- Good afternoon. Captions to be provided.

>>: Good afternoon even. My name is Kevin Hancock I'm the deputy secretary for office of long term living. Today is November 21. Before getting into our agenda, we're asking people to submit their questions to us via the box that will be in the upper right hand of your screen. If you type in your questions they will be printed out, we'll read them aloud and read them to the best of our ability.

We request that you not include individual participant information in any of those questions. But if you do have a very specific provider-related question we may elect to just let you know we'll be getting back to you directly without naming who the provider is. Otherwise the more general questions will be answered during the webinar unless they require for research and we'll go back to that.

Today's agenda is focusing on the community health choices phase 3 updates and electronic visit verification. Kristen who is our expert on electronic visit verification is here to provide updates.

Starting with CHC phase 3 implementation. At this point the participant information sessions have been largely completed. That includes the 72 participant sessions that were over seen -- stakeholders participated in many of those sessions. And at this point it's our understanding that we have more than 3000 attendees at 43 different sites across the state. 72 total. 43 states, 3000 attendees.

In aSIGS to those sessions we worked with the PA center for independent living and additional sessions were scheduled across the final state with 600 attendees covering topics about community health choices but focused on the under 60 disability session. I was able to attend one of those sessions heavily attended and I was happy to see that. A lot of great questions were asked and answered. And largely we considered both the ageing and living independent sessions to be a success.

I do think we have data we can share later on on some of the initial impact on advance plan selection. One of the objectives was not only to educate what community health choices but for people to select one of the three that best meets their needs. Specifically the providers and their networks. We do have some data and we'll talk about later on that will show the success of those sessions.

So in addition to the 72 age and health sessions and health sessions we'll be continuing our outreach sessions until December 20th which is the last day participants can make a plan change that's effective on January 1st. We are collaborating with the Mandoza group for special populations. We did this in the Philadelphia and southeast and found it successful for populations with special language requirements. Focus on populations that may be more difficult to reach and they're already under way. It will include community outreach events, stakeholder round tables and marketing and communication campaign. All of which are under way. I was lucky enough to attend a stakeholder round table in Lancaster with a diverse group of people and we had an interesting conversation about healthcare in general, not just about health choices but also community health choices as an integrative part of the healthcare system. Dental services, and long term services and support was in the conversation focused specifically about community health choices.

So in addition to the average activity, we did have system transition activities that occurred over the weekend of November 16th. And what that means is that if a participant had selected a plan, that plan they selected will be assigned to their eligibility record. If they did not select a plan, a plan would have been auto-assigned to them. In phase three, we did not have any particular -- we do have some components to the way these plans are assigned to a participant, for example in a health choices plan that is also participating in community health choices in that region. They would have moved that plan as part of the calculation for the auto assignment.

Some of the individuals in an aligned dual needs plan were moved into the community health choices align plan as part of the effort unless they made a different choice. But otherwise the auto assignments were fairly random and we -- like the distribution between the three managed care organizations was evenly parcelled so the percentages would have been for all three.

What we have found out at this point as of November 16th, 39% transitioning that have selected a plan. That puts us ahead of where we were both in the southwest and southeast. I have to say I am surprised. This is a very rural area. It's most of the state geographically but the population is very dispursed and I have to congratulation those individuals who are community partners including the centers for independent living and ageing and areas on ageing and all the partners and provider partners, et cetera to helping to achieve this. 39% of the population may not seem like a lot. But managed long term services support programs usually have a plan under 20%. That's a national standard. Pennsylvania now, 3 implementations

in a row has doubled that comparatively speaking. We hold the national record and looks as if we will hold the national record for total implementation for people who have selected the plan and we're going to credit that to all our community partners who were involved in the outreach efforts as well as a lot of our provider partners as well. This is good news and we're happy about this outcome and I didn't think we'd be able to achieve what we have achieved in the southwest and southeast.

In addition to participation outreach, we have provider outreach. In phase three, in addition to spring provider week-long meetings, we also had fall meetings, one day meetings in each of the zones to reinforce opportunity for providers to talk to managed care organizations and learn about community health and have questions answered. Hooks town university, and one in Clarion and Marion. And all three of those we had close to two thousand attendees participate. And most of those individuals did not attend the spring sessions so a lot of the information was new to them and they also had the opportunity to make connections with the three managed care organizations for contracting purposes.

