

Bureau of Long Term Care Quality Improvement Strategy 2020

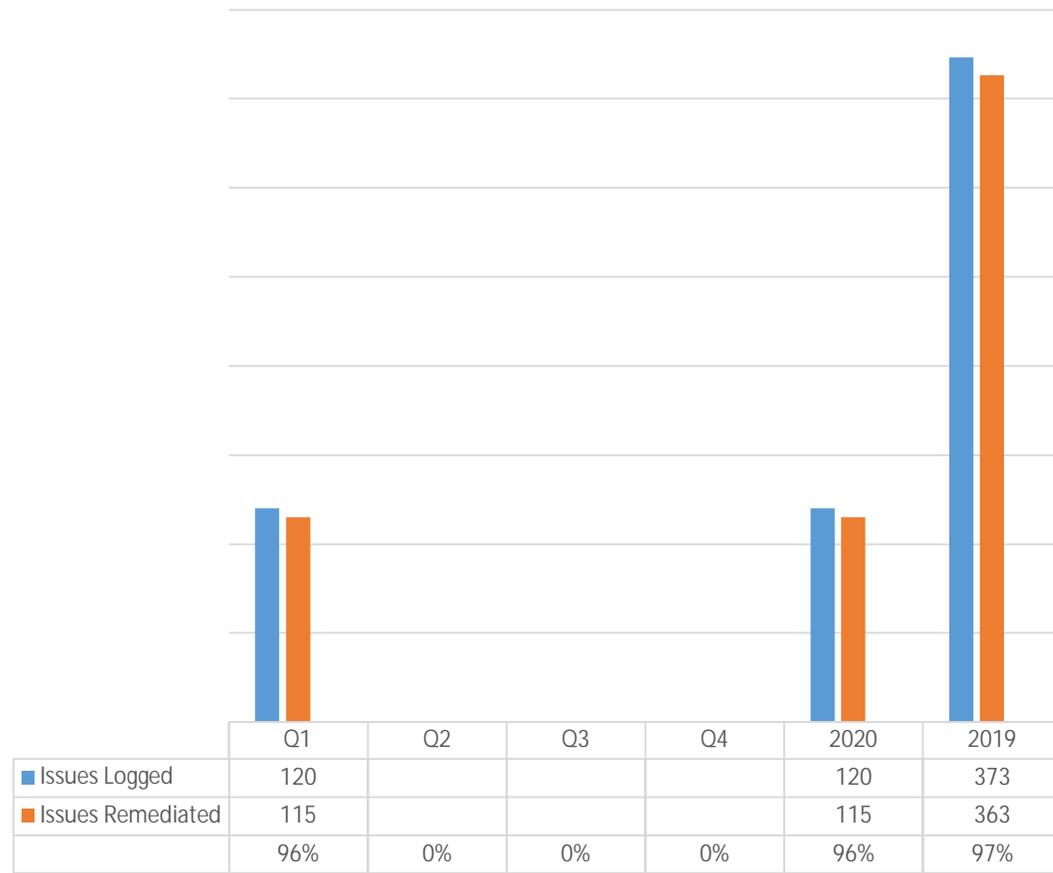
ADMINISTRATIVE AUTHORITY

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

DUAL ELIGIBLE CONTRACT MONITORING

Summary: Complaints related to MCO vendors and contracted providers are identified within the Dual Eligible Beneficiary Issue Log and are investigated within the appointed timeframes.

Managed Care Issues



Overview: BLTC staff oversee managed care organization (MCO) issues to ensure timely response and remediation by the applicable MCO. These issues are logged on a SharePoint that is accessible to both the MCO and the MCO Contract Monitor.

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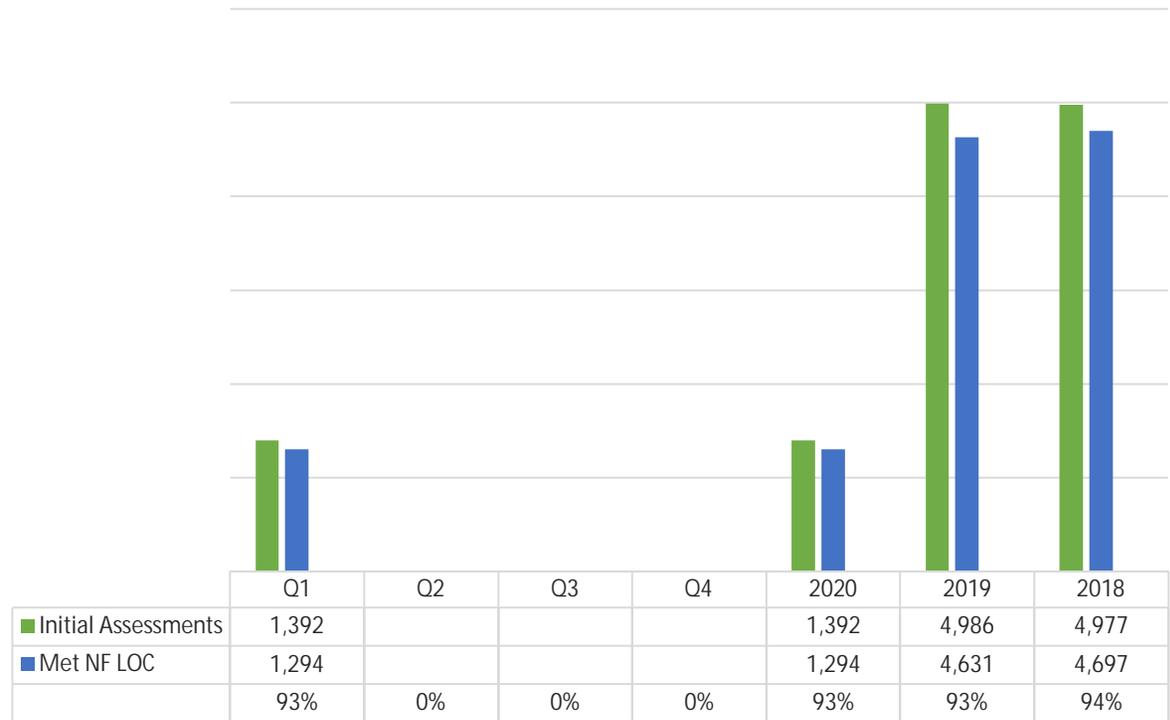
1.0 LEVEL OF CARE (LOC)

Assurance: The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver level of care consistent with care provided in a hospital, Nursing Facility or ICF/ID-DD.

Sub-assurance a: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

Summary: Over 90% of new applicants for Aged & Disabled (A&D) Waiver services met Nursing Facility (NF) LOC during their initial assessment.

Aged & Disabled Waiver Level of Care Assessments



Overview: The Level of Care Assessment is conducted by a Registered Nurse staffed with the Bureau of Long-Term Care (BLTC). Assessments are conducted using the Uniform Assessment Instrument (UAI). The UAI is a set of standardized criteria used to assess a participant's functional and cognitive abilities. The UAI provides a comprehensive assessment of a participant's actual functioning level and unmet needs to determine the level of assistance required for the participant, including those elements that are necessary to develop an individualized person-centered service plan.

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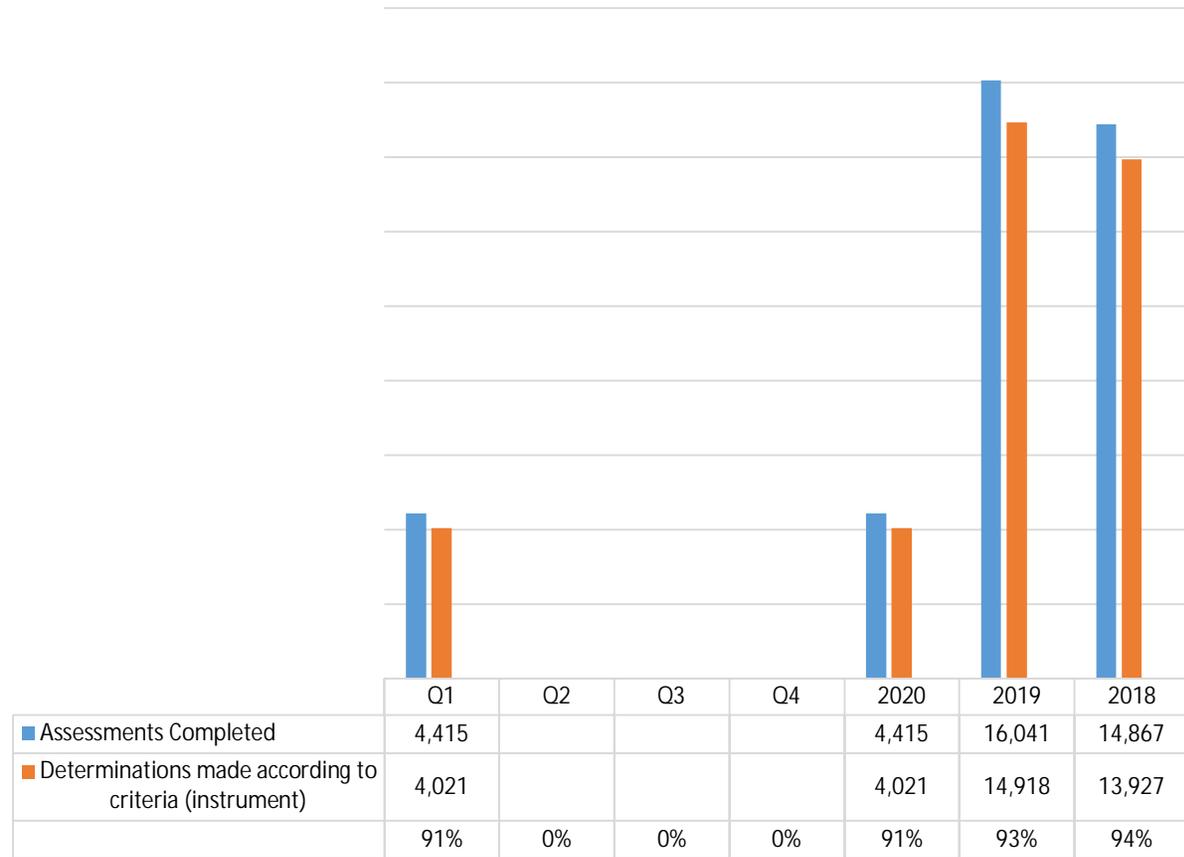
1.1 LEVEL OF CARE ACCURACY

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

Summary: The Assessment Certification Tool (ACT) has improved our ability to accurately capture data related to the LOC Determination Assessment.

BLTC continues to identify gaps to ensure that training is conducted with staff that do not make determinations according to criteria. The Nurse Manager is responsible to train all Nurse Reviewers.

System LOC Determination Accuracy



Overview: Reporting mechanisms pull data from the ACT system to determine the total number of assessments completed and the total number of assessments completed accurately per the Level of Certification (LCERT) Part B. The LCERT Part B determines if the Nurse Reviewer accurately selected the appropriate Program per the Level of Care assessment or selected Level of Care Not Met if applicable. Nurse Managers utilize the new reporting mechanisms to monitor staff on a weekly basis and to identify trends to develop focused training for staff.

