- # OLTL Webinar

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>> CART Captioner: I am all connected and standing by for the webinar.

>> The broadcast is now starting. All attendees are in listen-only mode.

>> Okay.

>> He did that.

>> Good afternoon, everyone.

This is Jo. Welcome to the third Thursday webinar. Just a couple of housekeeping items for folks that may be new to the webinar. If you have comments or questions, you can go to the bar on the right hand side of your screen, type the message and hit send and we will receive your questions. Okay. Let's go on to OLTL updates. Today we're covering a lot of information about the Phase 3 population, the phase 3 communications timeline. We're going to review the southeast implementation and launch indicators. Some southwest service denials, the LIFE program southeast enrollment update and CHC southwest and southeast enrollment updates. So just to re-- just a reminder for everyone. In 2019 our OLTL goals of course. CHC southeast ifermentation occurred on January 1, 2019. As part of that implementation we, of course, have maintained the same goal of assuring no interruption for participant services and assuring no interruption in provider

payment. And conducting monitoring to address any issues that occur. In the southwest, we're now insteady state operations and we continue to have regular monitoring of the southwest. We have ongoing oversight and monitoring through the submission of operations reports and regular meetings with the MCOs. and the we are focusing on initiatives such as housing, employment and nursing home transition or NHT. So a look at your phase three population. If you recall the beginning of each one of our phases, we've taken a good look at the different populations to make sure that we understand the needs of each area of the state. And phase 3 is no different than the other portions of the state in that it's not the same. In phase three, what is even more interesting is we have three zones included in phase three. So we have the Lehigh cap zone, the northeast zone and the northwest zone impmented for January -- we have a few folks that are receiving long-term

services and support benefits in phase three but they actually reside outside of phase 3. So we have 35 individuals that you want to just carve out of that population. So for phase 3 we have approximately 143,000 participants that will be transitioned and we do have a large number of nursing facility ineligible or NFI dual population.

In phase 3 we do have more folks that are receiving services in a nursing facility which was in contrast to the southeast where we had a larger number of participants receiving home and community services in the community. So here is a breakdown for Lehigh/capital by county. You can see the large number of the population is in Berks, Dauphin and Lehigh. We'll focus the communications on each one of the counties in each one of the zones. Here is a look at the northeast. This is a snapshot by county of that zone with the large population in Luzerne and Lackawanna county. Here is the northwest by county. You can see Mercer, Erie and Mercer top the list there. We're tacking at our top ten non-english languages by zone. And we do have breakdowns by counties for this. of course, and you can see after Hispanic we have a large number of Vietnamese, Arabic, Russian, Nepali, individuals. and we will be gearing our communication strategy for phase 3

based on the individual language needs across the different counties in phase 3. All right. So now we're moving into phase 3 communication. We have finalized the timeline while we are currently finalizing the contracts and the agreements for the venues for our provider workshops. We are committed to the dates on the slide for the actual provider workshops. Based on lessons learned we also added a transportation summit for each one of the zones during that week of provider sessions. So in Lee high cap, we'll kick off phase 3 running from May 14 through

the 17th. and then the summit June 4-8 and then running July through August, we will be sending out the initial participant touchpoint Flyer and the life program Flyers as we did in phase two. And the aging well mailer to participants letting them know that CHC is coming and that there will be participant education sessions will be going out August 1. And then the pre-transition notices round one will be

going out the week of August 19 through the 30th. In September through October, we will be conducting participant information sessions and as with phase two, we held 72 individual sessions. We will be having at least 70 sessions for phase three. We plan on touching each and every county to do education for participate pants and this time based on lessons learned and feedback from stakeholders We're looking at expanding the types of venues so we'll be adding CAO offices, FQHCs, health systems, are looking at hosting a few sessions as well as nursing facilities. We're looking at where folks are residing and hoping to hold sessions where folks already are or live. So we're looking at engaging some housing assistance there. So folks that are living in high rises, that type of thing or locations that we may have a community room, we will be looking to host participant sessions there. Also based on lessons learned from session -- from phase two, we

