believe have the requirement of 5 business days from implementation so they should be receiving it hopefully in the first week. We did have some delays in the southwest implementation as the questionnaire will certainly remember but we're not expecting those delays at this point. Some of the managed care organizations were hoping to proactively send out cards but we're not in a position to be able to do that but we have the participant list at this point and they would be gearing up to be able to send out those cards. So next question. Great question.

How do providers get lists of participants are which with MCO's. On and after January 1, 2020, you want to check the eligibility verification system that's tied to promise will indicate Medicaid eligibility as well as which CHC managed care organization the participant is enrolled in. So check EVV. EVS sorry. Next question is EVV. So EVS eligibility verification system and there is a way to do batch runs against the eligibility verification system and we have instructions how to do this on the health choices PA.gov landing page. Next question.

We already asked what's the status of the EVV extension request and I believe you've already answered that Kristin. Next question. I had a participant try to

change their plan yesterday and they were told it would not take effect until 2/1. That is not correct if they made a plan change yesterday it will be effective on -- it will be effective -- we're doing a technical check right now. It will be effective on January 1, 2020.

So it would continue via CHC enrollment site it doesn't matter it will still be effective on January 2, 2020 the enrollment site is providing incorrect information we'll have that validated to have that corrected thank you very much for bringing to our attention. Beginning in January 2020 will the physical health choices pay for nursing services day 31 to discharge if the member was discharged prior to CHC enrollment or nursing facilities continue to send claims to LTL for exceptional billing . Great question and really depends are they going to be enrolling, depends if they are enrolling in community health choices from the program or going to become eligible for long-term care. If they are going to be discharged after the, if they are going to be -- that's a really good question. If it's within the first 30 days and they are not CHC eligible the physical health managed care organizations will pay. If the person is going through long-term care eligibility and eventually will be transitioned into community health choices the providers will work with the physical health choices all the way up until the day of CHC enrollment. If the MCO's are going to be discharging the individual back into the community, the -- or if -- if it's an after day 31, it really depends on the particular circumstances of the service. It might be that the person is no longer eligible and may not be eligible for Medicaid funded services really depends on the circumstances. It's a great question but incredibly complicated question and I think we would have to talk to a lot of different specifics but thank you for asking it.

And then FES bulletin or other documents will be I should regarding the process. Bulletin has informational sheet has been issued regarding this process not only to the managed care organizations but also nursing facilities and I believe that information is available on the CHC website . We'll certainly validate to make sure it is. We have your contact information and we'll reach out to you directly if we find out otherwise. Thank you.

Next question related question, will this begin with the admission insist 2019 or 2020 or when the 31st day is effective. It will be based on the date of service. I'm going to have to make the assumption this person is asking if a person will be going through long-term care eligibility and there would be a retro active eligibility in nursing facility services up until the 31st day. If they are going into community health choices physical health managed care organizations will be responsible for that payment. If they are in a physical health managed care organization that will

be effective for the participants in if they go through admissions process in 2020. If it's part of phase 3.

Next question what happens if we cannot get EVV to work by January 1st if the CMS extension is not granted. Kristin what happens if we cannot get -- what happens if we don't get the extension for EVV good faith extension.

>> Kristin: So at this time we will proceed with the implementation and expect providers to implement as soon as possible. And we will release additional information once that final decision is received that will outline the time line and expectations for compliance measures as well as the date where denial of payment would be implemented. At this time it will not be implemented on January 1st, 2020.

>> So next question will we still be able to submit claims. So I think that Kristin answered that question for I think it's related to EVV will payment be held up.

>> I'm not sure because I have another question as well regarding billing promise. We did receive one question will providers still be able to bill promise through the month of December. That is correct you should continue to bill promise for services provided up until December 31st, 2019. After January 1st you will bill the MCO contracted with each participant for those services.

>> I'm just going to have to assume that's related to this question. Next question going forward in 2020 do long-term care residents who apply for Medicaid and county assistance office choose a CHC plan when applying for Medicaid. The answer to that would be yes. So how would that happen? In terms of the process. The participants and their families could work with the independent enrollment broker and the independent enrollment broker can help with that while they are going through the enrollment process.

