Third Thursday Webinar

- February 15, 2018

>> The webinar will begin shortly. Please, remain on the line.

>> Are we ready?

>> Yeah. So what do you want to start with?

>> Good afternoon, everybody.

This is Kevin with the office of long-term living. I am here today with representatives from long-term living, as well as the community health choices care organization. We're going to give some updates on the launch for the south west, as well as presentations on approach to meeting requirements for transportation. We will highlight requirements in the agreement. Then we'll hand it over to talk about their approach to transportation. We recognize that this is the beginning of a conversation when it comes to transportation and we're looking forward to ongoing feedback from participants, participants stake holders, and the provider community on how the approach to transportation can be provided. We'll go into more detail. But we understand that independence and independent living is written by open acts for transportation.

When they talk about their proposal, they will be talking about how they plan to meet this objective. So starting with the launch for community health choices, we have a quick update on data. But I'm just going to characterize. As everybody knows, hopefully everybody knows, south west portion of Pennsylvania went live with community health choices in January 2018. That was the beginning of a period we call launch monitoring. So we had some pretty significant -- we had some pretty significant data requirements that we required the organizations, as well as the independent broker, to provide to us to see how the launch is progressing and to see how they're doing. The primary objective in going through the launch was to ensure that there was no interruption of participant services and no interruption of provider payment. At seven weeks, we can actually declare the launch a success. Actually, really we're going to start calling it a pretty big success. The way we're measuring that success is largely -- and we have some data on this a little later -- on the very limited number of participant disruptions in services that actually occurred since the launch. We actually have reported less than -- or around 30, which is in line.

Then actually, it's less than what we would have expected to see. We've been able to work through issues that have been identified with provider payment. The manage care organizations, the providers, service coordinators, and the department have worked to address ongoing provider payment and data issues. So we are calling the south west launch a success. We know that there are individual cases where there are opportunities for improvement but in terms of initial launch, we're -- we're looking to now move forward for

program improvement. So we're very happy with where things are right now. We are more than willing to hear opportunities for improvement in the program and we're also looking for opportunities to address any individual cases that you may have identified. Please, let us know if anything's going wrong in the south west and we'll mic sure we're addressing it right away and the manage care organizations will work with participants as well. So moving into the launch. We had talked about the south west goals. I already mentioned no interruption of participant services and no interruption in provider payment. This was --

this was truly our measure for the launch. The slide you'll see here after will be framing how we have been looking at the plan and also some additional points of focus for us as we go forward. Also, we've also garnered a great deal of lessons learned that we'll not only be able to apply to ongoing program improvement in the south west but also the implementation and launch of the south east. As you may remember, south east will officially be launched on January 1st, 2019. We are moving towards focusing on that implementation now. So this is the population distribution for community health choices. No major surprises. This reflects data all the way up until January 31st. 73% of the program in the south west is made up of individuals who are dually eligible for Medicare and Medicaid but not in need of long-term services and support.

We call them our NFI duals or community duals. They are the bulk of our program. That actually has been a lesson learned for us in terms of communication. We did focus --

a fair amount of communication for this population but we know we could do more. The object of the communication will be to minimize confusion between Medicare and Medicaid for this population. The community based duals. These are individuals receiving long-term services and supports in the community.

Also, eligible for Medicare and Medicaid. That makes up about 10% of the population. Those individuals receiving long-term care services in the community but not dually eligible are 3% of the population. The long-term care duals are those duals receiving in nursing care facilities. Then 1% of the population are individuals in facilities who were not dually eligible for Medicare and Medicaid. So this gives a break down of the population by age and by category. The majority of the population is over the age of 60. The majority of the population actually falls largely within individuals receiving services dually eligible and receiving services in nursing facilities. And those individuals receiving services in the community who are in need of long-term care as well. So from the past model, it would have been aging waver resiprecipients. We are -- are --

many people have the perception that dually eligible individuals are over the age of 60. The reality is almost half our program are under the age of 60 dually eligible and not in need of long-term supports. We do have a significant population who are under the age of 60 as well. This shows the break down of enrollment distribution by managed care organization. This shouldn't be a surprise. UPMC had the largest percent share.

They have been a presence in the south west for quite some time.

Very familiar to the population in the south west. Amerihealth was third with 20%. This shows the distribution of how individuals actually selected manage care plans. This -- 41% of the total population actually actively selected a managed care organization. 48% were auto assigned. 11% were assigned to an aligned dual special needs plan if the individual was in a dual special needs plan, which is a Medicare advantage product, they were assigned to the corresponding or the sister community health choices MCL.

19% of the people who actively selected plans did so via a paper form. 20% via phone. 2% via web. The web enrollment was low. The actual functionality for that web enrollment didn't appear until early November. So we would expect that -- that volume to increase as we go forward with new enrollment for the program. We are actually --

although significant portion of the participants were auto assigned, we were still happy with results of the participant plan selection, active plan selection. 41% is the percentage that far exceeds the national experience for the roll out of long-term services and supports programs. Many other states -- many other states had below 20% when it came to active plan selection. That being said, our goal for us in the south east is to improve these numbers and improve our messaging so more people actively select their plans.

That is really an objective of the roll out for the south east.

More active plan selection. We are always looking for better ways to communicate and we're also open to suggestions as well. So now, getting into the actual data for the launch, which includes new population.

This slide shows a break down of new population. This is for the weekending January 26. We highlighted the most recent week and this is broken out by week.

This shows you the average enrollment and how it's distributed among the three managed care organizations. We believe we are getting to the point of more of a normalcy.

Pretty heavy with new enrollments but we are getting a little more toward normalcy in the way this is distributed.

This reflected individuals who were auto assigned as well as individuals who actively selected. This shows the same information in a different way.

It breaks up over 60 and under 60. You can see all the populations, the most significant portions of the population have been individuals over the age of 60. So that is a major area of growth for us in this program. Again, no surprise there. This slide shows plan transfers.

Surprising view of the presence ofin the south west. Pennsylvania health and wellness, the gaining plan. A lot of this has to do with the presence of UPMC in the south west. We do highlight some -- some -- some issues that -- that led to these plan transfers. The first of which is -- and the most prominent --

was the individual preferred another MCO's benefits. The reason why these are launch indicator is because we want to see if there is -- the data we've seen has not been a surprise to us at this point.