The number of people who attended to be great successes as well and we were happy to offer them a plan as part of the final phase roll out.

So at this point, phase three provider networks are progressing very well. This is the latest of some of the key providers that will be in community health choices. Nursing facilities with 318 total. Ameri health and Pennsylvania health and wellness 241, and UPMC 268. They are progressing very well for nursing facility contracting but as a reminder even if a contract is not completed by the time of implementation the three managed organizations will have a requirement for out of network contract. Provider will last for 18 months and if you remember, the continuity of care for nursing facilities participating in the Medicare program is indefinite. If they're receiving nursing -- at the point of implementation they will never have to move. All three managed care organizations to have a contract with every Medicaid participating facility.

Ameri health and PA health and University of Pittsburgh. All other nursing facilities and hospital contracts are in process.

And they will continue to report to us all the way through the implementation phase prior to January 1st. And also continue to report to us continuously on the status of their networks throughout the life of community health choices.

Just an update on clean up. Might seem like inside baseball information. But it is important to the implementation of the program especially for providers because

in our phase one implementation, this was a significant issue when it came to billing and the data population of authorizations of services.

So list serves have been set up about SAMS. This is particularly important because most of the data issues that occurred in phase one and even phase two were out of the SAMS system and we are strongly encouraging service coordinators to work through that data and have it as clean as possible so when the data comes through there's no risk of interruption of provider payment and no risk of interruption of participant services.

Data from SAMS will be used to population the managed care organizations and the cleaner it is the easier it will be to import.

In addition the managed care organizations if they cannot transition, and data elements, there will be impact continuity of care and provider payment. And we have made sure that the service coordination, of the 6 priority data fields and hopefully some are listening today and they include, care plan manager, diagnosis, Medicaid ID, client phone, consumer provider, service order needs to be populated correctly and the format we specified to make sure they're transitioned appropriately into the managed care field. We'll be happy to answer questions relating to those fields but those are the 6 we're asking to be cleaned up before the data transfer and implementation.

A quick reminder about service plan transition. Serving in phase three will continue to receive fee for service waiver. We continue to enroll people in the long term care system, especially long term care at a brisk pace and that includes phase three, specifically capital zone and service coordination entities will be offered by the independent enrollment broker as a provider for participants newly enrolled in the program all the way up through December. That's something you need to be aware of. You'll still receive cases up through December. We're hoping people are not making the assumption that managed care will be taking over in December. We had a few people ask that question. The answer to that is no. Managed care authorities have no authority to do plan over sight with participants until after January 1st in the final phase. So service coordination entities will continue to maintain those case loads and support their participants up to December 31st and including December 31st, just to be clear.

I think we did receive a question. Before I hand it off to Kristen to talk about EVV. The question, what percent of nursing facility residents selected auto enrollment. That's a great question. We do not yet have that data available to us. Likely in the December 3rd Thursday webinar and we'll be able to provide that break down.

Likely we'll provide that break down in the managed long term for December. That data has not yet been dissected yet to identify the difference between provider types and the types of services they're receiving. We'll have it. It's data we have available we have to work through it. Thank you for the question, not yet available.

With that I'll turn it over to Kristen who will give an update on electronic verification.

>>: Thank you Kevin. So before I get into some of the implementation updates, for EVV I want to provide a few quick reminders. We are required to provide electronic visit verification by January 1 of 2020. At a later date we'll focus on the home healthcare implementation requirements and that is not slated as a requirement until January 1, 2023. It's important that we work toward the January 1, 2020 deadline for providers in the office of long term living programs who provide participant direct to community support and respite and licensed settings. If we do not meet the expectations set out we will have our federal percentage match from CMS reduced.

So some of the updates to our current system. As you may remember, the Department of Human Services has contracted with our current promise vendor, DXC and their EVV vendor, and they are providing the EVV system through the Department of Human Services we're making available for any fee for service providers who do not have a system and also operating the aggregator which will receive data from EVV systems that providers have chosen to contract with separately or implemented in the past they want to continue to use going forward.

So that system went live on October 7th as planned. And as of this week we did wrap up the last of the in-person and live webinar trainings with San Sandata. We'll provide for trainings in the next couple months but our current plan has been completed and anyone who completed those trainings should have received a welcome packet so their agency can operate the system and train staff on the system.

We do ask that you do not use the system once you are credentialed with test data. That is a live system. The testing opportunities were held in the in-person training environment. So please do not enter test data into the Sandata system once you begin using it.

As far as implementation of EVV, the office of long term living vendor fiscal agent public partnerships did choose to use their own EVV system called time for care. And this went live or September 1st, public partnerships was ready to get that

system going so we had additional time to on board people. And they conducted webinar trainings starting in August and continue those -- and will continue those through the end of December. Currently the webinar schedule is through the end of November, but additional webinars will be released shortly.

They also conducted in-person trainings in October throughout the southwest, northwest, and lee high capital regions and this week they just wrapped up additional in person trainings in the southeast region and additional trainings in the Philadelphia region are being considered for near future.

The Department of Human Services is also in the process of applying for a good faith effort exemption through the centers of Medicare and Medicaid services. If we're approved for that, this will allow the department to extend our soft launch period so that provider payments are not impacted. So just to give you an idea, these soft launch periods is the phase we're in now. The reason we chose to launch the system in October rather than waiting until January is because we wanted to allow time for providers to acclimate to the system for workers to become comfortable with entering their data into the system before any sort of impact of payment would be initiated.

Due to some different system issues with the aggregator, and integrating third party systems, we do want to extend that soft launch period if we can receive that approval from the centers from Medicare and Medicaid services but at this time all providers must continue to implement EVV by January 1, 2020.

We understand there have been some difficulties particularly for those who have third party systems and completing those integration and service activities we appreciate your patience and encourage you to stay engageed with Sandata as we move through this process.

We will also be releasing EVV compliance policies. And those will be released through a joint office of long term living and office of development programs bulletin. Those policies are not yet finalized. Please keep an eye out for that bulletin to be released in the near future.

Recently the centers for Medicare and Medicaid services provided a response to an association regarding IVR technology. I want to touch on that clarification briefly as there's been a lot of questions about that recently. The clarification pointed out that telephonic verification through any type of interactive call in system. So not any type of smartphone app. But when someone is actively calling into a system and interacting with different voice prompts, those types of verification systems

must include some type of validation of the location of the services. Because a land line phone or a cell phone are not enabled with GPS unless they're interacting with a smartphone application, some type of verification must be used.

Cell phones are not acceptable unless they have this type of location verification. One of the examples of some systems we know are active in Pennsylvania that do this are telephonic systems that interact with a fixed verification device. It's a separate device from the phone that generate a code and they're associated with the address in which they are placed. So that type of code is then entered into the telephone during the voice prompts. So that would be an acceptable form of location verification. But just please keep that in mind that some type of location verification must be included because it is one of the 6th elements of the cares act. Other than that there are no additional changes to our EVV implementation due to any of the recent CMS guidance that has been provided.

For providers, any next steps, hopefully you're all engaged with the various vendors that you need to be moving forward. If you are a provider in community health choices, or you're in the ageing attendant care and independence waivers you have two options. You can either work with the MCO's to begin using their EVV system they chose to offer which is HHA exchange. Or you can send EVV data from a system that you have chosen separately to the MCO's. So if you have chosen your own system outside of the HHA exchange option you must contact HHA exchange at the email on the screen if you have not already to begin the integration activities because you need to be sending data to the system by January 1, 2020.

For fee for service providers, those providers are providers in the OBRA and Act 150 program. The DHS Sandata system is available to you if you'd like to use that as your EVV solution. Online trainings are still available on the website. This will be available throughout the use of the Sandata system. If you have new staff that needs trained you can use the webinar trainings to assist with training your staff on the system.

If providers are using a third party system, so another system you have chosen to contract with outside of the Sandata system you must work with Sandata to make sure you're using it by January 1, 2020. Listed on the screen here for you.

The next webinar is December 18th, 1-3 p.m. You did can go to the DHS website to register. If you have visited our site before, the URL has changed. The department updated and over hauled our website and as part of that many of the URL's have changed so please take note of the new website for the EVV system.

And as always, if you have specific questions regarding EVV you can send your questions to the resource account. And I want to make a note that the FAQ's are also in the process of being updated. We greatly appreciate the participation with our last public webinar on November 8th. We had 900 attendees and received over 350 questions. So we are working through those questions to make sure we answer them appropriately. And they will be added to the FAQ.

And with that, as always our CHC resource information.

And I think at this time we is received some questions.

>>: Thank you Kristen. We have three questions all of which are my questions. We have not received any questions on electronic verification.

First, is there a list you can issue by hospital of who are contracted with the free managed care organizations. The answer, that information is available on the independent enrollment broker website. Which is WWW.enroll CHC.com. You can see which have contracted with which hospital and that is updated on a weekly basis.

Next question, how will the data clean up be implemented in phase one and phase two areas. Are there consequences for not filling in all the proper information. So consequences are actually without appropriate data clean up, the consequences are affecting providers and participants. And which puts them, especially providers at risk of interruption or delay of payment. So emphasis is truly on the service coordinators to have that data cleaned up prior to implementation. To minimize the risk of disruption to provider payments which lead ultimately to potential risk of interruption of participant services. This did happen in phases one and two, most specifically in the southwest but also the southeast. There are managed care components to this, mostly in the way that the data is imported but this is mostly about the quality of the source data. The two main systems that house this data, HIX and SAM have data integrity issues which were created over a long period of time by individuals populating those systems. Most specifically service coordinators. They were populated in nonstandard ways or ways that don't really reflect the fields that were being populated. That is what we're asking to clean up. And just getting back to the 6 fields, we'll take you back to the slide on data clean up. The 6 fields we're asking to be focused on in the SAM system, care plan manager, diagnosis code, Medicaid ID, client phone, consumer provider and service order. Those fields are the primary fields we're asking to be corrected by the service coordinators prior to implementation to minimize disruption to participant services.

And the next question for me, you said that the continuity of care for nursing facilities is indefinite. The actual continuity care is for participants. It does not apply to providers. And then emphasizes no longer than 180 days. The 180 continuity care is for individuals enrolled in forfee service. Care waiver. Etc. So nursing facilities do not have a continuity care period. They do have a provision for 18 months that allows them to be able to be contracted with managed care organizations but there is no continuity care period for any provider type. That's for participants. And the way that works is that participants who are enrolled or receiving services in a Medicaid enrolled nursing facility and are enrolled in a Medicaid long term care program on the day of implementation will never have to move unless that provider elects no longer to participate with a Medicaid program. It's a benefit to the participant not the nursing facilities. I hope that is clear.

>>: We received one EVV, will it be required under the department of ageing. No they will not. So the office of long term living waivers only personal assistant services, respite and unlicensed settings and participant directed community supports are currently required to implement EVV. For the full list of services under the office of developmental program, if you're a provider for ODP as well you can use that full list of services on the DHS EVV website.

>>: Next question. My organization -- this is back to the original update for CHC. My organization has been made aware of numerous FCC providers in the zone who have been offered their participants 30-day notice. There are few providers accepting new participants at this time and providers who will not be able to accept all these people. What is being done to ensure that they receive much needed services?

So for service coordination specifically, there are some large service coordination entities and we're grateful to them who have been willing to fill in the gaps for a lot of these participants and for individuals who are with service coordinators who are actually planning to terminate before January 1st. A lot of that case load is actually being taken over by other service coordinators or service coordination have offered to take over that case load.

For other types of providers it's usually geographically specific. But when it comes to home care providers for example we do have capacity to be able to manage those cases. If there's anything specific you want to let us know about for any particular cases or any provider, please feel free to reach out to the office of long term living directly or 1-800-932-0939. Thank you.

>>: Additional questions we received about EVV, one is requesting whether or not the recent CMS guidance in relation to tell, and location verification, whether or not that applies to a land line. Someone who specifically has a home land line phone number that is associated with their address on file, they're asking if that would suffice for the location requirements. And it would. So a land line is absolutely acceptable because it would be associated with an address at the location where they would be calling in. And you can also have multiple land lines on file if you happen to be at a different location regularly and you use that land line for EVV, that is absolutely fine. It just should be associated with an address.

