Appendix H: Quality Improvement Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the state has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the state specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Improvement is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Improvement Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the state is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Improvement Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Improvement Strategy.

Quality Improvement Strategy: Minimum Components

The Quality Improvement Strategy that will be in effect during the period of the approved waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QIS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based discovery activities that will be conducted for each of the six major waiver assurances; and
- The remediation activities followed to correct individual problems identified in the implementation of each of the assurances.

In Appendix H of the application, a state describes (1) the *system improvement* activities followed in response to aggregated, analyzed discovery and remediation information collected on each of the assurances; (2) the correspondent *roles/responsibilities* of those conducting assessing and prioritizing improving system corrections and improvements; and (3) the processes the state will follow to continuously *assess the effectiveness of the QIS* and revise it as necessary and appropriate.

If the state's Quality Improvement Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Improvement Strategy, including the specific tasks the state plans to undertake during the period the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid state plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QMS spans more than one waiver, the state must be able to stratify information that is related to each approved waiver program. 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 that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

H.1 Systems Improvement

a. System Improvements

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.

The Office of Long-Term Living (OLTL) is responsible for the statewide administration of Pennsylvania's long-term services and support program, the Community HealthChoices (CHC). OLTL's quality strategy will be to meet federal and state requirements in a manner which will bring about maximization of the quality of life, functional independence, health and well-being, and satisfaction of participants in OLTL programs.

OLTL responsibilities include assessing and improving the quality of services received by participants in various long-term living settings and monitoring fiscal and regulatory compliance. Key bureaus focused on the operations of the Community HealthChoices program include:

- Bureau of Fee for Service Programs (BFFSP)
- Bureau of Quality Assurance and Program Analytics (BQAPA)
- Bureau of Coordinated and Integrated Services (BCIS)
- Bureau of Policy Development and Communications Management (BPDCM)
- Bureau of Finance (BOF)

All Bureaus play a role in ensuring CHC-MCOs and other related contractors comply with contractual obligations, and federal and state regulations. Data analysis is utilized to measure effectiveness of program design and operations, which will help in identifying strategies for continuous quality improvements in the delivery of service. Each of the contracts will have a contract manager to ensure vendor is meeting all contractual obligations, which includes IEB, F/EA, independent assessment, and the external quality review organization (EQR).

As part of stakeholder engagement, OLTL includes the Long-Term Services and Supports (LTSS) and Managed Long-Term Services and Supports (MLTSS) subcommittees of the Medical Assistance Advisory Committee to request feedback on quality management activities.

BQAPA's work consists of quantifying, analyzing, trending, and making initial recommendations regarding priorities and specific quality improvements to OLTL systems, and then monitoring system improvement changes for effectiveness. All bureaus will work collectively to review data that has been compiled from the CHC-MCOs, on-site OLTL monitoring and data analysis conducted by the External Quality Review Organization, (EQRO). These data sources are utilized to identify issues, trends and quality oversight, and is used in waiver reporting. All CHC-MCOs are expected to adhere to contract requirements, and follow all OLTL bulletins, operational memo, and notices and meet expected timeframes.

OLTL will implement a process for trending discovery and remediation information received from various points in the OLTL system as well as from the contracted EQR and the CHC-MCOs. Reports will be created by BQAPA to trend various aspects of quality including administrative authority, health and welfare, financial accountability, service plan development and implementation, level of care review, and provider qualifications. More detailed information, including performance measures, is

available under each of the appendices that pertain to the six waiver assurances (see individual Appendix A, B, C, D, G and I, respectively).

CHC-MCOs are also required to annually administer the HCBS CAHPS Survey to gather feedback on HCBS participants' experience receiving long-term services and supports. CHC-MCOs will administer the most current version of the instruments and report survey results to DHS/OLTL as required under the CHC agreement. This includes using the Supplemental Employment Module specifically designed to be used alongside the HCBS CAHPS Survey tool as well as Pennsylvania specific questions designated by OLTL that relate to service plan, transportation, housing, and preventative health care. In 2018, each individual CHC-MCO will survey a random sample that generates a targeted number of complete surveys. Starting in 2019, the CHC-MCO will select a statistically valid random sample based on a 95% Confidence Level, ± 5% Confidence Interval, and a 50% Distribution, proportioned by region.

