CHAPTER 4: Quality Assurance and Program Review

Policy: California Department of Aging (CDA) MSSP Section is the oversight agency for local MSSP sites. It is the policy of CDA to promote methods of monitoring performance that assures quality at all levels of program operation including the delivery of services to the participants.

Purpose: This chapter provides information on the components of quality assurance (QA) as applied to MSSP. CDA recognizes that MSSP sites operate within not only the framework of CDA requirements but the QA policies of their host organization. While the specifics of a quality assurance program may vary from one site location to another, there are certain required elements that must be addressed. Those elements are detailed in this chapter.

This chapter also describes the levels of program review and specifies the scope and methodology for the CDA Utilization Review (UR) and Fiscal Audits.

References:

- Home and Community-Based Services Waiver #0141.R07.00, Appendix H: Quality Improvement Strategy
- Centers for Medicare & Medicaid Services (CMS) Assurances:
  - ✓ Level of Care
  - ✓ Care Plans
  - ✓ Qualified Providers
  - ✓ Health and Welfare
  - ✓ Financial Accountability
  - ✓ Administrative Authority
- CDA Standard Agreement (Site Contract)
- Welfare and Institutions Code 14170
- Interagency Agreement between DHCS and CDA

4.000 Quality Assurance Concepts

Quality Assurance is a process for the systematic monitoring and evaluation of a program to ensure that standards of quality are being met.

4.010 Quality Assurance Components

The concept of quality as described by the Centers for Medicare & Medicaid Services (CMS) has a four-component cycle: Design, Identification, Remediation, and Improvement.

- Design: The QA process must include mechanisms to prevent problems from occurring, measure the prevalence of specific issues in the program, and identify issues which need action.

- Identification: The QA process, when implemented, should reveal problems or areas which need improvement.

- Remediation: Upon identifying a deficiency, it is critical that the site initiate a plan to address the problem in a timely manner.

- Improvement: Incorporating the information gathered to develop strategies to strengthen the overall quality of the program is the optimal outcome of an effective QA process.

Quality Assurance is a continual process which requires monitoring and reevaluation.

4.020 Site Quality Assurance Requirements

Each site will have a written policy or process describing their quality design, identification, remediation, and improvement assurance activities. At a minimum the policy will address the processes as they relate to the site's contract with CDA and the Site Manual (e.g., signatures, timeliness of care management activities, staff and vendor qualifications, etc.).

Within these parameters, the elements should:

- Identify the specific indicators and standards to be used to monitor performance.
- Create baselines against which performance is measured.
- Address how the monitoring of performance will be structured.
- Describe how the results will be used to improve program performance and/or remediate deficiencies.

4.030 Quality Assurance Elements

The specific elements, tools and processes employed should maximize quality outcomes for participants and foster the provision of best practices in care management services. In formulating a Quality Assurance policy, sites must include the following two elements:

1. Participant Satisfaction: Participant satisfaction surveys provide valuable information derived from the input from participants and their caregivers regarding all aspects of the program. There are different options pertaining to the type of process used to gather this information (e.g., phone survey, online survey, or written survey).
   Areas of inquiry should include: does staff interact with participants in a respectful manner; does staff respond in a timely fashion; satisfaction with the services in the care plan?

2. Peer/Internal Review: Peer and internal review focuses awareness on care management as it is being practiced within the program. The review must be a formal process. Peer/internal reviews can be organized around particular issues (e.g., LOCs, care plans, etc.), provide a forum to discuss difficult or problematic

care situations, or simulate CDA record review performed during a UR (Appendix 58).

CDA requires the site to complete both the Participant Satisfaction Survey and Peer and Internal Review at **a minimum of one time per year**. The policy identifies the frequency of each activity (annually, quarterly, or monthly) which is recorded on the Quarterly Report.

In addition to the two specific elements identified above, the Quality Assurance policy must address how the information will be utilized to:

- Assure participant feedback and input, and
- Develop policies and procedures that will identify, address, and prevent the following:
  - Abuse, neglect, and exploitation of MSSP participants.
  - Problems with participant access to Waiver Services.
  - Discrepancies between services that are specified on the care plan and what is actually received by the participant.