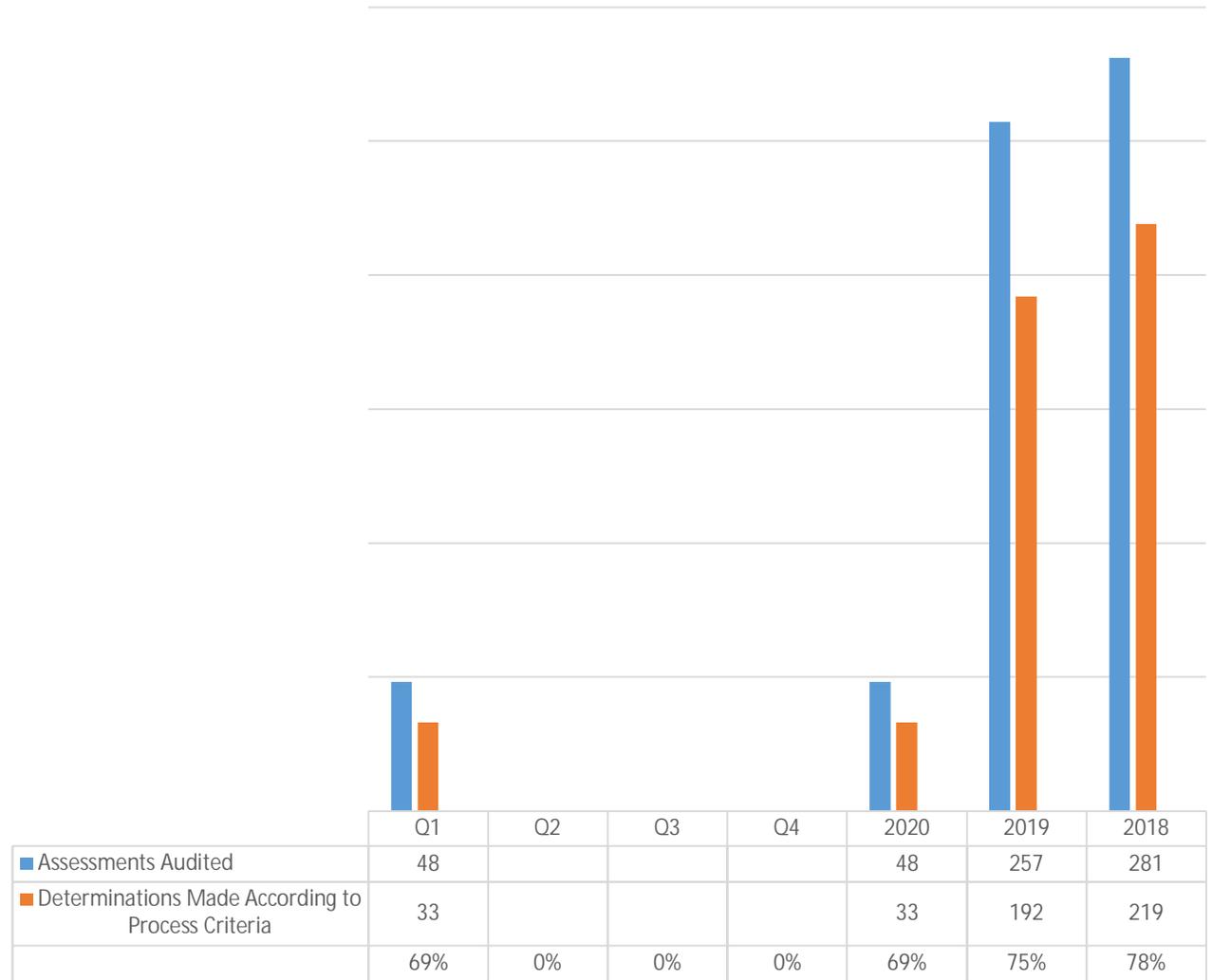
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INTERNAL AUDIT

Summary: The Nurse Managers conduct a required quarterly internal audit utilizing data directly from the Assessment Tool. The audit is designed to review a representative sample of LOC Assessments in depth, reviewing criteria to ensure the Nurse Reviewer conducted an accurate assessment.

Remediation: As Nurse Managers perform comprehensive audits of all assessments, they identify areas for improvement. Q1 audits were conducted for staff not assigned to the Nurse Manager. This methodology for auditing assessments allows the Nurse Managers to identify areas for statewide training of staff to ensure consistent business processes.

Internal Audit Clinical Determinations



Overview: The Internal Audit is conducted by the Nurse Managers on a quarterly basis. The Nurse Manager conducts three internal file audits for each Nurse Reviewer with a focus on clinical criteria.

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2.0 QUALIFIED PROVIDERS (LICENSED)

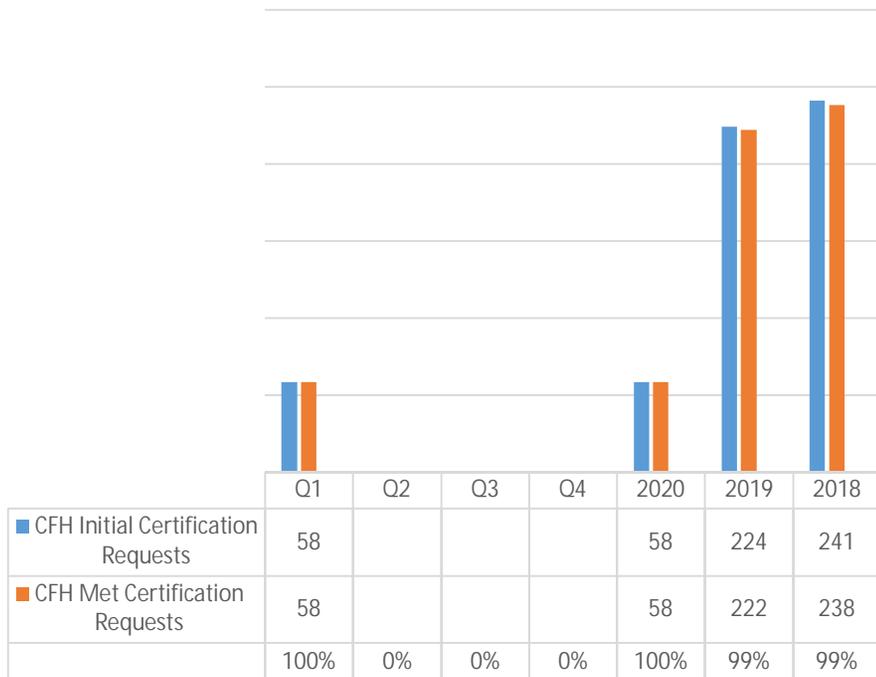
Assurance: The State demonstrates that it has designed and implemented an adequate system for assuring that all waiver services are provided by qualified providers.

Sub-assurance a: The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing waiver services.

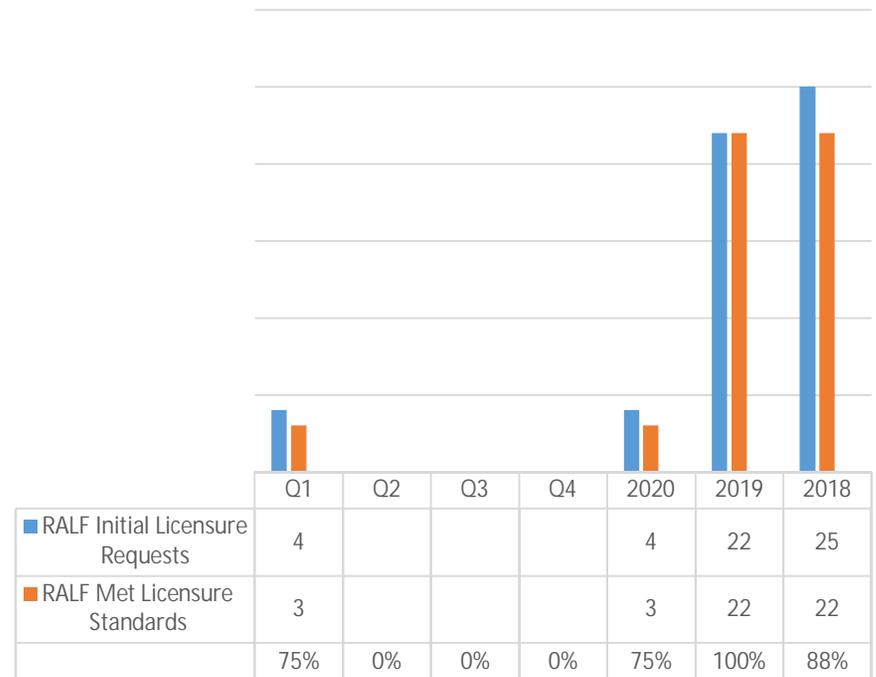
Overview: L&C manages the certification program for Certified Family Homes (CFH) and the licensing program for Residential Assisted Living (RALF) Facilities. L&C is responsible for the certification/licensing, inspection and survey of these provider types.

Summary: Initial applications for Certified Family Home and Residential Assisted Living Facility Certification and RALF Licensure request reviews were conducted by the Division of Licensing and Certification (L&C). Any facility that is not compliant is not certified and a license is not issued.

Initial Certification Request - Certified Family Homes



Initial Certification Request - Residential Assisted Living Facilities

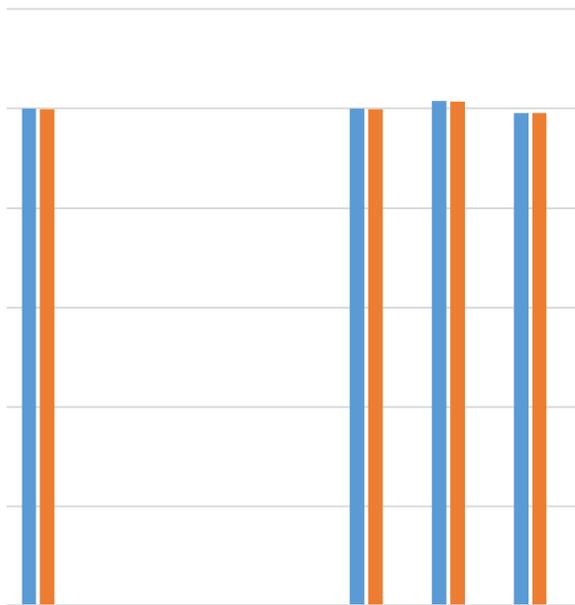


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Summary: L&C conducts all recertification assessments to determine if licenses will remain active. If standards are not met L&C manages all deficiencies associated with the licensure and certification standards.

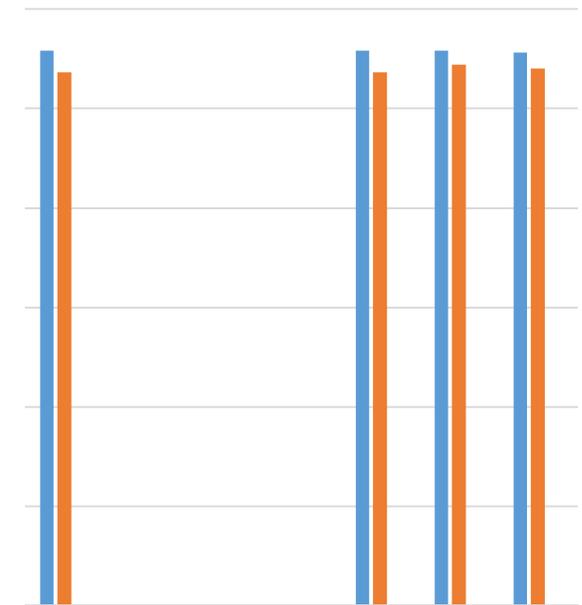
Overview: L&C manage the ongoing certification and licensure requirements for Certified Family Homes (CFH) and Residential Assisted Living (RALF) Facilities.