We're trying a new method here for answering questions. Is there any update on waiver requests for Feds regarding EVV we've already answered that question. Next question are all three managed care organizations assured of having transportation for all three counties. They have a transportation system in place but I have to say we know that transportation in this area is pretty spotty so it's something we're going to have to continue to monitor it's a great question so we know that they have some transportation available but are they able to cover it a broader question because it's an access issue we are struggling to be able to answer. January 2020 will all four CHC plans cover members in nursing facility contracted centers regardless of county. We have three managed care organizations in CHC and if

nursing facilities are participating in the Medicaid program and if they have Medicaid enrolled participants in their facilities they will continue to be covered indefinitely.

I have a scenario here if a resident is from Philadelphia enrolled in a case first CHC and submitted to Lehigh capital county does this resident need to switch CHC plans from keystone to a.m. Mayor tas. The answer no. They do use differentened branding depending on which part of the state. Same managed care organization there will be a county transfer that has to occur. There actually would be work associated with eligibility that would be relevant for this individual. Some work will be done and needed and but the participant could stay in the same managed care organization as part of it would just be changing the name from keystone to a.m. marry health. Or they can choose a different one. Keystone, UPMC and Pennsylvania health and wellness operate state-wide and regardless where they are they can stay with the same managed care organization or choose one of the other two. How do facilities get payment backed from skilled nursing facility assessment once CHC starts. That is a complicated question that I would love to be able to answer on the phone but I will likely put a lot of our other listeners to sleep so my strong recommendation to the person asking the question is to reach out to your association if you belong to leading age or the pH CA. Pennsylvania healthcare association and they will be able to provide you very specific detail on skilled nursing facility assessment. There is a fundamental difference between the assessment that relates to the managed care organization's payments. But your associations will be able to tell you how that will work and they are very much instrumental in making sure it is being managed with the managed care organizations. So I'm encouraging you to speak to your association. To over 180 day claims have to be sent through the CHC residents for the resident is enrolled in. So I'm not exactly sure what this means. If it's a claim from 2019 and you are in part of phase 3 I would still bill through promise but if you have claims that for services that occur after January 1, 2020 you would bill the managed care organization. The 180 day exception would really depend on the timing for the billing. If it's 2020 you would have to work through 180 day exception through the managed care organization.

So it's noted that only the residents has received notice for about 40% of their participants and if you need it find out more my strong recommendation would be for you to reach out to the independent enrollment broker and the independent enrollment broker number is 844-824-3655 sorry for the delay. I unfortunately don't have it memorized. We have new questions since that point.

>> We did receive a few additional EVV questions. One is EVV is required for adult day services it is not in the office of long-term living act 150. OBRA and community health services. The service is required to implement EVV by January 1, 2020 our personal assistant services, respite and unlicensed settings and directed community support. Personal assistant services and respite are applicable for both agency and participant directed model of care. Another question is if the EVV third party provider has contracted with has not been certified by data yet to sent what should you do. We encourage you to complete as timely as possible. As we mentioned before payment will not be denied on January 1, 2020 as we are aware several difficulties being encountered by EVV vendors they have selected in completing with the aggregator. Additional details on a time line for 2020 will be released soon.

>> Another issue where someone wasn't auto enrolled and they go to pick a plan and they were also getting it noted we'll make sure that information is shared with the independent enrollment broker that the information they are sharing on dates is incorrect. If they make a plan change before January or before December 20th, it will be effective on January 1st. 2020CHC plan transfer cutoff dates located on CHC publications appears to have been uploaded before it was corrected beginning March 2020 to the end of the year so we'll look at the CHC plan transfer cutoff dates for January 1, 2020 effective date cutoff date is 12/20 that would be tomorrow and they can make a plan change at any time after January 1st. And if they make a plan change in the beginning of the month that would be effective the first of the following month and if they make a plan change in the second half of the month it would be the first of the month after that.

>> Just one note on that plan transfer document, four individuals that are already in the southwest or the southeast the plan transfer cutoff date was December 13th.

