Support Coordination Agency Monitoring

Policy and Procedures Manual

LOUISIANA DEPARTMENT OF HEALTH
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SUPPORT COORDINATION AGENCY MONITORING
POLICY AND PROCEDURES MANUAL

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SUPPORT COORDINATION AGENCY MONITORING OPERATIONAL PROCEDURES

I. BACKGROUND

A. Purpose

The Centers for Medicare and Medicaid Services (CMS) defines Home and Community Based Services (HCBS) waiver requirements and is responsible for determining that each HCBS waiver meets the six federal assurances. The Office of Aging and Adult Services (OAAS) and Medicaid are accountable to CMS for the design and operation of our waivers. OAAS is required to report to CMS that the terms of the waivers and the assurances are met.

In conjunction with the Office for Citizens with Developmental Disabilities (OCDD) and consultants with the Human Services Research Institute (HSRI) and the Muskie School, OAAS developed the Support Coordination Monitoring (SCM) Review Process to assist in determining compliance with the following assurances:

1) Evaluation/Reevaluation of Level of Care
2) Participant-Centered Planning and Service Delivery
3) Participant Safeguards-Health and Welfare

These Operational Procedures provide structured guidance to OAAS staff and Support Coordination Agencies (SCA) for executing their responsibilities associated with the annual SCA monitoring review and for entering data into the Louisiana Support Coordination Application (LASCA) database.

In addition, information obtained through the SCA monitoring process enables OAAS to make determinations at the agency level, allowing acknowledgement of exemplary performance, identification of areas for improvement, and assurance that the SCAs are operating in compliance with established Support Coordination Standards for Participation (LAC 50:11I.Chapter5).

B. Overview

Support Coordination Agencies play a key role in assuring that the HCBS waivers work to meet participant needs and improve outcomes. A major goal of Louisiana's long-term care system reform efforts has been to streamline and make more effective its oversight of HCBS waivers including monitoring the performance of SCAs.

The Support Coordination Monitoring process provides valuable information to determine how well each SCA is meeting the standards of care set by Louisiana and CMS. It also provides a standard method for assessing statewide performance within and across HCBS waivers.

The SCA Monitoring Review Process consists of five components, each organized under domains corresponding to the desired outcomes of the program:

1) Agency Review (AR): Completed annually or less frequently, as determined by OAAS, for agencies with a history of Satisfactory Findings, i.e., all review elements are met.

2) Participant Record Review (RR): Completed for a statewide random representative sample of waiver participants.

3) Participant Interview (PI): Completed for a statewide random representative sample of waiver participants.

4) Home Observations (HO): Conducted in conjunction with the Participant Interview to verify through direct observation that assessments are accurate, medications and health-related task needs are being addressed, risks have been identified, and Plan of Care (POC) accurately reflects the participant's needs.

5) Support Coordinator Interview (SCI): Completed for Support Coordinators assigned to the participants in the Participant Interview/Record Review sample. At the discretion of the Review Team additional Support Coordinators may be interviewed.

In addition, Support Coordination is a vital service in Louisiana's Money Follows the Person (MFP) program, known as My Place LA. The federal MFP statute requires state Medicaid agencies to monitor the quality of all HCBS provided to MFP participants, guarantee their health and welfare in the community, and develop continuous quality improvement systems for HCBS.

CMS requires that the MFP Operational Protocol describe the continuous quality improvement activities used to discover and remediate problems. OAAS HCBS Support Coordination Training, Monitoring, and Quality Initiatives provide the fundamental basis for, and interface with required OAAS MFP Support Coordination Initiatives.

C. Continuous Quality Improvement and Design, Discovery, Remediation, Improvement

The SC Monitoring process is a component of the OAAS Waiver Quality Improvement Strategy (QIS), detailed in the Waiver application required by CMS. Data collected through monitoring provides information to evaluate how well OAAS and SC agencies are performing in relation to CMS HCBS Assurances. The core of the OAAS QIS is Continuous Quality Improvement (CQI). Integral to CQI is the use of evidence to drive continuous, cyclical improvement. These CQI principles are embodied in CMS' Design, Discovery, Remediation, and Improvement (DDRI) model.

Design refers to the plan for how the waiver programs are monitored and improvements are initiated. **Discovery** refers to the processes used to uncover deviations from program expectations and requirements in a timely fashion. These deviations are measured through OAAS Performance Measures related to CMS requirements. The focus of **Remediation** is to address and resolve all individual problems identified. While Remediation focuses on addressing individual problems,

Improvement focuses on making adjustments to the system's processes or procedures in order to prevent or minimize future individual problems. When system improvements work, discovery data improve.

II. SUPPORT COORDINATION MONITORING DESIGN (FOUNDATION)

The foundation of the SC Monitoring process is based on: (1) Participant-Specific Outcomes; (2) Agency-Specific Outcomes; (3) Monitoring Review Elements; (4) Interpretive Guidelines; and (5) the Louisiana Support Coordination Monitoring Application database.

A. SCA Monitoring Review Outcomes

The SCA Monitoring Outcomes for HCBS participants were developed by stakeholders as part the Quality Component of the Medicaid Systems Transformation Grant. These outcomes are based on the CMS HCBS assurances/sub-assurances and acceptable standards of home/community service delivery. The outcomes, from which the elements and sub-elements were generated, are divided into participant-specific and agency- specific as follows:

1. **Participant-Specific Outcomes**

a) Assessments are accurate, complete, and timely.
b) Health and safety risks are identified and mitigated.
c) Participants are involved in planning.
d) The POC has strategies to meet the participant's assessed needs and preferences.
e) POCs and service initiation are up to date and timely.
f) Participants are protected in the event of an emergency.
g) Participants have choice of applicable services and service providers.
h) Participants' needs are met.
i) Participants are safe.

2. **Agency-Specific Outcomes**

a) Support coordination agencies have qualified staff.
b) The support coordination workforce is consistent and stable.
c) Management structures and policies meet OAAS requirements and support an efficient and effective operation.
d) Data management processes of the SCA produce timely reports to be used for performance assessment, tracking trends and patterns, and decision-making.

B. SC Monitoring Interpretative Guidelines

The SC Monitoring Interpretative Guidelines is a critical resource for SC Agencies to understand the SC monitoring process and the specific performance expectations for which Support Coordinators will be held accountable by OAAS. In addition, this document is a compilation of

instructions for the Review Team to assist them in determining if an element/sub-element is ***Met.*** It is divided into five components that mirror the five monitoring components.

C. Louisiana Support Coordination Application (LASCA)

LASCA is an automated monitoring system that allows OAAS Review Teams to collect, store, and report data obtained through the performance review of SCAs. LASCA also provides a tracking function (Review Event Tracker) that stores the activities, action steps, and dates related to the review and remediation processes. Data from the Event Tracker can be extracted to measure and evaluate systemic remediation activities.

LASCA includes worksheets for the SC Monitoring components: Agency Review, Participant Record Review, Participant Interview, Home Observations, and SC Interview. Each LASCA Worksheet consists of Outcomes, Elements, and Sub-elements that are scored by the Reviewer. The numbering of elements relates to the Outcome being measured and is consistent across worksheets.

LASCA has the capability to score findings and generate the following printable reports/worksheets:

1) LDH SCA Quality Monitoring Report-Detailed Review Findings-Review Type: Agency: Displays the Finding for each OAAS Agency Review Element.

2) LDH SCA Quality Monitoring Report-Detailed Review Findings Review Type: ADHC Waiver OR Community Choices Waiver: Displays the overall Worksheet Count and includes the Sample Size, % Not Met, Harm Value, and Finding for each OAAS Waiver Review Element for the Record Reviews, Participant Interviews, Home Observations, and SC interviews.

3) Adult Day Health Care (ADHC) waiver and Community Choices Waiver (CCW) Participant Record Review Worksheets: Indicates the Review Elements Met and Not Met and any applicable details in the "Notes" section for each participant in the sample.*

4) ADHC and CCW Home Observations Worksheets: Indicate the Review Elements Met and Not Met and any applicable details in the "Notes" section for each participant in the sample.*

   *The agencies are provided a copy of every Record Review and Home Observations Worksheet in the monitoring sample. The SCA must review the details of all Not Met findings on the worksheet and perform remediation (resolution) of any individual participant findings. They must submit documentation of this individual remediation according to timelines indicated in the findings letter. Resolution must also be clearly documented in the participant's record.

