Appendix H: Quality Improvement Strategy (1 of 2)

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

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

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

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

Quality Improvement Strategy: Minimum Components

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

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

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

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

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

When the Quality Improvement Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and/or identify the other long-term services that are addressed in the Quality Improvement Strategy. In instances when the QIS spans more than one waiver, the State must be able to stratify information that is related to each approved waiver program. Unless the State has requested and received approval from CMS for the consolidation of multiple waivers for the purpose of reporting, then the State must stratify information that is related to each approved waiver program, i.e., employ a representative sample for each waiver.

Appendix H: Quality Improvement Strategy (2 of 2)

H-1: Systems Improvement

a. System Improvements

i. Describe the process(es) for trending, prioritizing, and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

The Iowa Medicaid Enterprise (IME) is the single state agency that retains administrative authority of Iowa's Home and Community-Based Services Waivers, ID (IA 242), BI (IA 0299), HD (IA 4111), PD (IA 0345), AH (IA 0213), CMH (IA 0819), and Elderly (IA 4155). Iowa remains highly committed to continually improve the quality of services for all waiver programs.

The IME discovered over the course of submitting previous 1915(c) waiver evidence packages that previously developed performance measures were not adequately capturing the activities of the IME. For this reason, state staff developed new performance measures to better capture the quality processes that are already occurring or being developed. That said, the QIS developed by Iowa stratifies all 1915(c) waivers.

Based on the contract oversight and performance measure implementation, the IME holds weekly policy staff and long term care coordination meetings to discuss areas of noted concern for assessment and prioritization. This can include discussion of remediation activities at an individual level, programmatic changes, and operational changes that may need to be initiated and assigned to state or contract staff. Contracts are monitored and improvements are made through other inter-unit meetings designed to promote programmatic and operational transparency while engaging in continued collaboration and improvement. Further, a quality assurance group gathers on a biweekly basis to discuss focus areas, ensuring that timely remediation and contract performance is occurring at a satisfactory level.

Iowa has acknowledged that improvements are necessary to capture data at a more refined level, specifically individual remediation. While each contracting unit utilizes their own electronic tracking system or OnBase (workflow management), further improvements must be made to ensure that there are not preventable gaps collecting individual remediation. The state acknowledges that this is an important component of the system; however the terrain where intent meets the state budget can be difficult to manage.

Improvements have already begun with the successful transition of contractors within the HCBS Provider Quality Oversight Unit. The new contractor brings efficiency and quality to the process which will create room for improvement and more detailed activities in the future. This unit will be taking on increasing remediation activities with the case managers and service workers such that all process can incorporate full remediation and improvement. These processes should be fully implemented by 2014.

The Balancing Incentive Payment Program will allow for infrastructure development that will ensure that choice is provided to all Medicaid members seeking services and that these services are allocated at the most appropriate level possible. This will increase efficiency at a case management and service worker level such that less time shall be spent on service/funding allocation and more time shall be spent on care coordination and improvement. A comprehensive system of information and referrals shall also be developed such that all individuals are allowed fully informed choices prior to facility placement. Most of these changes shall be implemented during 2013 and 2014.

The state is also developing a new Medicaid Management Information System that will allow for a more integrated approach to data storage and workflow processes. While the future of the Individualized Services Information System is not yet know (whether it may or may not be integrated into the new MMIS/MIDAS project) this novel system will afford the state many efficiencies and ease of use. This system shall be fully implemented during 2015.

ii. System Improvement Activities

Responsible Party*(check each that applies):*	**Frequency of Monitoring and Analysis***(check each that applies):*
☑ **State Medicaid Agency**	☑ **Weekly**
☐ **Operating Agency**	☑ **Monthly**
☐ **Sub-State Entity**	☑ **Quarterly**
☐ **Quality Improvement Committee**	☑ **Annually**
☑ **Other** Specify: Contracted Entity	☐ **Other** Specify:

b. System Design Changes

i. Describe the process for monitoring and analyzing the effectiveness of system design changes. Include a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The IME has acquired a state staffed Quality Assurance Manager to oversee the data compilation and remediation activities associated with the revised performance measures. The oversight of design changes and the subsequent monitor and analysis is handled by the QA Manager and the state policy staff during the weekly policy and monthly quality assurance meetings.
Prior to dramatic system design changes, the state will seek the input of stakeholders and test/pilot changes that are suggested and developed. Informational letters are sent out all relevant parties prior to roll-out with contact information of key staff involved. This workflow is documented in logs and in informational letters found within the agency server for future reference. Stakeholder involvement and informational letters are requested or sent out on a weekly/monthly/ongoing basis as policy engages in the continuous quality improvement cycle.
Unit managers, policy staff and the QA committee continue to meet on a regular basis (weekly or monthly) to monitor performance and work plan activities. The IME Management and QA committees include representatives from the contracted units within the IME as well as state staff. These meetings serve to present and analyze data to determine patterns, trends, concerns, and issues in service delivery of Medicaid services, including by not limited to HCBS Waiver services. Based on these analyses, recommendations for changes in policy are made to the IME Policy staff and Bureau Chiefs. This information is also used to provide training, technical assistance, corrective action, and other activities. The unit managers and committees monitor training and technical assistance activities to assure consistent implementation statewide. Meeting minutes/work plans track data analysis, recommendations and prioritizations to map the continuous evaluation and improvement of the system. IME analyzes general system performance through the quarterly management of contract performance benchmarks, ISIS reports, and Medicaid Value Management reports and then works with contractors, providers and other agencies regarding specific issues. The QA committee directs workgroups on specific activities of quality improvement and other workgroups are activated as needed.

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

The IME reviews the overall QIS no less than annually. Strategies are continually adapted to establish and sustain better performance through improvements in skills, processes, and products. Evaluating and sustaining progress toward system goals is an ongoing, creative process that has to involve all stakeholders in the system. Improvement requires structures, processes, and a culture that encourage input from members at all levels within the system, sophisticated and thoughtful use of data, open discussions among people with a variety of perspectives, reasonable risk-taking, and a commitment to continuous learning. The QIS is often revisited more often due to the dynamic nature of Medicaid policies and regulations, as well as the changing climate of the member and provider communities.