



Human Services
Research Institute

Best Practices in Provider Qualifications & Monitoring: Supporting and Ensuring Competent Service Providers

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ID Redesign Workgroup

Topics

- Overview of Provider Qualifications & Monitoring
- Evolution of Monitoring and Current Expectations
- Iowa's Monitoring of Community Service Providers
- Workgroup Discussion Points

Overview of Provider Qualifications & Monitoring



Provider Qualifications

- Provider qualifications help the state perform the important role of “gate keeper”.
- At minimum, states typically require a provider show a business license, qualified CEO and leadership staff, financial capacity to operate for a given amount of time, a Medicaid provider number, and policies and procedures in place that meet state and federal requirements.
- When the provider has met the eligibility requirements, they may be authorized to serve clients. Most states conduct a follow up site visit to new providers to review how well things are going – both for the provider and for the clients.





Gate Keeping is a Balancing Act

- **TOO EASY:** Providers that do not have wherewithal to sustain services are approved and fail. The state may expend significant resources providing technical assistance and monitoring prior to failure. Individuals and families are negatively impacted.
- **TOO HARD:** May inhibit new providers, or culturally competent providers from going into business. States are unable to facilitate interest in underserved areas and specialized services. This limits the growth of community capacity to serve people with developmental disabilities.
- **IT'S OKAY TO SET DIFFERENT QUALIFICATIONS FOR DIFFERENT SERVICES:** Core qualifications can be set for all providers, enhanced by specific qualifications for each service type. Medicaid and the operating agency can have different expectations, but expectations should work in tandem.

Provider Monitoring

A review process to determine the extent to which a provider meets federal and state requirements, and contract provisions.

- **Bottom line.** A provider is as good as the expectation to which it is held. State statute, regulation and policies are the foundation by which a provider's performance is measured.
- **Sanctions.** States need clear authority (free of political influence) to monitor and sanction (fine, increase oversight or remove) poor providers.
- **System improvement.** Aggregated performance data across providers (by type, by area/region, by service, etc.) can be used to identify areas for system-wide quality improvement.
- **Frequency of review.** Usually set by the state. Typically 1-3 years. States can vary frequency based on provider performance or type of service.



Monitoring Typology

Terms used to describe monitoring can mean something in one state but something else in another state. Generally, three categories:

- **Licensure** - Granting of a license, permission to practice, is issued to regulate activity considered to have potential danger to a person or which involves a high level of specialized skill. States usually license residential services according to state statute and regulations.
- **Certification** – Confirmation of certain characteristics of an organization established by some form of external review, education, assessment, or audit. Usually used to evaluate services that are not required to be licensed. In some states, particular services need to be both licensed and certified.
- **Accreditation** - A process in which certification of competency, authority, or credibility is presented. Used in many fields including health care and higher education. In the developmental disability field accreditation is usually done by CARF, CQL, or JACHO. States may encourage accreditation when they have a limited amount of funds to monitor. National accreditation organizations do not typically monitor against state rules without a contractual agreement in place.



Monitoring Yields Information about Individual Provider Performance & System Performance

- Adequate number and types of providers so that people have choice
- Are qualified (financial capacity, management capability, Medicaid provider authorization, staff trained and background checks, etc.)
- Have sufficient staff capabilities and capacity for people supported
- Have complaint and grievance process that's transparent and effective
- Maintain effective incident management systems that include full reporting, investigating and remediating incidents, mortality review, safeguards for restrictive interventions including use of psychotropic medications
- Protections for rights and promotion of rights
- Demonstrates a quality management culture
- Maintains financial integrity

Evolution of Monitoring and Current Expectations



THEN



- Services provided in one location, an institution; centralized location made monitoring logistically easier
- Primary focus was physical facility and health and safety code compliance
- Prescriptive standards
- Less federal oversight of use of public monies
- No public reporting of provider performance

NOW



- Services decentralized, community based; multiple service sites entail more involved logistics
- Focus expanded to include outcomes and satisfaction with services, individualized assessment of service fit
- Emphasis on CQI (continuous quality improvement)
- Greater federal oversight for use of public monies
- Public reporting of performance



