This is the third Thursday we can far for community health choices on Thursday, September 19th, 2019.
>> Today we're going to talk about phase three implementation updates and we'll also be talking about -- how it's affecting providers and participants.
And the timeline for the EDV.
We'll refer to this initiative as EDV throughout the presentation.
As a matter of housekeeping before we begin, just as always, listeners will be in listen only mode.
So if you have an interest in submitting questions, there's a box in your upper right hand corner of your screen.
Feel free to type questions into the box and they'll be printed out to us and we'll read the questions and go through the answers if we have the answers readily available throughout the course of the presentation.
We'll be pausing likely before we get into the electronic visit verification to provide implementation update questions.
Starting with phase three imMRELTation updates.
As you remember phase three population includes what we normally call the Pennsylvania -- the LeHigh northeast portion of the state.
Total population is 96% of individuals -- if you look at the lower left-hand side of your screen you'll see that 30% of the total population is in need of long term care meaning in the nursing facility or in a community based waiver but of the total population itself, 96% are --
the phase three objectives include obviously participant communication conducted through participant sessions as well as the mailings that have gone out to participants and continue to go out to participants throughout this implementation period.
We'll talk about this later but participant pretransition notices that inform participants that they will be going to the mandatory medicaid managed care program for long term services and support were mailed at the tend of August and the mailings were completed before the beginning of September.
But an additional mailing started to be mailed at the beginning of September and will be sent out through the entire month of September.
The purpose is to inform of this change and also to provide some detailed instructions to participants -- the key focus for participants is understanding the composition of the provider networks for the managed care organizations and understanding the difference of coverage and understand they don't need to make changes to medicare coverage unless they want to.
In addition to comprehensive participant communication we also have our robust readiness review process involving ensuring provider networks are adequate to meet the needs of par tis pants and provide participant choice and making sure that the managed care organizations are ready for day one for any type of technical and customer service

requirements they need to meet to communicate to participants and to provide a significant level of comfort that they have the infrastructure that's required to manage this very large long term care system that's funded by the medicaid program.
Providing communication and training is also important in CHC phase three involving training and communication by the managed care organizations but it also involves training the department is providing to the provider community and we have a slide later on that will go through the dates for some additional sessions scheduled in October in all three of the zones that are part of phase three there will be an additional opportunity to talk with the department and discuss their questions and concerns a bit.
Engaging with our independent enrollment broker for questions they have about managed care provider networks and selecting one to three managed care organizations to be their community health choices MCO.
That part of the process is particularly important to participants because they want to make sure that they're select a managed dear organization that has approvadeer networks that most reflect the 3R0 vieders they're using right now.
So talking to tinned pent enrollment broker's website which is in the website and talking to their service coordinators will provide helpful information for participants as they try to select their plan.
And then the last objective but not the least is making sure that we incorporate all of the lessons learned which occurred southwest January 1st, 2018, and southeast January 1st, 2019, making sure that we're building on our experience for implementation but also understanding the unique requirement for this final phase especially with regard to the challenges that I'm going to go through right now.
The challenge number one that we're most concerned about is transportation.
The main objective at least in early days is to make sure that we're not breaking anything that's working right now.
So objective number one with transportation is not to break what's working and objective number two is to make sure that we move towards the pathway to make sure that transportation is more readily available to participants in this final phase.
Geography is an obvious challenge.
It's most of the state.
And it is also a very rural area and all three of the zones trying to reach individuals participant outreach related to geography presents a significant challenge when we want to make sure we're providing as much participant communication as possible and reaching participants especially in remote areas continues to be somewhat problematic although we're making every effort to do that and part of the way to do that is not only having participant sessions in almost every single county throughout the final phase zones but also to make sure that we're reaching individuals where they like to be able to congregate.