The Quality Assurance Policy must also identify actions to be taken in the event it is determined that a participant's health and welfare has not been safeguarded, which may include making a referral to Adult Protective Services.

4.100 Utilization Review (UR)

4.110 Authority to Conduct UR

Under the provisions of MSSP's Home and Community-Based Services (HCBS) Waiver and the State Medicaid Plan, the program is required to establish and maintain a system of Utilization Review (UR). The authority to conduct these reviews is found in the following sources:

Federal – Title XIX, Social Security Act, Section 1915 I; 42 Code of Federal Regulations (CFR), Section 456; Federal Home and Community-Based Services Waiver.

State – Welfare and Institutions (W&I) Code, Section 14170; Title 22 California Code of Regulations, Title XXII, Section 51346; Interagency Agreement between DHCS and CDA, and CDA policies.

4.120 Levels of UR

In addition to internal reviews of program operations and quality assurance procedures undertaken at the site level, there are three levels of UR for MSSP:

1. **Centers for Medicare & Medicaid Services (CMS)** conducts periodic reviews to assure all requirements of the Waiver are met.

2. **Department of Health Care Services (DHCS)** conducts collaborative and independent oversight reviews of CDA's administration of the Waiver.

3. **California Department of Aging (CDA)** conducts collaborative and independent URs to monitor the program at the site level to ensure compliance with the Waiver, the Interagency Agreement (IA) between CDA and DHCS, and CDA MSSP policies. Existing sites are scheduled to be reviewed every other year. New sites may receive up to four on-site visits within the first year and are reviewed annually for the first two years. Follow-up reviews (remote or in person) may be scheduled with sites that are out of compliance with Waiver, program, and/or contract requirements. Additionally, CDA may schedule on-site visits to provide technical assistance.

4.130 Objectives of CDA URs

The objectives of the CDA UR process are:

1. To verify the medical necessity of services provided to eligible MSSP participants funded by the HCBS Waiver.

2. To ensure that available resources and services are being used efficiently and effectively.

3. To identify problem areas and to provide technical assistance.

4. To initiate corrective or plan of action(s), if warranted.

4.130.1 Elements of the CDA UR

The elements of the CDA UR are:

1. Review of the written responses to questions regarding fiscal/administrative practices, quality assurance, peer and internal review processes as well as other contractual requirements.

2. Review of a minimum of fifteen participant records, all except one to be selected by CDA. Of the records selected by CDA, a minimum of five records will be closed cases when possible.

3. Review of vendor contract files selected by CDA.

4. Review of Adult Day Programs and Congregate Meal Sites, to ensure all HCBS Settings requirements are met.

5. Review of the Quality Assurance Policies, including Participant Satisfaction Surveys and Peer/Internal Review Process.

6. A home visit scheduled with a participant selected by the site to be included in the review sample. When a home visit is not possible, such as during a remote utilization review, a telephone survey will be conducted.

7. Additional information may be gathered prior to or during the UR.

4.130.2 CDA Review Team

The CDA review team will usually consist of a nurse evaluator and a program analyst. Additional CDA and DHCS staff may attend and participate as needed.

4.130.3 Areas of Site Operation to Be Reviewed

The process followed by the CDA UR team involves a review of pertinent documentation, procedures and processes; consultation and discussion with staff; and an interview with a participant. Specific areas to be reviewed include:

1. Necessity of Services

   Standard
   The home and community-based services specified in the care plans are required to prevent eligible participants being placed in nursing facilities.

   Indicators
   Elements relating to the performance of this standard may be found in the Application, the Participant Enrollment/Termination Information Form, Medi-Cal status verification, the Level of Care certification, the monthly progress notes, the re/assessments, and the care plan.

   - Documentation must support the participants' need for services to prevent premature placement in a nursing facility.

   - Documentation confirms that participants meet the eligibility criteria of: age, level of care, able to be served within the program’s cost limitations, appropriate for care management services, and that Medi-Cal status was verified.

   - Documentation includes verification of each participant’s eligibility through Level of Care certification by the MSSP nurse care manager and finalized by the CDA MSSP Nurse using Title 22 criteria per the MSSP Site Manual.

