



HCBS Quality 101

Quality in the 1915(c) Home and Community-Based Services (HCBS) Waiver



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Training Objectives

- This training is part one of a two-part presentation.
 - HCBS Quality 101: Quality in the 1915(c) Home and Community-Based Services (HCBS) Waiver
 - Provide an overview of Federal requirements related to Quality Improvement Programs (QIPs) in 1915(c) waiver applications.
 - Discuss overall findings noted by CMS after analyzing multiple performance measures submitted in the 1915(c) waiver applications.
 - HCBS Quality 201: Quality in the HCBS Waiver – Health and Welfare
 - Discuss recommendations from OIG’s 2016 Health and Welfare audits.
 - Discuss Health and Welfare related findings from CMS site visits.
 - Provide CMS’ recommended performance measures for the Health and Welfare Quality Improvement System (QIS) sub-assurances to improve the existing QIS.



*Overview and Background – History of CMS
Oversight of 1915(c) Waiver Applications*



History of Guidance

- 1915(c) of the Social Security Act was enacted through the Omnibus Reconciliation Act (OBRA) of 1981.
- Required six assurances from the state in order to receive waiver approval.
 - State Medicaid Agency retains administrative authority.
 - Participants are determined to meet institutional levels of care.
 - Person centered service plans are reviewed at least annually.
 - Providers are qualified.
 - Health and welfare of beneficiaries is protected, and;
 - Payments for services maintain financial integrity.
- Initially, assurances were treated more like attestations.

1981-2003: CMS Oversight of 1915(c) Waivers

- Approximately one year before the renewal of a 1915(c) HCBS Waiver, CMS would schedule a site visit.
- Generally, CMS would focus on visiting waiver recipients randomly selected from active HCBS participants to determine if the program was being administered at a participant level as described in the approved waiver.
- The number of waiver recipients selected for audits and on-site interviews were based on the ability of the CMS site team to conduct the visits. The sample was not statistically significant.

2003 GAO Report

- In 2003, GAO issued a critical report (the Grassley report) about CMS oversight of waivers.¹
- In that report, the GAO stated that:
 - The monitoring and reporting of the quality of care under the 1915(c) HCBS waivers was inadequate.
 - CMS was not consistently reviewing the effectiveness of the program prior to renewing the waiver.
- In response, CMS convened State Associations to develop recommendations for ongoing monitoring. The outcome of the collaboration:
 - Assurances required by law were used as the basis to require performance measure collection and reporting by states to demonstrate waiver compliance.

2004 and 2007 Guidance

2004 Guidance

- CMS issued procedural guidance:
 - Site visits were to be conducted by CMS prior to approval of a waiver renewal.
 - CMS provided an outline of required elements for the site visit.
 - States were to submit a waiver quality improvement plan with each waiver renewal (or new waiver application).

2007 Guidance

- CMS updated the processes for the Regional Offices to request evidence from states and to determine whether statutory assurances were met.
 - More detailed information (referred to as sub-assurances) was to be provided as part of waiver renewals.
 - States would submit to CMS: (1) evidence the state was tracking and trending data to meet the assurances, and (2) the outcomes of the trending.
 - Deficiencies identified by the state during the period the waiver was in operation were to be addressed in waiver renewals.
 - A site visit during five year cycle was recommended (as opposed to required).
 - The annual “372 reports” were to include any health & welfare issues identified by the state and the steps to remediate deficiencies.

2009 Web-based Waiver Template

- Based on experience gained, CMS updated and reorganized the state's HCBS waiver application. Specifically, CMS:
 - Aligned the waiver template appendices by the statutory assurances.
 - Required additional information to be included describing how the state provided oversight of each statutory assurance.
- CMS also indicated that states should:
 - Identify and report on at least one performance measure for each subcategory under each statutory assurance.
 - Identify who was responsible for the measurement and what type of statistically valid sampling would be used.
 - Demonstrate how compliance was to be achieved and any remediation efforts.

2014 HCBS Regulation

- In 2014, CMS updated the HCBS regulations and included additional compliance options for CMS to use to ensure enforcement of 1915(c) waiver requirements, including the health and welfare assurances, such as:
 - Imposition of a moratorium on waiver enrollment until compliance is achieved.
 - Other corrective strategies as appropriate to ensure the health and welfare of waiver participants.
 - Withholding of a portion of Federal payments for waiver services until compliance is achieved.
 - Other actions determined necessary by the Secretary to address non-compliance.

2014 Quality Informational Bulletin

- In March 2014, CMS provided information on modifications to the 1915(c) waiver QIS.
- This bulletin was the work product of a committee composed of:
 - CMS
 - Three major state associations (NAMMD, NASUAD and NASDDDS)
 - 15 state administrators from 11 states.
- It was issued based on the recognition that the current reporting elements did not get to the heart of health and safety concerns and fiscal accountability.

2014 Quality Informational Bulletin

- The Bulletin focused on the following areas:
 - Systemic oversight
 - Four areas related to actions to be taken by a state as part of the Health and Welfare assurance:
 - Demonstrate that it identifies and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death.
 - Demonstrate that an incident management system is in place.
 - Ensure adherence to policies and procedures for the use or prohibition of restrictive interventions.
 - Establish and monitor providers against its overall health care standards.

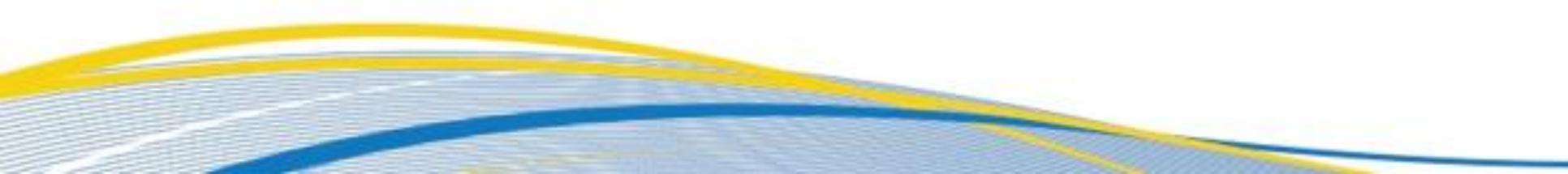
2014 Quality Information Bulletin (Continued)

- Additional changes included requiring states to establish quality improvement projects / remediations when the compliance threshold for a measure is at or below 85%.
 - Originally, the threshold was set at 100%, creating problematic expectations of a perfect system and potentially encouraging underreporting.
- States are to move to this system in any new waiver or waiver renewal submitted after June 1, 2014.
 - As of July 31, 2017, there are 88 waivers operating under the new system.
- CMS updated the Waiver Application and Technical Guide to include this guidance.
- More detailed information on the technical assistance provided by CMS can be found here:

<https://www.medicare.gov/medicaid-chip-program-information/by-topics/waivers/downloads/3-cmcs-quality-memo-narrative.pdf>



Overview and Background – Use of Performance Measures



Performance Measures

Background and Objectives

What are Performance Measures?

- Per 1915(c) Technical Guide, pages 304-305, a performance measure:
 - Is a gauge used to assess the performance of a process or function of any organization.
 - Can assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services.

- Three main types of performance measures:²
 - **Structural:** Measures an organization's capacity to achieve its goals.
 - **Process:** Measures how services are provided or how an organization ensures compliance.
 - **Outcome:** Measures the results of care. This could include improvement in individuals' well-being, individuals' experience in the waiver, or individuals' satisfaction with the services received.

Performance Measures

Federal Requirements

- As discussed previously, for 1915(c) HCBS Waiver applications, there are six separate assurances underneath the State's Quality Improvement Systems (QIS) that are linked directly to appendices in the application.
 - Appendix A: Administrative Authority
 - Appendix B: Level of Care
 - Appendix C: Qualified Providers
 - Appendix D: Service Plan
 - Appendix G: Health and Welfare
 - Appendix I: Financial Accountability
- Each Appendix consists of assurances and subassurances to determine the discovery and remediation of potential issues in the operation of the waiver.
- States are to develop performance measures that address subassurances.

HCBS Performance Measures

Home and Community-Based Service Performance Measure Structure

- A performance measure in HCBS waiver applications consists of the following elements identified in the 1915(c) application:
 - **Numerator:** Number of events that actually occurred (e.g., number of waiver participants who received a level of care assessment prior to waiver enrollment).
 - **Denominator:** Total number of observations possible (e.g., total number of waiver participants).
 - **Data Source:** Information regarding the data used to calculate the performance measures (e.g., program data, claims data, care/service plan data), the sample size, party responsible for data collection, and frequency of data collections.
 - **Data Aggregation and Analysis:** Responsible party for data source aggregation and analysis, and frequency of the data source analysis.

Evidence Collection, Analysis and Reporting Requirements

Two Main Requirements:³

States submit the following two documents to CMS to demonstrate meeting assurances:

1. CMS-372(s) Reports:

- Submitted 18 months after the waiver year ends.
- Contain two sections: Cost Neutrality and Quality.
 - **Cost Neutrality** is developed from fiscal information on an 18-month lag timeframe.
 - **Quality** addresses deficiencies noted and the state's plan for addressing those deficiencies in reference to the last complete waiver year.

