- March 15, 2018

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>> SPEAKER: Good afternoon, this is the community HealthChoices third Thursday webinar we'll be getting started in just a minute.

Good afternoon this is Jill from the Office of Long Term Living.

This is the community HealthChoices third Thursday webinar.

Just to review, for folks that might not be familiar over in the right-hand side of your screen, there is an area where you can expand the box and type a message and click send to get questions submitted to us.

We're going to get started and moving along today we'll cover the CHC launch update.

CHC areas of current focus.

The southeast implementation and some resources for you to get additional information.

So at this time I will turn it over to Randy Nol an who will give

us the CHC launch update.

>> SPEAKER: Good afternoon everyone.

How are you?

Well launch update here, we're about 2.5 months into the southwest.

Going on the close to the third month, things are going very well at this point in time.

Again our goals with community HealthChoices and all the zones will assuring no services are not interrupted and no interruption in provider pavement in the first phase out in the southwest we've had some issues back and forth on individual related participant issues and provider issues, they have all been worked through, fairly quickly by the MCOs.

It is included a lot of phone calls to the participants getting care plans in place including with working with the providers ensuring they're being paid including, cutting up checks four or five times a week for providers and going out and actually delivering text collects to provider.

The MCOs have been very responsive to the providers needs. And at this point in time, we consider the southwest to be successful in the launch so we're moving forward with steady state monitoring and ongoing monitoring of the MCOs in the southwest.

And, at the same time, we are moving forward with starting the start up days for implementation in the southeast.

So that's kind of where we're at on the launch of the program.

And as you can see this is our population distribution, and as of January.

Most of our population 73 percent are duals an a number of other populations 10 percent for home and community based duals 13 percent of long-term care duel and then we have a small percentage of none duals and, long-term care non-duals.

For the southwest, there is the age distribution of our population.

We broke did down by, not NFI duals, home and community based duals and home and community based non-duals nursing facility duals and non-duals then we also broke it down by age categories of over 60 and the under 60 population so this shows a break down of that, as you can see we have a large population much duals both on the home and community based side and nursing so -- also.

This slide shows you the percentage of plan distribution between the 3 MCOs, currently UPMC has about 52 percent of the population.

Pennsylvania health and we willness and AmeriHealth 20 percent.

These numbers change but only slightly.

As we're going through the phase of still having some change in plans and individuals initially in January and February that were auto assigned have worked on assigning -- accepting a plan they wanted.

There was some change of population moving around.

But these numbers have remained stable over the last two months.

We do anticipate there will be changes between plans every month, but it is a very small portion of the population at this point.

Plan selection method, in the southwest, people were assigned based on their D-SNP so 11 percent of the population was assigned to a CHC MCO was that aligned with their D-SNP Medicare plan.

Plan selection, by participants, 19 percent did it through the forms, paperwork forms, 20 percent did it over the phone and, 2 percent, um, fairly small percentage did it through the web.

And then, out of our population, we had, 48 percent of the individuals were auto assigned.

Um, next couple of slides will be some of the launch indicators we have continued to collect at this point in time.

We are down I think only 5 that we're still collecting the information on we started about 20 or so.

The launch indicators have showed that the launch is going very well . And now what we're doing is moving into our operational reports that the MCOs have to complete they're done, somewhat on a weekly basis a good number on a monthly basis and then on a quarterly basis that will capture some of the same data that we captured during the launch but also some other data, as we move forward. And on future third Thursday webinars we'll certainly be talking about our reports once they start coming in.

As can see from launch indicator number one, this is the weekly new

enrollment of participants in the CHC.

As of March 2nd, it shows that AmeriHealth had number broken down by 3 things, by home and community based services participants, long-term care participants or NFI participants which is the biggest part of the population you can see the break down, AmeriHealth and PA health wellness are pretty close and similar in the numbers of new enrollments that we got and then UPMC, um, has a -- slightly larger number especially on the NFI side probably about 100 more than the other two plans.

Launch indicator two talks about the weekly plan transfers captured these are the individuals that left one MCO and went to another as you can see from the numbers as of March 2nd, AmeriHealth lost 70 participants and gained 12, PA health wellness, lost 49 and gained 19. And threaten UPMC gained 103 and lost 15.

So, difference wise UPMC got an additional 88 individuals that transferred in the last week.

PA health wellness lost 30 and a may it please health lost 58.

So it is, if you look at the numbers over time, it is consistent over the last 3 weeks on the amount of people moving between plans.

Launch indicator 2B tells us about the weekly voluntary plan transfers by reasons.

The primary reason as you can see they, individuals transferred because they preferred another MCO's benefits there may be another

reasons under that, it could be prior network was better or the providers were in their network.

It could be that they preferred their added on benefits, um, for their needs.

One of the things we will do a little bit differently when we launch in the southeast, is we will modify this launch indicator, to get a better break out of reasons why they changed MCO plans.

Launch indicator 6 talks about the weekly participant critical issues.

That are reported from the MCOs.

We're looking at incidents related to abuse neglect or service interruption.

As you can see, from March 2nd the numbers are fairly small.

And compared across the board with the population and the break out seems to be pretty evenly distributed based on their participant population.

Launch indicator 7 talks about the, participants complaints and grievances we have received.

As you can see, um, grievances AmeriHealth had a few.

PA health wellness did not have any, UPMC had a few the numbers are very low we've taken a look at the complaints and grievance process.

The anticipation that we will see numbers change as we go through the first six months and go through continuity of care period.

We are also working with on -- one of the things as we move forward with the launch indicator for the southeast is better definition of complaints and grievances so that we're all reporting on the same information.