We believe that it will level out in the future. People who are auto assigned are just making their active plan selection after the launch of CHC. So it's not really that much of a surprise to us at this point. But going forward, we will continue to monitor this data. If we see that one plan is starting to lose significant portion of our population, we'll want to know why. So that's the reason we are looking at this data and why we'll continue to monitor it. So this is some additional data. We required all three of the managed care organizations to reach out to all their participants to make sure those home and community based participants did not have a perception of an interruption of services with the launch of community health choices. At this point, all three MCOs have been able to reach a significant portion of the population but not all the population. We continue to encourage them to do this outreach with the participants. I believe they're trying at least three calls with the participants. Then they're closing out with a letter to --

to -- to be able to determine if the participants have any concern with interruption of participant services. That's what this is displaying. We wanted to make sure participants had the opportunity to voice the perception of concern for interruption of services. The MCOs are currently actively doing this outreach. This slide shows the break down in critical incidents that also help us understand where we need to focus. The three -- there were three critical incidents that we are highlighting on this slide, although we are capturing a whole other list of critical incidents. Any report of abuse or neglect? Or any perceived service interruptions. We already talked about the low volume of service interruptions that are noted to the far right of this slide. That's part of the reason why we're viewing the south west launch a success.

This is a low volume of service interruptions. A common service interruption is missed shift for an individual's direct care worker. That happens, unfortunatelyunfortunately, more frequently than we would like. The object when that occurs is to implement the back-up plan participants may have. Are service coordinators engaged in the implementation of that back-up plan? All three organizations have been very aggressive in making sure that the service coordinators have what they need to be able to -- to -- to limit or address these service interruptions immediately.

Across the board, they've done a great job to address these issues. Again, that's another reason we're calling the south west launch a success. Limited interruption in participant services. We also have the monitoring complaints and grievances. We have very few grievances at this point in the program. Grievances usually occur when there is a limitation in services. Since we have an extended continuity of care plan for the home and community-based services and since we have an indefinite grandfathering of participants in nursing facility services, this limited number of grievances is not a surprise.

Just as a matter of refresher from last -- last month's third Thursday webinar, grievances occur when an individual disagrees with the -- the -- the service decisions associated with their personal centered care plan. They have a right to be able to file a grievance.

This volume has been very low at this point. And -- and the number of complaints have also been very low. They look like they're higher compared to the number of grievances but we've virtually had no grievances submitted at this point as of January 26th. The number of complaints themselves have been very low as well. Part of the reason is because the managed care organizations and their service coordinators have been actively working with participants to address issues as they emerge. This next slide shows the next focus of the launch. Provider claims payment. This is specific to provider type and also once again as of January 26th, for nursing facilities, this shows a low volume. But since this time period, we've had a much larger volume of nursing facility claims that were submitted. As you see here, home and community-based claims and all other types of claims have had significant enrollments from the managed care organizations.

This data is actually a little old. Some of the data we have that's more current would show a much higher volume of claims being processed by the managed care organizations at this point. This shows how claims are being processed by claim type as well. Shows that Amerihealth and UPMC have been focused on working on claims as they are submitted and reviewing those claims. Had a number of rejected claims. Majority, I don't want to speak for Pennsylvania health and wellness. They're here in the room. But they have characterized it largely relating to a different way that they process the provider number and they're working through that issue now. In many ways, that issue's already been corrected.

So they've been able to process many of the claims that have already been submitted and rejected. So -- and those issues, the reason we're viewing this as a success is because number one, providers are able to submit claims. We've been able to correct a lot of issues associated with provider authorizations. And number two, when emergent issues have been identified with providers, the managed care organizations have been able to work with those providers to address them. So at this point, we believe that we're progressing. This gives you a rejected claim break out by provider type. Gives you some reasons. I think we already mentioned with some of the rejected reasons -- some of the -- one of the main reasons have been for -- for claims that were -- that were for dates prior to January 1st, 2018.

Another main reason in the "all other" area is specific to the -- the -- the provider identifier that was used by Pennsylvania health and wellness. We were also tracking provider disputes. This has been a limited number as well.

The number of provider disputes shows there is a relatively low volume. Which means the managed care organizations and providers are able to work out questions and differences without having to go to a dispute level. We are monitoring this very closely to see if this will change in the future. But as of right now, the volume has been very low. It's early in the implementation of community health choices, so this may very well increase. But we're

-- but we will be monitoring it going forward. And with that, areas of current focus. We're going to just give some quick updates on how we are going to continue to monitor community health choices in the weeks and months ahead. We have daily calls with the manage care organizations.

Those daily calls are individual with the manage care organizations and they are intended to be able to identify emergent issues that are -- that arise from the participant community, the provider community, and elsewhere. The purpose is to be able to brain storm solutions or to be able to have the MCOs have a chance to be able to -- to -- to describe how they're addressing particular issues that have been identified. We also have daily calls internally with Department of Human Services and aging staff. The purpose of those calls is to be able to talk about these emergent issues and look for ways that we and the departments may be able to help to address them in support of the participants, providers, and managed care organizations. We have weekly calls with participants and participant advocates. The purpose of these weekly calls is to make sure participants have an opportunity to address any concerns they have about the program and also to address any points of confusion or problems that they're experiencing. The --

the biggest issue that's been raised so far has been confusion, specifically about Medicare and Medicaid. We've had some individual ELigibility issues as well. We've worked to address them. As they continue to be identified, we will continue to do that as well. We also have weekly calls with our provider associations. That includes nursing facilities and the home and community-based providers. That provides an opportunity to address any payment or communication issues they're having with the managed care organizations. Lastly, we also have weekly calls with the aging network. Aging network represents a significant number of coordinators. It also provides a significant amount of feedback for any front-door issues. The aging network is often a front door for seniors going through the long-term care process and they are able to provide us insight on participant experience in the new program. So these calls will continue through March. As we continue to be at a stable place for the program, we will -- we will -- we will start ramping down these calls. But the plan at this point is to ramp them back up again when we -- when we end the continuity care period for home and community-based services at the end of June. So that's the way we're planning on going with launch communication. Other areas of focus continues to be the HHA exchange software. All three of the managed care organizations are using HHA exchange for prior authorization. Other components of claims processing. There have been some emergent issues with HHA exchange, especially related to data integrity. Many of the issues have already been addressed, but we continue to focus on that with the MCOs and with providers to address any issues as they continue to arise. We are also working with claims commission for nursing facilities. That has largely been successful to our knowledge at this point. But we continue to look for any types of issues that are identified by the nursing facilities and their associations. As well as the nursing facility providers. The nursing facility providers have been a great partner in this process to educate the manage care organizations on specialty claims that have to be processed by them and through them. We continue to focus on Medicare and Medicaid participant and provider education. This has been a major point of confusion.

