

**Level of Care (LOC) - page 1 of 2**

Assurance Requirements	Monitoring Activity (WHAT)	Monitoring Responsibilities (WHO)	Data / Management Reports	Frequency	Plan (Timeline/Milestones)
<p>An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.</p>	<p>Division of Aging and Community Services (DACS), regional Offices of Community Choice Options (OCCO), conduct level of care (LOC) assessments for 100 percent of applicants for whom there is reasonable indication that services may be needed in the future. LOC assessments are conducted regardless of the availability of Waiver slots or funding.</p>	<p>The Regional OCCO Field Office Managers (FOM) send statistical reports to the State OCCO Regional Quality Manager (RQM) for review.</p>	<p>Since January 2006, OCCO has completed Quarterly Reports to analyze OCCO's LOC Audit Outcomes. During the First Quarter of 2006, OCCO staff completed a total of 8365 LOC approvals. Using unscientific random sampling methods, OCCO audited 111 (1%) of the 8365 LOC approvals. Using a standardized auditing tool, OCCO auditors reviewed and scored Pre Admission Screen (PAS) LOC Approval Health Service Delivery Plans (HSDP) for completeness (presence of required elements), and also evaluated accuracy (LOC outcomes consistent with service authorization) and timeliness. Because this is the first formalized audit in several years, this information will serve as baseline data for future analysis since there is no recent comparison data available.</p>	<p>Quarterly</p>	<p>Milestone: OCCO developed a database in the Winter of 2005 to collect PAS review results for future aggregation, analysis and trending of data.</p>
		<p>In coordination with the RQM to identify trends, the Quality Assurance Coordinator (QAC) in the Office of Community Choice Options, collects and analyzes data from the new Minimum Data Set (MDS-HC) server.</p>	<p>In addition, during the First Quarter, OCCO staff issued 144 denials. This represents 2% of 8509 total statewide approvals/denials completed for the same quarter. OCCO staff are required to contact their supervisor(s) to case conference every potential denial before making the decision to deny a case. Once it is determined that a participant doesn't meet NF LOC criteria, the DHSS Community Choice Counselor completes the MDS-HC and HSDP and issues a denial letter containing Fair Hearing information/instructions.</p>	<p>Quarterly</p>	<p>Ongoing</p>
	<p>100% of all denials for initial LOC determinations are reviewed. Prior to a finalizing denial assessment, the Community Choice Counselor (CCC) must contact his/her immediate supervisor to discuss the case and review the care needs of the client. After case conferencing with the supervisor, the CCC completes the assessment, indicates that the case is denied on the assessment, and then issues a denial letter to the client. The denial letter contains information for requesting a Fair Hearing. There are no formalized after-the-fact reviews of denials since the circumstances of every denial are discussed with the Field Office Manager (FOM) or Assistant Field Office Manager (AFOM) before the denial outcome is communicated to the participant. If the OCCO FOM/AFOM thinks that the LOC decision is inappropriate, a second LOC evaluation is conducted by a different CCC, to either validate the first CCC's initial findings or authorize LOC. Based upon the outcome of this second LOC evaluation, the participant is either approved or denied, with a denial letter being issued.</p>	<p>The Regional OCCO FOM and AFOM oversee the clinical performance of their CCCs. It is ultimately their responsibility to monitor that staff complies with the denial case conferencing rule. The CCCs record all cases and outcomes on a daily log that is turned in to their supervisor at the end of each month, thus enabling the FOM/AFOM to verify all denials that were case conferenced that month. The Central Office OCCO Quality Assurance Coordinator reviews the reports and creates a quarterly statistical report of the outcome of PAS assessments.</p>	<p>The 2006 Quarterly Reports as prepared by OCCO, identify that during the Fourth Quarter there were 8,022 LOC approvals and Denials statewide, 235 were denied meeting NFLOC. There are currently no secondary reports available yet for level of care data analysis of the actual denied cases.</p>	<p>CCC reports of completed PASs are provided monthly to the FOM/AFOM. Central OCCO provides quarterly summary reports of activities to GQ.</p>	<p>Ongoing</p>
<p>An unscientific random sample of Initial LOC approvals are evaluated for quality control each month. The FOMs and/or AFOMs are primarily responsible for conducting the audits for the initial LOC approvals. Central OCCO Office staff periodically assists with these reviews. The results of each audit are registered on a worksheet that is submitted to the Quality Assurance Coordinator (QAC) in Central Office. On a quarterly basis, the QAC compiles, analyzes and reports data outcomes and trends to OCCO and GQ. As deficiencies and areas for improvement are identified, staff training focusing on deficient areas will be arranged for staff.</p>	<p>Presently, OCCO is evaluating ADLs and cognitive impairment levels via a case by case auditing. The FOM and/or AFOM review each audit with the CCC who assessed the case. Areas identified as requiring remediation are discussed by the FOM/AFOM and CCC, and are resolved accordingly with FOM and/or AFOM oversight. The final outcome of each area of remediation is recorded by the FOM or AFOM on the audit tool.</p>	<p>The FOM/AFOM keeps an original copy of each case audit for future review. These audit records are stored onsite for a period of five years and then archived to DHSS records storage facilities per State records storage and retention protocols.</p>	<p>Monthly</p>	<p>Ongoing</p>	

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Assurance Requirements	Monitoring Activity (WHAT)	Monitoring Responsibilities (WHO)	Data / Management Reports	Frequency	Plan (Timeline/Milestones)															
<p><b>The level of care of enrolled participants is reevaluated at least annually or as specified in its approved waiver.</b></p>	<p>Care Managers (CM) are responsible for Reevaluating participant's continued eligibility by assessing the participants' needs and certifying that participants continue to meet LOC criteria. If the participant does not appear to meet LOC, the CM consults with the CM Supervisor. If both agree with the LOC reevaluation, the CM asks the client to voluntarily withdraw and offers other appropriate non-waiver services. If the person does not agree to voluntarily withdraw, the CM, in consultation with the CM Supervisor, requests that OCCO reassess the client. When the CCC performs a LOC reevaluation and agrees that the client no longer meets LOC, the case is reviewed with the FOM/AFOM. If both feel that the participant does not meet LOC, a denial is issued to the participant by OCCO. If the CCC and FOM/AFOM disagree with the CM reevaluation, the CCC reevaluation decision prevails.</p>	<p>Care Management Supervisors review and approve all LOC reevaluations. GQ County Liaisons review a sample of consumer records taking appropriate action if inappropriate determinations are made. Care Management Supervisor, OCCO CCC and FOM/AFOM are responsible for the reevaluation if the client does not voluntarily withdraw when not meeting LOC on a reevaluation. .</p>	<p>GQ County Liaisons review a sample of consumer records taking appropriate action if LOC reevaluations are inappropriately documented. After each on-site visit, a formal exit interview with Supervisor staff is conducted at which time, the Care Manager is advised to reassess the participant to determine if the participant continues to meet the state-defined NF LOC and document the findings accordingly, or make a referral to OCCO if necessary. Neither the GQ nor OCCO currently tracks the number of times, circumstances, or outcomes when a CCC is requested to conduct a reevaluation due to a CM LOC reevaluation denial. GQ and OCCO will develop a method to track and analyze these occurrences, including fair hearing requests and outcomes.</p>	<p>Care Management Sites are monitored every 18-24 months or more frequently as needed.</p> <p>Aggregate reports of findings collected during monitoring surveys are produced Annually and upon request</p>	<p>GQ has worked with OCCO to add a field to the MDS-HC face sheet that will enable OCCO support staff to enter the new code for Care Manager Request for Reassessment (CM-RR) when referrals come in from the Care Management site requesting reassessment for those waiver cases that were originally screened and determined to meet LOC at a previous point, but no longer appear to meet the criteria. Starting in May 2008, DACS will be able to request reports regarding the number of individuals that have been referred for a PAS because they no longer appear to meet LOC.</p>															
	<p>The State currently monitors this requirement through on-site survey visits conducted by a team of DACS Office of Global Options for Long Term Care and Quality Management (GQ) County Liaisons.</p>	<p>The County Liaisons review files to determine whether the Care Manager reevaluated the participant's Level of Care, whether the document was adequately completed, if the reevaluation was completed in a timely fashion, and whether the reevaluation was completed annually and/or when there was a change in the participant's status and if signed by the CM and CM Supervisor.</p>	<p>Beginning in May 2005, a electronic Consumer File Review Tool was used by GQ, during on-site visits, to evaluate consumer records as maintained by Care Management agencies. Findings from those audits, were consolidated into a database for reporting purposes.</p>	<p>Care Management Sites are monitored every 18-24 months or more frequently as needed.</p> <p>Survey results from each Care Management Site are compiled and results are shared as necessary within 30 business days of survey.</p> <p>Aggregate reports of findings collected during monitoring surveys are produced Annually and upon request</p>	<p>Milestone: A Policy Memorandum was issued on August 6, 2007 to clarify the criteria for clinical eligibility for Nursing Facility Level of Care, how it is determined, and how it is defined. In addition, the DACS has created an improved Level of Care Reevaluation form (WPA-1), instructions, and policy to provide better guidelines on DACS expectations to adequately document that participants continue to meet this requirement.</p>															
	<p>The State offers trainings to Care Managers to reinforce that participants must be reevaluated at least annually and to explain what procedures or practices constitute a complete and timely reevaluation.</p>	<p>Staff from the GQ provides these trainings to Care Managers, Care Coordinators, and CM Supervisors.</p>	<p>Between January 2006 and December 2006, GQ staff directly provided 24 group trainings reaching 796 individuals:</p> <table border="0"> <tr> <td>4 Care Coordinator Meetings</td> <td>150 attendees</td> </tr> <tr> <td>6 Care Management Meetings</td> <td>283 attendees</td> </tr> <tr> <td>10 Program or Core CM trainings</td> <td>195 attendees</td> </tr> <tr> <td>4 Assisted Living Industry Trainings</td> <td>168 attendees</td> </tr> </table> <p>Between January 2007 and December 2007, GQ staff directly provided 15 group trainings reaching 581 individuals:</p> <table border="0"> <tr> <td>3 Care Coordinator Meetings</td> <td>145 attendees</td> </tr> <tr> <td>3 Care Management Meetings</td> <td>162 attendees</td> </tr> <tr> <td>7 Program or Core CM trainings</td> <td>153 attendees</td> </tr> <tr> <td>2 Assisted Living Industry Trainings</td> <td>121 attendees</td> </tr> </table> <p>Training Agenda and Attendees lists are maintained on file by GQ.</p>	4 Care Coordinator Meetings	150 attendees	6 Care Management Meetings	283 attendees	10 Program or Core CM trainings	195 attendees	4 Assisted Living Industry Trainings	168 attendees	3 Care Coordinator Meetings	145 attendees	3 Care Management Meetings	162 attendees	7 Program or Core CM trainings	153 attendees	2 Assisted Living Industry Trainings	121 attendees	<p>Trainings are quarterly or as needed. Reports of trainings are run annually or as needed</p>
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	<p>The tool used by OCCO statewide for the Initial LOC evaluation, (Pre Admission Screening), is the Minimum Data Set – Home Care (MDS-HC). OCCO performs LOC assessments on individuals applying for any of the three Medicaid Waivers currently operated by the DHSS.</p>	<p>OCCO has assembled a team, within the OCCO Quality Assurance Unit, to review LOC approvals and the correct use of the new MDS-HC tool.</p> <p>GQ County Liaisons review a sample of participant records for use of the appropriate tool during initial assessments.</p>	<p>General analysis of the OCCO First Quarter data demonstrates the following statewide outcomes: A) 37% of the HSDPs were 100% completed, 60% of the HSDPs were 85% complete, and 3% of the HSDPs were 70% complete; zero percent of the HSDPs were entirely incomplete.; B) 18% of the Case Types included Track III DHSS/DHS Medicaid Waiver cases; C) 95% of the NF/SCNF/Waiver NF LOC approvals/Service Authorizations were determined appropriate, and 3% were not appropriate, 2% were reported as N/A.; D) 92% of the OCCO LOC determinations were reported as being completed within the established timeframe.</p>	<p>Quarterly</p>	<p>Milestone: OCCO automated MDS-HC Assessment tool in the Spring of 2006. DACS is also in the planning stages of incorporating the ADL Index and Cognitive Performance Scale into the MDS-HC algorithm. That will allow DACS to design automated reports based on the scores and improve the quality review of LOC determinations and redeterminations - Winter 2008.</p>															

