- November

>> An association conversation earlier this week and some of the nursing facilities told northeast reason why this is maybe because the nursing facilities and their participants have decided to go through auto assignment process. For a period of time the nursing facilities are going to be enrolled with the organization for a period of time. This shows the break down. Keystone first has the most of the people have selected managed care. Keystone first has the highest number at 69% at this point. Pennsylvania health and wellness and 16%. Pcm first has the most. They are organization that had the -- they are managed care organization that has known brand in the southeast so that is not surprising. It's similar to what we saw in the southwest. We don't focus on these key areas for the January 1 implementation. Participant education and outreach, provider education and outreach.

Population identification. Network adequacy and readiness review. We have updates on each of these areas. Starting with participation and outreach. We've completed the outreach sessions. Those sessions were conducted throughout the Philadelphia area and they were conducted in multiple languages including English, Russian. Chinese, Spanish and can't niece.

>> We looked to build these appropriate for the community were there were being conducted.

>> Service coordinator outreach efforts under way as well. We are asking service coordinators to reach out to all participants and go through what this change means the meme them and the informative choice. So service coordinators are they had received training. If they have any questions they can go through the training.

>> Even help them make the call or go on the web page for the independent enrollment broke tore go through network information and does what they would need to do to make a plan change. In addition to service coordinator we encourage nursing facilities to do the same thing. Nursing facilities have training online similar to service coordinators and nursing facilities can use that training as way to answer questions for their residents as well. We continue with provide herb education. We continue to send out blast on billing, service coordinationest.

And all are designed to make sure the providers have as much information as possible and have as many questions answered as possible so they can feel

comfort going into the contracting process. We did conduct where we had more than 2,000 and we had many lively discussions and questions.

>> We have a transportation summit scheduled for tomorrow. We hope the weather will improve. That transportation summit will involve answering a lot of questions for answering a lot of questions for the managed care organizations advocacy groups and participant groups so we can make sure some of the issues we had in the southwest will not be repeated in the southeast and we can get ahead of some of the challenges that maybe unique to the southeast so that there is a seemless transition for participants when it comes to transitions in the Philadelphia area. We are looking forward to that transition. We continue the look for population outreach.

We are going to be using in the future supporting communication for any type of new groups or groups that are self-identifying as needing some additional discussion for community health chases and the work they will be doing includes training. Public relations including radio and small ads and a round table discussion as well.

We want to Milwaukee make sure as much information to every group of individuals who are going to be touched are affected by community health choices have all the information they need to feel comfortable with what the change will be meaning for them.

As we move into the southeast , the we've had all mco submit policies for review. We're in the process of reviewing those. On the policy part of it we've done well. Our biggest focus is network adequacy. Someone to the department of human service.

We meet every other week to review reports.

The second report that they submit is what is a report that comes in through one of our vendors and then over to the iab. The basis of the report is on the website listing all the providers they have. If individual are looking for pcp, they will continue to be able to utilize them after a primary care physician.

They may not show up on the Medicaid website. They are in the process of a number of them to get the credentialing done. Even if they are not fully contracted by January 1, individuals still in the nursing facilities will be paid out of network provide around there should be a seamless transition for the population.

The other area we had concern son the hospitals and so we continue to work with the mco's to ensure we get the hospitals on board, openfully bucks and Chester county. But we continue to work through that process with them. We're working through ha. The other big one, part of that we continue to monitor that. One of our difficulties is to ensure network adequacy is getting the staff ratios or staff counts from providers ain regards to how many past workers they had. How many lpn's, how many aid.

