Third Thursday Webinar
October 20, 2016
CHC Update and Quality and Evaluation Activities

>> CAPTIONER: Hello [standing by]
>> MAIN SPEAKER: Good afternoon and welcome to the October 2016MLTSSwebinar. I'm Jennifer Burnett from the office of long term living and I'm joined today by [inaudible] and Kevin Hancock who is our chief of staff at the office of long term living. Before we get started I would like to go over a few items to participate in today's event. We will keep you a screen shot of the attendee interface. We will dive into quality and health choices. [inaudible]
Kevin and I will go into update evaluation and quality strategy. It will provide resource information and open it up for questions. Again you can use that chat function to send in your questions.
I'm going to do a few items that I just wanted to make sure people are aware of. October is disemployment employment awareness month. A large conference happened in Erie no together people we have a staff up from that attended the conference and said it was a very productive conference.
>> SPEAKER:
In response to that we developed a plan. The plan outlines steps to be taken by the department of human services by labor and industry, by education and other collaborative efforts thousand stakeholder [inaudible] programs to shift expectations towards the goals. Preparing young people to become working adults with disabilities, expanding private partnerships, private and public partnership, increasing public awareness. We are also working in that plan that was published a couple of weeks ago you can get it from the department of human services home page. Also transitioning students from secondary education to adult life. Assisting adults with a disability in getting and coping a job and improving access to reliable transportation to get to and from work on time every time.
We really want to lead by example. So we are improve owing our state contract for Commonwealth employment. We are also doing a lot of work in collecting and coordinating data and implementing monitoring and providing accountability. I also want to say that OLTL has taken step in employment for people with disabilities through several waiver amendment and our COM care independent waiver and OBER waiver, employment skill, job coaching and job finding. Those are all services that we are going to provide through the waiver. So our service coordination is the key. We have begun speaking to people about employment. OLTL is in [inaudible] the 5 services and some of the activities that we are doing with regard to that is recruiting providers, training providers, training service coordination. They will come in future months. We are also doing system changes to ensure that services are available to be added to the service plan and also to assure that
providers get enrolled and they are able to provide these services.
We also did an analysis of our recently issued review tool -- participant review tool which is now in operation. People are using the service coordination and working with consumers out in the field to talk to their about their service delivery and individual goals

of working. We do have some questions about employment. So we're going to be offering technical assistance it our service coordinators.
I wanted to -- I don't think we have done this but I wanted to go ahead and play a video which is now posted our our website. The video is a short video about community health choices and we're just going to go ahead and put it up on the scene to see if you haven't already. And here it goes.
Sorry.
I'm sorry, we are having a technical difficulty. We need to get the sound.
♪
health can be complicated. Maybe you have more than one provider. You might be covered by more than one insurance. Wouldn't it be nice if this was someone to help coordinate it t all? That's why Pennsylvania is starting community health choices. If you are 21 or older and have both Medicare and Medicaid or receive long term supports through Medicaid because you need help with every day personal tasks you will be covered by community health choices. Community health choices will coordinate your services to improve the quality of your healthcare experience. We'll serve more people in communities rather than in facilities giving them the opportunity to work, spend more time with their families and experience an overall better quality of life. Community health choices will roll in out in phases across Pennsylvania starting with the south west in 2017 the counseling east in 2018 and the remainder of the states in 2019. This will affect more than 420,000
Pennsylvanians. Are you one of them? Here are 4 things you need to know. Number 1 there is nothing you need to do until DHS contacts you. We'll reach out and help you make inform choices about the future of your care. 2, you will be able to choose a managed care understand in your area that will help improve the cord nation and quality of services and take the confusion out of healthcare. 3, all participants will be clearly informed about their participation in community health choices. 4, your coverage will continue uninterrupted you will have no gaps in coverage. Community health choices providing choice, promoting independence and making it easier for Pennsylvanians to live in their communities brought to you by Governor Tom wolf, the Pennsylvania department of human services and the Pennsylvania Department of Aging. For more about community health choices go to www.dhs.pa.gov.
>> MAIN SPEAKER: Please look at that at any time. It's available through the department of human services home page and going to the common hi health choices home page.
>> SPEAKER: When we think of the word home most of us envision a place where we feel safe, comfortable and happy unfortunately for many --
That video is available from our home page as you see there's a link to click on. If you want to show it to anybody, if you are working with somebody who is confused about what to expect it helps people understand what this is going to look like.
I wanted to start out talking about the software which is a procurement that is currently on the E marketplace home page. It will be posted there until early November. So vendors are coming in to give us -- come in to propose to us that they would like to participate in the program. It is a nationally known instrument created by professionals at the university of Michigan. The solution these tools have been tested, validated and standardized to help streamline program availability and create with care plans and