Launch indicator 15 talks about weekly claims paid, pending and rejected.

And we break it down by home and community based providers nursing providers and other providers which is physical health as can see, we do have claims being paid.

The pending claims, usually all of the pending claims are before, less than 15 days.

Being pennedded because the, MCOs continue to work through the process of -- reviewing all of the claims that come in.

On a nursing facility side, there's been very good success in paying the nursing facilities, with their claims and getting them through the system I think we're seeing, good things.

A lot of stuff you'll see, on the rejection side are because there is a duplicate billings or they were, invoice did not come in, the claim did not come in with the EOB from the other third party insurer.

So like I said with the launch indicators we're winding them down we're going to collect these other five for another week then we'll move into the operations report, had a number of reports, two reports that were due today.

They have four or five that are due by the end of the month and then, the full amount will come in in the middle of April we're working with the MCOs to capture that data make sure we're capturing what is relevant with us.

And then as far as moving through the launch, we initially started out back in December having daily huddle calls with the MCOs we had a 30 minute call every morning with each MCO.

Did that, on a weekly basis all the way through the third week in February.

Over the last two weeks we have tapered them off to two or three times a week and as of this week we are no longer doing those calls.

We continue to have weekly calls, with each of the MCOs.

And, the plan is to reimplement the daily huddle calls probably in Juan so we can address issues as we're working towards southeast implementation and then also, to address any issues that may occur, with the end of continuity of care in the southwest.

So we will continue to pick those calls up at that point in time.

Now, other weekly calls we have we continue to have, weekly calls with participants and advocates.

With the nursing facility associations and home and community based providers and the aging Nell work we continue those on a weekly basis to address any issues they're seeing out there.

So we will continue with those calls.

They may taper down to maybe other, every other week.

But again, they will pick up again as we move towards southeast implementation.

>> SPEAKER: Okay.

Okay so during our southwest implementation we did have some lessons learned so there's some areas that we're concentrating on right now to resolve like Randy said there were some issues that we are working on, on a case by case basis.

So a lot of those issues, were related to HHA exchange and data integrity issues.

So, um, authorizations were not able to be scene direct care worker authorizations between the managed care organizations and the SMS vendor.

Nursing facility and home and community based claims submission we, did some additional training with the MCOs in nursing facilities.

And, carefully watched the nursing facility claim submissions with the MCOs and also from home and community based providers.

We are expanding our Medicare and Medicaid participant and provider education.

So you'll see some changes there for the southeast that I'll touch on in a little bit.

We did see some enrollment issues, just data anomalies as we did

the transition for participants from the waivers to the new CHC waiver and, depending upon where the individual was in the waiver application process it could have caused some errors that we had to manually research and correct.

So those issues have been carefully scrutinized and placed into some categories that we're going to include in our data clean up for prior to the southeast implementation.

The person centered service planning process we are doing some specific training on the person centered service planning process.

And working with each of the MCOs regarding their procedures and policies.

Reviewing changes in the person centered service plan, any changes in service during continuity of care period are definitely areas that we're focusing on and we'll continue to focus on with the start up of this southeast.

Trappings we did have a transportation summit, with representatives from the MATT program, PennDOT, the shared ride Department of Aging, our MCOs and the MCO transportation brokers as well as our office of income maintenance.

We have, we're not process of developing additional communication materials to make that a little bit easier to understand for participants.

And um, make sure that everyone is on the same page regarding

transportation benefits being, um, medical nonemergency transportation as well as, the nonmedical transportation under eligible waiver participant benefit packages.

Also, the complaint and grievance process and notices for home and community based providers we based on the outcome of the financial rule there were some changes to the complaint and grievance process so we have really focused on doing some additional training there. And um, we will be making sure that information is posted on the web as well.

So all of these items that we have been really focusing on in the last, over the last 3 months with southeast implementation, southwest implementation, excuse me we're applying to lessons learned from the southeast I think Rndy mentioned that we're having regular weekly calls with our stakeholders so provider groups consumer groups, those the AAAs we're getting a lot of feedback from our provider organizations and our community to develop a really robust list of lessons learned we can apply for the southeast.

So where we have, where we have arrived at this point is, we can all agree that we need to have an earlier stakeholder engagement, with key population groups and group representatives.

Also, um, earlier an inperson provider communication sessions.

Later on I'll focus on some of the time lines that you can expect for southeast. Anden lanced communication materials regarding Medicare versus CHC.

There was a lot of confusion during CHC roll out with providers based on the timing it was open enrollment for Medicare as well as roll out for CHC.

So some providers were confused as to what a CHC the CHC program was.

We have been working with CMS to develop some communication for those providers as soon as that is finalized we'll also be posting that on our web and sending it out to our Listserv. And it is basic information about what is covered by Medicare versus the CHC program.

We'll also be enhancing our education and communication on the continuity of care provisions. And also adding to some reporting features for enrollment and plan transfer scenarios.

That goes back to the data anomalies and enrollment issues that I discussed.

So we're developing reports to identify those scenarios early on so we'll have an easier process for fixing any differences that may occur.

Earlier OBRA reassessments those have already started.

The communications have gone out.

More communication on the LIFE program as an enrollment alternative.

Earlier data clean up in HCSIS and SAMS those work groups are under way now so we have started earlier we will be looking at outreaching to our service coordinators to assist us in that process if there's any data discrepancies existing in care plans and HCSIS and SAMS so we can

get those cleaned up prior to transition.

Earlier pre-transition so we'll be sending out notices for pre-transition a little bit earlier for participants.