The overall results of the Pennsylvania OLTL HCBS CAHPS Survey will be provided to DHS/OLTL. MCOs will report on the aggregate information about experience of care related to the services and supports provided to the surveyed population. The current level and trend over time in the HCBS CAHPS composite measure scores will be reviewed by CHC-MCOs together with the component survey items that indicate actionable aspects of the experience of care. Opportunities for improving the experience of care will be identified and implemented. CHC-MCOs will submit a narrative report to DHS/OLTL with the results of each HCBS CAHPS Survey data collection. The narrative report will include a summary of what the plan learned about participant experience of care and aspects of participant health and welfare, potential areas of concern or opportunities for improvement, and steps to further investigate and/or address quality improvement opportunities.

BQAPA will convene monthly internal Quality Monthly Meetings (QM2) as well implement a Quarterly Quality Review Meeting (QQRM) to ensure that there are devoted meetings with each individual MCO to discuss key quality indicators, best practices and areas for improvements. The basis of these meetings will be an open, creative, collaborative dialogue between all OLTL bureaus and the CHC-MCOs with an emphasis on quality outcomes. The QQRM is an opportunity to review:

- CHC-MCO performance against stated goals;
- Investigate causes of missed goals and targets;
- Implement corrective action steps for plans that missed targets;
- Establish new targets;
- Identify opportunities for program improvements; and
- Develop special studies for populations being served under CHC.

OLTL has designed an approach in oversight and monitoring of the CHC program. This includes a comprehensive statewide Medical Assistance Quality Strategy for Pennsylvania, which outlines a number of key components on how OLTL will ensure quality assurance that will help identify system improvements for CHC to include: readiness review, early implementation and ongoing monitoring. CHC-MCOs will be required to support all key quality components, as follows but not limited to:

- Contractual Monitoring and Compliance, which will include early program launch and steady state monitoring. Using a two-prong approach will allow the state to coordinate its approach in each cycle impacting the CHC program implementation. This will also help ensure CHC-MCOs are ready to provide services, identify unanticipated implementation challenges and address them in real time, and conduct annual monitoring of plans.
- Complaints, Grievances and Appeals (see Appendix F under this application for more detailed information)
- Utilize the statewide EIM system for Critical Incidents

- Performance measures using indicators established by the Center for Medicare and Medicaid Service (CMS) and various national organizations:
    - Healthcare Effectiveness Data and Information Set (HEDIS)
    - CMS Medicaid Adult Core Measures
    - CMS Nursing Facility Measures
    - Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
    - Medicare Measures for Dual-Eligible Special Needs Plans (D-SNPs)
- PA-specific state measures which will help gauge performance, monitor compliance with state and federal regulations and guidelines, and ensure CHC participants are receiving quality services in a timely manner.
- EQRO will conduct independent series of external quality review activities involving MCOs providing LTSS, physical health services, and behavioral health services, as well as Medicare providers, and assist the state in ensuring coordination of care.
- Independent evaluation conducted by the Health Policy Institute, Medicaid Research Center at the University of Pittsburgh.

BCIS will be responsible for CHC-MCO annual monitoring and remediation activities. This includes a review of Corrective Action Plans (CAPs) submitted by CHC-MCOs to correct non-compliance issues, and will be reviewed and approved by BCIS. BCIS will work with CHC-MCOs to establish realistic timeframes for the successful completion of activities listed in the CAP. CAPs are closed only upon approved completion.