Also, a major lesson learned for us. We've been working with our federal partners the centers for Medicare services. They will be sending out information to their providers in Pennsylvania to be able to provide information about community health choices.

Working with their networks as well to provide that education.

Data integrity continues to be a focus and will continue to be an opportunity for improvement.

Enrollment issues have been addressed since the launch but we still have new ones being identified. Reviewing changes to the person-centered service plans. This is specifically for individuals who are in home and community-based services. This focuses largely on making sure that individuals are still receiving the services that were approved as part of their service plan prior to January 1st because it reflects their entitlement during a continuity care period. We'll continue to focus on claims processing.

We'll continue to focus on complaints and grievances and notices from home and community-based services. And we'll continue to work on gathering lessons learned so they can be applied to our launch for the south east and also improve operations in the south west as well. I skipped over transportation because this presentation is actually about transportation. We are going into the details for why we're describing it as a continued focus. There's been a lot of questions and points of confusion across the board for transportation. We're hoping to be able to provide some background at least for this.

But once again, we recognize that this is going to be an ongoing conversation. We continue to have opportunities for people to be able to reach out to us for any types of questions or concerns or even complaints. Please, feel free to use the participant help line if you have any concerns you want to raise to the office of long-term living directly. The independent enrollment broker is still available at this 800 number. They are also going to be supporting efforts for people if they have a plan change.

Ongoing communication for this includes -- we'll continue to have the MLTSS sub-MAAC. We're looking forward to the March --

to the March MLTSS sub-MAAC and once again, transportation will be part of that conversation.

We continue to answer questions for participants there. We will continue to participate in the long-term services and support sub-MAAC. We will continue indefinitely these third Thursday webinars, which will be able to provide relevant information. So for future agenda items, we'll continue to talk about each of these areas.

Performance measures for community health choices.

Coordination between Medicare and Medicaid. Services my way.

Services my way is a program offering in home and community-based services. We are looking for opportunities to grow this part of the program.

Behavioral health for older adults because this is a new service especially for older individuals who are in nursing facilities. We're looking for opportunities to talk about the enrollment. The use of NRIs.

Also, the comprehensive needs assessment process. We will be talking about transportation today. We'll also look for opportunities to provide further information about the life program. We're planning very soon to be able to discuss announcement for the independent enrollment broker. But at this point, we're still in active procurement. We're expecting to make announcement for the FMS procurement as well. We are hoping that announcement will occur within the next few weeks.

Then for aging well, aging well will be -- we're -- we're --

we've finalized the contract with aging well. It's going through the final stages of the signature process. There will be very near-term engagements with aging well to perform the long-term care clinical and functional eligibility that's required for continued enrollment or new enrollment in our programs. So that gives an update on some of our procurement activities.

Hopefully, you will be hearing soon announcements for the IEB and FMS. So with that, I'm not sure if we have any questions, Randy, that you want to highlight before we jump into transportation?

>> I got to raise some questions. My name is Roger.

Still waiting for the participants to be entered in HHA exchange by the MCOs, however, services continue to be provided without the ability to bill. What's the deadline for MCOs to get all the participants in the portal? We hope to have that resolved by March 1st so they're all in the portal. If you have specific cases or individuals, you need to send those to me. I am going to give you my e-mail address. It's RNOLEN at PA dot gov. So anything related to not seeing your participants in HHA, anything related to not being paid, like how do I handle not being paid? Send those to me because I will send your name and information to all three MCOs so they contact you.

Question also came in that they're not getting some of the assignment of participants to CHC. How can you see the assignments? I am assuming this is still with HHA so we'll work through that. Again, send me a specific list. One comment was because claims are able to be submitted, if they're not being paid, does that count as continuing to pay providers? I know the MCOs are working through this. They are paying outside their system. They are running check runs three, four, five times a week, which is not normal. They are paying people outside the system. They've hand delivered checks to providers. So if there's an issue with that, I will pass this on to the MCOs so they can work with you to

make sure you get paid. I think the bottom line is once we smooth these things out, the MCOs are actually going to pay you in a quicker manner than what the state did.

>> Because the state has a process of approving pay. It is very possible the payment will actually be processed more quickly. The only thing I would add to that point is that if you are waiting for payment, don't.

Reach out to the manage care organizations. Reach out to your provider network contacts in the manage care organizations to talk about your issues.

Don't wait for payments and don't wait for a resolution.

Reach out to the managed care organizations to discuss your issues. If you're not getting a response from the manage care organizations, reach out to us.

We will certainly intervene on your behalf. So next question.

Will you say again the difference between the NFI dual, ACBF dual, and the long-term care dual on your pie chart?

Okay. So I'm going to go back to that slide. Back here in the beginning. So I apologize for making you wait. The NFI dual or the community dual represents 73% of the total population.

Obviously, we are going to be publishing this webinar going forward. This will be published on our website. The home and community-based duals are individuals who are dually eligible for Medicare and Medicaid and also receiving their long-term care services in the community and that represents 10% of the total population. And the long-term care duals are 13% of the population and they represent individuals who are -- who are receiving their long-term care services in a nursing facility and they are also dually eligible for Medicare and Medicaid. This next slide, the break down included the break down by age. The nursing facility duals are 94% over the age of 60. Home and community based duals are 69.4% over the age of 60. NFI or community duals are. So I'm going to move back to the transportation header slide. Next question.

How many home and community-based participants were auto assigned? And how many were self-selected? A quick estimate. We enrolled between 81 and 85,000 as part of the entire launch period. That includes the data in January.