And also, enhancing the provider information that is on the independent enrollment broker web site.

As well as more provider training again focused on Medicare versus community HealthChoices.

So southeast implementation we've done some analysis on the southeast population it is quite different from the southwest.

In the southeast, um, we do still have a large percentage of NFI duals as you can see the home and community based duals represent about 30,000 of the population of home community based non-duals, 12,000.

LTC duals, again, approximately 12,000.

LTC non-duals, 1300.

Going on, for grand total of almost 130,000 folks in the southeast that will be part of the southeast implementation for community HealthChoices.

So that is almost double what we implemented in the southwest.

Here's an additional break down by county of individuals.

Those areas that are listed the 61 under review are folks that we're determining whether that's their country of residence or not, so that could be linked to a data clean up issue.

Urethrae could be in transition.

So, that's the under review of the 61 there, is part of our total.

So you can see the largest number are in Philadelphia County.

So for the southeast implementation we're focusing on the OBRA assessments.

Like I said those notices have gone out.

And those assessments are beginning.

>> MALE SPEAKER: Our communications planning, we have a draft time line put together for the communications plan for southeast roll out.

We do have some dates for provider outreach and education.

And, um, we are further working on some details for the population identification including language needs so that we can make sure that our communication is appropriate for the population in the given counties.

So I can share with you the Philadelphia providers sessions we are going to be holding those in Philadelphia the week of June 4th through the eighth.

And then the outside counties we're still solidifying those venues.

But they, we plan on having those also later in June.

Of course, um, time lines are subject to any types of change it's all draft at this point.

But we have moved our provider education sessions earlier in the implementation time line.

So resources I do believe that we did get some questions regarding

contact information and we are going can to be reviewing as many of these questions and provide answers as we're able to.

I could tell you if you don't get, a response to some of your questions that you have submitted, um, through the chat line, we will definitely reach back out to you, to provide you with a response.

Via your email contact.

So, if the participant help line number is on the screen.

OLTL staff a participant help line to address questions or concerns.

And when a participant has an issue if they're enrolled in CHC the first thing that we need you to do is, contact your manage thed care organization.

That being said, if you're not able to resolve your issue that is when you're going to contact the participant help line and our participant help line addresses any issues that you might have with your CHC MCO the independent enrollment broker.

Your service coordinator or anything associated with the program launch.

The independent enrollment broker number is here if you have not -- if participants have not received their post enrollment packet or they have questions or you need to change your CHC MCO in the southwest, you want to contact the independent enrollment broker.

On this slide we have listed some of the key links for information.

We have a community HealthChoices Listserv this is an email address

that we keep folks contact and every time we have a notification we send it out to this list.

To sign up for this Listserv to get more and current information about CHC, please follow that link and insert your email address and you'll be added to the list.

The community HealthChoices web site this is a has a plethera of information out there for you.

We have some really good narrated sessions on what is community HealthChoices and some dedicated sessions for service coordinators nursing facilities, um, providers, and we have really gotten some great feedback on those training sessions so please check them out.

There's also a provider QA that is broken down by subject key subjects.

So if you have a question you might want to check out the provider question and answer and that will you might find your answer out there.

We also have an MLTSS sub-MAAC the web site is listed there.

That is a monthly public meeting.

And if you have any questions you can send your questions or comments to the RA box that we have listed there, RA-PWCHC@pa.gov.

Our provider OLTL provider line number is listed there if you have a provider and you have any additional questions regarding enrollment or any issues that you may not be able to resolve with the MCOs.

And again the participant line.

The independent enrollment broker number is listed there as well as the web site.

I do believe that there was a question regarding MCO contact information.

So on this slide you'll see the MCOs listed AmeriHealth Caritas, Pennsylvania Health & Wellness, UPMC community HealthChoices. And, the links that are listed there first are for the provider email box and their web site and then their telephone number.

So any one needing to contact the individual MCOs there is your information.

This information is also listed out on the web site the HealthChoices web site.

That was referenced on the previous slide.

So now we can move into some questions.

I know that we've received quite a bit.

Um,.

>> SPEAKER: I'll read through the questions, um, question came in -- um from a SCE, already contacted with one MCO they want it know, how get response from the -- in zone 2 in the southeast.

What I will do is I will work with the 2 MCOs have not contacted you back, send the contact information.

So you -- um, get a call back from them.

Can also go online, for any one ever the 3 MCOs on the web site.

They have the application on there to be a provider.

They also had the provider hot line listed only the web site, so you should be able to call it, in that case I'll send your information out to them.

To talk with them, for them to talk back with you.

Question is, can the MCOs post on the information information on the participant advisory councils, specifically when and when the meetings are the travel cost how they will be reimbursed purpose of the committee hew to join and any accommodations for individuals, if you can join by video or phone if transportation is not involved.

I will ask the MCOs to do this.

And, what their plans are, as far as setting up, the participant advisory council I know they're working on that, they do have their first meeting scheduled I think they're all the beginning of April.

Are at the latest so, when I work with them, with regards to this.

Is there a max for one provider to have I'm assuming to have the participants to ensure the provider can no longer participate does not cause a crisis we do not max on what providers and how many participants they can have it is based upon their ability to provide the services.

As you know we have small providers that serve more than two people, we have large providers that serve hundreds or thousands much people.

There is no limitation on them for that.

As long as they can provide the service.

Question came in about not being paid by any of the MC Os since

services started.

I will reach out to the 3 MCOs have them contact you directly.

So I will do that hopefully today or tomorrow at the latest and get

an email back to you from them.