used nationally and internationally. We have identified as the new comprehensive needs assessment. Looking at all of the questions they have. They have on their tool and we're identifying data for a comprehensive needs assessment. The assessments can be used electronically through approved vendors acid fewed by the team. They have to be qualified. That's the reason we have put out the request for proposals out on the Department of General
Services E marketplace home page.
It was released on October 7 and it is supposed to be back on November 7. It is a request for quote. It is a different type of procurement. It is up this on the E marketplace website. In the same time we have developed a new determination based on many of the questions found in the healthcare. We would like this tool to be housed in the same system. Having the ability to upload the Pennsylvania specific tool would be very important as well as editing capability.
So we are really excited about this opportunity and next month we'll be reviewing and evaluating and scoring all of those vendors that come in saying they would like to help us with this.
On are user function such as notification when an assessment date is approaching or over Dow Jones and the ability to generate various reports which available through this procurement.
I wanted to turn it over now to Kevin Hancock to talk about the timeline
>> We announced 3 organizations immediately after the announcement [inaudible] it was explained because the review of their proposals. Following the debrief within the context of the debrief we received protests for the decision. The next step in the process and where we are right now is we are going to be reviewing those protests. On the merits of their concern. That means in is this area we say it [inaudible] we will not be engaging in any type of contract negotiations or rate negotiations with the offers and in terms of the timeline we are anticipating -- we are still anticipating implementation date for 2017. However, we are not engaging at this point. We are not going to discuss the readiness which they will describe in the last Thursday webinar. At this point we are still in a blackout period and -- these are on hold until we have a thorough review of the process. That's where we are at. I will turn it whack over to Jen.
>> Thank you, Kevin. We want to know no talking about our community health choices evaluation. So with that I will turn things over to Gonzalez.
>> SPEAKER: Thank you for inviting us here to speak with quality for community health choices. Very excited to be here. More importantly the last time that I spoke at this forum was on August 18 where we gave you an overall view of our plans on how to manage and basically implement quality for community health choices. This slide and the next slide you will see is a diagram that we shared at our last webinar that gives us a snapshot on our intent how we will monitor community health choices. Just lining Kevin has mentioned before Randy at the last webinar went into detail how we were going to be approaching readiness review and we are still working many of the details how we are going to do that. It gives you an opportunity to know that we recognize that we need to start evaluating and monitoring community health choices way before community health choices goes live next year. Readiness review is the first start making sure that the MCLs are ready to go and making sure
that systems adequacies are in place.

For purposes of today we really want to take what -- we want to have a discussion more in depth of quality and the role it plays in community health choices. I'm glad that we have with us Paul who has extensive experience not only with his experience working with Pennsylvania but he has also been very much involved at the national level with other organizations and in other states. So we're happy that he is helping us making sure that we're following all of the requirements and making sure that Pennsylvania has good quality and good approach for community health choices. There are so many moving pieces to community health choices and I think for today's discussion I want to make sure there are 2 things that have already occurred. Many of you are on the phone today have already participate and we certainly thank you for your feedback and your continuous feedback. That's very important. One of the very first things we have done that we have gotten public comment has been
our community health choices application tore PMS. This lists specific waiver assurances and requirements. This is how we are telling CMS that we will manage community health choices. More importantly this requires what systems are going to be in place to measure and improve performance in meeting the assurances. It also gives us an opportunity to identify systems in all of those areas. So the 6 areas that CMS wants to make sure we are looking apt and monitoring are administrative authority, Pennsylvania needs to make sure that we let CMS know how we are going to do oversight and provide operation to community health choices. The next area is the level of care. One of the things that we need to make sure in our application was to demonstrate how we were going to he Val at and reevaluate participant and level of care determination. This also includes qualifying providers. How are states going to ensure that providers who are providing services are qualified? That is also something that we put in our application. Service plan really important that we in detail talk about how do we ensure that service plans are adequate for consumers. And most important very critical that is health and welfare. How does Pennsylvania make sure that you are protecting consumers that you are serving under your program. And finally financial authority. That really is the area where we need to demonstrate to CMS financial accountability. We release a draft of that application and again like I said before we received a lot of comments. We're now in the process of reviewing those comments and making sure that the application incorporates those comments no the CMS application.
The other area -- and I won't go no too much detail. We will talk more in the presentation is something that you have participated in. That has been the long term evaluation plan for community health choices. This is something that we have been working very closely with the university of Pittsburgh health policy institute. Again, more -- we're going to have more information later on in the presentation. But for today what we really want to talk about that we really haven't had an opportunity up until now is really talk and walk you through the statewide quality strategy. It is a new topic of discussion for us. It is something that has been around in Pennsylvania as well as other states. It's something that we are going to go into in detail.
The one thing I want to remind you all today, remember 2 points with regards to quality. The first is quality is more than just assurances. It is also about improving things with time and it is always going to be continuous as the diagram reflects.