identified that after the enrollment or the pre-enrollment packets went out, we had providers that came and started asking questions about community HealthChoices. So evidently they maybe had missed the first round of provider sessions. So this time around we're going to be adding an additional session in each zone in the September, October time frame for providers that may have missed the first round of educational sessions. Then, of course, round one, two, and three of the enrollment packets will go out. Round two and three the pre-transition notices will be sent. In November and December, the last day for the plan selection before auto-assign element be November 13. And of course, like with phase two, even if they were not able to make a selection prior to the 13th they will still be able to make a selection up through December 20 for their MCO dhois be effective January 1. And a reminder for everyone. Folks can make a choice at any time if they are not able

to choose by December 20, then their plan choice will be effective February 1 and they'll have the auto-assigned plan for January 1. and now we're moving into southeast launch indicators. So I'm going to turn it over to Randy Nolan to cover that.

>> Good afternoon, everyone this is Randy Nolan. Just want to talk a little bit through the launch indicators. We went through the month of January and

collected information on a weekly basis to determine if there was any issues happening in the southeast zone. So we worked through that. So this will be the last time we present launch indicators. These mesh 1450URs that we collected through the launch indicators on a weekly basis will continue to be collected on the monthly or quarterly reports that come in. The first launch indicator that we have here is brand new enrollments in the southeast zone. As you can see, most of the enrollments came in to key stone first throughout the fif weeks this was capture and shows a breakdown of how much were, new NFIs, new home home and community based service. Most fell into new home and community based services but this is the breakdown of new enrollments. Launch indicator two talks about the weekly plan transferred

captured and these are individuals that transferred from one of the MCOs to the other MCOs. Most of the transfer in went to Keystone First. They gained every week that we had this measure. Both PHW and UPMC had a net loss every week of participate pants. These are mainly participants that were auto assigned who decided once they reviewed their provider list and the services available that they may switch from one of the plans to another plan mostly keystone first. Launch indicator six and these launch indicators don't go into numeric order. The reason is in the southwest we had them and we reduced some of them as we moved to the southeast because we collected data in the different ways. You are not missing launch indicator, this is just the numbers we use. Six talks about the critical incidences reported. We took a lock at service interruptions, neglect and abuse across the plans during January. As you can see our numbers are fairly limited.

With that and these are items that were addressed immediately when they were brought to our attention. So as far as in conjunction to the population per 10,000 participants the ins incidents are very low. Launch indicator seven talks about weekly participants with complaints and grievances. As you can see, over time, the numbers did go up and still very low compared to the -- we measured it out by 10,000 participants. So, for example, keystone first had one complaint per 10,000 individuals. So these are fairly low numbers at this point in time. The last launch indicator on this indicator we expect to be fairly low at this point in time as we move through the economy of care period we may see increases in this. Launch indicator eight we measured calls coming into the OLTL participant line. There's a number of ways we captured call data coming in. These are individuals that called in to the participant line. As you can see the numbers are fairly low. They

started high and came down. the amount of calls coming in and you see compared to the number that went to managed care lines is fairly low. Most people were

calling their managed care plans with questions. . Launch indicator nine calls that come into another OLTL line that we contracted out. a lot of them handled how to sign up for CHC and things like.

That they started up in the 500s and came down to less than 200 in week five. Most were transferred to the IAB or one of MCOs. 14A and B are launch indicators at that take a look at weekly claims that were submitted. 14a looks at the home and community based services coming.

In they had claims not add jute dated yet. Claims rejected and denied. a couple things to highlight here. Keystone First and PA health and wellness put their claims through a quality insurance process. That's why the amounts are a little bit higher at the beginning of the program and the other aanomaly is claims rejected. There was a glitch in the system with HHA where they were requiring a certain field on the claim from providers that was not necessary. So those claims were all rejected because of that that was corrected. Ought of those claims there were 19,000 all together. It says 16,000 here. But a little bit more than that. 95% have been reprocessed and paid and the other percentage were correctly denied for a variety of reasons. Those claims were reprocesses and adjudicated. 14b talks about other types of claims. Inpatient. Dental vision claims. As you can see here again the largest issue is with

keystone first. Large amount of claims not adjudicated. They are working through that system. They did have a glitch with HHA and claims not coming through properly through the system. They've corrected that over the last week and processing -- last two weeks and are processing the claims through. And they have in the last week they've been doing check runs twice a week and they've been averaging probably 50,000 claims in the check runs. So they started to catch up on getting their adjudicated claims through the system. Launch indicator 17 is weekly calls that come into the office of long-term living provider line. As you can see the calls were high.