Next question what percentage was the auto assign was the PWDs under

the age of 60 I don't have those numbers here.

I have to go back and check.

I have to check with Kevin and our data people to see if we have

that break down.

I will forward that onto see if we can get those numbers.

Question is, who is the auto assign insurance provider? How are

they designated or chosen to be auto assigned.

Auto assigned means they -- the system automatically assigned the

participant to one of the 3 MCOs they were assigned to one of the 3

based on some different criteria.

Out there so that is how the auto assignment was based so it -- it

is one of the 3 MCOs if they were auto assigned into.

Question is where do enrollments go to receive service coordination

as new cases as 1/1 not going to any of the external service coordinating

entities the MCOs are working with the participant to choose SCE and

must give them choice, some of the MCOs are working directl directly with the participants and providing service coordination

through the MCO itself.

But that's a process they have to work through. And they work with them once they get the information in.

Question experiencing payments in no cases no a payments with the MCOs difficult to resolve again I will also refer you to those two I refer to the two MCOs to contact you directly to work on that.

Question, calling from a AAA we're in zone 3, so not scheduled until January 20 we received a referral for OBRA waiver asking for level care due to the CHC implementation when we spoke to them, they were told they need to refer begin referring all the waiver customers for level of care now.

That is not correct.

We are working strictly for the OBRA assessments on zone 2 in the southeast.

There's probably about 500, of these assessments that will be done in the southeast.

We have not begun the process of the OBRA assessments for zone 3.

Which is the, um, the -- northwest and northeast and the capital Lehigh area those will not be done until this time next year.

In the southeast.

Or in the zone 3.

So, southeast we're doing now, to hopefully have them done, by June.

And, in June 3, they will start this time next year.

Do we have data on the four southwest LIFE programs in terms of new enrollments and transfers.

I do not have it with me I will speak to Jonathan Bowman who directs the LIFE program for the department and ask him to follow-up with you on that.

We have a consumer that we accepted from another agency in January we're still trying to get the authorization and HHA under our name so we can bill.

Why does it take so long? Part of the problem could have been if the agency that is losing the individual if they didn't close out the authorization that's why you can't see the new authorization in the system.

If you were able to email me the specifics about the individual and what MCO they belong to, I will be able to work with that MCO to try to get this moving forward so we can get the authorization closed out and we can get them back under your system.

You can contact me at rnolen@pa.gov.

And if you can give me the specifics I I'll be able to reach out and get this done.

And if you can send me that, that's fine.

If you didn't get that I'll reach out to you to make sure we can connect.

When will you be collecting reporting on the reasons for rejections

I'm assuming this is in regards to the claims.

We do have -- I know, a list I mean the primary rejections are because, it's a duplicate claim or, the EOB from Medicare was not submitted with the claim.

So it would need be resubmitted.

The other area that I think is big is it's for services that are not accessible or on the fee schedule for the program but what I can do is, work with the MCOs get a break out of maybe the top ten reasons for the denials some of it is because the providers numbers are not correct on the claim when it comes in.

Or the ID number, is not appropriate or they have the wrong information about the participant.

Those are some of the other issues we're seeing.

But I can work with the MCOs to get a breakdown we can provide the information.

Why are there so many pending claims for AmeriHealth, all a lot of the claims are all MCOs are going through all the claims at this point in time, once they feel comfortable with the claim submission they will not do manual review of all of the claims.

So they're kind of hands on with all the claims right now, my understanding is their still playing all the claims usually within 15-20 days.

They the caption is as we move forward your payments from the MCOs

will get to you quicker than what necessary did for the department that's why they're shown pending claims at this point in time they're working through that process.

Question came up I think I addressed this, the procedure about consumers swishes agencies what has to happen is the, the agency that looses the participant, should be closing out the authorization in the system.

So that the new agency can put their care plan and authorization into the system.

When those cases happen and you're not seeing this, um, you can work with us or work with the MCO for that individual to get that process moving.

Who is representing people with disabilities on the participant advocate call? I know Pennsylvania health law project is is on there, Levall and Fran.

Shermanak from the Pittsburgh area do you know who else is on that call? All right.

Well, what we'll do is I'll send a list out to you of who is on that call so that, that we know.

All right.

Providers are reporting usually low numbers and new consumers coming on since the roll out I talked about that earlier.

The department have any data on that? I do not.

The other question is backlog in the MMA enrollment process we're going through the normal process with the IEB, there's no report backlog from them.

Again, this is, how the MCOs are handling this.

So this is their responsibility to work through that.

Question in regard this is a communication question, so Jill will answer this you talked with Heather Hallman, about being involved with the online program you have seniors can provide valuable feedback have been doing continuing education with consumers you understand they would like to be involved think we have insights to contribute.

Again, I'll pass this one onto Jill so that her and Heather can talk about it in the communications meeting about -- yeah.

How to appropriately involve them on that.

So Jill will be in touch with you.

How many providers during the week with the State, I will forward this information over to Mr. Hancock who sets up the meetings for those weekly calls.

So I'll make sure he gets your contact information.

Currently there's only one MCOs using the HHE exchange for nonhome health-care services will all be asked to use so they don't have to work out different billing systems we can certainly discuss that with them but how the MCOs handle that system and utilize HHA versus their own system, is strictly up to them.

It is their responsibility to be able to work with the providers to

get billing down.

We will certainly discuss this with them.

Um, but as -- it's, the State we are not going to enforce them to use one system over another.

This is a responsibility.

Lesson learned please separate HCBS and LTSS.