<p>The process and instruments described in the approved waiver are applied appropriately and according to approved description to determine participant level of care.</p>	<p>The WPA-1 (Reevaluation of Level of Care) form is used to reevaluate the participant for ongoing LOC. The DACS has taken steps to make this requirement and determination process clearer to the aging network throughout the State. A Policy Memorandum was issued on August 6, 2007 to clarify the criteria for clinical eligibility for Nursing Facility Level of Care, how it is determined, and how it is defined. In addition, the DACS has created an improved Level of Care Reevaluation form (WPA-1), instructions, and policy to provide better guidelines on DACS expectations to adequately document that participants continue to meet this requirement. Moreover, at the Care Management Regional Meetings in September 2007, training was offered to further clarify the responsibilities of the Care Managers when completing Level of Care Reevaluations for DHSS Medicaid Waiver program participants.</p>	<p>Care Management Supervisors review and approve all LOC reevaluations. GQ County Liaisons review a sample of participant records for use of the appropriate tool, timeliness, and completion of LOC reevaluations.</p>	<p>Beginning in May 2005, a new Consumer File Review Tool was used by GQ to evaluate case records as maintained by Care Management sites.</p>	<p>Care Management Sites are monitored every 18-24 months or more frequently as needed. Survey results from each Care Management Site are compiled and results are shared as necessary within 30 business days of the survey.</p> <p>Aggregate reports of findings collected during monitoring surveys are produced Annually and upon request</p>	<p>Ongoing</p>
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**Plan of Care (POC) - page 1 of 2**

Assurance Requirements	Monitoring Activity (WHAT)	Monitoring Responsibilities (WHO)	Data / Management Reports	Frequency	Plan (Timeline/Milestones)
<p>Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.</p>	<p>Care Managers prepare an initial Plan of Care based on the original assessment completed by professional staff from the OCCO as well as their own assessment done during the initial visit with the participant. POC development includes consideration of participant and caregiver preferences and goals, the attending physician's recommendations, consultation with any informal supports, the participant's medical and social needs, and safety and risk factors.</p>	<p>All Plans of Care are reviewed and signed by the participant and/or his representative, the Care Manager, and the Care Management Supervisor.</p>	<p>Beginning in May 2005, a new Consumer File Review Tool was used by GQ to evaluate case records as maintained by Care Management sites.</p>	<p>Care Management Sites are monitored every 18-24 months or more frequently as needed. Survey results from each Care Management Site are compiled and results shared as necessary within 30 business days of the survey.</p> <p>Aggregate reports of findings collected during monitoring survey are produced annually and upon request.</p>	<p>Ongoing</p>
	<p>All of the tools utilized to develop Plans of Care, (the MDS-HC, and WPA-1) have components which evaluate the health and safety risk factors of the participant.</p>	<p>OCCO is responsible for maintaining and utilizing the standard comprehensive tool used when determining nursing facility level of care.</p>			
	<p>A sample of participant files is reviewed for evidence that participants' assessed needs are addressed in the POC. All files are reviewed for inclusion of the MDS-HC, HSDP, and Client Profile. All assessed needs identified in those forms are to be included in the POC.</p>	<p>GQ</p>			
	<p>When GQ monitors a sample of participant files, the files are reviewed for evidence that participant preferences are considered when developing the Plan of Care as well as on an on-going basis. Specifically, the GQ monitoring tool questions if the participant had a choice in the programs, services, and providers being utilized, and also questions if the personal goals of the participant are reflected in the POC.</p>	<p>GQ</p>			
	<p>Individual participants are interviewed in their own home for Client Satisfaction and asked if their personal goals are addressed in their POC. Consumer feedback is solicited either through these face-to-face interviews or through mailed surveys.</p>	<p>GQ</p>			
<p>In the process of developing the POC, the Care Manager and Waiver participant/legal representative identify those risk factors that would trigger the need for back-up plans, should services not be delivered. Back-up plans are discussed for these situations and are entered into the POC. In addition to the back-up plan strategies identified below, the availability of informal supports is discussed and identified in the POC, if viable. The Care Manager verifies that informal supports identified in the POC are valid.</p>	<p>Care Managers contact the participant monthly and visit quarterly as part of their responsibility in monitoring the participant's needs. Unmet needs are identified at those times and detailed in the POC with reasons for unmet needs. Future service planning addresses how the unmet needs are to be met. Each Care Management Agency has plans to identify back-up care managers for the waiver participant. Home and Community Services' providers develop their own internal system to provide back up services. Respite is a waiver service that can be identified in the Plan of Care and used in emergencies for participants who need crisis back-up services. The participant/legal representative receives information to call the Care Manager if services are not delivered. The Care Manager investigates and resolves the problem with the existing agency or changes the agency. If needed, the Care Manager arranges for emergency services.</p>	<p>Since 2005, during the onsite review of files, GQ staff interviewed at least one Medicaid Waiver participant, from each Care Management agency, face-to-face to determine his or her level of satisfaction. The Participant Experience Survey (PES) was the instrument utilized during face-to-face surveys.</p>	<p>Participant Interviews are completed every 18 -24 months. Mailed Surveys are requested annually through mass mailings.</p>	<p>Milestone: Client Satisfaction Reports from mailed surveys are run annually. The information collected using the PES instrument will be downloaded into a database in Fall 2008.</p>	
<p>The State monitors service plan development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in service plan development.</p>	<p>The GQ continues to monitor each of the Medicaid Waiver Care Management agencies on an 18-24 month cycle. A targeted sample of participant records is selected for review. All files are reviewed for the inclusion of a current and comprehensive POC, the timeliness of the development of the initial POC, the timeliness of consecutive POC, that POC include all formal and informal assessed needs, as well as unmet needs.</p>	<p>GQ</p>	<p>Between May 2005 and December 2006, all of the 24 ECO Care Management sites that were surveyed, except for one, were required to submit a Corrective Action Plan (CAP) to GQ. All of the CAPs were accepted when proof of the following was included:                      -- A copy of the cited document with applicable amendments attached;                      For document deficiencies that cannot be corrected with an amendment, a policy statement addressing how the agency will implement corrective actions in the future should be included;                      -- The actions to be taken (such as staff education, forms or policies to be revised, etc.) to ensure that deficiencies do not recur;                      -- The person(s) responsible for implementation; and                      -- A description of how each deficient area would be addressed in the Agency's Quality Improvement program.</p>	<p>Care Management Sites are monitored every 18-24 months or more frequently as needed. Survey results from each Care Management Site are compiled and results shared as necessary within 30 business days of the survey.</p> <p>Aggregate reports of findings collected during monitoring survey are produced annually and upon request.</p>	<p>Ongoing</p>
	<p>Ensuring that Plans of Care are developed by Care Managers in accordance with appropriate policies and procedures is one of the responsibilities of the Care Coordinators/Care Management Supervisors, who review and sign-off on each POC. When problems are identified by the GQ team during monitoring reviews, such concerns are discussed with the Care Management Supervisors on-site during the Exit Interview. A GQ Follow-up Letter outlines all concerns and requests that a Corrective Action Plan (CAP) be submitted to GQ within 30 days. Inadequate CAPs result in requests for additional information or actions to be taken and, if needed, GQ conducts a subsequent survey site visit before the regular 18-24 month cycle.</p>	<p>The GQ County Liaison summarizes a Follow-Up Letter for each monitoring review, in consultation with the other GQ team members. This Follow-up Letter, which requests the submission of a Corrective Action Plan (CAP) is reviewed by the County Liaison Supervisor before being sent. Corrective Action Plans are then reviewed by the GQ County Liaison and County Liaison Supervisor for approval or a request for further information and the decision to make a subsequent monitoring visit.</p>			
	<p>Care Management Supervisors/Care Coordinators are responsible for reviewing and approving all POCs and CAPs.</p>	<p>One of the questions asked on the GQ Consumer File Survey Tool is whether or not the CM Supervisor's signature is present on the POC - indicating his or her review and approval. Of the 146 ECO cases audited, 10 were cited as not having the Care Management Supervisor's signature on the Plan of Care.</p>			
	<p>Three Quality Assurance Trainings were held to address some of the deficiencies noted by State GQ staff during the 2001-2004 Care Management monitoring reviews. The trainings specifically addressed the assurance that the State is looking for with regard to the comprehensive development of Plans of Care, particularly including a list of all formal and informal support, changing a Plan of Care when warranted by a change in the participant's needs, and documenting any unmet needs.</p>	<p>DACS consistently offers trainings regionally throughout the State. Quality Assurance has been a regular agenda item for several years. Earliest dates include: 11/6/03, 1/13/04, and 4/8/04.</p>			
	<p>The GQ has developed a Plan of Care policy that emphasizes POC development in accordance with the State's &amp; CMS's requirements such as the inclusion of participant's goals, preferences, risk factors and back-up plans.</p>	<p>GQ - Training Academy</p>			
<p>POC policy training was included in the Regional Care Management Meetings held twice a year, or two times in 2006.</p>	<p>Updated as necessary</p>	<p>Updated as necessary</p>	<p>Updated as necessary</p>	<p>Milestone: In the Summer 2006, GQ developed Internal Database to track trainings: dates, audience, # of attendees, and topics</p> <p>Introduced draft POC Policy. Form and instructions for comments in Fall of 2006. POC has been approved and finalized and will be distributed in Summer 2007.</p>	

