

ATTENDANT CARE WAIVER

ASSURANCES AND PERFORMANCE MEASURES

Attendant Care Performance Measures and Assurances

Assurance 1: Administrative Authority

Sub-assurance:

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

Performance Measures:

- Medicaid review of aggregated performance measure reports, trends, remediation efforts, and system improvements generated for improved services to participants.
- Number and percent of local non-state entities that meet provider agreement obligations.
- Number and percent of recommendations and approvals of quality improvement interventions/initiatives identified and implemented in the Quarterly Quality Management Meeting and Quality Council Meetings.
- Number and percent of new policy implementation monitored and remediation activity reported by non state entities to the Office of Long Term Living.

Remediation:

When the administrative data and QMET onsite monitoring visits identify agencies that are not meeting their requirements related to participant waiver enrollment, level of care evaluation, review of participant individualized service plans and Quality Assurance and Quality Improvement activities as outlined in the contractual agreement, the agency will receive written notification of outstanding issues with a request for a corrective action plan (CAP). The CAP is due to the QMET within 15 working days. QMMA staff will review and accept/ reject the CAP within 10 working days. Monitoring by the QMET will occur to ensure the corrective action plan was completed and successful in resolving the issue in accordance with the timeframes established for corrective action in the CAP. If the CAP was not successful in correcting the identified issue the technical assistance will be provided by the QMMA unit, Bureau of Individual Supports and Bureau of Provider Supports (BPS).

The Medicaid Agency monitors all quality activities through Bureau reports internally, non-state entities reporting and administrative data. As issues

are identified the corrective action will be implemented within 15 calendar days and documented by the bureau with a monthly report to the QMU. The QMU will track and trend remediation efforts, develop initial recommendations and present findings at the Quarterly Quality Management Meetings and at the Quarterly Quality Council Meetings to be addressed in the Medicaid Quality Improvement Process. The Director of the Office of Quality Management and Metrics and Analysis (QMMA) will report to the Deputy Secretary of OLTL.

All new policy implementation will require the non-state entities to monitor implementation and report remediation efforts to the Medicaid Agency through the QMU. The QMU will track and trend remediation activities, and recommend actions through the Quarterly Quality Management Meetings and at the Quarterly Quality Council Meetings to be addressed in the Waiver Quality Improvement Process.

Assurance 2: Level of Care

Sub-assurance:

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

Performance Measure:

- Number and percent of all new enrollees who have been deemed nursing facility eligible prior to receipt of waiver services.

Sub-assurance:

- b) The Levels of Care enrolled participants are reevaluated at least annually or as specified in the approved waiver.

Performance Measure:

- Number and percent of waiver participants who received an annual re-determination of eligibility within 12 months of their initial LOC evaluation or within 12 months of their last annual LOC evaluation.

Remediation:

The QMS will notify the AAA of late redeterminations on a monthly basis and require completion within 14 calendar days of notification. The QMS will review the next monthly report to verify completion of the late redeterminations. The AAA will be required to submit a CAP to prevent further late redeterminations. If the redetermination results in the participant's ineligibility, the QMS will inform the AAA to initiate the recoupment process.

Sub-assurance:

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

Performance Measure:

- Number and percentage of LOC determinations that were accurately rendered.

Remediation:

The QMS will notify the AAA Director when LOCs are inaccurately rendered. The AAA will be required to render an accurate LOC within 3 business days of notification. The QMS will verify that the corrections have been made. The AAA will be required to submit a CAP to address the issue within 30 days. The QMS will review and approve the submitted CAP within 30 calendar days upon receipt of the CAP.

The QMS will notify the AAA Director of identified errors that occur with LOC specific to each AAA or where indicated with specific staff/ assessors. Specific areas regarding completion of the LOC instrument and documentation will be addressed by the QMS with the AAA Director and affected AAA staff on a quarterly basis via direct training.

Assurance 3: Qualified Providers

Sub-assurance:

- 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.

Performance Measures:

- Number and percent of new waiver provider applications, by provider type for which provider obtained appropriate licensure/certification in accordance with state law prior to service provision.
- Number and percent of providers, by provider type, continuing to meet applicable licensure/certification following initial enrollment.