We do have the precise numbers but our enrollment numbers for our Medicaid long-term care program and Medicaid programs in general are dynamic. They change because of changes in eligibility status pretty frequently. So we would only be able to give you a point in time. So roughly, for 48,000 individuals represents about 40,000 individuals who were auto assigned. That's 48,000 individuals. Then we had another 11% of individuals who were assigned in a -- in a -- a -- a sister plan for their dual special needs plan. That 11% represents about 8,000 people.

So total auto assignment is roughly about 48,000 -- anywhere from 48 to 50,000 people. Sorry for the rough estimate. It's just -- we just are trying to make sure that it's clear that our specific enrollment numbers are dynamic. Okay. So then moving on to the next question.

Would you have any suggestions about education for Medicare and Medicaid? And on the consumer side, not the provider. This is a great question. We are open to suggestions but we believe that the best approach is to have as many opportunities for participants to be able to attend participant sessions as possible. We believe we're going to be increasing the number of participant sessions in the south east, which is the second roll out. And we are going to look for opportunities to augment that information about differentiating between Medicare and Medicaid in those sessions. We will also be publishing as much information as possible for participants.

We might be including information in the pretransition letters that go out to participants during the transition process as well. So we are open to suggestions on how to get the messaging out there. We recognize this is a definite lesson learned and we're looking for opportunities to be able to minimize that confusion.

>> Okay. How should home care providers enroll with the three insurance companies? I will send your e-mail address to all three of them. They can send you their website so you can go on their website and start the enrollment process with them.

>> The information for -- for the contacts for each one of the MCOs for providers is on our health choices website under resources for providers. Each one of the MCOs' websites and telephone numbers and e-mail addresses specifically for provider communications is on that website.

>> All right. So you can go out and get the information off the website. But I will also send your e-mail address over to all three MCOs so they can contact you. Question specifically for nursing facilities. Most claims cover an entire month. January claims are submitted in early February.

Are there any results yet for successfully adjudicated nursing facility claims? I do know for the most part working with all three MCOs and talking to the associations that only about 60% of the nursing facility claims have actually been submitted because facilities are waiting to see if payments are going through. I mean I work with them, for the most part, claims are being processed by them and set for payment. Our hope is that the nursing facilities will start submitting the rest of their claims within the next week to get January all cleaned up. But I would think -- I don't know if you guys have a percentage of how much have cleared through.

>> Yeah. I put him on the spot now.

>> All right. While he's doing this, one question was can I repeat my e-mail? Amerihealth has processed 76% of their nursing facility claims. There is a number pending. I think they're all about that percentage between 70 and 80% that they've all processed through.

The ones that have not processed through have either denied appropriately or they are reaching out to the nursing facilities to address the issues that came up. They will also be reaching out to the nursing facilities on all the individuals that they have not received claims for to determine why they were not submitted yet.

So you should be getting outreach in regards to that situation. My e-mail address.

RONEL at PA dot gov. You mentioned an extended continuity care period. Is this beyond the 180 days? Please, clarify.

>> The continuity care period is 180 days. The reason we call it extended is because the standard is actually 60 days in the agreement. Extended continuity care period for home and community-based services includes that 180-day period.

>> The answer is no, you will not submit claims -- you will submit those to the MCOs. Or for CHC related services. Lot of questions about how to handle NHT consumers enrolled in an MCL. We're working prior to 1/1/18. Do we bill for activities in HHA or continue to enter service deliveries in SAMS?

>> We recognize with nursing home transition in general, we recognize that we have a lot of guidance that has to be provided. We have had a lot of questions about nursing home transition. For claims -- for activities that occurred prior to January 1st, the expectation is that you would be paid through the previous system.

Working with the managed care --

managed care organizations, all three have models of nursing home transition they're working through and recommendations for how individual managed care organizations are managing nursing home transition. We recommend you reach out to them.

We, as a department, will also be working with the managed care organizations to make sure we're providing more guidance both inside of the Medicaid program and outside of the program as well. More to come on this. We recognize this is an area but my immediate recommendation is that you reach out to your care organization first. If you are not getting any relief or still have questions, please, feel free to reach out to us and we'll be happy to answer your questions. So there was a question, will there be a specific webinar or conference in advance of the start up of the south east to clarify any issues with provider allocations, et cetera? The answer to that question is yes.

We did this in the south west late July time frame. July 2017. Lesson learned for us and part of it was just a challenge we had with our procurement process. But we will be doing everything in the south east earlier. So expect to hear opportunities to be able to attend these types of sessions in the south east in the May/June time frame. We will be doing all those sessions earlier.

>> The current break down in the south west, how many are participating in mental health programs? Receiving mental health therapy? Or behavioral consultation? I'm not sure if you are talking about participants themselves. But all three of the community health choice MCOs are required to coordinate services with the four behavioral health MCOs in the south west. They are in the process of finalizing their agreements with them to provide those services. Then they will work together to coordinate all services for individuals as they need them in the south west. At this point in time, I don't think we have a break down of how many participants are actually receiving services or requesting services at this time.

>> Next question? I think we may be able to take one more question. As a service coordination entity, we have had to do CNA for event. I am assuming a CNA is a report for a triggering event. So that means more units than what was authorized. We have sent a communication to the MCOs but no units get added so we're not able to invoice for those. This and all other specific service issues, your first step is to talk to the MCOs directly about the cases. If it turns out that you're not getting any relief or if the MCOs aren't being responsive, please, reach out to the department. We'll ask the MCOs about these issues. But we're encouraging providers on specific case issues, grade issues, and service issues that are not being authorized, to start with your MCOs first. If they're not being responsive, as cited in this particular question, please feel free to reach out to us and we will make sure to put this in front of the MCOs for a recommendation. You already brought this to our attention, for the person who submitted the question. The MCOs have had the opportunity directly in front of us to hear this issue. So in the future, they'll have an opportunity to be able to respond and also to address it with a specific provider. So we don't know which MCO. So we're making an assumption that it applies to all three. We can take one more question I think.