III. SCA MONITORING PROCESS: ORGANIZATION

A. SCM Entities: Who's Involved

1. Support Coordination Agency: agencies that assist participants in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, housing, and other services.

2. OAAS
   a) Regional Office: conducts the SCM Review (Discovery), collaborates with the SCA throughout the Remediation period, and identifies areas needing improvement.
   b) State Office
      (1) Generates the representative, random sample participant list and accompanying alternate list as described in the Waiver Application and notifies monitoring staff of their respective samples.
      (2) Upon request, the SC Program Manager, Regional Operations Manager, and/or Quality Manager review SCA monitoring results and consult with Executive Management as necessary.
      (3) At least annually, the OAAS Quality Review Team reviews all SCM aggregated discovery and remediation data and makes recommendations for improvement.
   c) **SCM Core Trainers Role and Responsibilities**
      The SCM Core Trainers are OAAS staff with expertise in assessment and care planning. These trainers conduct periodic training on these subjects for OAAS, SCA, and provider staff. The training group is apprised of negative SCM findings that indicate a need for additional trainings or training reinforcement.

B. Timelines for Monitoring, Remediation and Data Entry

In order to meet HCBS CMS evidentiary report requirements states must provide both discovery and remediation data valid towards meeting the federal assurances for each Waiver Year.

Waiver Year: The Waiver Year begins on the CMS Waiver Effective Date.

A representative sample is generated and **activities of the previous waiver year are reviewed**. Based on these findings, remediation and improvement activities are implemented.

The **LASCA Monitoring Period Start and End Dates are the same as the Waiver Year start and end dates.** This is the range of time being monitored and supplies the annual reporting discovery data for all performance measures which utilize SCM Record Review (LASCA) as the data source.

MONITORING PERIOD IN LASCA IS THE WAIVER YEAR BEING MONITORED

Based on *FISCAL/WAIVERYEAR*: July 1st – June 30th

←ANNUAL DISCOVERY DATA for CMS REPORTING→

JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MARCH	APRIL	MAY	JUNE
"Monitoring Period Start Date" July 1st											"Monitoring Period End Date" & "Review Due Date" June 30th

SCM is comprised of a monitoring review phase and a remediation phase. The end of each phase is marked by a completion due date. This process facilitates the generation of a full-sample annual report that contains both the discovery and remediation data required as part of evidentiary reporting.

SCM REVIEW and REMEDIATION Phases Based on *CALENDAR YEAR*: January 1st – December 31st												
SCM REVIEW Phase						**SCM REMEDIATION Phase****						
JAN	**FEB**	**MARCH**	**APRIL**	**MAY**	**JUNE**	**JULY**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**	
←SCM Reviews→						**←Remediation Activities→**						
Reviews Begin **1-1**	• **Reviews performed throughout but all MUST be finalized in LASCA by June 30th** • **Remediation Activities begin the day after Review Finalized**				**Reviews End** **6-30**	**Remediation Continues**	• **All Remediation activities must be completed and entered into LASCA on or before December 31st.**				**Remediation Ends** **12-31**	

The Agency, CCW and ADHC monitoring reviews are performed in the same visit for each SCA. Likewise, remediation and progress report requirements for Agency, CCW and ADHC reviews share the same due dates.

The process allows flexibility within the regions to complete monitoring of all regional SC agencies within a half-year monitoring review phase and flexibility to complete remediation activities by the end of the remediation phase.

Each review requires a separate response based on the Level Determinations in the findings reports. The remediation activities for all three reviews are due at the same time.

After discussion with the Review Team and after the Review Team Leader has validated the review and saved the findings, the OAAS Regional Monitoring Manager or Lead Reviewer is responsible for finalizing the monitoring review in LASCA.

C. SCM Look-back Period for Waivers

The Look-back Period is the window of time that SCM reviewers go back in conducting record reviews. This window begins with the first day of the previous Waiver Year (July 1st) and extends to the review finalization date. Whereas reviews require inspection of both the assessment-POC development processes and ongoing service-delivery processes, the look-back parameters vary as follows:

1. **POC Development Measures**: Review the most recently approved POC/MDS-HC.

2. **Critical Incident Report (CIR) Review related to POC Development (RR.2.1.a):** Review CIRs which go back one year from the POC development date.

3. **SC Documentation Measures**: Review SCD from July 1st to Record Review date. Review each POC and subsequent revisions that were in effect at the time of the SCD look-back month.

4. **CIR Reporting Measure (RR.9.3.a):** Review CIRs entered from the July 1st until time of Record Review.

D. SCM Look-back Period for the Agency Review

1. For all policy-related Review Elements, the reviewers score the agency according to what is discovered at the time of monitoring.

2. For qualifications and orientation Review Elements (10.1, 10.2, 11.1.a, 11.1.b, 11.1.c), the monitors review information for all new employees not included in the last review.

3. For mandatory training Review Element 11.1.d, the reviewers adhere to the following protocol:

    a) For agencies on a Calendar Year Policy, review all employees with one full year of employment in the previous calendar year.
    b) For agencies on an Anniversary Hire-Date Policy, review all employees with one full year of employment from anniversary date to anniversary date.

4. For 12.1.a. Staff Coverage, the reviewers assess POC Expiration Data from the last Agency Review Findings Letter Sent date until the date of the Agency Review.

E. Sample

1. Once each year the OAAS data section generates a random proportional participant sample from the combined OAAS waiver populations. The sampling criteria are as follows:

    a) The population size is based on the maximum number of unduplicated participants who are served in each year that the waiver is in effect as described in the waiver application.
    b) The sample size is large enough for a confidence level of 95% with a confidence interval of + or – 5%.
    c) The number of participants from the statewide sample to be included in each support coordination agency's sample is proportional to the percentage of participants linked AND certified to each agency on the date the sample is generated. An SCA's sample size is determined separately for each region in which the SCA operates.

d) The original and alternative samples should be generated to reflect at least one participant per waiver per region when applicable.
e) The regional offices receive their portion of the sample at least one week prior to the beginning of the monitoring review phase. The Lead Reviewer enters the participant random sample received from OAAS state office into LASCA.
f) If a sample participant is unavailable for interview, either due to waiver discharge, acute care setting admission, or transfer to a new agency, the OAAS Waiver Quality Manager or designee will identify an alternate participant from the sample.

2. There will be instances when the same participant appears in the subsequent review sample AND a new POC has not yet been approved. In these circumstances, the reviewers adhere to the following protocol:

a) These participants must be included in the sample in order to maintain sample validity.
b) Review any POC revisions OR SCD since the last complete POC to determine if items previously scored as Not Met have been addressed through a revision or the SCD. If addressed satisfactorily, score as Met. If not addressed, score as Not Met.
c) Score the SCD Review Elements according to the protocol addressed under the SCM Look-back Period for Waivers Section above.

IV. SCA MONITORING PROCESS: IMPLEMENTATION

A. Annual Monitoring Notification

Annual monitoring visits are announced 3 business days prior to the Entrance Conference. The agency Executive Director/Project Manager is notified by telephone and in writing (SCA Monitoring Visit Notification letter OAAS-PF-13-001as a scanned attachment to an e-mail with read receipt confirmation) of the Entrance Conference date by the Regional Manager. Written notice must not include any information on the random sample of cases.

B. Monitoring Review Team

The Regional Manger identifies Team Members and designates a Review Team Leader. A Review Team is composed of at least two staff, dependent upon the sample size and resource availability. The Review Team Leader is responsible for assigning workload and recording findings in LASCA.

The Regional Manager continually collaborates with and provides support to the Review Team during the entire monitoring process.

C. Entrance Conference

The purpose of the Entrance Conference is to: (1) explain the monitoring process; (2) provide the agency with the names of participants in the Participant Record Review/Participant Interview sample; (3) coordinate scheduling of interviews with participants and support coordinators; and (4) inform SCA of the documents required for the monitoring review (policy/procedure manuals, personnel records, case records, and other records as necessary). Prior to the Entrance Conference, the Review Team leader meets with the Review Team to discuss and review the information to be covered in the Entrance Conference. The Review Team Leader secures signatures of those present on the SC Monitoring Entrance Conference form.