Remediation:

Before a provider is enrolled as a qualified waiver provider: it must provide written documentation to the Office of Long Term Living (OLTL) of all state licensing and certification requirements, as well as any other waiver requirements. When OLTL discovers a new or existing provider is enrolled as a waiver provider, but has not obtained appropriate certification or licensure, OLTL will send a letter to the provider informing it of the need for the licensure or certification, and a Corrective Action Plan (CAP) for the provider to complete. The letter will also warn that it has no more than 30 calendar days to obtain appropriate licensure before OLTL will begin to disenroll the provider as a qualified waiver provider. The CAP must concisely state how and when the provider will obtain the needed licensure or certification. The provider has 5 business days to submit its CAP to OLTL. OLTL will review and approve the CAP within 5 business days of submission. In the case the CAP is insufficient; OLTL will work with the provider to develop an appropriate CAP. In the case of a staff member not meeting necessary state licensing or certification standards, the staff member cannot provide service to waiver participants until the providers verify staff compliance with state licensing and/ or certification requirements. If the provider is unable or unwilling to obtain the appropriate license or certificate the provider will be notified in writing by OLTL of its intention to disenroll the provider. The provider will have the right to appeal.

Sub-assurance:

- b) The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.

Performance Measure:

- Number of non-licensed/non-certified provider applicants, by provider type, who met waiver provider qualifications prior to service provision.
- Number of non-licensed/non-certified provider, by provider type, who met waiver provider qualifications.

Remediation:

Upon application, OLTL will review verification submitted by the provider to verify it meets the qualification as established in the waiver. If a provider does not meet one or more of the waiver qualifications, OLTL will provide technical assistance to the provider to assist it in building necessary systems to meet the qualification(s). If a provider is unable to meet qualifications even after technical assistance is provided, the application to provide waiver services will be denied. Within two years of becoming a waiver provider (and every two years thereafter), OLTL will conduct an on-site visit of a provider to ascertain whether they continue to meet the provider qualifications outlined in the waiver. The Quality Management Efficiency Teams will be the monitoring agent for OLTL. The QMET monitoring tool will outline each qualification a provider must meet. The qualifications will be categorized according to provider type. The QMET tracking database will collect the information found by the QMETs for data analysis and aggregation purposes. Through this process, if a QMET discovers a provider does not meet one or more of the qualifications, the provider, with technical assistance of the QMET will develop a Corrective Action Plan (CAP). The provider will need to demonstrate through the CAP that it can meet all the waiver provider qualifications within 30 calendar days of the QMET review. The provider will have 5 business days to submit a completed CAP to the appropriate regional QMET, and the QMET will review and approve the CAP within 5 business days of submission. In the case the CAP is insufficient; the QMET will work with the provider to develop an appropriate CAP. If the provider is unable or unwilling to resolve the deficiency in meeting one or more of the waiver provider qualifications, the provider will be notified in writing by OLTL of its intention to disenroll the provider. The provider will have the right to appeal.

Sub-assurance:

- c) The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Performance Measure:

- Number and percent of providers, by provider type, meeting provider training requirements.

Remediation:

The QMET monitoring tool will ascertain if the provider has completed training in accordance with waiver requirements. OLTL will directly supervise QMET activities through the QMET statewide coordinator to ensure that the state policies and procedures for verification that training is conducted in accordance with state and waiver requirements. In the case a QMET does not verify the provider is training, OLTL will be made aware through the QMET tracking database. The QMET state coordinator will require the appropriate QMET team member to review provider records to assure the training was completed. If a provider has not met training requirements, the provider will be required to submit a CAP. The provider will need to demonstrate through the CAP that it can fulfill all the training requirements within 30 days of the QMET review. The provider will have 5 business days to submit a completed CAP to the appropriate regional QMET, and the QMET will review and approve the CAP within 5 business days of submission. In the case the CAP is insufficient; the QMET will work with the provider to develop an appropriate CAP. The QMET will verify the CAP is in place according to the timeframe as written in policy and the CAP. If the provider is unable or unwilling to resolve the deficiency in meeting one or more of the waiver provider qualifications, the provider will be notified in writing by OLTL of its intention to disenroll the provider. The provider will have the right to appeal.