The clarification is really regarding using a cell phone as part of a telephoney verification system and lack of data that would be submitted with that, that would not be cares compliant.

Can you confirm caregivers who live with their -- must use EVV. Yes, recently, allowed the states to determine whether or not they would like to require EVV for live-in caregivers. Because of the complexity of the definition of a live-in caregiver as well as the difficulty in trying to figure out how to implement that type of exception that would be equitable to our participants and our workers as well as not put us at data validity risk we decided to proceed requiring EVV for all workers regardless of their live-in status.

>>: At this point we have no further questions. But we're going to wait another 5 minutes to see if we receive any additional questions. A little early yet to close out. Please post any questions if you have any.

>>: Thanks for waiting we do have three new questions. First are the administer plans going to post how to bill for -- yes they are. I believe they're already being scheduled all the way up until implementation and likely after. But I strongly encourage providers to reach out to three managed care organizations to find out when they're being scheduled. Reach out to your provider network contact and they should be able to tell you where and when they're being scheduled.

Next question, what message should nursing facility providers pass on to their CHC providers when their hospital is not contracted with a CHC plan. If the individual is a dual eligible, the answer to that would be nothing. They don't need to make any changes. If a participant has Medicare and Medicaid they can keep

their primary care physician. If they are Medicaid only, and if their Medicaid physician is not enrolled in community health choices and they selected one of the three managed care organization plans, the strong recommendation is to reach out to the managed care organization to find out which physicians are participating and that's rare because we have a very small, very small population of individuals who are in nursing facilities and are Medicaid only. There are a few. But that population is very small. It's more likely that they're dually eligible for Medicare and Medicaid and if they are, and they have a Medicare participating physician they don't need to make any changes.

If they have a Medicare participating physician and dually eligible they do not need to make any changes.

Next question, nursing facility reached out to behavioral health in our county about providing for residents, but the behavioral health said they don't provide services to nursing facilities. What is next steps. That is disappointing to hear. Thank you for indicating which of the behavioral health it was. We will make sure that organization, which participated is aware they will have individuals in nursing facilities enrolled in their behavioral health organization on January 1st and will be required through their contracts to be able to provide those services. The person they spoke with was incorrect. They will be providing behavioral health services with participants in nursing facilities. Thank you for bringing this to our attention.

Right now we do not have any additional questions. We'll wait a few minutes and see if we get any more.

>>: So we received quite a few questions related to EVV. So for the first question, some participants have expressed concern that they take their family member into the community and sometimes it's taking longer than the approved amount of hours. What if the location is not at the participants home? So there are two different questions here. One is the issue when services are provided beyond the authorized amount of hours. So that, if that occurs, then the worker or the agency, or if you're the common law employer of that worker need to work with your service coordinator to make sure you have enough hours on your service plan for your needs throughout the day. If you are utilizing EVV, which I think was eluding to and you are not at the home, of the participant, that is perfectly fine. We are not requiring that services start and end in the home. In that case you would want to be using some type of mobile application on a smartphone-type device. For the most ease and flexibility to clock out at any location. You can always use a land line

outside of the home. You'll just have to associate that with the address. But in this case using a mobile app would be the easiest way to use EVV while in the community. EVV should in no way change how services are provided. We don't want to limit people's ability to participate in people's lives in the community. So please do not feel that you have to begin and end at the home.

So there's a question here about Act 150. This Act 150 provider is asking if they should continue to bill through promise after 1-1-2020 or if they should use HHA exchange to bill. If you're an Act 150 you should continue to use Promise for billing. And if you -- I see there's some mention here of the DHS Sandata system so to meet the Act 150 service requirement you can use the DHS Sandata system and that allows you to bill through that system if you were to choose to do so or you should continue to bill through Promise but not through HHA exchange for Act 150 services.

So for EVV, next question, if a participant wants their worker to meet them somewhere will EVV allow that? As we mentioned before you only need to use electronic visit verification at the beginning or the end of the shift. You do not need to interact it with in any way and it is not tracking you throughout the shift. If you want to start or end a shift outside of the home, that is absolutely acceptable.

