Design and Management of Evidence-Based HCBS Quality Improvement Strategy

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HCBS CONFERENCE 2010

QUALITY IMPROVEMENT FOR HCBS PROGRAMS

Anita Yuskauskas
CMS Technical Director, HCBS Quality
WHAT DOES CMS EXPECT???
WHAT DO MEDICAID BENEFICIARIES EXPECT?

WHAT DOES CONGRESS EXPECT?
CMS Quality Vision: The Triple Aim

Improve the health of the population;
Enhance the patient experience of care (including quality, access, and reliability); and
Reduce, or at least control, the per capita cost of care.
## CMS QUALITY ARCHETYPE

### Telling the Story

<table>
<thead>
<tr>
<th>Are People Better Off?</th>
<th>Outcome Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are People Receiving Quality Services?</td>
<td>Quality of Care Measures</td>
</tr>
<tr>
<td>Are States Doing What They Agreed To?</td>
<td>Process Measures</td>
</tr>
</tbody>
</table>
LTC Expenditures by Payer: United States, 2005

- Medicaid: 48.9%
- Medicare: 20.4%
- Out-of-Pocket: 18.1%
- Private Insurance: 7.2%
- Other Private: 2.7%
- Other Public: 2.6%

Source: Georgetown University Long-Term Care Financing Project
Chart 1: Percent of Medicaid Long-Term Care Expenditures for HCBS, FY 1997 - 2009
Medicaid Institutional and Community-Based Expenditures in 2005 Dollars: FFY 1980-2005

Source: CMS Form 64 Reports, adjusted for price increases based on the Skilled Nursing Facility Input Price Index.
Projected Changes in Coverage by 2019

Total new coverage = 32 million

Source: Congressional Budget Office, M: Centers for Medicare & Medicaid Services
RECENT LEGISLATIVE TRENDS & QUALITY MEASUREMENT

- Deficit Reduction Act
- The Recovery Act
- CHIPRA
- Affordable Care Act
AFFORDABLE CARE ACT: MORE THAN COVERAGE EXPANSION

Quality:

– Adult Health Quality Measures in Medicaid

– National Strategy for Quality Improvement in Health Care:
  • Interagency Work group on Health Care Quality
  • Convene Multi-stakeholder Groups to provide input on quality measures

– Other Provisions call for Collection & Reporting of Quality Info: Health Homes, Community First Choice
<table>
<thead>
<tr>
<th>PROVISION</th>
<th>QUALITY MEASURES/SYSTEMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 2701 Adult Quality measures</td>
<td>Core set of adult health quality measures, Establish a Quality Program</td>
</tr>
<tr>
<td>Section 2401 Community First Choice</td>
<td>QA system that monitors health &amp; well being, incorporates feedback from consumers, includes standards on training, appeals &amp; reconsideration procedures</td>
</tr>
<tr>
<td>Section 10202 Balancing Incentive Program</td>
<td>Set of core quality measures, consumer/caregiver experience w providers, satisfaction with services, employment, health stability, participation in community life &amp; prevention of loss of function</td>
</tr>
<tr>
<td>Section 2703 Health Homes</td>
<td>QI &amp; outcomes re chronic disease management, care coordination &amp; cost savings</td>
</tr>
</tbody>
</table>
Medicaid HCBS Quality
based on Section 1915(c) program

Method

1. Continuous Quality Improvement applied to Statutory Assurances

- **Design**: State defines QI strategy in web-based application, including performance measures & sampling strategies
- **Discovery**: State monitors implementation of QI strategy & reports on results using performance measures
- **Remediation**: State corrects individual areas of noncompliance and reports on results
- **Improvement**: State institutes systemic corrective actions to improve performance
Medicaid HCBS Quality
based on Section 1915(c) program

Method

2. Evidence-Based Approach

- State produces data on performance measures
- CMS requests data/evidence report from State
- CMS provides Findings report to State based on submitted evidence one year prior to Waiver renewal.
  - Findings report includes recommendations for needed changes in renewal application
What Does CMS Expect? : The Triple Aim

Improve the health of the population;
Enhance the patient experience of care (including quality, access, and reliability); and
Reduce, or at least control, the per capita cost of care.
What Does CMS Expect?

• The State and provider are fulfilling the obligations as set out for the HCBS program – i.e., as defined in statute and regulations (and provider agreements, as appropriate).

• Recipients of HCBS services are better off.