We have providers not willing to provide the tried information to the mco's because of whatever concerns they may have with that. We have sent out a couple of communications to providers explaining the reason we need that data. That's why we made the provider count so we can ensure we have enough providers. [indiscernible]

all of them went fairly well. We have final reports we'll be putting out in regards to those visits. As I said earlier the mco's are continuing to go through the contracting process and going through the credentialing proS. I talked to all the mco and asked them to expedite had as much as possible. As far as what the mcos are doing, they are providing a lot of trainings, a lot of face to face trainings, webinar and interactive training on how to interact with the mco, who your volume, one of the trainings they did is they did two three day training sessions with the service coordinators ob how to use this tool. It was a trainer type of program. So that occurred the end of October. They are doing testing with the nursing facilities and other providers incher doing training on how to utilize the hhs.

They are walking through everyday training with the individuals. The review is going well.

We continue to monitor it and we'll continue to work with them through process.

>> We have a few questions regarding the southeast update I'm going to go through quickly. First, a listener stated they haven't had communication from their service coordinator and they want to know who to call. If they are representing participants we recommend you reach out to the participant line. Let them know who your service coordinator is and you are expecting outreach and the department will intervene on your behalf to send them an email and ask the service coordinator to get out there to do that silent visit.

What we call meaningful contact. How can an individual who has not chosessen an hmo by the deadline find out which hmo they've been assigned. We use the term managed care organization or mco. That is just fy I can.

The independent enrollment broker will be able to tell the participants which they were assigned into. As a reminder people can make a plan change that will still be effective on January 1 all the way up until December 21. Even if they were auto assigned into a plan, they can make a plan change and that change will be effective January 1 as long as they call before or submit that change before December 21. And they would reach out to the independent enrollment broker 1-84-824 will have 3655. They will be receiving a post enrollment packet in the late November early December time frame that will advise them of which managed care organization was selected for them as well. Next question was they represent social services and health education organizations and would like to become a service coordinator. Please guide through the process.

The recommendation is you reach out the our oltl provider line. That will be able to give you that specific guidance on what you need to do to become a Medicaid provider or work with a managed care organization to become a service coordinator. That provider line 1-800-932-0939. So that is all the questions we have so far about the southeast implementation. Now we're going to jump into lessons learned about the southwest implementation that have been applied to the southeast.

>> So the first -- what did we focus on with lessons learned? We focus on everything. When we started compiling lessons learned as a way to transform them into areas of opportunity for improvement in the future implementations. We saw themes that occurred in these five key areas. Outreach and education, communications, information technology, processes, training and processes and training and transportation. So we're going to go through each of the lessons learned. Talk through them a little bit and look forward to seeing and answering your questions about them if you have any. Participants expressed a need for a better understanding of chc. So we use this as an opportunity with regard to outreach and education to put more document tons website. We put the examples of documents we put on the website include complaints and grievances. We have a little more information about the complaint and grievance process on the website. Just to be honest and transparent , the

complaints and grievance process by regulation is very complex. If you think that you in some way need support through that process, you may want to look at this at some of the information on this website about the complaints and grievance process and maybe do outreach for additional questions. It is complex. Just by regulatory design. But it is there as a right to protect you. It's very important that this chc participants understand the process and know your rights.

>> We had a lot of questions in the southwest aabout what continuity of care meant. And providing details on what the end of the continuity of care period means as well. All of that information is on that document. And it provides education , the continuity care period for people that received long term care in the community is six months. Charge time the managed care will be doing assessment to see whether services are appropriate or if any changes need to be made in reflection of more services available or different service levels etc. That will provide more information. Participant plan selection pool is another document and we've gone through that. It describes the fact that participants can make a plan change at any time, when that change would be effective and what the transition from one plan to another means as well with regards to ongoing continuity of care, etc., etc. And then we have a very extensive question and answer document that keeps on growing all

the time. I think we have more than hundred offense questions I know we have answered by category. It's searchable at this point. We strongly encourage you if you want to know community health choices in the weeds, and types of questions people are asking about the program, look that the question and answer document. It will give you a thorough overview of all of the specific components of the program. Highly recommend you look through it. If you are understanding in interested in how the program works on a very detailed level. We learned the need for more expansive communication. That includes extensive effort for doing community based sessions that are language specific. That's more reflective of what we saw in the specifically about the population in the southeast.

We recognize we need more sessions for a larger population and to do them earlier. That's an important component of the outreach effort. We're going to continue those efforts as I mentioned. Anytime we have opportunities to talk to participants or providers or participant groups or provider groups we'll accept that invitation.

We'll look for every opportunity to be able to do that. We've also looked with regard to communications expanding level understanding of the program. This is an interesting point. A lot of staff weren't as familiar with community health choice in the southwest and we realized this is opportunity to do education with county based services. And mostly about what changes with behavioral health. We wanted to make sure the county based staff and individual county based services have an understanding of how this change effects them especially with rashed to the program the behavioral health services they see at the county level. In addition we elected to provide education on the program. We had a lot of provider based

education for the southwest but we recognized that the more education we offer , the better it will be for providers and getting that education out to providers earlier would be 74ful. We started earlier provider education. The

sessions we scheduled in July of 2017 for the southwest were moved to early June in 2018 for the southeast. And we may even do them earlier in the rest of the state just to be clear.

We might start our outreach sessions in the may time frame. It's important to get the providers are comfortable with this change as early as possible so that they have an informed conversation with the managed care organization when they start talking about the contracting and continue newty of care process.

>> Chris: We wreck recognize the opportunity to expand spacability and scheduling for outreach sessions and the reasons why we can that. We had a number of sessions -- we had a number of sessions that really just didn't have enough space for all the people who showed up.

We wanted to make sure that was never an issue. That was successful in the southeast.

We never had a session to my knowledge that was cramped with people. There was enough space for everybody. Also expanding provider based education sessions we talked about this as well.

We have more providers in the southeast than the southwest so it made sense for to us do more.

We wanted to make sure the sessions were scheduled earlier and giving providers as much notice as possible so they were able to attend them. With regard to communications we also modified the chc website so it would be easier to navigate and making the site more user friendly and making things easier to find on that website. We want the website to be used heavily. We saw there were people had given us feedback there were challenges in identifying where information could be available.

We wanted to make sure that was something that was addressed and made easier for people to be able to navigate to get the information that they need.

>> We wanted to make sure we had a lot more life provider education. We added a lot of materials for the southwest for the life program.

We recognized we want to make sure participant understands if they are eligible for the life program that it is truly the enrollment alternative for community health choices and it is a great managed long term service option. If it's a mod of care that will will work for them.

We increased material.

We partnered with life providers to develop content and information that made the option clear to participants and developed a fact sheet for the life program.

We continue to work with the life plans as well as other entities to improve communication and one of those key entity it is independent enrollment broker. We wanted to Mike make sure they were communicating clearly about the life program as an offering and to provide more handoff between the independent enrollment broker to the life plan so participants are able to have questions answered by a life plan member immediately.

So there is no gap and part pants are able to be directed to a program of care that may be something they are interested in enrolling in. The life plan developing more content was a real goal because we want the life plan the life program to grow as we move forward with community health choices. It's a great service offering.

Rewellly want to encourage participants to consider it as an option. Moving into information technology.

A key focus of lessons learned. We had a lot of lessons learned when it came to information technology. Information technology is always a challenge in any implementation. One of the key areas where we had challenges was related to data integrity. That was in a case management system specifically. We had coordinators to stress the importance of good data entry and making sure that service coordinators and other entities were entering in contents consistently. We also provided information on primary care election. For some dullly eligible.

They may not be required the have a primary care physician and we wanted to be sure all of that was clear.

>> We wanted to make sure we were improving education and information related to the directory and search functionality.

We wanted to make sure the directory was improved so it was easier to navigate. We had a webinar focused on the search tool. We went through this already. It's

available on the website. Lessons learned was we needed to improve the functionality because people were challenged by whether they were part of a managed care network or not and we wanted that question to be answered for those participants right away. We also wanted to dress challenges with regard to waiver transfers. If the challenge we had in this area is if somebody was moving from one waiver to another or to community health choices sometimes it was hard to translate from one service system to the other.