Secondly, he evaluation is another source for us to look at information that will help supplement all of the data analysis that the department will be receiving that we will be getting directly from the MC organizations and other resources. With that I want to invite Paul to help us walk us through the next few slides. Paul?
>> Paul: Thank you. I'm sorry I was muted. I'm here now, thank you, wilma. So in the next slide what h is the quality strategy? There is, as many of you know, a significant set of federal regulations that governs Medicaid managed care. So at a minimum the state needs to ensure that they are meeting those requirements and all of the quality requirements within them. Earlier this year CMS issued a significantly updated Medicaid managed care regulation. They had not been updated significantly since the late 1990s. Since that time managed care has really become the design interest mode that states use to deliver Medicaid services. And so managed care has become the mainstream way of delivering those services. CMS also wanted to make sure that the Medicaid managed regs are in alignment with other important programs where there is also interface specifically the new coverage options under the affordable care act, Medicare coverage for those that have Medicare and Medicaid coverage and to some extent also align with commercial coverage options. They also had not updated the regs since managed long term services and support became popular with states.
So some earlier guidance that CMS had issued around managed long term services and support essentially got incorporated into the regs giving it the force of law, making it enforceable.
So the quality strategy is a requirement of the federal regulation. And it requires the state that is going to do Medicare managed care to submit essentially a blueprint or a road map to CMS as to how it's going to ensure that the program does comply with all of the quality requirements. If you're interested in looking at those quality requirements in detail, we have put the specific regulatory citations there on the bottom of the slide.
So the road map is meant to tell CMS and stakeholders how is it going to approach quality assurance and quality improvement. So quality assurance being how do you make sure that service health and safety and other standards are met. Quality improvement meaning, you know, how do you assess engage what the current quality of the program is and improve upon that going forward.
So how will it meet all of the relevant federal requirements, what is the plan and how will it be implemented.
So going to the next slide Pennsylvania currently has a quality strategy because it has had managed care for a long time. But not in this area. Not in long term services and support. So there is currently a quality strategy that addresses physical health choices and behavioral health. Those parts of the plan are being updated because they haven't been for some time. In addition, some additional programs including CHC will now be included in Pennsylvania's quality strategy. CMS requires and Pennsylvania wants to get stakeholder input on the quality strategy. And so it will be published later this fall for a 30 day comment period and we encourage everybody to pay attention had it gets published and to provide feedback on it so that you can impact how the state is looking at and measuring quality.
The next slide I'll turn it back over to wilma Marie.
>> Thank you, Paul. The quality strategy component the plan describes 3 areas, CMS wants to know how are states organizing all of its quality functions when operating a

managed care system. It also is interested in learning how will the state monitor its program and detect issues and concerns and how will you solve them.
More importantly it will also want to know how are you, Pennsylvania, improving your performance over time. So when you look at those 3 areas and -- and you will look at the plans that we release, those are the 3 areas that we have within our plan, within our section.
Now as Paul mentioned there are other program offices that are going to be included in this plan, the office of medical assistance, OMS which operates choices, office of mental health and service, office of developmental program, ODP, OCYF, office of long term ling, OLTL and the CHEP program. Areas that the plan will cover that CMS will want to respond to they will want to know from every program office things like your managed care goals, objectives and overviews. In this section we will want to make sure we are talking about the background and community of healthcare choices. A lost the activity you have seen we want to make sure we are including these in the regions that are covered. So many of those programs, the state structure and how will we ensure that we are identifying local quality advisory committees. That's a big one for CMS. That is something that obviously we will want in Pennsylvania.
Another area, another section is assessment. In this section it talks about overall CMS wants to make sure that things are actually working in Pennsylvania. You need to tell us how you are actually going to do it. So for the assessment area things like making sure the national measures are being met. They will want to know what kind of things do you have in place to manage and provide oversight on the quality side for consumers. And really they also want to make sure that we sell out how we are going to monitor and meet compliance. How are we going to be monitoring the managed care organization and how do we ensure that they are following compliance. For that as you all know there is a draft agreement that's out there. That document is something that the NC organizations are already looking at making sure that they are following all of our requirements.
Another section within the plan is entitled state standards. And in this state standard it really talked about consistency between all of the federal requirements and ensuring that MC organizations are following all contractual obligations. Things like asking the MC organizations, you know, structure and operations how would you be managing your plan and how would you be serving your consumers. So again a lot of this stuff we can refer back to the draft agreement we have today. But it is something that again CMS wants to make sure that we are incorporating within our plan.
Another session within the equality plan is improvement and interventions. What does that mean? Basically in a nutshell what CMS is asking how will Pennsylvania make improvements as you identify good things that are happening within the program or things that are challenging or not working.
So how are we going to plan on doing that? So all of this has to be spelled out in the quality plan. Not only do we need to publicize it for a 30 day quality period. CMS also has to review it and approve it as well well.
The last 2 sections in the quality plan is a delivery systems Lee form. In this area it really not only talks about identifying performance measures what is Pennsylvania going to be looking for as far as services, as far as the various populations that you are serve I think but it also is interested in hearing from states will you be developing performance