D. Conducting the Review

Prior to on-site review, the Regional Office will: (1) collect and review data reports (OTIS, Medicaid Data Contractor); (2) review MDS-HC and Notebook; and (3) review the previous LASCA monitoring review results. The Review Team collects information utilizing the worksheets and periodically confers when necessary to share information, concerns, and issues relevant to the scoring determination.

1. Participant Record Review

The Participant Record Review is conducted for all participants in the sample. Record review takes place on-site by accessing assessments, POCs, and SCD.

NOTE: The Record Review is a data source for multiple CMS waiver performance measures. All Review Elements under the Participant Record Review must be scored as Met or Not Met in order to maintain the correct evidentiary sample size. A score of "Met" indicates there is no evidence of non-compliance for the measure. The score of N/A should never be utilized for any of the Record Review scoring items except RR 13.2 as described below.

EXCEPTION: RR.13.2. must always be scored as N/A. The primary purpose of this Review Element is to provide the reviewers with a place to document concerns that are not captured under another Review Element.

If the SCA cannot make record review required documentation immediately available, the reviewers will allow the SCA to locate the documentation at the time of discovery. If the missing information cannot be immediately located or explained by available SCA personnel, the reviewer will make arrangements to interview and review the records with the SCA Director and/or SC. The SCA Director and/or SC will be allowed to explain and/or clarify the reason for the missing information. If the explanation/clarification is acceptable, then the item will be scored as Met. If the explanation/clarification is not acceptable or the documentation is not produced, the item is scored as Not Met.

The timeframe for producing missing information must be no longer than 3 days from the Entrance Conference. For the Participant Record Review, if the information had to be re-printed from the SC's personal data, the reviewer requests the CMIS Required Action Report from billing staff to ensure that the date of service indicated on the log corresponds to the date of service billed by the SCA.

2. **Home Observations**

The **Home Visit has two components: Home Observation** and **Participant Interview**. Review elements that are observed during the home visit may show inconsistency with the corresponding Participant Record Review element. The inconsistency will not change the Participant Record Review element's score. However, it will generate a score and a Level Determination for **Home Observation corrective action.**

The Home Observations Review Element findings are scored and can result in corrective action requirements. For this reason the SCA is given these worksheets. The SCA must review the details of all ***Not Met*** findings in the worksheet and perform remediation (resolution) of any individual participant findings. They must submit documentation of this individual remediation on the Corrective Action Strategy Plan/Progress Report (CASP/PR) according to timelines in their findings letter.

The reviewer must complete a visit to the participant in their home. Direct observation in the home is necessary to fully evaluate whether a participant's needs and safety risks are being addressed. If the participant is unavailable until later in the day, (e.g., ADHC participants) the reviewers may employ flexible hours or compensatory time to complete the Home Observation. When there is difficulty scheduling a home visit with both the participant and a responsible representative in the home, the reviewers may visit the person in their home and contact the responsible representative via telephone or at another time. Visiting the participant at the ADHC cannot be substituted for conducting the Home Visit at the person's home.

3. **Participant Interview**

The **Participant Interview** is a powerful addition to the SC Monitoring process: it empowers the participants and provides a reliable avenue for them to voice problems/ concerns AND provides them with an opportunity to express experiences with the SC Agency, Direct Service Providers and how well the program is working for them in general. For both OAAS and the SC Agency, the information gathered through the Participant Interview has significant value because it: (1) validates (or refutes) record review findings; (2) provides information for quality trending; and (3) highlights staff training needs and areas for improvement.

The Participant Interview is conducted for all participants in the sample. The purpose of the Participant Interview is to obtain information, verbally and through observation, to determine that: (1) assessments are accurate, complete, and timely; (2) known risks have been identified and mitigated; (3) SCs provide appropriate support and guidance in the planning process; (4) SCs effectively monitor how well the POC meets the participant's needs/preferences; (5) participants are protected in the event of an emergency: (6) participants have choice; (7) participants feel safe; and (8) participants know how to voice complaints.

The Review Team Members are responsible for scheduling participant interviews and home visits.

The SCA should assist the Review Team by providing current contact information and other pertinent information to facilitate this component of the review process. Prior to conducting the Participant Interview/Home Visit, the Review Team prints the corresponding Participant Record Review worksheet. This will assist in responding to Outcome 16, the Home Observation section.

NOTE: The Participant Interview and Support Coordinator Interview worksheets are not shared with the SCA because answers are not scored as the other components and do not result in a Level Determination. In addition, participant responses are confidential.

4. **Support Coordinator Interview**

The **SC Interview** provides important information to make a determination about how knowledgeable and skillful the SC is in performing SC duties. The value of the SC Interview is that it: (1) identifies training needs at the agency or SC level; (2) provides information for quality trending; and (3) offers a mechanism for comparison of SC performance against the state and regional norms. The reviewer must interview all SCs linked to the participant sample. If the SC is linked to more than one participant in the sample, the reviewer is not required to interview the SC more than once and the results are entered into LASCA only once. However, at the discretion of the Review Team, other SCs may be included in the interview process to assist in identifying quality improvement and/or training needs of the agency.

It is preferable that the SC Interview is conducted in person, but may be performed via telephone at the reviewer's discretion.

5. **Agency Review**

The **Agency Review** is a distinct review, separate and apart from the Waiver review. Also, LASCA reports are generated specifically for the Agency Review. This review consists of an examination of the policies and procedures as they relate to: (1) assessments; (2) health and safety risks; (3) POC development, monitoring, and revision; (4) complaints; (5) emergencies; (6) participant choice; (7) qualified staff; (8) efficient and effective agency operation; and (9) continuous improvement of services and outcomes.

The Agency Review also includes, in the first SCM year, a 100% review of SC qualifications and orientation requirements. Subsequent years will include review of 100% of SC's hired or promoted to SC Supervisor since the finalization date of the last review. In addition, compliance with annual training requirements during the previous calendar years will be reviewed for 100% of SC's for whom the requirement applies.

NOTE: AR 10.1.b. and AR 11.1.c. In cases where **back-up SC Supervisors** are approving POC packets ONLY, the following qualifications are required:

a) 2 years of experience
b) Training in:
   (1) Documentation;
   (2) Population-specific service needs and resources;
   (3) Support coordination supervisor's role in CQI systems.

If the SCA cannot make Agency Review required documentation immediately available, the reviewers will allow the SCA to locate the documentation at the time of discovery. If the missing information cannot be immediately located or explained by available SCA personnel, the reviewer will make arrangements to interview and review the documentation with the SCA Director and/or SC. The SCA Director and/or SC will be allowed to explain and/or clarify the reason for the missing information. If the explanation/clarification is acceptable, then the item will be scored as ***Met.*** If the explanation/clarification is not acceptable or the documentation is not produced, the item is scored as ***Not Met***.

The timeframe for producing missing information must be no longer than 3 days from the Entrance Conference.

The SCA should ensure an efficient monitoring process by assuming the following responsibilities:

a) Providing policy and procedure manuals, personnel records, case records, and other documentation as request.
b) Providing space for documentation review and SC interviews
c) Coordinating agency SC interviews.
d) Assisting with scheduling participant interviews, i.e., current contact information and best times to contact participants.

E. Exit Conference

Prior to the exit conference, the Review Team meets to review the data obtained and summarizes conclusions about the overall performance of the SCA including agency strengths, weaknesses, priorities, and urgent concerns as applicable. For Level 3 Worksheet Determinations, the review team decides upon the timelines for corrective action.

The Review Team may conduct an informal exit conference prior to finalizing reviews in LASCA. During the informal exit conference, the Review Team will review findings with the SCA. If the SCA disagrees with a finding(s), the Review Team will allow the SCA to dispute findings by producing documentation or other evidence which may affect the outcome of the review element. The SCA has three business days to dispute or respond to any deficiencies. After this process is complete, reviews are finalized and closed in LASCA.

The Review Team Leader is responsible for scheduling and facilitating the exit conference with the SCA Executive Director/Project Manager. During the exit conference, the Team Leader verbally presents an overview of findings including Agency strengths, weaknesses, priorities, and urgent concerns as applicable. The Team Leader also explains the actions required based on the findings and Determination Levels. In addition, the Team Leader explains the timelines required for actions based on Agency Review and Record Review Level 3 Worksheet Determinations.

NOTE: In the event that an SC agency withdraws from the Waiver program prior to finalization of monitoring findings, the Regional Office must notify the State Quality Manager and the SC

Program Manager as soon as possible. The SC monitoring sample will then be adjusted in order to maintain the integrity of the sample and comply with CMS reporting requirements.

V. Guidelines for Scoring the Review

Participant record reviews and participant and support coordinator interviews are used by OAAS to assess: (1) compliance with state and federal requirements; and (2) performance in meeting the needs of participants on the waiver. After completing an SC Agency Review, the Review Team must make conclusions about the performance of an SC Agency and the need for any corrective or enforcement action.

For a quick overview of the scoring criteria please refer to *Summary of Scoring Criteria for SCM Waiver Reviews*.
Also refer to *Finding Criteria with Required Follow-up Actions and Timelines for Waiver/Agency Review* chart which gives guidance for the Review Team to:

1. Score the monitoring tool;
2. Decide what action to take based on review findings;
3. Determine necessary follow-up monitoring activities.

A. Scoring Principles

Scoring the agency's performance takes into account:

1. Whether a review element is ***Met*** or ***Not Met***:

Applying the ***OAAS Interpretive Guidelines***, the Review Team member identifies whether a sub-element is ***Met, Not Met*** or ***does not apply (NA)*** for each sampled participant. If any sub-element of a review element is ***Not Met***, the review element is ***Not Met***.

NOTE: For the Waiver Review, NA is NOT an option for ALL Record Review sub-elements except RR 13.2.a and all Home Observation sub-elements, except HO 16.5.a. which applies only to OCDD. The reviewer must select either *Met* or *Not Met* for all other RR and HO sub-elements.

2. Whether harm or the potential for harm resulted when an element was ***Not Met***.

Each time a Review Element is identified as ***Not Met,*** a **Weight Value** is associated with it. In LASCA, the Weight Value is called Harm Value. This Value is pre-assigned for most Review Elements. Other Review Elements are given a range of Weight Values (2-3) within which a reviewer assigns a value based on individual circumstances.

a) Weight Value 0 - No actual or potential impact on health and welfare. The only Review Elements assigned a Weight Value 0 are the Home Observations. This Weight Value 0 is essentially a place holder for the LASCA Harm Value field. The actual weighting of Home

Observation Review Elements is built into the scoring criteria for the determination levels. (Please refer to *Summary of Scoring Criteria for SCM Waiver Reviews*).

b) Minimal Weight Value 1 - Minimal actual or potential impact on participant's health and welfare. A deficient element that results in or could result in only limited consequence to the participant.

c) Moderate Weight Value 2 – Moderate actual or potential impact on the participant's health and welfare. Moderate impact is defined as a situation that results in, or could result in, a negative outcome that compromises a participant's physical, mental and/or psychosocial well-being.

d) Serious Weight Value 3 – High priority situation requiring immediate corrective action because the agency's noncompliance with one or more elements has caused, or is likely to cause, serious injury, harm, impairment, or death to a participant served by an agency or its provider. When a Weight Value 3 is assigned by the Review Team, the Review Team must document the risk that warrants this determination. This documentation provides support and justification for the resulting score.

e) Weight Value Range 2-3 – The Review Team has the flexibility to assign either a 2 or 3 Weight Value on Review Elements that have this range designation, based on individual circumstances encountered. Whether there is likelihood of a system failure given the prevalence of review elements ***Not Met*** or the number of participants affected by a particular element.

The number of times a review element is ***Not Met*** is divided by the total number of times an element applies to derive an element-specific score. Total system scores are calculated in the same manner.

B. Scoring the Participant Record Review, Home Observations, and Agency Review

1. Scoring Categories

There are five categories of action that can be taken in response to a review. These five categories are applied to each review element in the **Participant Record Review**, **Home Observations** and the **Agency Review**.

a) **Satisfactory**
Review elements that are identified as ***Met*** are considered in full compliance with requirements. No further action is necessary.

b) **Notice of Findings (Does not apply to Agency Review)**

The purpose of Notice of Findings is to bring to the attention of SC agencies those review elements that, while not prevalent across most of the sample, must be addressed

and brought into compliance with standards. A Corrective Action Strategy Plan (CASP) is not required in these cases. However, individual and systemic problems must be addressed and documented at the agency level The SC Agency must continuously monitor and improve performance.

Criteria for **Notice of Findings** determination is as follows:
(1) Review element with Weight Value 1 (Minimal Weight Value) is ***Not Met*** in less than 10% of participant records.
(2) Review element with Weight Value 2 (Moderate Weight Value) is ***Not Me***t in less than 5% of participant records.

c) **Statement of Determination**

(1) **Level 1**

(a) Review element with Weight Value 1 (Minimal Weight Value is Not Met in 10% or more of participant records.
(b) Review element with Weight Value 2 (Moderate Weight Value) is Not Met in 5-49% of participant records.

Corrective Action Strategy Plan/Progress Report (CASP/PR) for Level 1 Determination includes:

- Identification of the problem
- Actions/interventions for improvement
- Responsibility and timetable for implementing interventions
- Measurable indicators for assessing performance related to the situation
- Plans for monitoring desired progress and reporting results

Submittal of a progress report to OAAS is based on the timeline identified in the CASP/PR. No follow-up visit is expected unless the CASP/PR shows lack of sufficient understanding or progress.

(2) **Level 2**

(a) Review element with Weight Value 2 (Moderate Weight Value) is Not Met in 50% or more of participant records.
(b) Review element is cited as a Level 1 in two consecutive years with no improvement (no change or higher % Not Met).
(c) Home Observation review element is inconsistent with record review (Not Met) for one or more participants (but less than 50%).

CASP/PR for Level 2 Determination includes:

- Identification of the problem
- Full description of underlying causes of the problem
- Actions/interventions that target each underlying cause
- Responsibility, timetable and resources required to implement intervention

- Measurable indicators for assessing performance
- Plans for monitoring desired progress and reporting results

CASP/PR is to be submitted to OAAS. A Follow up review will be scheduled based on the CASP timetable and progress reported.

(3) **Level 3**

(a) Review element with Weight Value 3 (Severe Weight Value) is Not Met.
(b) Review element is cited as a Level 2 in two consecutive years with no improvement (no change or higher % Not Met).
(c) Home Observation review element is inconsistent with record review (Not Met) for 50% or more of participants sampled.

When a Level 3 Determination is identified, the Review Team Leader must notify the OAAS SC Program Manager and/or Quality Manager.

Under guidance of the regional office, SC's must take immediate action to assure the participant is protected from further harm and they must respond to any emergency needs of the participant. Other immediate actions include convening planning meetings that may be needed to resolve any critical issues that may potentially jeopardize participants' health and safety and develop strategies to prevent or mitigate the likelihood of similar problems occurring in the future or for other participants.

For all Level 3 determinations, the regional office will designate the timelines for all corrective actions. The due date for the Level 3 CASP/PR is based upon the urgency of the monitoring results. The timelines for Progress Reports and Follow-up Reviews are at the discretion of the regional office but at a minimum no later than that described in Level 2.

The significance of a Level 3 determination is that it alerts the SC agency of a problem requiring rapid implementation of systemic improvement strategies in order to prevent adverse outcomes for participant(s). The regional office should be contacted early and often to assist the SC agency in determining effective strategies for improvement. Level 3 findings do not result in adverse actions against an agency anytime the agency works actively with their regional office to correct problems and implement agreed upon strategies for improvement.

OAAS, as applicable, takes enforcement action to assure the safety, health and welfare of participants. Adverse actions will only be taken when there is repeated noncompliance and an absence of reasonable effort to collaborate with the regional office and implement systemic improvement. Decisions regarding adverse actions against an agency can only be made at the state office level and require evidence of repeated noncompliance and noncooperation with regional and state office recommendations.

Actions include but are not necessarily limited to:

1) Transfer of participants who are or may be in jeopardy due to the agency's non-compliance.
2) Agency removed from Freedom of Choice Provider List
3) Suspension of all new admissions
4) Financial penalties
5) Suspension of provider contract/certification

C. Consequence of Consecutive Level 1 or 2 Determinations for a Review Element

If a Review Element finding was a Level 1 or Level 2 determination for the previous monitoring period and performance did not improve in the subsequent monitoring period (% Not Met did not improve or worsened), it will advance one Determination Level from the actual finding. This process alerts both the SCA and the regional office that the improvement activities implemented in the previous year were either:

1) Not effective,
2) Not implemented thoroughly, or
3) Not implemented soon enough to affect the next monitoring period

This process alerts the SCA that a previous year's performance improvement activities were not fully effective. The SCA and regional office may then utilize this information to avoid detrimental delays when focused improvement activities are required early into a monitoring period. This active approach of Continuous Quality Improvement by the SC Agency is necessary in order to meet the CMS performance standards required of Medicaid Home and Community Based Service programs.

NOTE: Review elements from the Participant Interviews and Support Coordinator Interviews differ from the Participant Record Review, Home Observations and Agency Review in that they do NOT generate corrective action levels.

VI. Discovery

Discovery refers to the monitoring process used to amass data for analysis and decision-making. It is during the discovery process that any significant quality problems should be revealed. The "discovered" information plays a dual role in driving immediate corrections of identified problems as well as overall changes in pursuit of system-wide improvements.

In the SCM process, data is collected to determine compliance with each Review Element. The SCA takes action to correct findings for each non-compliant Review Element. OAAS aggregates this data on the Agency, Regional, and State-wide levels. Many of the Review Elements correspond with formal performance measures. These performance measures are a component of the OAAS Quality Improvement Strategy (QIS) as required by CMS for the HCBS programs. Data on these measures are reported to CMS and provide OAAS with information on how well the QIS design is being implemented and is functioning as intended.

In the CQI model, the CQI teams at the SC and state levels collect, analyze, and interpret data and then brainstorm causes and solutions.

A. Entering Data into LASCA

Data obtained from the worksheets are entered by Regional Office staff according to the LASCA User Manual. "Notes" entries are made on the individual Worksheets to document concerns and assist the SCA in identification of the non-compliance. "Notes" entries provide professional, accurate, pertinent details related to the elements/sub-elements and may provide additional detail for use during the remediation phase or future monitoring periods.

The Review Team Leader reviews all monitoring data to ensure completeness. After all monitoring data is entered, the Team Leader (1) validates the review and saves the findings according to LASCA procedures and (2) alerts the Regional Manager that the review is ready for his/her review and finalization. The Regional Manager then reviews the LASCA data for completeness, discusses the findings with the Review Team, and validates and finalizes the review.

1. LASCA Review Event Tracker

Systemic remediation activities which address noncompliant SC Monitoring Review findings are documented within the LASCA database. Data entry of the events listed below is a critical component towards meeting the federal HCBS requirements for systemic remediation.

a) **Due Date Events**

Enter the following due date events for tracking purposes.

(1) Review Findings Due
(2) Plan of Correction Due
(3) Progress Report Due
(4) Follow Up Review Due

b) **Mandatory Tracking Events for Level 1 Determinations or Higher**

(1) Review Created (Automated)
(2) Notified SC Agency of Monitoring Date
(3) Entrance Interview
(4) Exit Interview
(5) Review Completed (Automated)
(6) Review findings mailed to agency
(7) Plan of Correction received
(8) Progress report received
(9) Either
    (a) Plan of Correction approved: notice sent
        OR
    (b) TA to agency on Plan of Correction
(10) All actions complete

c) **Remediation Phase**

(1) Either:
    (a) Progress report approved: Notice sent
    OR
    (b) Progress report not approved: Notice sent
(2) Either:
    (a) Follow up review conducted: compliance noted
    OR
    (b) Follow up review conducted: Notice given for repeat Plan of Correction and Progress Report
(3) Individual Remediation Actions Complete

d) **Additional Events as Applicable**

(1) Overdue Plan of Correction: Notice sent
(2) Overdue Progress Report: Notice sent
(3) Other (Describe in Event Tracker Notes)

e) **Adverse Actions (To be applied only upon SO direction):**

(1) Agency removed from Freedom of Choice Provider List
(2) Transfer of Participants whose health and safety are at risk
(3) All new admissions suspended
(4) Financial Penalty Letter sent
(5) Medicaid Enrollment Suspended

NOTE: **Anniversary Date** is non-applicable unless it is useful for the regions and they choose to use it.

B. Findings Documents

After the review is finalized in LASCA, the Review Team Leader assembles the Findings Documents and submits to the SCA as follows:

1. OAAS-PF-13-010 SCA Monitoring Results
2. LASCA Detailed Review Findings Reports (Printed from LASCA)
    a) Agency Review
    b) CCW Review
    c) ADHC Review (if applicable)
3. LASCA Worksheets
    a) All Participant Record Review Worksheets
    b) All Home Observation Worksheets: The Regional Office will **remove the Participant Interview elements from the LASCA print-out** because the Participant Interview answers are confidential.

4. Agency Review Worksheet

It is important that all LASCA Reports and Worksheets are saved electronically to ensure that official SCM back-up documents are available.

VII. Remediation

The purpose of discovery activities is to identify instances where the program is not operating as intended and is out of compliance with federal and state requirements. Discovery activities are not an end in themselves, but rather a means to identifying problems so that they can be addressed, i.e. Remediation. The focus of remediation is to address and resolve all individual problems uncovered in the course of discovery.

CMS expects that states address all individual problems as they are discovered. Compliance is achieved by addressing all detected problems with appropriate strategies to correct them and documenting such in the participant record. In addition, CMS expects that compliance is sustained over time by preventing future problems from occurring.

As with discovery evidence, aggregated remediation evidence is necessary to summarize the types and numbers of actions to address performance measure data that indicates substandard operations. Aggregated data about remediation actions, in the form of remediation reports, provides firm evidence to CMS that valid efforts are being made to correct identified problems and maintain improvements. These reports are also valuable at the agency, regional, and state levels to identify and analyze trends related to non-compliance.

A key component of CQI is the capability to discover problems close to their occurrence. This enables a quick response to correct the problem or to recognize if remediation actions in progress are inappropriate and/or untimely. Prompt and appropriate actions to address identified non-compliance are crucial to providing evidence of improvement and avoiding advancement of a Determination Level in the next monitoring period which may also include potential adverse actions.

SCM Remediation is documented by the SCA in the participant record and via the Corrective Action Strategy Plan/Progress Report. The OAAS verifies that remediation efforts were effective through review of the CASP/PR, other ad hoc documentation, and on-site via the formal Follow-up Review.

> Refer to *Finding Criteria with Required Follow-up Actions and Timelines for Agency Review* and *Finding Criteria with Required Follow-up Actions and Timelines for Participant Record Review and Home Observations (OAAS-PC-12-004).*

A. Corrective Action Strategy Plan/Progress Report

The CASP is a comprehensive instrument used by the OAAS RO and the SC Agency to identify and document the required components necessary to rectify SCM findings and to verify the status of progress in completing corrective actions. It is a structured tool that provides both entities with

a format to track improvements for individual and systemic issues. A CASP is required for any Level 1, Level 2, and/or Level 3 findings based on the Record Reviews, Home Observations, and Agency Review. The OAAS "Support Coordination Monitoring Form Instructions" provides detailed guidance in completing the CASP and Progress Report for both the RO and SCA.

The CASP/PR consists of two sections: (1) Corrective Action Strategy Plan; and (2) Progress Report. The CASP section identifies the specific non-compliance and the SCA must respond with the steps taken to correct issues, how progress is tracked and ensured. The SCA then must describe the status of individual and systemic remediation in the Progress Report section.

Using the ***Support Coordination Monitoring (SCM) Form Instructions***, the regional office reviews the SCA CASP/PR and determines if it is acceptable. After the CASP is received from the SCA, the RO must notify the SCA of approval or disapproval within 10 business days of the CASP/PR receipt date. If the CASP/PR is not approved, the SCA then must submit a revised CASP on a timeline specified by the RO.

In the event that the SCA demonstrates difficulty in developing an acceptable CASP/PR, the RO utilizes the ***Instructions on How to Provide Technical Assistance*** and an example of an approved CASP/PR as a resource to assist the SCA. The SCA must complete the following CASP columns: (1) What Steps will Agency take to correct the issue? (2) How will Agency track progress? (3) How will Agency ensure ongoing progress?