Over the last two weeks they've come down considerably. Again, a lot of providers are calling directly to the MCO lines with questions. A lot of these calls that came in through the provider hotline had to do with follow up billing issues or enrollment issues but the volume is pretty low. Launch indicator 24 talks about PPL which is the enter dwhrait we use to pay direct care workers and payment failures that we've had working with them. We work with PPL on a weekly basis. We meet with them. Each of the three MCOs meet with them on a weekly basis to try to resolve the situations. As you can see there were areas with problems with authorizations that need to be corrected. We continue to monitor this on a weekly basis with PPL.

Launch indicator 26 is the calls that came in to the MCOs call centers. So this is to the participant lines. As you can see, expect that keystone first has the most amount of calls over the last two weeks. It's

kind of leveled off. And same with the other two MCOs. When you look at the -- we give you the number of calls that were answered within 30 seconds. The contract expectation is that they answer 85% of the calls within 30 seconds. . Keystone first met that four out of five weeks. Health and wellness admitted last three weeks and UPMC meet it the last four weeks. Monitoring that call volume very well. As an aside you heard people have long call wait sometimes when they are calling into the service coordination lines which is something we don't track. We've been talking to the MCOs weekly on that. to ensure that the call wait times on those lines are improved. They are moving additional staff over there to handle the call volumes and we're really working with the service coordinators to make sure they are not calling into those lines and clogging up the amount of volume that is coming in. We'll determine if we do have an issue.

If we feel it's an issue going forward we'll take additional measures to monitor that and potentially make it a reportable issue in regards to having the service level agreement that we can hold them to then to make sure that they improve that part of the line. That's one of the things we'll work through. We look at all this stuff as we move through whether we need to address it on a quality basis and collect more data on it. We'll continue to monitor that line. That's the launch indicators that we collected. As I said, we have now moved into steady state with reporting and all of these indicators will now be report on the usual operations reports that we have coming in. So next area that we'll move in and talk about a little bit is southeast service denials. This is one of the operations reports that comes in to us called OPS report-021 which shows the number of increases on the person centered service plan. It shows the number of decreases. As you see the percentages

have been very low in regards to decreases. So it's something that we continue to monitor and that we're interested in as we move out of the continuity care period in the southwest. the expectations that some of the numbers may go up as well the 3MCOs are sending out denial letters and have started that process. Owe so there may be anticipation that some numbers will go up as we move throughout the rest of the year in 2019. We'll continue to monitor this. the other part of OPS21 takes a look at whether the decrease in services was due to the MCOs decision following a new assessment. So as you go through there, again, fairly small numbers at this point in time as they move through with getting all participants reassessed and a

new person center care plan done with now. the other part of OPS021 is the total number of PAS hours reduced due to MCO decision. UPMC is working through the denial notices since December. They are showing a reduction in services. The other MCOs

will start showing that as we move to January and February's data. And then this is a -- part of the report that shows the C -- CHC participants with reduction following a reassessment. This is the number of individuals affected by this. The numbers for UPMC equate back to the number of hours reduced. As far as individuals, I mean over the four months that they've been looking at hours it's affected 34 individuals. So it's been a fairly low number at this point in time. This report is QMUM7 this takes a look at denials across a number of areas.

This is some data that has come in. These are denial requests that have come in. The percentages are fairly low tip point in time. Again, UPMC starting in September is less than 5%. The other two MCOs are less than 1%. Anticipation is at PHW, Pennsylvania health and wellness has been able to send out denial notices within the last month. Amerihealth has been doing so since December but they are looking through the process and doing training for the service coordinators on the plan and how to appropriately write goals and objectives and service plans. So the anticipation is we'll start seeing denials coming from them also. On QMUM-7 we're looking at denials against transportation, [inaudible] and taking a look at all of those. So the next slide moves into life enrollment and Mr. Hancock has joined us and I believe he is going to talking about this.