Also partners for independent learning and service coordination entities are working together to be sure we're identifying locations where these sessions would be the most helpful and then encouraging them to attend the sessions.
And last but not least is the implementation of electronic verification.
Phase three is a particular challenge for home care providers in the system who have to do both at the same time especially if they're part of the final phase of CHC and as they undergo this significant change in the way that they're going to be verifying services.
>> We did a report from all three of the -- on a number of things.
One is the status of how many nursing facilities, hospitals, and other providers that he had have and they submit reports directly to us.
Submit an operations report that is utilized by the EEB to populate providers out there.
And then they also send a report to the department of health who reviews and monitors their network building capacity.
So as of last week, there's a list here of how many providers they've actually contracted with so on nursing facilities and phase three there's 318 nursing facilities and it's contracted with 215 health and wellness and 127 UPMC with 240.
On the hospital side there's 93 hospitals.
AmeriHealts contract with was --
all of the nurse facilities and hospitals have contracts in in their hands and have for a while.
It's just a matter of getting through the process of being signed off on and then having the providers fully credentialed by the plans so those numbers up above are fully credentialed providers.
So we continue to work through with that.
We're not hearing of any really big issues with nurse facilities and hospitals.
So our next big push is to make sure that we get specialists and PTPs and LCSS providers all into the network.
So they keep submitting this weekly and we'll keep monitoring it.
We work every other week with the department of health and discuss it weekly.
It is one of the biggest things that we're working on at this point in time.
Little bit about -- kind of talked about training but each of the MCOs will conduct a various number of trainings for providers that enroll with them including how to work with the MCO, who to contact, how to be in touch with them, how to do billing and invice voicing, how to work through care plans and get stuff onto HHA appropriately.
They work with providers and answer the questions about why is keystone -- that's all part of what they'll discuss.
Sometimes keystone does them a month at a time and that is in the HHA.
The authorizations are actually for a longer period of time.
It's just what's showing in HHA the number of hours for that month at a time.

They'll also be doing training along with the department on the EVV system so anything related to providers is doing training.
They'll do a combined training on each phase on the inter-RAI for providers.
Keep in touch with the MCOs once you get enrolled with them.
I do not know about LeHigh valley.
I know it's still in discussion with the MCOs.
I don't know that they fully contracted with them at this point in time but they continue both of them continue to be in contact with them.
>> That's the question that came in right now for network providers.
I'm going to turn it over to --
Jill.
>> Okay. Hi, everyone.
This is Jill.
So exciting from last year we received feedback regarding some providers that were not aware of CHC and how to answer particular questions that they received from participants once those letters went out.
So this year, we added three additional provider summits in the fall.
So if you recall we did provider summits in the fall this year so these will be one in each of the three zones of phase three.
We'll be at Mary university in Scranton and on the 28th we'll be at cookstown university.
The breakout of the event is similar to the session in the spring so there will be a morning overview session and then there will be breakout sessions in the afternoon to include physical health.
Behavioral health, nursing facilities.
Service coordinators, home LELTH providers and then we've added transportation.
So if you know providers not familiar with community health choices, please make sure that they get this information.
Feel free to share.
The information is on our website as well so registration is now open and we're about half capacity for each one of these sessions now so make sure that you check it out and get enrolled.
You have to scroll down to phrase three provider subjects and click on click here and register for the session that you're interested in.
We'ral the process of conducting participant outreach activities.
So just as a caveat, we have a comprehensive communication strategy for phase three.
48 counties up for phase three.
So we've taken our lessons learned from southwest and southeast and combined some additional communication outreach activities for phase three to ensure that everyone is aware of community health chatss and what they need to do and what it means to them.

So I think Kevin touched on we have already started our outreach to participants in July and August.
The initial touch point flyer and life program flyers went out in July.
Our aging well participant information session mailer went out in August and that gives information about all of the aging well sessions that are being conducted in September and October.
The first mailing of the pretransition notices occurred the week of August 19th and the meaningful contact activities began.
So aging well is in the process of training service coordinators to conduct meaningful contact with all of their existing participants.
So what that means is participants that currently have a service coordinator will have information, receive information from their service coordinators about community health choices and what that means to them.
How they would select a managed care organization.
So we're in September and October timeframe currently.
72 participant information sessions are going on right now.
There is still some registration open for these sessions.
So if you go onto our website on the participant side, you can still sign up for them through the web or you can call the number on the flyer to register for an event.
These are the sessions that aging well is conducting for us.
They are spread out across the three zones.
And there will be an additional 11 sessions conducted by our centers of independent living in the next month or two so we will have a schedule for that being distributed soon.
And also, we have contracted with a grass roots vendor to do some targeted community education and participant education about CHC and that's basically faith based organizations and groups that represent folks that may not have English as their first language.
So those will be conducted over September, October, or October, November, timeframe.
As Kevin said, our participant enrollment packet mailings are going on now.
Of course service coordinators will be conducting ongoing meaningful contact outreach and activities with participants over the next two months.
Another additional tool that will be available is the training that's been posted for participants.
They're narrated sessions out on our web is that mirror what our provider events are.
We'll be hearing more about that in a little bit.
November and December is very important.
November 13th will be the last day for plan selection for participants before an auto assignment will occur.