The CASP should contain the following characteristics:

1) The identified steps to correct the issue are relevant to the problem.
2) The identified steps to correct the issue are specific enough to correct the problem.
3) The person/position responsible for implementation of the solution is identified.
4) The identified methods to track progress are clear, measurable, and specify the frequency/timeframe.
5) The SCA identifies how tracking of progress is documented.
6) The method identified to ensure ongoing progress is reasonable and realistic.
7) Does the plan make sense?

Remediation methods must be appropriate to the issues identified in order for the efforts to be effective in correcting the issues. It is the responsibility of the Regional Manager to approve the CASP/PR.

The Progress Report is due from the SCA within three calendar months of the CASP/PR approval date. The regional office reviews progress reports, makes a decision to approve/disapprove the SCA progress report and notifies the SCA within 10 business days of receipt of the Progress Report. If the Progress Report is not approved, the SCA must submit a revised report within 10 days of notification of the disapproval, and the regional office provides technical assistance as applicable.

There are two distinct sections of the Progress Report: (1) Individual Remediation; and (2) Systemic Remediation. Individual remediation is required for all non-compliance issues that are specific to individual participants, SCs, SC supervisors, etc. Systemic remediation is required to

achieve agency-wide improvement through training, policy development or revision, procedural revision, etc.

In the "Status of Individual Solution(s) to the Issue" column, the SCA must describe how Levels 1, 2, and 3 findings were or will be resolved. The identifier # and a detailed description of the resolution specific to each participant issue should be included. In the "Status of Agency Solution to the System Wide Issue" column, the SCA describes how identified system-wide issues were addressed/resolved.

SCA's are allowed and encouraged to implement their own agency practices in addressing identified problems and OAAS does not dictate sample sizes, how progress is tracked, or who should be responsible for corrective action implementation and tracking of progress.

B. SCM Follow-up Reviews

The Follow-up Review procedure is an integral component of the SCM process and the CQI model.

1. Definition

A Follow-up Review is an on-site visit of the SCA conducted by OAAS reviewers. The Follow-up Review is a SCM activity based on the recent annual monitoring review results and is a crucial step in the remediation phase of the annual monitoring process. The Follow-up Review visit is **required** when the monitoring results include Level 2 and Level 3 Determinations for the Participant Record Review, Home Observations, and/or Agency Review.

2. Timeline and SCA Notification

The Follow-up Review shall be conducted after the Progress Report is received, not to exceed 6 months from the Findings Letter Sent date. Prior approval of the Progress Report is not required in order to perform the Follow-up Review. OAAS notifies the SCA of the follow-up at least 3 days prior to the visit with the "Follow-up Visit Notification" letter (OAAS-PF-13-019).

When scheduling the Follow-up Review, the Regional Office should allow enough time for completion of the on-site review and the Exit Conference in order to prevent overlap of the remediation phase and subsequent monitoring phase. Factors to take into consideration when scheduling include: (1) history of the SCA's previous performance; (2) complexity/severity/pervasiveness of findings; (3) previous technical assistance provided; and (4) Regional Office resources/schedules.

3. Purpose and Process

Depending upon the nature of the findings, the Follow-up Review process includes, but is not limited to, the review of: (1) the agency's Corrective Action Strategy Plan (CASP)/Progress Report (PR); (2) participant records; (3) policies and procedures; (3) training records; (4) personnel records; and (5) other relevant documentation provided by the SCA that verifies implementation of

the CASP /PR and remediation of individual and systemic issues. The reviewers may, if necessary, also conduct focused interviews of participants and/or SCs, in person or via telephone, to corroborate information provided. **The documentation must provide evidence that the identified actions/strategies were instituted to address and correct ALL previous monitoring sample findings.**

The Follow-up Review Team reviews those aspects of the SCM process related to the non-compliant review elements to verify that corrective actions have been implemented as described in the CASP/PR and that systemic improvement strategies appear effective. For Level 2 and 3 Determinations, the Regional Office assesses compliance with the ***Not Met*** review Elements**.** If the Reviewers deem it necessary to review any Level 1 findings during the Follow-up Visit, there must be evidence in support of these actions as well.

The Follow-up Review Team convenes to determine whether or not approval is achieved and to document the results on the CASP/PR. The results are then communicated to the SCA.

4. Follow-up Review Approval Criteria

The criteria for approval is credible evidence to support that all strategies and actions described in the CASP/PR have been implemented for all of the Individual Remediation, Level 2, Level 3, and as applicable Level 1 findings.

If the criteria for approval are not met, the Review Team must provide the SCA with appropriate technical assistance in order to achieve compliance.

5. Documenting the Follow-up Review

When the Follow-up Review Team has concluded the review and compiled the findings, the Team makes a determination whether to approve or not approve the Follow-up Visit findings based on the criteria. The last page of the CASP/PR should be completed with the Follow-up Review Team's decisions regarding Approval/Disapproval for the ADHC, CCW, and Agency Review as applicable. In cases where Approval is designated, the Review Team has the option to supply additional pertinent information under the "Regional Office Follow-up Comments/Feedback/Recommendations" section.

For those Reviews that are Not Approved, the Follow-up Review Team must clearly identify the justification for the determination and any technical assistance measures conducted or indicated to bring the SCA into compliance. This documentation is very useful to OAAS as a reference for the upcoming annual monitoring review. It is also beneficial for the SCA to establish effective strategies for remediating current non-compliant issues and preventing future ones, as well as sustaining improvements achieved.

6. Follow-up Review and Exit Conference

a) Scheduling

The Team has the flexibility to conduct the Exit Conference on-site immediately after results and conclusions are identified, or regroup and confer to make the final determination. In cases where the Team decides to conclude the Follow-up Review and Exit Conference at the same time, the Review Team communicates the results, provides technical assistance as applicable, and leaves a copy of the CASP/PR with the SCA. In other circumstances, it may be necessary for the Team to take more time to document "Comments/Feedback/Recommendations" and decide on approval or non-approval at a later time and off-site. In this case, the Review Team should conclude the review, make the final decision, send the completed CASP/PR to the SCA, and conduct the Follow-up Review Exit Conference, either in person or via telephone/email, within 10 business days of the last day of the Follow-up Review.

b) Information to Cover

The Review Team informs the SCA management of their Follow-up Review results. In the Exit Conference, the Review Team recognizes the agency's positive achievements and encourages the agency to maintain those aspects of the CASP/PR which were successfully implemented. They also inform the SCA that future monitoring results are affected by how quickly effective systemic improvement activities were implemented following receipt of monitoring results. Agencies are encouraged to be proactive and implement changes at the earliest point possible after findings are received in order to benefit participants and to ensure future compliance. If improvements are not implemented early and effectively in the remediation period, it is possible that noncompliance will be discovered in subsequent monitoring periods, as well. Encourage the agency to do its own quality monitoring on an on-going basis.

The Review Team refers the SCA to the "Finding Criteria with Required Follow-up Actions and Timelines" charts (OAAS-PC-12-004) and emphasizes the timelines and actions required. The Review Team clarifies with the SCA its standing for the next monitoring period and how continued non-compliance could result in harsher findings for the subsequent monitoring review. That is, continuing non-compliance has a cumulative effect advancing the deficient results to the next Level thus requiring more urgent and swift actions by the SCA. The Review Team should also inform the SCA that when there are persistent non-compliant findings, adverse actions may be taken such as removal from Freedom of Choice List, suspending new admissions, or application of financial penalties.

Designation of "Not Approved" by the Follow-up Review Team does not mean that the Follow-up Review period continues until approval is achieved. Nor does it mean that the SCA is not held accountable for the remaining non-compliant issues. On the next annual monitoring review, the Monitoring Team uses the results documented on the CASP/PR Follow-up Visit Comments/Feedback/ Recommendations as a reference of unresolved issues which require closer scrutiny during monitoring.

It is expected that the SCA take prompt, thorough actions to address and correct individual and systemic issues. By expeditiously implementing systems improvements, the SCA can avoid

continued non-compliance in the next monitoring review. Subsequent annual monitoring reviews will verify the effectiveness of the agency's systemic actions.