2. Appropriateness of Services

   Standard
   Services included in participants' care plans are suitable for meeting their individual needs. These services are provided to supplement participants' abilities in:

- Activities of Daily Living (ADLs) that are critical and linked to functions/behaviors necessary to prevent institutionalization; and

- Instrumental Activities of Daily Living (IADLs) that are basic and essential to maintain the ability to live as independently as possible in the home setting.

Services purchased with program funds are limited to those permitted and defined under the Waiver and listed in the MSSP Site Manual Chapter 3, Section 3.1430, Purchased Waiver Services. Objectives can be generally described as outcomes in the areas of health, safety, habilitation, independence, rehabilitation, medical, and/or psychological stabilization.

Indicators
Elements relating to the performance of this standard may be found in the re/assessments, care plan, and monthly progress notes.

- Documentation verifies that the services are essential to prevent institutionalization and are appropriate in type, quantity, and cost to meet participant needs.

- Documentation confirms monitoring was conducted and that specific outcomes have been noted as a result of the services.

3. Level of Care

Standard
A participant's need for care is at the level provided in a nursing facility. The criteria applied in the determination of level of care are set forth in the California Code of Regulations, Title 22, Division 3, Subdivision 1, Chapter 3, Article 4, Sections 51118, 51124, 51334 and 51335 (Appendix 18).

Indicators
Elements relating to the performance of this standard may be found in the level of care certification statements and the re/assessments.

- Documentation supports the LOC criteria.

- Documentation reflects compliance with certification and recertification timeliness requirements.

- Documentation confirms the LOC was completed by a site nurse and finalized by a CDA MSSP Nurse (Chapter 3, Section 3.110.5, Level of Care Submission to CDA for Final Determination of Initial LOC and Section 3.110.11, Submission to CDA for Final Determination of Recertification LOC).

4. Care Plan

Standard
Upon enrollment in MSSP, a care plan must be activated before Waiver Service funds are used. The care plan must be updated annually after enrollment but should be reviewed and changed more frequently depending on the needs of the participant. The care plan addresses all types of services whether formal or informal, purchased or obtained through referral. It consists of:

- The care plan, and
- The Service Plan and Utilization Summary (SPUS).

The care plan documentation must clearly describe coordination of services, taking into consideration: the participant's functional status; goals; effectiveness of existing services; and identification of specific services to be provided. The care plan must reflect input from the participant and the interdisciplinary team of the nurse and social work care managers culminating in final approval by the supervisor. The process should be extended whenever possible to include the participant's caregiver and/or family if appropriate and the participant has consented.

Indicators
Elements relating to the performance of this standard may be found in the re/assessment summaries, the care plan, the progress notes, and the SPUS.

- Documentation indicates that the care plan was completed within two weeks of the re/assessment.
- Care plans are activated: signed by the primary care manager and the supervisor (SCM) within two weeks of the re/assessment and prior to authorization of service delivery.
- Documentation indicates that the care plan was reviewed with the participant and that the participant is in agreement with the provisions of the care plan.
- Care plans are signed by the participant on or before the first quarterly contact.
- Care plan problems are clearly stated in specific and objective terms and describe the participant's functional status; goals are realistic and measurable; and the interventions relate to the issues, needs, and preferences of the participant.
- Vendors and providers, as well as provider type, are listed on the care plan if known or in the progress notes to align with the SPUS.

- Care plans are renewed annually at a minimum. Interim updates are made either by amending or revising the existing plan.

5. Payment of Services

Standard
MSSP is the payor of last resort. Purchases made with Waiver Service funds must have supporting documentation regarding the participant's need, the identification of the service or item as an intervention, and that other funding sources were not available.

When purchasing services and goods, vendor selection should follow specific guidelines including:

- The most cost-effective qualified vendor will be sought.

- Vendors of services purchased with program funds must deliver services appropriate to meet the needs of participants.

- Vendors must meet the provider qualifications and assurances as set forth in the site's contract with CDA and the MSSP Site Manual.