>> Thankee, Randy. So when we met with the management long-term services and support sub MAC one of representatives on the sub MACed is for historical life enrollment. The next two slides show how life enrollment has changed if at all for the southwest and the southeast, CHC zones. We're going back from June 2017 through January 2019. This first slide shows the southeast life enrollment. As you see, especially since August 2018 we have seen some significant enrollment. We believe that the January 2019 month did not show completed enrollment at this point. We could say that that was the number of enrollments we know were captured in January of 2019. That may not be a completed number. from August through December of 2018 we did see some significant increases which means that we believe that there was some impact to the additional mailings that we Institute the as part of communication programs. We're happy to see these numbers. We also have to

say that the life program has shown consistent growth even with the implementation of community HealthChoices statewide. This is specific to the

southeast. Moving on to the next slide, this shows the distribution for the southwest. If you remember since the southwest went live in January of 2018, we had some concern that there was not a significant. We were expecting an increase in enrollment in the life program as well. We weren't seeing it but we have to say that we're starting to see more significant growth in the life program and once again, we're attributing this in part to some of the mailing activity we have with the program and we had some significant mailings for the -- for the life program throughout 2018 and we do believe it is starting to see some impact in growth. That being said, we'll continue to do all we can to improve the program because we want to encourage people to at least consider taking a look at the program as the enrollment

alternatives to community HealthChoices. Life will continue to be offered as the enrollment alternative for community HealthChoices at thing managed care offering and we're looking for every opportunity to see the program grow. In addition to focusing on communication about the program, we have also recently published requests for proposalsed for the remaining parts of state that do not have an active life program. We'll be looking for -- we'll be looking for opportunities not only to grow the program in enrollment with the existing life plans but also to increase the availability of the program to the rest of the state. We look for the numbers to continue to change and continue to progress in growth and enrollments in the months and years to come.

With that I turn it back over, I think to Jill who is going to provide CHC enrollment updates.

>> Okay. So for the southwest, if you recall, we transitioned approximately 79,000 participants for phase one in the southwest. We are approximately 81,000 at this point. As you can see on the slide for February one, we're showing a breakdown of population buckets for southwest new enrollment by MCO. So in February we received 820 new enrollments. In line with phase one, we can see that large number of them went with UPMC. So for southeast enrollment figures, just to refresh for phase two one one 2019 we transitioned approximately 131,000 participants in the southeast and we do see a lot amount of growth in the southeast area with enrollment figures totaling 31,000 -- excuse me 3100 within the month of February. And, again for southeast, you can see that a large number of the participants chose keystone first as their plan. I do know that we do have some questions on circling over to the resource slide for you so you can have the MCO contact

information, providers, participants if you need your numbers to the health plans. Amerihealth, Pennsylvania health and wellness or UMMC, the contract information is on these slides and, again, resource information. If you are not already signed up for the listserve, please do so. Put in your email address and receive all the email updates we send out. Our web site, our HealthChoices web site is a great resource if you are looking for any fact sheets. We do have narrated training out there and we also have a large Q and A document that has a table of contents so you can look for any questions that you may have, get some answers out there. Also we have the MLTSS subMAAC web site. That's a public meeting and all of the materials are posted at this link. Enough questions related to CHC that you don't know where to go, you can always send it to the email box at RA-PWCHC @pa.Gov. We list the provide line -- provider line and participant line and the

independent enrollment broker web site. At this point we can start taking questions. Randy do you want to?

>> I'll read and we'll answer. One that came in: I'm not going to mention the specifics but there's a concern about patient pay responsibility towards the cost of care. I will be reaching out to the MCO in question and have them contact the person that sent this question in. I'll get something out to them today to get back to you hopefully this week yet to discuss the issue. And I'll probably send you a follow-up email also to Garner more information in regards to.