>> Submitted through the portless portals. Each MCO has a different -- some are through a portal. Some through a clearing house. If you have questions directly how to submit your claims, you need to call their provider hot line and they will be able to walk you through that. directly how to submit your claims, you need to call their provider hot line and they will be able to walk you through that. I think we're out of time. Just reiterating, the launch is a success. But looking for opportunities to address ongoing issues. So now, at this point we're going to turn it over to the focus topic, which is transportation. The reason this is a focus topic, we just have had a lot of questions about transportation. We want to make sure we're taking an opportunity to highlight MCO approaches to transportation and the requirements for the agreements. Once again, and I can't say this often enough, because transportation is one of the corner stones of community -- community -- community-based long-term services and supports, transportation is a participant's access to the community, access to community integration, and access to the outside world. So it's a central part of our offering in this program. The MCOs have an opportunity to be able to describe how they're approaching it. But the first step is to talk about what they were required to do. So this information was available in the agreement or this -- this information is directly pulled from the agreement with the manage care organizations.

First, must provide all participants with medically-necessary emergency transportation and medically-necessary non-emergency ambulance transportation. Must provide all

participants with medical transportation and non-medical transportation. Home and community based waver service.

Must provide nonmedical transportation to other participants at its own discretion and own cost. That goes to the populations who are community duals or NFI duals, as well as others who may request.

We put that in there as a clear indication of an opportunity for the MCOs to be able to provide those services. And we note here nonmedical transportation includes transportation to community activities, grocery shopping, religious services, employment of volunteering.

This includes but is not limited to. So this gives you an idea of what type of services are under that umbrella. Must provide non-emergency transportation. That is a little different from the physical health well choices program. I know it's also different for people receiving services for home community based wavers and also our community duals not in need of long-term service and supports.

Must also provide any specialized nonemergency medical transportation for participants and that includes transportation for participants who are stretcher bound. All other nonemergency medical transportation is covered by the -- the -- the Medicare and covered services must be arranged through the vendor.

There are some cases where the services may also be payable by the assistance offices as well.

So MATP specifically is responsible for non-emergency medical transportation to a medical service that is covered by Medicare or CHC. Also includes transportation to another county as medically necessary to get medical care, as well as advice on -- on -- on locating a train, bus, or route information. Reimbursement for mileage. If the participant used their own car or someone else's car to get to a provider is also eligible under the MATP program if approved. Is responsible for arranging non-emergency medical transportation, specifically for urgent appointments with the participants. Participants can make arrangements themselves but the CHC is also responsible for helping arrange those services.

Some participants may qualify for non-emergency medical transportation through the shared ride program. Shared ride is a payer that may -- may be used for individuals over the age of -- I believe over the age of 65. We're looking forward to opportunities in the future to be able to make sure that we're providing clear information for when shared ride would be used versus when MATP would be used and also when the CHC would also be responsible for transportation. MATP is a last resort. Must look at other opportunities for transportation before they would look at the MATP program. That's -- that is a statement that is true across the Medicaid program. MATP is truly the last resort. So CHC, MCOs must coordinate transportation through all other available opportunities before they go to MATP. But once MATP is truly the last available option, will work with the participants to help coordinate that transportation. Agencies have been instructed to contact the CHC for

verification. The participant's request is a covered service. That's something they will do with the -- with the MATP agencies to help provide that information.

Must arrange and coordinate information with the MATP provider so participants receive MATP service outlines in their service plan. So that's all part of what they are required to do for transportation. Now, with that we're going to try to go over to the manage care organizations themselves who are going to talk about how they're planning to enact those requirements. I think we always tend to do these alphabetically.

It's probably going to be the first managed care organization that I bring up on my screen.

But it looks like Amerihealth is the -- the -- the first up because they were the first that I was able to identify on the screen. So I am going to be turning it over to Amerihealth.

>> Hi. Thank you. My name is John. I'm the director of NEMP services at Amerihealth. I support community health choices. Okay. I provided --

or prepared a lot of information. I don't think we have time to go through all of this. But the -- I do have some detail toward the bottom of the screen about certain aspects of the program. Probably want to focus on the first probably four slides there and talk about the interaction among the different organizations that are involved in providing participant transportation. This -- the first slide and I hope this is a logical way to present the information in terms of a flow chart. This is for participants living at a nursing facility.

This is for non-emergency medical and non-medical trips.

On the left side, the nursing facility, the first option is whether the nursing facility can provide the trip themselves. If they can, that's what happens.

Participant receives the trip from the facility and the facility invoices community health choices. If the facility cannot provide the trip, then the nursing facility contacts the service coordinator or personal care coordinator to arrange transportation.

Transportation is provided by MTM and that's sort of the end of that process.

>> I just want to make one clarification on the service coordination PCC line that the nursing facilities would be contacting. We know service coordination is a new benefit for the nursing facility individuals. So they would be contacting internal Amerihealth care cost. There is a specific line the nursing facilities contact to help arrange that transportation. Not the existing service coordination entities.

>> All right. The next population is the nursing facility care eligible living in the community. This is for medical and non-medical trips.

For medical trips, the participant calls their county-specific MATP provider.

If they can provide the trip, they do so. If they can't, the request comes to the community health choices service coordinator or personal care coordinator. They request the non-emergency medical trip be provided by MTM either through public transportation, mileage reimbursement, or by a contracted transportation provider. For non-medical trips, the service coordinator requests of MTM to provide those non-medical, non-emergency trips. Next option is the nursing facility aligned meaning that the participant has community health choices for Medicaid and for Medicare an Amerihealth snip plan. The participant on the left, participant calls to arrange the trip. The Amerihealth Medicare transportation provider looks to assess whether the trip limit has been met or exceeded. If they haven't, then our Medicare transportation provider provides the trip. If they have reached the limit of 24 one-way trips, then the Amerihealth Medicare transportation provider asks the participant to arrange transportation through MATP.

The last one is the nursing facility and eligible dual nonaligned. For -- on the top left, medical trips. Does the participant's medical plan offer transportation? If they do, then the participant calls the snip Medicare transportations provider. If the participant's Medicare transportation provider can't provide the trip, then the participant contacts MATP to provide the medical trip.

Non-medical trips originate with the care coordinator. The care coordinator contacts our transportation broker, MTM, to arrange for non-medical trips for those participants. Again, public transportation, mileage reimbursement, or contracted transportation provider. Just a couple comments about the MTM transportation provider network, which is the community health choices transportation broker.