If they do not like the plan that they were auto assigned, they can still make a change to be effective January 1st as long as they make that choice by December 20th.
And if it's after December 20th, then their change will become effective February 1st and they'll work with their auto assigned plan in the month of January.
At this time, I can turn it over to Michael to talk about the meaningful contact activities.
>> So good afternoon.
Thank you, Jill.
Long term living has an agreement with analing well of Pennsylvania to provide outreach and education.
Most of the service coordination entities should have received an email or notification from aging well as well as a mailer from the office of long term living about these meaningful contact activities.
They're all part of the outreach and education effort that we've been trying to do for all participants to make sure that participants are contacted one way or another and have been supplied the information regarding changes to CHC.
And how it affects them specifically.
We're obviously doing the participant sessions but also on a more one-on-one level we're trying to make sure that service coordinators also meet with their case loads.
So we determined that the SCs responsible and we're fully supportive of what aging well is doing, our contract with them to do these meaningful contacts.
But we want to make sure that everybody understands that it's something expected by the department and by the office of long term living and other service coordination entities.
So we're interesting to be aware of the requirements outlined in the memo sent out many March by aging well and the following emails you'll receive.
Try to be sure you're responding accordingly.
Go to the next slide.
I don't have the star ship control panel.
So each service coordination entity has a list of service coordinators so that they can all be registered by aging well.
Once registered all the service coordinators are given access --
you can start making your meaningful contacts but I think there's a short testing at the end of the online training and the service coordinator has to be able to pass that training in order for your meaningful contact to count towards agency.
So if you haven't passed the test at the end of the training you won't be able to enter your contact numbers and your contacts into the system you won't get credit for the contact to ensure that you're all being asked questions regarding CHC phase three.
Make sure if you can that you take your training and that you have passed that training and then afterwards make sure getting all that information into the system when we are asked to do that.

What happened is meant by a meaningful contact.
A meaningful contact and we've kind of softened that from the very, very original so in the last two years meaningful contact is a contact that is made where information has been shared and the recipient of that information shows that they understand what's going to be happening in CHC to their case.
Next question is if you're in the SCE in zone two and zone three, do we just follow what we did for zone two regarding meaningful contacts?
We've not received an email from aging well regarding zone three.
I would try to be in touch with analing well if you can, if have you that information.
If not, yes, you're going to follow the same thing in zone three that you did in zone two.
But I would since you already have contact information with aging well, I would get in touch with them.
Thank you.
We encourage everyone listening to this call right now to go to this website.
This website has a significant amount of information about the individual provider networks as well as a comparison flyer that showshows value added and expanded services.
They can also reach out to the independent director directly at 1{844}824-3655.
On the 844 number they'll be able to answer questions about the provider network statement, what can be found on the website or they will be able to go through the value added benefits that may differentiate between the three plans.
The enroll CHC website also has information about meaningful contacts and it's also this website is also a good resource for service coordinators and nursing facilities to work with case loads of residents to be able to help walk them through what plan selections will need to be.
And in addition to this information we would also enrage people to go tout the community health choices website to find out more information on the participant modules including training how much -- and nursing facility training.
The training itself I'm going to turn over to Jill who is going to provide a quick overview of what has been a new addition to the community health choices web page since the implementation of phase -- since we started implementation for phase three.
>> Thank you, Kevin.
This is very exciting.
We've been working on this training for quite some time.
It is a nail biter.
It's a nail biter.
We have within working on this quite some time and in conjunction with our stakeholders we've gotten feedback from our consumers regarding the content of these trainings.