Another suggestion, lesson learned is make separate benefit comparison charts that reflect differences in copays if someone has only Medicaid versus a DSNP plan that might pick you up all of their out-of-pocket expenses a lot people thought that the they would start having copays under CHC it's been confusing that is certainly a suggestion that we'll take as we work on the communication in the southeast.

In regards to the OBRA reassessments there's specific PC form that needs to be filled out can can we use your old PC form?

Do you know what form they're using I think you can use the existing form you have with that one.

Some other additions for lessons learned, clear materials that define what CHC can do for the NFI duals.

This is a typically around care management and other benefits.

Reassurance that Medicare still someone's main insurance and then, they don't need to talk they don't need to talk about it with the CHC plan making sure Medicare is the remains the primary.

So we will add that in our ongoing communications.

You mentioned earlier communication on a LIFE program what do you have in plan for future roll outs?

>> SPEAKER: Well at this time we're actually working with the LIFE providers we are making sure that all of the LIFE information, is listed as as an enrollment option on the materials going out.

>> SPEAKER: We'll be a little bit clearer in the information that goes out with that, so we'll continue to work together with the LIFE program to make sure that, appropriate information is disseminated.

Please provide an update about the transition of aging waiver consumers and nursing home residents to behavioral HealthChoices in the southwest.

Both of the OLTL and OMHSAS in the transition we've a lot of discussion over the last two weeks in regards to the behavioral health services as a department we have been concerned that we have not seen a lot of up tick in the use of the behavioral health services.

Um, we've discussed this with OMHSAS and on our provider calls.

Both with the participants and advocates with the aging net work and also with the nursing facility associations.

And initially what we think, there's a couple of things that we think are at play right now.

One is we're kind of the emphasis on trying to get everything transitioned in the CHC and assuring that current services are being provided and paid for is one of the issues we see.

The second issue that we see is, that we feel that there might be some or needs to be education provided to the nursing facilities in regards to these services since it is new for them.

So the plan is, that we will set up a meeting with OMHSAS, OLTL the behavioral health MCOs and the community HealthChoices MCOs and the nursing facility associations to discuss the services and how think can be put into place.

And the third thing is, the other thing is that, since we're dealing with care plans on the continuity of care phase, a lot of these care plans especially for folks who are in the aging waiver, do not have the behavioral health services identified and the anticipation is that once the care plans are redone and they reassessed that we will see more emphasis on behavioral health services so something that we are talking about and we'll continue to monitor.

When the local home care agencies in the southeast hear from the MCOs we have a kick off with the MCOs on March 26th we'll be talking with them in regards to lessons learned.

And, starting the full phase move to get implementation started in the southeast.

We have put specific time lines in and at that point in time we'll

be directing them that they really need to start full force in reaching out to providers.

We have provided them a list of all the nursing facilities in the southeast.

We have provided them a list of all the SECs in the southeast.

And we will also be providing them the files with the list of all of the providers in the southeast.

So we'll be encouraging them to start that as of April.

Another lesson learn idea that maybe we should use a visual picture of options that shows what your choices are, if you pick this Medicare DSNP whether it's aligned unaligned how original Medicare works with the CHC plans so, try to make it a picture flow type of format.

Have been challenges regarding the behavioral health services in the first 3 months I talked about that the challenges we found with that.

For slides 5-8 you indicate percentages what the total number of participants in the southwest, little over 79,000.

Please list your contact information again.

That is a one time thing.

[laughter]

Um, no, it's RNOLEN@pa.gov.

All right home mod general contractor who should I contact for assistance in getting enrolled as an approved vendor.

>> SPEAKER: If you are not enrolled as a medical assistance provider then you would need to contact our Office of Long Term Living provider enrollment area.

That can be found out on the web site.

If you were already enrolled as an MA provider you have an MA ID you would want to reach out to the 3 MCOs listed on the slide via their provider contact information.

>> SPEAKER: When can home care providers expect to have assigned contracts with the MCOs they have not responded to our numerous emails I will follow-up with them and have them contact you.

PPO units are not being up loaded into HHA exchange by UPMC even though the State authorizations were up loaded, where can we go from here?

>> SPEAKER: Um, so if you are not seeing that authorizations have been loaded to HH exchange for particular MCO, I would contact the MCO.

We are currently working with all 3 MCOs to make sure that all of the authorizations are loaded into HHA exchange.

So if you are having issues seeing an authorization in HHA exchange, for a particular MCOs please contact that MCO.

If you are not able to resolve that, then we can follow-up, so please, um, send us an email through the RA box if you don't get that resolved.

>> SPEAKER: That would be the same response back about UPMC being up for online submission I thought they were, accepting claims online.

So I'm not sure.

>> SPEAKER: Correct.

>> SPEAKER: -- I'm not sure what issue is.

All 3 MCOs are accepting online claims or, paper claims at this point in time.

So that should not be an issue.

>> SPEAKER: Do we have their contact information on there for both instances?

>> SPEAKER: Yeah for most of these I'll reach out to UPMC have contact both of you.

Okay.

[pause]

Regarding new enrollments must MCOs give a choice of SC providers including external provider questions are members of networks and agencies have confirmed they have got new participants yes. I mean the MCOs are required, for all of their participants to give them a choice of SC and SC entities they should be giving them a complete list of all of the entities in their area.

When they meet with them, um, they should be again asking them if

they want a different SC.

Even in a situation that an individual is in the nursing facility, when they, they are assigning SCs at nursing facility when they meet with the individual, um, they need to give them the option also, to change SCs if they want to have someone else as their SC.

So they do need to provide that choice.