Quality Monitoring Landscape Shifts

- Enhanced accountability with reduced public funds. Need to ensure that funds are spent for services that improve the quality of people's lives.
- Increasing federal expectations to monitor and report on particular aspects of service delivery, and to look for and seek to improve areas of weaker performance
- Exposure of national problems (e.g., GAO report on recommending CMS require mortality review for DD waivers, NDRN report on segregated work)
- Emergence of self-determination, self directed services
- *Olmstead* decision and recent federal enforcement; need to move people to community based services
- Staff shortages: DSPs, dentists, primary care docs with DD expertise
- Expansion of supports to individuals on a waiting list & waiting list lawsuits
- Involvement of stakeholders to monitor services formally & informally



Monitoring: What do we want?

- Transparent, well understood expectations, monitoring tools & process
- Minimal disruption to provider and individuals receiving service
- Streamlined, as non-duplicative as possible, without gaps in critical areas
- Use state's resources efficiently and effectively to ensure provider pool meets service population's needs for accessible and available providers, cultural competency, choice, most integrated services, and evidence based services
- Providers are supported to deliver excellent services that lead to outcomes of important to individuals and families
- Monitoring data is shared across state agencies
- Data for reporting to authorities is collected, analyzed, & shared with stakeholders
- Keep good providers; offer technical assistance; remove poor providers

RIGHT-TO-KNOW CAMPAIGN

***A RIGHT TO QUALITY HUMAN SERVICES =
A RIGHT TO KNOW***

People with disabilities and their families have the right to make informed decisions on behalf of ourselves and our loved ones. We have the **right to know** if a public or private sector provider has a history of high turnover. We have the right to know a provider's record on abuse and neglect, staff turnover, medication errors, restraint usage, and staffing ratios. We have a right to know we will be safe in our own homes.

QUALITY CARE REPORT CARD	
<u>Category</u>	<u>Grade</u>
Staff retention	?
Abuse/neglect	?
Facilities	?
Finances	?
Medication errors	?
Staff ratios	?



Value in Multiple Information Sources

- In the past, states relied primarily on one or two monitoring processes such as licensing and reviews of Medicaid expenditures.
- Good practice now is to have multiple data sources to track performance: licensing, state QA monitoring, national accreditation, provider reporting of QI initiatives, incident management, financial oversight, complaints, satisfaction surveys, etc.
- With multiple sources of performance data, its important to ensure that the oversight entity is reviewing data across the data sources to evaluate provider performance and identify systemic problems
- Streamlined, non-duplicative and sufficient evaluation (no gaps) is even more important with multiple monitoring mechanisms. Sometimes duplication is important (financial, rights restrictions, etc.)