Assurance 4: Service Plans

Sub-assurance:

- a) Service Plans address all participants' needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or other means.

Performance Measure:

- Number and percent of waiver participants who have Individual Service Plans (ISPs) that are adequate and appropriate to their needs, capabilities, and desired outcomes, as indicated in the assessment.

Sub-assurance:

- b) The State monitors service plan development in accordance with its policies and procedures.

Performance Measures:

- Number and percent of Individual Service Plans and related service plan activities that comply regarding who develops the plan, who participates in the process and the timing of the plan development.
- Number and percent of Individual Service Plans and related service plan activities that comply regarding how waiver services and other non-waiver services are coordinated.
- Number and percent of Individual Service Plans and related service plan activities that comply with how the participant is informed of the services that are available under the waiver.
- Number and percent of waiver participants whose Individual Service Plan included an assessment including risk factors and needs.

Sub-assurance:

- c) Service Plans are updated or revised at least annually or when warranted by changes in the waiver participant's needs.

Performance Measures:

- Number and percent of Individual Service Plans (ISPs) reviewed and revised before the waiver participant's annual review date.

- Number and percent of waiver participants whose Individual Service Plans (ISPs) was revised as needed, to address changing needs.

Sub-assurance:

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

Performance Measures:

- Number and percent of waiver participants who received services in the type, amount, and frequency specified in the Individual Service Plan (ISP).
- Number and percent of waiver participant satisfaction survey respondents reporting the receipt of all services in the Individual Service Plan (ISP). (*SMW)

Sub-assurance:

- e) Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.

Performance Measures:

- Number and percent of waiver participants whose records contained appropriately completed and signed Freedom of Choice forms that specified choice was offered between institutional care and waiver services.
- Number and percent of waiver participants whose records documented a list of waiver services and providers was provided and discussed with the waiver participant.

Remediation:

If a waiver participant's Individual Service Plan (ISP) is discovered to be deficient in accordance with the sub-assurances, the Bureau of Individual Supports (BIS) will contact the Supervisor of the Care Manager responsible for development of the ISP. The Care Manager and Care Manager Supervisor will be expected to have the deficiency corrected within 3 working days. If, through tracking and trending it is discovered that a specific provider has multiple deficiencies, the Quality Management Efficiency Team (QMET) will be alerted. The QMET will pull a random sample of the provider's records and review the ISPs to verify they meet participant needs adequately and appropriately. If the sample reveals a provider wide deficiency in developing an ISP which adequately and

appropriately addressing the needs of the waiver participant, the provider must complete a Corrective Action Plan (CAP) within 5 days. The QMET will review and approve the CAP within 10 days of submission. In the event the CAP is insufficient; the QMET will work with the provider to develop an appropriate CAP. The QMET will verify the CAP is in place according to the timeframe as written in policy and the CAP.

If the Intake or Annual Participant Satisfaction Survey responses indicate that a waiver participant has unmet needs, BIS will investigate if deficiencies exist in the ISP. If a deficiency is present, the remediation plan listed in the previous paragraph will be initiated.

Assurance 5: Health and Welfare

Sub-assurance:

The State, on an ongoing basis, identifies addresses and seeks to prevent the occurrence of abuse, neglect, and exploitation.

Performance Measures:

- Number of reportable incidents by type: Abuse, neglect, and exploitation. (*SMW)
- Number and percent of waiver participants with more than three reported incidents of abuse, neglect, and exploitation in a calendar year. (*SMW)
- Number and percent of incidents requiring investigations by type: abuse, neglect and exploitation. (*SMW)
- Number and percent of incidents substantiated by type: Abuse, neglect and exploitation. (*SMW)
- Number and percent of incidents of abuse, neglect, and exploitation investigated within required timeframe. (*SMW)
- Number and percent of incidents of abuse, neglect, and exploitation for which corrective actions were verified within required timeframe. (*SMW)
- Number of providers who failed to report incidents of abuse, neglect and exploitation incidents. (*SMW)
- Number and percent of Waiver participants who indicate knowledge of how to report abuse, neglect or exploitation.
- Number of complaints by type: Basic service delivery issues, abuse, neglect or exploitation. (*SMW)
- Number and percent of complaints investigated regarding basic service issues, abuse, neglect or exploitation. (*SMW)
- Number and percent of complaints addressed within required timeframe regarding basic service issues, abuse, neglect or exploitation. (*SMW)