improvement projects or PIP at many at the national level is something that's talked about. Many states have begun. That's also something that we need to make sure we are incorporating within that section.
Then lastly, within the plan is making sure that we are identifying successes and best practices. In this area, this really gets to making sure that on an annual basis we are producing a record card. So you have a quality plan. You identify how you are flag on do it. How do you tell us but also tell the public how well are you doing. So this quality plan CMS has sent out technical assistance to all of the states. It has identified and outlined for all states to follow. A lot of the outline that I talk to that I mentioned today really does talk about what is what CMS is going to be looking for under this plan. The 2 components that I think are very critical and very important that today we need to talk about, again it's something that -- it is not new but we are going to be covering it in more detail today. That is within the plan we talk about external quality review. And we also are going to be talking about pearl form answer measures. Again,
while the performance measures are in draft, it is something that we're recommending. It is something that we definitely want stakeholder input.
Later on at the end of our presentation I want to make sure that I have an opportunity to also give you an update on where we're at with the evaluation plan.
So I think with that I will ask Paul to come back. Paul, come back and explain about the EQR.
>> Paul: Thank you. The external quality review organization is something that a state must contract for under the CMS regulation that I mentioned earlier. And in the quality strategy, the state has to talk about how it's going to use the external quality review organization or EQRO. The require meant to have an independent external entity that takes a look at certain aspects of the quality program and reports to CMS once a year. They can do lots of other work for the state and they do. They do in Pennsylvania. They do in most states. They tend to be very very good organizations with great capacity for doing quality studies and for calculating measures and all of kinds of things you associate with quality.
So although it's a requirement and it's there because CMS is not just taking the state's word for it that certain things are happening they want it externally confirmed or validated it is really a partner with the state to make sure that the program is of the quality that all stakeholders are looking for. So as wilma Marie mentioned there is an EQRO in Pennsylvania. When CHC starts up, it will have an EQRO as well as required. The external quality review report has to include at least 4 mandatory reporting activities which are called protocols. But it's really activities or areas that the EQRO has to look at. And those 4 mandatory areas the state must ask the EQRO to do some work in. Now in addition to that, the state can also contract with the EQRO to do 6 additional voluntary activities that CMS approves. If the state chooses to do that, they still get the federal match on that activity which is why they are specified by CMS. CMS says if you do these additional things we will pay a share of the cost of doing that. As I mentioned these are called protocols. Again, we have given you a link here if you want to take a look at those protocols for yourself.
So let's take a look at the mandatory protocols. These are the ones where the state has to work with the EQRO to do these 4 things. Assess compliance, validate measures,

validate the performance improvement projects and validate network adequacy. Let me talk about each one of these and give you some examples of how these might be used. So assessing regulatory compliances is just like it sounds. CMS wants to know that the state and MC organizations are complying with the federal Medicare regs in particular the quality aspects.

Then in addition to that, if there are state regulations on top of that that the MCO is complying with those as well. So what are some examples of regulatory compliance that might be important-parly important in an LTSS program. Accessibility. There are physical accessibility requirements in the regs. The accessibility of service sites. Can you get into the building? But also diagnostic equipment. Are there appropriate examining room tables and equipment and so on.

The EQRO might validate that the program is compliant with those things. Another example would be a Valbuilt and use of HBCS as an alternative for institutional care. Person-centered service planning, what does that mean? How is it defined? How is it interpreted? Is it happening in the MC organizations? Those are all examples of things that the EQRO would look at to assess whether the program is in compliance.

The second area validate performance measures wilma Marie mentioned performance measures. We will talk a little bit more later. But these are essentially calculations that are made that indicate what the state is looking at in particular to assess the quality of the program. And so the MCo will be responsible for collecting the data, calculating the measure and and submitting it to the state. So what this activity does is it takes those measures the EQRO will take the measures from the MCo and they will check to see that they are valid. First of all they followed the instructions. They calculated the measure in the way that the state asked you to. For example, how does the state calculate a successful nursing home transition? Did they calculate it in the way that the state instructed them to?

Is their data system capable of collecting that kind of information with accuracy? And so on. So that when the state gets those performance measures, they will have been essentially checked over by the EQRO to make sure that they were done properly.

The third mandatory validate improvement process. They need to do at least one a year. And the state can direct the MC organizations to do a specific improvement project or they can let the MCO decide for itself and sometimes the state will direct one and let the plan choose a second one.

But in any case, it is looking at a very specific area and saying, okay, what is the performance in this area? What is the plan for improving it in the next year? And how are you going to implement that plan?

So for example person centered planning if there is a concern or even if we're just wondering how person-centered planning occurs, an MCO might develop a project around person centered planning. If we take this additional step to include the consumer at this particular point in time, that would be more person centered. Let's try implementing that and then measure to see whether it worked or not.