**Plan of Care (POC) - page 2 of 2**

Assurance Requirements	Monitoring Activity (WHAT)	Monitoring Responsibilities (WHO)	Data / Management Reports	Frequency	Plan (Timeline/Milestones)
Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.	The GQ monitors all of Medicaid Waiver Care Management agencies on an 18-24 month cycle. A targeted sample of participant records is selected for review. All files that are reviewed are examined to see if the POC changes when the participant's needs change and updated and revised at least annually.	GQ	Beginning in May 2005, a new Consumer File Review Tool was used to evaluate consumer records. GQ Supervisors continually review the data and reports generated, sharing general results, on an as needed basis, with the GQ Quality Team, which meets twice a month. Discussions are had to determine if programs are operating in accordance with established standards. Remediation methods, above and beyond the Corrective Action Plans received by CM agencies, are developed by the GQ Quality Team. In addition, in March 2007, the GQ Supervisors provided aggregate reports and a presentation of the GQ Quality Assurance process to the DACS Extended Management Team.	Formal reports of aggregated data are generated at least annually and upon request.	Ongoing
	In addition to file review, during on-site quality assurance monitoring reviews, State GQ County Liaisons interview Case managers. Among other things, Care Managers are asked to identify the circumstances under which they would alter a participant's POC.	GQ	Beginning in May 2005, a new Review Tool was used to evaluate Case manager feedback. The information that was discovered from the Case manager Survey is attached in an aggregate report. Between May 2005 and April 2006, 215 respondents completed the Case manager Survey. Of the 215 respondents, the most common answer to when a POC would be altered included: 12% when participant is hospitalized, 11% when requested by participant, 11% when input is given from family or service provider.	Case manager Surveys completed every 18 -24 months Reports requested Annually	Milestone: Aggregate report of the Case manager Survey is attached.
	Individual participants are also surveyed by GQ Liaisons and asked if services are adjusted to meet their needs when their condition changes. Consumer feedback is solicited either through face-to-face interviews or through mailed surveys.	GQ	Beginning in May 2005, a new Survey Tool was used to evaluate Client Satisfaction. The information that was discovered from the ECO Client Satisfaction Survey is attached in an aggregate report. Of the 35 respondents, 13% Strongly Agreed and 13% Agreed that services are adjusted to meet their needs when their condition changes.	Participant Interviews and Questionnaires completed every 18 - 24 months Reports requested Annually	Milestone: Aggregate report of the Client Satisfaction Survey is attached.
Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan	State GQ County Liaisons review records for evidence that current comprehensive Plans of Care include the specified type, amount, duration, scope and frequency of services needed. The files are also reviewed for evidence that the Case manager is verifying that services are actually being delivered in accordance with the POC, such as regular contacts with the client, regular contacts with the provider agency, regular contacts with the family or caregiver, and other means of verification (stopping into the clients' home to witness service delivery unannounced periodically.)	GQ	Beginning in May 2005, a new Consumer File Review Tool was used by GQ to evaluate case records as maintained by Care Management sites. Findings from those on-site surveys have indicated that of the 146 ECO cases audited, 1 case was cited as not sufficiently verifying that services were rendered as defined in the Plan of Care.	Care Management Sites are monitored every 18-24 months or more frequently as needed. Survey results from each survey are shared with QualityTeam, as necessary, within 30 business days of the survey. Aggregate reports of findings collected during monitoring surveys are produced annually and upon request.	Ongoing
	In addition to file review, during on-site quality assurance monitoring reviews, State GQ County Liaisons interview Case managers. Among other things, Case managers are asked how they verify that services are actually being delivered as specified in the participant's Plan of Care.	GQ	Beginning in May 2005, a new Review Tool was used to evaluate Case manager feedback. The information that was discovered from the Case manager Survey is attached in an aggregate report. Between May 2005 and April 2006, 215 respondents completed the Case manager Survey. Of the 215 respondents, the most common answers to clarify how Case managers verify service delivery included: 20% when speaking directly to participant, 19% when speaking directly to family, 18% with on-site observation of service delivery, and 17% when checking billing or spending reports.	Case manager Surveys completed every 18 -24 months Reports requested Annually	Ongoing
	Individual participants, whose files are reviewed during the GQ monitoring visit, are surveyed by GQ Liaisons and asked if services are being delivered to them as described in the Plan of Care. Consumer feedback is solicited either through face-to-face interviews during the GQ monitoring visits or through mailed surveys shortly after the monitoring visit.	GQ	Between May 2005 and April 2006, eighty-five (85) Client Satisfaction Surveys were distributed, and 35 (41%) were returned to GQ. The information that was discovered from the ECO participant respondents is attached in an aggregate report. Of the 35 respondents, 46 % Strongly Agreed and 31% Agreed that services are being delivered to them as described in their POC.	Participant Interviews and Questionnaires completed every 18 - 24 months Reports requested Annually	Ongoing
Participants are afforded choice: between waiver services and institutional care; and between/among waiver services and providers.	Upon completion of the original Level of Care evaluation to deem eligibility, the OCCO Community Choice Counselor advises the individual on all Medicaid waiver or State-funded program options. The Choice of Care (CP-6) form, as identified in the approved Waiver, is completed and signed by the applicant to indicate the program that he or she has selected as an alternative to institutionalization. After enrolling the applicant into the ECO Medicaid Waiver, the OCCO forwards the case to a ECO Care Management agency where it is assigned to a Case manager.	OCCO is responsible for securing a completed CP-6 form and forwarding it to the Care Management agency in the Referral Packet. The GQ continues to monitor each of the 24 ECO Care Management agencies on an 18-24 month cycle. A targeted sample of participant records is selected for review. All files that are reviewed are examined to see if the CP-6 was signed by the client with a copy maintained in the record.	Beginning in May 2005, a new Consumer File Review Tool was used by GQ to evaluate case records as maintained by Care Management sites. Findings from those on-site surveys have indicated that of the 146 ECO cases audited, four cases were cited as not identifying formal assessed needs in the Plan of Care/Resident Service Plan, and five cases were cited as not identifying informal assessed needs in the Plan of Care. Furthermore, of the 146 ECO cases audited, one was cited as not having the Choice of Care form which indicates that the participant had the choice between institutional care and community-based care.	Care Management Sites are monitored every 18-24 months or more frequently as needed. Survey results from each survey are shared with QualityTeam, as necessary, within 30 business days of the survey. Aggregate reports of findings collected during monitoring surveys are produced annually and upon request.	Ongoing
	The GQ continues to monitor Care Management agencies by reviewing a targeted sample of participant records. All files that are reviewed are examined to see if narrative in the Monitoring Record reports that the Case manager has explained alternatives to the client and entries that demonstrate that client's desires to retain or change components of his or her program are effectively addressed.				
	In addition to file review, during on-site quality assurance monitoring reviews, State GQ County Liaisons interview Case managers. Among other things, Case managers are asked the extent to which they afford the clients choice in all aspects of the programs.	GQ	Beginning in May 2005, a new Review Tool was used to evaluate Case manager feedback. The information that was discovered from the Case manager Survey is attached in an aggregate report.	Case manager Surveys completed every 18 -24 months Reports requested Annually	Ongoing
	Individual participants, whose files are reviewed during the GQ monitoring visit, are surveyed by GQ Liaisons and asked if they had choice of waiver services versus institutional care, as well as choice of types of waiver services and providers. Consumer feedback is solicited either through face-to-face interviews during the GQ monitoring visits or through mailed surveys shortly after the monitoring visit.	GQ	Beginning in May 2005, a new Consumer File Review Tool was used to evaluate consumer records. GQ Supervisors continually review the data and reports generated, sharing general results, on an as needed basis, with the GQ Quality Team, which meets twice a month. Discussions are had to determine if programs are operating in accordance with established standards. Remediation methods, above and beyond the Corrective Action Plans received by CM agencies, are developed by the GQ Quality Team. In addition, in March 2007, the GQ Supervisors provided aggregate reports and a presentation of the GQ Quality Assurance process to the DACS Extended Management Team.	Formal reports of aggregated data are generated at least annually and upon request.	Ongoing