If you recall, we last year had posted training for different provider types on the provider side of the website.
And we've gotten nothing but great feedback about the content and format.
It's a narrated training with some fact check questions involved.
So we decided to do that for some participants.
We receive feedback from stakeholders wanting to have something they could watch with family members or direct care workers.
So we have developed three separate trainings.
One for dual eligible participants.
One for folks residing in a nursing facility and one for folks receiving home and community based services.
I know that nursing facilities are using this training to place for residents so that they can all watch it and discuss questions and resources together.
So we're really excited to offer this new resource to anyone that would like to use it.
So as you can see, it is narrated.
The menu is along the left side and there is a transcript so you can read along if you don't have audio or have trouble hearing.
This is where you will find the training.
And I encourage everyone, we get questions frequently regarding where to find different types are resources so our website is a really great resource for you.
So copies of enrollment packets.
Copies of notices.
Any information we're sending to participants if you get a question regarding a letter, you can come to our website and you should find that letter so you're able to look and see what they're asking questions about.
And now I'm going to turn it back over to Kristen who is going to talk about electronic visit verification.
>> Before Kristen goes I got a couple of questions that I want to answer here.
A follow up to the question about LeHigh valley [Indiscernible Audio].
All three MCOs have contracted with LeHigh valley.
All three of them continue to work on main and the provider network so they continue to work through that.
So LeHigh valley is contracted with all three and ready to go.
Question.
Will other medical expensed will billed to the MCOs.
[Indiscernible Audio].
It will be drafticly reduced under community health choices because some of them are now accessible services to the program or they are add on benefit services through the MCOs.
Those that are not will be billed as they currently are.

They will be deducted from the patient pay.
And that amount will be submitted many the nurse facility bills the MCO so they will be handled in the same manner.
If they go to an out of network provider they'll handle that in the same manner than in the past.
They'll be responsible for payingna and will encourage people to go within networks and they are building up a more robust dental network than in the service program but if somebody prefers to go to a dentist than a network then they'll have -- they'll try to contract with them and if not they'll have a contract with them to pay for those services.
The last question is how the contact made?
>> We prefer in person but if can't be done in person by phone is acceptable.
>>> And now to EVV.
>> Thank you.
So this is a reminder as we provide some quick updates on EVV. We are required by the 2 1S century cures act to implement the use of EVV for personal care services by 2020.
That includes personal assistance services and respite in unlicensed settings.
Home healthcare services will be implemented by January 1S, 2023 but that's not part of the current implementation.
As we continue with that we are proceeding with an open vendor model as a reminder what that means is the department of human services will contract with an EVV entity who will not only provide an EVV system for providers to use free of cost if they were to choose to do so but it will also provide an aggregator.
The aggregator is important when you have multiple systems operating.
So we have our managed care organizations who have chosen to use their own system and we also have many providers who have invested in their own EVV systems and would like to continue to use them.
For providers who do not choose to use the system provided by the department of human services, they can send EVV data to the state aggregator and continued to use their personal system.
So as we continue we discussed earlier that EVV is a challenge as we continue to implement VHC and one of biggest challenges is understanding the different steps providers need to take based on what programs you're enrolled with.
If you're a provider who will continue after January 1S of 2020 -- you are able to use the DHS data system if you don't already have an EVV system.
Training on that data system in person starts next week as well as webinar training.
So if you have not yet registered for that and you do plan to use that system, you will want to get rebelled for that on our EVV website which will be listed at the end.
If you are a current provider in CHC or you're a provider in the aging care and independence --

and don't have your own system, the system that will be available to you free of charge from the MCOs is HHA exchange.
You'll not use the data system because that's built nor the fee for service environment but you will need to reach out to each of the MCOs and work with them to make sure that you are credentialed and follow all the training steps for HHA exchange to begin using it this fall or January 1st of 2020 if that's be you're transitioning to CHC.
You'll need to take two different steps depending if you're in fee for service or CHC.
If you're in fee for service which still -- you will need to work with data to make sure that you're EVV system can send data to the state aggregater.
The number is listed on this screen and you can contact them to make sure you're taking the proper steps to integrate your system with the state aggregator.
On the flip side of that if you're in CHC or you're transitioning to CHC on January 1st of 2020 you don't need to integrate with the aggregator.
You'll need to work with the MCOs to make sure your system is --
>> If you have not registered for that, you can register for that on the EVV website listed.
FRSZ that's all that I have.
We'll wait a few minutes to see if we have any questions.
Justice one correction.
The next public meeting on September 23rd is actually on Monday.
Thank you.
>> Reeveed two questions regard things EVV.
The first question is whether or not providers need to use EVV.
They do not need to use EVV.
The only providers in OLPL programs who need to use EVV as of January isst 2020 are personal assistance providers, respite providers, and providers in the participant director program providing personal assistance or pre tis pant directed community support.
The other question is regarding a recent CMS document that allows some additional flexibility to states with a few different EVV components and this particular question is asking about whether or not we have taken a stance of the state on the allowance for live in washings to be -- at this time, we're analyzing the impacts of all of the -- future information on our stance --
>> We're going toe wait just a few more minutes.
If anyone has anymore questions for us feel free to send them.
So we're still getting feedback on our communication that we'll be releasing to providers for the unique ID for EVV.
As of right now, we have implemented the unique ID with the participant directed population.
And I think almost all of the direct care workers through that program have received their unique IDs.