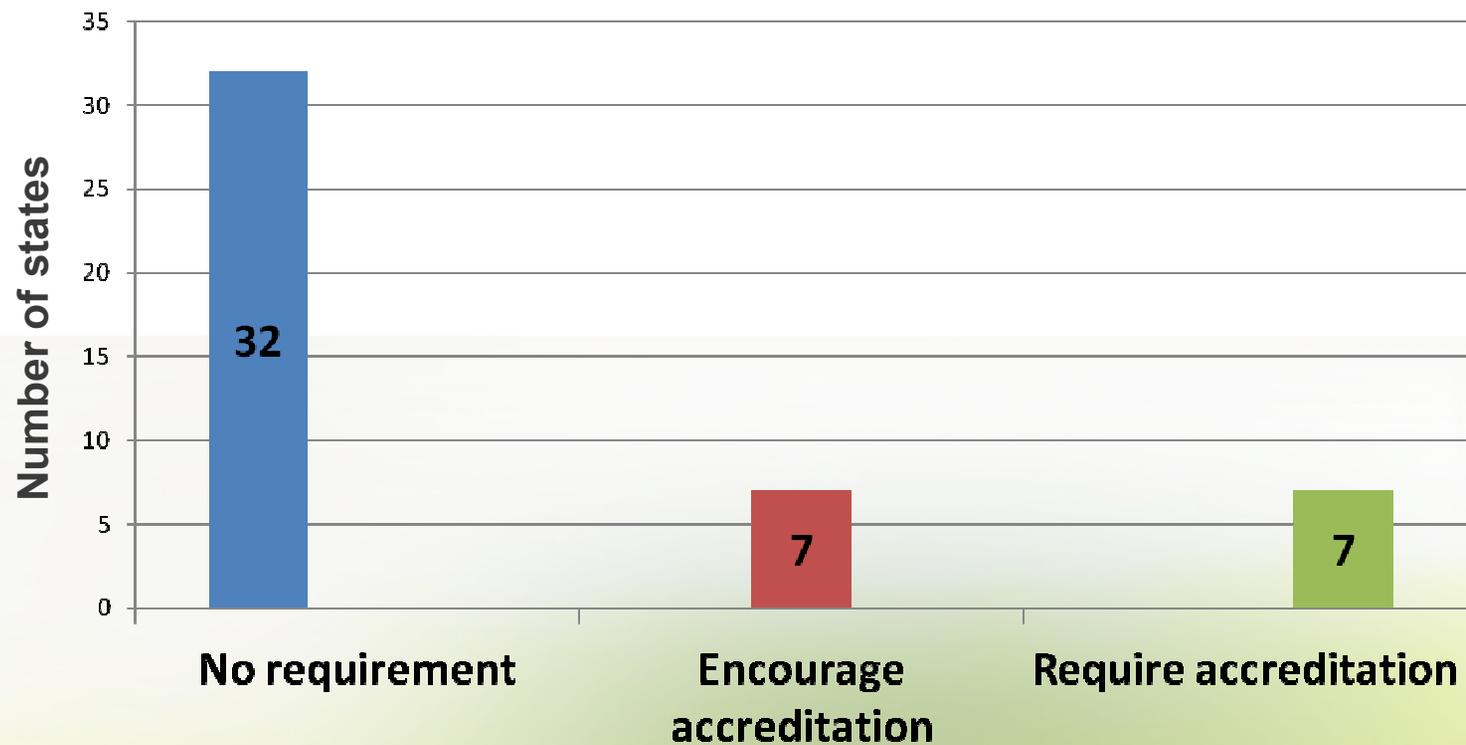


Survey of States' Use of Accreditation to Monitor Provider Performance

HSRI conducted a survey of state practices regarding national accreditation of community service providers for Missouri's DMRDD. 46 states responded:

- State managers view accreditation as an adjunct quality assurance process that complements, but does not replace, state quality monitoring.
- 70% states neither require nor formally encourage national accreditation. 30% require national accreditation.
- States are more likely to encourage/require accreditation of day services than residential services. This practice appears to be long standing as policies regarding accreditation of day services in 10 states had been in place for more than 10 years.
- States that require or encourage provider accreditation are equally split between those that waive quality oversight requirements and those that do not. Most frequently waived is provider certification (7 states).

Position of States on Community Provider Accreditation



Monitoring Independent Providers

CMS strongly encourages states to make participant direction a central feature of all waivers. How to monitor the services of an independent provider is an important question. National Quality Enterprise staff prepared a monograph for state managers on monitoring independent providers with recommended considerations, including:

- Individual providers should meet universal, essential basic qualifications.
- Individual providers should have the training to effectively support the person including person-specific knowledge (i.e., service plan).
- Mechanisms should be in place to track at individual and system levels:
 - services are delivered according to plan (can use billing data)
 - back up plans are in place for when scheduled staff are unavailable
 - person receives services free of abuse, neglect, or exploitation
- Information about individual providers is readily available to individuals and families in order to make informed choices in providers.

Federal Government Wants Evidence of Performance



- The Centers for Medicare and Medicaid Services (CMS) now requires information on a regular basis, not just every 5 years.
- CMS has sets higher expectations for monitoring and the use of information for quality improvement.
- States now must analyze information, identify trends, and put in place quality improvement strategies for areas of weaker performance.
- State has the primary responsibility for monitoring.
- State makes Assurances to CMS. CMS ensures the state is sufficiently monitoring the program and is in compliance with Assurances.