**Qualified Providers - page 1 of 4**

Assurance Requirements	Monitoring Activity (WHAT)	Monitoring Responsibilities (WHO)	Data / Management Reports	Frequency	Plan (Timeline/Milestones)
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The GO Medicaid Waiver is comprised of several components: Adult Family Care (AFC), In-home services, and Assisted Living services. AFC is personal care and services, provided by an approved caregiver, in the caregiver's private home. All AFC activity is under the jurisdiction of a licensed Comprehensive Personal Care Home (CPCH), or by an Assisted Living Program in Subsidized Housing. ALP is a coordinated array of personal care and support services available throughout the day to tenants of select subsidized housing settings. The provider of any assisted living services who live in non-licensed community homes, as an alternative to nursing facility placement. Individuals enrolled in GO in their own home receive services from individuals who may be the participant's employee as well as from agencies and other providers.

A Provider of GO services is an individual or entity that demonstrates competence to qualify as a provider of services pursuant to the approved Medicaid Waiver criteria and who provides authorized services to a participant, pursuant to a Plan of Care. There are three types of Providers:

**Traditional Provider:** an individual or entity provider/worker who provides authorized services to a participant and who is enrolled as an approved Medicaid provider able to bill UNISYS directly for the authorized service.

**Non-Traditional Provider** – An individual or entity that is not enrolled to bill UNISYS directly for services but who demonstrates competence to qualify as a provider of services pursuant to the approved Medicaid waiver criteria and provides authorized services to a participant.

**Participant-Employed Provider** – An individual provider/worker who provides authorized services as a direct employee of the participant.

The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other State standards prior to their furnishing waiver services.	UNISYS, the State fiscal agent, for the NJ Medicaid program verifies that all program requirements have been met before the provider is Medicaid enrolled and assigned a provider number.		Unisys maintains a database of all approved traditional providers. DACS maintains a database of all approved non-traditional Providers including those that the participant has chosen to personally employ.			Milestone: In 2006, Unisys completed a three year re-enrollment of all qualified traditional providers.		
	<b>Service</b>	<b>Provider</b>	<b>Qualifications</b>	<b>Entity Responsible for Verification</b>	<b>Frequency</b>	<b>Other Standard</b>		
	Care Management	Area Agency on Aging (AAA)	45 CFR 132.1	DACS	Annual	Agency designated pursuant to 45 CFR 132.1 and Medicaid approved. Case manager must meet experience or education requirements identified in ECO Waiver renewal if not a licensed RN or certified or licensed Social Worker.	Annually	Ongoing
		County Welfare Agency	RN (NJSA 45:11-26) or Social Worker licensed to practice in NJ (NJSA 45:1-15)	DACS	Every 18-24 months		Every 18-24 months	Ongoing
		Proprietary or Not-for-profit Care Management entity	RN (NJSA 45:11-26) or Social Worker licensed to practice in NJ (NJSA 45:1-15)	DACS	Every 18 - 24 months	Agrees not to self-refer waiver participants. Medicaid approved.	Every 18-24 months	Ongoing
		AFC Sponsor Agency	NJSA 26:2Y	DHSS	Annual	Medicaid approved	Annually	Ongoing
	Homemaker	Licensed Medicare Certified Home Health Agency	NJAC 8:42	DHSS	Every 2 years	Medicaid approved	Every 2 years	Ongoing
		Accredited Homemaker Agency		NJ Commission on Accreditation, Inc. or National Home Care Council Community Health Accreditation Program	Annual	Medicaid approved	Annually	Ongoing
	Respite	Licensed Nursing Facility	DHSS NJAC 8:39	DHSS	Annual	Medicaid approved	Annually	Ongoing
		Licensed ALR or CPCH	NJAC 8:36	DHSS	Annual	Medicaid approved	Annually	Ongoing
		Licensed Certified HHA	NJAC 8:42	DHSS	Every 2 years	Medicaid approved	Every 2 years	Ongoing
		AFC Caregiver - Licensed AFC Sponsor Agency	NJSA 26:2Y	DHSS	Annual	Medicaid approved	Annually	Ongoing
		Employment Agency or Health Care Service Firm	NJAC 13:45B	Law and Public Safety Div. Of Consumer Affairs	Annual	Signed agreement with DHSS to provide services; individual meets competence requirements of Addendum 2 to Appendix B-2 in the 2004 ECO Waiver Renewal (Available as requested)	Annually	Ongoing
		Accredited Homemaker Agency		NJ Commission on Accreditation, Inc. or National Home Care Council Community Health Accreditation Program	Annual	Medicaid approved	Annually	Ongoing

**Qualified Providers - page 2 of 4**

Assurance Requirements	Monitoring Activity (WHAT)		Monitoring Responsibilities (WHO)			Data / Management Reports	Frequency	Plan (Timeline/Milestones)	
	Service	Provider	Qualifications	Entity Responsible for Verification	Frequency				Other Standard
<p><b>CONTINUED</b>  The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other State standards prior to their furnishing waiver services.</p>	Environmental Accessibility Adaptations	Various trade persons	State licensed contractor	DACS	Prior to providing initial services	NJAC 5:23-2 Signed agreement with DHSS to provide services/Prior Authorization for EAA over \$500	Prior to providing initial services	Reviewing & updating current process to assure that non-traditional providers continually meet standards/requirements	
	Transportation	Individual PEP	Licensed to operate a motor vehicle registered and insured in NJ	Case manager		Prior to providing initial services	PEP must be approved by CM, Criminal Background Investigation and Fiscal Intermediary to work as an employee of participant	Prior to providing initial services	Reviewing & updating current process to assure that non-traditional providers continually meet standards/requirements
		Various vendors	Authorized to do business in NJ. Vehicle appropriately registered, inspected and insured. Driver licensed to operate the vehicle.	DACS		Prior to providing initial services	Signed agreement with DHSS to provide services	Prior to providing initial services	Reviewing & updating current process to assure that non-traditional providers continually meet standards/requirements
	Special Medical Equipment & Supplies	Medical Supplier	Agreement with DACS to provide SME	UNISYS		Every 18 - 24 months	NJAC 10:59-1.3 Medicaid approved/Prior Authorization for amounts over \$250	Per Regulations	Ongoing
		Various vendors		DACS		Prior to providing initial services	Signed agreement with DHSS to provide services	Prior to providing initial services	Reviewing & updating current process to assure that non-traditional providers continually meet standards/requirements
	Chore Services	Individual PEP	See "Other Standard"		Case manager	Prior to providing initial services	PEP must be approved by CM, Criminal Background Investigation and Fiscal Intermediary to work as an employee of participant and demonstrates competency to complete required task.	Prior to providing initial services/monthly	Ongoing
		Private Contractor	Demonstrated ability to provide service/warranty/guarantee	DACS		Prior to providing initial services	Signed agreement with DHSS to provide services/Prior Authorization for amount over \$50.	Prior to providing initial services	Reviewing & updating current process to assure that non-traditional providers continually meet standards/requirements
		Subsidized Independent Housing for Seniors	NJSA 52:27D-184 qualified housing agency	DACS		Prior to providing initial services	Signed agreement with DHSS to provide services	Prior to providing initial services	Reviewing & updating process to assure that non-traditional providers continually meet standards/requirements
	Personal Emergency Response System (PERS)	Electronic communication equipment vendor and monitoring agency	Provides proof that device meets required standards	DACS		Prior to providing initial services	Signed agreement with DHSS to provide services. Authorized to install, implement and monitor the device. Device must be UL approved and meet FCC standards	Prior to providing initial services	Reviewing & updating current process to assure that non-traditional providers continually meet standards/requirements
	Attendant Care	Individual PEP	R.N. must observe PEP in performance of required task		Case manager/RN	Prior to providing initial services	Standards available in Waiver Addendum 2 to Appendix B-2 (Available as requested)	Prior to providing initial services	Ongoing
		Licensed Medicare Certified Home Health Agency	DHSS NJAC8:42	DHSS		Every two years	Meets standards under DHSS. Signed agreement for services	Every 2 years	Ongoing
		Accredited Homemaker Agency	Accredited	NJ Commission on Accreditation, Inc. or National Home Care Council Community Health Accreditation Program		Annual	Signed agreement with DHSS to provide service	Annually	Ongoing
		Registered Professional Nurse	NJSA 45:11-26	Board of Nursing		Every two years	Signed agreement with DHSS to provide service	Every two years	Ongoing
	Adult Family Care	Licensed AFC Sponsor Agency	NJSA 26:2 Y	DHSS		Annual	Medicaid Enrolled	Annually	Ongoing
	Assisted Living Program in Subsidized Housing	Assisted Living Program	NJAC 8:36	DHSS		Annual	Medicaid enrolled	Annually	Ongoing
	Social Adult Day Care	SADC agency	Meet Waiver Criteria	Area Agency on Aging or DACS		Annual	Meets criteria for SADC outlined in Waiver (Available as requested); Medicaid Enrolled	Annually	Ongoing