In order to prioritize quality management issues, BQAPA has assigned each of the five waiver assurances to a quality management (QM) liaison to review various quality reports through tracking and trending, and determine possible causes of aberrant data or compliance issues. Quality data is gathered for performance measures from numerous sources, including OLTL discovery and remediation activities, on-site monitoring by the OLTL, as well as internal OLTL activities/reporting. This information is aggregated for tracking and trending. The QM liaison makes initial recommendations and prioritizes issues for problem-solving or corrective measures. The QM liaison reviews and responds to aggregated, analyzed discovery and remediation information collected on each of the assurances, and makes initial recommendations and prioritizes issues for problem-solving or corrective measures. In addition to trending and analyzing, this structure allows BQAPA to review for possible internal OLTL systemic changes and to identify possible program training or technical assistance needs.

BQAPA internally reviews the assessments made by the QM liaison. For those issues that are considered critical by the QM liaison, an expedited process of review is implemented by working closely with other OLTL bureaus. The QMU summarizes the list of priorities and recommendations in a monthly report to present at the monthly QM2 meetings, which are attended by key personnel from all OLTL bureaus. The comments from the quality meetings are considered and included in a revised report for discussion with the MCOs during weekly update meetings. OLTL Bureau Directors will collectively submit final recommendations as to any action needed for system improvements to the Deputy Secretary of OLTL. The implemented system improvements return to the quality cycle through monitoring and remediation.

ii. System Improvement Activities

Responsible Party *(check each that applies):*	**Frequency of monitoring and analysis** *(check each that applies):*

X State Medicaid Agency	**X Weekly**
☐ Operating Agency	**X Monthly**
☐ Sub-State Entity	**X Quarterly**
☐ Quality Improvement Committee	**X Annually**
☐ Other Specify:	**☐ Other** Specify:

b. **System Design Changes**

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. If applicable, include the state's targeted standards for systems improvement.

BQAPA assists the OLTL in developing quality management improvement strategies for needed system design changes. BQAPA ensures the strategies are implemented, evaluating the effectiveness of the strategies against tracked and trended data. Additional reports to narrowly track the effect of system changes are developed and produced by the contracted EQRO, or provided by the CHC-MCO's and given to BQAPA for analysis. The analyses are reviewed in the same manner as other reports, creating a cycle of continuous quality improvement.

CHC will be implemented starting in January 2018. OLTL plans to meet regularly with CHC-MCOs to discuss operations issues and to apprise the CHC-MCOs of administrative changes and updates that may have an impact on service delivery. In addition, our intent will be to mirror the existing HealthChoices program, and implement a Quarterly Quality Review Meeting (QQRM)to ensure that there are devoted meetings with each individual MCO – to discuss key quality indicators, best practices and areas for improvements. The basis of these meetings will be an open, creative, collaborative dialogue with OLTL and the CHC-MCOs with an emphasis on quality outcomes.

BCIS will also monitor CHC-MCO agreements, review and approve subcontracts, identify areas of non-compliance, approve corrective action plans and recommend sanctions and penalties where appropriate. It will also monitor the CHC-MCOs to ensure the provision of a fair enrollment process into the provider network.

ii. Describe the process to periodically evaluate, as appropriate, the Quality Improvement Strategy.

The Quality Improvement Strategy (QIS) is evaluated on an on-going and continuous basis through the implementation of the continuous quality cycle. Periodic evaluation also occurs during the monthly quality meetings. The results of aggregated information pertaining to the delivery of services including all corrective action plan activities of the CHC-MCOs, CHC-MCOs billing information, analysis of CHC-MCOs adherence to performance measures established, etc. will be reviewed and discussed to evaluate the effectiveness of program success. Any needed alterations to the QIS will be made on an ongoing basis.

H.2 Use of a Patient Experience of Care/Quality of Life Survey

a. Specify whether the state has deployed a patient experience of care or quality of life survey for its HCBS population in the last 12 months (*Select one):*

- ● No
- ○ Yes *(Complete item H.2b)*

b. Specify the type of survey tool the state uses:

- ○ HCBS CAHPS Survey;
- ○ NCI Survey;
- ○ NCI AD Survey;
- ○ Other *(Please provide a description of the survey tool used)*: