

Appendix H: Quality Improvement Strategy (1 of 2)

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances;
- The *remediation* activities followed to correct individual problems identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the OIS* and revise it as necessary and appropriate.

If the State's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the State plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

- i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Children's Residential waiver quality management plan is part of an overall quality management plan for the three 1915 (c) HCBS waivers operated by the OA. The other waivers include the Adults with developmental disabilities waiver, (0350) and the Support Waiver for children and young adults (0464). While some data may be collected during the same onsite provider review, the sample for each waiver is independently selected and collected for later trending and aggregation. The samples are drawn separately and the results aggregated separately.

A representative sample is selected by the Operating Agency at the beginning of the waiver year. Reviews are then scheduled and conducted throughout the year. Each performance measure in the application specifies the frequency of data collection and data aggregation. Data collection is continuous and ongoing throughout the year and individual problems are remediated as they are identified. All data collected including the timeliness of remediation activities is summarized quarterly and shared with the Quality Management Committee which meets quarterly. The data is analyzed and evaluated for trends on a quarterly and annual basis. As trends are identified, proactive remediation is initiated. For each trend identified, the State establishes remediation plans by identifying the responsibilities of the Medicaid and Operating Agencies and identifying timeframes for completion. The Quality Management Committee collectively tracks the remediation activity. Annual reports are produced with trends identified based on the full representative sample and/or 100% review of data.

The front line of the quality assurance system is the ISSAs who are employed by the ISC entities under contract with the OA. ISSA staff who are QIDPs visit each waiver participant quarterly to check on their general health and well-being. The ISSAs use a standard tool and protocol that includes such areas as physical environment, individual rights, health, service plan implementation and behavioral supports. A sample of the completed tools for each ISSA is reviewed on an annual basis by the OA during annual ISC reviews. The ISSAs must be independent of any direct care providers and are charged with identifying issues and initiating problem resolution as needed. In the event issues cannot be resolved at the local level, the ISSA must refer the situation to the Operating Agency. The ISSAs are provided with a standardized form for these referrals. The OA tracks such reports and follow up activity in a central referral database. Summary and analytical reports are completed and reviewed by the State's Quality Management Committee for trend identification and system improvement. The MA actively participates in this committee and its reviews and recommendations. Additional information regarding the Medicaid Agency is provided below.

1. Level of Care

- The OA reviews all authorization requests for waiver services to ensure that the applicant has been accurately determined eligible for an ICF/MR level of care by the independent entities. During the initial process, QIDPs and other clinical staff, for example a physician, clinical psychologist, or nurse employed by the Operating Agency, provide further review of the LOC determinations, as needed.
- The ISC entities are surveyed annually by the OA for contract compliance. For these reviews, a sample of individual records is drawn from each of the contracted entities. Surveyors record their findings on a standard tool. The data collected for each of the contracted entities is compiled and summarized via an electronic report.
- State staff reviews system performance at least annually through an analysis of progress or regression in the scope of overall findings and of findings by agency. This typically occurs as part of the annual 372 report process and during routine Quality Management Committee meetings.
- The MA and OA review LOC eligibility and timeliness of redeterminations for a representative sample of participants during residential provider onsite reviews.
- The State's Quality Management Committee reviews summary reports of survey findings and recommends corrective action. Corrective action can include training or technical assistance.

2. Support Plan

- Annually the OA surveys ISSA providers to review individual support plans based on a representative sample of participants to ensure plans are based on adequate assessments, address the participant's needs and are completed on a timely basis.
- When support plan inadequacies are found, the OA takes remedial actions, which include notification of deficiencies and, a plan of correction, if warranted. Systemic actions may include policy or rule changes,

clarifications, technical assistance and training.

- The OA reviews informed choice as a component of the annual review of the ISC agencies for compliance with the contractual agreements.
- The ISSA is a participant in the support planning team. When issues involving the support plans or choice cannot be resolved locally, the ISSA refers individual issues to the OA for technical assistance and follow-up actions as necessary.
- The OA maintains a database to track referrals and follow-up actions.
- Annually Child Group Home providers are monitored by the OA and MA based on a representative sample to ensure that individual support plans comply with contractual and waiver requirements. The review includes the assurances for service plan development, updates, timeliness and implementation for a representative random sample of participants.
- The OA and MA review through a representative sample of participants that participants were given informed choice of waiver services and service providers during the residential onsite reviews.
- Summary reports regarding support plans are reviewed by the State's Quality Management Committee for identification of concerns, patterns and trends and for development of suggestions for improvements. Selected reports are shared with the Statewide Advisory Council. The Quality Management Committee summarizes each meeting, maintains a log of suggestions for improvement, and tracks the implementation of the suggestions.

