

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.

Illinois has a quality management strategy based on the federal waiver assurances and sub-assurances. Key to the quality management design is the elements of discovery, remediation and systems improvement. The MA and the OA meet quarterly, for scheduled Quality Management Committee (QMC) meetings, to discuss waiver oversight and monitoring, including measuring system performance and deciding on and reviewing system improvements. Participants in this meeting include Healthcare and Family Services (HFS) program and fiscal staff (the MA), and Department of Human Services (the OA) program and fiscal staff, the OIG, and other key staff.

A representative sample is selected by the OA 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 QMC 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 MA and OA 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.

Discovery activities are described in other parts of the application. State staff conduct discovery activities and review discovery information on an ongoing basis. For on-site and off-site record reviews, discovery information is reviewed and discussed with the waiver providers at the time of discovery.

This information is assimilated and reviewed by both the OA and MA. Findings are prioritized for remediation and improvement. This occurs informally and on an ongoing basis through discussion when issues are identified and more formally through interagency meetings including the quarterly QMC meetings.

The front line of the quality assurance system is the ISSAs, employed by ISC entities contracted by the OA. They visit each 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. Completed tools are reviewed on an annual basis by the OA. The ISC entities 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 OA. 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 QMC for trend identification and system improvement. Additional information on the complaint referral process is included in Appendix G. Additional information regarding MA oversight activities is provided below.

The Children's Support Waiver quality management plan is part of an overall quality management plan for the three 1915 (C) HCBS waivers operated by the Dept. of Human Services (OA). The other waivers include the Adults with Developmental Disabilities Waiver, (waiver control #0350.90) and the Children's Residential Waiver (waiver control #0473).

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.

The state's process for implementing system improvements is discussed in each federal assurance category below.

1. Level of Care (LOC) Determination

- The OA reviews all authorization requests for waiver services to ensure the applicant has been accurately determined eligible for ICFIDD level of care by the independent ISC entities.
- The ISC entities are surveyed annually by the OA for contract compliance. 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.

- The OA reviews LOC eligibility and timeliness of redeterminations for a representative sample of participants during annual onsite and record reviews. The MA participates in selected reviews as part of oversight activities.
- State staff reviews system performance at least annually through an analysis of progress or regression in the scope of overall findings by ISC entity.
- The State's QMC reviews summary reports of survey findings and recommends corrective action. Corrective action can include retraining, technical assistance, contract changes, etc.

2. Service Plan

- Annually the OA reviews service plan development and implementation based on a representative sample of participants to ensure individual support plans are based on adequate assessments to address the participant's needs and are completed on a timely basis. The MA participates in select reviews as part of oversight activities.
- When support plan inadequacies are found, the OA takes remedial action and identifies the most appropriate response. General responses may include work with participants and their providers, revising service plans, retraining staff, voiding claims, technical assistance, increased monitoring, and requiring a plan of correction. All individual findings are addressed by the OA. Systemic actions may include policy or rule changes, clarifications, contract changes, technical assistance and training.
- The ISSAs are participants in the individual support planning team. When issues involving the support plan or choice cannot be resolved locally the ISSA refers the issues to the OA for technical assistance and follow-up actions as necessary.
- The OA maintains a database to track referrals and individual remediation.
- The OA reviews that participants were given informed choice of waiver services and service providers based on a representative sample of participants during the annual onsite and record reviews.
- Summary reports regarding support plans are reviewed by the QMC for identification of concerns, patterns and trends and for development of suggestions for improvements. Selected reports are shared with the Statewide Advisory Council. The QMC summarizes each meeting, maintains a log of suggestions for improvement, and tracks the implementation of the suggestions.

3. Qualified Providers

- The OA monitors direct support (DSP) training and QIDP qualifications, initial training, and continuing education requirements as part of the annual provider and ISC entity reviews.
- The Financial Management Services (FMS) entity/entities under contract with the OA verifies that non-licensed/non-certified providers who are self-directed are qualified and have required background and registry checks upon waiver enrollment.
- The OA verifies provider qualifications for other non-licensed non-certified providers (for example, transportation providers) upon enrollment. Entities that do not meet requirements are not enrolled.
- The OA reviews qualifications and training during annual onsite and record reviews of providers. The MA participates in select reviews as part of oversight activities.
- Documentation of provider qualifications is a component of the OA and MA review of the FMS entity/entities for compliance with contractual and waiver requirements.
- Summary reports of provider qualification are reviewed by the State's QMC 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

- The OA reviews health and welfare provisions for a representative sample of participants during annual onsite and record reviews. The reviews include interviews with guardians and participants (as possible), ISSAs and Information and Assistance in Support of Participant Direction providers (if applicable). The MA participates jointly in select reviews as part of oversight activities.
- In response to identified trends and emerging issues, the OA issues written communications on health and safety policies and procedures. These notices are posted on the OA website under DD Information Bulletins.
- The OA provides training on issues where trends and patterns appear to be systemic.
- 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.
- In response to identified trends and emerging issues, the OA issues written communications on health and safety policies and procedures. After approval by the MA these notices are posted on the OA website.

The OA provides training on issues where trends and patterns appear to be systemic. Summary reports of health and welfare findings are reviewed by the State’s QMC 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 Authority

- The MA works closely with the OA through an interagency agreement. Activities are designed to assure the State meets the statutory assurances of the 1915 (c) waiver and to verify that the OA is fulfilling the obligations of the interagency agreement.
- The OA has ongoing communication with the MA through monitoring activities; testing and monitoring claims; participation in training; discussion and approval of policy and system changes; and approval of policy and rule changes through the MA Policy Review System.
- The MA conducts waiver appeal hearings and makes the final administrative decision on all appeals.
- The OA conducts program monitoring of a representative sample of participants that includes review of service providers, service coordination, FMS vendors and claims. The MA participates in select reviews.
- Staff from the MA and OA participate in quarterly Quality Management Committee meetings. Typical issues discussed include reviews of findings and follow-up activities, quality management planning, discussion of rules, training, and 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 reviews and analyzes rejected claims and other error reports to determine if system changes are needed.
- Based on findings, the OA notifies the MA Fraud Unit as required to provide information about potential fraud investigations.
- 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 report to verify that the OA followed their post-payment review procedures and that appropriate remediation activities were taken.
- All summary reports are shared with the MA and discussed within the QMC where systemic issues are identified, and suggestions for improvements are made. The QMC 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: <input type="text"/>	<input type="checkbox"/> Other Specify: <input type="text"/>

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 review activity to identify trends and shares 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 requirements and curricula, issuance of clarification memos, revision of contract language, and/or modification of performance measures. Other types of actions include voiding or adjusting claims as a result of post payment reviews and changes to administrative requirements.

The Quality Management Committee meets quarterly to discuss findings, trends and the effectiveness of system design changes in response to identified issues. The Committee prioritizes system corrections and enhancements on an ongoing basis. The Committee will determine who is responsible for implementation of each correction or enhancement and the time frames for completion. The Committee will track implementation and whether the changes had the desired effect and whether further modifications are needed.

At least annually, the Committee will discuss issues such as the need for waiver amendments including capacity changes, changes to covered services, provider qualifications and other major design changes. Since there are three waivers operated by the Dept. of Human Services, Division of Developmental Disabilities, system design changes takes into account all three waivers (IL.0464.IL.0473, and IL.0350.90). However, each waiver is analyzed separately. Some design changes may be specific to one waiver or may involve multiple waivers.

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. Key staff from the MA and OA are members of the Committee. 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 Quality Management 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.