That expect to hear something from me on that. Question is when will the MCOs be receiving the enrollment eligibles file for other regions?

The daily files that the MCOs get that list the participants on for the phase 3 regions begin in November. They gain population data at that point. What is the time frame for the MCO to put in claims?

By contract they have to pay 90% of clean claims within 30 days and 100% need to be adjudicated within 45 days of receipt. They have a tight turn yarn on those.

If you are running into an issue where the claims are not getting through, let us know and we'll work with the MCOs to make sure they help you out with that. What constitutes a complaint?

We complain to each MCO. HHA exchange and the state rep, does that count?

On the launch indicators the complaints were participate pant driven complaints not provider driven complaints. I do know that the individual that sent this

question in that we've been working with you. I'll reach out to you again to see if there's outstanding issues that you have but I know we've had some communication back and forth. I'll reach out to you also to see if there's anything different. On the launch indicators themselves the complaints and grievances listed there are participant driven, not provider driven. and then a question, we need your urgent help there's three parts to this question: You have some issues with individuals not showing up in HHA. You have some issues because participate -- participants have changed and you have to figure out what MCO they are in. Participate apartments have a right to change -- participants have the right to change MCOs on a monthly basis if they choose to do that. The best way to know is to look in EPS and

that's probably the easiest way to figure out which one they are in. I'll have more contact with you on that. The third part is -- I'm not fully understanding here. You are saying that there's waiver code issues. And then when we go back to reenrolled there's gaps in service. I'm not sure what the waiver code issue is. I know it happens sometimes with redeterminations if individual participants do not get their redeterminations in to the CAO, sometimes their coverage, MA coverage lapses. So we're working on that issue. The MCOs are responsible to assist and coordinate with participants to make sure they get information to the CAOs for the redetermine so there's no lapse in services. We're working through that. I'll be reaching out with an email to you to begin more information about your issues and to see what I can do to help expedite some of the concerns that you have especially with getting people in HHA to make sure you are getting naid a timely man

consider -- paid in a timely manner. I'll be reaching out to you on that. At this point, that is the only questions we've had come in. If you have additional questions --

>> We'll give you a few minutes.

>> We'll give it a few minutes and see if anything else comes.

In I don't know if there's other updates anyone wants to give at this point. We'll hold for a couple minutes.

If we have addition questions come in, we'll go through those. If not, we'll wrap it up at that point in time.

>> So we do have a few additional questions. First, we provide -- this is from a provider this provides home mod tikses. They've not been requested to evaluate any participants homes or provide a proposal for services. the statement goes on that they provided several000 a year and have not received one in the next two months. The question is about the referrals for certain types of service. We have the name of this provider. We'll do a little bit of oust reach with this provider but we also need to know a little bit more about whether the MCOs are reviewing and evaluating for home modifications. We know they are looking at and we know they are being approved so this might be something important for the provider to ask the MCOs directly but we will look at this to see if there's any particular issue with the number of approvals for home modifications coming through with community HealthChoices one mentioned some of the numbers were skewed due to even rollment

of a certain class of individuals from a particular community. So happy to reach out this individual for raising this issue. But I'm not completely sure I agree with the statement that the numbers are skewed. It just shows -- it may not show that. It shows that the program is increasing that we want to see. So I'm not completely sure I agree with the point of the person sending the questions. But I certain agree with the clarification that the direct causal relationship for increasings in enrollment may not not necessary I I will be related to some of the communication attempts are trying to education about the life program. the contract between the MCOs and providers does that have to be something that is renewed every six months. It's a question more appropriate to the individual MCO but -- we would expect that the MCOs be very clear to their network providers on what the contracting requirements would actually be.

>> I think initially through the continuity of care period the MCOs are doing six month contracts certainly with certain providers as they evaluate on-going relationships with them after the continuity of care period. I think it's the same they've done in the southwest as they are doing in the southeast. It's kind of how they are going through and evaluating the relationships with the providers my suggestion is you have ongoing discussions about extending the contracts.