Existing Facility Reviews - Certified Family Homes



	Q1	Q2	Q3	Q4	2020	2019	2018
CFH Existing Licensure/Certified Providers	2,498				2,498	2,535	2,475
CFH Met Licensure/Certification Standards	2,495				2,495	2,533	2,474
	100%	0%	0%	0%	100%	100%	100%

Existing Facility Reviews - Residential Assisted Living Facilities



	Q1	Q2	Q3	Q4	2020	2019	2018
RALF Existing Licensure/Certified Providers	279				279	279	278
RALF Met Licensure/Certification Standards	268				268	272	270
	96%	0%	0%	0%	96%	97%	97%

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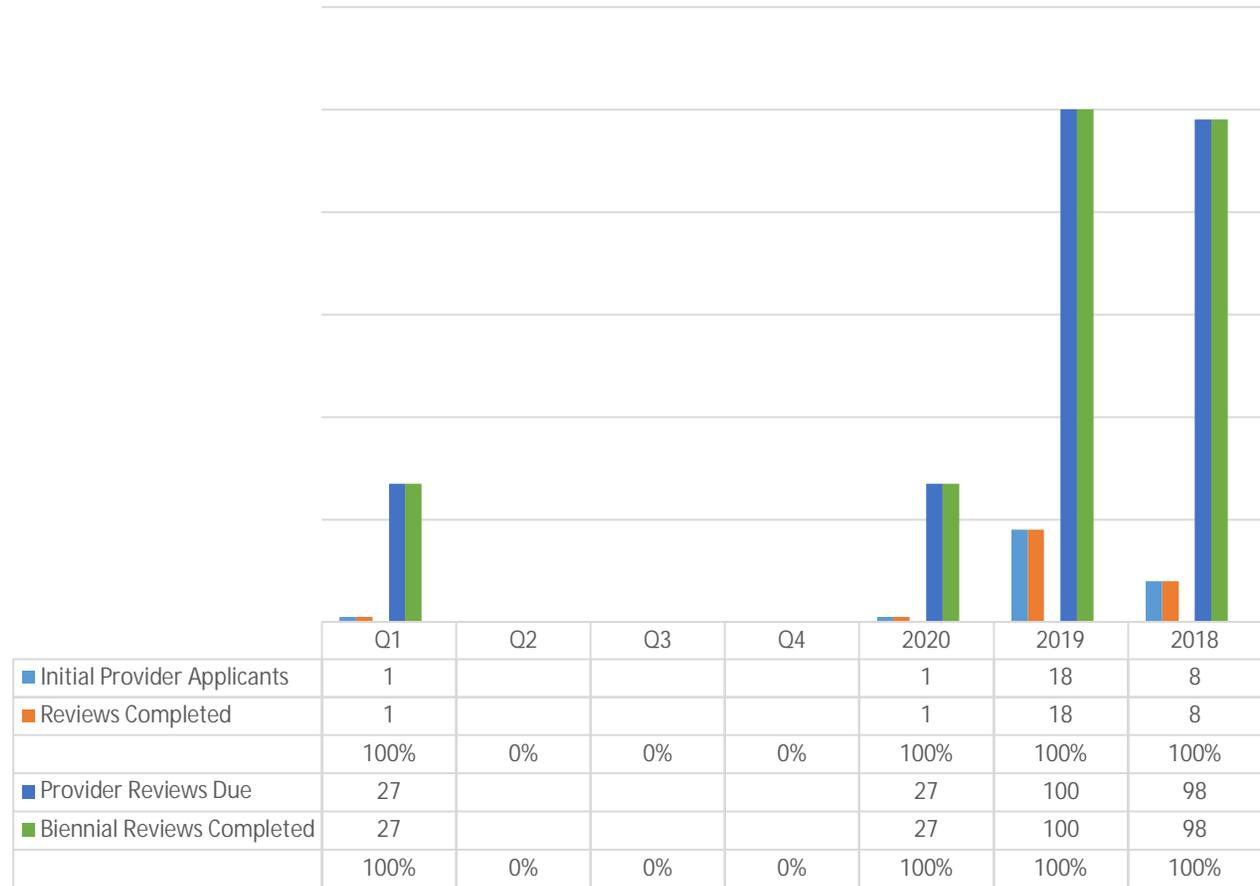
2.1 QUALIFIED PROVIDERS (NON- LICENSED)

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

Summary: Audits continue to be completed by required timelines. Process improvements have contributed to BLTC improvement in meeting required timelines, and we continue to evaluate our operational processes to further enhance our audit process.

Audits beginning mid-March were conducted solely as a Desk Review due to the COVID-19 pandemic. The Quality Assurance Team was able to conduct all required provider reviews during this timeframe.

Non-Licensed Providers



Overview: Biennial audits are conducted for all providers that conduct services for participants receiving State Plan Personal Care Services and A&D Waiver services. Additionally, BLTC has oversight to review policies and procedures for new non-licensed providers to ensure compliance to all IDAPA rules and contractual obligations. The provider auditing methodologies include a comprehensive provider self-audit and a BLTC desk audit that is completed prior to the on-site provider audit.

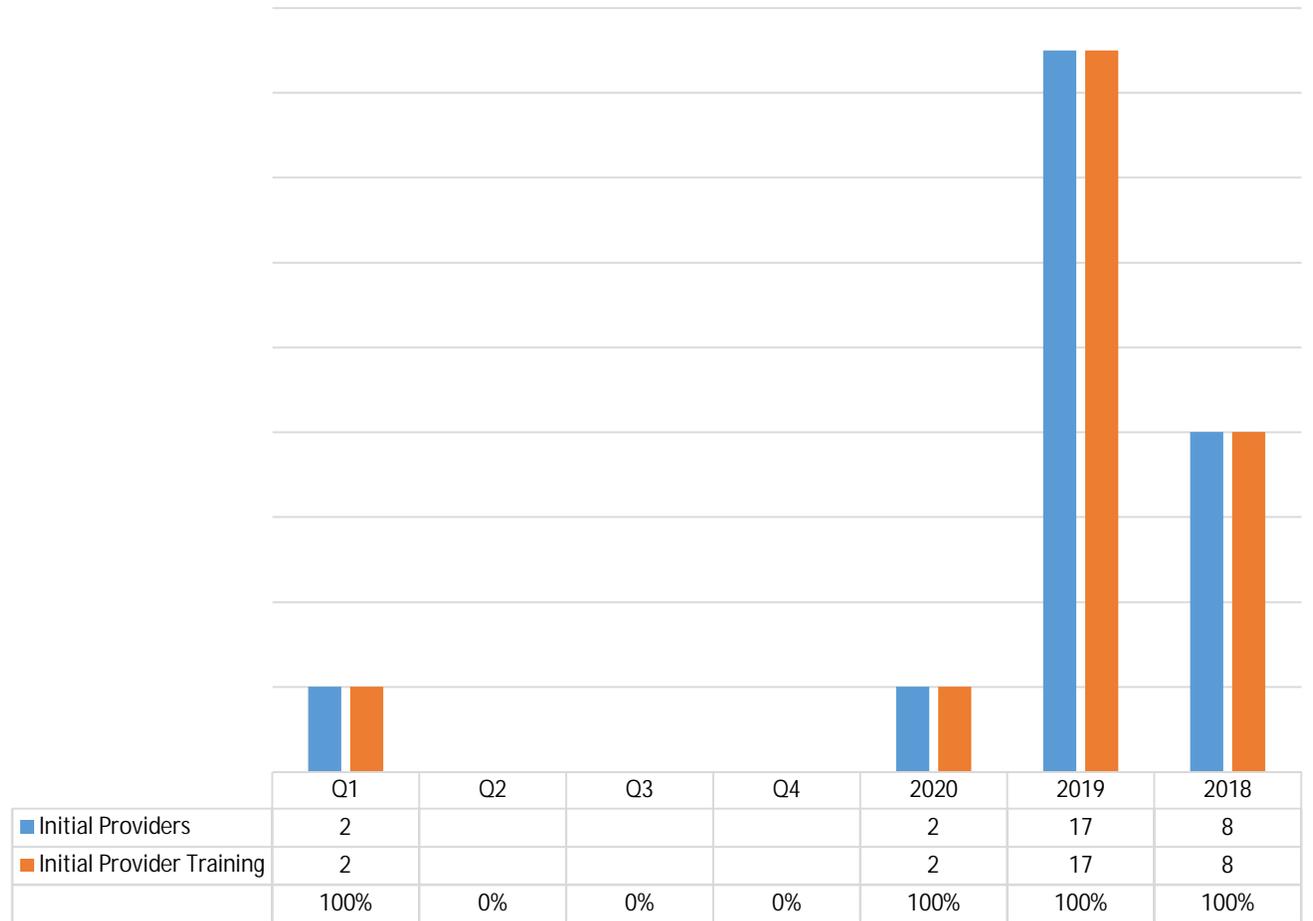
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2.2 QUALIFIED PROVIDERS (NON- LICENSED)

Sub-assurance c: The State implements its policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.

Summary: All newly eligible providers approved in quarter 1 of 2020 were provided training.

New Non-Licensed Provider Training



Overview: Upon approval of policies and procedures for initial non-licensed providers, training for the provider agency is required prior to any services being delivered to Idaho Medicaid participants. Training is conducted by Quality Assurance Specialist staff within the BLTC.

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3.0 SERVICE PLANS

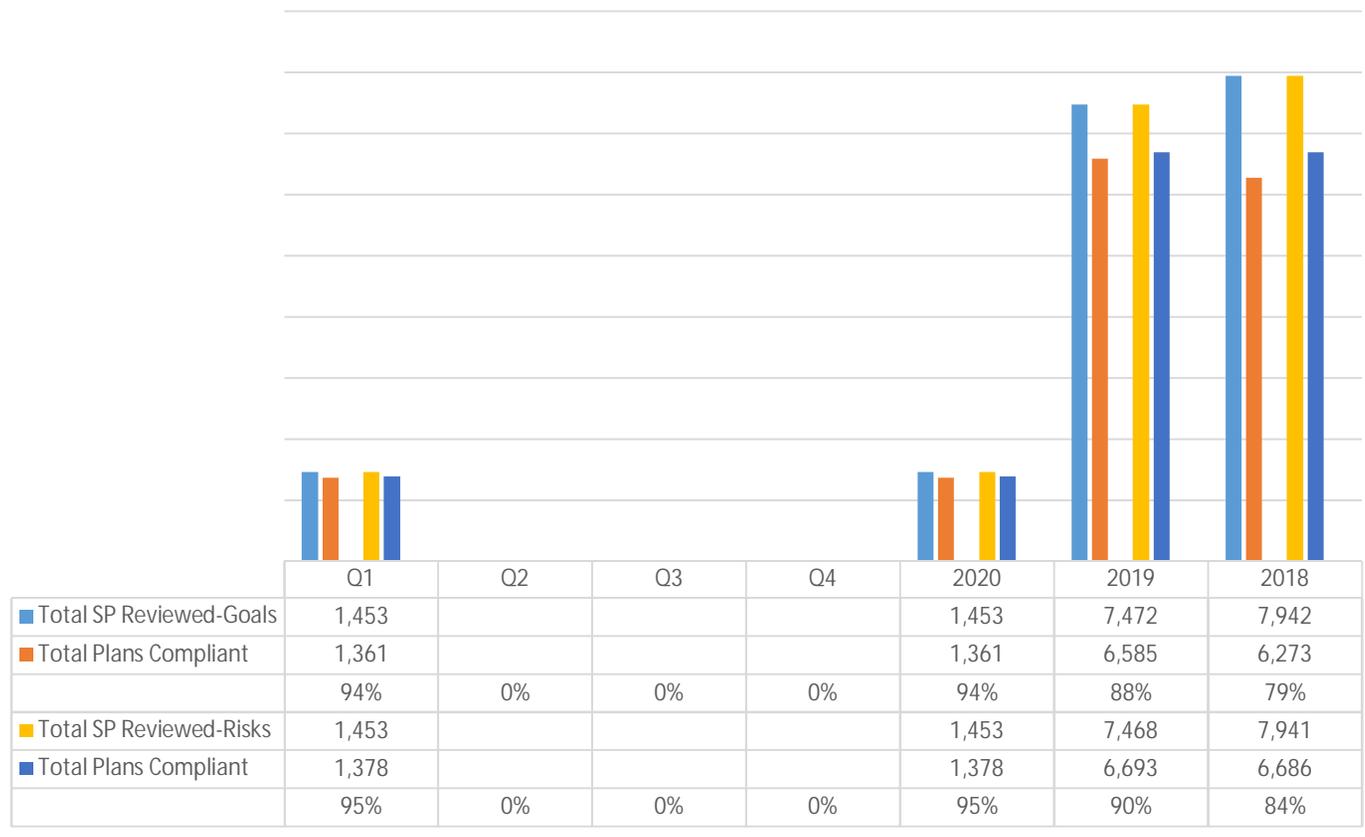
Assurance: The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for waiver participants.

Sub-assurance a: Service plans address all members assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.

Summary: Nurse Reviewers audit and report on 100% of Service Plans at the time of the Annual Assessment. The data is distributed to providers on a quarterly basis. The BLTC QA team monitors the data to provide technical assistance to providers to ensure remediation of deficient Service Plans. There has been continued improvement in compliance with required Service Plan elements.

Remediation: Quality Survey Reports are sent to providers on a quarterly basis with deficiencies clearly identified. Immediate remediation is expected by all providers. BLTC QA staff have spent time developing training materials specific to Risks and Goals. This training has helped to improve compliance.

Service Plan Elements: Participants Risks and Goals



Overview: Participant Service Plans are developed by the providers based on the findings from the LOC Assessment. Risks and Goals are required elements that are reviewed on an annual basis by the Nurse Reviewer at the time of the Annual Assessment. The Service Plan review sampling method was modified from a representative population sampling through the provider Quality Assurance (QA) process to a whole (100%) audit. This approach is expected to improve Service Plans for participants and better identify quality improvement areas that need to be addressed.

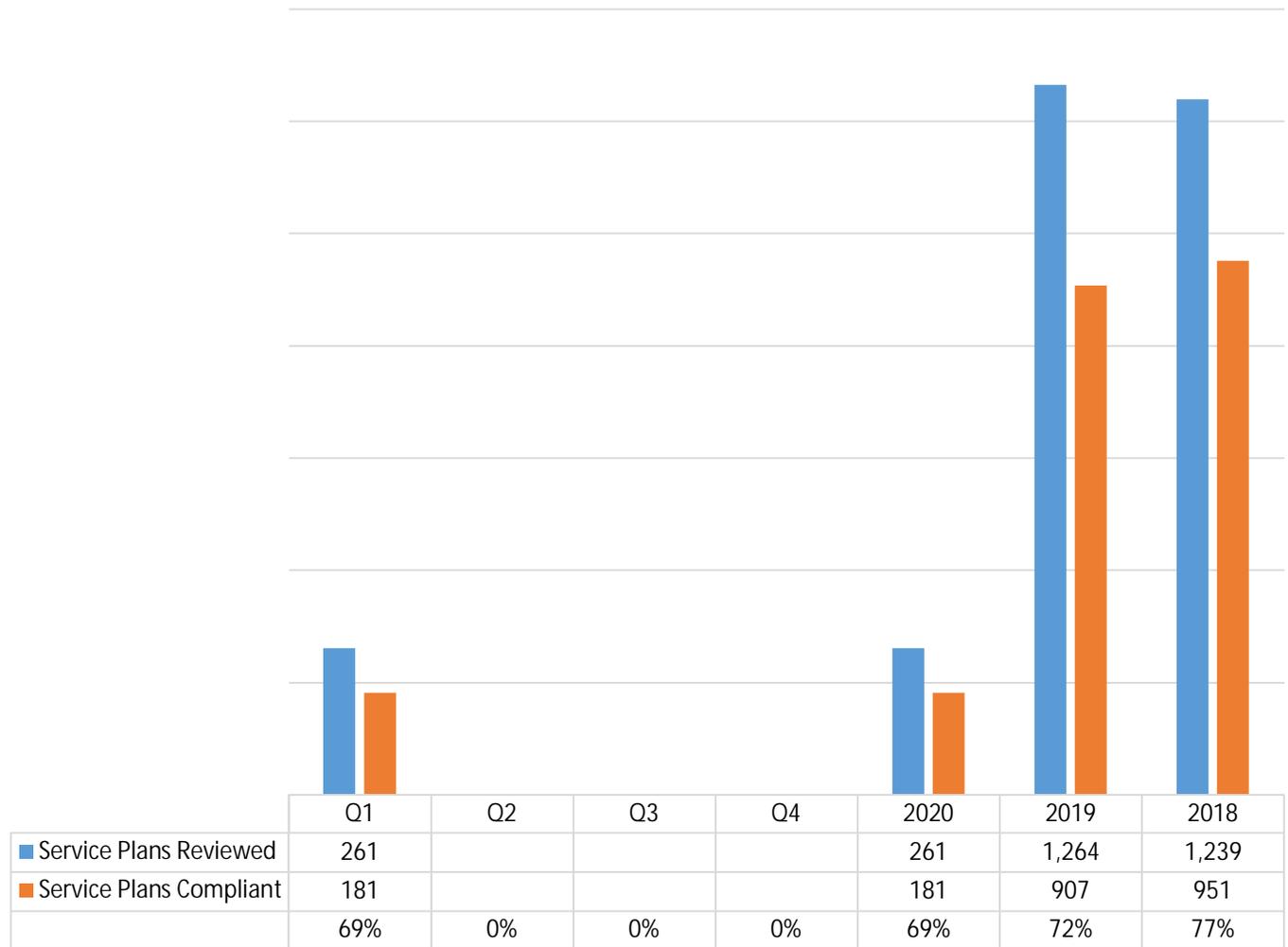
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BACKUP PLAN

Summary: The Backup Plan is a component of the BLTC Service Agreement that is sent to all providers upon the completion of the LOC Assessment. Most providers have adopted the IDHW Service Agreement as their participant Service Plan which helps to ensure that all appropriate Backup Plan elements are present. BLTC identified that Backup Plans were still lacking information to satisfy appropriate requirements with most of the deficiencies in the area of narrative. Providers with identified deficiencies are provided technical assistance as necessary to ensure compliance.

Remediation: BLTC QA staff continue to train providers and offer technical assistance throughout the Provider Review process. We have recently implemented a two-month provider review for all new providers to help them remediate deficiencies earlier and ensure they are meeting the expectations, ideally while the participant census is low as this provides the provider an opportunity to improve prior to growing their agency. Backup Plan compliance has improved, however in Q1 we have identified the written portion of the plan for most agencies requires improvement.

Service Plan: Backup Plans



Overview: Participant Service Plans are developed by the providers based on the findings from the LOC Assessment. Backup Plans are a required element and are reviewed biennially by Quality Assurance Specialists at the time of the provider audit. The current audit sample size is 30% of the entire Medicaid population serviced by the identified provider.

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3.1 SERVICE PLANS

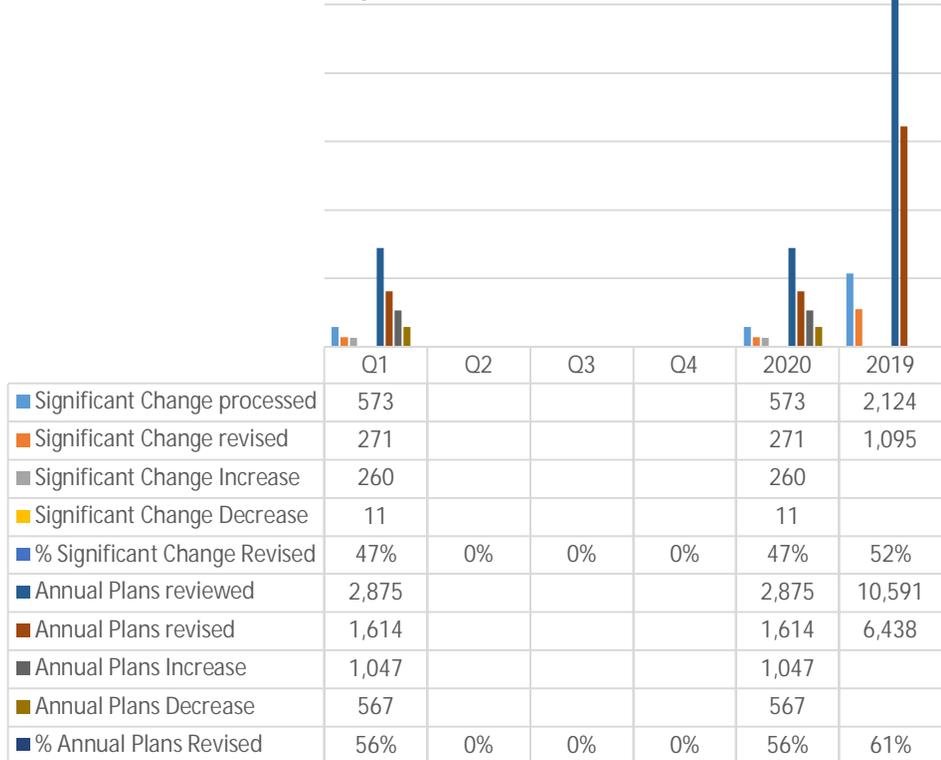
Sub-assurance c: Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

Overview: Significant Change is identified as any change in services after the Annual or Initial LOC Assessment has been completed. Significant Changes generally result in a change in the LOC score.

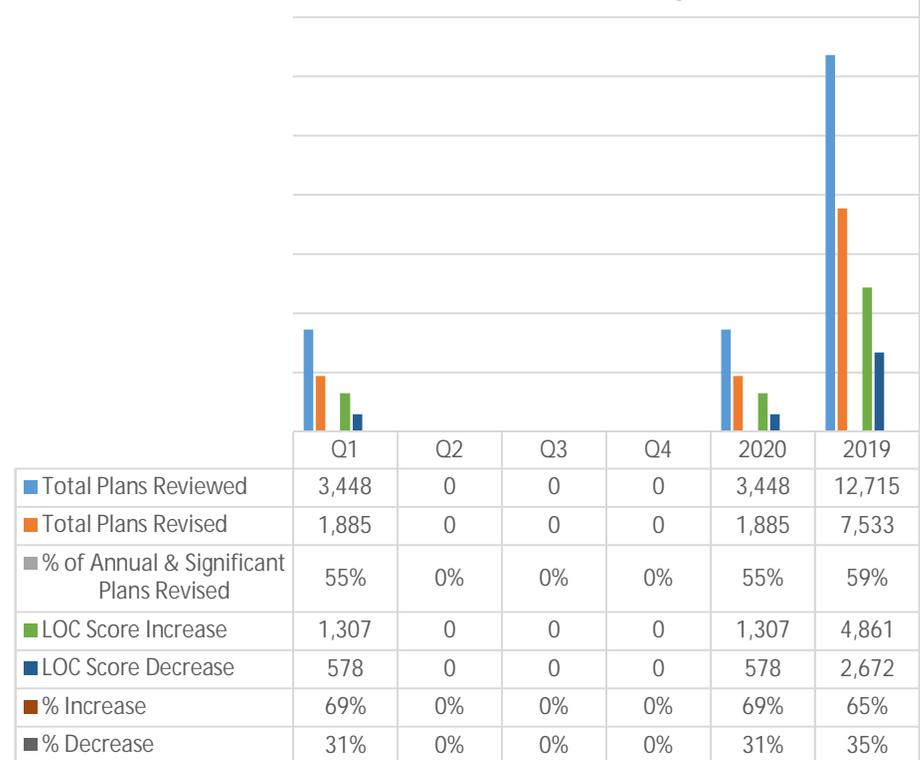
Summary: Reporting has identified that 56% of all Annual Assessments are revised from the previous year's LOC score. Furthermore, 47% of Significant Change Assessments are revised from the existing assessment score. Providers are not reporting Significant Changes as often as Annual Assessments indicate.

Remediation: BLTC continues to offer training to providers in the importance of identifying and reporting Significant Changes to participants LOC needs. A new form was created and implemented in Q3 of 2018 for the sole purpose of providers reporting Non-Use of services by participants.

Annual and Significant Reviewed/Revised



Total Assessments and LOC Changes



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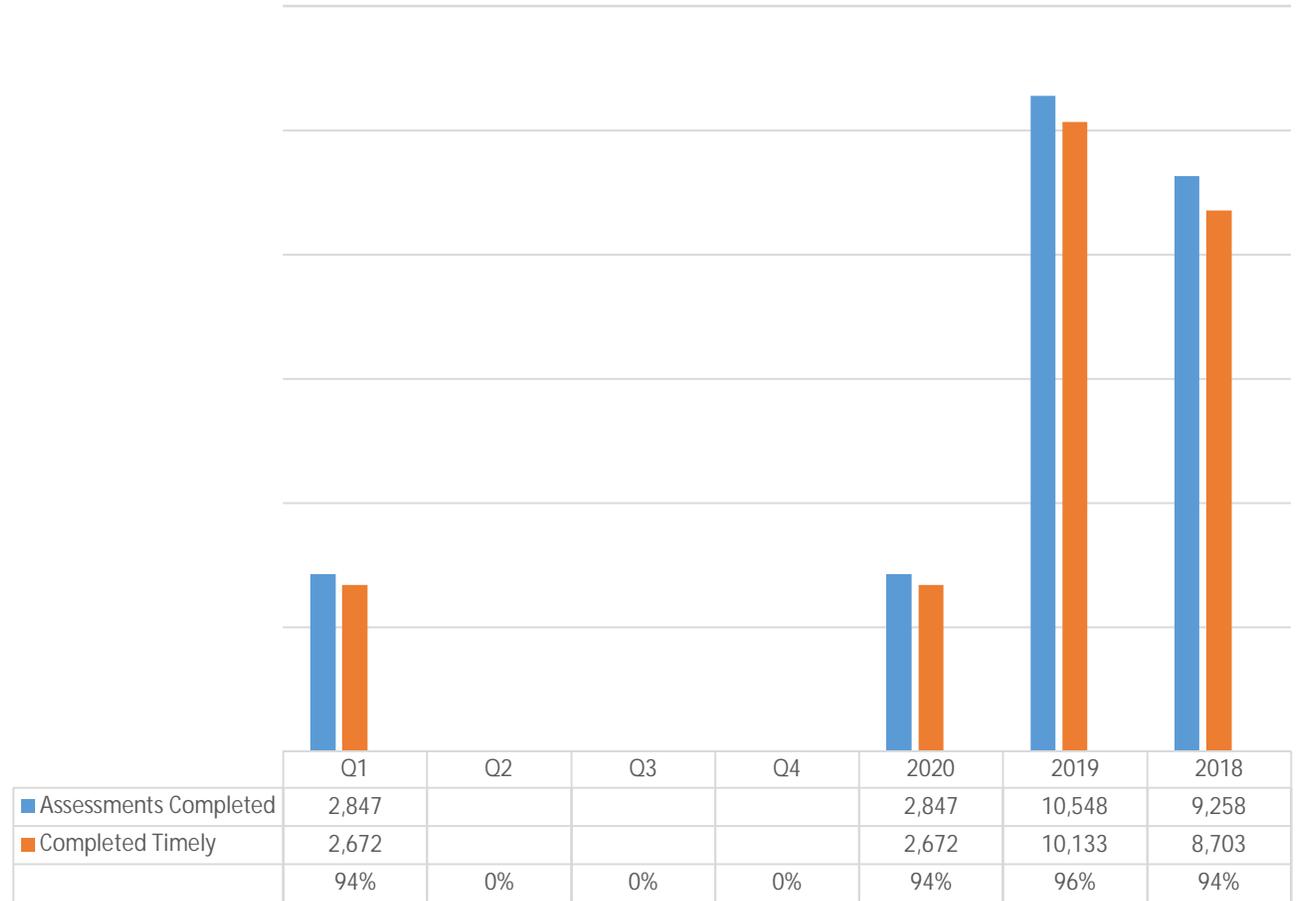
ANNUAL ASSESSMENT TIMELINES

Summary: BLTC reporting systems provide multiple tools to monitor the accuracy of adhering to timelines required to complete an annual assessment (364 days). The tools include:

1. A Worklist to identify upcoming LOC Annual Assessments.
2. A Late Annual Assessment Worklist and report.
3. The Internal Audit Report which tracks the number of days between the Redetermination date and the assessment being completed.

Remediation: Managers monitor staff performance and provide training to ensure compliance. The BLTC has developed a new Processor Model which has increased productivity on the number of assessments staff can complete in a month by more than 50% which also has improved our compliance for meeting our required timelines.

Annual Assessment Timeline



Overview: The ACT system allows for real time reporting on late assessments. This information is available to all BLTC staff to ensure that all redetermination assessments are completed within 364 days from the prior assessment. The BLTC has identified that meeting the required timelines of Annual Assessments is an area identified for improvement and has developed specific tools and reports to help managers identify trends such as caseload distribution, participant geographic areas and staff performance.

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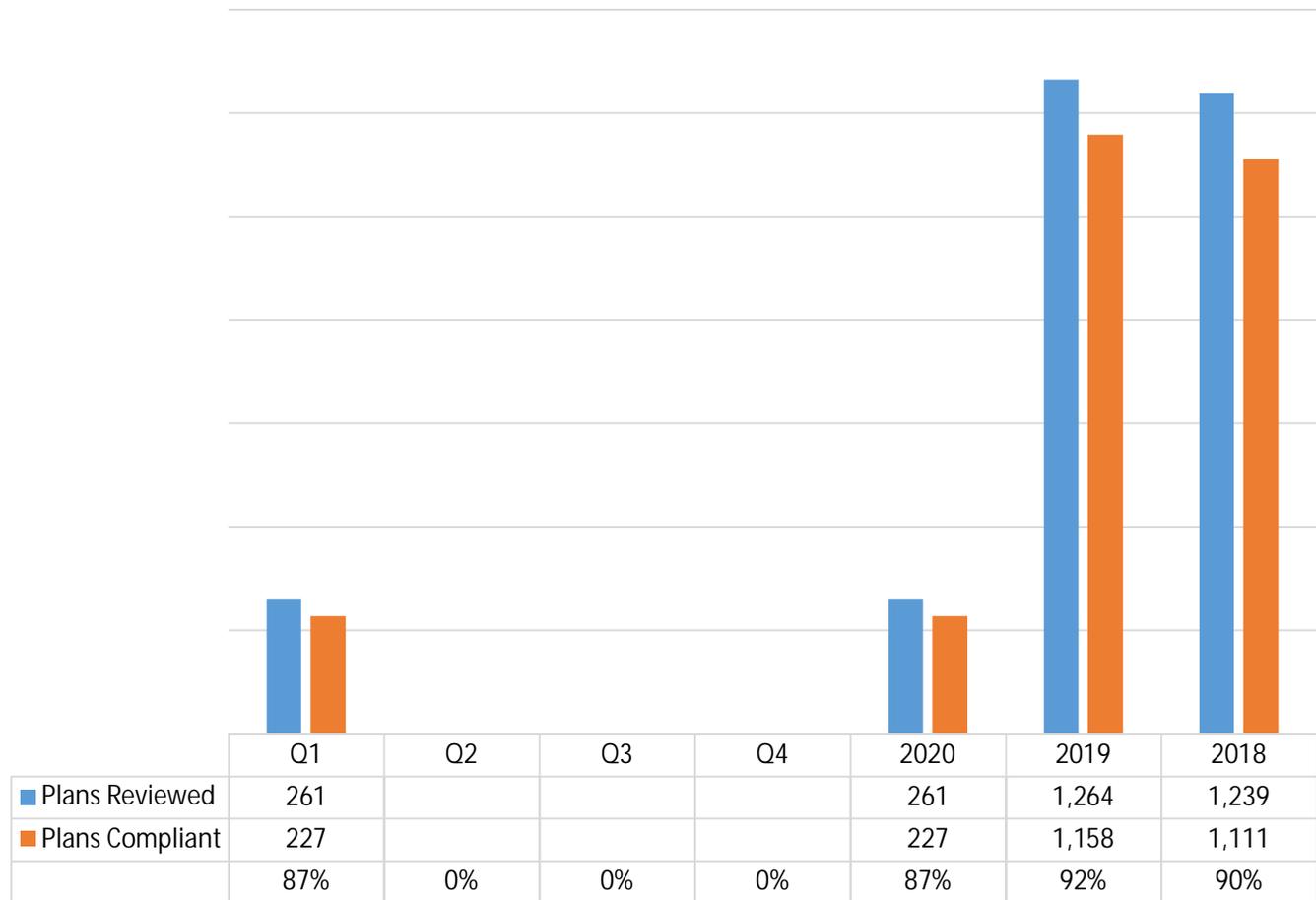
3.2 SERVICE PLANS

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

Summary: Providers are required to identify Amount/Type and Frequency on the participant Service Plan. Quality Assurance Specialists review a 30% sample size of all Service Plans at the time of the biennial provider audit.

Remediation: Providers with deficiencies are provided individualized technical assistance at the time of the Provider Audit. Providers with deficiencies are also closely monitored and if necessary, targeted annual reviews may be conducted to ensure compliance to all rules and regulations.

Service Plan: Amount/Type/Frequency



Overview: The Service Plan is required to be completed by all provider types in accordance with IDAPA regulations. The Amount/Type and Frequency requirements are monitored by the Quality Assurance Specialist staff at the time of the provider audit.