>> Next question how will HHA exchange portal be sent to us as we can set up participants. I strongly encourage you to reach out to the managed care organizations and they will provide you instructions for that. Families often submit dental and eyeglass invoices to be used for other medical expenses in subsequent months. In practice we have applied the OME to the monthly expense that was incurred. Will we continue that after January 1st when the ren dent is enrolled in CHC by entering the adjustment in promise. You will be working with a managed care adjustments for entering the other medical expenses but otherwise it would be the same.

So for transportation services for long-term care in a skilled nursing facility, we need to call the MTO to arrange approved transportation for parents. That is not

correct you will arrange it. You will work with the managed care about your nursing facility payments but they will rates baked into the transportation is baked into the nursing facility rates. Nursing facilities will be providing transportation to their participants.

Is the EVV required for the options program.

>> No EVV is not required for the options program only required for the OBRA waiver, act 150 program and community health choices waiver under the office of long-term living.

>> For the 180 day exception claims with MLA approval be billed to a MA because it does not start after a few days after eligibility is approved and does not retro back. Not sure how to answer this question. We'll take this back to our provider unit and have them look at more and get back to you directly.

If a provider EVV system is not ready at of 1/1/10 could they bill through promise.

>> Providers who will continue in the fee for service system whether it is OBRA or act 150 you will continue to bill through promise regardless of which EVV system you are using. Unless you choose to use the billing module provided through the data EVV system. Even once you implement EVV you will continue to bill through promise unless you choose to use that billing system.

>> So for skilled nursing facility residents do all outside providers patients do they need to participate in CHC network. I'm going to restate the question. Do all physical health or behavioral health providers that support participants in the skilled nursing facility need to participate in CHC. If they are duly eligible and Medicare is the primary payor for those services. They do not need to participate. We hope they do but they do not need to. If there's any balances that would be remaining on those services they coulding billed to the community health choices regardless. But the, Medicare is the primary payor for the service the participant providers do not need to participate in community health choices.

Next question do home care providers who provide unskilled home care for pediatrics have to have EVV.

>> So in the office of long-term living we do not serve participants under the age of 18. If you serve any participants through the office of developmental programs, you will need to check the EVV website for the office of developmental program

waiver services subjected to EVV or contact the office of developmental programs with questions.

>> Just a confirmation question, will all client authorizations and data be ready for January 1, 2020. We strongly encourage you to reach out to the managed care organizations to determine when that information will be made available to you. It really will be up to the MCO's how that information will be made available to the providers but we believe they have the data ready to be able to do that. The best source for that the answer to that question would be the managed care organizations themselves.

So at this point that's all the questions we have. We'll be waiting just a few more minutes to see if anymore come through. We have a few new questions will CHC reimburse hearing aids for non-CHC provider. You would want to reach out to the managed care organizations if it's a value added service but it's my pdzing hearing aids are not part of the adult benefit package.

So the question regarding billing fee for service before an individual is enrolled in CHC. CHC works different than health choices. Individuals identified when approved the CHC -- VA level and are immediately rolled in the CHC plan of their choice. No waiting period and fee for service. Thank you for the information. Kristin already answered the question do we need to do EVV on over 50 clients she answered correct you do. Question are we aware that providers do not receive sufficient care plans and have to reach out to the managed care organizations for more information and authorization updates. Are we also aware that providers do not receive sufficient care plans and have to reach out for more information I guess is a repeat of the same question. We have been made aware of specific circumstances where providers were not given the level of information they were requesting regarding care plans and we have certainly provided that feedback to the managed care organizations and it's something we do monitor to make sure providers have enough information they need to be able to provide the appropriate amount of services.

Continuity of care are supports able to bill 180 days effective 1/1/20. Are you also providing service coordination for somebody who is in an OLTL home examine community based waiver. Answer is yes like will I yes. If not ODP covered services are not in any way related to community health choices. That's all the questions we have for the moment but we're going to wait a few minutes to see if we get anymore. So looks likes we haven't received any new questions. Once again iment to thank you very much for the opportunity to present today on phase 3 updates. Wanted to thank everybody engaged in the implementation of community health

choices to make it such a resounding success. Hopefully that will continue through phase 3 mrems and with that we're going to be signing off. Happy holidays everybody and best wishes in 2020. And the new decade thank you all and happy holidays