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00:00:13:02 - 00:00:24:07
Welcome to the Provider Preparedness Summits for performance-based contracts. This is the 1st of 4 sessions providing details on all proposed performance standards

00:00:24:07 - 00:00:41:19
for performance based contracting for residential services. Today's session is scheduled for 2 hours. The format for today's session is an ODP led presentation that will allow for scheduled question and answer breaks.

00:00:41:19 - 00:00:49:18
Participants are encouraged to type your questions into the Q&A at any time during the presentation.

00:00:49:18 - 00:01:01:00
ODP. Staff will be responding to questions submitted through the Q&A Due to the large audience size, we will not be opening microphones during the session.

00:01:02:02 - 00:01:10:19
Copy of today's presentation is available for download using the link that was just placed in the chat.

00:01:10:19 - 00:01:21:19
Today's session is being recorded and it will be posted to my ODP and announced, when ready for viewing.

00:01:21:19 - 00:01:28:19
Let me introduce today's presenters. 1st we have Deputy Secretary Kristin Ahrens.

00:01:28:19 - 00:01:34:09
We also have Jeremy Yale, the director of the Bureau of Policy and Quality Management.

00:01:34:09 - 00:01:46:03
And we also have Lauren House, the Director of the Bureau of Community Services. And with that, Deputy Secretary, I believe you're beginning the presentation.

00:01:46:03 - 00:01:58:19

Great, thank you for the introduction Robin and welcome everybody. Do you want to remind everybody I'm glad we've got great attendance here today and I hope that we do for all 4 sessions.

00:01:58:19 - 00:02:17:19
I do want to remind everyone we are not repeating this the 4 times. Rather we essentially have split up each of the performance areas into these 4 different summits where we'll be going through each performance area and each of the performance standards and measures that accompany that.

00:02:17:19 - 00:02:26:21
The other really important thing I want to remind everyone is that what you have in front of you, what you have in terms of the toolkit.

00:02:26:21 - 00:02:37:19
What you have that we will be presenting to is based on what was proposed. I, we still have public comment coming in until tomorrow.

00:02:37:19 - 00:02:57:19
We have, we are receiving a pretty high volume of that, which we're pleased about. Again, this is really significant systems change and we have certainly invited all of you to provide feedback as to how we can really be successful at addressing the objectives here through this performance-based contracting.

00:02:57:19 - 00:03:14:00
So. Again, I think we can anticipate based on the volume of comments. Some of the areas that we know have been, are kind of hot button issues that have been shared across different stakeholder groups and are being shared in volume,

00:03:14:00 - 00:03:20:19
I think we can anticipate that there will will be some changes from what we proposed to what is final.

00:03:20:19 - 00:03:32:19
This we are just putting in front of you what was proposed and walking through all of that but based on that public comment, it is subject to change.

00:03:32:19 - 00:03:44:19
Alright, go ahead to the next slide. And let me share a little bit. So we'll be, in this session, we're gonna be going through a handful of different performance areas.

00:03:44:19 - 00:03:54:05
So today we're gonna hit on continuum of services. Referral and discharge practices, administration, data management, and risk management.

00:03:54:05 - 00:04:02:19
Again, we've kind of split this up across the 4 sessions for each of these areas we are going to review the measure itself.

00:04:02:19 - 00:04:14:18
The data sources that will be used any other specific measure related details and then whether or not it's subject to pay for performance.

00:04:14:18 - 00:04:24:19
For some of these we have some relevant data that we will share back with you just in terms of statewide either you know better performance.

00:04:24:19 - 00:04:30:19
Or statewide data as to kind of where we are in terms of our measuring these standards as of today.

00:04:30:19 - 00:04:45:19
I know Robin mentioned, please use the Q&A pod to enter your questions. We're, gonna stop after either in some of these cases one after some 2 and take questions specific to these different areas.

00:04:45:19 - 00:04:57:19
So we hope we can get some good. Interactive. Good day going here and make sure that we're getting to your questions as you're thinking about the implementation.

00:04:57:19 - 00:05:07:19
Alright, next one. The other thing that we thought might be helpful is just making sure that people are, we're all on the same page.

00:05:07:19 - 00:05:15:19
We're using, there are a number of new terms. And within the ODP space now with the move to performance based contracting.

00:05:15:19 - 00:05:24:19
So. You may still hear the term selective contracting. We again, that what we are calling this now as we move forward is performance based contracting.

00:05:24:19 - 00:05:36:19
Selective Contracting is the specific name that CMS uses to describe this 1915 B 4 of the social security act.

00:05:36:19 - 00:05:52:19
This waver of social security rules is the technical CMS term is selective contracting so you're you you will still occasionally hear that and it really refers to the CMS authority that we're using, which allows state Medicaid programs.

00:05:52:19 - 00:06:04:15
To define specific criteria for provider contracting, in a fee for service delivery system and then create sort of restrictions and requirements around who is providing that service.

00:06:04:15 - 00:06:11:07
But, you know, from here forward, I hope we can kind of get rid of that term. I know we have used it.

00:06:11:07 - 00:06:28:19
We used it when we released the concept paper. We have moved away because I think performance-based contracting really does describe what we're trying to do here much better than selective contracting, but the term will will still rise up because it is the formal CMS term.

00:06:28:19 - 00:06:44:19
Pay for performance. Again, this is another term that, you know, does come out of a CMS and it is essentially a payment approach that provides added incentive payments to provide high quality and cost-effective care.

00:06:44:19 - 00:06:54:19
So these next 4 sessions. We will be going through which of the performance, standards, pay for performance will be attached to.

00:06:54:19 - 00:07:04:19
Performance area. So these 3, when you are looking at the performance, the matrix that outlines all the performance measures.

00:07:04:19 - 00:07:10:19
You can kind of read this from left to right. So the performance area is the main category, right?

00:07:10:19 - 00:07:15:24
This is we're going to talk about continuum of service. So that's the performance area that we are focusing on.

00:07:15:24 - 00:07:26:19
Then each performance area has measurable standards that we've identified. You know, here's what we want to get to in terms of ensuring access to services.

00:07:26:19 - 00:07:37:06
So that's the standard where we start to say, okay, to get to a continuum of services, you know, we need providers doing 2 of 3 of the residential types of service.

00:07:37:06 - 00:07:41:19
And then we get into the performance measure. So again, you're going to read this left to right.

00:07:41:19 - 00:07:57:19
You've got the the broad category, the description of how we're gonna demonstrate that and then the very specific way how we're going to evaluate that standard, how it is completed or how ODP will be scoring.

00:07:57:19 - 00:08:09:16
So again, read your document left to right in terms of area standard measure. Alright, next slide. So we're gonna jump into it here as the 1st of our areas.

00:08:09:16 - 00:08:19:19
Our performance areas that we're going to take a look at in this case, the performance standard is to provide 2 of 3 services in a residential continuum.

00:08:19:19 - 00:08:29:04
Meaning 2 of 3 residential rehabilitation and licensing unlicensed doesn't matter here this is based on the service itself.

00:08:29:04 - 00:08:35:19
Residential habilitation, life sharing, or supported living. That's 2 of the 3.

00:08:35:19 - 00:08:52:06
And I'm gonna go back to the, the why here. So this performance area is one that we identified because it is incumbent upon our office and our service system.

00:08:52:06 - 00:09:16:19
To make sure that people have an opportunity to live in the most inclusive settings possible. In the least restrictive settings we know life sharing and supported living are when we look at our quality of life and satisfaction with services surveys are both supported living and life-sharing are have higher marks in terms of satisfaction.

00:09:16:19 - 00:09:23:19
And then lastly when we look at our larger objectives about system sustainedability and addressing workforce.

00:09:23:19 - 00:09:42:19
This is one of the many solutions that you're gonna see. I within these different performance areas, the more that we can rely on services that are not heavy don't have heavy requirements for traditional direct support professionals.

00:09:42:19 - 00:09:48:19
The better in terms of trying to address our workforce. So again, that's that's the why here.

00:09:48:19 - 00:09:59:02
Why we've got this emphasis on the continuum of services. Very specifically, we've got 2 different, performance measures here.

00:09:59:02 - 00:10:08:00
One is that we're gonna require to be a select provider. This does not apply to primary doesn't apply to clinically enhanced.

00:10:08:00 - 00:10:22:19
We are going to be looking for the provision of 2 of 3 services during that time period. In this case, ODP will be pulling authorization and claim data, to look at, you know, providers that have provided 2 of the 3.

00:10:22:19 - 00:10:36:23
And we are gonna pull that point in time for July 1st of 2,024. This is not an area that we're going to be looking at pay for performance and our data source here is claims.

00:10:36:23 - 00:10:48:12
Alright, next slide. So here's 1, yeah, I said where we have some data that's going to be relevant for you to help you kind of understand the lay of the land and the context here.

00:10:48:12 - 00:10:53:19
This is one. So this is where we were as of December, the 31st of 2023.

00:10:53:19 - 00:10:58:15
The how many providers we had providing each type of service.

00:10:58:15 - 00:11:09:19
So of our 402 providers rendering services on that date. We had 390 that provided residential rehabilitation.

00:11:09:19 - 00:11:20:04
78 that provided life sharing, 28 that provided supported living and 90 providers that provided 2 or more of those different service types.

00:11:20:04 - 00:11:33:19
You can get a sense of where when we talk about select providers, we know that as of December, the 31st there were 90 that potentially qualified as select in that select category based on this criteria.

00:11:33:19 - 00:11:46:19
Of course, there's lots of criteria that are going to go into, that but this is obviously one that's pretty pretty easily measurable in terms of meeting that standard.

00:11:46:19 - 00:11:51:19
Alright, next slide.

00:11:51:19 - 00:12:04:08
Alright, second one of the performance measures for continuum of services is we are asking all providers to report on the number of individuals with a successful transition from residential.

00:12:04:08 - 00:12:11:17
Habitation to live sharing or supported living. And the idea here again is it's supported living life sharing are not for everyone.

00:12:11:17 - 00:12:23:19
We do not expect that they are for everyone, but they should be options. That are offered to individuals, particularly individuals that are going to benefit from those kinds of settings.

00:12:23:19 - 00:12:35:02
They make up a pretty small portion of our overall residential, footprint right now. And certainly we could be offering those on a much larger scale than we are.

00:12:35:02 - 00:12:47:04
So hence, you know, that we this is an area for pay for performance. The way we're going to be evaluating this is we will be collecting information from providers.

00:12:47:04 - 00:13:00:05
Related to the number of individuals that have transitioned, we will validate that information for successful transitions through looking at authorization and claim data.

00:13:00:05 - 00:13:08:08
And we will continue using the form that is currently available called the Transition to Independent Living Request Form.

00:13:08:08 - 00:13:25:17
Is the form right now that triggers an incentive payments to identify and support somebody to transition and then 6 months later when someone has successfully lived in that new life sharing or supported living setting second payment.

00:13:25:17 - 00:13:39:08
So we will be continuing those incentive payments that pay for performance in this space. And again, the way we will be, collecting data here is through, some basic provider survey questions

00:13:39:08 - 00:13:48:17

and then reviewing claims and the submission of those forms, which would trigger those pay for performance payments that will be available.

00:13:48:17 - 00:13:53:17
Alright, next slide.

00:13:53:17 - 00:14:01:17
So let's, I imagine there we've got some Q&A coming in and having got.

00:14:01:17 - 00:14:05:09
Team members here who can jump in while I start evaluating them.