MTM only uses fully-credentialed transportation providers. They do not use Lyft or Uber to transport participants. They only use taxis if they are fully credentials. I received some questions about the transportation providers wishing to join the MTM network, and MTM provided me with the two links that are being shown here. One, if the transportation provider is for para lift and the other if it's ambulance. Those links will take you to the appropriate websites. I also have a list of the provider list of MTM's cab and para lift providers. You can see them there. I hope that's not -- the font is not too small. And on the ambulance side, these are the lists of providers. All right. I have -- not sure how much more time I have to go through any of this.

>> We are running a little bit out of time. We're probably going to hit on some of these when we get to some of the questions. We probably need to give an opportunity for the other MCOs to present.

>> Thank you.

>> Thank you very much. We are now going to be turning it over to Pennsylvania health and wellness. Pennsylvania health and wellness.

>> Right here?

>> Yep.

>> Okay. All right. Well, thank you. Seven weeks in, we're still learning a whole lot about transportation. Probably one of our larger challenges that we have. But we're working it out. I'll go through this quickly. We also are using MTM for our transportation provider.

Individuals that are seeking transportation information can call our phone number right there. 844-626-6813. Select number two for transportation and you will be transferred depending on what your need is.

If services are a non-emergency medical, call is transferred to MATP to secure transportation services if eligible. If determined to be non-emergency, non-medical, LTSS services, MTM will book your travel for you.

If services are expanded beyond the benefit transportation MTM books that. For the individuals that do not have transportation identified on their person-centered service plan or they're not in a nursing facility, Pennsylvania health and wellness does have a value-add benefit of one round trip for any of our enrolled participants. That's maintained by our transportation provider.

Okay. For non-emergency medical transportation, again, we did provide you with the number.

We're doing this again. You would select number two. To get in front of transportation concerns, we have identified a subject matter expertise team on transportation. When you call through, if you are having any difficulty with your transportation, you can request to talk to someone and they will work your issue for you one on one. We found this to have significantly reduced the transportation concerns that we were seeing early on. For non-medical transportation for nursing facilities, nursing facility ineligible -- sorry --

the transportation must be tied to the person centered service plan. Authorizations are determined on what would be the most cost-effective manner and that's working with your service coordinator. Again, call our number. Press number two. We have tried to stream line this as much as possible so folks don't have to go through a lot of hoops to get their transportation met. Mileage reimbursement. Much like you've heard before, we will reimburse mileage if the family -- for family and friends that transport individuals. Again, based on the needs of the individual and identified in their person centered service plan. MTM. Lots of providers to join the network and it's not limiting folks to complete service areas. We've been encouraging our partners and all of our nursing facilities as well to sign up with MTM. If you are having difficulty, we will send a training team out to work with you on how to get signed up. This makes it more accessible for individuals to get access to transportation.

Especially, in more rural areas that don't see that as often.

Let's see if I have anything else there. I don't. Easy.

More information to come as we figure this out.

>> So we are now going to be moving to UPMC. I believe they are participating through phone.

UPMC. If you are willing to let me know when you want to advance the slide, please, do so.

>> Thanks, Kevin. My name is Andrea Ferrell and I am director of the ancillary network. I will give you a brief over view of our transportation process.

So if you can advance to the next slide. Okay. So UPMC community health choices will also be using a call center. We are using a different call center. Our call center is CTS.

They will be functioning in the same manner as the other two MCO call centers. For home and community-based services, they will be coordinating non-medical transportation. The medical transportation will go through MATP. For nursing facilities, they will be coordinating non-emergency and non-medical transportation. The call center will be billing UPMC/CHC directly for all transportation and reimbursement.

>> You're breaking up just a little bit.

>> Is that better?

>> That's much better. Thank you.

>> Okay. So we will be using the call center to bill UPMCHC for transportation so that the -- neither the providers, the service coordinators, or the nursing facilities will be responsible for the payment.

That will come directly to us.

We have educated all the nursing facilities effective 2/12 of 18 to begin using the call center.

We are working with the call center and the nursing facilities to ensure that the transports are coordinated.

Again, they will be coordinating all non-emergency and non-medical transportation. We have not educated the service coordinator agencies yet to begin using the call center. We are finalizing the details on the Medicaid participation for the call center. Once we have that finalized, we will begin transitioning the call center for use by the service coordinator agency. Can you transition to the next slide, please?

>> Sure.

>> Okay. So I'm going to talk first about the nursing facilities. As I said, we did send out education to everyone.

It was sent to the administrative offices. So if you are somebody on the phone and you have not received it, it was requested to be disseminated down. You can either contact us directly or contact your administrators and verify whether they've received the information or not yet. It did include all the telephone numbers to call so that you can coordinate your transportation.

I know some facilities have called in. So it seems as though that is functioning and you did receive the information.

We did reimburse the nursing facilities during the month of January outside of the call center. We have suggested that everybody submit a transportation worksheet. If you are on the call and you don't have that worksheet, again, please contact us so you can get that to us. We are allowing facilities to use that worksheet also in the month of February for any trips that were already scheduled. We didn't want to have to cancel a trip and schedule it through the call center. However, any new transportation should be worked through the call center and have them coordinated that way. We did request from all nursing homes, lists of the providers that they are using, the transportation providers. We are making every effort to make sure we have contracts with them. A nursing facility can request whoever they would like to request to be the -- to -- to provide the transport. We can't guarantee that we'll be able to use that provider. But you can request and CTS has been informed to make every effort to use that provider if they can.

We do request that the non-emergency, which would be the physician office or outpatient and then the non-emergency, which are social events, et cetera, transports are placed on the member's plan of care. We do have the service coordinators in the facility, which can assist if you guys have any questions about it or are having any difficulties, you definitely can speak to them and they can reach out to us.

Although, in general the transportation process is coming through UPMCHC's department. We are asking that the nursing facilities confirm if there is primary insurance coverage if the member is a Medicare dual eligible. Many dual eligible plans do offer transportation.

UPMC for life dual does offer a 51 way trip dual eligible transportation. CTS will be coordinating both trips. So it will be sort of seamless for the nursing facility. But if there is primary coverage that's not UPMC, we have to either get coverage so we can assure that Medicaid is the payer of last resort. Okay. Kevin, next slide. For the service coordinator agencies, what we are asking right now is that you continue to use your current process to coordinate transportation and bill UPMC/CHC directly for the transportation.