C. Remediation Responsibilities

1. **Review Team Leader**

a) When corrective action is required, compiles corrective action documents as a component of the Findings documents packet submitted to SCA:

   (1) Corrective Action Strategy Plan/Progress Report (CASP/PR): OAAS-PF-13-012.
   (2) CASP/PR Instructions: OAAS-PF-13-011.

b) Upon receipt of the CASP/PR from the SCA, reviews the document and makes recommendations to the Regional Manager or designee.
c) If the CASP/PR is not approved, the Review Team Leader and Regional Manager notify the SCA and provide feedback on necessary improvements.
d) If the revised CASP/PR is disapproved again, the Regional Office refers this to the OAAS SC Program Manager or designee for possible adverse action.
e) Provides technical assistance and training for the SCA as necessary.

2. **Regional Office Remediation Responsibilities**

For monitoring results requiring corrective action, the RO then reviews the SCM documentation and completes the identifying information at the top of the CASP/PR and the following columns:

1) Monitoring Type
2) Review Element/Sub-element
3) Finding Level
4) Identified Issue/Participant Identifier # and Individual listed by initials (if applicable)

The CASP/PR is sent to the SCA within 10 business days of the SCM exit conference.

3. **SC Agency Remediation Responsibilities**

When the SCA Monitoring Review indicates that corrective action is required, the SCA must submit a CASP/PR to the Regional Office. The timelines for submittal vary with the different Levels as follows: a) Levels 1 and 2: within 30 business days of receipt of findings notification; (b) Level 3: based on the urgency of the monitoring results and at the discretion of the Regional Office.

For each Review Element requiring corrective action, the SCA must gather the participant records associated with the non-compliant Participant Record Review Worksheets and/or

Home Observation Worksheets. The SCA should review the "Identified Issue" column from the CASP/PR and review the Worksheet notes and participant records to identify if additional causes for the non-compliance become apparent. Based on this analysis, the SCA completes the CASP/PR to address how correction will be attained. (See CASP/PR Instructions). The SCA is responsible for remediating individual participant issues and systemic issues.

The SCA is required to submit a Progress Report on implementation of the CASP/PR within 3 months its approval. For Level 3 Determinations, the SCA must take immediate action to respond to the urgent needs of the participants, institute appropriate protections, and resolve high priority risk issues.

VIII. Improvement

A. Overview

Correcting individual problems as they occur is an essential component of CQI, but if the same type of problem occurs repeatedly, assessment of possible systemic causes is warranted. Identification of where and how the recurrent problems persist is then used to develop strategies to prevent future occurrences. Examining aggregate discovery and remediation data over several weeks or months is a good way to determine if there are trends indicating the need to go beyond strategies that address individual problems and initiate those that are more systemic and would result in better performance.

While Remediation focuses on addressing individual problems, Improvement focuses on making adjustments to the system's processes or procedures in order to prevent or minimize future individual problems. When system improvements work, discovery data improve.

Discovery data can be formatted into visual charts and graphs to facilitate analysis and interpretation to assist in identifying issues for further action. For example, discovery data may indicate a system-wide problem with timely reporting of critical incidents, and show where breakdowns in the process are occurring. Based on this data, a CQI team may develop new guidance, protocols, or trainings for relevant staff. The impact of this improvement can be measured by repeating original data collection by the SCA or through Follow-up Review and/or subsequent SCM monitoring by OAAS.

Improvement activities/studies are executed at the Agency, Regional and State Level. CQI teams with the appropriate knowledge and expertise should be involved in Quality Improvement activities to determine where improvements are needed and the targeted goal.
CMS instructions for the waiver application QIS state: 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. These concepts are applicable at all levels of service delivery, i.e. participant, agency, regional, and state. CMS recognizes that the scope of the QIS extends beyond regulatory requirements and should be continuously evaluated for effectiveness.

The Support Coordination Monitoring process is one component of the CQI approach. In concert with the Support Coordination Agencies, OAAS strives to move beyond simply meeting the CMS regulatory assurances and sub-assurances in an effort to achieve:

1) Meaningful participant quality of life (as opposed to freedom from abuse and neglect
2) Efficiency of service provision
3) Efficacy of services and supports
4) Quality outcomes relative to expenditures

B. Basic Quality Improvement Steps

There is no required formula for conducting a quality improvement project. Listed below are some basic steps, taken from a range of CQI models, and is consistent with DDRI framework for implementation of individual quality improvement projects.

1) Assemble a team familiar with the area/system targeted for improvement.
2) Formulate a well-defined goal.
3) Decide what is needed from the improved system or set of processes.
4) Define measures for assessing success.
5) Collect and use data to drive decisions.
6) Identify a range of strategies for improving processes.
7) Test different strategies to refine system changes
8) Repeat as needed (the "Continuous" in CQI).

C. SC Agency Improvement Responsibilities

The focus of Quality Improvement at the Agency level revolves around making broad systemic changes to address the underlying causes of quality problems. These problems present as a trend, pattern, or pervasive practice that has a negative impact on participants, service delivery, agency/staff responsiveness, etc. or on staff capability/ability to perform their duties. These problems are discovered through direct observation, review of documents, or interview with staff and participants.

Systemic improvement actions include but are not limited to: (1) developing new policies/procedures; (2) revising current policies/procedures; (3) revising documentation forms; (4) conducting/facilitating staff training; (5) eliminating/reducing barriers that negatively impact efficient agency operation; (6) improving stakeholder communication network.

D. Regional Office Improvement Responsibilities

Annually, the Regional Office staff examines SCM data, charts and graphs compiled by State Office. This data includes the current monitoring data (Monitoring Period End Date June 30th) and historical SCM data from previous reviews for comparison. Regional staff analyzes the data and identifies areas that show need for improvement, which may be at the individual agency level

or regional level. The Regional Manager submits identified issues for statewide improvement projects to State Office.

There may also be indications of quality failures that span other regions, e.g., SC Agencies operating in multiple regions. This data analysis may indicate specific training needs, or the need for HCBS policy/procedure clarification/reinforcement which may need to be addressed regionally and/or statewide.

E. State Office Improvement Responsibilities

The Quality Management Program Manager compiles the SCM data into user-friendly charts and graphs for review and analysis. State Office receives recommended Quality Improvement Projects (QIP) from the Regional Managers, prioritizes the project(s), and devises an improvement plan using the Basic CQI Steps.

Results of the QIP is presented to the Quality Review Team for review, recommendations, and decision on how to proceed in the future to maintain improvements, or next steps to make adjustments if improvement is not realized.

Information from the following documents was used for the **Design, Discovery, Remediation, and Improvement** Sections**:**

U.S. Department of Health and Human Services, *Understanding Medicaid Home and Community Services: A Primer, 2010 Edition, 2010* (Appendix. Medicaid HCBS Quality*)*, 231-237, http://aspe.hhs.gov/daltcp/reports/2010/primer10.htm.

Sara Galantowicz, *Implementing Continuous Quality Improvement (CQI) in Medicaid HCBS Programs*, National HCBS Quality Enterprise, January 21, 2010, http://www.dpw.state.pa.us/cs/groups/webcontent/documents/document/d_007056.pdf.

IX. DEFINITIONS

Agency – A provider of support coordination services and authorized to operate in Louisiana.

Annual Review – the SC monitoring review conducted on an annual basis which consists of Agency Review, Participant Record Review, Participant Interview/Home Observations, and Support Coordinator Interview.

Confidence Interval – a statistical estimate of the range of values within which the true population value is likely to fall. Confidence intervals are often denoted by a single number that identifies the margin of error, such as + or – 5%.

Confidence Level – a statistical estimate used in random sampling, stated as a percentage, of the degree of certainty that the true population value is within a specified range of values.

Entrance Conference (Interview) – initial face-to-face meeting with the SCA director or designee and review team to discuss monitoring site visit logistics, secure on-site work space for reviewers, and field questions regarding the process.

Exit Conference (Interview) – A summary of conclusions about the overall performance of the SCA including agency strengths, weaknesses, priorities, and urgent concerns as applicable. For Level 3 Worksheet Determinations, the Team Leader informs the SCA of the timelines for corrective action.