00:14:07:10 - 00:14:16:19
Yeah, good afternoon, everybody. This is Lauren. Just want a real quick sort of question, a general question related to the, summits that we're hosting.

00:14:16:19 - 00:14:31:19
Question came in through the question and answer pain that I thought would be really helpful to answer for everyone live is the question came in so all 4 sessions the content is going to be unique the 4 sessions are not a repeat

00:14:31:19 - 00:14:44:23
and so we would definitely encourage, those of you who have not registered for the remaining 3 sessions to go ahead and do that because the content during those sessions will be different from what you are hearing today.

00:14:46:16 - 00:14:53:00
Lauren. Got a couple here. So, is, is unlicensed life sharing acceptable?

00:14:53:00 - 00:15:03:13
It is. So for residential habilitation, we, licensed, unlicensed, either count as residential habilitation, same for life sharing.

00:15:03:13 - 00:15:12:24
It's not, it's the service itself, not the license status. That counts in terms of the services, the 2 of 3 services.

00:15:12:24 - 00:15:27:11
So. Good, good question. I'm gonna summarize this question. This is about 92 different measures for select here will all measures have to be met in terms of the tier determination.

00:15:27:11 - 00:15:36:03

So I'm going to broaden this to the question of for each of the tiers do all of the standards have to be met.

00:15:36:03 - 00:15:48:21
We put out for public comment that yes, all of them had to be met. This is one area where we know we have already received quite a bit of public comment on us.

00:15:48:21 - 00:15:58:19
Re-considering that position and I'm pretty confident that we will continue to get a public comment on how we are doing that evaluation.

00:15:58:19 - 00:16:10:19
So as of what we proposed, yes, you had to meet all of those standards. Again, this is an area that we may we may adjust based on public comment.

00:16:12:13 - 00:16:20:21
All right, what's the rationale behind clinically enhanced not having to provide 2 of 3 services? Thanks for this question.

00:16:20:21 - 00:16:33:24
This was one. So when we proposed the the concept paper actually had 2 of 3 for kind of all those top 2 tiers that I don't even remember what we called it back then.

00:16:33:24 - 00:16:41:07
We spent a lot of time with the residential strategic thinking group. So through public comments, 1st round, residential strategic thinking group,

00:16:41:07 - 00:16:54:01
we really tried to separate out what we wanted built in terms of the clinically enhanced service, which didn't necessarily meet with providing 2 of the 3.

00:16:54:01 - 00:17:04:01
The other reason that we really split that out is to make sure that smaller providers had the opportunity to be in a selector clinically enhanced tier.

00:17:04:01 - 00:17:27:00
So there was a lot of deliberation about kind of how where it made sense to incentivize. Both building clinical capacity and, this, concept of clinically, sorry, of continuum and the determination was made between concept paper and the proposed changes to the waiver, to separate those 2 things out.

00:17:27:00 - 00:17:28:15
But very, very good question.

00:17:30:17 - 00:17:44:14
Take another one here quickly. The performance measure, they're asking the question relative to, individuals transitioning, performance measure says to simply just report out the number of individuals.

00:17:44:14 - 00:17:51:01
And so the question is, asking to confirm that a response of 0 is an acceptable response and it is, right?

00:17:51:01 - 00:18:00:19
This really is just reporting out by provider agencies. The expectation is that providers participate, help us to kind of set that baseline expectation.

00:18:00:19 - 00:18:07:10
So if the number is 0, that's okay. We're just asking that you respond to the survey questions.

00:18:09:07 - 00:18:11:14
Alright, is that the signal to move on?

00:18:13:08 - 00:18:14:16
I think so.

00:18:14:16 - 00:18:17:15
Right, Robin, you're the timekeeper. I don't know how we're doing here.

00:18:19:15 - 00:18:21:17
I think we should move on.

00:18:21:17 - 00:18:24:17
Let's move on. We've still got. Yeah, we've got lots of other performances.

00:18:24:17 - 00:18:28:10
So thanks for the questions. We'll, we'll try to, input answers too.

00:18:28:10 - 00:18:34:08
And if you're asking questions about later performance measures, we're going to hang on to those till we get to those sections.

00:18:35:04 - 00:18:46:05
Alright, so let's move on to referral and discharge practice here. And again, in terms of The performance area and what we are trying to do here.

00:18:46:05 - 00:18:57:16
We need to ensure timely access to residential services and particularly we need to ensure timely access to services that meet people's needs.

00:18:57:16 - 00:19:08:24
We have, There and there's a couple of things happening here one generally we, are not always great systems partners.

00:19:08:24 - 00:19:22:00
We have people that are spending time in county jails or correction settings past when they should have been released because we are struggling to find.

00:19:22:00 - 00:19:32:08
Suitable place for them. We have people living in emergency rooms or hospital settings in inappropriate settings.

00:19:32:08 - 00:19:40:15
This is happening well too often. Because we don't have capacity to kind of meet their their clinical needs and meet them timely.

00:19:40:15 - 00:19:51:02
So there's the need at the individual level, at a systems level, to be good systems partners, and then importantly with the 1,915 B.4

00:19:51:02 - 00:20:02:01
application, one of the things that we have to assure the federal government when when a state says we are going to use the B 4 and selectively contract for a service.

00:20:02:01 - 00:20:16:22
The state has to assure the federal government that beneficiaries have access to that service. So you have to, you know, lay out what are the access standards, like how are you going to measure that and assure that how will you continually be evaluating that?

00:20:16:22 - 00:20:31:02
One of the things that is in our proposal to the federal government, which they will be reviewing is that we timely access means for residential rehabilitation, 90 days or less.

00:20:31:02 - 00:20:43:02
An individual who has, needs a residential service. 90 days post acceptance of the referral by a provider they are receiving that service for residential habilitation.

00:20:43:02 - 00:20:52:04

Again, licensed or unlicensed. For life sharing and supported living. We know this takes a little longer to set these situations up in many cases.

00:20:52:04 - 00:21:03:01
And so we have said that 180 days on average would be what we were looking at in terms of post acceptance of that referral to service begin.

00:21:03:01 - 00:21:17:01
So, you know, this, we've got, 3 different performance measures here for this standard of getting at timely service delivery.

00:21:17:01 - 00:21:25:18
And this is what you're going to see here is this is an area that right now ODP does not have a lot of visibility into.

00:21:25:18 - 00:21:30:17
You know, I can share in most people in the system can probably share some of these stories as providers.

00:21:30:17 - 00:21:35:07
You're probably aware, you know, yes, we took this referral and we had to find a home.

00:21:35:07 - 00:21:42:14
We had to find, we had a higher staff, we had to get staff trained, we had to do modifications to the home like these things take time.

00:21:42:14 - 00:21:49:19
One of the things we don't have system wide is a lot of visibility into what this looks like.

00:21:49:19 - 00:22:00:22
On average. What are our average times? What are the reasons? I think we, again, we can all conjecture and think about why we think most referrals aren't accepted.

00:22:00:22 - 00:22:11:23
Sometimes it's, you know, it's inappropriate. I've got a vacancy. And a home with to a 50 year old and a sixty-year-old and this is for a nineteen-year-old or a twenty-year-old.

00:22:11:23 - 00:22:19:13
This not, you know, this isn't an appropriate match or it's an area where you know you've got more staff vacancies than others

00:22:19:13 - 00:22:26:24

and so you're aware that in terms of staffing it's phenomenally difficult or the time period is just going to be too extended.

00:22:26:24 - 00:22:32:20
So one of the things that we need here is to gain some visibility into it.

00:22:33:15 - 00:22:54:15
So we've got 3 different performance. Measures here that are aimed at both supporting us, getting some visibility into what are those time frames, what are the reasons, what are the deriving reasons when for referral denial.

00:22:54:15 - 00:23:06:21
What are the driving reasons around discharge practices? Another area that ODP has historically gotten many complaints from from individuals and families is around discharge practices

00:23:06:21 - 00:23:20:10
and feeling that there was some discharge practices that really violated the the regulations and were on you know unfair and certainly unwarranted.

00:23:20:10 - 00:23:27:05
So again, this is not an area we have a ton of visibility into and particularly data to kind of help us understand what's happening.

00:23:27:05 - 00:23:41:03
You know, we've got requirements here that will help us gain that visibility. Around timeliness reasoning, and then also help us build what does good performance look like?

00:23:41:03 - 00:23:50:05
We're now investing in the system for, you know, in terms of pay for performance. We're investing in the system in terms of enhanced rates.

00:23:50:05 - 00:24:03:03
That are aimed at building capacity in the system. What what does good performance look like around referral and discharge and I think that's 1 of these measures that will build an understanding over time.

00:24:03:03 - 00:24:14:05
Right now, this is a reporting measure across the board for primary select and clinically enhanced. I'll talk a little bit more because there are some different standards.

00:24:14:05 - 00:24:28:10

For clinically enhanced and select related to this but this is the sort of general objective here and what we're trying to do is build some visibility into this so that we can establish what could performance looks like and ensure access.

00:24:28:10 - 00:24:36:21
We need the reporting to make sure we are meeting the federal standards as well. Alright, go ahead to the next one.

00:24:38:05 - 00:24:55:05
Alright, so, this, 1st one is, to attest to, and we will be putting together attestations for providers to review a test that system is going to be in place January one of 2,025 to track and report.

00:24:55:05 - 00:25:07:13
That time from I said you know we said yes as an agency to supporting this person We will, what day did we actually begin serving that?

00:25:07:13 - 00:25:15:13
So you'd be tracking that time period. So in terms of what those system requirements are, they are detailed here.

00:25:15:13 - 00:25:26:06
So providers are going to attest to they're going to need to develop a system, go live January 1st that can meet all of these below requirements.

00:25:26:06 - 00:25:32:14
So. To in terms of the tier determination we're going to need that at testation.

00:25:32:14 - 00:25:41:11
And then the requirements are what tracking all the referrals that come in to your agency by type of residential service.

00:25:41:11 - 00:25:51:18
Did this come in as a residential habilitation, as a supported living? As a life sharing? And then documenting if you accepted or rejected that.

00:25:51:18 - 00:26:11:21
Tracking the time from when you said yes to when service was delivered, reporting on the number of discharges that you initiated and the reasoning for that discharge and then on those denials of referrals, we want to know why.

00:26:11:21 - 00:26:26:04

Is this because of the age of the person? Is this around gender, clinical needs that you were unable to meet the location geography where this person you know is there this person needed to be in a specific area of the state that you simply cannot.

00:26:26:04 - 00:26:33:08
Provide that service or vacancy status of your in terms of your workforce. So we want to know the reasoning.

00:26:33:08 - 00:26:53:06
Okay, to again build our understanding here. Primary providers are going to need to have some policy to ensure that they're not accepting new referrals for needs group 4 or more and let me say here this is an area that we have received a very high volume of comments on.

00:26:53:06 - 00:27:01:05
And we are taking them to hard. So again, the what is in front of you is what we put out for proposed.

00:27:01:05 - 00:27:17:05
There are things in here that are likely to change before we submit a package to the federal government. And then the last thing here is, we're gonna want the data for, calendar year, 24.

00:27:17:05 - 00:27:27:23
That's, that's when we will begin to, look at these data. Alright, so where we're gonna get the information from is provider survey.

00:27:27:23 - 00:27:34:05
Ultimately this should be built into we're anticipating this is going to be built in at enterprise case management.

00:27:34:05 - 00:27:53:14
And then I think the sort of burden on provider reporting will be significantly less. But until we have enterprise case management, we need another way to build out this, data tracking that, again, is, will help us build an understanding of performance, but is also going to be a required federal reporting requirement.