That was our first rollout of the process.
We learned quite a few lessons through that process and we're working on additional enHassments to the system to make it aly bit easier for other providers to implement.
For those workers in that program, if they are also an employee of an agency, they can continue to use that unique ID to satisfy their requirement.
Workers will only need one unique ID and as you're implementing EVV, it will be expected that if a worker does have a unique ID, regardless of what employer they have obtained it from, that unique ID needs to be used in the direct care worker profile in the EVV system.
You'll be required to either submit a unique ID or if they do not have one, the last five digits of the Social Security number into the EVV system until a unique ID is obtained but at this time we have not released the official guidance Fer the unique ID for agency workers but that should be coming in the coming week ease.
>> Where are the packets on the website.
>> Actually, if you go to our health choices.PA.GOV website, you click on the community health choices button.
You go to the information -- I need information on services.
And then you go to the communications to participants.
You scroll all the way down and you will see the series of notices that go out to that are sent out to the par tis --
participants and right blow that is the preenrollment packet.
>> All right.
Thank you.
All right.
When will the meeting dates be announced?
>> They are looking to schedule them now.
They have sites that they've already identified sites right now finalizing the dates we should probably have finalized dates early next week if not by the end of next week.
How confident are you that the HCV SPROSHGS vieders are confident to take on the EVV implementation by 1/1/2020 I believe it should be.
>> So we're very confident with where we are in the EVV implementation.
They were actually able to launch their system early.
Their system went live in September to allow for additional time to work with common law employers and direct care workers within that system since there are approximately 20,000 direct care workers and 16,000 individual common law employers.
So we anticipate that being a higher list and at this time, even though we're still only in the first few weeks of that implementation, we do have over 65% utilization at this time.
We have quite a few more months to do direct outreach and work with those different workers to make sure they understand and get the training they need by January 1st of 2020.

We're doing the same approach with providers and agencies and are monitoring which providers are using EVV when the system goes live in the first week of October.
We'll also be monitoring how many how many have providers have completed training -- or data.
And based on all of those activities, we'll determine which providers have not yet implemented EVV throughout November and December and be doing direct outreach to them to make sure we can assist in whatever they need whether their system is not running properly, they just don't understand the requirements, they need additional training assistance.
So we'll be doing direct outreach as we move forward and are monitoring everyone's status.
>> All right.
Once we've gone through the online course we'll send data and gotten the certificate what is the next step?
We want people to start using the system when it goes live in October.
So that it gives you some time to work out the process and understand it with your workers.
>> They mentioned testing data but we have not received that.
I'm not sure what exactly data testing data you're referring to.
So if you can send in the clarification we'll try to answer that.
>> Will the power point be available to print out?
>> Yes.
The power points are always available on our website so it will be posted in the coming days.
>> All right.
Is the expectation that 100% of personal care members will be on some form of EVV on day one?
>> That is the goal.
And that is the federal expectation via the EVV mandate.
Yes.
>> All right.
Will they be reaching out to providers to set up the trainings.
The MCOs are reaching out to providers.
They will be sending information out about all the trainings that they do with them that we work with them directly.
So the MCOs will be doing that.
If a provider uses a third party provider do we have the option of continued billing until January 2020.
Or do where to go through the MCOs?