If you're hearing that they don't, that's something we can certainly address with them.

How do you find out who the participant service coordinator is? Ask a participant, that would be the number one area.

The second area might be, to discuss it with the MCO if you know which MCO they belong to.

Providers view the contracts between the State and the 3 MCOs to understand what the requirements are.

Couple points there, um, they're known as agreements and not contracts.

And yes, we are working on posting them hopefully in the near future they will be out there for everybody to view.

Are there any numbers on LIFE referrals by the IEB? I don't know that we have any.

I mean we can check on that to see if there's been fully referrals from the IEB.

I know that the LIFE program itself is handling all their

enrollments the IEB is not, if there is numbers on that, we can can check on that.

>> SPEAKER: If the, someone contacts the IEB and asks the question about LIFE they do provide the information about LIFE so they can, contact them with the LIFE enrollment representative.

We'll have to see if they're actually capturing those transfers and hand off.

>> SPEAKER: Can you share the time line when participants will receive choice letters in southeast PA? We will start sending out letters as early as September.

We will send a number of batch of letters out and we'll be holding probably at least more than 50 sessions with participants in the southeast.

>> SPEAKER: From September to October is when we plan on, holding the participant sessions.

>> SPEAKER: We received a question indicating that they're interested in job opportunities in the Philadelphia area involving CHC implementation or any of the MC Os can you connect me with any resources? I would say if you're interested in working with one of the MCOs that you use the contact information that is listed on

the slide or and/or on the web site regarding any employment opportunities.

>> SPEAKER: Question here is there a plan to publish the payment rules for other HealthChoices funded services for CHC members in nursing homes and clarification on what services nursing homes are to provide?

I'm not sure I really understand the question.

Um, in regards to HealthChoices funded services for CHC members, nursing facilities provide all services for individuals, that are medically necessary, they provide transportation, they're working with the MCO toss provide all services including nursing home transition.

So, I'm not, quite sure exactly what is meant here.

I don't know if you're talking about behavioral health services, what I can do is I can reach out to the individuals to get clarification of what we're -- what you're inquiring about.

Where can providers get more information how to close out a participant's alternate HHA, training comes from the HHA or the MCO?

>> SPEAKER: Um, well HHA does have a link on their web site to have additional assistance and I do know that they are doing training for providers as requested.

If it looks like a provider is having issues being able to fix

successfully submit or access through the portal, they do reach out so I would start with them, but also I would notify the MCO that you're contracted with so that they're aware that you're in need of assistance.

>> **SPEAKER:** Does the State track how the MCOs handle home mods?

Nonmedical transportation, home

deliver meals, DME we do monitor, it's part of our responsibility to monitor all the work they do, by the MCOs we not have any data at there time, being this is a two month old program.

But it is something that we'll be monitoring as we move forward.

We have worked very closely with the MCOs, to transfer the ongoing or the in process home modification cases so they know is what going on we provided a lot of information with regards to in process NHT cases so that they understand who is in the process of being transitioned out of the nursing facility.

We have also provided all the information of who is receiving services through the program and other DMEs we continue to work with them on that.

Suggestion to help distance clearly who who to call when looking at nursing home facility or home and community based -- we'll make sure they have to work with the IEB as they're requesting services.

Would it be possible to get more in-depth communication pertaining to when and to what extent the CHC plan or HealthChoices plans are

reimbursing our Medicaid pending population?

Um, I think what I'll do is I'll contact this individual and have a conversation.

So I'll reach out to you.

All right, coming back to the question about submitting online.

They're saying UPMC's codes are not working I will reach out to them and have them contact you, to see what is going on.

Follow-up I think to the answer you did gave Jill I did contact UPMC about the authorizations they suspended they were up loaded whenever I check HHA exchange the authorizations are there, but not, PPLs.

>> SPEAKER: Is the contact information there?

>> SPEAKER: Yep.

>> SPEAKER: I'll follow-up with you, this is Jill.

>> SPEAKER: Suggestion also connect the MCOs in the southeast with groups banks senior housing sites other nonmedical community groups that can help educate consumers we're allias in this group we want to help get this information out to them we will certainly do that.

>> SPEAKER: That is great.

Thank you. And -- we are going to keep your contact information I

do know the communications work group, will be meeting collectively next week we have representatives from all of our different program offices and we are looking very much at utilizing our community organizations so absolutely you will be hearing from us.

We have a follow-up question about the criteria that we stated for the MCO auto assignment.

Um, when the participant is receiving the information to select an MCO if they do not select one then there's criteria that is used to help them select one if they contact the IEB that will be if they're already, they already have aligned their Medicare coverages with one of the MCOs, then that MCO would be their assignment.

If they have someone else in the household that already has one of the MCOs, or, from the HealthChoices program, then, that would be assigned.

And then other than that, they are randomly round Robinned process of auto assignments for the MCOs.

>> **SPEAKER:** If a resident has an MCO in a nursing facility goes out to the doctors who is responsible for the copay if the doctor is not enrolled in the MCA.

MMCO, that would be considered another medical expense that would be handled like other medical expenses are, it will come out of the res dented's patient pay amount you will be nursing facility

would bill that amount back through.

So OMEs will continue to work the same as they do currently.

The hope is that, as we move into CHC that more and more of these providers, at least be enrolled in the MA program and we won't have as much OMEs as we currently do.

Because they are covered services.

Question about slide six I'll come back do that we'll have to get back to slide six here.

Question will all providers be required to work with HHA exchange in order to bill can we continue using other software yes. I mean, the MCOs allowing you to use the clearing houses, some are requiring that you go through HHA it is a discussion, that you need to have, with each of the MCOs.