00:27:53:14 - 00:27:58:14
All right, and this is not an area for pay for performance.

00:28:01:05 - 00:28:11:07
All right, so another second one of these is to be considered for Select and clinically enhanced services.

00:28:11:07 - 00:28:21:19

The residential provider must be serving 10 or more individuals in residential services as of the 31st of December of 2024.

00:28:21:19 - 00:28:29:03
This is like the needs group 4 referrals. This is another area we have received a very high volume of comment on.

00:28:29:03 - 00:28:40:05
So again, this is we are sharing with you what is, what we proposed. And, and in this case, we've got again this, you select and clinically enhanced.

00:28:40:05 - 00:28:55:16
May accept referrals for needs group 4 and greater. This will be using our own, we will be pulling the data related to all this, so there is no provider requirement to submit to anything related to this measure.

00:28:55:16 - 00:29:00:05
And there's no, pay for performance on this one.

00:29:00:05 - 00:29:08:05
Alright, next the last one here. So this again is for select and clinically enhanced. This one's a little different than primary.

00:29:08:05 - 00:29:20:14
In this case, we do want to demonstrate timeliness of response to referrals. So you're going to read the the tracking system that we're looking for is the same across all providers.

00:29:20:14 - 00:29:34:05
We need all of those data sources just the same across all providers. In this case though, we want a demonstration of this timeliness from selecting clinically enhanced.

00:29:34:05 - 00:29:50:06
There are enhanced rates going to select and clinically enhanced providers. So we really want to see that that average time for primary you're just going to be reporting out to us what time frames you you had between acceptance of referral and service.

00:29:50:06 - 00:29:58:09
For clinically enhanced and select, we want to see that those average days are in that ninety-day period and that 180 day period.

00:29:58:09 - 00:30:03:00
Again, this is average. This is not for, you know, each individual. These are averages.

00:30:03:00 - 00:30:16:17
So. In the instances because we know there's going to be some for, you know, the variety of reasons I said before and again over time, we expect that this will improve as we build up capacity within our system.

00:30:16:17 - 00:30:22:17
We know there will be people that fall outside of the 90 and the 180. Again, these are averages.

00:30:22:17 - 00:30:28:07
We want to know why. Why what were the driving reasons why this couldn't be done in 90?

00:30:28:07 - 00:30:33:09
What were the driving reasons this couldn't be done in 180? So again, data collection.

00:30:33:09 - 00:30:39:17
The onus is on the state to make sure with the federal government that we are meeting those standards.

00:30:39:17 - 00:30:46:06
So we do want to look at this. Provider by provider. We want to understand why it's taking longer.

00:30:46:06 - 00:30:51:07
And the onus is on the state to, really get us to those average time frames.

00:30:51:07 - 00:31:00:08
Alright, I believe we're up for questions again here. Next slide. Okay. Let's do some QA.

00:31:04:07 - 00:31:10:12
I have I have not reading them while I'm presenting so if somebody else has got some you want to jump in

00:31:10:12 - 00:31:17:06
A lot of great questions here coming in, related to referral and discharge. So thanks everybody.

00:31:17:06 - 00:31:25:06
A question came in basically around just what constitutes a referral. If I can kind of summarize in in an easy way.

00:31:25:06 - 00:31:33:24
I know sometimes right supports coordination will send over. Kind of a, are you interested or do you want to receive the entire packet?

00:31:33:24 - 00:31:46:08

And so really I think this comes down to what is your organization's sort of policy and determination around what is a referral and how do you process those referrals that are coming across your desk?

00:31:46:08 - 00:31:52:08
You know, what are you kind of doing with those now and do you wanna take this opportunity to change practice right at this point?

00:31:52:08 - 00:32:06:21
The other thing that I will say is that really the state that we're in now is thankfully only temporary in that once we have enterprise case management up and running for our home and community based service systems.

00:32:06:21 - 00:32:30:07
Referrals will exclusively be sent through the ECM platform. And so supports coordination will, formally initiate that referral that referral request will go to, corresponding provider agency that that individual or family might want to have evaluate that referral and everything will be able to be tracked through the system.

00:32:30:07 - 00:32:39:04
And so we will also then have some insight like Kristin was talking about, you know, the importance of, you know, knowing what those timeframes look like and that sort of thing.

00:32:39:04 - 00:32:56:16
And so hopefully, right, like I said, this really is only a temporary place where there's maybe some question about what constitutes a referral, but would definitely, encourage providers to now take a look at what those practices are in anticipation of performance based contracting.

00:32:59:01 - 00:33:06:03
Good questions here that are pretty quick. Is there an expectation that providers will accept a certain percentage of approve of referrals.

00:33:06:03 - 00:33:12:10
No, there is not. Again, this is an area we are trying to gain visibility into what this looks like.

00:33:12:10 - 00:33:19:13
At a provider level so no we do not have an expectation at this point. Down the road, maybe. I don't know.

00:33:19:13 - 00:33:36:04
But we do, we do not have a percentage. Expectation at this point. Can clinically enhance providers except referrals for needs group 1 2 3 yes you can and when will the 1st initial provider survey be released?

00:33:36:04 - 00:33:43:04
That would be on July, the first.

00:33:43:04 - 00:33:45:10
Lauren if you got some others here.

00:33:45:10 - 00:33:54:10
Yeah. Yeah, have a question. Why would the SE send a referral for someone who's needs group 4 to a provider who's not eligible.

00:33:54:10 - 00:34:05:19
Again, this really is hopefully only a temporary. Sort of state that we're in, we will be hosting sessions with supports coordination, to really reinforce,

00:34:05:19 - 00:34:21:13
after performance based contracting does start to be implemented as of January 1, 2,025 that they are not to be sending referrals for folks who are needs group for or higher to primary providers.

00:34:21:13 - 00:34:31:04
However, you know, we know that, you know, we're all human, right, and these things happen, but eventually with ECM, we will have the appropriate sort of parameters built into the system.

00:34:31:04 - 00:34:38:04
The system will be smart enough to know. That provider would not be eligible to receive that referral.

00:34:38:04 - 00:34:45:04
And so the system would basically apply a stop to that.

00:34:45:04 - 00:34:52:04
Alright, well, provided be held accountable for referrals that have been accepted but delayed due to family and or SC delays.

00:34:52:04 - 00:35:01:04
This is report. So particularly for primary, this is reporting. We're just asking you to give us that information back.

00:35:01:04 - 00:35:08:07
For selecting clinically in house enhanced we have we are asking for a demonstration that you can do this time.

00:35:08:07 - 00:35:24:07

We know there are going to be situations for any number of reasons that create delays on this, including, you know, the contractor that we had lined up is no longer able to do the modifications that is required for this individual

00:35:24:07 - 00:35:29:07
know, there's, something occurring, you know, family structure that means that you, got delays.

00:35:29:11 - 00:35:47:21
That's where we just need you to tell us. Why was that one delayed? The objective here is to hit those average days, but we do know that there are lots of reasons for things to take in some cases very long periods of time from that acceptance to that 1st day of service.

00:35:54:17 - 00:36:01:17
And Robin, we're gonna ask you to keep us good on time here. Do you have any others?

00:36:01:17 - 00:36:09:17
I think we answered a bunch of these.

00:36:09:17 - 00:36:23:04
So, I think what we're asking, here for this question is when we're able to send referrals through, enterprise case management will those referrals only be sent to providers with vacancies?

00:36:23:04 - 00:36:42:05
And really I think, number one, we need to account for individual choice and preference and so even if a provider has not necessarily indicated that they might have a vacancy, but an individual and family, you know, might still be interested in your agency receiving that referral.

00:36:42:05 - 00:36:50:17
The SE is, you know, likely to honor that, you know, as long as, you know, sort of meets all those other criteria.

00:36:50:17 - 00:37:00:21
If you're, let's say, you know, person with the needs group, 3 assignment being referred to primary provider who may not necessarily indicate that there's a vacancy,

00:37:00:21 - 00:37:11:13
they may, you may still receive that referral, but again the importance is, that we are not sending a standard that you're accepting a certain percentage or a number of referrals.

00:37:11:13 - 00:37:23:12
But that you replied timely. That really is really what we're driving at, especially with sort of the initial rollout, is making sure that you evaluate, whether you could support that person,

00:37:23:12 - 00:37:34:10
in, you know, some sort of residential service and then that you close the loop with supports coordination to say I really don't have any vacancies at this time and you know we're

00:37:34:10 - 00:37:42:08
not necessarily going to be looking to expand for another, you know, 6 months. We really just want to keep that communication going.

00:37:42:08 - 00:37:53:08
Thank you, Lauren. So let's move along. We can always, answer more questions if time remains at the end.

00:37:54:16 - 00:37:59:16
Jeremy is gonna be presenting this one I think.

00:37:59:16 - 00:38:13:16
I am. Good afternoon, everyone. Thank you, Kristen. So, the 2, performance measures for administration, focus in on the standard of demonstrate transparent and sound corporate governance structure.

00:38:13:16 - 00:38:25:16
So you see the for the 1st administration. Performance measure. This applies to both all 3, the primary select and clinically enhanced tiers.

00:38:25:16 - 00:38:32:16
And what we're looking for, with this, test, with this performance measure is an attestation.

00:38:32:16 - 00:38:44:16
And then additional required documentation that support that attestation. And it really focuses in on standards around successful passage of a fiscal readiness review.

00:38:44:16 - 00:38:54:16
Submission of current financial statements. And as you'll recognize this is now a request and built into the waiver.

00:38:54:16 - 00:39:11:16
Disclosure of the following conflict of interest policy and associated documentation. Criminal convictions of officers and or owners. The 3rd one is licensing status in Pennsylvania for non-ODP license settings.

00:39:11:16 - 00:39:22:16
History of licensing. Revocations, enforcement actions, and other states in which provider renders services to individuals with intellectual and developmental disabilities.

00:39:22:16 - 00:39:30:16
If applicable new providers that are not enrolled to provide residential services through ODP by December 31st of 2024

00:39:30:16 - 00:39:38:16
with licenses revoked in other states will not be eligible for contracting.

00:39:38:16 - 00:39:55:16
And then for the select. And clinically enhanced providers. For administration 1.2 We know that stakeholder engagement really is is a critical set of activities that that we manage kind of at all levels of the system.

00:39:55:16 - 00:40:08:16
Whether it's at the provider or the a county level certainly for the state the work that we're doing related to public comment is a really important critical part for us to get this right.

00:40:08:16 - 00:40:17:16
And we certainly know that there are a number of avenues for at the federal scope or CMS to really engage with stakeholders.

00:40:17:16 - 00:40:29:16
So. 1.2 is looking for documentation that the governance of the board of directors is informed by voices of people with lived experience.

00:40:29:16 - 00:40:36:16
And that question has come up. What, what does that mean, operationalize? What does people with lived experience mean?

00:40:36:16 - 00:40:44:16
That's either a person. With an intellectual or developmental disability or autism. Or a family member.

00:40:44:16 - 00:40:56:16
That's on the board or so in addition to, boards of directors, kind of opening up this opportunity for additional input.

00:40:56:16 - 00:41:09:16
Through advisory committees or subcommittees that could be comprised of people with lived experience. Evidence that board deliberations are informed by input of people with lived experience.

00:41:09:16 - 00:41:15:16

So we could go to the next slide.

00:41:15:16 - 00:41:22:16
So for 1, one. We are looking for.

00:41:22:16 - 00:41:33:16
Some type of submission provider submission of the current financial statements, provider completion of the following sections of the provider survey.

