



Improvements in 1915c Waiver Quality Requirements

*Division of Long-Term Services & Supports
Disabled and Elderly Health Programs Group*

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Overview

- Background (why the changes)
- History & Composition of the Quality Workgroup
- Improvements in Quality Requirements
- Revised Decisions Rules for Determining if an Assurance is Met/Not Met
- Implementation
- Q & A

Background

- State Associations' request to work more closely in partnership with CMS on requirements
- Natural process of Continuous Quality Improvement (CQI)
- Decrease State reporting burden
- Focus on measurement (evidence) most meaningful for program quality

Quality Workgroup

- Formed in Autumn 2011
- Representatives:
 - CMS Central & Regional Offices
 - State Associations (NAMMD, NASUAD, NASDDDS)
 - 11 States, representing
 - Medicaid Agencies, ID/DD & Aged/Disabled Operating Agencies
 - National Quality Enterprise (logistics & consulting to CMS)

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Quality Workgroup, con't

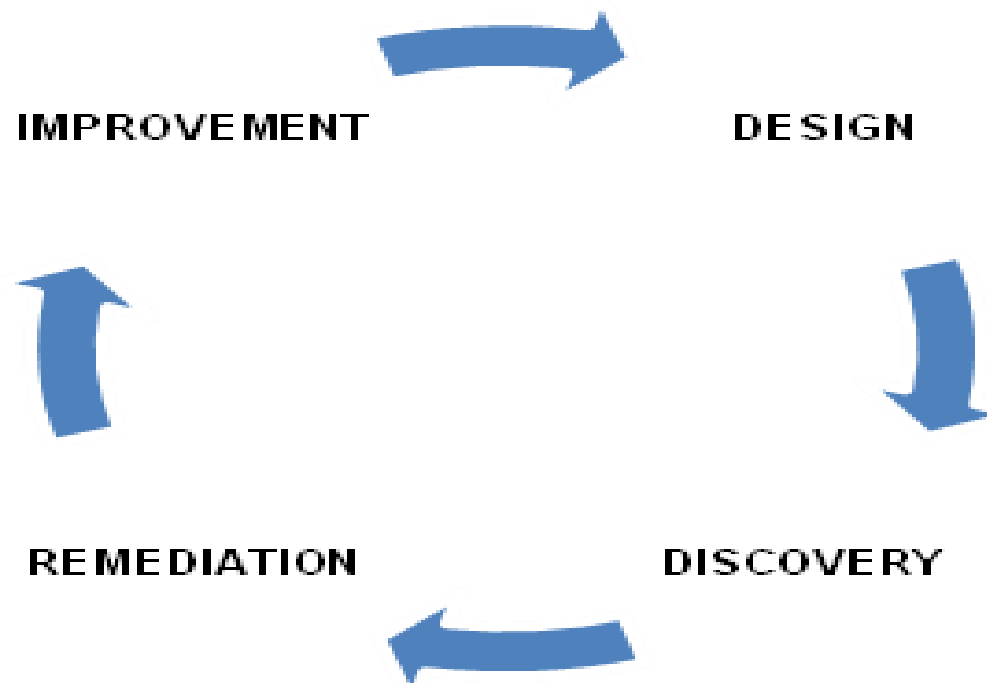
- Met 18 times
 - Between 10-6-2011 and 3-13-2013
- Additional smaller workgroup meetings between full workgroup meetings
- Workgroup recommendations
- Internal CMS review process

Improvements In Quality Requirements

Improvements in Quality Requirements

- Overview
 - Assurances and Subassurances
 - Reporting on Remediation
 - Quality Improvement Projects
 - Consolidating Reporting Across Multiple Waivers

No Change in CQI Life Cycle Expectations



Evidence Collection & Analysis Requirements

- No change
- Collect and analyze “Discovery” data as specified in the approved waiver
 - Frequency of data collection & analysis can vary by Performance Measure (PM)

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Evidence Collection, Analysis & Reporting Requirements

- Submit Evidence Report to CMS
 - Evidence for each PM specified in waiver application
 - For waivers approved for 5 years:
 - Evidence submitted 21 months prior to expiration
 - Minimum of 3 years of evidence
 - For waivers approved for 3 years (some new waivers)
 - Evidence submitted 15 months prior to expiration
 - 18 months of evidence

Reporting on Remediation: Revision

Reporting on Remediation

- Current Requirement
 - Evidence Report must include aggregated remediation reports
 - Tables/charts on number and types of remediation actions taken in response to instances of < 100% compliance on a given Performance Measure
 - Constitutes evidence that remediation at individual level has occurred

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Reporting on Remediation, con't

- Revised Requirement
 - Remediation does not have to be reported in Evidence Report
 - Exception: Substantiated instances of abuse, neglect and exploitation
 - Expectation that State has a mechanism for measuring its effectiveness in addressing non-performance
 - Mechanism and measurement results are subject to audit by CMS

Revisions to Assurances & Subassurances

Level of Care Revisions

- No change in Assurance wording
- Decrease in number of subassurances from 3 to 2
- Revision: Reporting on annual re-evaluations no longer required
 - States must still conduct annual re-evaluations, per statutory requirement

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Level of Care Revisions, con't

Level of Care – Current	Level of Care -- Revised
<p>Assurance: <i>The State demonstrates that it implements the process and instrument(s) specified in the 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.</i></p>	
<p>a. Subassurance – An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be need in the future</p> <p>a. Subassurance -- The LOC of enrolled members is reevaluated at least annually or as specified in the approved waiver</p> <p>b. Subassurance -- The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care</p>	<p>i. Subassurance – An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be need in the future</p> <p>ii. Subassurance -- The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care</p>

Service Plan Revisions

- No change in Assurance wording
- Decrease in number of subassurances from 5 to 4
- No reporting on service plan (SP) development
 - States must still develop SP in accordance with their policies/procedures
- Reporting on choice now focuses on choice between/among waiver services/providers
 - States must continue to ensure the individual has been offered choice between waiver services and institutional care, as required by statute, but do not have to report on this task for quality purposes

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Service Plan Revisions, con't

Service Plan – Current	Service Plan -- Revised
Assurance: <i>The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for the waiver participants.</i>	
<p>a. Subassurance -- 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</p> <p>b. Subassurance -- The State monitors service plan development in accordance with its policies and procedures</p>	<p>I. Subassurance: 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</p>

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Service Plan Revisions, con't

Service Plan – Current	Service Plan -- Revised
<p>c. Subassurance – Service Plans are updated/ revised at least annually or when warranted by changes in the waiver participant’s needs</p> <p>d. Subassurance -- Service plans are delivered in accordance with the service plan including the type, scope, amount, duration and frequency specified in the service plan</p> <p>e. Subassurance -- Participants are afforded choice Between waiver services and institutional care; and between/among waivers services/providers</p>	<p>ii. Subassurance – Service Plans are updated/ revised at least annually or when warranted by changes in the waiver participant’s needs</p> <p>iii. Subassurance -- Service plans are delivered in accordance with the service plan including the type, scope, amount, duration and frequency specified in the service plan</p> <p>iv. Subassurance – Participants are afforded choice: between/among waiver services/providers</p>

No Change in Qualified Providers

- No change in Assurance wording
- No change in Subassurances

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No Change in Qualified Providers, con't

No Change in Assurance or Subassurances

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

- i. **Subassurance** -- 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
- ii. **Subassurance** – The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements
- iii. **Subassurance** – The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver

Health and Welfare Revisions

- Assurance wording revised to focus more broadly on health and welfare
- Four (4) new Subassurances, with focus on:
 - Abuse, neglect, exploitation & unexplained death
 - Incident management
 - Restrictive interventions
 - Health care standards
- New Subassurances consistent with Waiver Application, Appendix G - Safeguards

Health and Welfare, con't

Health and Welfare – Current	Health and Welfare – Revised
<p><i>Assurance: On an ongoing basis the State identifies and seeks to prevent instances of abuse, neglect and exploitation</i></p>	<p><i>Assurance: The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare</i></p>
	<ul style="list-style-type: none"><li data-bbox="981 565 1773 733">i. Subassurance – The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death<li data-bbox="981 768 1812 936">ii. Subassurance -- 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<li data-bbox="981 971 1812 1139">iii. Subassurance – State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed<li data-bbox="981 1173 1746 1342">iv. Subassurance --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

Financial Accountability Revisions

- Assurance wording revised to more broadly reflect the financial accountability requirement
- CMS added one subassurance to address consistency of rate methodology over the waiver cycle
- Expectation that States continue to report evidence that claims are coded/paid in accordance with rate methodology

Financial Accountability, con't

Financial Accountability – Current	Financial Accountability – Revised
<p>Assurance: State financial oversight exists to assure that claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver</p>	<p>Assurance: The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program</p>
	<ul style="list-style-type: none"> <li data-bbox="981 696 1816 905">i. Subassurance - 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 <li data-bbox="981 962 1789 1129">ii. Subassurance – The State provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle

Administrative Authority

- No change in Assurance description
- No subassurances
- PMs required for delegated functions unless covered by PMs associated with other Assurances

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Administrative Authority

- States should continue to focus PMs, as applicable/necessary, on:
 - Uniformity of provider agreements across all geographic areas of the State
 - Equitable distribution of waiver openings across all geographic areas of the State
 - Compliance with HCBS settings requirements and other **new** regulatory components

Administrative Authority, con't

Administrative Authority – Current	Administrative Authority – Revised
<p>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.</p>	<p>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.</p>
No Subassurances	No Subassurances

Implementing Quality Improvement Projects

Implementing Quality Improvement (QI) Projects

- Less than 86% on any Performance Measure
 - Threshold for indicating need for improvement
 - Triggers the need for further analysis to determine the cause(s) of performance problem(s)
- Based on further analysis, if state determines problem is systemic, then QI Project must be developed
 - Unless State presents justification, accepted by CMS, that no QI project is necessary