**Qualified Providers - page 3 of 4**

Assurance Requirements	Monitoring Activity (WHAT)		Monitoring Responsibilities (WHO)			Data / Management Reports	Frequency	Plan (Timeline/Milestones)	
	Service	Provider	Qualifications	Entity Responsible for Verification	Frequency	Other Standard			
<p><b>CONTINUED</b> The State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other State standards prior to their furnishing waiver services.</p>	Home-delivered Meal Services	Restaurant or Food Service Vendor	NJAC 8:24	DACS	Initially	Signed agreement with DHSS to provide services	Prior to providing initial services	Reviewing & updating current process to assure that non-traditional providers continually meet standards/requirements	
		Title III Supplier	Title III Approved Provider	Area Agency on Aging	Annually	Federal OAA standards and Chapter 24 of State Sanitary Code; Title III approved provider. Signed agreement with DHSS to provide services	Annually	Reviewing & updating current process to assure that non-traditional providers continually meet standards/requirements	
	Caregiver/Recipient Training	Individual with appropriate experience to train the participant/Caregiver required by the POC.	If required by scope of practice, e.g. RN, NJSA 45:11-26	R.N. or CM assures that qualifications are commensurate with topic	Every 2 years for RN Prior to service delivery for other provider types	Licensed, Certified, or Registered in NJ if required by scope of practice. If licensure, Certification or registration not required, must submit credentials for approval. Signed agreement with DHSS to provide service.	Every two years if RN Prior to providing initial services for other provider types	Reviewing & updating current process to assure that non-traditional providers continually meet standards/requirements	
	Home-Based Supportive Care	Individual PEP	See "Other Standard"	Case manager	Prior to providing initial services	PEP must be approved by CM, Criminal Background Investigation and Fiscal Intermediary to work as an employee of participant and demonstrates competency to complete required task.	Prior to providing initial services/monthly	Ongoing	
		Employment Agency or Health Care Service Firm	NJAC 13:45B	Department of Labor and Public Safety, Division of Consumer Affairs	Annual	Individual meets competence requirements established in Addendum 2 to Appendix B-2 of 2004 ECO renewal. (Available as requested)	Annually	Reviewing & updating current process to assure that non-traditional providers continually meet standards/requirements	
		Temporary Health Service Firm	NJAC 13:45B			Individual meets competence requirements established in Addendum 2 to Appendix B-2 of 2004 ECO renewal (Available as requested). Signed agreement with DHSS to provide services	Annually	Reviewing & updating current process to assure that non-traditional providers continually meet standards/requirements	
	Assisted Living:	Assisted Living Residence (ALR) and Comprehensive Personal Care Homes (CPCH)	Licensure per NJAC 8:36	UNISYS Provider Enrollment; and Surveyors from DHSS, HFEL	Annual	Medicaid Approved. Assisted Living Residences and Comprehensive Personal Care Homes must be licensed as a pre-condition of Medicaid Provider Enrollment. Staff in the Office of Community Programs reviews the Medicaid Provider application to assure that Medicaid reimbursement rates do not exceed the amount that a private pay resident would pay for the same services. One hundred percent of ALRs and CPCHs that provide services to Assisted Living Waiver participants complete this process.	Annually	On-going	
		Recently the State executed a three-year process of reviewing the qualifications of all Medicaid providers. The State Medicaid Fiscal Agent, UNISYS, is responsible for contacting providers requiring them to re-enroll as Medicaid providers, thereby having to submit documentation that they continue to meet required licensure, certification or other standards.		UNISYS. UNISYS, the State fiscal agent, for the NJ Medicaid program verifies that all program requirements have been met before the provider is approved and assigned a provider number.			On an as needed basis, GQ can have provider reports printed from MMIS databases. These reports provide a comprehensive list of all current Medicaid qualified providers by type of service provided.	On request	Ongoing
		The State verifies annually that 100 percent of the providers subject to regulation/licensure and/or certification (Assisted Living / Comprehensive Personal Care Homes) meets regulations and required State standards.		DACS works in collaboration with staff from the 21 Area Agencies on Aging and their approved subcontractors, and surveyors from the Division of Health Facilities Evaluation and Licensing (HFEL) to oversee the quality of care in Assisted Living.			HFEL survey information is entered into a database maintained by HFEL. HFEL has tailored special reports for GQ so there is an ability to collect, aggregate, and analyze data to identify trends of deficiencies by providers or corporate management. Care Managers are notified of all deficiencies in any facility where they provide services. While individual residents are not permitted to be identified, HFEL reports deficiencies are indications of systemic problems.	Monthly	Ongoing
				Staff from HFEL visits each AL program initially and then, unannounced, on an annual basis, in response to a complaint, or as a follow-up to an earlier visit.			HFEL notifies GQ of any deficiencies and enforcement letters that are processed. E-mail alerts are sent to the Care Coordinators, Care Management Supervisors, and Care Managers assigned to AL facilities in counties impacted by HFEL actions.	Monthly for Deficiencies Enforcement Letters as they are sent.	
	<p>DACS requires that 100% of providers of the Waiver services identified above meet the standards for each service prior to providing services to Medicaid Waiver participants. If a provider applicant is a "Non-Traditional" provider, e.g. Meals-on-Wheels, PERS, Environmental Accessibility Adaptations, etc., a responsible party must complete a six-page application that requires general information such as Legal Name of Applicant, Business/Company Name, Federal Identification Number, Addresses (Headquarters, Mailing and Billing), and Contact information for Individuals –one each at the Headquarters and Billing addresses. The applicant must also complete the following forms: Certification Regarding Debarment and Suspension form, Ownership Disclosure Form, and part 1 of the W-9 Questionnaire. Participant-Employed Providers have ongoing State Criminal Background Investigations and Federal checks every two years. Participants determine whether the employee that they have hired is performing satisfactorily.</p> <p>Based on average monthly claims processed by Public Partnerships, LLC (PPL), the Fiscal Intermediary for non-traditional, non-Medicaid enrolled providers, there are 128 Participant-Employed Providers and an additional 219 non-traditional providers as follows:</p> <ul style="list-style-type: none"> <li>- Attendant Care Evaluation 2</li> <li>- Chore Service 1</li> <li>- Caregiver Recipient Training 1</li> <li>- Environ. Accessibility Adaptations &amp; Evaluations 17</li> <li>- Home-Based Supportive Care Agency 136</li> <li>- Home Delivered Meal Service 16</li> <li>- PERS Installation &amp; Monitoring 46</li> </ul>						Numbers of specific provider types - as needed	Ongoing	
	UNISYS enrolls Traditional Waiver Service Providers, such as Care Managers, Homemakers, Respite Agencies/Nursing Facilities, Adult Family Care Sponsor Agencies, Assisted Living Program providers, and Social Adult Day Care Agencies in the Medicaid System. All Waiver service providers in this category are licensed, accredited, or otherwise approved annually or on a regular basis to provide services.						According to Regulations	Ongoing	