The other question here is how can EVV verify a location if a caregiver is runninger errands and clocking out how can we document that in EVV exchange. EVV will capture whatever location the worker is clocking in or out at if they are using a mobile app on a smartphone. And we have not set any parameters around requiring certain types of locations to be entered. So they can continue to clock in and clock out at any location as long as the location is being captured regardless of where it is. For how you document that with the HHA exchange system you want to work with HHA exchange and the CMO's for how that makes the most sense with their particular EVV system.

And then a second question here regarding HHA exchange. Providers using HHA exchange do we need to add any additional location information for participants with cell phones as they only use the cell phone as the source of the telephone. And if I'm not understanding that question correctly feel free to send in clarification. But if you are using HHA exchange and need additional location devices so they can use the cell phone at multiple locations, they tend to frequent and start and end shifts at those locations you need to reach out to the MCO and HHO exchange to obtain those devices.

With that, I think we'll sort through a couple more questions we just received.

>>: Some of these questions are general questions and a few are still related to EVV. First general question can we continue to provide services without a valid SAF

>>: So if you have an SAF the service authorization form is for coordinators to -- in the fee for service. As of 1/1/2020 you're under the continuity of care with MCO so you should be providing services as you always did through that continuity of care period. But from there on you need to make sure that you are using the HHA exchange system with the MCO's to receive your authorization. You'll no longer receive an SAF but recommendations through the HHA system.

>>: Next question, will people in the over waiver -- the answer to that is no. The case management is still HIX and will still be billing promise and the promise services will be offered via HIX. It will continue to be a fee for servic

Medicaid, the provider is not registered -- and participant will not switch. Are they obligated to pay. It's a complicated question. I would have to say, it's a complicated question. I would have to say that the answer to that would be yes. Actually. If they're using that individual as a primary care physician they're out of network. It's rare that individuals are straight Medicaid only and if this person would like to send this case to the department directly. If you're talking about a particular case we would like to research it a little bit. There are probably extenuating circumstances. The three will contract with pretty much any provider that is willing in the system. More likely the department care physician does not want to contract with the Medicaid managed care physician. But as the Medicaid knows that individual is supporting a participant and Medicaid fee for service physician, more likely the case they'll go through the contracting process. So I'm hoping this is just a scenario. But if it's a particular case, it might be better for the office of long term living to research it with you more directly.

We are brand new providers do we need to enroll, MCO, after choices go live and if you're a long term care nursing facility provider the answer to that is yes if you want to provide services with all three MCO's.

>>: That is all the questions we received, we'll wait a few more minutes to see if we receive any more.

>>: Kristen and I are having a discussion about the primary care physician. We're going to discuss it as the scenario that it's the contracted physician that supports the nursing facility. In that case it's different. The nursing facility would have to be enrolled with the program, but the contracting physician supporting the nursing facility does not have to be enrolled with the managed care. If that's the scenario, it's a different role. We are more focused on the primary care physician in answering the question. But if they work with a nursing facility they don't have to be enrolled because the nursing facility does the billing. We'll wait a few more minutes but none yet have come back.

>>: So we received a question regarding HIX and SAM data that will be transferred to the MCO's during continuity of care. Is there a specific date the MCO's will pull to upload into exchange. That process will be starting in December. But that will be continually updated throughout January. So there is no drop date until January begins as to when all of that data would be transferred over.

>>: The quicker the data is cleaned up the better off the whole system will be. So just to be very straight forward in responding to that question, we're asking people to move through as quickly as possible.

Another question,EVV, if PC agencies, I think you're referring to personal care agencies have HHA exchange do they need to use the Sandata system? If you are only participating in community health choices after January 1, 2020 you just need to use HHA exchange if that is the EVV system that you have selected. However, if you are providing services in OBRA and Act 150 after January 1, 2020 or you are providing services in the fee for service waivers in the office of developmental programs, you must implement EVV for those programs as well. You have a choice, because you have decided to work with HHA exchange you could choose to speak with HHA exchange to see if they could meet your needs outside of the scope of the MCO system. You could also speak with Sandata about using their system specifically for your fee for service clients or you could look into another vendor to meet those needs. You only need to use Sandata or some type of system outside of HHA exchange if you are participating in programs other than community health choices.