Indicators
Elements relating to the performance of this standard are found in the SPUS, the Vendor Application (Appendix 41), the vendor agreement (contract, purchase order) between the site and vendor, billing records, and the vendor insurance, licensing, certification, and training documents.

- Provider data indicates rate standards are followed.

- Provider data indicates alignment with State mileage rate if transportation is a component.

- Documentation confirms providers meet the assurances and qualifications in the site's contract with CDA and in the MSSP Site Manual.

- Documentation confirms services were provided as authorized in the care plan; any difference is noted along with its resolution.

- Documentation reflects the site utilizes appropriate methods to monitor the performance of its vendors.

- Documentation reflects that each vendor completes all required training (Chapter 7, Section 7.110, CDA Privacy & Information Security Awareness Training).

6. Participant Rights

Standard
The participant and/or their designee have the right to:

- Be fully informed about MSSP services and the alternatives to participation in the program.
- Participate in care planning.
- Refuse services and be informed of the consequences of the refusal.
- Be assured of confidential treatment of personal and medical records and to authorize or refuse release of information to any individual outside the program.
- Be treated with courtesy, consideration, and respect.
- Be assured MSSP staff and vendors are fully qualified through education, training, and experience.
- Be informed of the processes for registering complaints, termination procedures, and appeals.

Indicators
Elements relating to the performance of this standard are found in the Application for the Multipurpose Senior Services Program, the MSSP Authorization for Use and Disclosure of Protected Health Information form (AUDPHI), the care plan, progress notes and in correspondence. At least one home visit or phone interview is conducted during the UR.

- Documentation indicates participants or their designees have been duly informed of service alternatives, and the procedures regarding release and sharing of information.
- Participant records and data are maintained in a secure environment; backup procedures are appropriate.
- Documentation confirms denial/change/termination actions are carried out according to procedures and time guidelines specified in the MSSP Site Manual.
- The home visit or phone interview to a participant confirms the site operates in a manner that delivers quality services which meet the needs of the recipient and that the participant is aware of their rights.

7. Quality Assurance

   Standard
   Each site will have a written policy describing Quality Assurance (QA) measures. This QA policy must include a process of Peer/Internal Review, and a method to solicit participant input regarding satisfaction with services.

   Indicators
   Elements relating to the performance of this standard will be found in the review to the responses from the questions asked in the UR announcement letter, the review of QA documents and interviews with site staff as needed.

   - Documentation confirms that a QA policy is in place, which meets the minimum criteria set forth in this chapter Sections 4.000 – 4.030.

   - Documentation reflects the site utilizes an effective policy to obtain, analyze, and utilize input from participants regarding their satisfaction with the services of the program (Participant Satisfaction Survey).

   - Documentation verifies the Peer/Internal Review includes participation by all care management staff.

   - Documentation confirms that the Participant Satisfaction Survey and the Peer/Internal Review are completed annually.

8. Recovery of any unwarranted payment of Federal Financial Participation (FFP).

   Standard
   When an exception to program standards has been identified, reconciliation of any unwarranted expenditures will be undertaken.

   Examples of such expenditures include but are not limited to:

   - Services billed, including care management, provided to ineligible participants.

   - Services billed, including care management, that were not provided to the participant.

   - Services provided by vendors who failed to meet the qualification and training assurances.

   - Services found to be inappropriate or unnecessary.

   - Services purchased without following Medicare/Medi-Cal protocol.

- Services provided that are not identified in the care plan.
- Services provided prior to approval of the care plan.

Indicators
Documentation that review exceptions have been satisfied, and any/all associated expenditures have been identified and/or recovered.

4.130.4 CDA UR Tools
The CDA review team uses several tools in preparing for and conducting URs. Sites may use the electronic Utilization Review tool in preparation of the CDA baseline and biennial Utilization Review (Appendix 58).

4.130.5 UR Report
A written report of the findings and recommendations is issued to the site within 45 business days by CDA, along with a request for a Corrective Action Plan (CAP), if required. If a CAP is required, the site must respond to CDA in writing within 30 days of the UR report date with a formal plan to address any deficiencies identified. The plan is then monitored by CDA. A copy of the UR report is forwarded to DHCS. For sites in their first year of operation, a Plan of Action (POA) may be issued which follows the same time frame as the Corrective Action Plan.