We worked hashed to make sure the information transfer was more streamlined so there was never risk of individuals going through this type of transcription to fall through the cracks. We leave it's successful and certainly has been improvement for participants.

These kind of changes are relatively rare but when they did happen, especially early in the implementation for the southwest it was particularly challenging for participants. So a lot was to improve accuracy. In addition one issue was Sames itself. Sames is the is the case management platform that was used by coordinator. We found in Sames that some of the fields were not used in a consistent way and we've worked diligently for the southeast so when we transition from fee for service to the managed care platform that a lot of those data integrity issues are addressed at this point. We are much more comfortable with the Sames data levels as it transitions to managed care and we believe the services are going to be more clearly established and translated for the managed care organizations as they go through the continuity of care period N. addition we focused on improved file sharing and some of the key partners including the public partnerships limited. The financial

management services for individuals who are receiving home and community based services in the community and are a consumer employer or participant employer. We held ta sessions with pbl and the managed care organizations this past sum tore talk about lessons learned and make sure that the process works better. So that's information technology. Why don't we take a break and go through some of the questions we've received so far.

>> We're going to go through some of the questions we've had so far.

Has the department of health signed off on the adequacy of networks? We consider it to be an ongoing process. We have successfully passed the date. Since network development is an evolutionary process Randy and his team continue to work with the department of health to make sure that networks cannot to be developed and we receive weekly reports on where they are at with the networks.

>> We continue to work on the network adequacy for the southwest. They continue to get reports in. The mco's have to submit when they lose providers. It's an ongoing monitoring piece.

>> So somebody was asking how they would be able to be a service coordinator.

It depends on if you want to be a service coordinator or enroll as a provider.

You would have to enroll in the Medicaid program. You would have to reach out to the provider line to understand how the enroll as a Medicaid provider. 1-800-932-0939. If you wanted to reach out to the managed care organizations and talk about the provision of service coordination reach out to them directly as well. Later on I will have their email address and phone numbers I guess they are asking where they can get training for all three of the managed care organizations. I will have their 1800 number listed at the end of the presentation as well. Could the department put together a brief frequently asked questions on chc and immigrant eligibility.

>> Our office would be heavily involve in the development of such frequently asked question development. But we're more than willing to consider developing something like that. I think it's a great idea.

Are you hearing about a backlog on the provider enrollment page for the office of long term living? It was stated we're reviewing applications for may. We are not aware -- there is a -- I wouldn't call it a backlog but the process sometimes takes a long time to go through. At this point it is possible that there may be delays in the review of that. That is a good point. Request to have the independent enrollment brokers number relayed again. I'll do it again. 1-844-824-3655 and the hearing impaired line is 1-833-254-0690.

>> had where do you find your site I.D. and number for your up mc station form. Reach out directly and they'll be able to sprue provide you with that guidance. Refer to upmc is what we would ring ag remember mend you do. Next one of the mco's is working with change hc as their clearinghouse and this is not a change for the skilled nursing facilities for the service. Is upmc going to offer the same service? That would be something you'd want to have the managed care organization answer directly for you so you'd want to reach out directly to have that answered. Especially since I don't know what it meanings.

>> They are using different billing clearinghouses that are allowing you different methods to bill.

>> Next question who receives new service referrals? That is an interesting question.

I'm going the make an assumption on what I think it means. If you mean new services for people enrolled in the program new services would be something that would Bo Golden Gauntlet through the review process for the managed care organization.

>> Thank you. I'm happy to hear you are pleased. There was a team of people who worked very hard to bring it to fruition and it's a credit to their dedicated and focused work bring that about. [indiscernible]

collectingquestions at round tables and sessions held in other languages. We will take that back as a really good idea.