Especially, as you're contracting with them.

So that will be a discussion with them.

Slide six can you add a column that shows the number for each row? If you're able to read these numbers now, please do.

We have the percentages but I don't have the numbers.

I'm assuming on this -- I mean certainly something I can discuss whether we can break there out a little bit further next time around in the actual numbers of the individuals.

>> SPEAKER: Couple more here.

Resident Medicaid still active for copayments? I'm not sure what you mean here.

There is I mean if you're a nursing facility there's no copayments for residents in a nursing facility.

That doesn't change under CHC.

I have a nursing home resident who is getting their teeth pulled for den yours anesthesia is not covered by the MCO who pays the anesthesia bill.

Good question.

It will not be me.

[laughter]

I would assume Medicare may cover it if the individual is a dual.

But certainly if you provide me a little bit more information of which MCO this is, I will certainly have a discussion with them about that not being a covered service by them.

Because it should be.

>> **SPEAKER:** It's part of the adult benefit package.

So we would have to have a little bit more detail so we are clear on what the scenario is.

>> **SPEAKER:** If you can send me specifics about the individual, the dates of service, and the MCO, I will look into that for you.

>> **SPEAKER:** What is the draft time line for the CHC roll out in the southeast? Like Randy said we'll start with kick off with the MCOs the end of this month.

A communication will be coming out from the department the beginning of April, regarding -- to our providers.

And there will be ongoing activities with the MCOs reaching out to contact providers in the southeast.

There's also some additional provider workshops that will be in the outlying counties of the southeast.

In the June time frame.

And during the time all of the reassessments are under way.

Those have started now.

The participant sessions will begin in the September time frame and run at least through October and then, the -- pre-transition notices the initial I think what you're looking for is the initial touch point flier to participants will be in July. And then all of those things will follow along behind it.

So provider kick off will begin April and the sessions will be in June.

As -- and, expect some continuous communication there participant education the initial touch flier will be in July and ongoing education and dedicated sessions will be in the September begin in September and

run through the fall.

Of course, that is that's what we're doing.

We will be working with community agencies and provider associations to get out additional ongoing information so expect to see those types of things as well.

We have a question about a contract that a provider had with UPMC, back in January and they have not heard anything so I'm going to give this one to Randy to follow-up with UPMC and have them contact you.

Also, after a continuity of care are MCOs required to continue offering choose of service coordination entities.

With the, um, the implementation of community HealthChoices service coordination is a an administrative function of the MCO.

During the implementation they are working with service coordinator entities and evaluating performance and establishing relationships.

Yes, participants will be required to have their choice of service coordinator after continuity of care is, that is a contract requirement.

To be clear, all of the largest SC agencies in the southwest zone are not receiving nea new cases since 1/1.

We can follow-up with the managed care organizations and have them contact you.

Most participants have both physical and behavioral health disabilities at the same time.

But current programs only allow them to have one or another program

so they choose program with physical disability benefits rather than behavioral they don't want to admit or think they don't have a mental illness issues and decline behavioral health programs.

These two programs physical and behavioral need to be combined in one program and service coordinator can determine if participants need one or another benefit or bone beige at the same time.

It does make sense.

Under the community HealthChoices agreement, that is the purpose of a person centered plan.

There is supposed to be a group of individuals including the Medicare PCP working with the service coordinator the service coordinator is like the hub of that to coordinate all of those services behavioral and physical health we are, really closely working with, a special needs plan for Medicare.

And our Office of Mental Health & Substance Abuse here at DHS.

OMAP counterparts and OLTL, collectively, to try and enhance the collaboration across those programs, to make that a more of a comprehensive solution for each individual participant so, thank you for that comment.

Currently, ANGEL care service coordination is authorized for all waivers for different services.

SC home mods, Pers is that allowed in CHC? And what services are considered a conflict of interest to provide through the same entity,

for example SC and PADS as a contact now not allowed.

So, um, each MCO will be looking at the model that they want to take to deliver those types of services.

As the agreements are put together with individual providers.

So, um, if you are working with a particular MCO, and as a service coordinator, and um, are in the position to provide those types of services that is a discussion you need to have with the individual MCOs.

>> SPEAKER: Okay.

Why was there no up take in MA services post roll out I think, I discussed some of the reasons earlier in regards to the fact we're just getting the program up and running.

>> MALE SPEAKER: Behavioral health services are new.

For a large portion of our population, which would have been anyone in the aging waiver and anyone in the nursing facility, which is both large numbers of the population.

Anticipation is that as we see new assessment and care plans done, that we will see increases in behavior health services, required.

We will also providing educational sessions out to nursing facilities and providers and in regards to the behavioral health services so the expectation is, we will, as we work on this, we'll see

an up tick in services being provided.

We are working very closely with the Office of Mental Health & Substance Abuse, services on this.

What steps are being taken for stemmings with CHC implementation in the southeast we have learned a lot about transportation as we implemented the southwest.

Many things we did not know were occurring, from the department's perspective, and providers out there, transportation continues to be a -- a, hot topic issue.

We will work on this continuously.

With the understanding that we have a very different system in place in the southeast.

With public transportation and, the against are Wednesday by density of the population we'll continue to work through that in the southeast not as much of an issue as we rolled out the southwest.

>> SPEAKER: I can add that, while our providers, sessions for the southeast, will be -- in June time frame, there will be a separate transportation summit scheduled for transportation providers in the southeast area.

So um, we are are working on trying to set that up so stay tuned.