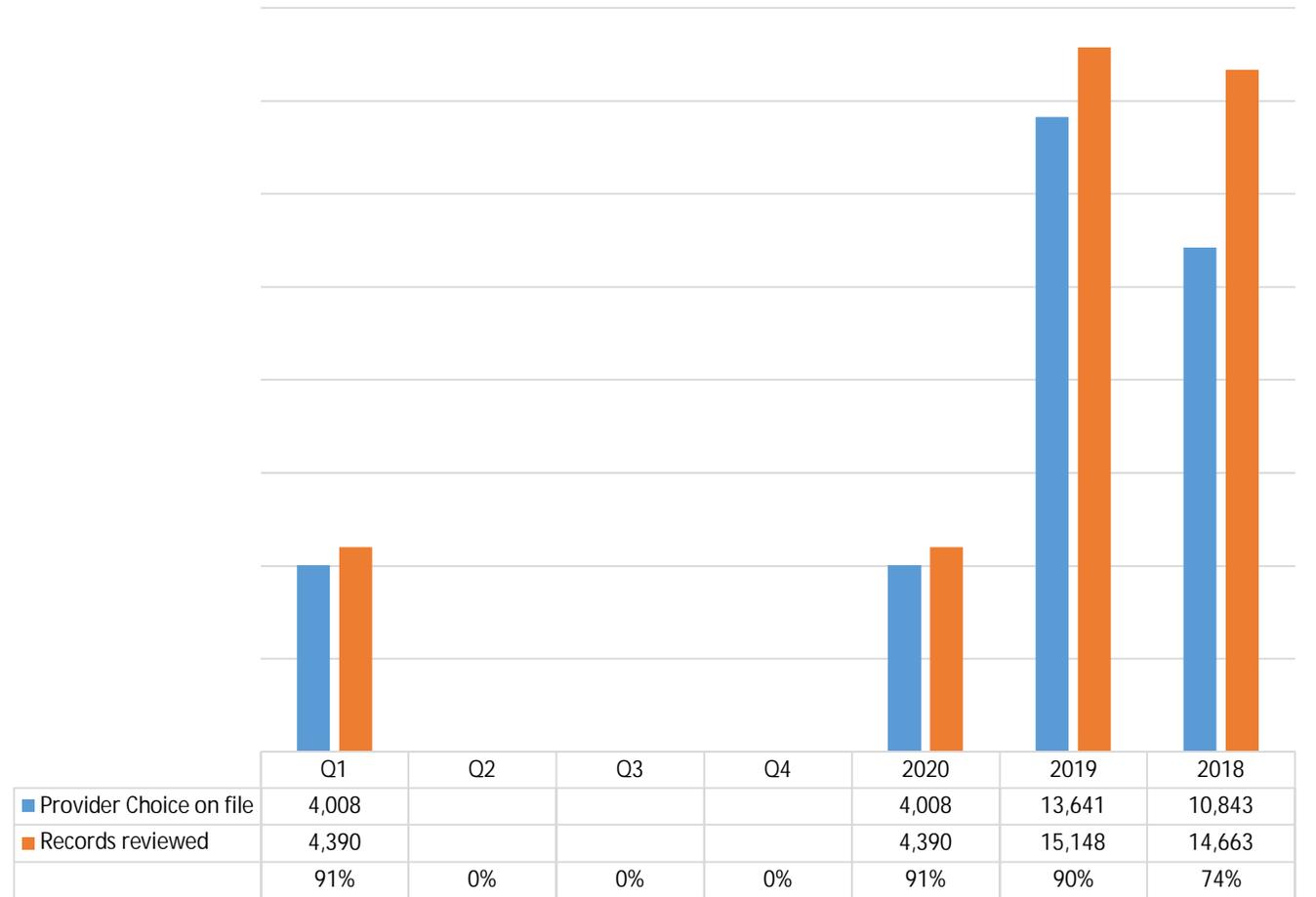
3.3 SERVICE PLANS

Sub-assurance e: Participants are afforded choice between/among waiver services and providers.

Summary: BLTC monitors Provider Choice by reporting mechanisms that identify if the correct forms are on file. BLTC has implemented solutions to improve compliance in this area, including the following:

1. The Managed Care Organizations (MCO) are required to upload Provider Choice documentation to each participant file with the Medicare Medicaid Coordinated Plan (MMCP) on a weekly basis. This was previously done on a quarterly basis.
2. BLTC developed an electronic version of the Provider Choice form.

Service Plan: Participant Acknowledgment for Provider/Service Choice



Overview: All participants for PCS and A&D Waiver services are afforded choice between/among waiver services and providers. Reporting allows for 100% sample size audit to ensure each participant's provider and service choice acknowledgement form is on file, validating this measure.

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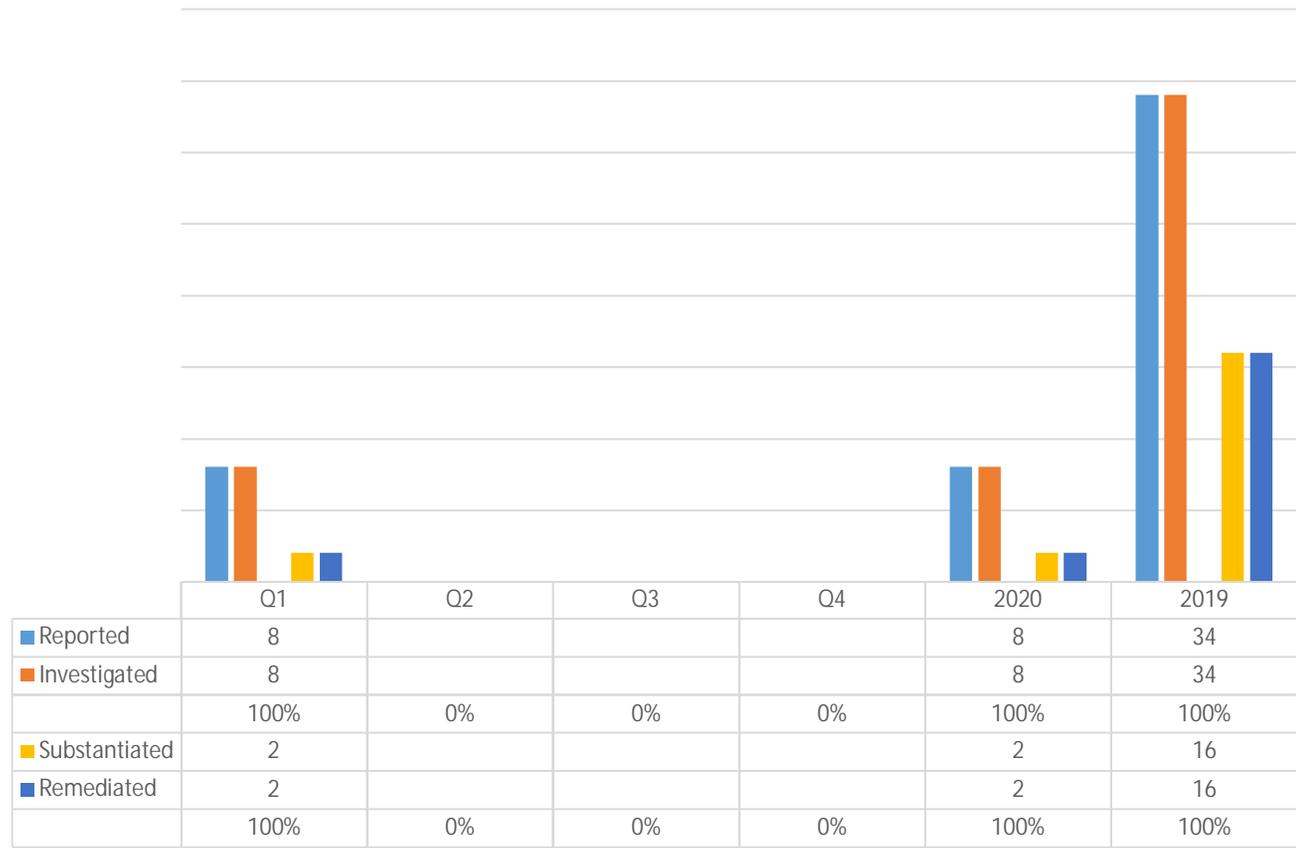
4.0 HEALTH & WELFARE

Assurance: The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

Sub-assurance a: The State demonstrates on an ongoing basis that it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.

Summary: Complaints related to Abuse/Neglect/Exploitation are identified within the BLTC Complaint database and are investigated within the appointed timeframes.

Abuse/Neglect/Exploitation Complains



Overview: Complaints intake is the responsibility of all available staff within the BLTC. Regional Nurse Reviewers are first responders to all complaints. After reporting to Adult Protection or Law Enforcement all complaints related to Abuse/Neglect or Exploitation are immediately forwarded to Quality Assurance Specialist staff for further investigation. Additionally, the UAI indicator of Abuse/Neglect or Exploitation is designed to immediately notify the QA staff.

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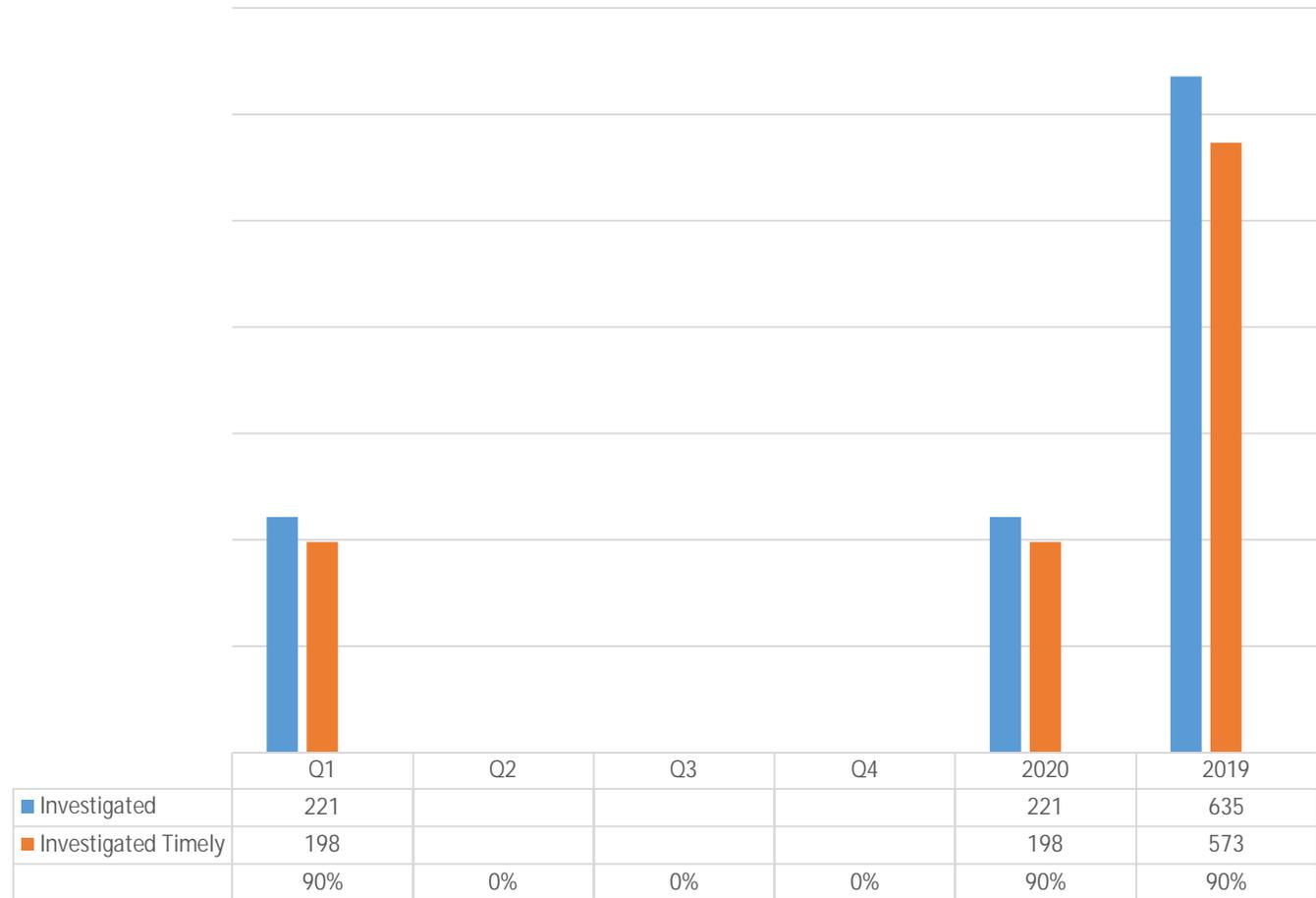
4.1 HEALTH & WELFARE

Sub-assurance b: The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.

Summary: Nurse Managers are designated as front-line staff to triage and investigate all complaints and determine severity through the Complaints database. The database captures the remediation and outcome of all complaints and tracks timelines to ensure compliance.

In Q4 2019 a new Complaint Submission System was implemented with enhanced reporting mechanisms. This allows us to identify areas of improvements and gaps in the investigation of complaints. The new system also allows MCO vendors to use this complaint system.