- **Findings Categories –** five scoring classifications applied to each Review Element denoting level of action required by the SCA in response to the Finding. (See "Findings Criteria with Required Follow-up Actions and Timelines for Participant Record Review and Home Observations" chart and "Finding Criteria with Required Follow-up Actions and Timelines for Agency Review" chart). **Satisfactory –** Review Element is in full compliance and scored as ***Met***. No further action is required.
- **Notice of Findings –**The Notice of Findings alerts the SCA of the Review Elements that, while not prevalent across most of the sample, must be addressed and brought into compliance with standards. . A CASP/PR is not required. (Notice of Findings does not apply to the Agency Review).
- **Level 1 Determination –** Statement of Determination requiring a CASP and, if applicable, a Progress Report. An on-site Follow-up Review by Regional Office staff is not required unless the CASP/PR show lack of sufficient understanding or progress.
- **Level 2 Determination–** Statement of Determination requiring a CASP and Progress Report.
- **Level 3 Determination –** Statement of Determination requiring immediate action by the SCA and, as necessary, by OAAS. A Level 3 Determination also requires a CASP/PR and Follow-up Review.

Follow-up Review – on-site visit of the SCA conducted by OAAS reviewers. The Follow-up Review visit is **required** when the monitoring results include Level 2 and/or Level 3 Determinations for the Participant Record Review, Home Observations, and/or Agency Review.

LASCA - automated monitoring system to collect, store, and report data obtained through the performance review of support coordination agencies. LASCA also provides a tracking function (Review Event Tracker) that stores the activities, action steps, and dates related to the review process.

Lead Reviewer – Regional Office staff person who assigns reviewers and utilizes LASCA to create reviews, enter sample sizes, enter participant demographics, complete worksheets, print reports, calculate scoring, validate and finalize review. Lead reviewers can enter the action steps of the review (events) in Review Event Tracker.

Monitoring Look-back Period Start/End Dates – the actual "look back" period that sets the date parameters for the review. The Look-back period begins with the date of the Findings Letter Sent from the previous monitoring review and goes to the current day.

Monitoring Review Phase (Period) – the time period that the RO conducts the SC monitoring review.

Monitoring Start and End Dates– in LASCA, the waiver reporting year which is the timespan for all monitoring and remediation activities, i.e., July 1st to June 30th. It is not the same as the Monitoring Look-back Period.

Remediation Phase (Period) – the time period allowed for the SCA to correct all non-compliant citations and the Regional Office to verify compliance and conduct necessary Follow-up Reviews. The Remediation Phase occurs July 1st through December 31st.

Representative Sample – a sample is considered representative of the population if the characteristics of the sample (e.g., age, gender, type of disability) are similar to the distribution of these characteristics in the overall population.

Review Event Tracker – feature of LASCA that provides a method to track activities associated with a review from start to finish. Each step of a review can be documented and tracked to assist Lead Reviewers, Regional, and Central Office staff in managing the support coordination monitoring process. The following events comprise the Review Event Tracker:

- ***Notified SC Agency of Monitoring Date** – date that Visit Notification letter (OAAS-PF-13-001) was sent to the SCA.
- ***Entrance Interview** – date that the Entrance Conference was conducted on-site.
- ***Exit Interview** – date that the monitoring review concluded with the Exit Conference.
- ***Review Created** – **automated**: date that initial monitoring data was entered.
- ***Review Completed – automated:** date that all monitoring data monitoring data was entered and the review finalized.
- ***Review findings mailed to agency** – date that the SCA Monitoring Results letter (OAAS-PF-13-010) and accompanying documentation was sent to the SCA: Within 10 businessdays of Exit Conference.
- ***Plan of Correction received** – date that the CASP/PR (OAAS-PR-13-012) was received by OAAS RO.
    - **a. *Plan of Correction approved: notice sent** – date SCA was notified of CASP approval: Within 10 g business days of CASP received date.

      OR
    - **b. *TA to agency on Plan of Correction** – date that OAAS RO provided technical assistance to the SCA on how to develop an acceptable CASP (Use this Event when CASP is not approved).
- ***Progress Report received** – date that the PR was received by OAAS RO.
    - a. *** Progress Report approved: Notice sent -** date that the SCA was notified of PR approval by OAAS RO via OAAS Response to Progress Report for SCA Monitoring (OAAS-IF-12-038): Within 10 business days of PR received.

      OR
    - **b. *Progress report not approved: Notice sent –** date that the SCA was notified of PR not approved by OAAS RO via OAAS Response to Progress Report for SCA Monitoring (OAAS-IF-12-038): Within 10 business days of PR received.
- Follow-up Review conducted: Compliance noted – date that the SCA was notified of compliance results of Follow-up Review via Notification of SCA Monitoring Follow-up Results letter (OAAS-PF-13-018) and CASP/PR (OAAS-PF-13-012): Within 10 business days of Follow-up Review.

- Follow-up Review: Notice given for repeat Plan of Correction and Progress report – date that the SCA was notified of non-compliance results of Follow-up Review via Notification of SCA Monitoring Follow-up Results letter (OAAS-PF-13-018) and CASP/PR (OAAS-PF-13-012): Within 10 business days of Follow-up Review.
- Overdue Plan of Correction: Notice sent – date SCA was contacted that the CASP was overdue: Not submitted within 30 calendar days after Findings Letter Sent.
- Overdue Progress Report: Notice sent – date SCA was contacted that the PR was overdue: Not submitted within 3 calendar months after the Progress Report was received.
- ***All actions complete –** date that the SCA completed ALL remediation (Individual and Systemic) within the remediation period.
- Review Findings Due – latest date that monitoring findings must be entered into LASCA: June 30th.
- Plan of Correction Due – latest date that the CASP/PR must be submitted to OAAS by the SCA: Within 30 calendar days of Findings Letter Sent for Level 1 & 2 Determinations.
- Progress Report Due – latest date that the PR must be submitted to OAAS by the SCA: Within 3 calendar months of PR approval.
- Follow-up Review Due – latest date that OAAS conducts the Follow-up Review: After PR approved, but no later than 6 months from Findings Letter Sent.
- *****Agency Removed from Freedom of Choice Provider List***
- *****Transfer of Participants whose health and safety are at risk***
- *****All New Admissions Suspended***
- *****Financial Penalty Letter Sent***
- *****Medicaid Enrollment Suspended***
- Anniversary Date – NA unless useful for the RO.
- Other – items not included in dropdown list. Specify in the Notes field the "Other" activity being tracked.
- ***Individual Remediation Actions Complete –** date that the RO verifies that the SCA has satisfactorily completed all individual remediation.

  *** Mandatory Event**

  ***** To be applied only upon State Office direction***

Scoring Summary – LASCA feature that lists the worksheet types, number of worksheets completed, number of elements ***Met*** and ***Not Met***, and the findings based on the scoring guidelines.

Validate Worksheet – LASCA feature that allows the reviewer to check the completeness of a worksheet. The system will show how many questions remain if the worksheet is not complete.

Weighted Value ("Harm Value" in L ASCA) – the numerical value assigned to each Review Element (0-3) denoting the impact on the participant's health and welfare. The Weighted Value is a component of the LASCA scoring logic for automatically calculating findings levels i.e. Satisfactory, Notice of Findings, Level 1/Level2/Level 3 Determinations.

- **Weight Value 0** – No actual or potential impact on participant's health and welfare.
- **Weight Value** 1 – Minimal actual or potential impact on participant's health and welfare.
- **Weight Value 2** – Moderate actual or potential impact on participant's health and welfare.

- **Weight Value 3** – High priority situation requiring immediate corrective action to protect the participant's health and welfare.

X. ACRONYMS

ADHC – Adult Day Health Care
AR – Agency Review
CASP/PR - Corrective Action Strategy Plan/Progress Report
CCW – Community Choices Waiver
HO – Home Observations
LASCA – Louisiana Support Coordination Application
MDS-HC – Minimum Data Set – Home Care
OAAS – Office of Aging and Adult Services
OCDD – Office for Citizens with Developmental Disabilities OTIS—
Online Tracking Incident System
POC—Plan of Care
PI – Participant Interview
PR – Progress Report
RO – Regional Office
RR – Record Review
SC—Support Coordinator
SCA—Support Coordination Agency
SCD – Support Coordination Contact Documentation
SCI – Support Coordinator Interview
SCM – Support Coordination Monitoring