00:41:33:16 - 00:41:44:16
So financial conflict of interest disclosure, criminal conviction, all of these areas that we just addressed licensing and regulatory status disclosure.

00:41:44:16 - 00:41:53:16
Provider submission of attestation, a factual representation of financial documentation, conflict of interest, criminal background licensing, etc.

00:41:53:16 - 00:41:59:15
And the data sources for this, again, will be the attestation. We'll be collecting some of this.

00:41:59:15 - 00:42:09:16
Through the the standard survey that we've been referring to and any additional documentation submission that the provider would make.

00:42:09:16 - 00:42:18:16
Financial statements previously submitted during 2324 are not required for resubmission. We already have those.

00:42:18:16 - 00:42:25:16
And this is an area that we're not looking for pay for performance. Not girl and considered.

00:42:25:16 - 00:42:37:16
So, for, administration, 1.2. This again is a reminder is for select and clinically enhanced providers.

00:42:37:16 - 00:42:48:03
What we're, what we're looking for is more of that, that engagement. We're looking at through our survey providers could can submit.

00:42:48:03 - 00:42:58:16
Documentation that reflects board and advisory and subcommittee membership. And documentation such as those meeting minutes to reflect board deliberations.

00:42:58:16 - 00:43:22:16

Are informed by input from people with lived experience. And we included a few examples here. Board membership requirements and a sample of meeting minutes that would include those details that people would lived experiences had an opportunity for input and that that input was was considered by the board.

00:43:22:16 - 00:43:34:16
Again, our data source is survey and documentation review and this is not. Being considered for paper performance measure right now.

00:43:34:16 - 00:43:38:15
So it's open up for questions.

00:43:52:16 - 00:44:05:16
Okay, I see a question here for, administration 1.2. Could that individual or family member be part of the organization or do they need to have a separation period?

00:44:05:16 - 00:44:10:16
So again, great question because, you know, I think it's reflective.

00:44:10:16 - 00:44:26:16
That folks are starting to think about this and, and think about how this could apply. We haven't defined it quite that way around affiliation, but again the the further we're able to demonstrate conflict of interest.

00:44:26:16 - 00:44:38:02
I think the the better off we are. But really looking for, meaningful individual and family input within that organization.

00:44:47:16 - 00:44:54:13
So Jeremy, I only see one other question specific to administration. Not sure if you want to take that question at this time.

00:44:54:13 - 00:44:59:16
Or keep going.

00:44:59:16 - 00:45:04:16
Robin, I see a number of questions on fiscal writings. I think Rick is gonna jump in.

00:45:04:16 - 00:45:06:16
Alright, very good. Rick, hi.

00:45:06:16 - 00:45:15:16

Yeah, good afternoon, everyone. Sorry, I was trying to figure out how to work my computer. So a couple questions about what the, fiscal readiness to review will look like.

00:45:15:16 - 00:45:21:16
I would anticipate, you know, that will evolve over time. But probably initially, we'll be looking at.

00:45:21:16 - 00:45:33:06
You know the financial statements you submitted We'll be looking at. Things like liquidity. Ratios from the financial statements and access to capital.

00:45:33:06 - 00:45:41:08
Basically, you know, pretty basic questions. About how you're, managing your financial shop.

00:45:44:16 - 00:45:52:16
Thank you. Rick was I don't see another. Is there another fiscal readiness question that you had in mind, Kristen, or that was the one?

00:45:52:16 - 00:46:00:16
There were a number of fiscal readiness questions, but I think Rick answered that they all had the same general sort of feel to them.

00:46:00:16 - 00:46:02:16
So I think Rick answered that.

00:46:02:16 - 00:46:06:16
Okay, Jeremy, shall we move forward?

00:46:06:16 - 00:46:10:10
I think that makes sense. Thanks, Robin.

00:46:12:16 - 00:46:24:16
Alright, I'll take the next section, relative to data management. And, just wanna say, you know, I think this has become, quite clear for folks already.

00:46:24:16 - 00:46:35:16
But data management is really going to be a critical element, in terms of a provider's success going forward with performance based contracting.

00:46:35:16 - 00:46:43:16
And so, you know, having a good handle on being able to draw down data out of a variety of systems.

00:46:43:16 - 00:46:57:16

Ways to organize data and then what you'll see here in some of these performance measures will be a provider ability to successfully submit that data for evaluation.

00:46:57:16 - 00:47:06:16
So, Robin, we can really move on to the, next slide. We'll get into the details for, 1.1.

00:47:06:16 - 00:47:15:16
So the definition of the the standard here again is that a demonstrated production of data reports. Through the adopted technology platform.

00:47:15:16 - 00:47:25:16
The performance measure is we're expecting providers to submit a completed test case file. In the format that is required or requested by ODP.

00:47:25:16 - 00:47:33:16
And then the process detail here is that providers will be submitted to submit a test case file upon the development of

00:47:33:16 - 00:47:41:16
The provider analysis services provider portal. So this implementation is not targeted until, 2026.

00:47:41:16 - 00:47:53:04
Because we do not yet have that vendor on board yet. The data source here eventually will be, the ability for the provider to submit that documentation.

00:47:53:04 - 00:48:08:16
And this is not a pay for performance measure. But again, I think the takeaway here is I know that this one will be deleted until 2026 and really this is about being adept at submitting.

00:48:08:16 - 00:48:15:16
Data files to us for evaluation.

00:48:15:16 - 00:48:40:16
And the next measure in this same standard. Is relevant for select and clinically enhanced providers only. And what we're looking for here is for providers to submit one sample of an operational report or quality report that's currently being used for internal monitoring and implementation of quality management initiatives.

00:48:40:16 - 00:48:52:22
So this could be a written description of how providers are using and, conducting data analysis around things like incidents, medication errors, health.

00:48:52:22 - 00:49:04:16

Restrictive procedures, staff retention. There's a couple of other examples here. But effectively we're looking for one submission of an operational report, or quality report.

00:49:04:16 - 00:49:17:00
The way that we will collect this information is through that provider survey and with that. Provider survey providers will have the ability to upload a sample of this operational or quality report.

00:49:17:00 - 00:49:27:16
Through the survey when it is released. The data source will be that provider survey and corresponding documentation review.

00:49:27:16 - 00:49:31:16
And this is not a pay for performance measure.

00:49:34:16 - 00:49:41:16
Moving on to the next standard, so this is a new standard still within the performance area of data management.

00:49:41:16 - 00:49:55:16
We've got one performance measure that applies to, select and clinically enhanced providers. And what we're looking for here is for providers to report the electronic health record that's in use.

00:49:55:16 - 00:50:01:16
And what functions of that software are currently being utilized. So for example, if you're using.

00:50:01:16 - 00:50:21:16
Medication administration. The elements of that software package. If you're using it for, keeping track of physician notes, any sort of integrated care pathways, basically anything that you might be using an electronic health record or EHR for we just want you to report out on that.

00:50:21:16 - 00:50:34:16
And similarly, this will be collected through provide the provider survey. And providers will report the specifics around what elements of, the EHR providers are using.

00:50:34:16 - 00:50:43:16
So the data source here is provider survey documentation, submission, and we are looking to make this a pay for performance measure.

00:50:43:16 - 00:50:56:16
So providers who are making those important investments in utilizing electronic health records. We are looking to, be able to incentivize that.

00:50:56:16 - 00:51:03:20

I think that's the end. Yep. So we'll stop here for some questions on Data Management.

00:51:06:16 - 00:51:13:16
So we've got, does the use of fair app for service note submission count as the use of an electronic health record.

00:51:13:16 - 00:51:37:16
We haven't necessarily defined, you know, what those electronic health record systems are. What we're looking for is tell us what those systems that you're using are what are you using them for But again, this would be if you have not already submitted some public comment, specific to, what we would be looking for here.

00:51:37:16 - 00:51:42:14
Definitely recommend that you go ahead and include, some of those details.

00:51:45:16 - 00:51:56:13
Question is DM 1.2 also delayed until 2,026 this one's not going to be delayed until 2026 because we are only using that.

00:51:56:13 - 00:52:07:18
Provider survey and documentation submission. We have the ability to do that now. It's just the collection method that will be used.

00:52:07:18 - 00:52:14:05
Once we do have the performance analysis services vendor online, that's the, measure that's delayed.

00:52:23:16 - 00:52:35:16
For the question here on. Ehr, can you operationally define what is meant, or provide what an integrated care we is.

00:52:35:16 - 00:52:54:10
This is a function of some EHRs where essentially it sounds to me like it's a plan for the care of an individual based on a condition or conditions that are presenting but a health care term, that can be found in EHRs

00:52:57:17 - 00:53:08:16
When will the requirements for test case be released? Will likely be looking, to put together some additional requirements.

00:53:08:16 - 00:53:23:16

Once we do have the performance analysis vendor up and running. So don't have an exact timeframe for when that will be but once they're up and running and again we committed to kind of pushing this to 2026.

00:53:23:16 - 00:53:29:16
So that they can, establish their system and make sure that it's, functioning in the way that we need it to.

00:53:29:16 - 00:53:35:16
So nothing specific yet, but, that will be forthcoming.

00:53:35:16 - 00:53:42:16
Lauren, if you'd like to take one or 2 more questions on this. Category and then we'll move on.

00:53:42:16 - 00:53:46:16
Sure, sounds good.

00:53:46:16 - 00:54:04:19
Alright. Yeah, getting a lot of questions around specific. Ehr platforms. Again, we're really looking for tell us what it is that you're using, whether it's something that you've purchased or something that maybe you've developed, independently.

00:54:04:19 - 00:54:10:04
Just tell us what it is that you're using, what, functions of that EHR are being used.

00:54:10:04 - 00:54:19:16
That's really what we're looking for at the outset. So we're not necessarily saying, you know, this one meets the criteria and this one doesn't meet the criteria.

00:54:19:16 - 00:54:28:12
We're looking for what EHR are you using and of that suite what what functions are you utilizing

00:54:35:16 - 00:54:38:16
Alright, I think we can move on, Robin.

00:54:38:16 - 00:54:45:16
Alright. Risk management who's taking the lead.

00:54:45:16 - 00:54:46:16
I'll keep going.
Very good.

00:54:46:16 - 00:54:57:16

Alrighty. So I'll lead us the rest of the way through, risk management specifically, today we're going to be talking about incident management.

00:54:57:16 - 00:55:04:16
And certainly everybody on the call knows, that incident management is by no means, a new requirement.

00:55:04:16 - 00:55:19:04
And neither is measuring provider performance in the area specific to incident management. Many of our assurances that exist today with in our current Weber applications and agreement with the federal government.

00:55:19:04 - 00:55:28:05
Really revolve around provider compliance with incident management. And so this is a lot of these are things that have already been happening.

00:55:28:05 - 00:55:36:18
In terms of, ODP. Making sure that providers are compliant. With the incident management.

00:55:36:18 - 00:55:49:16
Requirements that are set forth in policy. So the definition of the standard here is demonstrated fidelity to incident management procedures as outlined in policy.

00:55:49:16 - 00:55:58:16
We've got 4 performance measures to determine, a providers, performance in this relative to this particular standard.

00:55:58:16 - 00:56:14:16
And the other thing that you'll see. With these 4, specific performance measures is that, these sort of elevated, write requirements or the way that we're looking at these, they apply only to select and clinically enhanced.

00:56:14:16 - 00:56:25:16
For primary providers. All of the same incident management requirements, will exist as of January one as they do today.