The Federal Monitoring Floor

States must provide evidence that these Assurances are being met for 1915(c) waivers for HCBS:

Level of Care - Persons enrolled have needs consistent with an institutional level of care

Service Plan - The service plan that is appropriate to their need and that they receive the services/supports specified in the plan

Qualified Providers - Waiver providers are qualified to deliver services

Health & Welfare - Participant health and welfare is safeguarded & monitored

Financial Accountability - Claims for waiver services are paid according to state payment methodologies

Administrative Authority - State Medicaid agency is involved in the oversight of the waiver and is ultimately responsible for all facets of the program

CMS Waiver Assurances: Provider Qualifications

- The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.
- The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.
- The State implements its policies and procedures for verifying that provider training is conducted in accordance with state requirements and the approved waiver.

Source: CMS Waiver Application, Appendix C-2



CMS Waiver Assurances: Provider Qualifications

- For each type of individual or agency provider identified the state must specify the provider qualifications.
- The waiver application provides for 3 types of provider qualifications:
 - A license issued under the authority of state law.
 - A certificate issued by a state agency or other recognized body, i.e., a recognized accreditation organization
 - Other standards specified by the state; may be in addition to a required license or certificate and must be specified.
- CMS has not promulgated minimum provider qualifications for waiver services. States have latitude in establishing qualifications. Like other Medicaid services, waiver services are subject to any relevant requirements contained in state law. Provider qualifications must be reasonable and appropriate in light of the nature of the service. They must reflect sufficient training, experience, and education to ensure that individuals will receive services from qualified persons in a safe and effective manner.



Performance Outcomes Measured by States to Meet CMS HCBS Assurances

- Assessments are accurate, complete and timely
- Health and safety risks are identified and mitigated
- Individuals participate in planning
- The POC has strategies to meet participant needs and preferences
- POCs and services are up to date and timely
- Participants are protected in the event of an emergency
- Participants have choice
- Participants' needs are met
- Participants are safe
- Provider agencies have competent staff
- Management structures support an effective and efficient operations
- Data management systems produce timely and useful information
- Services and outcomes are continually improved

The Monitoring Frontier

Use of community members, including family members and individuals receiving services, to conduct aspects of monitoring such as interviewing people receiving services about the community activities, work, home, choice making.

Few states have sustained statewide citizen monitoring to date. Though logistics are challenging, a parallel monitoring with citizens reviewing quality of life is an exciting format.





Iowa's Monitoring of Community Service Providers





Current Service Quality Monitoring

- Iowa Code, Chapter 24 certification requires TCM satisfaction surveys
- Iowa Code, Chapter 25 requires all counties to participate in QA activities
- Iowa has moved away from individual outcomes approach in surveying because of limited resources.
- Iowa is pushing providers to get national accreditation. State reviews for state-specific standards.
- DHS reviews complaints.
- DHS conducts focused reviews that are issue specific. Current focus is incident management. 125 agencies reviewed/year for focused review.
- A quality review of direct services is done at least once every 5 years. If State certified, every 3 years. IME reviews 125 agencies/year for QA purposes.



Current Financial Monitoring

- Annual desk review by IME of cost reports for specific services: SCL, SE, respite, IMMT and Family and Community Support Services (CMH waiver).
- HCBS QA will review records and make referrals to program integrity (IME) if there are issues.
- DHS fiscal auditor spends 100% of time looking at service documentation. All other services are paid by fee schedule and have not been audited to date.
- CPC/county based financial audit of providers - Counties ask providers to submit their annual audits. The 67 counties that participate in CRIS (County Rate Information System) require their host providers to submit their annual audit with their cost reports to the CRIS accounting firm. Each cost report is reconciled to the provider's annual audit.



Workgroup Discussion

Key Discussion Points



Points to Discuss

- How can provider qualifications and monitoring efforts support desired outcomes?
- What expectations should the state have regarding quality improvement practices within provider organizations?
- What steps can be taken to measure individual outcomes across settings (i.e., ICFs/MR, community residences, etc.) What is the best tool to use to monitor individual outcomes?
- Is the state's reliance on accreditation bodies sufficient to ensure quality?
- What data does the accreditation body make available to the state to ensure adequate oversight and remediation of problems?

Points to Discuss

- What monitoring functions are best performed at the local, regional, and state level?
- To what extent can these functions be streamlined? What infrastructure changes or improvements would be needed to support this effort?
- What types of technical assistance can be made available to providers enhance quality?
- What is the best way to make the information generated from quality assurance efforts transparent? How should information be shared with the public?
- How can Iowa take advantage of existing resources?