>> Thank you, Randy. So we did receive a provider specific issue about an MCO issue relating to durable medical equipment or DME in a given region. We strongly encourage this provider to reach out to the MCO but if you continue to have difficulty, we are accepting provider complaints with MCOs we would -- we would be happy to talk it through with them we want to you work with the MCOs about provider issues. If it's quality and communication we make sure we can make the

connection with the MCO but we encourage providers to continue to communicate with MCOs about issues or making sure that that you know who is the right contract person for any -- but we have information for this provider and we're happy to make the connection with the MCO as well. Next question: Has there been any changes for transportation benefits while a person in a nursing facility for the southwest region?

We did provide clarification in 2018 about how transportation is provided and we made it clear that the nursing facilities would work with MCOs on how they are providing transportation. But since transportation is a the way it's calculated, transportation would be something that the nursing facility wodz be expected to provide to the residents. In partnership with the managed care organization. So I think clarification was provided in late 2018 and physical this particular provider has not received that clarification, please reach out to us and we'll make sure that you can get it -- an additional copy of it. Another provider asked the department to reach out to them about HHA exchange and issues with communication between the MCOs and HHA exchange. We'll be happy to do that. That being said, it would be helpful for us to know particular examples of something that you are dealing with with regard to HHA exchange and the MCOs and to know what you've

already shared with the MCOs. It's important that you continue your communication with the MCOs about all the related issues especially HHA exchange but the department is very willing to certainly talk to the MCOs if you find they are non-responsive.

>> I would reinforce that we received feedback from providers working with HHA and not getting their issue resolved. If that's occurring, please go back to the MCO. Go back to the MCO and let them know you are having those difficulties. Because I think that a lot of times that information is not getting over to the MCO so you have detailed examples we would be glad to get that over to them.

That is your next step if you can't resolve issues with HHA, don't wait. Get it over to the MCOs.

>> Thank you, Jill. So additional -- another HHA exchange issue. When a provider is receiving a new patient being HHA exchange, there's often not enough information provided. Only the length of service, total number of units and if the provider wants more information they have to call the service coordinator to get that. Is there improvement coming to access via HHA exchange?

We've had this feedback before. We had this feedback in the southwest implementation. Reaching out to the service coordinator or the MCO should be the first step new need more information. I think there's an expectation that HHA exchange, which is more like a prior authorization system is to be working like the case management systems worked in fee for service. That is not the mod that the managed care organizations in general are using for HHA exchange so we're going back to the MCO ward to service coordinators for additional information. It appears to be the right approach. Once again we encourage you to reach out to your MCOs if you have suggestions on how additional information may be provided or if you are receiving barriers that might affect a participant's quality of care. They are saying medical assistance residents at nursing homes are being denied services that a physician office if they don't have funds for

the copayment. They are calling the facilities to cover the copayments when the resident ariffs and denying that somebody -- arrives and denying that payment. If they are dually eligible one would wonder why the physician would be -- how this is different from fee for service. I'm curious to know if this is a change. So I think we need to know a little about it more information about this and we'll reach out had to this provider directly. Reach out to your managed care organizations. If they have not provided you with contact information, they should have, but the screen shows contact information for providers via email for the managed care organizations and they should be the first line of questioning when it comes to issues with payment. Next question: Actually looking at the rest of these questions, I don't see any new questions offer. We'll wait a few more minutes to see if any new questions come in at this point.

>> Folks we had a couple more questions. We'll go through these. What conflict of interest rule as ply for service coordinator -- apply to service coordinators if any. I'm not sure what you are asking specifically. Service coordinators have regulations they have to follow. I'm not sure what conflict you may be looking at.

>> an example of a conflict for service coordinators would be if they -- it's an express conflict if they are also a service provider. Service coordinators in the CHC mod ll be an administrative -- mod ll be an administrative function. If they have an expressed conflict by providing direct services as well, it was something not allowed in the fee for service system and it's certainly a conflict of interest with the community HealthChoices program as well. and then in particular do the MCOs set the rules or the rules in the PA coord in regards to service coordination?