00:56:25:16 - 00:56:41:16
And certainly. None of this is to say that primary providers. Can't and shouldn't continue to prioritize their responsibilities with respect to incident management.

00:56:41:16 - 00:56:46:16
Alright, so we'll go on to, the next slide, Robin. And get into.

00:56:46:16 - 00:56:58:16
The, performance measure, which is, the maximum number of critical incidents. Potentially indicative of abuse or neglect.

00:56:58:16 - 00:57:10:16
Not reported may not exceed 1% of overall reported incidents by the provider. So I just wanna take one quick second to kind of level it with everyone on the call.

00:57:10:16 - 00:57:20:16
Probably just about 2 years ago now. We released, announcement, 22 dash 1 1 5.

00:57:20:16 - 00:57:32:16
Which effectively details the, process for matching incidents in the ODP Enterprise Incident Management System with Medicaid claims.

00:57:32:16 - 00:57:47:09
And so what we were and continue to look for here is we can see when someone presents to a hospital or emergency department with certain types of procedure codes for treatment.

00:57:47:09 - 00:58:01:16
Some procedure codes are specific, enough to tell us that someone may have been a abused neglected or have a serious injury that would require an incident to be reported.

00:58:01:16 - 00:58:17:16
So we take that information and. And again, we match that up against our enterprise incident management system to see if in fact that provider agency did enter that incident into the system.

00:58:17:16 - 00:58:29:16
And so you likely have seen many, many of you have probably seen, good news is that our performance here is, is pretty high, which is a good thing.

00:58:29:16 - 00:58:37:16
But maybe you've gotten, some outreach from, an administrative entity saying, hey, we have this claim in the system.

00:58:37:16 - 00:58:42:15
We don't see a corresponding incident here. And we kind of need to know what happened.

00:58:42:15 - 00:58:49:24
Was this person in services where they receiving services with the agency at the time that this claim was generated.

00:58:49:24 - 00:59:01:16

Because, you know, we have some, you know, sort of evidence to say there may be an incident that requires, to be, that is required to be entered into the system.

00:59:01:16 - 00:59:08:16
So that work has been happening, like I said, for approximately 2 years at this point. And we do have a slide.

00:59:08:16 - 00:59:17:16
We don't not going to move on yet, Robin, but we can look at statewide performance here, with respect to, this particular performance measure.

00:59:17:16 - 00:59:30:16
But really, with the process details here are are walking us through. How we are kind of arriving at whether or not the provider does have, unreported incidents.

00:59:30:16 - 00:59:37:16
And so again, we have a data system. Where we're looking, we're extracting incident management data.

00:59:37:16 - 00:59:54:16
For providers who are providing residential services. And then at the individual provider level, the number of incidents, reported per provider during that calendar year is calculated using the discovery date which you're all familiar with.

00:59:54:16 - 01:00:04:10
And then we're looking at, incidents with the status of open or closed. And then, we are not including incidents that ultimately get deleted.

01:00:04:10 - 01:00:09:16
So, just for, your awareness and, you know, how we're extracting that data.

01:00:09:16 - 01:00:18:16
And then again at the MPI level, the number of incidents, identified as unreported through that claims matching process that I just described.

01:00:18:16 - 01:00:36:16
Are recorded. Per provider during that calendar year. And now we can see that every individual MPI has been associated with the number of incidents that were discovered as I'm reported and the total number of incidents that they've entered for that calendar year.

01:00:36:16 - 01:00:49:16
And so you see here effectively what creates the numerator and the denominator. In order for us to calculate, where we're provider falls in terms of their performance with this measure.

01:00:49:16 - 01:00:59:07
So percentage of unreported incidents are calculated per MPI. So the number of unreported incidents over the total number of incidents.

01:00:59:07 - 01:01:20:16
Times 100 will create that percentage. The way that we're, the data sources for this particular measure are of course that Medicaid claims data, enterprise incident management, and then this is not an area where we're looking at pay for performance.

01:01:20:16 - 01:01:28:16
So next slide, thank you, Robyn. Here's where I promised we would look at, some statewide data.

01:01:28:16 - 01:01:36:16
So what we're looking at here is the maximum number of critical incidents which are potentially in indicative of abuse or neglect.

01:01:36:16 - 01:01:45:16
Not reported. They can't, this is the performance standard. So we're not, wanting to go over 1% of those total reported incidents by provider.

01:01:45:16 - 01:01:55:16
For calendar year 2023 the 1st 3 quarters We have 281. Residential providers with 0.

01:01:55:16 - 01:02:08:16
So that means, are doing a good job reporting. And then, we do have a number of, providers falling into, the 0 point 2 to 1%.

01:02:08:16 - 01:02:15:16
So still, right, this is our total grouping of providers who are, compliant with, that measure.

01:02:15:16 - 01:02:28:16
We do have a handful of providers where they are not compliant with that measure and then for data suppression purposes we can't share data of anything less than And so you see here we do have.

01:02:28:16 - 01:02:38:16
Small number. Providers who have sort of fall into those sort of higher percentages.

01:02:40:16 - 01:02:43:13
We can move on, Robin.

01:02:45:16 - 01:02:57:16

Alright, so, next performance. Measure here. Is maximum number of critical incidents, potentially indicative of abuse or neglect, not reported timely.

01:02:57:16 - 01:03:10:16
May not exceed 10% of the overall reported critical incidents by provider. So this sounds pretty similar to the performance measure that we just reviewed.

01:03:10:16 - 01:03:21:16
However, what we're looking for here is specifically, timeliness related to getting these incidents entered into the system.

01:03:21:16 - 01:03:33:19
And so what we're looking for here is at the MPI level, the number of incidents reported late for, the provider during the specific calendar year is calculated using the data element.

01:03:33:19 - 01:03:45:16
1st section compliance status. Only incidents with open or closed status are included and again those incidents where they were deleted are excluded.

01:03:45:16 - 01:03:54:16
At the MPI level, the number of incidents reported per provider during the specified calendar year is calculated using Discovery Day.

01:03:54:16 - 01:04:10:16
Again, only using opener closed incidents. Now that gets us to each MPI being associated with the number of incidents that have had a late 1st section, submission as well as that total number of incidents.

01:04:10:16 - 01:04:18:18
That have been entered for the calendar year. And so we get to the percentage of, late reported incidents, right?

01:04:18:18 - 01:04:30:16
So, number of late incidents over total number of incidents reported. Times 100 gets us to a providers compliance with this particular measure.

01:04:30:16 - 01:04:38:06
Data source here is going to be enterprise incident management and this is not a pay for performance standard.

01:04:39:16 - 01:04:50:16
And on the next slide is current statewide data for calendar year, 2,023 quarters one through 3.

01:04:50:16 - 01:04:59:16
And so, we have again, significant number of residential providers, falling, within that compliant.

01:04:59:16 - 01:05:09:16
Percentage range. And so, the 1st 2 that you see here would be considered compliant.

01:05:09:16 - 01:05:18:16
And then the remainder, would be non compliant with this performance standard.

01:05:18:16 - 01:05:21:16
Come on, Robin.

01:05:21:16 - 01:05:35:16
Alright, the 3rd performance measure here is timely finalization of incidents demonstrated by at least 90% of incidents finalized within 30 days of discovery.

01:05:35:16 - 01:05:43:24
So process details here. Again, or at the MPI level, of the number of, incidents.

01:05:43:24 - 01:05:52:16
Reported compliant or provider during the specified calendar year is calculated. By using the data element. Final section compliance status.

01:05:52:16 - 01:06:03:16
And again, only incidents with open or closed status are included. At the MPI level, the number of incidents reported for the provider.

01:06:03:16 - 01:06:15:16
During the specified calendar year is calculated using discovery date. We now have, every MPI has been associated with the number of incidents that have a compliant final section document.

01:06:15:16 - 01:06:25:03
As well as the total number of incidents that they've entered for the associated calendar year. Again, this is where we create our numerator and denominator.

01:06:25:03 - 01:06:35:16
So a percentage of incidents finalized timely. Is calculated per MPI by number of incidents with timely finalization.

01:06:35:16 - 01:06:44:01
Over number of incidents reported. And just that these can be a little bit tricky to kind of understand.

01:06:44:01 - 01:06:49:16
So do just wanna take, a second to, maybe try and say this another way.

01:06:49:16 - 01:06:57:06
But we place a really heavy emphasis on timely finalization of incidents, for a lot of reasons.

01:06:57:06 - 01:07:11:16
1st and foremost is that the further and further we get from the date of that incident happening or allegedly happening and pushing out the timeline, the finalization of those incidents.

01:07:11:16 - 01:07:29:16
We get further and further away. of really conducting meaningful corrective action so that we can prevent that thing from happening again and making sure that that individual is, you know, getting all of the services and the right services that they need at the time.

01:07:29:16 - 01:07:41:16
And so really we're placing a heavy emphasis here on timely finalization with this measure. It by not using incident extensions.

01:07:41:16 - 01:07:56:11
We really want to encourage providers to move away from, sort of the, routine practice of, kind of automated requesting an extension for, incident finalization.

01:07:56:11 - 01:08:04:16
We really want to start to get to timely finalization. Within that 30 days of discovery. And we can move to the next slide.

01:08:04:16 - 01:08:14:16
And share some data here, Robin. So, this particular performance standard, you've got here on the screen.

01:08:14:16 - 01:08:28:16
Number of closed incident or the percentage of closed incidents. Finalized in calendar year 2023. The number of providers who are above 90% here that number is at 68.

01:08:28:16 - 01:08:50:16
So you can see otherwise the distribution of where providers are falling with respect to performance in this measure. And again, really can't state enough how important timely incident finalization is when it comes to genuinely protecting people that we're supporting.

01:08:50:16 - 01:08:57:16
And then we'll go on to the last one here for the day. Performance vendor is.

01:08:57:16 - 01:09:02:12
And again, you know, we'll kind of talk about this one in a couple of different ways.

01:09:02:12 - 01:09:13:16
Because it, I think it'd be hard to wrap your head around. But what we're looking for is at least 95% of all incidents to be finalized by the due date.

01:09:13:16 - 01:09:30:16
And the due date may only exceed 30 days in no more than 5% of those incidents. So due dates, the reason for this, right, is because due dates may exceed 30 days when the provider has notified the department in writing that an extension is necessary.

01:09:30:16 - 01:09:42:16
And the reason for that extension, which is not changing, it's, it continues to be the process, of requesting, requesting an extension in, the Enterprise Internet Management System.

01:09:42:16 - 01:09:53:16
But what we're looking at here is again, commitment to, reducing the sort of reliance on requesting those extensions.

01:09:53:16 - 01:10:06:16
And so similar process details. For this one, that at the MPI level. The number of incidents reported during the specified calendar year is calculated using that discovery date.

01:10:06:16 - 01:10:18:16
Each MPI then has the number of incidents that had a compliant final section document as well as the total number of incidents that they've entered for that calendar year.

01:10:18:16 - 01:10:30:16
The percentage of incidents finalized timely is calculated by the number of incidents with timely finalization over the number of incidents reported times 100.

01:10:30:16 - 01:10:37:16
And so that's gonna get us how many, at what percentage of incidents were finalized timely.

01:10:37:16 - 01:10:44:16
And then to move on to, that next step. Of those incidents that were finalized timely.

01:10:44:16 - 01:10:51:16
So by the due date originally assigned in the system for each MPI. The data element of extension filed will be examined.

01:10:51:16 - 01:11:12:16

If an extension has been entered, the due date will be 31 plus days after that discovery date. So a percentage of incidents finalized timely more than 30 days from the date of discovery of the incidence is calculated by using the number of incidents with timely finalizations and extensions filed.