2. Evidentiary Reports:

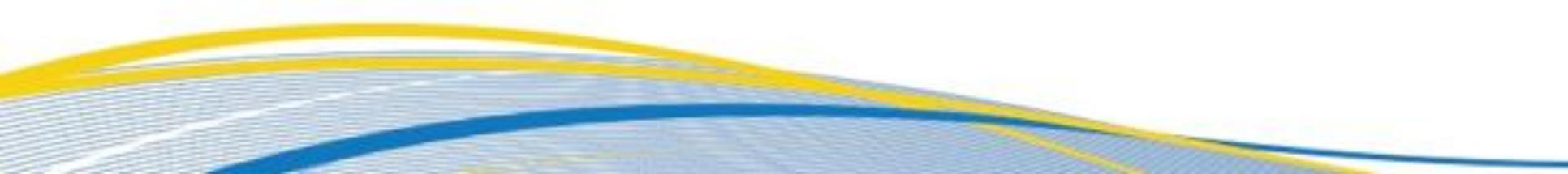
- Submitted 18 months before waiver expiration.
- Minimum of 3 years of evidence.
- Address all assurances, subassurances and state data analysis and corresponding trends identified.

Evidence Collection, Analysis and Reporting Requirements Continued

- The state must achieve a threshold of 86% or greater for all sub-assurances to be deemed compliant for an assurance.
- States are to have a mechanism for measuring its effectiveness in addressing nonperformance.
 - Involves trending compliance rates to determine whether a systemic intervention improves performance.
 - Mechanism and measurement results are subject to audit by CMS.



Current Status of Quality Measurements:
*Overall Findings from an Analysis of State-
Reported Performance Measures*



Performance Measure Analysis *Overview*

- The purpose of this section is to share information from an analysis of a sample of 1915(c) applications on the existing performance measures in the QIS process.
- CMS reviewed performance measures from 79 applications, with an effective date after March 2014, covering 36 out of 50 states (72 percent).
- Two main objectives for this effort:
 - Provide information about performance measures used.
 - Provide states with some commonalities identified among performance measures for specified sub-assurances.

Performance Measure Analysis *Overview*

- From the applications:
 - We grouped similar performance measures across all applications and created a new description for consistency.
 - We noted that multiple performance measures intended to capture the same information with slightly different wording. We collapsed those into a single performance measure based on intent.
 - We also noted promising practices and observations.

Performance Measure Analysis

General Observations

Findings Based on Analysis of Performance Measures

- Performance measures do not vary widely across target populations or other traits of the waiver.

- Although the ideal quality assurance system uses a combination of structural, process and outcome performance measures to drive improvement, we noted states mostly use process performance measures.

Performance Measure Analysis

General Observations

Findings Based on Analysis of Performance Measures (Continued)

- The validity of results generated from performance measures encompassing multiple criteria is not clear.
 - For example, a state's performance measure for QIS D (e.g., *Services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan*) could be the following: “Percent of waiver individuals that receive services and supports in **the type, scope, amount, duration and frequency** specified in the service plan.”
 - Failing any one of the criteria (i.e., scope, amount, duration, or frequency) results in failure of the entire measure.
- CMS recommends states create separate performance measures for each criterion when possible.

Performance Measure Analysis

General Observations

Findings Based on Analysis of Data Source, Data Aggregation and Analysis

- Most states use a 100% sample size.
 - If less than 100%, states should apply a sampling methodology.
- States may also use a stratified sampling methodology to combine data for waivers, however CMS did not identify any states using this approach.
 - States are allowed to combine data across waivers, especially when:
 - State operates more than one waiver that serves similar target population.
 - When multiple waivers employ similar quality improvement methods.
 - 1915(c) Technical Guide, page 244 states: *“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 for each approved waiver program, i.e., employ a representative sample for each waiver.”*

QIS A: Administrative Authority

Overview and Findings from PM Analysis

Overview

- QIS A measures how the Medicaid Agency retains ultimate authority and responsibility for the operation of the waiver program.
- Reflects compliance with the processes described in 1915(c) Waiver Application Appendix A, “Waiver Administration and Operation”.

Findings from Performance Measure (PM) Analysis

- Many of the performance measures submitted for QIS A are better suited for other appendices.
 - For example, a number of states measured the percent of claims overpayments that were appropriately and timely remediated as part of QIS A instead of QIS I.
- CMS recommends states move performance measures related to level of care determinations, qualified providers, service plans, health and welfare and financial accountability to their relevant appendices.