• The services and care provided are beneficial and aim to achieve good outcomes.
But, now I will tell you a secret – a mystery. Those who suffer need you to be something more than a doctor; they need you to be a healer. And, to become a healer, you must do something even more difficult than putting your white coat on. You must take your white coat off. You must recover, embrace, and treasure the memory of your shared, frail humanity – of the dignity in each and every soul. When you take off that white coat in the sacred presence of those for whom you will care – in the sacred presence of people just like you – when you take off that white coat, and, tower not over them, but join those you serve, you become a healer in a world of fear and fragmentation, an “aching” world... that has never needed healing more.

Yale Medical School Graduation Address
Donald M. Berwick, MD, MPP
New Haven, Connecticut: May 24, 2010
HCBS CONFERENCE 2010

CQI DESIGN & MANAGEMENT FOR HCBS PROGRAMS

Beth Jackson, Ph.D
NQE Director, Thomson Reuters
CONTINUOUS QUALITY IMPROVEMENT (CQI)

IMPROVEMENT ➔ DESIGN

REMEDICATION ➔ DISCOVERY

“DDRI”

The National HCBS Quality Enterprise, a Grant Funded by CMS
CQI PARADIGM

• Evidence-based
  – State must use evidence to monitor the waiver
  – State must use evidence to demonstrate compliance to CMS

• Cyclic in nature

• Monitoring and improvement ongoing
  – Not a one-time event

• State has the primary responsibility for monitoring
  – State makes assurances to the Federal Government

• CMS’ role is to insure the state is sufficiently monitoring the program and in compliance with assurances
QUALITY IMPROVEMENT STRATEGY

State’s road map (*Design*) – for producing and using evidence to monitor & improve the program.
Quality Improvement Strategy (QIS)

• Tied to the 6 Assurances
• Performance Measure(s) required for each assurance/subassurance
  • Will indicate whether the state is in compliance with a particular assurance
  • Will indicate the extent to which the state must “remediate” problems discovered
1915(c) Waiver Assurances

State commits to Federal Government it will meet all assurances

1. Persons enrolled in the waiver have needs consistent with an institutional level of care (Level of Care)
2. Participants have a service plan that is appropriate to their need and that they receive the services/supports specified in the plan (Service Plan)
3. Waiver providers are qualified to deliver services/supports (Qualified Providers)
4. Participants’ health and welfare are safeguarded and monitored (Health and Welfare)
5. Claims for waiver services are paid according to state payment methodologies (Financial Accountability)
6. The State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for all facets of the program (Administrative Authority)
SUBASSURANCES

• For several assurances, CMS has articulated subassurances
  • Subassurances operationalize CMS’ interpretation of what assurances mean
  • Further define the assurances
  • Insure that states monitor the aspects of the program CMS deems fundamental

Examples of Subassurances

Level of Care (b): The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver

Service Plan (a): Service plans address all participants’ assessed need (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means

Service Plan (c): Service plans are updated at least annually or when warranted by changes in the waiver participant’s needs
I. Designing Your QIS

• Designing Discovery Processes
• Designing Remediation Process
• Designing Improvement Process
Designing Discovery Processes
Designing the Discovery Process

• Developing Performance Measures
• Insuring Data are Representative
• Determining Where the Data for the PMs will come from
• Specifying who is responsible for “collecting” the data
• Specifying who is responsible for generating reports
• Specifying how frequently reports will be run
• Specifying who is responsible for monitoring discovery data for compliance and trends
<table>
<thead>
<tr>
<th>Performance Measure:</th>
<th>Data Source [e.g. – examples cited in IPG]</th>
<th>Responsible Party for data collection/generation (check each that applies)</th>
<th>Frequency of data collection/generation: (check each that applies)</th>
<th>Sampling Approach (check each that applies)</th>
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</thead>
<tbody>
<tr>
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<td>☐ State Medicaid Agency</td>
<td>☐ Weekly</td>
<td>☐ 100% Review</td>
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<td>☐ Other: Specify:</td>
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<td>Data Aggregation and Analysis</td>
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WHY PERFORMANCE MEASURES (PMs)?

Well-crafted PMs become indicators of whether the state is meeting the assurances made to CMS in the approved 1915c waiver.

PMs drive the waiver’s Quality Improvement Strategy.