Another area for performance improvement might be coordination with the behavioral health. That might be a particularly good one to consider in Pennsylvania where a separate behavioral MCO will be doing that piece. So whatever the topic is, the MCO take on the topic and then the EQRO is tasked with validating it.

So validating that topic includes first of all looking at the study methodology. So the way the MCO decided to do this study was it appropriate way? Are they looking at appropriate things that will tell them something about this area.
And then verifying the study findings and evaluating overall whether it was a valid study or not.
So that's the third mandatory area. The fourth area we don't have a lot to say about yet because it was one of the new mandatory activities that the new mandatory activity that was recently added when the federal regulation was updated that they are -- CMS will want the EQR O to validate network adequacy. We don't know until they issue the protocol. Once they issue the protocol it will take effect one year after that happens. We can guess that it means things like the state will have standard whether there are enough HCBS producers and they will have to produce statistics about that and it will probably have to do the EQRO validating those statistics maybe calling those providers to see if they are accepting new people and things of that nature. We don't know the specifics until the new protocol is issued.
So let's go on to the next slide in the voluntary activities. These are all things that the state would want to do up with way or another. But the question is whether the state wants to use its own capacity to do these or whether it will contract with the EQRO since those federal matching funds are available for it and it helps expand the state's own capacity.
So validating and counter data first of all for those not familiar with the terminology an encounter is an enter action that you have with the healthcare system. If you go to see your doctor and you have an office visit, that's an encounter. If while you are there you have some blood drawn and there's lab work done, that's an encounter. So on and so forth. If you have an hour of personal care, someone coming to your home to provide personal care that is an encounter. In the current fee for service system we call those claims because they all have a dollar value attached to them. But in managed care the claims go away because now the state is paying for a package in a big bundled price if you will. Without that detail of the claim the state needs another way to still be able to Monday tornado what's going on in terms of service delivery, how many hours of personal care have been delivered, how many days of nursing home care have been delivered and so on and so
forth.
So encounters are critical. They are submitted by the MC organizations to the state. The MC organizations develop them out of the claims that they get from the providers. But the data is massive as you might imagine when you are talking about 400,000 people all of whom probably have several encounters in a month. It's a lot of data and so validating it includes looking to see that the encounter was defined in the way that the state defined it and then whether it can actually be documented. If they were to do a chart review did those encounters actually occur and so on.
So very important to have good encounter data and it is possible to use the EQRO to validate that encounter data and in some states validate the encounters themselves.
Second optional EQRO area conduct or validate consumer or provider surveys. There will be both consumer and provider surveys in CHC. Both are contractual requirements. So the plan will be responsible for implementing these surveys. On the consumer side, for example, strong consideration is being given to a band new tool that has just

recently been CAP certifiesed. That is a national consortium that certifies surveys of all types in the healthcare area. They have just certified a new survey which is designed especially for people who are getting home and community-based services.
And so if that is ultimately the tool that the state specifies the plans will implement that with their members once a year and the external quality review organization could be used to validate the survey. So that would include for example did the health plan choose the appropriate sample. Did they survey enough people so that the results are generalizable? Did they get a high enough response rate so it is not only how many surveys you send out but how many come back properly completed. Did they administer it the right way? The HBCS survey for example is not a mail survey. It has to be administered by phone or in person. Did they do that? Did they draw the correct analysis from their results? All of those kind of things. The EQRO would help with. Calculate additional measures not provided by MCO. It is going to arrive at those measures in its own way and so for example you might want to do something that requires looking at medical records so the EQRO would go in and look at a sample of medical reports that the QRO would cope. Conduct additional PIPs. So again there might be in addition to the required annual PIPs, the state might want to engage in more performance improvement projects and if so it could again engage the EQRO in validating those.
Focus studies. So sometimes questions come up about whether something is happening or not. Or the data are showing that there might be a problem in a certain area but you can't quite tell from just looking at numbers. So the state can ask the EQRO to go out and do a focus study on that topic. The topic could be anything the method can be anything. But the point is you've got the support from the EQRO if you want to do it. I mentioned earlier behavioral health cord nation. That might be one area where people say you know we're not quite sure. We're hearing different things. We can't quite tell from the numbers. Let's have the EQRO go out and look at both the medical records of the behave oral health organization and CHC organization and see if we can detect any coordination going on across those 2 entries. So that might be an example of a focus study. The nice thing about focus studies is often times the data that you look at are ambiguous. You can see that
something looks a strange but it doesn't explain anything to you. So you can use the focus study to go out and talk to people and learn more and try to get into an issue. Assist with the quality rating system. This is a new voluntary activity. It is another new one from the regular. The new Medicaid managed reg require them to have a quality rating. What does that mean? It means something like the star rating system in Medicare if any of you are familiar with that the state the look at data and create composite measures. When you add all of those measures together a plan will get 1 star, 2 stars or 3 stars. As a consumer it is designed to be very easy to use. So as a consumer you would know that a 3 star plan is extent. 2 star plan is okay. 1 star is not so great. So that is still yet to come. CMS has to issue the guidance on the QRS. Everybody expects they will be complicated and challenging to develop. Had
they do get developed the state will be able to use the EQRO for help with that. So with that I'll turn it back to wilma Marie to talk about performance measures.
>> Thank you, Paul. I really do hope that folks on the line are really -- have an opportunity to really learn about our goals and try to make sure that we are not only just

