



Quality in Home and Community Based-Services Authorities Part 1



Disabled and Elderly Health Programs Group
Center for Medicaid and CHIP Services

Topics this Webinar Covers

- Brief review of multiple quality initiatives within CMS/HHS currently underway
- New quality measures for some Medicaid authorities
- Consolidated reporting
- Part 2 (February 8, 2017)
 - Establishing an approach to quality: Models of Quality and Models of Improvement
 - Moving beyond compliance reporting to implementation of an overall quality plan

**BRIEF REVIEW OF QUALITY INITIATIVES
WITHIN CMS/HHS CURRENTLY
UNDERWAY**

National Quality Strategy: Three Broad Aims

These aims will be used to guide and assess local, state, and national efforts to improve health and the quality of health care.

- **Better Care**: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities**: Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and, environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care**: Reduce the cost of quality health care for individuals, families, employers, and government.

National Quality Strategy:

Six priorities

To advance these aims, the National Quality Strategy focuses on six priorities:

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family is engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

HHS Strategic Plan 2014-2018

Four strategic goals, all related to improving health and quality of life for all Americans

- Strategic Goal 1: Strengthen Health Care
- Strategic Goal 2: Advance Scientific Knowledge and Innovation
- Strategic Goal 3: Advance the Health, Safety, and Well-Being of the American People
- Strategic Goal 4: Ensure Efficiency, Transparency, Accountability, and Effectiveness of HHS Programs

<http://www.hhs.gov/about/strategic-plan/introduction/index.html#strategic-goals>

**QUALITY IN HOME AND COMMUNITY-
BASED SERVICES (HCBS)
DISABLED AND ELDERLY HEALTH PROGRAMS GROUP
CURRENT EXPECTATIONS**

Progression of Quality in Home and Community-Based Services

- Service systems and the co-existing expectations and definitions of quality have evolved over the years.
- 2001 HCBS Protocol Issued; Regional Office Reviews within the Waiver Renewal cycle. States expected to use the protocol to design Quality Assurance and Quality Improvement systems
- 2002 HCBS Quality Framework established

Progression of Quality in Home and Community-Based Services

Continued:

- 2008 1915(c) HCBS Waiver Application 3.5 moves from emphasis on quality improvement efforts described to a more structured approach to requiring specific elements in the Quality Improvement (QI) strategy
- 2014 HCBS guidance for 1915 (c) includes expectations for states' Quality Improvement Strategy including describing the parameters for development of performance measures by State Medicaid Agency
- New 1915(c), 1915(i) and 1915 (k) authorities have home and community based settings requirements which emphasize outcomes (integrated community lives) and rights of people with disabilities

Quality Related Changes in 1915 (c) Waivers: 2014

Collaboration between State Associations, states and CMS resulted in March 14, 2014 guidance:

Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers

Key Changes:

- Emphasizes health and welfare monitoring and outcomes
- Although states must continue to remediate issues, reporting on individual remediation to CMS will not be required except in substantiated instances of abuse, neglect or exploitation
- States' quality improvement projects/remediation will be required when the threshold of compliance with a measure is at or below 85%
- Quality measures of multiple 1915(c) waivers may be combined when waivers are managed and monitored similarly

Final Home and Community-Based Services Settings Rule

- To enhance the quality of Home and Community-Based services and provide protections to participants in each Medicaid authority.
- To ensure that individuals receiving long-term services and supports, through home and community based services under the 1915(c), 1915(i) and 1915(k) Medicaid authorities, have full access to benefits of community living and the opportunity to receive services in the most integrated setting

Final Rule published January 16, 2014 / Effective March 17, 2014

**QUALITY ASSURANCE IN HOME
AND COMMUNITY-BASED (HCB)
AUTHORITIES**

All §1915 HCB Authorities

- Require Quality Assurance and Improvement Plan
- Applies to the system covered within the authority
- Must describe how state(s) will conduct activities around
 - Discovery
 - Remediation
 - Improvement of the system