They form the basis of the evidence state provide to CMS to demonstrate the state has met the assurances.
Characteristics of Good PMs

• Measurable
• Stated as a metric
• Able to be aggregated
• Have face validity
• Based on the correct unit of analysis
• Representative
NQE Quality Forums on Performance Measures

NQE Website: www.nationalqualityenterprise.net/nqe

- Performance Measures – Part 1 (January 2010)
- Performance Measures – Part 2 (March 2010)

Copies of slides and recorded calls are available on the NQE website
A PM SHOULD BE MEASURABLE AND STATED AS A METRIC

- Measureable: can take on different values
- If measurable, the PM will indicate when the assurance/subassurance has or has not been met, and to what extent it has been met
- PM should **not** be a description of a policy or procedure
- Most PMs are stated as a percentage

**Unacceptable PM:** The Division of Aging conducts record reviews to assess whether service plans of waiver participants are reviewed and updated annually.

- Describes monitoring process, not the outcome of the monitoring

**Acceptable PM:** Percent of waiver participants whose service plans were reviewed and updated annually.

- Describes the outcome of the monitoring process (what was found when monitoring was conducted)
FORMAT OF PMs

3 Components:

• Number
• Percent
• Specify Numerator and Denominator

Example:

• *Number and percent of participants with a risk assessment conducted*
• *Numerator = number of participants with risk assessment completed and in participant’s record;*
• *Denominator = all record reviews conducted*
PMs SHOULD BE ABLE TO BE AGGREGATED

- Data must be able to be aggregated across waiver participants, providers, claims – depending on the assurance or subassurance
  - Way to summarize how the waiver, as a whole, has operated
- Aggregation allows for the generation of reports on the entire waiver population, providers or claims
  - Provides the big picture
- Aggregated PM reports help the state monitor program quality
- Aggregated PM reports provide information on compliance with the assurances/subassurances
PMs SHOULD HAVE FACE VALIDITY

- Does the PM truly measure the subassurance?
- “On the face of it” does it track with the subassurance?
- PMs with face validity are instrumental in monitoring the state’s performance on a given subassurance
- Risk a state runs if PM lacks face validity:
  - Collection of potentially useless information
  - Potential waste of resources
  - Inability to monitor one aspect of the waiver
  - Inability to demonstrate to CMS compliance with an assurance/subassurance
CHOOSING THE CORRECT UNIT OF ANALYSIS

• Unit of analysis refers to the group/entity your PM pertains to
• Certain assurances tend to focus on waiver participants
  • Level of Care
  • Service Plan
  • Health and Welfare
• One assurance focuses on provider
  • Provider Qualifications
• One assurance tends to focus on claims
  • Financial Accountability
UNIT OF ANALYSIS EXAMPLES

• For LOC, SP and some H&W the correct unit of analysis is the participant

  – Number and percent of participants with adequate and appropriate service plans

  – Number and percent of participants who have a valid level of care prior to receiving waiver services

• For some H&W performance measures the unit of analysis may be critical incidents or deaths

  – Number and percent of critical incident reviews/investigations that were completed within required time frames as specified in the approved waiver

  – Number and percent of unexplained, suspicious and untimely deaths for which review/investigation resulted in the identification of preventable causes
UNIT OF ANALYSIS EXAMPLES, CON’T.

• For Provider Qualifications the correct unit of analysis is the provider
  – *Number and percent of home care agencies meeting the state’s qualifications at annual recertification*

• For financial accountability, the correct unit of analysis is often claims
  – *Number and percent of claims for which payment was made for beneficiaries eligible for Medicaid on date of service rendered*
  – *Number and percent of claims for which payment was made where service was included in the participant’s service plan*
Representativeness of Performance Measure Data

- Performance Measure data must be representative
  - Of the waiver population as a whole
  - Of providers
  - Of claims
- If not representative, then the Performance Measure data will not provide sufficient information to describe the waiver’s performance on any given subassurance
Two Paths to “Representativeness”

– **PM data are based on a 100% “sample” – the entire population**
  - Administrative data usually the source of population-based data
  - Inefficient to “collect” data on the entire population if the population is large
  - If the waiver size is small, it may make sense to use 100% sample

– **PM data are based on a “representative” sample**
  - Efficient – don’t have to review every case record or survey every waiver participant
  - Select a subgroup to represent the whole population
  - Sample must be randomly selected
  - Sample parameters must be credible
  - Sample size must be large enough
Sample Size: What is Large Enough?

NQE Quality Forum on Sampling
(May 2010)

NQE Website: www.nationalqualityenterprise.net/nqe

Copies of slides and recorded calls are available on the NQE website
Examples of Assurance-Based Performance Measures

Performance Measures – Part 1
(January 2010)

Performance Measures – Part 2
(March 2010)

NQE Website: www.nationalqualityenterprise.net/nqe

Copies of slides and recorded calls are available on the NQE website
Where will your data come from?