wrapping our arms around all of the requirements that CMS wants us to do but also making sure that as we hear from the public, as we hear from the stakeholders we are incorporating that and really making it state specific. The next slide talks a little bit about performance measures. You have heard it throughout the presentation. Most folks call it performance measures. Other folks will reference it as quality measures. It is still the same thing. Many of those quality measures that we are proposing are coming out of the draft agreement acid mentioned before. There is an enormous amount of requirements in the draft agreement. We have gone through the exercise we meaning the office of long term living as well as department of abling have already gone through the agreement and really pulled out
those reporting requirements making them make more sense when we are designing these quality measures. So when you are looking at performance measures we want to make sure not only are we collecting the information we want to know how is the actual program doing. We want to be able to use that data to compare this information with other MC organizations and other organizations. We also want to do it over time and be able to see the he effectiveness of the plan.
Here are 3 types of measures. And this graph the intent of this graph is to give you a flavor of the framework on the errors we will look at. When you look at in the area of structure we are interested in learning what MCOO s have in place. A good example of that is identifying adequate number of service coordinators available for consumers. The other area as many processies. One of the things that we want to make sure is that we are looking at certain things and what things are done. This area is really more consumer directed and this includes making sure that the consumer is part of the development of the service plan. That's a good example of that.
And finally the other area is outcome. The description for this particular type of area is consumer changes that result from services being provided. And here in this area we really want to make sure we focus on transition. Making sure that the individual is transitioning from a long-term care setting into a home-like environment. That will be very key. That will be very important.
Some of the on are things that I would like to share with you at this time is I think we should go to the next slide -- I think this is where I'm hoping that a lot of you are probably eager and excited to hear, we have begun drafting what we think are the performance measures. One of the things that many of you know is there are national standards out there that stakes must neat. You have heard of healthcare effectiveness information set. They are collected by the MCO. The EQR validates it and they sent it through the state. Paul also mentioned that one of the things that Pennsylvania is interested in implementing is having surveys available for consumers. So consumer assessment of healthcare provision and provision is something that we're also very entered in using. That's something that we are recommending as well to ensure that it is part of something that we want to collect both by the MC organizations and also it is something that we are considering for the
fee for service program as well.
And obviously the men um data set, that is something that nursing homes are already doing it. So it already exists.
Where states have an opportunity to identify performance measures is where we're at today. I would like to share with you very general some key areas that I think are going

to be important for us particularly for community health choices. Obviously we are going to be looking at complaint and grievances. That is part of our list. We want to make sure that we are looking at consumer type of issues for instance I want to give you at least an example. In the complaint and grievances we want to make sure not only are we capacity you aring the number of complaints coming in. We want to evaluate and analyze what kind of complaint and what types of grievances are coming in and be able to evaluate and analyze those and react to those and solve those issues.

In the area of community based services measures one the things that we want to make sure is how do we capture the number of participate meeting nursing facility eligibility who want to go back into the community. In the area of advanced planning directs -- and I think that is something for the abling population has been very key -- is how do we make sure that members are receiving event planning and counseling. Again, these are all part of measures that other states have developed and we are recommending that we adopt in Pennsylvania.

Key for Pennsylvania as many of you know is in the area of employment and in housing. So by want to make sure we are capturing data to ensure that individuals have choice, that they have an individual to hear what employment opportunity are out there. More importantly, making sure that they know there are options that are available in the area of housing if they are interested and that that should be part of their service plan.

In the service coordinating area, I think that this is something that in other states they also recommended which was something very important something we want to also recommend in Pennsylvania how do we make sure we are capturing information of participants who receive face to face assessments for LTSS services in a non-emergency situation.

So making sure that people are -- that MCO and service coordinating agencies are being responsive to consumers who are interested in participating in community health choices. Another area is making sure that members receive timely service coordinator assignment after a request for a service coordinator has been made by a participant. I think that's also very important. It's something that we have adopted from another state. I thought that this was another area that I thought was interesting. That is service coordinating entity turn over. Ensuring that we are looking at how turn over is happening with service coordinating and being able to look at the data by region.

Some of the other things, other sources that I think are important to know, you heard from Paul about the role of the EQR and the amount of data that they are going to be collecting for us. But there is data that Pennsylvania, that OLTL will be living. We will have today a service coordinator hotline a provider hotline. So it's making sure that we are looking at those calls and finding out what's happening, what kind of concerns are coming through that hotline number, being able to solve them and if we don't solve them right away or if if they have anything to do with impact or the program that we are responding appropriately. That is something that we want to make sure we are incorporating as part of our performance measures.