Thank you Aaron. Immigration is an interesting focus especially because it's been significant. It will not just be an issue in the southeast. It will also be an issue in the other three zones as well. We think it's a great suggestion and we'll probably reach out to you directly to see how we can make it happen. Next question, how can we have education sessions in my organization? My strong recommendation to the person who sent this is to reach out to us through the mailbox that I'll list at the end of the presentation and we'll be more than happy to reach out to you to talk about the how the sessions might be arranged. And I think at this point we're going to jump back into the presentation.

>> [indiscernible]

so one lesson learned and this was a no brainer or the honest. Have the independent enrollment broker engaged in the communication efforts so their messaging with their enrollment specialist was aligned with the communication strategy that the department in our communication vendors were using in our participant outreach. That has been successfully accomplished and we believe there is better alignment between the broker and all the participant communications in the southeast as an improvement over our education efforts in the southwest. Additional process improvements. Improvement in service authorization process has been a real focus.

We've had the managed care organization set up providers as early as possible to be able to access provider authorizations earlier. This was a challenging issue in the southwest especially in the early months. A lot of providers weren't able to see prior authorization until after significant amount of time and there had to be a lot

of communication with the managed care organization so the providers had a clear understanding of what services were authorized. In addition the prior authorization entity used by all three organizations has been engaged in provider outreach and efforts as well.

They were in all of the provider forums and they did help provide background information about how their software works and supported the managed care organizations in education and training. There was key provider training held in October as well. That was meant to try to get ahead of some of the issues we saw in the southwest. With regard to training, we had lots of lessons learned.

First, focused training for service coordinators on chc. Especially if they were providing service coordination, really did have to understand how community health choice was different. And the fundamental difference and I have said this a thousand times and I'll say it 1,001 times.

Service coordination in community health choices is an administrative function of the managed care organization. When you are moving into the community health choices after the continuity care period you have to look at yourself as being part of the managed care organization its. When we talk about the managed care function, we don't talk about it as a service. We talk about it as an administrative function of the administrative care organization. No separation. Mco are doing service coordination. So training was updated for the service coordinators to better understand this requirement. And we had service coordinators assisting in the educational efforts as well. This includes asking some of our southwest coordinators to participate in some of the discussions about service coordination with service coordinators moving into the southeast.

That was helpful because they were able to talk about how they were able to make it work for them and how to navigate and survive this change as it goes forward in anew region. The service coordinators were the best resource for describing what this change meant for them. We are grateful to them for being willing to do that. For nursing facilities for training. We wanted to make sure we were improving training for facility staff. In a key area of focus has been on behavioral health services. The general function when it comes to long term care services hasn't changed except with regard to the fact that now participants are enrolled in the behavioral healthcare organizations and nursing facilities now have a partner with the behavior health organization. We develop aid session that described this new relationship. Head nursing facilities. And the behavioral mcos all meet together to discuss how they can make the process worn better. And we developed the fact sheet.

Also with regard to training improving service coordination trainening to mcos an their roles. I think I touched on this which includes understanding their systems, reassessment process etc. Making sure the service coordinators are comfortable as they transition into their roles. And the last area of focus is on transportation. One of our biggest challenges in the southwest and continues to be a challenge in the southwest. I will put it out there transportation has always been a challenge in the Medicaid system and long term care system. But transportation has been a challenge. And we have done all we can to make sure we not only address the service challenges for participants but provided more comprehensive education on what the transportation benefits were for participants. Whether they are nonmedical transportation, nonemergency medical transportation is offered through nursing facilities or the transportation program.

Emergency medical services etc. So we developed the transportation fact sheet. Provided clarification and guidance for nursing facilities on transportation and we are hosting a transportation summit tomorrow.

Hopefully weather permitting to go through different types of transportation offerings that will be available to Medicaid recipients.

We're hoping that communication will address transportation issues so that the transportation change will be seamless for participants as possible. And we also recognize the value as a partner in the Philadelphia area to be able to be part of that communication strategy and understand what chc means for them. And with that we're going through additional questions that were received before we get into resources.