4.140 CDA Fiscal Audits
MSSP sites are subject to an audit of home and community-based services within three years of the close of any given State Fiscal Year. Pursuant to the Interagency Agreement between DHCS and CDA, these audits are conducted by CDA Audits and Risk Management (ARM) Branch to ensure that payments to sites made for services performed under the Waiver are in accordance with fFederal and State requirements. The audit trail tracking the purchase of Waiver Services from care plan through payment of vendor bills for selected participants will be included in CDA fiscal audits. Copies of fiscal audits are forwarded to DHCS.

4.150 Recovery of Funds
Funds that are designated for recovery upon completion of a UR, year-end Closeout, or fiscal audit, will be collected through formal channels administered by DHCS Third Party Liability and Recovery Division.

Funds are recovered when a determination is made by either CDA MSSP Section staff or CDA ARM staff that the expenditure was not supported by the reimbursement. Sites must use sources other than MSSP funds to redress such a finding and repay the amount in question.

When CDA MSSP staff initiates the recovery based off findings from a UR the MSSP Section staff will use the following process:

1. Upon completion of a UR, the MSSP Section staff that conducted the UR will identify funds, if any, marked for recovery. Following issuance of the UR report, CDA will send a letter (Notice of Claim Adjustment) to the site that identifies the specific expenditures targeted for recovery and the procedures for appealing this determination.

2. Following resolution of any appeals (Section 4.150.1, UR Recovery Appeal Process), MSSP will prepare the Recovery Memo that will be sent to DHCS to initiate the recovery of the payment.

3. In the event that the site does not pay the amount due within sixty (60) days from the issue date on the demand letter, the Medi-Cal Fiscal Intermediary may withhold payments due the site until the balance is satisfied.

When a recovery is initiated by the findings of the CDA ARM Branch staff the following process will be followed:

1. Upon completion of a fiscal audit, the CDA ARM Branch will identify funds, if any, marked for recovery. The audit report or Notice of Audit Determination (NAD)will be sent by CDA to the site. Appeals procedures are sent by DHCS, Third Party Liability and Recovery Division.

2. Following resolution of any appeals, MSSP will send the NAD and Recovery Memo to DHCS to request payment.

3. In the event that the site does not pay the amount due within sixty (60) days from the issue date on the demand letter, the Medi-Cal Fiscal Intermediary may withhold payments due the site until the balance is satisfied.

4.150.1 UR Recovery Appeal Process

In the event of a dispute regarding the Notice of Claim Adjustment that identifies a recoupment resulting from the UR, the site must submit a written request for appeal, within fifteen (15) working days of receipt of the letter from CDA, with any evidence to the Division of Home and Community Living Deputy Director.

The appeal must include a description of the disputed issues, the legal authority/basis for each issue which supports the site's position, and the remedy sought. The Deputy Director shall, within fifteen (15) working days after receipt of the site's written appeal, make a determination on the dispute and issue a written decision and reasons therefore. All written communication shall be pursuant to Exhibit D, Article XVII of the site's Contract Agreement. Should the site disagree with the decision of the Division Deputy Director, the site may appeal the decision to the Chief Deputy Director of the California Department of Aging.

The site's appeal of the Division Deputy Director must be submitted within ten (10) working days from the date of the decision of the Division Deputy Director; be in writing; state the reasons why the decision is unacceptable; and include the original complaint, the decision that is the subject of appeal, and all supporting documents.

Within twenty (20) working days from the date of the site's appeal, the Chief Deputy Director or designee shall meet with the site to review the issues raised on appeal. The Chief Deputy Director shall issue a final written decision within fifteen (15) working days of such meeting.

The site may appeal the final decision of the Chief Deputy Director in accordance with the procedures set forth in Division 25.1 (commencing with Section 38050) of the Health and Safety Code and the regulations adopted thereunder.

The site shall continue to carry out the obligations under the Site Manual and the Contract Agreement during any dispute. Costs incurred by the site administrative/court review are not reimbursable by the Department.