• Likely multiple sources, depending upon the PM
  – Administrative data
  – Chart reviews
  – Critical incident system
  – Provider surveys
  – Etc.

• Important step in developing PMs
  – Identify the source of data for the numerator and denominator of a PM
Other things to determine in designing your *Discovery Process*

- Specifying who is responsible for “collecting” the data
- Specifying who is responsible for generating reports
- Specifying how frequently reports will be run
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47
Designing Remediation Processes
b. Methods for Remediation/Fixing Individual Problems

b.i Describe the State’s method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the State to document these items.
Remediation Methods

- What actions you will take to address (fix) non-compliance in each Performance Measure?
- Time frames for accomplishing remediation actions
- Sanctions (if any) imposed for non-compliance or remediation not occurring in a timely fashion
- Who is responsible for monitoring that remediation occurs?
  - That correction actions are issued?
  - That corrective actions are implemented?
Tips for Designing Remediation Actions

• Remediation actions must be tailored to each non-compliance in each PM/subassurance
  – May need different remediation actions for different subassurances under the same assurance
  – 3.5 has one remediation section for ALL subassurances

• Important step in designing remediation: develop specific actions that will be invoked for non-compliance with a given PM/subassurance.
### Remediation Data Aggregation

<table>
<thead>
<tr>
<th>Remediation-related Data Aggregation and Analysis (including trend identification)</th>
<th>Responsible Party (check each that applies)</th>
<th>Frequency of data aggregation and analysis: (check each that applies)</th>
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</table>
Designing Quality Improvement Processes
Designing the Quality Improvement Process

H.1 Systems Improvement

H.1.a.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.

H.1.a.ii

<table>
<thead>
<tr>
<th>System Improvement Activities</th>
<th>Responsible Party (check each that applies)</th>
<th>Frequency of monitoring and analysis (check each that applies)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Medicaid Agency</td>
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</tr>
<tr>
<td>Other: Specify:</td>
<td>☐ Other: Specify:</td>
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</tbody>
</table>

H.1.b.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, and how the results of the changes and the assessment are communicated (and with what frequency) to stakeholders, including participants, families, providers, agencies and other interested parties. If applicable, include the State’s targeted standards for systems improvement.

H.1.b.ii Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.
Designing the Quality Improvement Process

• Focus is on SYSTEM and Improvement
  – Different than Remediation of individual problems identified in the discovery process
  – Focus is on system redesign and QIS redesign
Designing the Quality Improvement Process

- Processes for establishing priorities, developing strategies for assessing system improvements (design changes)

- Processes to evaluate effectiveness of system improvement and revise if necessary

- Process/timelines for compiling improvement info and communicating to stakeholders (participants, family, providers, public, etc.)

- Frequency and processes for evaluating and revising the QIS
II. Managing Quality
Managing Quality

• Managing Discovery Activities
• Managing Remediation Activities
• Managing Quality Improvement Activities
Discovery Activities

• Generate Discovery Reports
  – On a routine basis
  – As you indicated in the waiver application
    • “Frequency of data aggregation...”

• Analyze Discovery Reports
  – On a routine basis as specified in the waiver application
    • “Frequency of data aggregation and analysis”
  – Assess level of compliance with each subassurance
  – Link to Remediation Activities
Elements of a Discovery Report

- Time period the evidence covers
- Date report generated
- Performance Measures identified
- Initial compliance rate (percent, number/sample size)
**Example of a Quarterly Discovery Management Report**

Second Quarter CY 2010
Discovery Report
Report Generation Date: July 15, 2010

**PM:** Number/\% of participants who received an annual redetermination of eligibility within 12 months of their initial LOC evaluation or within 12 months of their last evaluation

<table>
<thead>
<tr>
<th></th>
<th>Compliance Rate Jan-Mar 2010</th>
<th>Number Sampled Jan-Mar 2010</th>
<th>Compliance Rate April-June 2010</th>
<th>Number Sampled April-June 2010</th>
<th>Cumulative Compliance Rate CY 2010</th>
<th>Cumulative Sampled CY 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance</td>
<td>82%</td>
<td>67</td>
<td>88%</td>
<td>72</td>
<td>85%</td>
<td>139</td>
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<tr>
<td>Non-Compliance</td>
<td>18%</td>
<td>15</td>
<td>12%</td>
<td>10</td>
<td>15%</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>82</td>
<td>100%</td>
<td>82</td>
<td>100%</td>
<td>164</td>
</tr>
</tbody>
</table>