Have you to build -- bill through promise through December 3rd 1S 2019 but after that you can no longer bill to promise and you have to bill through the MCOs and they use different clearing houses to do their billing so you need to just work with the MCOs to make sure the billing is compatible with your clearing house and with their system.
>> And just to add to that, you will be billing through promise for any claimed data service extending all the way to December 31st so you could bill promise after December 31st but it would have to be for a data service that is prior to January 1st.
>> Right.
>> So you l be paid through the service system all the way up to December 31st.
What about direct service providers who DRIFR meals.
>> They do not need to use EVV because it's not part of the mandate.
>> And what about services with W 17934 TT clustered living code.
Do they need to use EVV?
>> Providers who provide personal assistance services will need to use EVV for traditional personal assistance services but EVV is not required for clustered shared living services based on CMS guidance, they've provided some exceptions for services provided in a more settings not billed as discreet units.
We did not have to use it for cluster living.
It just appeared to be more burden some for those providers.
>> I will have to check on that.
It's my understanding that at least one of the three managed care organizations contract with St. Lukes but we can provide a further update.
Reaching out to the managed care organizations directly.
The managed care organizations can speak to participants about the composition of their provider network.
>> This is for Kristen.
Any chance that EVV will be pushed back in the third region until providers implement CHC?
No.
Current aging attending care and I understand pend labor providers.
We expect you to focus your efforts right now on working with the [Indiscernible Audio] in using EVV in the CHC on January 1st.
>> Kristen if a consumer does not have a telephone will the employees be allowed to use their own telephone?
>> Yes.
So we are allowing a flexible model where if whatever devices available can be used.
So if the direct care worker device is the most appropriate device available they can use that device.
If the participant's device is the most accessible and the participant is willing to allow the direct care worker to use that device that is also acceptable and we have agencies

who have chosen a different path where they have purchased a single tablet for each participant's home in all of the workers work, that participant use that same tablet within the home.
This are a lot of different approach owe to make sure.
>> Are smart phones required?
>> No.
It depends on the system as far as what alternatives you'll have.
Guidelines through the agreement to the MCOs on what the qualifications for service coordinators and service coordinated supervisors are but the MCOs are the entities hiring individuals and they have asked us about this in the past and if they find good candidates there's discussions about the qualifications but it certainly is a discussion to have with each MCO.
>> How are employees registering for their unique identifier and when should they start doing this.
>> Participant directed workers have already registered for their employee identifier through the direct care worker registry created by the --
we have not provided directions on when a direct care worker who is an employee of an agency should do so so that will be released.
>> Question.
What if we have service coordinators with bachelor degrees.
I think we answered that by checking in with your MCOs to see the qualification requirements.
>> Correct.
>> There's another question here are you getting my questions.
And to that person, yes, we actually read one of them.
So, yes, we are if the and answered one so we're getting your questions.
Yes.
>> And we have three additional questions that came while Michael was reading.
First if we don't know how to proceed with a unique caregiver ID how do we start using EVV now?
>> So you can use EVV now by using the last five digits of the Social Security number acting as the unique ID for now.
We understand that the implementation of the unique ID --
>> Do -- required to use the EVV system and I'm assuming they mean the providers.
>> Any provider providing personal assistance services participant directed community supports through the participant directed program with public partnerships or this is more of a gammopathy.
It was mentioned that once we do the online course for the aggregator access, they will send testing data that we can then send to our software provider but this provider has not yet received anything.

So this might be a specific follow up.
We have this provider's information and we'll follow up directly with them.
>> All right.
We got a couple more questions that came in.
My understanding was that geo location must be enabled from the caregivers phone otherwise the location is not known.
Am I wrong?
>> No.
You're correct.
If you're using a smart phone or some type of mobile device like a tablet to use EVV, have you to have location services enabled.
That is how the technology captures location and location is one of the six required pieces of information under the 21st century cures act.
>> All right.
The plan comparison chart on the CHC website is -- is that what's being mailed to participants?
I'm not sure the chart is being mailed out but I will double check.
I'll double check but it is the appropriate service charge that they're providing.
And they're doing it across all -- all the answers are the same across the bole program.
The value answers.
>> And [Indiscernible Audio] a doctor at the hospital is not with the same MCO will they receive a separate bill from the hospital?
>> So the hospital contracted with the MCO but the doctor is not.
And if the doctor does separate billing then they'll probably bill the MCO separately.
For the services the .
>> Most physician groups in the hospital though that are part of the hospital are going to enroll in contract with the same MCO.
All right.
Do we bill --
[Indiscernible Audio].
>> I'm not sure what that is but all billing goes through HHA.
Or you can bill directly to the MCOs.
But I'm not sure off the top of my head what 7094 is.
[Indiscernible Audio].
That would be billed through HHS.
>> [Indiscernible Audio].
Assuming that you're talking about 1694 when is personal assistance purposes, we're confirming that, that particular procedure is something that is required validation with EVV.
It has .