**Qualified Providers - page 4 of 4**

Assurance Requirements	Monitoring Activity (WHAT)	Monitoring Responsibilities (WHO)	Data / Management Reports	Frequency	Plan (Timeline/Milestones)																
<p><b>The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements</b></p>	<p>For those Waiver service providers that are considered "Non-Traditional" such as the ones that deliver Attendant Care, Chore Service, Caregiver Recipient Training, Environmental Accessibility Adaptations &amp; Evaluations, HBSC, Home Delivered Meals, and PERS, it has been practice to verify ongoing conformance with the established standards by:</p> <ol style="list-style-type: none"> <li>1. Checking provider qualifications in response to questions raised by Care Managers or the Public;</li> <li>2. Requiring proof of new licensure when a provider notifies MIS &amp; DM of a change in ownership;</li> <li>3. Relying in part on the knowledge that other state or county agencies/programs have contracts/agreements with mutual providers; and</li> <li>4. Checking Internet sites that list the names of licensees.</li> </ol>	<p>While the identified practice has served DACS to this point, we believe this system is insufficient and will improve it by:</p> <ul style="list-style-type: none"> <li>· Contacted all non-traditional providers by mail by October 1, 2007 to request proof of current licensure/certification or adherence to standards;</li> <li>· Updating agreements as necessary by April 1, 2008 based on responses to the request for proof of licensure/certification; and</li> <li>· Reviewing current enrollment and provider verification processes to determine the most efficient, effective way to assure that these provider types meet standards initially and ongoing. In addition, a DACS Director of Provider Relations was appointed September 1, 2007, who is determining the most efficient, effective way to assure that all provider types meet ongoing standards. For example, an online registry, through the Department of Law and Public Safety, Division of Consumer Affairs, maintains a list of Health Care Service Firms (may provide Home-Based Supportive Care) at <a href="http://www.state.nj.us/lps/ca/ocp/agency.pdf">http://www.state.nj.us/lps/ca/ocp/agency.pdf</a> that includes the expiration date of the Health</li> </ul>	<p>The State assures prospectively that provider applicants meet all criteria/standards for delivering a specific service through the application process, which requires documentation that the applicant meets the standards and an agreement signed by the applicant and Assistant Commissioner confirming eligibility to provide services.</p> <p>The agreements are currently under review by staff from DMAHS (Division of Medical Assistance and Health Services – Medicaid) and DACS. They will be revised as necessary to include requirements for the provider to give proof on a periodic basis that it continues to meet the standards for the service. The revised agreements will be sent to current providers, if applicable, for re-enrollment.</p>	<p>The review and revision of agreements will be completed by April 30, 2008. The re-enrollment process will be completed by June 1, 2008.</p>	<p>Contact non-traditional providers by 10/1/07 to request current proof of eligibility to provide services. Update agreements as necessary by 4/1/08. Reviewing &amp; updating current enrollment and provider verification processes - Ongoing</p>																
<p><b>The State implements its policies and procedures for verifying that provider training is conducted in accordance with State requirements and the approved Waiver.</b></p>	<p>A Care Management Manual was developed for Care Managers, which is used to train staff at new Care Management sites.</p> <p>The GQ created an Operational Manual for Care Managers to use as a daily reference for the completion of their responsibilities.</p> <p>All Medicaid Waiver Care Managers complete NJEASE 8-day Core Care Management training.</p> <p>Medicaid Waiver Care Management trainings to review the training manual and basic policies and procedures are conducted.</p>	<p>GQ</p> <p>GQ</p> <p>GQ</p>	<p>Between May 2005 and April 2006, all of the Medicaid Waiver Care Management sites that were surveyed, except for one, were required to submit a Corrective Action Plans to GQ. All of the CAPs were accepted when proof of the following was included:</p> <ul style="list-style-type: none"> <li>-- A copy of the cited document with applicable amendments attached;</li> <li>For document deficiencies that cannot be corrected with an amendment, a policy statement addressing how the agency will implement corrective actions in the future should be included;</li> <li>-- The actions to be taken (such as staff education, forms or policies to be revised, etc.) to ensure that deficiencies do not recur;</li> <li>-- The person(s) responsible for implementation; and</li> <li>-- A description of how each deficient area would be addressed in the Agency's Quality Improvement program.</li> </ul> <p>Between January 2006 and December 2006, GQ staff directly provided 24 group trainings reaching 796 individuals:</p> <table border="0"> <tr> <td>4 Care Coordinator Meetings</td> <td>150 attendees</td> </tr> <tr> <td>6 Care Management Meetings</td> <td>283 attendees</td> </tr> <tr> <td>10 Program or Core CM trainings</td> <td>195 attendees</td> </tr> <tr> <td>4 Assisted Living Industry Trainings</td> <td>168 attendees</td> </tr> </table> <p>Between January 2007 and December 2007, GQ staff directly provided 15 group trainings reaching 581 individuals:</p> <table border="0"> <tr> <td>3 Care Coordinator Meetings</td> <td>145 attendees</td> </tr> <tr> <td>3 Care Management Meetings</td> <td>162 attendees</td> </tr> <tr> <td>7 Program or Core CM trainings</td> <td>153 attendees</td> </tr> <tr> <td>2 Assisted Living Industry Trainings</td> <td>121 attendees</td> </tr> </table> <p>Training Agenda and Attendees lists are maintained on file by GQ.</p>	4 Care Coordinator Meetings	150 attendees	6 Care Management Meetings	283 attendees	10 Program or Core CM trainings	195 attendees	4 Assisted Living Industry Trainings	168 attendees	3 Care Coordinator Meetings	145 attendees	3 Care Management Meetings	162 attendees	7 Program or Core CM trainings	153 attendees	2 Assisted Living Industry Trainings	121 attendees	<p>Annually</p> <p>Care Coordinator/CMSupervisor meetings are held quarterly. Care Manager meetings are held 6x a year - twice in each of three 3 regions. Other trainings are held as necessary.</p>	<p>Ongoing</p> <p>Ongoing</p>
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**Health and Welfare - page 1 of 2**

Assurance Requirements	Monitoring Activity (WHAT)	Monitoring Responsibilities (WHO)	Data / Management Reports	Frequency	Plan (Timeline/Milestones)
<p><b>The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.</b></p>	<p>Care Managers continually monitor participant's health and welfare with monthly contacts and quarterly visits and take prompt remediation actions when needed.</p>	<p>Care Manager. Care Plans indicate the participant's health and welfare needs. Monitoring Records note when the Care Manager suspects any changes to the health or welfare of the participant and how that is addressed or if applicable if a referral was made for further investigation.</p>	<p>Care Mangers have monthly contacts with each participant. At that time, as well as during Quarterly Visits, a client would be assessed for any changes to their health or welfare. Beginning in May 2005, a new Consumer File review Tool was used to evaluate consumer records.</p>	<p>Care Manager monitors monthly. GQ completes QA survey visit every 18-24 months. Management reports are generated following each QA survey. Aggregate reports are generated at least annually or upon request.</p>	<p>Ongoing</p>
	<p>Care Plans and Level of Care reevaluations are reviewed and signed by the Care Management Supervisor to assure that services to meet participants' health and welfare needs are provided.</p>	<p>Care Management Supervisor</p>	<p>Beginning in May 2005, a new Consumer File Review Tool was used to evaluate consumer records. The tool specifically looks for the inclusion of the Care Management Supervisor's signature on POCs and LOC reevaluations. The information is currently being downloaded into a database so that aggregate reports can be run on findings collected to date.</p>	<p>Care Management Supervisor reviews all POC and LOC done by Care Managers. GQ completes QA survey visit every 18-24 months. Management reports are generated following each QA survey. Aggregate reports are generated at least annually or upon request.</p>	<p>Ongoing</p>
	<p>State quality assurance survey file reviews and participant interviews are utilized to monitor Care Manager and Care Management Supervisor actions to assure participants' health and welfare.</p>	<p>GQ. When problems are identified during the GQ on-site monitoring of CM agency care plans or level of care reevaluations, the CM Supervisor is alerted to the deficiencies immediately during the Exit Interview. In a Summary Report sent by GQ as follow-up to the on-site review, the CM agency is instructed to submit to GQ within 30 days a formal Corrective Action Plan.</p>	<p>When warranted, a Corrective Action Plan (CAP) is to be submitted to GQ. To be accepted all CAPs are to include proof of the following:  -- A copy of the cited document with applicable amendments attached;  For document deficiencies that cannot be corrected with an amendment, a policy statement addressing how the agency will implement corrective actions in the future should be included;  -- The actions to be taken (such as staff education, forms or policies to be revised, etc.) to ensure that deficiencies do not recur;  -- The person(s) responsible for implementation; and  -- A description of how each deficient area would be addressed in the Agency's Quality Improvement program.</p>	<p>GQ completes QA survey visit every 18-24 months. Management reports are generated following each QA survey. Aggregate reports are generated at least annually or upon request.</p>	<p>Ongoing</p>
	<p>Critical incidents or events are reported to the particular county APS office, or to the State's Public Awareness, Information, Assistance and Outreach Unit toll-free number. Other sources that receive calls include the APS State Coordinator's office, the Department of Health and Senior Services, Division of Aging and Community Services, and the Governor's Office. The county APS Provider Agency is responsible for evaluating reports. Reports are evaluated based on the definitions of a vulnerable adult, abuse, neglect and exploitation as defined in statute and regulations (NJSA 52:27 D-406 et seq). Reports are substantiated when the preponderance of evidence supports the allegation. The county APS supervisor assigns an APS worker to the investigation. An APS investigation is a thorough assessment of a potential at-risk adult. A face-to-face meeting with the adult by a trained APS social worker is required. During this meeting the potential client is interviewed in private. Every effort is made to determine the competence of the adult. Other individuals or agencies that have knowledge of th</p>	<p>The APS Provider Agency will conduct an evaluation of the client within 72 hours of receiving the referral unless there are indications of immediate physical harm or clear and substantial risk of death, which then requires an immediate evaluation. If the referral is substantiated during the evaluation, the client would be taken to the hospital, if warranted, or the incident reported to law enforcement. Reports not requiring immediate evaluation require a face-to-face contact within 3 working days. The APS worker has 30 days to make a determination of the substantiation of the report and to complete the Client Evaluation Form, which is entered into a database.</p>	<p>Beginning in May 2005, a new Survey Tool was used to evaluate Client Satisfaction. Among other questions, the Client Satisfaction Surveys give clients the opportunity to say if they feel they are treated with respect and questions if they know who to contact in case they have a problem. In 2005/2006, approximately 428 surveys were mailed to program participants, and of them 192 were returned (45%). In 2007/2008, a total of 3,900 surveys were mailed to program participants and results of those that have been returned are being tallied.</p>	<p>In-home interviews with participants are incorporated into on-site survey visits. Client Satisfaction are solicited through the mail annually. Reports requested Annually</p>	<p>Ongoing</p>
	<p>Critical incidents or events are reported to the particular county APS office, or to the State's Public Awareness, Information, Assistance and Outreach Unit toll-free number. Other sources that receive calls include the APS State Coordinator's office, the Department of Health and Senior Services, Division of Aging and Community Services, and the Governor's Office. The county APS Provider Agency is responsible for evaluating reports. Reports are evaluated based on the definitions of a vulnerable adult, abuse, neglect and exploitation as defined in statute and regulations (NJSA 52:27 D-406 et seq). Reports are substantiated when the preponderance of evidence supports the allegation. The county APS supervisor assigns an APS worker to the investigation. An APS investigation is a thorough assessment of a potential at-risk adult. A face-to-face meeting with the adult by a trained APS social worker is required. During this meeting the potential client is interviewed in private. Every effort is made to determine the competence of the adult. Other individuals or agencies that have knowledge of th</p>	<p>The APS Provider Agency will conduct an evaluation of the client within 72 hours of receiving the referral unless there are indications of immediate physical harm or clear and substantial risk of death, which then requires an immediate evaluation. If the referral is substantiated during the evaluation, the client would be taken to the hospital, if warranted, or the incident reported to law enforcement. Reports not requiring immediate evaluation require a face-to-face contact within 3 working days. The APS worker has 30 days to make a determination of the substantiation of the report and to complete the Client Evaluation Form, which is entered into a database.</p>	<p>When the investigation is complete a report is submitted to the APS Supervisor who will then consult with the social worker and determine if the adult is at risk of abuse, neglect or exploitation. All information generated by the investigation is confidential. The participant is advised of the results of the investigation within 60 days. The APS worker will work closely with the client to ensure the client is safe, the risk is removed, and if necessary, services in place. Because of confidentiality mandated by the APS statute (NJSA 52:27 D - 406 et seq), the only investigation results that are shared with agencies are information that is needed for that specific provider/agency to deliver services, e.g., medical information may be given to a VNA that is providing services to the client. A court order is necessary to make the case file public.</p>	<p>DACS has established a central registry for the receipt and maintenance of all reports of suspected abuse, neglect and exploitation of vulnerable adults. The APS State Coordinator oversees this database. The APS client data is sent electronically in a Secure File Transfer Protocol by the county APS agency to the state coordinator. In the future, the information will be collected through a web-enabled database with the ability to collect reports at any time.</p>	<p>The APS State Coordinator provides oversight of the county APS agencies through annual monitoring of the agency for compliance and intervention when complaints are registered.</p>