>> SPEAKER: Who running the participant sessions in Philadelphia?

>> **SPEAKER:** Aging well will be doing those participant sessions and -- um, following our communication kick off, the beginning of April, aging well will be reaching out to some individual en en at this timities do I believe they worked with for the southwest.

Expect to hear more from aging well.

To seek assistance in conducting those sessions.

>> **SPEAKER:** Okay folks this is the last time, get your pens and pencils ready --

[laughter]

My email address is RNOLEN@pa.gov.

>> **SPEAKER:** All right.

Agency is saying they want to add to the list of -- agencies that are not getting new referrals.

From the MCOs.

They're saying that the HHA portal is being fixed but it is just taking some time to do it.

Clarification question, still not clear about service coordination, coordination after the transition period.

Do the plans have to offer a choice that includes an SC not employeed by the CHC plan? And again, you know I think as we said, throughout the process, service coordination is administrative function

of the MCOs, it is their responsibility to provide service coordination.

Some of them will be doing it through a hybrid model meaning they will be utilizing their own internal staff as service coordinators and hiring service coordinators.

And also utilizing some of the agencies that currently provide service coordination services out there.

It will be up to the discretion of the MCOs, to determine how they will present the options to the individuals.

Yes. They have to provide options.

But it can be options of their own internal service coordinators, it can be options of the service coordinators, entities in the community that they contract with.

It is is strictly their requirement to do that.

Now, from our respective we will monitor this closely in respect to provider network adequacy and if we get complaints from participants that their service coordinators are not accessible to them, or the coverage of services are not adequate, then we will address that with the MCOs.

So this is a, a process that we're going to go through with them.

We have a couple more questions here.

Are we able to provide the claims submission number for AmeriHealth for nursing facilities.

I don't, I don't see it was 15 this is the weekly pays pennedded and

rejected.

Nursing facilities for AmeriHealth shows that they had 259 pending.

For the week they're working through and 6 that they rejected.

They do not show any were paid in this week.

So this is something we'll continue to monitor.

To make sure that they are getting those paid.

>> SPEAKER: If there are additional questions that we have not addressed it could be that we need to go back and do some research or get the right person to respond to you.

So if we have not addressed your question please know that you will get a response we'll respond back to your email address.

Making sure that we have the correct person to address your concerns and questions.

>> SPEAKER: Question is if all of the waiver programs are transitioned into one CHC waiver and they will be, except for the OBRA waiver in the zone, does that mean all participants will have access to all waiver benefits?

>> SPEAKER: No.

So folks will still need to meet the criteria to be able to have waiver type services.

So that would mean, that they would have to be NFCE nursing facility eligible to be able to receive the additional waiver

services.

>> SPEAKER: Their concern is now they have transfer a participant

from one waiver to another, to get them supplies or DME if they're

requiring that service they meet the criteria --

>> SPEAKER: It's medically necessary.

>> SPEAKER: Yeah.

>> SPEAKER: Yes.

>> SPEAKER: Yes. Paragraph.

>> SPEAKER: Question, um, appears the best attempt to keep people

with mental illness, secondary with a neurological disease Alzheimers

and cognitive disease like Alzheimers woofer the family more than

consultation and direct care, like is done in childrens services and

I their reserving to such things as children services of TSS supports or

personal care assistants.

And if we provide those services it will be less costly than a

monthly nursing home cost.

Not to mention a benefit of the -- keeping the person in the

community, in their home with their family.

The question is, will the state cover such direct behavior modifiers

if they're deemed medically necessary by a psychologist or psychiatrist,

this is say policy related question in regards to services.

We will take this back and discuss with our policy area.

There are services available for that I mean to keep an individual home we do, provide the services of you know like a a pass worker or a home health aid or RN to assist in keeping people at home.

I understand the question you're asking is, it will, allow for a, a -- different type of worker whether it's a TSS related worker for adults or behavioral worker for adults so that, is something we will need to take a look at, it is an issue with individuals with neurocognitive disorders that also have behavioral health disorders that go along with that.

It is a, a major concern with the population it is an issue keeping individuals at home it's also an individual, being able to provide appropriate care for these individuals in nursing facilities.

When could be potentially harmful to themselves and others it is a system issue that needs to be lookeddality and addressed.

But certainly we'll have some further discussion about this.

>> **SPEAKER:** Okay it looks like we're out of questions you do have Randy's email address.

[laughter]

If you have additional questions.

Darn I spoke too soon.

Okay.

But I am -- I'm scrolling here you're MCO contact information on -- I'll leave that up for you.

But, also the resource information if you need to send a follow-up question you can use our -- our RA box and, send it to us.

>> SPEAKER: Last question regarding earlier questions about becoming an approved vendor.

Will we be going through a similar application process as we did during our initial enrollment process.

If you're already enrolled with the Medicaid program, you do not have to go through the enrollment again if you're already contracted with an MCO and gone through their credentialing process in the southwest, um, I believe they're going amend your contract, or to add the southeast services to that, if you're an MA provider you're a MA enrolled provider for the State of Pennsylvania.

The question is in regards to, will you be able to work in the southwest and the southeast? That's a question you'll have to ask the MCO that you're contracted with.

>> SPEAKER: And do -- um, remember,s an MA enrolled provider you're still subject to the recertification process, so um, whether that comes around, um, we have to do that revalidation process and the MCOs do need

to do their credentialing process on an annual basis.

So with that if there's no additional questions we'll close out,

thank you for your great questions. And participation and, we will talk

to you next month.

>> SPEAKER: Have a good day folks.