01:11:12:16 - 01:11:23:16
Over the total number of incidents finalized timely, right? Multiplied by a hundred you get you're getting a percentage of incidents finalized timely with an extension.

01:11:23:16 - 01:11:29:20
So the easiest way, there's a couple of ways I think that we've talked about, you know, trying to describe this.

01:11:29:20 - 01:11:42:16
And making sure that providers understand. So, 95% of the time. Incidents have to be compliant with timely finalization, right?

01:11:42:16 - 01:11:50:01
And that can be accomplished effectively in 2 ways, right? One of 2 ways. Either one. Meeting that 30 day.

01:11:50:01 - 01:12:00:16
Timely finalization requirement, right? That is sort of originally there. Or by meeting the time frame that's established by extension.

01:12:00:16 - 01:12:14:16
And so no more than 5% of all incidents may be finalized after the due date. So hopefully that gives, some clarity around this particular performance measure.

01:12:14:16 - 01:12:26:16
And just to round this out. This one the data source is also, EIM or Enterprise Incident Management, not a pay for performance standard.

01:12:26:16 - 01:12:32:16
And then lastly, we have some data to share. On the next slide.

01:12:32:16 - 01:12:42:16
Where we can see for calendar year, 2023. The number of providers at or above.

01:12:42:16 - 01:12:56:16
95% compliance is a hundred 93 so providers are doing. Ia number of providers are doing well, with this particular performance measure.

01:12:56:16 - 01:13:00:00
And I think that's it for this section.

01:13:03:00 - 01:13:19:16
Let you get cut up on questions here, Lauren. I can take a couple of these. So, few of you were asking, whether or not, since we're doing this by MPI, have we excluded the non-residential services?

01:13:19:16 - 01:13:31:16
Are we only looking at residential services since we said MPI? We are looking but at MPI only residential services that is how we have pulled the data.

01:13:31:16 - 01:13:50:16
Another question. That came through was about the 2 more questions here. One. Was, where a provider can see these data to how the question is essentially, you know, how does a provider comply with this when we can't see the data?

01:13:50:16 - 01:13:58:05
So. 2 things. One, within enterprise incident management, you have dashboards for the finalization.

01:13:58:05 - 01:14:12:12
You've got some really good dashboards that we've built into enterprise incident management. So if you're not familiar if you don't have people in there routinely, those are very good data tools to give you a sense of performance related to incident management.

01:14:12:12 - 01:14:30:16
In terms of the unreported incidents that claims matching piece, you're contacted. We contact you if you have an unreported, if you have an incident that matches a claim that, meets that criteria for, unreported suspected abuse or neglect.

01:14:30:16 - 01:14:39:16
You will be contacted by the ODP regional office. So, you, don't have access to the claims data that's coming from hospitals.

01:14:39:16 - 01:14:48:16
In patient emergency rooms but you do get contacted by UDP. And then one of the, there was a few comments here.

01:14:48:16 - 01:15:03:08
I'll grab these and hopefully Lauren you've got a chance to catch up. There's a couple of comments here just about sort of recognizing that there are things that interfere with timeliness of finalization.

01:15:03:08 - 01:15:19:03

Of incidents and we know we know that in the instances of death in particular, law enforcement, some, you know, things that require hospitalization, that those are often going to require extensions.

01:15:19:03 - 01:15:24:16
And that is where that 90% came from. And as you could see from the, the data.

01:15:24:16 - 01:15:41:16
You know, we, do pretty well on that, but we do understand that there is a certain percentage of incidents that are never going to be able to be finalized in that thirty-day time period because of those other circumstances, the external circumstances that providers can't control.

01:15:41:16 - 01:15:46:16
It is part of why we also have the extension process. So we're talking about that timely finalization.

01:15:46:16 - 01:15:53:14
The expectation here is really twofold, right? One is that you're not overusing the extension process.

01:15:53:14 - 01:16:01:16
That you are using it for the circumstances where there are truly things beyond your control in terms of finalizing those incidents.

01:16:01:16 - 01:16:12:15
And then when you are finding the other pieces, regardless of whether or not you filed, if you needed an extension or not, that you then may meet whatever deadline you're bound to.

01:16:12:15 - 01:16:20:16
So that's the second part of that. Measure. But we absolutely recognize that there are things that are good reasons for extensions.

01:16:20:16 - 01:16:28:16
That is something that we have to keep built into the system because of those external factors. Alright, I'll let somebody else jump in and I'll keep reading.

01:16:28:16 - 01:16:31:16
There's a lot of questions on incident management here.

01:16:31:16 - 01:16:42:16
Yeah. So question around the standards for, maximum, reported. I'll sort of shorten it to that.

01:16:42:16 - 01:16:53:16
Do they only apply to incidents of abuse or neglect so what we're looking for here is the incidents that are potentially indicative of abuse or neglect that were not reported.

01:16:53:16 - 01:17:12:19
So again this is where we're using very specific. Codes that are utilized in medical settings hospital systems that sort of thing to tell us whether or not the injury right is potentially a result of abuse or neglect.

01:17:12:19 - 01:17:24:16
And so that's the the sort of qualifier there. Next question is will ODP differentiate between confirmed abuse and not confirmed abuse.

01:17:24:16 - 01:17:35:16
Since all alleged abuse is to be investigated, providers who do report all get allegations, would bump up against or exceed the 1%.

01:17:35:16 - 01:17:44:16
Even though they're doing the right thing so appreciate this question also because an important.

01:17:44:16 - 01:18:02:17
Sort of call out to make is that we are not absolutely not under any circumstances. Looking to disincentivize providers from reporting any incident regardless of whether it's abuse or neglect or you know any of the incident types or categorizations,

01:18:02:17 - 01:18:13:16
we are not measuring, you know, how many incidents in a particular year did a have and using that as a measurement or evaluating the quality of a provider.

01:18:13:16 - 01:18:32:16
We want providers absolutely to be reporting and the intention is reporting to fidelity that's written in the incident management policy bulletin that sort of thing so So, that would, that would not necessarily have any sort of impact, right?

01:18:32:16 - 01:18:43:16
Because that 1% is being generated, like Kristin said around your, getting that contact that outreach around there's something that we suspect went on reported.

01:18:43:16 - 01:19:03:16
Whereas if you're reporting it, it won't show up at all, right? So that would not necessarily be something that influenced, that, that 1% for the, the first, st incident management measure here, the maximum number of, critical incidents unreported.

01:19:03:16 - 01:19:06:15
It's the unreported piece that's that we're measuring.

01:19:09:16 - 01:19:21:16
Jump in Lauren, will you get a chance to take a look at these? A couple of questions here about timing and timeframe for what time period we are looking at data.

01:19:21:16 - 01:19:43:16
For the initial tier assignment. beginning January one of 2025 what we have put forward in our proposal is that we are using calendar year 23 data so that's what you've seen here and we say, you know, 95% of, incidents are finalized.

01:19:43:16 - 01:19:54:04
Finally that those are calendar year, 23 data. There was another question about what timeframe we intend to use data.

01:19:54:04 - 01:20:12:16
So what we have put forward is the proposal is we will always be reviewing the prior calendar year data. So when we are taking a look in, March, April of, 26, we will be using calendar year, 25 data.

01:20:12:16 - 01:20:17:20
So each, you know, will always be, we looking at that prior your calendar data.

01:20:20:16 - 01:20:24:14
Question here that asks about late reporting.

01:20:24:14 - 01:20:36:12
Please distinguish between late reporting when the provider is aware of the incident and late reporting. When the provider is unaware that an incident occurred.

01:20:36:12 - 01:20:44:12
If the provider submission is within the time frame. When notified of the incident is the incident considered late.

01:20:44:12 - 01:20:53:21
So this is, you know, kind of this is different for residential providers than it might be for, you know, let's say in home and community support providers for example.

01:20:53:21 - 01:21:14:21
And there are some circumstances I will say with respect to the incident fidelity and claims matching work where an individual is receiving a residential service and maybe they or visiting with family, right, for a weekend or something for a holiday or a family party or something.

01:21:14:21 - 01:21:36:21

So they go home and maybe they they fall and unfortunately you know they maybe break their arm right they present to an emergency department they have a broken bone and the entire time right they were with their family they were not receiving services with the residential provider.

01:21:36:24 - 01:21:47:16
They will show up, right, on the initial sort of claims matching will say we have visit with a particular.

01:21:47:16 - 01:21:57:09
Procedure code that is indicative of potential abuse or neglect. This is where, our county administrative entity.

01:21:57:09 - 01:22:03:19
Partners, they're doing the outreach to residential providers to understand what was going on at the time.

01:22:03:19 - 01:22:21:00
Because that's an incidents where we would not be looking for the residential provider to report. If that person was not in service with that residential provider at the time when that individual presented to the emergency department and receive treatment for that broken arm, right?

01:22:21:00 - 01:22:28:03
And so that's an example of when I would say a provider might be unaware, right? If that family did not call you right away.

01:22:28:03 - 01:22:34:09
And again, that person was out of service. Not there's not a requirement for you to report that.

01:22:34:09 - 01:22:41:03
And we, would that would not, sort of be included right in the calculation.

01:22:41:03 - 01:22:57:09
For an unreported, event that would meet this criteria. Otherwise, you know, residential providers have effectively, right, you're someone's in your services, 24, over 7, there really shouldn't be an instance.

01:22:57:09 - 01:23:07:24
Other than right that kind of example where a person's out of service where a residential provider is sort of unaware that an incident.

01:23:21:16 - 01:23:24:16
Reading through these learners quite a volume.

01:23:24:16 - 01:23:25:16

Yeah.

01:23:25:16 - 01:23:39:16
I said, Notation here about the importance of quantitative data related to incident management, but a concern about whether or not ODP is using qualitative data.

01:23:39:16 - 01:23:51:16
Particularly related to supporting individuals with needs group 5. Who have may have a high volume of incidents.

01:23:51:16 - 01:24:01:16
So question about whether or not the timeframes should be, adjusted or specific given those challenges.

01:24:01:16 - 01:24:08:16
And then a concern that if it's not, it could affect the overall rating or position of that provider.

01:24:08:16 - 01:24:20:16
And, and I appreciate the comment and the thought and obviously as we were, Working with the residential strategic thinking group on all of these measures.

01:24:20:16 - 01:24:35:16
You've heard us talk, probably at length about how the, standards, the performance areas, the performance standards and the performance measures are really aimed at trying to balance a number of things.

01:24:35:16 - 01:24:47:16
So. And the tier designs also to obviously help move our system objectives forward and produce better outcomes for individuals.

01:24:47:16 - 01:25:01:16
So Select and clinically enhanced, you know, investing a significant amount of funding into really building capacity to support the clinical needs of individuals.

01:25:01:16 - 01:25:21:09
Part of that is really sound risk and incident management for individuals who are arguably may need it most. So although I appreciate the the comment and concern there, you know, we are really trying to invest, make sure that we've got providers who can kind of do all of that peace.

01:25:21:09 - 01:25:36:16
With people with really complex and challenging needs coming to you. The way we design the standards around referral and discharge around clinical support.

01:25:36:16 - 01:25:50:16
Around incident management all of that is really trying to balance all of these things pretty delicately so again you know I know it's not much time between today and tomorrow afternoon when we close the public comment.