**Projected Sample Size for CY 2010: 330**
Compliance

<100% Discovery Evidence + 100% Remediation Evidence = 100% Compliance
Remediation Activities

• Identify Need for Remediation
  – Anything less than 100% compliance
    • In the Discovery Phase

• Identify Types of Remediation Actions Needed
  – Remediation must address/fix the problem
discovered (tailored to the problem)
  – PM and Subassurance-specific

• Insure Remediation Actions are accomplished
  – And accomplished in a timely fashion as specified
  by state
Remediation Activities, con’t

• Document Remediation Actions
  – Requires a system for documenting

• Generate Remediation Reports
  – On a routine basis
  – As you specified in the waiver application
    • “Frequency of data aggregation...”

• Analyze Remediation Reports
  – Assess completeness of remediation
  – Assess timeliness of remediation
Elements of a Remediation Report

– Enumerate Remediation Activities
  • Categories of remediation actions
– Tie to prior non-compliance
– Include # of actions per category
– Identify/address outstanding remediation actions not completed
Example of a Quarterly Remediation Management Report

<table>
<thead>
<tr>
<th>Remediation Actions</th>
<th># of Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-evaluation conducted; still eligible</td>
<td>12</td>
</tr>
<tr>
<td>Re-evaluation conducted; not eligible</td>
<td>2</td>
</tr>
<tr>
<td>• Referred to state-funded program</td>
<td>2</td>
</tr>
<tr>
<td>• Claims from period of ineligibility excluded from FFP</td>
<td>2</td>
</tr>
<tr>
<td># Remediation completed ≤ 30 days</td>
<td>1</td>
</tr>
<tr>
<td># Remediation completed 31-60 days</td>
<td>1</td>
</tr>
<tr>
<td># Remediation completed ≥ 60 days</td>
<td>0</td>
</tr>
<tr>
<td># Outstanding remediation actions*</td>
<td>1</td>
</tr>
<tr>
<td>Total instances of non-compliance addressed</td>
<td>29</td>
</tr>
</tbody>
</table>

*One annual redetermination remains outstanding. Case notes state that the participant temporarily hospitalized out of state and arrangements underway to conduct redetermination.
State Report Generation

Not Just For CMS Evidence Request

Continuous and Ongoing
Managing Quality Improvement Activities

• Trend Discovery and Remediation Data
• Identify quality improvement actions/projects
• Prioritize implementation of quality improvement actions/projects
• Evaluate the effectiveness of quality improvement activities
When is a Quality Improvement Activity Warranted?

- Persistent initial non-compliance (based on Discovery data) in a given subassurance
  e.g., low compliance month after month in service plans addressing risks

- Persistent difficulty in achieving remediation

- Persistent difficulty in achieving remediation in a timely fashion

- An aspect of the QIS design is not working
  e.g., categories of remediation actions need tweaking

- State wants to make enhancements to the waiver
  e.g., add self direction option

- State desires to improve efficiency of waiver
  e.g., implement an automated case management system
Developing QI Projects

• Identification of project need based on analysis of Discovery and Remediation data
• Research cause of problem
• Identify improvement intervention targeted to problem/cause
• Implement intervention
• Measure impact of intervention (using Discovery/Remediation Data at a later point)
When QI Projects “Fail”

- Was it the right intervention?
- Did the intervention get applied correctly and consistently? (fidelity)
- What might be the reasons you could not sustain the impact?
CONTINUOUS QUALITY IMPROVEMENT (CQI)

IMPROVEMENT → DESIGN

REMEDICATION ← DISCOVERY

“DDRI”
National HCBS Quality Enterprise

- National Quality Enterprise website:
  - www.nationalqualityenterprise.net/nqe
  - Individuals can join (state staff) or preview (other users) to access all content.
  - Includes materials related to CMS quality requirements, technical support materials and discussion forum.
  - States may request TA through on-line form

- HCBS Quality Forums
  - Bi-monthly public calls specifically focused on Medicaid HCBS quality issues
  - All materials available on NQE website
Previous NQE Quality Forum Topics

- Continuous Quality Improvement (November 2009)
- Performance Measures – Part 1 (January 2010)
- Performance Measures – Part 2 (March 2010)
- Sampling (May 2010)
- Meaningful Use: Medicaid HCBS Monitoring and Reporting Strategies (July 2010)
- Copies of slides and recorded calls are available on the NQE website

Watch for Announcement of November 18th Topic