>> I have five St. Lukes centers listed here.
One in LeHigh and one in Schuylkill and Monroe and LeHigh county.
[Indiscernible Audio] just to add to at that it's my understanding that UPMP also had a contract with them and I think Pennsylvania health [Indiscernible Audio].
>> It may be in their process and has been updated yet because we want them to be fully credentialed before they report it to us.
>> Question is last question I have here is any research been done on the turn around time for payment of ARs in the southwest?
>> I think we're assuming the question means how quickly the MCOs are paying.
>> Right.
>> And I think that's one of our standards we have in our agreement for the MCOs have to report on in terms of their performance with providers.
The answer to that would be yes.
>> Our bureau finance gets the report every month in regards to claims that are paid from hospitals.
Nursing facilities.
It shows all the claims.
And the turn around time on the DLAM payments themselves.
It is honored monthly.
>> All right.
Couple more.
They go with the plan that they're contracted with what happens as far as billing for the other.
To rephrase that I'm assuming your the participant with five different doctors and they all contract or are going to contract with different MCOs.
So MCLA, B, C.
What happens the they decide to go with one MCL.
The other doctors don't provide services.
All right.
First comes the apology.
I came in late.
But I'm curious when will the actual resident applications be arriving.
Only received about five and they were addressed to our facilities and not directed to the residents in the nursing facilities.
If you have particular folks that you feel did not get a packet, you can send that information into us but the last round for phase one has --
they've already been mailed.
We do have these two coming up so if there were new will you eligible participants that may not have been captured in round one, we have round two of our mailings starting the end of this month.

So they will be getting through packets through that but if there are folks that have been there and you feel that they should have gotten a packet then identified in this first large initial run then please feel free to send that information in to us.
>> Kim, what you can do is sending information in to me if you have a list of residents not receiving the packet yet.
You can send it to RNOLEN@PA.governor.
If you send me a list I'll work with the IB to ensure.
We don't have any additional questions but we'll wait a few more minutes to see if anymore come our way.
Okay. We have a couple of more questions so we'll read through these and then wrap it up.
>> High-rise buildings and mobile homes don't recognize GPS with EVV.
Are they an accessible exception?
>> So I'm not exactly sure if you want to send in clarification I'm not sure I understand the question.
You're referring to maybe a building that for whatever reason is constructed and cannot access maybe a cellphone signal while in the building, that should not impact the actual cellphone application from capturing the EVV visit as well as the GPS location.
But if you have additional information on maybe the issues you're trying to describe, please send that in.
FRSZ .
>> In clarification, W 7094 is for conal dated waiver.
>> Yeah.
We probably shouldn't answer that question.
>> Right.
Go to the EVV website and all of these services under the office of developmental policemans required use EVV are listed.
>> It's not a service for office of long term living.
>> Yeah.
And we would not want to misspeak about a service or an offense of developmental bathrooms service.
>> How many EVV --
each state is required to gather six data elements so one is the name or the identity of the person receiving services.
The person providing the services.
The location.
The time the service started and the time the service ended.
So we have technical specifications -- and the location services.
So we have technical specifications that I know I've been confusing for some providers because although we're only required to collect those six pieces of information when