Other things that have also been identified from other states with regards to -- this already exists for the nursing home industry who uses the system. This information is already being captured under this system. That's residents that transition from a nursing facility to the community. So we have that data available so that's something again that

we could look at and make sure that we are evaluating and analyzing and appropriately being able to report that out as well.
Another area that is also captured within the system is residents with pressure ulcers. This is more medical but this is for managed care there is a lot of ears where we talk about measures more on the medical model. For community health choices obviously we want to make sure we are identifying key performance measures that are going to be measuring -- and they are going to be identifying based on the LTSS area.
Another area that also is being captured in the system is resident physically being restrained. That's something that the nursing home industry is already collecting within the system. That is something for us that is easy for us to make sure that we include as part of our performance measure. Another E measure as well for the aging popular as you know many of the folks that we are going to be serving are over the age of 60 and residents experiencing one or more falls with major industry.
How do we do that? If we know that a number of individuals are falling specifically in a specific region how are the MCOs managing that and providing support for consumers? Now these are just -- I'm just giving you a flavor of the kind of things that we think are going to be important. These measures will definitely be refind as we hear from all of you as stakeholders when we release the quality plan later this fall. Our hope is to also include a in more detail the quality plan at one of our up coming meetings. We will have an opportunity to hear from all of you during the public comment period once the quality plan has been released. And we will also make sure that if there are other opportunities for us to share and talk more about the quality plan we will definitely want to make sure we do that as well.
Some status on the independent program evaluation as I mentioned before and then many of you have already heard from us with regards to the evaluation plan, the university of Pittsburgh health policy institute has presented on the number of oceans at the MLTS. I believe here on the third Thursday webinar plans on implementing a long term evaluation plan for community health choices.
So I'm happy to tell you that we posted the plan and we did a 30 day comment period. We received over 2200 comments from stakeholders and we have summarized all of those comments. We have incorporated them within the plan and our goal will be to release a revised evaluation plan including executive summary of those comments in the next couple of weeks. So stay tuned for that. This evaluation plan is a fluid document and so while it is on our website and it is -- it has included stakeholder input. It is something that we definitely will continue to look very closely and revise as appropriate.
The last thing I just want to mention again as we close our presentation today is that like -- I'll just reiterate we will publish a draft of the quality strategy for public comment very shortly which will include a draft of the performance measures for community health choices. I can't stress enough I encourage everyone on the call or who is listening after the broadcast to review the draft of the quality plan for Pennsylvania and provide feedback.
And with that, I think that I am done. Thank you all for participating today. I will turn this back to deputy burnett.
>> SPEAKER: thank you very much wilma and thank you Paul for your presentation. As you hear from the 2 presenters they are doing a lot of work. It is a very, very critical

piece of success of community health choices is to be sure that we are measuring quality and we are doing something about it. So I think what they presented really demonstrates that we are pretty committed to that.
I have a bunch of information of websites and the first one is the community health choices website which is easily accessible from www.dhs.pa.gov. There is a list of hot topics and community choices is under the top topics. We have a lot of information on our website including the recordings of these third Thursday webinars. You can go back to July of 2016 and his en to the third Thursday webinars. We have all of the documents that we generated to generate the RFP back in March. All of the comments that came in on the RFP have been posted on the community health choices website as well. A lot of our documentation is found up. As you saw earlier built into that 2 to 3 minute video that that may be something you want to share when you are meeting with people who are concerned about this. It is a high level coming out of what community health choices is all about. Then the next website is our page web page for the MLTSS for managed long term services and supports. That
has all of the transcription from our meetings. We have been meeting since we have kicked it off in September of 2015 and we meet every month and all of those meeting transcriptions are on the MLTSS sub MAAC page. You can link to the home page as well. So there are several different ways. That's a live meeting. You want to open that up. If you want to register for a list service if you want to get announcement from office of long term living there are several list serves that are focused on the work of long term living. Register for a list serve and stay up to date via E-mail. That is the list serve for the department of human services which is a listing of all of the list serves for DHS. There is specifically community health choices as well as several other OLTLs that you might be interested in. You can always comment our comments to RA-MLTSS&PA.GOV. Questions. We had a few come in while our presenters were presenting and tile start out by reading the
question out loud and then we'll work on answering it for you.
First question that came in said I am very concerned that seniors and their families are unaware of this new change to managed care. What is being done to inform families and how will the process of transferring first degrees to managed care be handled? We are committed to getting as many people as possible to sign up for the managed care organization that they want to. As opposed to auto enrolling. In order to do that we have to do a very good job of outreach and education. That will be a multi facet all hands on deck approach to outreach and education. And it includes looking at this from a very strong-centered perspective which we are also concerned and know that we want to make sure that seniors not only seniors and their families are aware of what is happening but younger people with disabilities who use any of our home and community-based waivers as well as individuals who are in nursing facilities. So we are doing a lot of work with associations that
represent the variety of providers that we have and we're trying to educate as many people as possible so they can talk to the consumers and the participants that they work with and we are going to be putting together materials and we have a bunch -- several pre-transition notices that are going to go out
These pre-transition notices are going to be vetted by our managed long term services and support subcommittee. They are currently being vetted by the subcommittee where