01:25:50:16 - 01:25:55:06
We really will, we are reviewing all the comments as they're coming in and taking this

01:25:55:06 - 01:26:00:07
Very much to heart because the we never want to disincentivize providers from

01:26:00:07 - 01:26:03:09
taking people with more complex needs. I think, you know, another place

01:26:03:09 - 01:26:17:21
You can see where we're trying to get that balance is. The standards and we'll get into this I think 2 sessions from now when we start talking about the the complex needs all of those performance areas and performance measures.

01:26:17:21 - 01:26:40:21
One of the things that we're doing is reporting. We're asking for reporting and providers to be using your data on incidents, on restraints, on restrictive procedures on poly pharmacy, on the involvement of law enforcement, so that as as a community we can really start to understand what good performance looks like.

01:26:40:21 - 01:26:50:18
How to measure it, how we can see that in data. So really I do appreciate the comment at the same time.

01:26:50:18 - 01:27:10:05
It is critical for us that we are making sure that people with those most complex needs have that same access to, you know, reporting fidelity and, timely resolution of all of the investigations and incidents.

01:27:10:05 - 01:27:16:16
So. Appreciate it if you want to flesh that out in comments. We, we would certainly be open to hearing that.

01:27:20:08 - 01:27:32:08
I had another question related to. Basically the review period. For the incident management data as we move into the implementation period.

01:27:32:08 - 01:27:42:08

And assignment of providers into tiers. And so we are at this point looking to use calendar year 2023 data.

01:27:42:08 - 01:27:53:08
In order to make those determinations, again, that's kind of why I led with, the fact that you know incident management is certainly not a new requirement.

01:27:53:08 - 01:28:09:08
And we've had a really, I think a lot of effort, placed over the last couple of years, especially to really help providers, you know, sort of elevate the incident management.

01:28:09:08 - 01:28:15:08
Process internally, giving you those tools, so that, this data is at your fingertips.

01:28:15:08 - 01:28:22:08
It's not, you know, necessary for providers to go in and create, you know, special extracts or custom reports.

01:28:22:08 - 01:28:30:09
We've built these dashboards so that in real-time, you know, as soon as you log in to, it's a couple of clicks and you've got your incident timeliness data right there for you.

01:28:30:09 - 01:28:45:19
You've got your incident timeliness data right there for you. And so we are looking at, like I said, calendar year, 2023, for, the incident management related, performance measures.

01:29:11:08 - 01:29:20:10
And I'm scanning to see if we've missed any here for incident management before we go to others that we've missed or general.

01:29:20:10 - 01:29:24:12
Okay.

01:29:39:00 - 01:29:50:07
Share this, Another question this is kind of related to the, the concerns about percentage calculations.

01:29:50:07 - 01:30:00:00
So sort of like the, the last one I did with the Needs Group 5. This one is a question or concern if an agency has very few incidents.

01:30:00:00 - 01:30:10:00

One late finalization could prevent an agency from being able to be in select or clinically enhanced. 3 thought being given to making it a non percentage-based analysis.

01:30:10:00 - 01:30:19:06
At this point we have not because the volume of incidents in residential does tend to be quite high.

01:30:19:06 - 01:30:24:02
Again, you know, we are still, this, we are still acting on what is proposed.

01:30:24:02 - 01:30:36:04
So you certainly have the opportunity to comment before tomorrow, on, you know, a different way to calculate that or how we would consider that.

01:30:36:04 - 01:30:39:11
Based on different services or setting types.

01:30:41:06 - 01:30:47:06
Yeah, there's a couple questions still, sort of lingering, I think, about the use of extensions.

01:30:47:06 - 01:30:59:01
And so some sort of pretty specific examples coming in around. Sometimes an incident has to be extended many times, right?

01:30:59:01 - 01:31:06:06
Because there are all of these other sort of extenuating circumstances. Really, you know, I think encouraging folks to think about.

01:31:06:06 - 01:31:14:06
You might have an instance where unfortunately because of those circumstances, you know, we do, you know, rely on those extensions.

01:31:14:06 - 01:31:24:06
But it's the, you know, bulk of the remainder of your incidents, right, that are being reported and that, are not requiring, incident extensions.

01:31:24:06 - 01:31:35:16
Right then we're talking about you know averages over the course of one year so where you might have a situation that runs a little bit longer.

01:31:35:16 - 01:31:44:06
Hopefully, right, the majority of what, providers are able to do in terms of incident management, a timely compliance.

01:31:44:06 - 01:31:58:09
Is gonna fall right within the standards that we've established and again you know those standards are only applicable to select and clinically enhanced in terms of those percentages.

01:31:58:09 - 01:32:10:02
You know, all providers are required to be compliant with the incident management process, but we're gonna have these additional standards for our select clinically enhanced.

01:32:15:06 - 01:32:20:06
Do you wanna go on to any other general questions that we didn't get to?

01:32:20:06 - 01:32:34:06
I think we've got quite a few general questions here. Let me start with, you know, you were there was we had initially indicated that we would be getting the provider agreement out.

01:32:34:06 - 01:32:47:06
June 1st was an expectation that you were submitting it, June 30.th we heard, this is a public comment when we don't even feel like we need to finish having public comment, come in to adjust.

01:32:47:06 - 01:33:04:06
We got a lot of comment, from providers that, given that the expectation given that the public comment doesn't even end until June, the 4, th that you would be signing something by June 30th prior to us submitting a final proposal to the federal government.

01:33:04:06 - 01:33:16:06
Seems like we had our, you know, problematic timelines. We agree. So we will, you should see the provider agreement tomorrow.

01:33:16:06 - 01:33:35:18
We will also be changing the deadline for submission until the 31st of July. So that will all go out in a publication tomorrow, which lines up much better in terms of what we're doing with reviewing public comment and getting a submission to the federal government.

01:33:39:06 - 01:33:51:06
Alright, got a bunch of general questions here so I'll just Jeremy Lauren Rick if you wanna jump in as we're going I'll try to take a few here.

01:33:51:06 - 01:34:07:13
There's, this is a question of time frames in the self-assessment, referencing July 1st a number of times for the, when will be, calculating data or getting information.

01:34:07:13 - 01:34:15:06
What's, so the question here is what's the distinction. And relationship to requirements 7, 1, one.

01:34:15:06 - 01:34:30:10
So as proposed, ODP intends to evaluate providers. So you'll submit data. There's a number of places where we'll be pulling sort of point in time.

01:34:30:10 - 01:34:37:06
For July 1st and some days you'll be submitting some data during that data and documentation during a time period.

01:34:37:06 - 01:34:55:06
That will go into ODP making a tier. Determination, which we will publish in November so that on January, the 1st you have your tier determination as conditional primary select or clinically enhanced.

01:34:55:06 - 01:35:04:15
There are a number of things in the self-assessment where you'll see that it's It is a moving forward time frame.

01:35:04:15 - 01:35:11:06
So, you know, that you have to have that the referral, discharge tracking system so you're able to start tracking January first.st

01:35:14:04 - 01:35:32:22
So there's a number of things where the the activity that you will be doing begins on January 1st but the point of doing some of that collection prior and why we use July 1st is because we're making the tier determination so that those tier determinations are active on January 1, st 2025.

01:35:37:06 - 01:35:45:06
There's a lot of questions around. The measures that would be eligible for pay for performance.

01:35:45:06 - 01:35:57:06
And some questions around, basically when we see that select or clinically enhanced for some of them might not be eligible for pay for performance.

01:35:57:06 - 01:36:08:06
There there are some circumstances where we really want to focus on providers that are falling into the primary category. To be able to.

01:36:08:06 - 01:36:22:06
Get them, some of those pay for performance dollars, for things like we didn't cover this today, but we will in a future session around like DSP credentialing, frontline supervisor credentialing,

01:36:22:06 - 01:36:37:17

and the other thing right to kind of keep in mind is that as proposed and again largely dependent on the state budget but we're looking to for select providers and for clinically enhanced

01:36:37:17 - 01:36:52:11
providers to receive the fee schedule plus additional percentages and so while that doesn't necessarily look like you know the pay for performance structure in the for the primary provider category

01:36:52:11 - 01:37:14:06
there is some kind of built-in additional funding for meeting those higher standards right so the higher standards related to you know provided clinical supports and that sort of thing or you know enhanced training for staff so it is sort of built into the additional rate that we are

01:37:14:06 - 01:37:23:06
that has been proposed. But just wanna make sure that, that we called that out specifically.

01:37:23:06 - 01:37:29:06
And a few. I'll grab, one will the Q&A's be made available after the webinar.

01:37:29:06 - 01:37:40:06
They will not. Remember we are all of these are based on what is proposed. This webinar will be recorded and will be available to re-watch.

01:37:40:06 - 01:37:50:06
In terms of Q&A's, we will, we know we will have to have many question answer like FAQ documents in terms of the implementation.

01:37:50:06 - 01:38:03:19
Clearly we will need a lot of supportive activities in terms of providers implementing this. We will base those FAQs on what is final proposed that we submit to the federal government.

01:38:03:19 - 01:38:15:08
So, you know, I think there, again, we're still in this public comment period. We're trying to, you know, be a supportive as possible to providers through these summits.

01:38:15:08 - 01:38:22:06
But I think we'll be best providers will be best served by actually basing FAQs on the final.

01:38:23:06 - 01:38:38:11
If I could also just tag on to that response as well. One thing that we did commit to doing for provider summits specifically, again, making sure that the information is available and accessible.

01:38:38:11 - 01:38:56:06

We will we won't be putting out the Q&A's like you said but we will post a transcript that will be available in both English and Spanish and then if there are languages that any provider would need to translate that into you know you can effectively .

01:38:56:06 - 01:39:04:06
Copy and paste the English transcript and hopefully generate in another language the better reads your needs.

01:39:04:06 - 01:39:28:00
Sorry. A question will do all providers have to complete a new provider agreement by July first? st So I don't know if this came in before I was responding to the fact that we're publishing the agreement tomorrow with a notation on it that those aren't due until July 31.st

01:39:28:00 - 01:39:46:05
So you have till the end of July to submit a new residential provider agreement. So for providers you provide multiple service types for ODP you will have 2 agreements, one agreement for those non-residential services, one for the residential services.

01:39:46:05 - 01:39:51:06
The current one you have for non-residential stands, that's fine. You're not resigning that.

01:39:51:06 - 01:39:55:14
You're just signing one for residential.

01:39:57:06 - 01:40:06:08
I'll take one. Specific to, the administration, performance measures that we took a look at earlier.

01:40:06:08 - 01:40:26:06
Our officers defined as board members or board members. And executive team members. So it would be the latter it would be board members and executive team members and as as we currently have it drafted it also includes owners.

01:40:27:06 - 01:40:35:18
Thanks, Jeremy. Couple more. Can providers change tiers based on the review of data each year?

01:40:35:18 - 01:40:42:13
So The first, st cycle, the 1st contract. Will actually be 18 months.

01:40:42:13 - 01:41:02:06
So we're gonna begin January, you'll, receive your, tier, for January 1st and then you will stay in that tier until June 30th of 26 so an 18 month period after that, tiers will be reevaluated each year.

01:41:02:06 - 01:41:13:06

And each fiscal year. So July one to June 30 the data that we will use what we will review to determine those tiers will be the prior year.

01:41:13:06 - 01:41:22:00
Calendar year. There's, there's a pretty decent graphic in the presentation, the overview presentation that we did.

01:41:22:00 - 01:41:28:08
I believe it's a pretty good graphic in the, sorry, the overview that we did for these sessions.

01:41:28:08 - 01:41:33:18
If you haven't watched that, please go back and watch that. I think it gives a nice.