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Implementing QI Projects, con't

- Evidence Report must describe QI Project(s) undertaken and its status
- States are encouraged to leverage existing state quality activities as available to target identified issues (i.e. fall prevention program)

Possible Justifications for Not Conducting a QI Project

- One QI Project addresses performance issue that spans two or more PMs that are below 86%
- State demonstrates significant movement toward 86%, suggesting 86% will be met within the year
 - e.g., three consecutive years of measurement: 76%, 80%, 83%

Conducting a QI Project

- Identify probable cause(s) of problem
 - Often involves further analysis of issue
- Develop intervention(s) designed to improve performance
 - Interventions should be specific to cause of problem
 - Possible Interventions: training, revised policies/procedures, additional staff, different staffing patterns, monetary incentives and/or penalties, etc.

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Conducting a QI Project, con't

- Allow enough time for intervention to have an effect
- Measure impact (does performance increase, decrease, remain the same?)
 - Was the impact enough?
 - Did the intervention work? If not, why not?
 - Was it the right intervention?
 - Was the intervention implemented as intended (fidelity)?
- If results not positive, explore other interventions
- **REPORT ALL OF THE ABOVE IN THE EVIDENCE REPORT**
 - IF QI project not complete when you submit evidence, report on accomplishments to date (status of QI Project)

Consolidating Reporting Across Multiple Waivers

Consolidated Reporting Across Multiple Waivers

- Evidence Report includes Discovery (PMs) and Quality Improvement activities for multiple waivers combined
- Rationale:
 - If waivers are managed & monitored similarly, Discovery and Improvement results for the “system” are expected to be the same as for each individual waiver
 - More efficient Discovery methods (i.e., sampling when invoked)
 - Sample size for consolidated report smaller than sum of samples for individual waivers

Pre-requisites for Consolidated Reporting

- To combine waivers for reporting (Evidence Reports), five conditions must be met:
 1. Design of the waivers is same/very similar
 2. Sameness/similarity determined by comparing waivers on approved Waiver Application Appendices:
 - C: Participant Services
 - D: Participant-Centered Planning and Service Delivery
 - G: Participant Safeguards
 - H: Quality Management

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Pre-requisites for Consolidated Reporting, con't

3. Quality management approach is the same/very similar across waivers, including:
 - Methodology for discovering information (e.g., data systems, sample selection)
 - Manner in which individual issues are remedied
 - Process for identifying & analyzing patterns/trends
 - Majority of Performance Measures are the same
 4. Provider network is the same/very similar
 5. Provider oversight is the same/very similar
- All of these conditions must be met

Sampling for Consolidated Reporting

- Sampling method must be proposed in Waiver Application (or through amendment), and approved by CMS
- Various sampling approaches are acceptable

Consolidating reporting for Waivers on Different Waiver Cycles

Waivers may be on different cycles and have different Evidence Report due dates

	Expiration Date	Evidence Due
Waiver 1	June 30, 2016	March 31, 2014
Waiver 2	September 30, 2016	June 30, 2014
Waiver 3	February 28, 2018	November 30, 2015

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Consolidating Waivers on Different Waiver Cycles, con't

- State must propose to CMS when Consolidated Evidence Report will be submitted
- If PMs are not exactly the same for all waivers, State must propose to CMS when “outlier” PMs will be reported to CMS
 - Logical options:
 - With Consolidated Evidence Report
 - When Waiver Evidence Report would normally be due

Revised Decision Rule:
Determining if an Assurance Is
Met/Not Met

Revised Decision Rule

An assurance is NOT MET if any of the following occur:

1. State did not provide Performance Measure evidence for each subassurance (under the given assurance)
2. A Performance Measure for one or more subassurances (under the given assurance) is less than 86% in any waiver year

AND

The State has not initiated a Quality Improvement (QI) Project **AND/OR** does not provide acceptable justification for why the QI Project has not been initiated to address the performance issue

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Revised Decision Rule, con't

3. A Performance Measure for any subassurance (associated with the given assurance) is below 86% for three (3) or more years, regardless of whether a QI Project has been implemented
 - *Exception: Unless there has been steady improvement over the years and CMS and the State agree that performance is likely to exceed 85% the following year*
4. CMS discovers that adequate and appropriate remediation for any Performance Measure associated with any subassurance (under the given assurance) did not occur

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Revised Decision Rule, con't

In addition, the Health & Welfare Assurance shall be considered NOT MET if:

5. The State did not provide an aggregated report on individual remediation for substantiated instances of abuse, neglect and exploitation (*Health & Welfare Subassurance ii*)

Implementing the Improved Quality Requirements

Implementing the Changes

Changes to be implemented via Waiver Amendment, Renewal or Initial Application

- Short Term - CMS issued an Informational Bulletin in March, 2014
 - All new waivers and renewals submitted after June 1, 2014 must have the new system
 - The bulletin is on the 1915(c) waiver page on Medicaid.Gov
- Long Term- CMS is in process of updating the Waiver Application and Technical Guide

QUESTIONS ?

Follow up questions may be sent to:

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