>> Interesting question where does ate na better health fit into this? I'm not sure but I think ate na better health is a Medicare advantage plan. I'm not positive about that. My recommendation would be to reach out the them to ask that specifically F. they are a Medicare advantage plan they fit into this because the chmco have a coordination requirement and they will be working with ate na to be able to word Nate that coverage. Participant need not make any changes to their Medicare coverage unless they want to make changes to their coverage. They have a requirement in their agreement to coordinate Medicare and Medicaid services as holistically as possible. I'm assuming that's the answer to your question. Next question how are modifications happening and what is the process and what are the lessons learned from the southwest implementation?

>> This individual was talking about how modifications was an opportunity for lessons learned. The biggest challenge was modifications approved prior to

understand flight with the coordination with chc. We developed a new process for the southeast based on lessons learned for the southwest.

I appreciate this question. That process has a better handoff from the fee for service system to the managed care system where theyth managed care organizations are clear on what they are communicating to participants on thousand modifications are being completed. Giving them more status. Ultimately making clear who is responsible for coordination and who is responsible for payment. And making sure the modifications get completed, especially if they've been approved. So that process is in development. And that is a very important lesson learned. We had a lot of challenges with that. I appreciate the question very much. Will service coordination agencies be filling services through one of the three managed care organizations? And did the managed care organizations have to approve such services?

>> After the continuity of care period service care will be part of the organizations. They will have to review and approve such service as part of the assessment process and the service coordinators will work with participants to make sure that the appropriate services are identified and delivered to the participant at the appropriate levels in reflection of the goals. The answer is yes. The chc email sent out on November 14 with the managed care billing fly area tached. Medicaid is the payer of last resort. Once Medicare any other insurance coverage paid for claims Medicare can be build for the remainder of claim.

I'm assuming this person is asking for clarification. Medicaid has always been the payer of last resort and their primary would have to be build first. There are a lot of services not eligible during that system. For specific billing requirements with regard to Medicare and Medicaid wen courage to you reach out to the managemented care organization to to the answer those questions.

>> So the next question is who receives new referrals for participants who don't have services already in place? Depends. It's possible that the new service revels for participants would be offered through -- I'm assuming this is a home and community based provider of some sort. So the managed care organization would provide new service referrals to participants if participants did not select a provider to provide services within that network. It dependence what the participant did with regard with provider choice. Next question is there an acronym work sheet available. There are so many. I could not agree more.

No, we don't put out accused I don't anymore work sheets because we like people to be challenged -- I'm just kidding. We have a glossary on our website and we'll

make sure it's available. Go to the chc health choices website and you'll find a resource for acronyms. I I agree with you completely.

We toned overdo it when it comes to acronyms. It is a challenge to be able to navigate that.

We make light of the fact we use acronyms too often.

The reality is it is a real challenge and we have do have a glossary that is available for you. After this session is it possible to have the power point emailed to all attendees? We publish the power points on our website so that we don't have to send it out to all attendees F. you go out to the website on the health choices web page for the department of human service you will be able to find this power point available. It will be published within the next several weeks. Next question we have no contact from the independent enrollment broker who should we contact?

>> Dependence your question.

A general contact you should still use the independent enrollment broker number. I'm going to go to that page right now. 1-844-824-3655. If you are not receiving a response reach out to the department specifically the provide ore participant line and they are noted on the screen. 1-800-932-0939. 1-900-757-75 had 2.

We edge courage to you use those if you are not getting responses. The next point you learned today exchange will not be accessible until mid December is that true. That is something we can follow up on.

>> Some of it depends on the actual mco you are dealing with. I can reach out. Is their email address on there. I will reach out and get more details and get you a better answer.

>> Randy will be reaching out to you directly.

>> Just to go through additional resources. This slide shows the three managed care organizations websites and email addresses.

We encourage to you reach out to the managed care organizations with any questions. If you are a provide around have not talked to a managed care organization, please do so immediately.