Individual Authority Details

§1915(c) Home and Community-Based Services waivers:

- Compliance with waiver assurances and sub-assurances, and how state will provide quality oversight, monitoring, discovery, remediation and improvement.
- State's Medicaid agency must describe quality improvement strategy for each of the following, including performance measures in each area:
 - Level of Care
 - Qualified providers
 - Service Planning
 - Health and welfare
 - Financial Accountability
 - Administrative authority

§1915(i) State Plan Home and Community-Based services:

- States required to develop and implement a quality improvement strategy that includes methods for ongoing measurement of program performance, quality of care, and mechanisms for remediation and improvement proportionate to the scope of services in the state plan HCBS benefit and the number of individuals to be served
- Quality assurance and improvement plan including how state conducts discovery, remediation, and quality improvement.

Individual Authority Details (continued)

§1915(j) State Plan Option for Self-Directed Personal Assistance Services:

- State must provide quality assurance and improvement plan that describe discovery, remediation and improvement process including:
 - Critical incidents or events that affect participants and corrects shortcomings
 - System of performance measures, outcome measures, and satisfaction
 - Indicators approved or prescribed by the Secretary

§1915(k) Community First Choice State Plan Option:

- State must establish and maintain a comprehensive quality assurance system that at a minimum, includes:
 - Standards for training, appeals process, and reconsideration of individual service plans
 - Incorporates feedback from consumers, other stakeholders, and the public, and maximizes consumer independence and consumer control
 - Monitors the health and well being of each individual, and includes a process for mandatory reporting, investigation and resolution of allegations of neglect, abuse or exploitation
 - Provides information about these standards and policies to each individual receiving services.

Continuous Quality Improvement – (CQI)

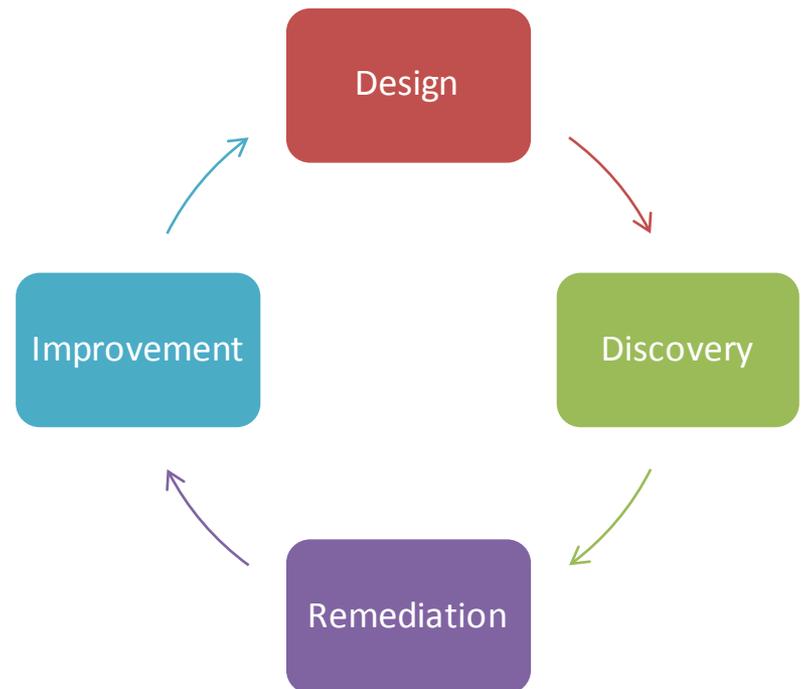
CQI is the foundation of a Home and Community-Based QI strategy. It drives CMS' partnership with states in improving the lives of beneficiaries.