So sort of a statement and a question here, so HHA exchange does not let you verify a shift if the caregiver clocks in our out outside of the address. How can we authorize these addresses without manual entry -- so when it comes to the technical details of how the HHA system operates you need to work with the MCO's and HHA exchange to meet the needs of the operating system of the daily shifts and satisfying requirements. Work with them on how their system operates and what you need to do to verify the visits. The MCO's are aware that the EVV can be used outside of the home address and understand that those visits need to be verified regardless of where the provide is. Work with them to meet those requirements.

>>: So we'll wait for another 5 minutes for questions. Thank you.

>>: So a few additional EVV questions. Is first one, if a family caregiver forgets to clock out, and they were scheduled to clock out at 11 a.m. but they did not remember to clock out of their shift, until after it was finished and they remembered around 1 p.m., the question is should the provider change the information from 1 to 11? So yes, this is going to be -- something's going to happen frequently as you first begin to use EVV. It will take workers time to acclimate to the system. So if they forget to clock in or clock out, and that time needs to be adjusted that's absolutely okay.

At some point in the future we will be setting expectations on the number of EVV visits that we expect not to be manually edited. We'll set percentage expectations for compliance but we have not done that at this time for the soft launch period. We want people acclimated to the system and become comfortable with their staff.

So this next question, will there be a fixed device option added to the Sandata system. And no, there will not. The state Sandata system only allows for telephonic verification through some sort of land line system. Or use of the mobile application on a cell phone.

>>: Question if expires December 31 -- so if a service -- not completely sure how to answer that. But I would tell you, like the services that are approved in the service plan at the point of implementation will continue throughout the year. So if the service is in place, say for example, someone has 10 hours a day of personal hours in place December 31st that 10 hours will continue throughout the continuity

care period throughout the next 6 months. There won't be an interruption of the services. The managed care organizations might be working with the participants and they determine that an increase would be needed but there wouldn't have to be a change or decrease in the services until after that 6-month time period is over.

>>: The one caveat here may be in the circumstance where there is a temporary service increase that was added say for maybe a month after a hospital discharge, just to provide additional assistance when that person originally moved back to the home. So something like that. Temporary service increases would not continue into January if they ended in December.

>>: What about a situation where a hospital, an individual resident of a nursing facility is sent to a hospital, and that individual is Medicaid only. And that hospital is not participating in one of the three CHC MCO's. So if it's an emergency situation -- so nursing facilities should know which hospital the managed care organizations are participating in and those are the hospitals that would be best used. But for emergency situations, the nursing facility should use their judgment in the best interest of the participants to make sure their needs are met.

>>: We received a question, can a skilled nursing facility look up their residents in EVS to determine which MCO the resident chose? You can, EVS is the source of truth when it comes to eligibility and MCO assignment. But those MCO plan assignments will not be visible until January 1st since the participant can continue to change those plans as they need to through December 20th.

>>: We're going to pause for a few minutes to see if we have any additional questions.

>>: So the question related to data clean up, do the service coordinators need to close all services in HIX and SAMS ending December 2019. That will be done through a department process. So the answer to that would be no.

And we'll be waiting a couple more minutes to see if we get any more questions.

>>: Great question about home modification. How will deal with home modifications that should have been started before December 31st but did not because of the contractor. Can a home modification take place -- on a CHC plan chosen by the participant -- that depends the office of long term living would be aware of these changes and it's likely the contacts for home modification would work with the organizations and with the providers to determine what would be the next best thing. The managed care organizations may have pursued reassessments about the modifications and the office of long term living based on the information given that assessment was appropriate. In another case the -- prior to CHC stood and that was the home modification. It depends is the answer. And case by case. In such cases as the office of long term living will likely be involved. That's all our questions at this point.

So we appreciate your time and attention and we're very grateful, great questions, especially with regard to the EVV and we look forward to once again talking to you third Thursday in December. Thank you and have a great day everybody.