There's stuff in agreement in regards to the qualification of service coordinators, what the service definition is. That's all in the agreement. So I mean, as Kevin just

said it's a -- now a administrative function of the MCOs. Certainly they are directing things related to service coordination, what the expectation is, what the case loads are. We've directed to the MCOs, the qualifications of service coordinators and service coordinator sup advisors. -- supervisors. That is how the flow has changed as we moved to CHC.

>> Just to emphasize what Randy just said, service coordination is a administrative function of a managed care organization. What that means is when we talk about service coordination, we're talking about the work of the managed care organization. There's no separation. And the department has requirements in the agreement that we expect service coordination -- how we expect service coord Nice be perform -- coordination to be performed. That being said, the MCOs define within the requirements the execution of service coordination. So if you have particular questions about service coordination, once again we strongly encourage to you reach out to the managed care organization to define their model they are planning to use to meet the requirements of the agreement.

>> Somebody asked about the transportation clarification. We'll send that out to you. Question whether I can get additional information about transportation. There's information in a number of fact sheets on the CHC web site in regards to transportation. That would be the first place to go ahead and start. Can the state provide an update on the MCO participant advisoryy committees?

I don't have one right now. They formed their committees and are meeting on a quarterly basis. Can I get an update from the three MCOs and we can present that at next month's meeting. Does a provider have to report to the FC. The provider should be entering critical incidents and you should let the FC know. The FC is assisting with the participant's care and care plan so plan. So it would be a viability responsibility to notify the FC because it's their responsibility to note if I the MCO. the question is: I am assume it's a follow-up question, if you are not getting satisfactory answers from the MCO who would you contact?

The participant line and the provider line also. That comes to the office of long-term living and those are worked through the monitoring teams to work with the MCOs to resolve them.

>> Just in terms of emphasis, if issues are raised on the provider line, we will prioritize payment related issues. One of our objective with any launch with community health choices is to make sure slz no interruption in payment F. your issue relates to interruption and provider payments then that will be prioritized. When it comes to other issues such as not receiving referrals or understanding

instructions with regard to how the MCOs want care to be provided or if it comes to specific issues or questions relating to the service plan for participants, your first request should be with the MCOs themselves. with your contracted MCOs if you have questions about the participant -- participant services et cetera, et cetera. Provider payment will be prioritized but we're encouraging you to talk to the MCOs first if you are asking about referrals and how CHC services are administered by the managed care organization.

>> and if you don't get resolution, especially on the billing issues and you call the provider line, there's certain information we need to know. You need to provide us information on what you are billing for. Who you are billing for, who the MCO is so we can try to track the services and see Y. what attempt you've made in talking to the MCO so follow through with that. There was a question that came in about the IEB sending information out to a nursing facility resident. I need more specifics on that. The individual that sent that in, if she can email directly on that we talked back and forth on a lot of things. Email me directly. Last one is can you repeat what Randy said about the time frames for MCOs to pay providers. Jill going to read from the agreement.

>> Okay. The adjudication timeliness standards are as follows: 90% of clean claims must be adjudicated within 30 days of receipt. 100% of clean claims must be adjudicated within 45 days of receipt. 100% of all claims must bed as adjudicated within 90 days of receipt. The adjudication timeliness standards do not apply to claims submitted by providers under investigation for fraud and abuse from the state of service to the date of accuseddation of claims. The CHC, however, must provide immediate notification to the department of any types of discrepancies with the timeliness standard as our MCOs are held accountable for timeliness standards and could be sanctioned for any adjudication outside of these timelines.

So we'll wait a few more minutes and see if we get additional questions. So.

>> we've received your attention and your time today with regard to both southwest operations and southeast implementation. We'll -- we do have individual questions that will require some follow-up but we are -- just want to make clear at this point even with some of the concerns and questions and some of the communication issues that we've heard today, the southeast implementation is going from our perspective very well. We're seeing minimum interruption of participant services and we're able to address very quickly some of the challenges that we're seeing with interruption and provider payment. Once again we

appreciate your time and attention and we look forward to discussions in the next MLTSS subMAC and the consumer subMAC and the next Thursday webinar. Thank you and have a great day.