Please reach out to the managed care organizations. Let them know you are an existing provider for service in the southeast.

And you want to know what you need to do next to be able to continue to provide services. Just to be very clear, senator using a different name in the southeast.

We don't have four managed care organizations. We have three. It's just they are using a different name in the southeast. Three managed care organizations, one with two names based on the zone. This is the standard resource information. If you've not signed up. That provide a lot of our up to date community health choices information. We encourage to you do that. We also encourage to you go out to the website and see all the information on community health choices including this presentation, including information relating to the subMack. Which includes our transcripts.

The recently asked questions or the questions discussed previously, trainings and any other related information that is critically important that you go on that website to get that information. If you have any email comments or questions, please use the ra mailbox. Please use our provider line. Athat is 1-800-932-9339.

>> participant issues for concerns -- the independent Ien rollment broker is -- the hearing impaired line is -- or you can use their website. Or you can make a plan selection or plan change. Research provider and network information for the managed care organizations or do managed care organization plan comparisons as well. With that we're going to go through anyway divisional questions we may have. At this point we don't have any additional questions.

We're going to wait for a couple of minutes to see if anymore questions come through.

>> We have a few new questions. How long does it take to become a service coordinator. It depends.

It could take a couple of weeks to a cup of months depending on how much information is required if you. Et na, I didn't know they went by better health choices.

Thank you for the clarification. That is a pretty significant question. If an individual is in one of our home and community based waivers and they are not dually eligible for Medicare and Medicaid, they would be in health choices plan that could be et na better health. They would be required to change organizations when they

transition into community health choice sos it does represent a plan change for them.

They will have to make a change to a managed care organization. That's a great question.

Thank you for the clarification. Question about whether transportation is door to door.

I'm not sure I understand the question. For the medical assistance transportation program, community health choices won't impact the way benefits are currently being provided. Your understanding is most likely correct. There won't bay change to the benefit. And somebody also made it known that the joke I made about acronyms was funny. I agree, I thought it was funny.

Randy did not think it was that funny. We're going to wait to see if there are anymore questions and I'll have a discussion with Randy about why he thinks I am or am not funny.

>> we've not received any new questions so we're going to close out a little early.

We appreciate your time and interest in community health choices. We're going to focus on the southeast implementation in the December 3 webinar.

Looks like we have questions so we're going to hold off on our goodbyes.

>>

>> Are ovr looking to address long wait times for participants. Can't speak to ovr when it comes to staffing and funding.

We are in the process of developing an agreement with ovr on how we can have the process move quickly.

We want individuals to be able to as early as possible they want them to be able to access vr services or be able to access the oltl waiver services as quickly as possible. Appreciate the question and the answer is broadly yes, we have a discussion in the works with ovr on how the move the process along more quickly.

We're looking to see if we can follow the office of development template as well. It seems to work fairly successfully. What if anymy consumers haven't received their mail. We strongly encourage to you reach out to the independent enrollment

broker or encourage your participant to reach out to the independent enrollment broker themselves. To have that packet remailed out to them.

They have until December 21 to make a plan change that will be effective on January 1. So for whatever why that packet didn't make et to the participant, call the independent enrollment broker and have it resent or make sure they have all other questions answered about what plan selection or plan change would mean for them. That's what we encourage to you do at this point. The question can you provide guidance what the service coordination entities on what they need to do to ensure the [indiscernible]

we provide aid lot of that guidance. I would encourage to you call our provider line to have some of those questions answered more directly. If you haven't received that guidance we want to make sure you receive it on the provider line can point you in the right direction for where that guidance can be received.

>> Can each mco use a different claims clearinghouse? The answer would be yes they can. The mcos themselves will answer that question for you. We encourage to you reach out to them on using these three contact points on the slide on the screen right now. That is all the questions we have available and we will be closing out. We appreciate your time and attention today and we look forward to continued future discussions about the southeast implementation and ongoing operations in the southwest. Thank you and happy Thanksgiving everybody.