Remediation:

The Bureau of Individual Supports (BIS) will contact the provider regarding the incident. If immediate action is needed to protect the health and welfare of the individual, BIS will instruct the provider to take such action. The provider will be required to provide BIS with a clarification of why the incident did not meet waiver standards and develop a Corrective Action Plan (CAP). The CAP will address the root cause as to why the waiver standard was not met as well as outline a method to prevent the deficiency from occurring in the future. The clarification and CAP will be due to BIS within 5 business days. BIS will have 10 business days to review and approve the CAP. If the provider does not develop a sufficient CAP, BIS will provide technical assistance to improve the CAP. If after 30 days, the provider is unwilling/ unable to develop an acceptable CAP, OLTL will begin the process to disenroll the provider. The provider will have the right to appeal. The QMET will be responsible to do an on-site review, if applicable, to ensure that the CAP is being implemented as written and within the timeframes listed.

If the Office of Quality Management, Metrics and Analytics (QMMA) discover that a complaint was not acted upon in accordance with waiver standards, the following remediation strategy will be enacted.

QMMA will contact BIS leadership and request an investigation be conducted as to why the complaint did not meet waiver standards. BIS will have 5 business days to report back to QMMA on the root cause as to why the complaint did not meet waiver standards. BIS will also develop a quality improvement strategy to address the root cause and work with QMMA to ensure the strategy is implemented.

If it is discovered that a waiver participant does not know how to report a complaint or incident of abuse, neglect or exploitation, the following remediation strategy will be enacted: BIS will contact the Supports Coordinator supervisor regarding the need to provide appropriate information to the waiver participant. The Supports Coordinator supervisor is responsible to meet with the consumer, review how to report abuse, neglect or exploitation, and obtain written verification that the participant understands and is knowledgeable on how to report a possible incident or complaint of abuse, neglect or exploitation. The Supports Coordinator supervisor is then responsible for providing the written verification to BIS.

Assurance 6: Financial Accountability

Sub-assurance:

State financial oversight exists to ensure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.

Performance Measures:

- Number and percent of claims coded and paid according to the rate methodology specified in the waiver application.
- Number and percent of providers submitting accurate claims for services authorized by the waiver and being paid for those services.
- Number and percent of Services My Way participants who spend 80% or less of their spending plan.
- Number and percent of Services My Way participants who are directed to other service models because of non-authorized use of funds.

***SMW** – These performance measures will be stratified for Services My Way participants.

Remediation:

If providers submit claims for services not covered by the waiver and are paid for those services with waiver funds, Bureau of Provider Supports will initiate steps to recoup inaccurate payment. QMET will work with provider to establish a Corrective Action Plan to prevent billing for unauthorized services. The Quality Management Efficiency Teams will be the monitoring agent for OLTL. The QMET tracking database will collect the information found by the QMETs for data analysis and aggregation purposes. Through this process, if a QMET discovers a claim does not meet correct payment methodology, the provider, with technical assistance of the QMET, will develop a Corrective Action Plan (CAP). The provider will need to demonstrate through the CAP that it can meet all the waiver financial accountability qualifications and resubmit the claim within 30 calendar days of the QMET review. QMET will review adjusted claim submissions to assure that recoupment was done correctly. The provider will have 5 business days to submit a completed CAP to the appropriate regional QMET, and the QMET will review and approve the CAP within 5 business days of submission. In the case the CAP is insufficient; the QMET will work with the provider to develop an appropriate CAP. If the provider is unable or unwilling to resolve the deficiency in meeting one or

more of the waiver provider qualifications, the provider will be notified in writing by OLTJ of its intention to disenroll the provider. The provider will have the right to appeal.