Complaints & Critical Incidents



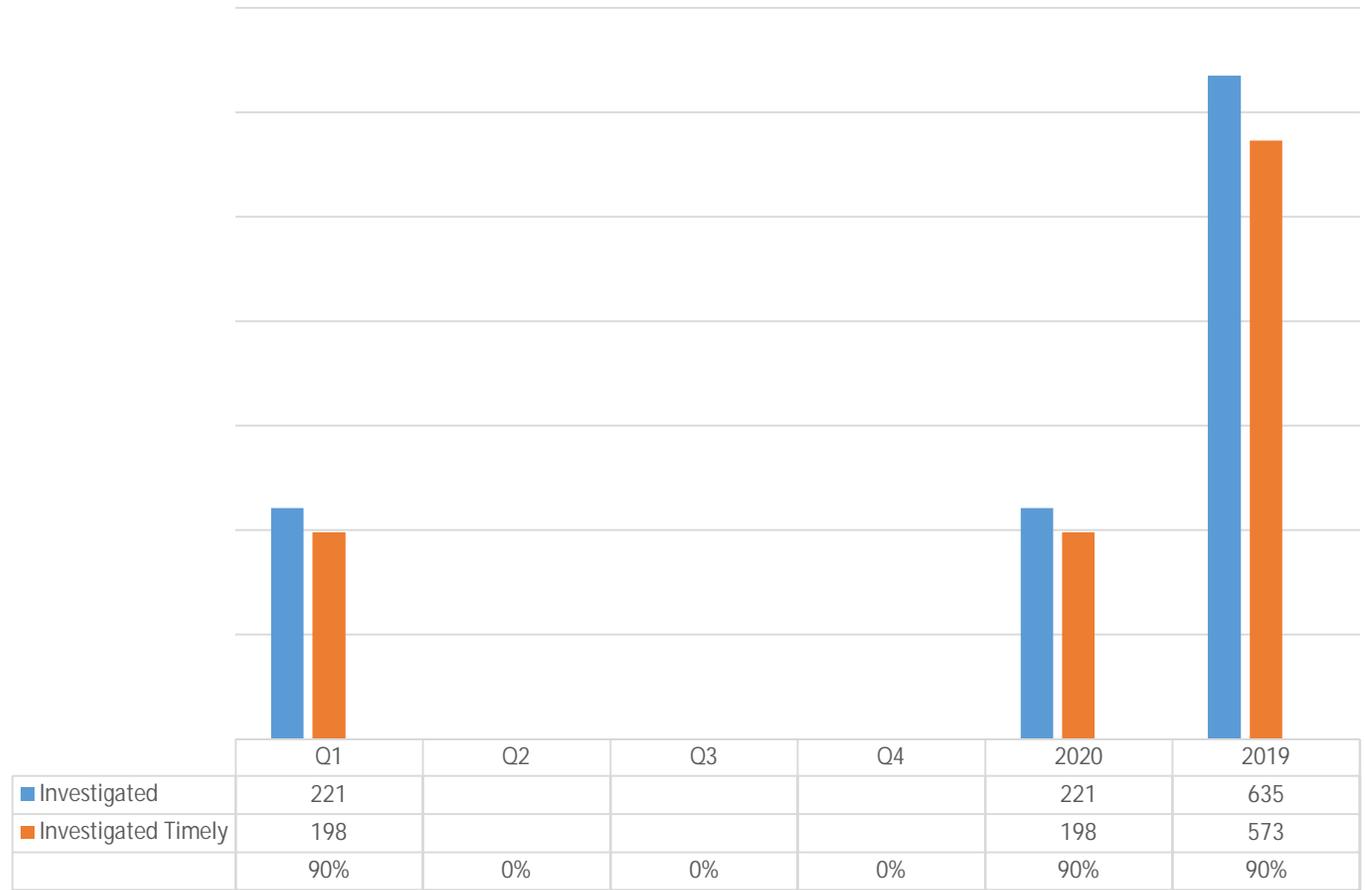
Overview: The BLTC Complaint Intake database is available to all BLTC staff for the intake of all complaints. Regional Nurse Managers are the first responders to all complaints and determine if further assistance is required from QA staff, Adult Protection or Law Enforcement.

4.2 HEALTH & WELFARE

Sub-assurance c: The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Summary: The State has implemented an Exceptions process in the event a provider has to limit access to an HCBS setting quality that poses a health and/or safety risk to the participant. These Exceptions will be reviewed for approval by the participant's Nurse Reviewer (NR). Currently, we have no such Exceptions on file in the state.

Complaints & Critical Incidents



Overview: Participants receiving home and community-based services in provider-owned or controlled settings, such as Residential Assisted Living Facilities and Certified Family Homes, may need an Exception in place if access to a specific setting quality poses a health and/or safety risk. Exceptions are participant-centric and require approval by the participant's NR prior to being put into place by the provider.

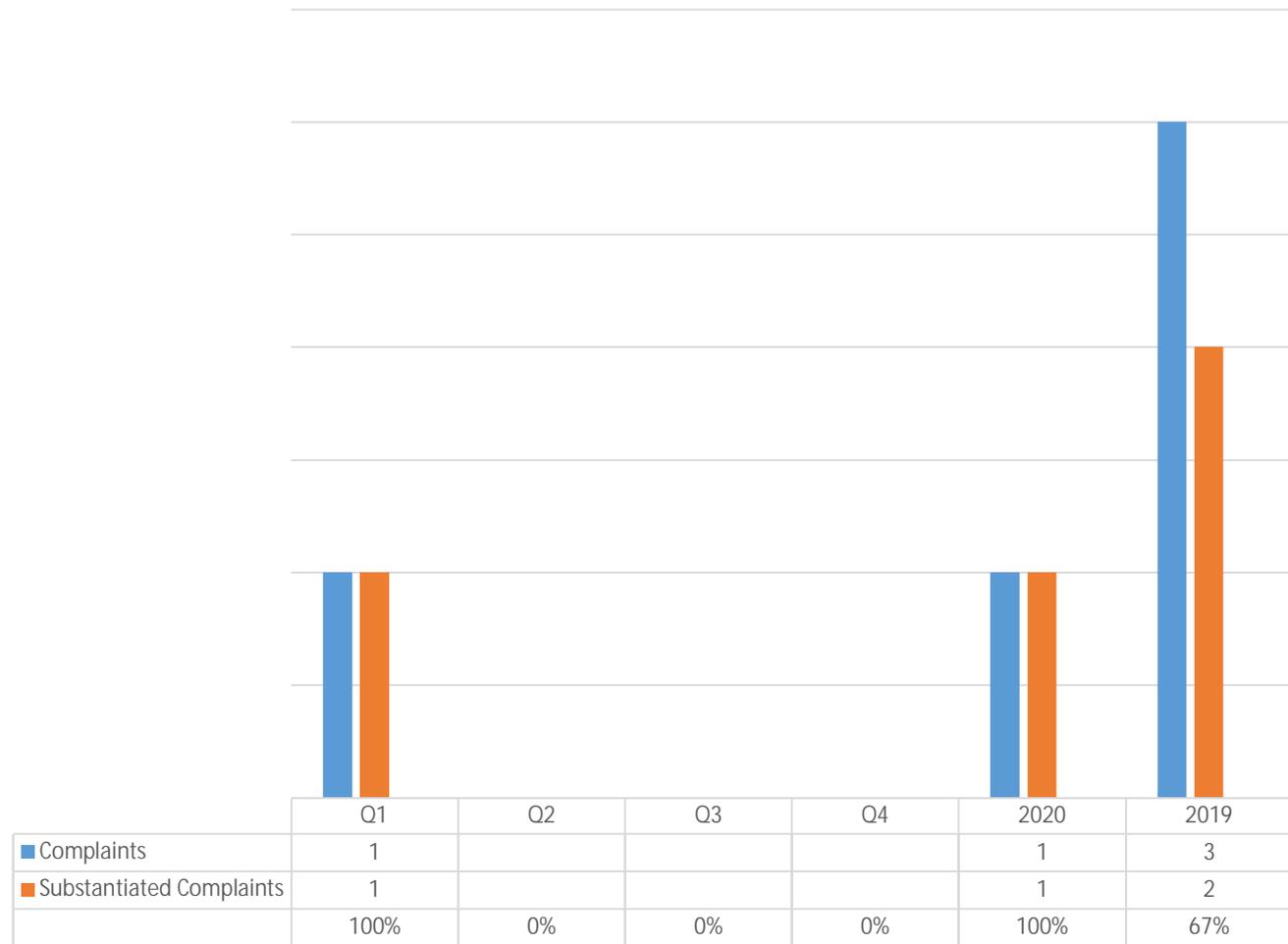
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EXCEPTION COMPLAINTS

Summary: Nurse Managers are designated as front-line staff to triage and investigate all complaints, including HCBS setting quality complaints. These complaints are typically forwarded to Quality Assurance Specialist staff for additional review. Violations may be identified via the participants through a report or the Quality Survey, or by Nurse Reviewer observation during an assessment, all of which are tracked in the BLTC Complaint Intake Log.

Remediation: BLTC continues to provide staff training to ensure staff recognize possible HCBS setting quality violations during their assessments with participants.

Complaints - HCBS Setting Quality



Overview: The BLTC Complaint Intake database is available to all BLTC staff for the intake of all complaints. Regional Nurse Managers are the first responders to all complaints and determine if further assistance is required from QA staff, Adult Protection or Law Enforcement. All complaints related to HCBS Setting Qualities are forwarded to Quality Assurance Specialist staff for further investigation.

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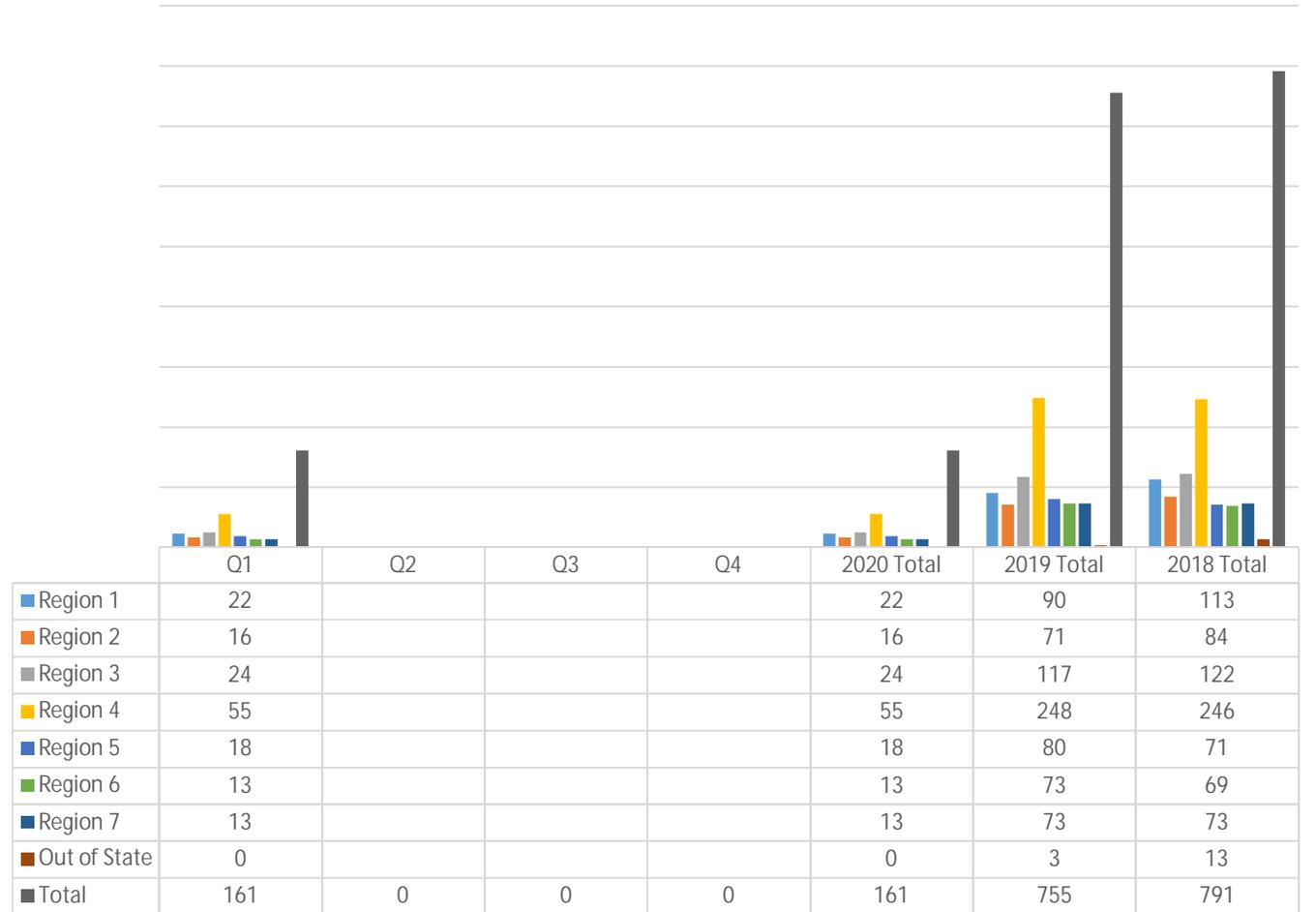
4.3 HEALTH & WELFARE