3. Qualified Providers

- The Department of Children and Family Services conducts focused surveys of the group homes annually and licensure surveys every four years to ensure that licensure requirements are met. The MA and OA review copies of the licensure reports.
- The MA and OA review provider qualifications and training for direct service persons and QSPs (QMRP) serving the participants.
- Summary reports of provider qualification reviews are reviewed by the State's Quality Management Committee for identification of concerns, patterns and trends and for development of suggestions for improvements. Selected reports are shared with the Statewide Advisory Council.

4. Health and Welfare

- ISSAs continuously monitor the waiver participant's health, safety and welfare during their required quarterly visits, or more often as needed. The ISSAs refer individual issues that cannot be resolved locally to the OA for technical assistance and follow-up actions as necessary.
- The OA maintains a database to track referrals and follow-up action.
- The OA issues written communications on health and safety policies and procedures.
- The OA provides training on issues where trends and patterns appear to be systemic.
- The MA and OA review health and welfare provisions through a representative sample of participants during the residential provider onsite reviews. The reviews include visits to the residential sites and interviews with guardians and participants and staff.
- The OA and MA review of Child Group Home and the OA reviews of ISSA providers includes verification that staff have been adequately trained in the reporting of allegations of abuse, neglect and exploitation to the appropriate authority.
- Summary reports of health and welfare findings are reviewed by the State's Quality Management Committee for identification of concerns, patterns and trends and for development of suggestions for improvements. Selected reports are shared with the Statewide Advisory Council.

5. Administrative Oversight

- The Medicaid Agency has an interagency agreement with the OA.
- The OA has ongoing communication with the MA on issues involving program monitoring; testing and monitoring of claims; participation in training; discussion of policy and system changes; and approval of policy changes through the Medical Policy Review System.
- The MA conducts waiver appeal hearings and makes the final decision on all appeals.
- The MA participates onsite with the OA in conducting comprehensive program monitoring of agency providers and participants. The monitoring protocol includes a review of all waiver services and supports that impact the participant.
- Staff from the MA participate in quarterly Quality Management Committee meetings with OA staff. Issues discussed include quality and financial review findings and follow-up activities, quality management planning, and rules, policy and system changes.

6. Financial Accountability

Financial oversight of claims is delegated to the OA to insure that they are coded and paid in accordance with the reimbursement methodology specified in the approved waiver.

The OA conducts post payment reviews of claims based on the sampling specified in Appendix I.

The OA submits a quarterly report to the MA with their findings and remediation activities. The Medicaid Agency conducts a validation review based on the OA report of post-payment activities to verify procedures were followed and that appropriate remediation activities were taken.

•The QA reports are discussed within the Quality Management Committee, issues are identified, and suggestions for improvements are made. The Quality Management Committee summarizes each meeting, maintains a log of suggestions for improvement, and tracks the implementation of the suggestions.

ii. System Improvement Activities

Responsible Party <i>(check each that applies):</i>	Frequency of Monitoring and Analysis <i>(check each that applies):</i>
<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
<input checked="" type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
<input type="checkbox"/> Sub-State Entity	<input checked="" type="checkbox"/> Quarterly
<input type="checkbox"/> Quality Improvement Committee	<input checked="" type="checkbox"/> Annually
<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<input type="checkbox"/> Other Specify: <div style="border: 1px solid black; height: 20px; width: 100%;"></div>

b. System Design Changes

- i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The OA compiles results of all review activity to identify trends and presents these findings with the MA. Based on identified patterns of concerns, corrective action is initiated by the OA to address and prevent similar problems with other providers. Such action is dependent on the specific identified issue but may include revision of training curricula, issuance of clarification bulletins, revision of contract language, and/or modification of performance measures.

- ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The process to evaluate the State's Quality Improvement Strategy is conducted annually as part of the Quality Management Committee activities. A portion of one meeting per year will be devoted to an overview of the previous year's activities and whether changes are needed to the Quality Management Committee procedures, membership and scope.

On a quarterly basis, key staff from the MA Bureau of Interagency Coordination meet with key staff from the OA to review all Performance Measures and remediation activities. Summarized evidentiary data are reviewed, trends are identified and additional remediation activities are developed and incorporated into the Quality Improvement Strategy. Meeting summaries of the Quality Management Committee track remediation activities and outcomes that are incorporated into the State's Quality Improvement Strategy.

On a quarterly basis the OA shares the data collected in the previous quarter on performance measures identified in the Waiver. Findings and identified trends are discussed. Changes to the QIS are made based on identified trends.