you develop technical interfaces between different systems, it does require a significant amount of data to begin to match those systems.
So our EVV system is integrated with our MMIS system and will also be integrated with the MCO billing system so when you add in the billing things like the identity of the provider not only does that require a day the field to capture the first and last name of the direct care worker but it also requires fields to capture the provider agencies, the NPI number.
Different information in order to consolidate for billing.
I say all of this because I know there's a lot of technical fields outlined in the technical specifications for providers using all EVV.
So that is the reasoning that it appears to be a significantly higher portion of the data elements than are outlined in the cures act.
It's really for data interfaces and data integrity.
>> And the last question of the day.
If a participant prefers AmeriHealth -- have AmeriHealth.
This is health insurance so whatever MCO though the belong to whether it's UPMC or AmeriHealth, that program is providing their health insurance.
If they're currently under UPMC under health choices, but they see something reason that they want to switch to AmeriHealth, they would switch but be in that MCO where their health insurances and long term services and support.
>> If you're referring to someone with medicare coverage and they have UPMC for their medicare coverage and they wanted to use AmeriHealth as their CHC MCO, that is absolutely fine.
CHC does not impact medicare coverage in any way.
And a participant can choose traditional med care or one of the 11 or ten -- within the state special needs plans or med advantage plans across the state if they choose them for their medicare coverage.
So specifically CHC is for medicaid coverage and they do not have to select the same MCO to deliver both medicare and medicaid.
>> Just to reiterate that.
Medicare does not change.
We are not making people change plans.
They can continue with their coverage.
So they can certainly have UPMC's med care coverage plan and pick AmeriHealth's medicaid coverage plan.
Obviously we were just handed a list of more questions so we will continue to answer these.
>> Next question if a participant -- prefers to have AmeriHealth as their MCO -- did we already answer that?
>> Yeah.

We just talked about that.
>> How often will enrollment packets go out to newly eligible long term care?
Are these --
how often will enrollment packets go out to newly eligible long term care medicaid participants who are approved now until the end of December.
And our waiver programs that have been identified as those that would be eligible for community health choices.
Those individuals were part of the first phase of communications so those are the participants that have just gotten the pretransition notices and the preenrollment packets.
We now are in the process of running another extract which is phase two.
That would now be identified as eligible for community health Shoshins as of January 1st.
So phase two is approximately 38,000 par tis pants so we'll have approximately 4,000 mailers going out now in phase two and they will get their pretransition notice and preenrollment packet.
We'll do this again in nah and again do it in December.
So that we have captured everyone right up to the beginning of community health choices for phase three that would be eligible for community health choices.
>> Thank you, Jill.
>> Very interesting question.
If a resident needs a hearing aid, does the facility have to be sure the audiologist is connected with CHC.
And the facility is responsible for knowing which CHC each is enrolled in.
For the hearing aid, that would be a question we think you'll have to ask the managed care organization because hearing aids P may be offered by the managed care organizations as a separate benefit so we're recommending that the provider asking this question reach out to the managed care organization directly.
The next question, the facility is responsible to know which CHC -- is the question.
The answer to that would be it would be pending interest of the facility to understand the provider networks of all three managed care organizations to be able to help communicate that to your residents.
That might help the residents make a choice that best suits the needs of their individual provider profile.
So the answer is possibly.
A GPS does not recognize high-rise and numerous parts and GPS cannot receive an individual apartment.
This is part of a comment.
>> That was building on a question earlier.
That is absolutely okay for EVV.

We have tried to make the location requirement as flexible as possible as we implement EVV because we understand that GPS technology can be problematic so we want to learn about GPS as we move forward in many policemenation.
>> To match with that address.
Even if you are outside of the perimeter of the GPS recognizes for an address, it will not stop the payment of services.
We do not want to prohibit payment of services based on GPS function only.
We really just plan to collect the data and analyze how effect I have the system is moving forward out of the location requirement.
>> We're going to take three more questions and have to close out.
We appreciate the engagement in today's session.
Our next question is who is supposed to generate the person centered service plan and I think that's the service list and that would be the managed care organization service coordinators.
>> Question is doctors and hospitals do not take all MCOs and if the person prefers a change MCO -- it's just something that you need to talk to your par thank yous pant about.
Yes.
Not all doctors and hospitals will contract for all three MCOs through the continuity of care period.
They want to continue to work with those providers but after that, it will be a discussion that service doored nayeders will have with the par tis pans in regards to how to better serve semiand eh ensure they're getting what they need.
There may be cases where they have to switch positions but maybe situations that the MCOs decide to pay those positions out of network positions.
Those are all questions or concerns that is what goes through choosing the MCL that they discuss with their providers.
Why are the MCOs not providing to all providers?
>> They provide the PCSP to the participant.
They provide the service task list to the agencies doing the services.
But they do not provide the full plan to every provider that's providing services to the individual.
The participant controls the person centered service plan.
And they can share that as they see fit to do.
Thank you, Randy.
>> At this point, this is all the questions we have available and we're almost out of time.
We appreciate once again your participation today.
We look forward to continued engagement.
Thank you and have a great day.