Sub-assurance d: The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Summary: Approximately 2% of all A&D Waiver fee-for-service participants completed an annual Wellness Visit during quarter 1 of 2020. 60% of all participants receiving services are identified as Dual Eligible and receive services including the Wellness Visit from the MCO.

Remediation: BLTC will continue to identify opportunities to encourage participants to complete an annual Wellness Visit with their PCP.

Wellness Visit Totals by Region



Overview: BLTC has developed a reporting mechanism to begin the data collection for participants accessing a Wellness Visit with their Primary Care Physician (PCP).

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5.0 FINANCIAL ACCOUNTABILITY

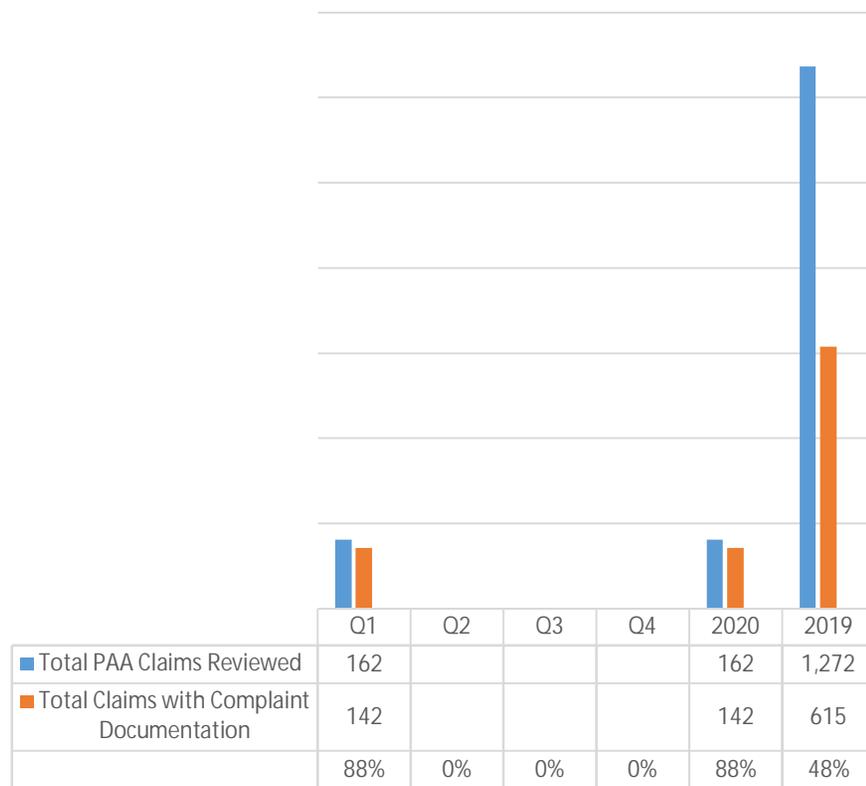
Assurance: The State must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the waiver program.

Sub-assurance a: The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.

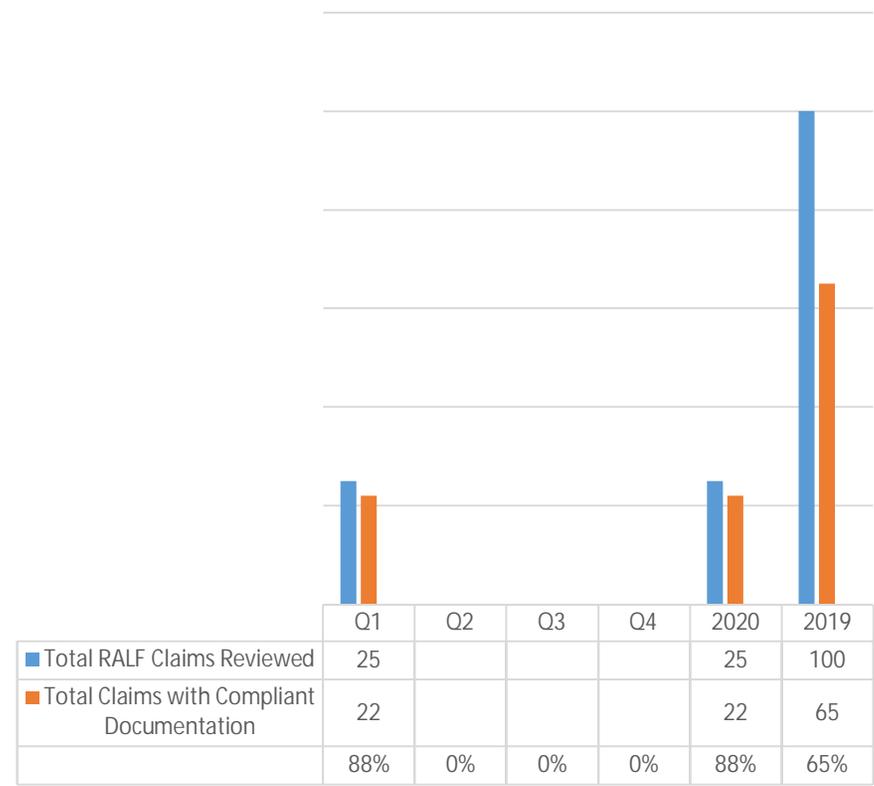
Summary: BLTC Quality Assurance (QA) staff review a random sample of claims for providers during routine QA activities. Staff review submitted claims and compare those to documentation from the provider to ensure services billed were rendered by the member.

Remediation: BLTC QA staff provide technical assistance to providers during audits.

Billed vs Rendered - PAA



Billed vs Rendered - RALF



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5.1 FINANCIAL ACCOUNTABILITY

Sub-assurance b: The State provides evidence that rates remain consistent with the approved rate methodology throughout the five-year waiver cycle.

*Because of changes to waiver performance measures that were implemented in July 2016, data collection points and graphs for the sub-assurances under this waiver assurance were removed from this report beginning in 2017. Compliance with financial accountability areas is monitored and reported via other mechanisms, including the Medicaid Program Integrity Unit (MPIU) and the Bureau of Financial Operations. The MPIU identifies Medicaid overutilization of services by providers and participants, and routinely monitors for improper billing patterns. The MPIU also conducts special studies to make program and system recommendations. Internal BLTC processes include referrals to MPIU when potential improper billing patterns are identified. The Bureau of Financial Operations ensures that reimbursement rates are consistent with the approved waiver methodology.

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BLTC – OTHER PROGRAM RELATED SUMMARY REPORTS

MONEY FOLLOWS THE PERSON DEMONSTRATION GRANT - IDAHO HOME CHOICE

Overview: Idaho Home Choice (IHC) is Idaho's federal Money Follows the Person Grant. The program is designed to help individuals who are currently institutionalized move back to the community utilizing Home and Community Based Services. The grant was received in 2011 and is scheduled to continue through September 30, 2021.

Summary: Idaho Medicaid has transitioned 666 individuals from institutional care to Home and Community Based care through the Idaho Home Choice Program. The grant continues to meet the established benchmarks and has been instrumental in re-balancing long term care spending from institutional care to HCBS care. The two Transition Benefits have also been sustained in the Medicaid Enhanced State Plan Benefit and the Aged and Disabled and Developmental disabilities 1915 (c) waivers.

Waiver	Q1	Q2	Q3	Q4	2020 Total	2019 Total	2018 Total	Total IHC for all years
DD Waiver	5				5	23	7	127
A&D Waiver	11				11	42	52	459
Enhanced	4				4	14	14	80
Total	20	0	0	0	20	79	73	666
Qualified Institution	Q1	Q2	Q3	Q4	2020 Total	2019 Total	2018 Total	Total IHC for all years
ICF/ID	4				4	20	8	110
IMD	1				1	1	8	41
SNF	15				15	58	57	515
Total	20	0	0	0	20	79	73	666
Qualified Residence	Q1	Q2	Q3	Q4	2020 Total	2019 Total	2018 Total	Total IHC for all years
Supported Living	3				3	20	3	90
Apartment	10				10	26	10	276
Own Home	3				3	8	3	98
Family's Home	2				2	9	2	67
CFH	2				2	7	2	71
RALF					0	8	0	10
Total	20	0	0	0	20	78	20	592

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PRE-ADMISSION SCREENING & ANNUAL RESIDENT REVIEW (PASRR) PROGRAM

PASRR TOTAL BY REGION

Overview: PASRR operation is required of the BLTC Nurse Reviewers based on federal rule.

PASRR is conducted at the time an individual is recommended by a physician for a Nursing Facility admission. The program ensures that individuals with mental illness or intellectual disabilities meet Nursing Facility Level of Care and receive Specialized Services during their stay.

PASRR Total by Region	Q1	Q2	Q3	Q4	2020 Total	2019 Total	2018 Total
Region 1	233				233	1041	985
Region 2	128				128	593	569
Region 3	218				218	1021	1,099
Region 4	481				481	2040	1,878
Region 5	242				242	1008	1,049
Region 6	233				233	827	875
Region 7	187				187	757	778
Total	1,722	0	0	0	1,722	7,287	7,233
PASRR Total % by Region	Q1	Q2	Q3	Q4	2020 Total	2019 Total	2018 Total
Region 1	14%	#DIV/0!	#DIV/0!	#DIV/0!	14%	14%	14%
Region 2	7%	#DIV/0!	#DIV/0!	#DIV/0!	7%	8%	8%
Region 3	13%	#DIV/0!	#DIV/0!	#DIV/0!	13%	14%	15%
Region 4	28%	#DIV/0!	#DIV/0!	#DIV/0!	28%	28%	26%
Region 5	14%	#DIV/0!	#DIV/0!	#DIV/0!	14%	14%	15%
Region 6	14%	#DIV/0!	#DIV/0!	#DIV/0!	14%	11%	12%
Region 7	11%	#DIV/0!	#DIV/0!	#DIV/0!	11%	10%	11%
Total	100%	#DIV/0!	#DIV/0!	#DIV/0!	100%	100%	100%

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PASRR REVIEWS WITH A POSITIVE DIAGNOSIS

Summary: 1,722 PASRRs were completed during quarter 1 of 2020. Of the PASRRs completed, 98% (1,665) of them had positive diagnoses.

PASRR with Positive Diagnoses Total Completed