As already discussed, MATP should be used for all non-emergency medical transportation when it's a viable option. The authorization must be on the participant centered plan of care for any non-medical transportation. If it is NHAA and you can see that right now, you are

able to go in and bill the W6110 for any -- you put the amount in of the transport and the claim will process through.

If you cannot see the authorization in HHA or if a member doesn't have an authorization for a transport, you should communicate either through HHA or through right fax the request for authorization so it's on the plan of care and can be billed. When you're billing through HHA, again you will use W6110 for non-medical transportation. You can also use -- if you're transporting anything that is -- that is exceptional medical, you can contact us directly and we'll talk that one through. We think we're going to open the call center for that for you guys here very shortly. One unit equals one trip. We -- we consider a trip to be whatever trip it is that you're using for that non-medical, whether it's ambulance, wheel chair, medical taxi, bus pass, a mileage log for friends and family transportation, cab tickets, things along those lines. We may come back to you at some point and ask you what type of transport that was but as long as it's on the plan of care, you should be able to bill it through HHA. You want to enter the exact amount of the transportation cost in HHA. So it's' a bus pass and was $90, it would be one unit for $90.

Transportation code is for all non-medical transportation so it would be used for any of the services you would be billing.

Okay. Next. I think -- oh -- I don't have any more. Okay. So feel free to contact us through CHC providers at UPMC dot EDU.

If you have any questions, month of the folks on the call probably have my e-mail directly or one of the network managers.

You can outreach to any of us and we can work through any questions you might have.

Especially, if the service coordinators have questions on billing those transports, we are more than welcome to have those discussions with you. I want to say one more thing. If -- if you're a service coordinator agency and the -- and you cannot see your member in HHA yet, please, submit the alternate payment work sheet with your transportation on that. If you have questions, you can contact us and we'll walk you through that. But it's the same work sheet. Just use the W6110 coded.

>> Thank you, Andrea. We have a number of questions for all the MCOs and some for individual MCOs. We will get through as many as we can in the time we have left. When a resident is returning from a hospital, the hospital coordinates the return transportation. Will they be able to coordinate through the CHCMCOs? My assumption is yes.

Anybody disagree with that?

>> This is Andrea. The only thing I'll add, in many cases, that would be an actual physical health covered transportation that the hospital -- in our case, the hospital potentially would be coordinating that through our physical health coordinator because it would be a covered either Medicare or Medicaid benefit.

>> Thank you, Andrea.

Andrea, this next question is for you. Would you mind repeating your name and the name of your transportation broker?

>> Okay. My name is Andrea Farrell. I will repeat the name of the transportation broker but remember if you are a service coordinator entity, we have not introduced this to you yet. So we're asking that you not outreach. That's why the phone number wasn't on my slide. But the agency we're using is coordinated transportation solutions. We refer to them as CTS.

>> Thank you. So next question for the MCOs using MTM.

What does MTM stand for?

>> Medical transportation management.

>> Medical transportation management. Thank you. Next question. I think this was for one of the MCOs talked about 24 one-way trips per year.

>> Right.

>> You want to verify that?

Do you want to describe what that benefit actually means?

>> So that actually applies to when somebody is -- this is Amerihealth -- so when someone's enrolled in our aligned D snip product as well as community health choices program, there is a specific number of trips that are part of the benefit package within the Medicare D snip program. So once that benefit package has been exhausted, then it would transfer down to the community health choices for the medical -- non-emergency medical transportation. It's coordinating with the primary carrier's benefit.

>> Thank you. My next question. Are nursing facilities required to contract individually with MTM in order to bill or receive reimbursement?

>> So this is Amerihealth again. So as we move forward with the nursing facility reimbursements, we would ask that the facilities do enroll with MTM as providers for the transportation services at this time to be consistent with UPMC and the other MCOs, we are allowing that spread sheet document submission for the transportation in January.

That's coming directly to Amerihealth specifically. We did send out a notice to the associations and to the facilities if you do not have that, please send an e-mail to CHC providers and we will be happy to get that information out to your organization again. do not have that, please send an e-mail to CHC providers and we will be happy to get that information out to your organization again.

>> We would ask that they enroll with MTM.

>> Okay. So this next question is directly related to transportation but about south east provider in general. So south east providers are interested in beginning the process for enrollment. Is there any way all three of the MCOs starting with Amerihealth, once again alphabetically, you would want to -- how -- how providers should start engaging with you?

>> Please, send the e-mail to our mailbox. CHC providers at Amerihealth care toss dot com.

Please include your information, phone number. We do have a team monitoring that and we will reply back to you regarding enrollment with Amerihealth.

>> With regard to transportation providers, Amerihealth, MTM's got on the website -- I had it on one of the slides I presented -- links for people wishing to become contracted with MTM to go to those links and get the process started.

>> So the process that I mentioned previously about the e-mail is for the LTSS home and community-based providers and nursing facilities.

>> Great.

>> I don't have that e-mail address in front of me.

>> Anna dot M dot Keith at PA wellness dot com.

>> We're preparing an outreach to south east providers. Hopefully, the first in March providing them the instructions on completing their application. It is available on our website at UPMC health plan dot com under providers. Then under home and community-based services, there is a contact --

a contract with us link that they can use to complete the online application. Or like I said, we will be outreaching to everybody hopefully the first week in March.

>> Okay. Thank you, Andrea.

Next question. Amerihealth, you made a point of fully credentialed. How do you define fully credentialed?

>> Folks from MTM are here.

Do you want to address that? Or would you like me to?

>> Sure. I can address it.

Hi, my name's Nikki Stevens. I am a community outreach trainer with MTM. So when it comes down to being fully credentialed, we have different specifications and we have a credentialing team that will go out and make sure all the drivers meet every single qualification. So they will do background checks.

They'll inspect vehicles.

>> ONG to make sure that the providers are not excluded from participating in Medicare or Medicaid plans.

>> Yeah. Exactly. So I don't have all the specific credentials that they'll go through. But it's definitely a long list of things that they'll have to pass in order to be credentialed to become a transportation provider with MTM.

>> Background checks. Drug screens. That sort of thing.

>> So when you say long list, that might be frightening to people. It's a comprehensive list.