**Health and Welfare - page 2 of 2**

Assurance Requirements	Monitoring Activity (WHAT)	Monitoring Responsibilities (WHO)	Data / Management Reports	Frequency	Plan (Timeline/Milestones)
<p><b>CONTINUED</b> The State, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation.</p>	<p>DACS administers the Adult Protective Services (APS) program that oversees 21 County-based APS sponsor agencies. These agencies provide services for any NJ resident who is 18 years of age or older, living in the community and subject to abuse, neglect or exploitation.</p>	<p>DACS APS Unit</p>	<p>All information generated by the investigation is confidential. The DACS APS Unit does, however, maintain a database of all investigations. The APS Unit generates an annual report noting APS State trends.</p>		<p>Milestone: Fall 2006 - State APS Office modified its database to collect Waiver data.</p>
	<p>Complainants may be participants, family members, formal caregivers, Case managers, agencies or any interested individuals. An APS investigation is a thorough assessment of a potential at-risk adult. Within 72 hours of a referral's receipt, a face-to-face meeting with the adult by a trained APS social workers is required. During this meeting the potential participant is interviewed in private and every effort is made to determine the competence of the adult.</p>	<p>When the investigation is complete, a report is submitted to the APS Supervisor who will then consult with the social worker and determine if the adult is at-risk of abuse, neglect or exploitation.</p>		<p>Annually</p>	<p>Ongoing</p>
	<p>Care Managers are informed as to their responsibility, as professionals, to report all incidents of suspected neglect, abuse, and/or exploitation of participants to the proper authorities. Care Managers make referrals to APS and also make referrals to the Ombudsman for the Institutionalized Elderly (OOIE) and the Division of Health Facilities Evaluation and Licensing on behalf of participants in AFC or ALP, Assisted Living facilities, or nursing facilities..</p>	<p>DACS, GQ, APS Unit, and the Office of the Ombudsman for the Institutionalized Elderly</p>	<p>The APS database has been altered to collect information on APS participants involved in the long term care Waiver programs administered by GQ. At the present time the APS State Supervisor is working with a very small database though it is growing daily. The information applicable to GQ and the Medicaid Waiver can only be found at the time of termination of the APS case. The terminations typically are not for at least 90 days after the APS referral is made. Though the APS database reflects quite a few registrations and open investigations, right now there are very few terminations because the database began April 1, 2007.</p>	<p>Quarterly</p>	<p>Ongoing</p>
		<p>GQ, during its State Care Management quality assurance surveys, regularly reviews the files of participants using APS or OOIE services. Data from the file reviews are collected and downloaded into a database for review and analysis.</p>	<p>Beginning in May 2005, a new Consumer File Review Tool was used to evaluate consumer records. Of the 146 ECO files reviewed, GQ noted that two participants were actively involved with APS and four had a history of APS participation. Case managers referred two Waiver participants to APS.</p>	<p>GQ completes QA survey visit every 18-24 months. Management reports are generated following each QA survey. Aggregate reports are generated at least annually or upon request.</p>	<p>Ongoing</p>
	<p>Care Managers are responsible to report all incidents/allegations of abuse, neglect or exploitation of waiver participants to GQ County Liaisons immediately. GQ County Liaisons document all incidents, actions taken towards resolution, and investigations undertaken to assure that appropriate intervention is initiated and resolution occurs.</p>	<p>Care Managers                      Care Management Supervisors, as necessary                      GQ County Liaisons                      DACS Administrative Staff, as necessary</p>	<p>Presently, GQ "Critical Incident Reports" are compiled by hard copy and kept in a file created to track Critical Incidents.</p>	<p>As Needed</p>	<p>By 3/1/08, GQ will develop a Critical Incident Reporting Policy to ensure that Care Managers consistently document and report incidences of abuse, neglect, and exploitation to GQ staff. A 'Critical Incident Report' form has been created which will collect information about the incident, present status of the participant, and summary of referrals made to investigate. By 5/1/08, GQ staff will in turn track this information in a database to better monitor the health and welfare of waiver participants.</p>
	<p>DACS works in collaboration with surveyors from the Division of Health Facilities Evaluation and Licensing *HFEL) to oversee the quality of care in Assisted Living.</p>	<p>HFEL sends electronic copies of enforcement letters to DACS Supervisor, which are shared with applicable staff and forwarded to the Care Managers who serve the participants that reside in the cited facility.</p>	<p>From January 2006 through December 2006, HFEL surveyed 183 Medicaid enrolled provider facilities and notified DACS electronically of deficiencies in 129 of them; 30 had enforcement actions taken.</p>	<p>Monthly Deficiency Notices Enforcement Letters as issued.</p>	<p>Ongoing</p>

**Administrative Authority - page 1 of 2**

Assurance Requirements	Monitoring Activity (WHAT)	Monitoring Responsibilities (WHO)	Data / Management Reports	Frequency	Plan (Timeline/Milestones)
<p>The Medicaid Agency retains ultimate 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 contracted entities.</p>	<p>The State Medicaid agency, Division of Medical Assistance and Health Services (DMAHS), has designated the DHSS as the Operating Agency for the Assisted Living Medicaid Waiver.</p>	<p>DMAHS has established a Quality Management Unit (QMU) in its Provider Relations office, staffed by clinical specialists. The first meeting of the QM Unit with DACS took place on August 14, 2006. A second meeting took place on August 17, 2006. Regularly scheduled meetings have been held on the following dates:</p>	<p>The following reports include data that when reviewed by DMAHS, assists in assuring that operational and administrative functions are adequately being carried out.</p>		
	<p>The DMAHS uses the following methods to ensure that the DHSS Division of Aging and Community Services meets Waiver requirements in carrying out its operational and administrative functions:</p>	<p><u>December 2005</u>: Meeting of Ann Kohler, then Director of DMAHS and Patricia Polansky, Assistant Commissioner of the Division of Aging and Community Services regarding Waiver Oversight.</p>			
	<p>Reviews and approves annual CMS 372 S reports</p>	<p><u>January 31, 2006</u>: Meeting to strategize a protocol to determine the frequency and type of oversight of monitoring reviews.</p>	<p>372S Reports</p>	<p>Annually</p>	<p>Ongoing</p>
	<p>Reviews and approves all State Plan Amendments, waiver renewals and IPG progress reports</p>	<p><u>September 28, 2006</u>: Met with the Office of Policy and Procedure (Jean Cary) to discuss Medicaid's role for Waiver oversight. (Minutes on file in the Quality Management Unit's files.)</p>	<p>State Plan Amendments</p>	<p>As Needed</p>	<p>As Needed</p>
	<p>The NJ Department of Human Services' Division of Medical Assistance and Health Services Quality Management Unit is copied on all letters that are sent to care management agencies with regard to DACS Survey Visits, including the Notification Letters and Follow-up Letters, and Corrective Action Plans, when required.</p>	<p>New Jersey's three operating agencies (DDD, DDS, DACS) meet quarterly to discuss various issues as it pertains to their individual Waivers and their quality assurance strategies. The DMAHS' Quality Management Unit participates in all of those meetings.</p>			
	<p>The Medicaid Agency, Quality Management Unit (QMU) will provide ongoing evaluation and documentation of CMS quality assurance measures to assure that funds are appropriately utilized; members are eligible for the services provided and services are appropriately rendered. The QMU Quality Assurance &amp; Improvement framework encompasses scheduled annual comprehensive desk audits, interim targeted desk audits, interim targeted on-site audits, topic audits, QMU and DACS collection and analysis of aggregate data; as well as participating in the DACQ Quality Review Committee meetings and Interagency Meetings.</p>	<p>In addition, the QMU is in the beginning stages of establishing an internal <b>Quality Assurance Advisory Committee</b> to oversee QMU program operations; formation of a task force for the development of standard guidelines, and plans to proceed with topic audits in 2009 once information is synthesized to determine what aspects of the waiver programs need to be addressed for improvement.</p>			
	<p>All desk audits are conducted on QMU premises and preceded by a written 4-6 week advance notice to the care management agencies with corresponded copied to DACS. Annual comprehensive desk audits include retrospective reviews of randomly selected waiver participant records and supporting documents opened with the past 24 months. Desk Audits are based on a percentage of the records reviewed by DACS. Assessment captures the level of care need determinations, the responsiveness of the plans of care to participant needs, the assurance that individuals are addressed, and fiscal accountability is assured for the services rendered.</p>	<p>Medicaid Agency, Quality Management Unit (QMU)</p>	<p>Upon audit completion, a written audit report will be sent to the agency with in 30-45 days summarizing general findings, any identified areas requiring remediation as well as agency strengths.</p>		
	<p>A Plan of Correction will be required if documentation of any assurance is lacking in more than 10% of the records audited. Identified areas of non-compliance that have the potential for adversely affecting the health and well-being of participants or functioning of staff are followed up on an urgent basis by QMU administrative staff.</p>	<p>For those care management agencies requiring a Plan of Correction, based on either the QMU or DACS audit, QMU staff will schedule a follow-up interim desk audit to be conducted approximately two months from the date of the submitted and approved Plan of Correction.</p>	<p>All interim targeted desk audits include random selection of waiver participant records and supporting documents, which assess the components targeted for remediation in the Plan of Correction. The purpose of the interim targeted desk audits is to track continued compliance to the Plan of Correction. Unresolved findings, if noted, on interim targeted audit will require a joint on-site visit (interim focused onsite reviews) by QMU and DACS staff to reach resolution.</p>		
	<p>Reviews Waiver reports from all relevant DHSS divisions, including field survey reports, in order to participate in DACS Quality Review Committee meetings and contribute to planning remediation and quality improvement activities</p>	<p><u>November 14, 2006</u>: Initial Waiver Oversight and Monitoring Work Plan (Working Draft) presentation to DDD, DDS and DACS at their Quarterly Interagency Meeting as mentioned above.</p>	<p>GQ Quarterly Survey Reports and DACS quarterly reports</p>	<p>Quarterly</p>	<p>Ongoing</p>
	<p>Annually reviews and has input into modification of the DACS Quality Management Strategy</p>	<p><u>On-going</u>: Continuing to develop the work plan as DMAHS' oversight and monitoring activities become more defined.</p>	<p>Quality Management Strategy updates</p>	<p>Annually and as needed</p>	<p>Ongoing</p>