Design– Design of a quality improvement strategy

Discovery– monitoring and data collection

Remediation– plan to address deficiencies

Improvement– measurable change in quality issues system-wide



1915(c) SPECIFIC ASSURANCES

Quality Improvement Strategy

- For each 1915(c) HCBS Waiver application, the state is expected to have a Quality Improvement Strategy (QIS)
 - At minimum, sets out how the state will meet the assurances from 42 CFR 441.301 and 441.302
 - Can exceed the minimum assurances and include areas the state deems critical in achieving the purpose of the waiver
 - At the time of application, the QIS must be in place; expect it will change over time
 - Describes the sampling approach used: simple, systematic, stratified, or other methodology
 - Describes the roles and responsibilities of all who have a role in any aspect of discovery, remediation or systems improvement

Assurances within 1915(c) waivers

- Administrative Authority (Quality Improvement: Appendix A)
- Level of Care (Quality Improvement: Appendix B)
- Qualified Providers (Quality Improvement: Appendix C)
- Service Plan (Quality Improvement: Appendix D)
- Health and Welfare (Quality Improvement: Appendix G)
- Financial Accountability (Quality Improvement: Appendix I)

CMS guidance on the assurances and sub-assurances can be found here:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Downloads/3-CMCS-quality-memo-narrative.pdf>

Administrative Authority

Assurance: The Medicaid Agency retains ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of the waiver functions by other state and local/regional non-state agencies (if appropriate) and contracted entities.

Sub-assurances	Summary of Revisions and Performance Measures/Reporting
No Sub-assurances	<p>Performance Measures (PMs) are required for delegated functions unless covered by PMs associated with other Assurances.</p> <p>As necessary and applicable, states should continue to focus performance measures on:</p> <ul style="list-style-type: none">• Uniformity of development/execution of provider agreements throughout all geographic areas covered by the waiver• Equitable distribution of waiver openings in all geographic areas covered by the waiver• Compliance with home and community based settings requirements and other new regulatory components

Level of Care

Assurance: The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NF, or ICF/ID-DD.

Sub-assurances:	Summary of Revisions, Performance Measures and Reporting
i. An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	Requires PM
The LOC of enrolled members is reevaluated at least annually or as specified in the approved waiver. (must be tracked, but not reported on to CMS unless requested)	No longer required to track as a PM, however, statutory requirement for meeting re-evaluation still exists.
ii. The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine <u>initial</u> participant level of care.	Remains intact. PM needed.

Service Plan

Assurance: The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-assurances	Summary of Revisions, Performance Measures and Reporting
i. Service plans address all members' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.	Requires PM
The state monitors service plan development in accordance with its policies and procedures.	No longer reported to CMS routinely, however state must still develop service plans in accordance with their policies and procedures
ii. Service plans are updated/ revised at least annually or when warranted by changes in the waiver participant's needs.	Requires PM
iii. Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.	Requires PM
iv. Participants are afforded choice between/among waiver services/providers	Requires PM on choice between and among services and providers (No longer required to report on choice between HCBS and Institutional care)

Qualified Providers

Assurance: The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Sub-assurances:	Summary of Revisions, Performance Measures and Reporting
i. The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to furnishing waiver services	Requires PM
ii. The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.	Requires PM
iii. The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.	Requires PM

Health and Welfare

Assurance: The State demonstrates it has designed and implemented **an effective system for assuring waiver participant health and welfare.**

Sub-assurances:	Summary of All New Sub-assurances and Performance Measure Reporting *
i. The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death	Waiver Application Appendix G: Safeguards must report on the sub assurance in evidence reporting.
ii. The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible	Waiver Application Appendix G: Safeguards must report on the sub assurance in evidence reporting.
iii. State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed	Waiver Application Appendix G: Safeguards must report on the sub assurance in evidence reporting.
iv. The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver	Waiver Application Appendix G: Safeguards must report on the sub assurance in evidence reporting.

*States may elect to include participant self-direction in these performance measures.