01:41:33:18 - 01:41:39:18
Overview there's a couple good graphics in terms of how the timing of all of this works.

01:41:39:18 - 01:41:47:22
So I'd definitely advise to do that. Another, I'll take one more here and then I hand it over to colleagues again.

01:41:47:22 - 01:42:04:08
We've got a question about if a provider is let me just read it what tier will providers be placed into if they don't meet the standards for primary tier, but they also do not meet the standards for conditional tier?

01:42:04:08 - 01:42:19:18
Meaning they don’t have a revoked or provisional license. So a provider that doesn't meet the standards for primary will essentially receive either a corrective action plan or a directed corrective action plan.

01:42:19:18 - 01:42:28:12
to come into compliance. Providers that are out of compliance are essentially going to be out of compliance with the waiver qualification standards.

01:42:28:12 - 01:42:37:18
So we will sort of in terms of remediation, we will follow our typical, remediation standards.

01:42:37:18 - 01:42:54:18
So, we, the way we have contemplated this, we are not, if a provider doesn't meet the primary tier, they will need to correct it or they won't qualify any longer, but we're not going to drop them to conditional or, but we're not going to drop them to conditional or provisional license.

01:42:54:18 - 01:42:59:18

Or conditional tier. Sorry, that's the better way to say it.

01:42:59:18 - 01:43:12:22
Take another one, Kristin. So one general question regarding primary providers. Is ODP looking at long term goal to eliminate primary providers as a provider who currently falls into this category but meets a high standard of measures,

01:43:12:22 - 01:43:21:04
we as all the other providers who may not offer 2 types of services or other requirements have a worry of getting rid of smaller agencies.

01:43:21:04 - 01:43:44:06
Absolutely not. That is not our intention here. We are not looking, to eliminate an entire category of provider primary providers that the naming the reason right that we even came to the name primary providers is because you will continue to be our sort of primary resource when it comes to residential services.

01:43:44:06 - 01:43:56:08
And so we, you know, we know that we will always need, primary providers. And being a primary provider, is absolutely not a bad thing.

01:43:56:08 - 01:44:02:18
It's, you know, things are kind of will be in, 2,025 as they are today.

01:44:02:18 - 01:44:09:13
You'll continue to build fee schedule rates. You'll be eligible for, some pay for performance.

01:44:09:13 - 01:44:22:06
And so, you know, we do not see being a primary provider as a bad thing. And there is no, long term plan to eliminate, that category of providers.

01:44:24:02 - 01:44:34:18
Carol, a question here. Was, is the goal to fade out residential rehabilitation and move to independent living.

01:44:34:18 - 01:44:47:14
It is not. I think, you know, we have a continuum of services for a reason. I think historically we've not, we have some but not enough providers,

01:44:47:14 - 01:45:06:05
that have a really successfully supporting people with higher acuity needs in supported living or in life sharing we've done a lot of work on rates particularly in the life sharing space trying to really make sure that that is an

01:45:06:05 - 01:45:33:18
option for people who have, you know, needs groups, 3, 4, needs group 5. This, you know, this is an area that, when, when you look at our overall statewide data, we, I, I don't think we can say that anyone needing a 24, over 7 residential has opportunities to live along that continuum and we want to make sure that's the case.

01:45:33:18 - 01:45:45:18
We also believe that we will need residential rehabilitation very long term. We also believe that, we do not have an adequate number.

01:45:45:18 - 01:45:55:24
Of homes and providers that can really provide that structured therapeutic setting that many individuals coming to us are in need of.

01:45:55:24 - 01:46:09:08
So no the goal is not to fade out residential rehabilitation to move to independent living.

01:46:09:08 - 01:46:23:18
I don't I don't see that as a future I think very long term we are going to need residential rehabilitation and increasingly we will need resilient residential rehabilitation to serve people with very high acute needs on the behavioral mental health side and on the medical complexity side in some cases both.

01:46:23:18 - 01:46:29:18
I hope that, answers your question.

01:46:29:18 - 01:46:41:18
Yeah, if anything, Kristen, right? It is a effort to. Fortify and really support that space so that we do it have it as a long-term resource within the continuum of care for people.

01:46:42:18 - 01:46:49:18
Correct. Yeah, yeah, no, and thanks for jumping in and I and I will say we have some.

01:46:49:18 - 01:47:01:18
Some really incredible stories and settings, people with some really significant needs being successfully supported. In both supported living and life sharing.

01:47:01:18 - 01:47:08:08
We know it's possible and we know that we can and should be doing more of it, making sure that those options are available.

01:47:08:08 - 01:47:22:18

So, you know, this is again 1 1 more way to really try to wrap. Our policies. Our program policy and our fiscal policy around making that a reality for people.

01:47:22:18 - 01:47:33:18
I'm gonna jump in with a higher level process question. So the question is when are any changes as a result of the end of the comment period expected to be made?

01:47:33:18 - 01:47:42:18
So as, everyone on this call hopefully knows the public comment period ends tomorrow at 1159.

01:47:42:18 - 01:47:52:18
So if you haven't gotten your your public comment in comments in, please, you know, finalize those and get them over to us.

01:47:52:18 - 01:48:07:18
It really is our intent to, in corporate all of the impact from public comment. Into the 1915 c and the proposed 1915 b 4.

01:48:07:18 - 01:48:26:18
And submit that as as a package to CMS by July. So we, We certainly have a tight timeline, but we are already starting to organize the the many public comments that have come in.

01:48:26:18 - 01:48:29:18
For for those purposes.

01:48:33:18 - 01:48:40:09
You' the interruption just to give you a time check. It's 3 22 or scheduled to end at 3 30.

01:48:42:18 - 01:48:47:18
Thanks, Robin. I'll jump in. I found another, incident management related question.

01:48:47:18 - 01:49:00:14
And so, essentially asking if the ODP or AE review and approval or disapproval process

01:49:00:14 - 01:49:05:20
has any impact on timely finalization and it doesn't, right?

01:49:05:20 - 01:49:18:18
So the timely finalization, is a process exclusive to, what's the responsibility of the provider agency and then the closure process, right?

01:49:18:18 - 01:49:23:22
finalization and incident closure are a sort of distinct from one another.

01:49:23:22 - 01:49:43:18
So if there is sort of the sometimes back and forth that. County is requesting some additional information for example why didn't a particular witness you know why weren't they interviewed that sort of thing that that would not factor into.

01:49:43:18 - 01:49:48:06
The timeliness of finalization.

01:49:55:18 - 01:50:08:04
Good number of questions about pay for performance here. About the kind of the frequency of payments if they would happen annually.

01:50:08:04 - 01:50:18:18
So I think there's a there's a couple of things here and The the 1st one you know we intend to get out some pay for performance that will help.

01:50:18:18 - 01:50:34:07
In terms of the capacity building at the front end of this related to workforce. I know we're not talking about workforce until a later session, but that's 1 we've heard quite a bit from providers to get credentialing off the ground.

01:50:34:07 - 01:50:47:18
Is, you know, there's definitely costs associated with it. So that's the one we're focusing on 1st in terms of frequency of, payments.

01:50:47:18 - 01:50:55:18
You know, I think, there will be, some upfront in terms of capacity building and then thinking about milestones or benchmarks.

01:50:55:18 - 01:51:07:18
So yes, I think the answer is that you know the frequency of those payments we intend to make them such that they're going to be supporting your activity.

01:51:07:18 - 01:51:19:05
So I would expect for some of those, you know, we may have, you, you, you would have eligibility to some of the paid for performance on at least an annual basis, yes.

01:51:24:18 - 01:51:30:15
I was gonna jump in on the rates. There's some questions about the rates.

01:51:30:15 - 01:51:37:18

Will the rates replace the current waver rates or are they in addition to the waver rates based on the providers category.

01:51:37:18 - 01:51:44:18
And the answer to that is yes, they are in addition to the existing fee schedule rates. So as it's currently in vision.

01:51:44:18 - 01:51:54:18
If you're in the select category, it would be p schedule plus 5%. Currently enhanced it would be fee schedule plus 8%.

01:51:54:18 - 01:51:59:00
So similar billing practice, but the rates would just be set up with those percentages.

01:52:03:18 - 01:52:11:18
There are a number of questions that came through. Asking about some detail or additional examples of conflict of interest.

01:52:11:18 - 01:52:28:18
So again, that relates back to the administration. Proposed. And so, I mean, in essence, we're looking at, where there are multiple interests for executives and decision makers and board members.

01:52:28:18 - 01:52:41:18
That that tend to have a financial implication. Or a personal implication. Or there are preexisting relationships that really should that would need to be disclosed.

01:52:41:18 - 01:52:48:18
About that person's, relationship to the organization.

01:52:48:18 - 01:52:57:15
There's plenty of information available online if you're if you're looking for more information.

01:53:07:18 - 01:53:21:04
And I'm going back and I see there's still a number of questions related to electronic health records and you know I think characteristics of electronic health records are they are you know

01:53:21:04 - 01:53:39:18
housing some extent of an individual's medical record whether that's you know medical history medications treatments treatment plans the other characteristic of an EHR is that it can it has the ability to communicate with other systems so there was

01:53:39:18 - 01:53:48:05

a question whether or not daily notes if you have a system that's keeping daily notes. Would that meet a requirement for an EHR?

01:53:48:05 - 01:54:00:18
It would not if that's the only basic function is keeping service notes. That is that would not meet the requirements to be considered an electronic health record.

01:54:00:18 - 01:54:07:18
There was another question about whether or not an Excel spreadsheet could meet the requirements to be an electronic health record.

01:54:07:18 - 01:54:21:18
It cannot. So, you know, I think just, having an understanding of what, kind of information it is keeping, and the fact that one of the key characteristics of the electronic health record.

01:54:21:18 - 01:54:25:06
It has some ability for for interface.

01:54:27:18 - 01:54:37:18
There was another question and it's a great opportunity to reiterate what Kristin had said earlier around the provider agreement and when that will be.

01:54:37:18 - 01:54:54:18
Completed and submitted. So we hope to have the provider agreement available and out to the public tomorrow. And as the Deputy Secretary mentioned, we were originally looking for submission by July first.st

01:54:54:18 - 01:55:02:10
Because of the late availability of that opening that up to July 31st

01:55:07:18 - 01:55:19:18
And then I think this may be our last question unless there's another short one here. Will the needs exception process remain the same?

01:55:19:18 - 01:55:27:18
And the answer is yes, the the NEA, the needs exception process will remain the same as it is today.

01:55:27:18 - 01:55:30:14
We have not proposed an changes to that.

01:55:31:18 - 01:55:38:23
Alright. That was, I really appreciate everybody's engagement. A lot of really good questions here.

01:55:38:23 - 01:55:47:18
Certainly hope you found this helpful in working through this 1st set of performance areas and look forward to seeing you all again next week.

01:55:47:18 - 01:55:57:18
Again, if you missed the recorded pre recorded overview session, please do that and we certainly recommend that residential providers are attending all 4 sessions.

01:55:57:18 - 01:56:02:18
As you can see, we're really trying to focus. We started getting lots of questions about other performance areas.

01:56:02:18 - 01:56:13:19
We're going to stay focused during these sessions on the performance areas we're covering because each of them certainly deserves its own own time and your opportunity to ask questions and get some feedback from us.

01:56:13:19 - 01:56:21:07
So. Thank you everybody and get those public comments in before tomorrow. Right tomorrow, not before tomorrow. Bye tomorrow.

01:56:21:07 - 01:56:25:14
Alright, Thanks