>> Comprehensive. Yes.

Thank you.

>> But it doesn't sound like it's any different.

>> Right. It's like our provider requirements. Okay.

So next general question.

Interesting question. If a consumer goes through art therapy, is that considered to be a medical or non-medical service? Starting, Virginia Brown, we do not have art therapy in our wavers. It's a time service. So it starts with our requirements for what is a defined waver service? And we would not define that as a -- as a waver service.

>> Right. But if -- if the person is getting home community based waver service, that could qualify under non-medical transportation providing that that service is included in the person centered service plan.

>> Okay. So that's our requirement. It would fall under the umbrella of non-medical transportation.

Next for Amerihealth. They did not see how ambulance service covered in southern Pennsylvania. My assumption is you are going to be building that out in Pennsylvania.

>> Correct.

>> In terms of MTM, on different -- on the difference between transportation for community and long-term care customers, is there any way you would want to highlight the difference by MTM for -- between individuals receiving services in nursing facilities versus in the community? So I will restate the question a different way. So one of the questions we've received pretty frequently is how are nursing facilities often have much more direct involvement in coordinating care and provider services, including transportation for their participants. Many times -- in many ways, they actually provide those services for the participants. How would you differentiate that in the way that you are approaching transportation and community health choices versus the way it was in the fee for service system? I mean community-based transportation is kind of what it is. You would coordinate through a non-transportation provider or non-medical -- yeah, right.

>> That's where our service coordinatrr would come and basically any of the home and community based participants, part of their service plan, the items if it's approved go there and the service coordinators would then coordinate to help identify a provider and arrange that transportation from a community-based perspective.

Nursing facilities as of right now, again, we would encourage them -- we want them to enroll with MTM to become a provider.

We understand that there are some differences in how active they are involved in the transportation and that's where communicating with the service coordinators will come into play, as well as helping arrange that transportation.

>> For PA health and wellness, this is Anna and for the community, we are going to support independence as much as possible. An individual would want to define what their transportation needs would be.

It would go under their person centered service plan. Then the services would be coordinated accordingly with our transportation provider or through bus passes or whatever it is the individual would want to utilize for their transportation. For nursing facilities, the coordination looks very much like it did prior to 1/1. At this time, we are still learning processes and how best to coordinate the services with our nursing facility partners. But all in all, we would have them coordinate through MTM on the community-based transportation for their residents.

>> Thank you. Next question.

How is transportation managed with discharges from hospitals or nursing facilities? I am assuming it's a skilled nursing facility. Or emergency rooms?

>> It's Andrea. I can speak to that on UPMC's end. It goes back to what we just talked about. All these members do have medical benefits and that -- that would fall, in general, under a medical benefit as a facility-to-facility transport.

Which means they are going from a hospital to a nursing facility and would be covered under their physical health benefits. We can provide additional education out to the nursing facilities if there are still questions on that so that there is a better understanding of the level of benefits. Medical benefit.

Transportation benefit. Then LTSS non-medical benefit.

>> What about from hospitals to home?

>> Hospitals to home are a covered benefit under Medicare as well as under Medicaid.

Under our coverage. As long as -- I'm sorry -- let me throw that in there, I'm sorry, as long as they're medically necessary. If they are not medically necessary, they could either -- they would go down the -- the -- the eligibility. So it would either be the medical transport or it would be a --

they could use their snip transport. If that wasn't available, they could use their CHC benefit.

>> Do either of the MCOs have anything to add?

>> I think it should be improved with the integrated plan now. Hospitals being able to work with our clinical, as well as the service coordination team so that should help them.

>> And that's a goal for community health choices. Thank you for mentioning that.

>> Yes.

>> Next question. What is your mileage reimbursement rate?

>> Amerihealth is $0.50.

>> UPMC?

>> For the service coordinators that are submitting it now, we're saying just to use the -- the rate that you have used. Then once we turn that over to CTS, we will define our rate. But I believe $0.50 is the rate. So I'm pretty sure that's what we will go with also.

>> Great. We are running out of time. We have four minutes left.

>> Couple quick ones. Any emergency transportation should be set up with our regular providers as it is now. Is that correct?

>> For UPMC, the answer to that is correct. Dial 911 and that will be covered under their physical health benefits.

>> All right. Do the MTM drivers have any medical background? Are they CPR certified? Can they handle blood sugar drops or any other critical incident?

>> They have -- they have CPR and first-aid training in all cases. But they do not provide advanced or basic life support.

So that's a no to the second part.

>> All right. Specific to PA health and wellness, for non-medical transport, if the members have had this service on their service plan or did prior to roll out, how is this delivered to them? I understand that MTM provides transportation but how do they provide a non-medical transport?

>> They would want to coordinate with their service coordinator on what the needs are and then we would work to ensure continuity of service for that individual.

>> Are aides allowed to come with individuals during transports?

>> Yes for Amerihealth. An escort is allowed. Needs to be requested at the time that the reservation is set up to ensure the vehicle capacity is sufficient but yes.

>> Yes, we do allow that. PA health and wellness allows an aide to attend with the individual.

>> Andrea?

>> Yes, you can attend. If it's a nursing facility, it's --

we have had this question. It is not a reimbursed service to the nursing facility but the attendant can go with them. You have to let the call center know that's occurring.

>> How do we reach out to MTM to start the processing in becoming a non-medical provider?

Can you give us the links again?

>> Non-medical transportation provider.

>> Right. Well, the links are a little long to read here.

>> The links will be in the presentations and the presentations including all the transportation slides will be placed out on the website once they're finalized.

>> At this point, we are out of time to be able to answer any more questions. Most of the questions we received overlap

some of the questions we've already answered. We appreciate the time of the managed care organizations to be able to answer and go through your approach for transportation. To highlight, this is our resource page. So if you have any additional questions or comments, you can always e-mail them. We also have information on our health choices website.

WWW dot health choices PA dot com. We encourage you to go to that website because you will be able to view the third-Thursday webinar information, as well as information about sub-MAAC and any additional information. We have our call lines available as well. This is the contact information for the three managed care organizations as you see on your screen, as well as the 1-800 number. If you have specific questions from the managed care organizations.

With that, we've finished our questions and we appreciate your time. Thank you very much and have a great afternoon.

(Concludes)