QIS B: Level of Care

Overview and Findings from PM Analysis

Overview

- QIS B measures how the Medicaid Agency oversees the implementation of the Level of Care (LOC) determination.
- Subassurances reflect compliance with the processes described in 1915(c) Waiver Application Appendix B-6, “Evaluation/Reevaluation of Level of Care.”

Findings from Performance Measure Analysis

- Measures report whether:
 - LOC determinations were performed.
 - Assessors were using a correct form or assessment tool.
- Measures do not current evaluate whether the assessment tools are used appropriately.

QIS B: Level of Care

Commonly Used Performance Measures

- Based on our review of applications, the following are the most commonly used performance measures (PMs) by states:

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

Subassurance (a)

An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Percent of new enrollees with an approved LOC determination prior to receiving services.

Subassurance (b)

The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine initial participant level of care.

Percent of LOC determinations completed using approved processes and instruments.

QIS C: Qualified Providers

Overview and Findings from PM Analysis

Overview

- QIS C measures how the Medicaid Agency ensures that all waiver services are provided by qualified providers.
- Subassurances reflect compliance with the processes described in 1915(c) Waiver Application Appendix C-1/C-3, “Service Definitions.”

Findings from Performance Measure Analysis

- Measures report whether waiver providers meet qualification and training requirements.
- Measures do not currently include measurement of whether the waiver providers meet the qualifications and training requirements *prior* to delivering services.

QIS C: Qualified Providers

Commonly Used Performance Measures

- Based on our review of applications, the following are the most commonly used performance measures by states:

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.

Subassurance (a)

The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

Percent of licensed / certified waiver providers that continue to maintain a valid license / certification.

Subassurance (b)

The state monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Percent of non-licensed / non-certified waiver providers that continue to meet contract requirements and provider qualifications.

QIS C: Qualified Providers

Commonly Used Performance Measures

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.

Subassurance (c)

The state implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver.

Percent of waiver providers who meet waiver training requirements.

QIS D: Service Plan

Overview and Findings from PM Analysis

Overview

- QIS D measures how the Medicaid Agency oversees the implementation and monitoring of service plans.
- Subassurances reflect compliance with the processes described in 1915(c) Waiver Application Appendix D-2, “Service Plan Implementation and Monitoring.”

Findings from Performance Measure Analysis

- Measures report whether individuals are offered choice, are receiving services in compliance with their service plans and have service plans that adequately address their needs.
- Measures currently do not include:
 - Measurement of whether or not service plans are addressing unmet needs of individuals.
 - Separation of multiple criteria into individual measures.

QIS D: Service Plan

Commonly Used Performance Measures

- Based on our review of applications, the following are the most commonly used performance measures by states:

Service Plan Assurance:

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

Subassurance (a)

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.

Percent of service plans that identify and address the waiver individual's assessed needs.

Subassurance (b)

Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Percent of services plans that were reviewed and revised when warranted by changes in the waiver individual's needs.

QIS D: Service Plan

Commonly Used Performance Measures

Service Plan Assurance:

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

Subassurance (c)

Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.

Percent of waiver individuals that receive services and supports in the type, scope, amount, duration and frequency specified in the service plan.

Subassurance (d)

Participants are afforded choice between/among waiver services and providers.

Percent of service plans that document the waiver individual was offered and made a choice of waiver service providers.

QIS I: Financial Accountability

Overview and Findings from PM Analysis

Overview

- QIS I measures how the Medicaid Agency ensures financial accountability of the waiver program.
- Subassurances reflect compliance with the processes described in 1915(c) Waiver Application Appendix I-1, “Financial Integrity and Accountability.”

Findings from Performance Measure Analysis

- Results should allow the SMA to determine whether claims are paid with the correct rate and for authorized services.
- Appendix I QIS demonstrated the fewest number of performance measures and the measures were not as robust as those used for other QIS provisions.

QIS I: Financial Accountability

Commonly Used Performance Measures

- Based on our review of applications, the following are the most commonly used performance measures by states:

Financial Accountability Assurance:

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

Subassurance (a)

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.

Percent of claims paid with the rate specified in the waiver application.

Subassurance (b)

The state provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.

*Percent of claims paid with the rate specified in the waiver application.

*This measurement may not be an accurate measure of adherence to rate methodology.

Summary

- We reviewed the measures states use to report on 1915(c) QIS with the exception of health and welfare and have identified several general observations across multiple waiver applications regarding their use of performance measures.
 - Performance measures do not vary widely across target populations or other traits of the waiver.
 - States mostly use process performance measures.
 - States should create separate performance measures for each criterion when possible.
- Part 2 of this presentation will focus on Appendix G, QIS Health and Welfare.

References

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Questions & Answers

For Further Information

For questions contact:

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