they are reading them and giving us feedback. We are trying to use very transparent processes to make sure that those notices are able to be understood by seniors and younger people with disabilities receive them.
The other population that will be receiving them are people outside of the long term services and support system is a population of more than 300,000 people who are duly eligible for Medicare and Medicaid. They will need to be educated as well.
We also have a nice public-private partnership with the Jewish healthcare foundation and others around the state who have held a hand up saying we want to help you get the word out. They have put together a website that people can register for. We are going to be putting information about that up as well. The other thing is eventually people will get the conversion notices. A number of activities that will be done beginning about 6 months before we move the system no the south western part of the state. So generally speaking that would be in January we will start to work after the holidays. How will providers identify which Medicare organization each consumer has selected especially when there are several thousand consumers being serviced. This question has opinion asked several times and never seems to be answered. As with health choices which is our managed care program for people -- for physical health services in Medicaid, as with health choices enrolled providers
will be able to verify participant eligibility and Medicare organization information through the electronic verification system or EVS.
UPNC has been non-responsive. Have you received complaints about them being non-responsive. The answer is no we have not received complaints about them being non-responsive but we are right now not in communication with knife the MCOs.
Next is for Kevin.
>> SPEAKER: thank you, Jen, could Kevin please repeat what he said about the timeline for southwest PA implementation we are Tillman for the July 1 southwest implementation date. That will be sometime later fall. For. Kevin stated that the roll out is still planned for July 1, 2017. I did. No delay has been -- no anticipated delay at this time. Thank you. Back over to again.
>> Jen: Once the contract is set how often is will it renegotiated. The term for the contract is 5 years and we are commit today receiving consumer input. It is always considered -- the contract requirement may be changed based on consumer input that we receive. We will continue to hold these third Thursday webinars. We will be doing quality meetings in the region so there's going to be a lot of opportunity for receiving consumer input. The other thing that both wirma and Paul talked about various opportunities for looking for consumer input through the consumer assessment of health provider systems, the caps toll is one way. There are many other ways that we will receive consumer input. Thank you.
>> SPEAKER: How often are consumers able to change their plan once it is chosen? There is no limit to how often they change their plan. The effective date for any requests change will depend on the date they make the request in a given month. If in the first half of the month the change will be in effect the first of the next month. Second half it will be in effect the first month after the first month. There is a time frame. We can only make the changes halfway through the month.
>> SPEAKER: Just to be clear you can make your change request at any time, we have rules that go into effect. You will always have the opportunity to make a change.

>> SPEAKER: How do you anticipate the [inaudible] rules and recommendations. This is a good recommendation and one we can incorporate in our many coordination efforts with the Department of Health and with other state agencies we are really working to make sure that we are coordinating with our sister agencies in order to have a smooth transition. We'll look at the EQRO as another opportunity for that interface with the Department of Health. Couple more here.
>> SPEAKER: How will [inaudible] that were not affected by any organizations at that time. The response to that is there will be a 6 month care period but that means any sort of coordination entity will continue to oversee the home and community-based service plan for participants transitions into community health choices for the first 6 months following the effective date. After that service coordination entity will have to be affiliated with a managed care organization to reiterate they will be an administrative function. It is more direct contracting with managed care. The next good do [inaudible] contact anyone. I will make an assumption. Do we need to contact any managed care organizations. At this point any entity clouding anticipated network provider or service coordinator may reach out to any managed care organization they wish. It is just that we are because of the stay and the procurement process we are not in a process decide who you should be contacting
.
>> SPEAKER: What happens to the provider [inaudible] change it coming. The provider will contract with managed care organizations and will continue during the continue knewty of care period will continue to provide services for the individual. So I think that is responsive. I think we are done. That is all of the questions we had today. I want to take this opportunity to thank you for participating in today's third Thursday webinar. I would appreciate any kind of input that you would give to us via the E-mail address that I had up there or via an evaluation that will be coming out about today's event and by certainly look forward to you providing us with ideas for future third Thursday webinars and materials that you would like to see us talk about. We have one more question that has come in.
>> SPEAKER: Where when are the RFPs employment assistance training expected to be released? We are working on those right now. The employment assistance training that I talked about earlier when I talked about disability employment aware month. We are working on those trainings and we're also working with providers of those services. I anticipate they will come sometime in the wintertime we'll be doing webinars on them. So thank you for that question and we're glad that providers are interested in that training.
With that thank you very much. And have a good month. I will see you next month.
[meeting ended]