Important note on Individual Remediation

- States with an HCBS 1915(c) waiver which has been approved or renewed after March 17, 2014 **must continue to report individual remediation activities to CMS which are related to any substantiated instances of abuse, neglect, or exploitation.**
- For all other remediation activities, states within these approval parameters need only report systemic data.

Financial Accountability

Assurance: The State must demonstrate that it has designed and implemented an adequate system for ensuring financial accountability of the waiver program.

Sub-assurances: Revised	Summary of Revisions, Performance Measures and Reporting
i. The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered	Adjusted to include “only for services rendered”.
ii. The State provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle	Newly added sub-assurance to assure consistency with methodology for the duration of the waiver cycle.

Revised Evidence Report Decision Rule: Determining Whether an Assurance Is Met/Not Met

Assurance is determined NOT met when:

- State did not provide data for a performance measure
- Performance measure is less than 86% in any waiver year **AND** state has not initiated a Quality Improvement (QI) Project **AND/OR** CMS does not accept justification why QI Project has not been initiated
- Performance Measure is below 86% for 3 or more years, regardless of whether a QI Project has been implemented. *Exception: There has been steady improvement over the years and CMS and the state agree that performance is likely to exceed 85% the following year*
- CMS discovers that adequate and appropriate remediation for any Performance Measure associated with any sub-assurance (under the given assurance) did not occur
- State did not provide an aggregated report on individual remediation for substantiated abuse, neglect and exploitation (*Health & Welfare Sub-assurance ii*)

Systemic Quality Improvement (QI) Projects

- If compliance on any performance measure is less than 86%, state must conduct further analysis to determine the cause(s) of performance problem(s).
- Based on further analysis, if state determines the problem is systemic, then a QI Project must be developed.
- Evidence Report must describe QI Project(s) undertaken & status.
- States are encouraged to mobilize existing state quality activities as available to target identified issues (e.g. a state's fall prevention program).

TYPES OF REPORTING: REMEDICATION AND CONSOLIDATED

Remediation Reporting Requirements

Current Revised Remediation Reporting

Individual remediation does not have to be reported in the Evidence Report Submitted by the state, with the exception of substantiated instances of abuse, neglect and exploitation.

Expectation that state has a mechanism for measuring its effectiveness in addressing non-performance; results are subject to audit by CMS.

States must ensure they are conducting remediation in areas where lower than 86% performance levels exist. CMS may institute an audit to assure remediation is occurring

Evidence Reports Include Systemic QI Project Reports

Common Steps in a QI Project Report:

- Identify probable cause(s) of problem (use of a systemic, analytical approach such as the 7 Basic Quality Tools to identify).
- Identify goals for performance improvement.
- Develop intervention(s) to improve performance (targeted to address the cause of problem).
- Allow adequate time for intervention to have an effect.
- Measure impact (does performance increase, decrease, remain the same?)
Was the impact enough? Was goal met?
- Did the intervention work? If not, why not? Was it the right intervention?
Implemented as intended?
- If results are not positive, explore other interventions.
- Report all of the above in the evidence report. If QI project not complete at time of report, provide a description and progress to date.

Consolidated Reporting

State(s) may desire to achieve efficiency by consolidating reporting for some, or all, 1915(c) HCBS Waivers.

CMS may accept a consolidated evidence report for multiple HCBS waivers when all of the following conditions are met:

- Design of the HCBS waiver(s) is same/very similar, AND
- Sameness is determined by comparing:
 - Participant services and
 - Participant safeguards and
 - Quality management , AND
- Quality Management approach is the same, or very similar, across HCBS waivers, including:
 - Methodology of discovery, and
 - Manner in which individual issues are remediated, and
 - Process for identifying and analyzing patterns/trends is same or very similar, and
 - Majority of performance indicators are same, AND
- Provider networks is same or very similar, AND
- Provider oversight is same or very similar

Wrap Up

- Questions
- Next Steps
- Next Webinar sponsored by CMS:

For Further Information

For questions contact:

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Thank you for attending today's webinar!