**Administrative Authority - page 2 of 2**

Assurance Requirements	Monitoring Activity (WHAT)	Monitoring Responsibilities (WHO)	Data / Management Reports	Frequency	Plan (Timeline/Milestones)
<p><b>CONTINUED</b> The Medicaid Agency retains ultimate 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 contracted entities.</p>		<p>February 28, 2007: February 28, 2007: DACS, QMU and DMAHS' Office of Policy and Procedures conference call re: 372 Reports</p>	<p>N/A</p>	<p>As Needed</p>	<p>As Needed</p>
	<p>Oversight of the use of Sub-Contractors to provide Waiver Services</p>	<p>DMAHS/DACS</p>	<p>Review Agreements and Sub-Contracts</p>	<p>Met 5/10/07, 5/23/07 and 6/29/07 to discuss Agreements &amp; Subcontracts</p>	<p>Ongoing</p>

**Financial Accountability - page 1 of 2**

Assurance Requirements	Monitoring Activity (WHAT)	Monitoring Responsibilities (WHO)	Data / Management Reports	Frequency	Plan (Timeline/Milestones)
<p>State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved Waiver.</p>	<p>In Adult Family Care (AFC) and the Assisted Living Program (ALP), there are fixed all-inclusive per diem rates paid to providers for services delivered to participants. Claims submitted for an amount greater than the per diem rate will be denied. Other waiver services for which individuals enrolled in AFC or ALP are eligible are limited in order to prevent a duplication of services. Participants in both programs may attend Social Adult Day Care, up to three days a week, with prior authorization from GQ County Liaisons. AFC participants may have a cost share after payments for room and board, a personal needs allowance, and other allowable deductions.</p>	<p>Staff periodically review a random sample of Sponsor Agency billings to assure that cost share is being deducted when applicable.</p>	<p>In Adult Family Care (AFC) and the Assisted Living Program (ALP), there are fixed all-inclusive per diem rates paid to providers for services delivered to participants. Claims submitted for an amount greater than the per diem rate will be denied. Other waiver services for which individuals enrolled in AFC or ALP are eligible are limited in order to prevent a duplication of services. Participants in both programs may attend Social Adult Day Care, up to three days a week, with prior authorization from GQ County Liaisons. AFC participants may have a cost share after payments for room and board, a personal needs allowance, and other allowable deductions. Staff periodically reviews a random sample of Sponsor Agency billings to assure that cost share is being deducted when applicable. Since the program is so small, only 50 participants as of 12/31/06, it is a regular process to spot check the UNISYS claims system to detect any Sponsor Agency billing abuses. To date, none has been detected.</p>	<p>Every six months</p>	<p>Ongoing</p>
	<p>GO participants who opt for other home and community-based services have a spending cap for waiver services of \$2,841 a month, including Care Management. The CM may determine during home visits or follow-up contacts that services and/or supports identified in the initial Transition Plan/Plan of Care are inadequate, and that the plan should be modified. The two significant factors that may prompt an increase to the POC are 1) a change in clinical condition or 2) a change in the informal support system. If the increase will remain under the cost cap of \$2,841, the CM submits the request to the Care Coordinator or Care Management Supervisor for review and approval/denial. If the request is over \$2,841, the CM submits it to OCCO Regional Quality Manager for approval/denial. Both Reviewers are to evaluate the request to modify the POC; review the updated MDS-HC assessment, POC, written justification, and SCR; evaluate the impact of the changes on the participant's ability to improve deficits in ADLs/IADLs; ensure that the proposed changes to the POC and to the individualize</p>	<p>DACS Offices of MIS &amp; DM, Fiscal Analysts, and GQ County Liaisons during Survey Visits                      Care Management Agencies</p>	<p>We received the first SURS report on June 11, 2007. The files of 1,906 participants from November 2005 through April 2007 were included in the study. Seventy individuals (3.6%) exceeded \$1,300 a month in Waiver services for at least two consecutive months. Since the report is sorted by Care Management Site, participant, and identifies providers, services delivered, provider of the services, dates of service, units of service, claims and payment amounts, we are reviewing the report to detect possible trends among Care Managers and Providers that will be addressed immediately.</p>	<p>Quarterly</p>	<p>Ongoing</p>
	<p>Monitoring of financial accountability is governed by the Fiscal Intermediary contract between UNISYS, the State Fiscal Agent, and the Division of Medical Assistance and Health Services (DMAHS), the State Medicaid Agency, in the Department of Human Service</p>	<p>Staff from the DHSS Medicaid Management Information System (MMIS) in the Senior Benefits Utilization Management Division is stationed in the UNISYS State room with the DHS State Monitoring Unit.</p>	<p>MMIS and the DHS Monitoring Unit can identify UNISYS processes for staff, work on project or report requests and follow-up on any issues that DHSS may have regarding a provider.</p>	<p>As Needed</p>	<p>Ongoing</p>
	<p>Parameters for providers are set such as participant eligibility files, procedure codes for services permitted under the Waiver, and financial records for claims payment data. Provider groups are analyzed to identify problems.</p>	<p>The SURS (Surveillance Utilization Review Subsystem) Unit in the Office of Research in DMAHS.</p>	<p>The SURS Unit reviews all claims for over utilization. It is responsible for reviewing reports on paid claims and identifying billing errors strictly of over utilization. Those with the greatest number of billing errors are referred to the Bureau of Admin</p>	<p>Quarterly</p>	<p>Ongoing</p>
	<p>Edits placed in the system monitor payment limits and prevent overpayments.</p>	<p>UNISYS</p>		<p>Quarterly</p>	<p>Ongoing</p>
	<p>Financial irregularities or billing errors are identified, addressed, and corrected.</p>	<p>DMAHS Bureau of Program Integrity                      DHSS also provides for an independent fiscal audit of its waiver providers/services in order to ensure financial accountability. The independent accounting firm of KPMG conducts an annual audit of the Medicaid Agency in conformance with the Single Audit Act (31 U.S.C. 7501-7507). DACS has relied on that audit for the independent audit of the Waivers.</p>		<p>As Requested</p>	<p>Ongoing</p>
	<p>The UNISYS Provider Services Department provides comprehensive training services to the provider community. The training sessions are held at UNISYS, provider sites, or other locations throughout the State of New Jersey.</p>	<p>DMAHS</p>	<p>Training schedules and agendas available upon request</p>	<p>As Requested</p>	<p>Ongoing</p>
	<p>State continues annual CMS 372 reviews</p>	<p>DMAHS</p>	<p>DMAHS reviews and approves all CMS-372 (373Q) reports prepared by DHSS to confirm compliance with Waiver assurances regarding cost neutrality as well as the health and welfare of beneficiaries.</p>	<p>Annually and in Response to RALs sought by CMS 11/9/06</p>	<p>Ongoing</p>
	<p>Section XIII of the Interagency Agreement between DHSS and DHS details the specific responsibilities of each Department regarding reports, forms, and procedures that largely deal with fiscal matters. DHS provides DHSS with a number of fiscal reports identified in the Data/Reports column.</p>	<p>Provision of reports by DMAHS and UNISYS. Review of reports by DHSS, including GQ, staff to assure that approved services are delivered to eligible participants in limits defined by the Waiver and cost caps.</p>	<p>Copies of the Management and Administrative Reports (MARs), which contain payment information on a date of payment schedule. MARS reports are downloaded monthly by a fiscal analyst in the DACS Office of Management Information Systems and Data Management</p>	<p>Monthly</p>	<p>Ongoing</p>
		<p>Quarterly Surveillance and Utilization Reviews (SURS), which contain utilization information.</p>		<p>Quarterly</p>	<p>Ongoing</p>
<p>SeniORs reports of current data</p>			<p>Monthly &amp; as requested</p>	<p>Ongoing</p>	
<p>Office of MIS &amp; DM</p>		<p>Narrative explanation of the analysis, findings, trends, corrective actions taken and outcome measures based on all paid claim data</p>	<p>Monthly</p>	<p>Ongoing</p>	

**Financial Accountability - page 2 of 2**

Assurance Requirements	Monitoring Activity (WHAT)	Monitoring Responsibilities (WHO)	Data / Management Reports	Frequency	Plan (Timeline/Milestones)
<p><b>CONTINUED</b>                      State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved Waiver.</p>	<p>Adequate records and information must be maintained to support financial accountability. In accordance with 45 CFR 74.53, records and additional documentation to support financial accountability must be maintained, at a minimum, 3 year from the submission of each CMS-372 (S) report. The DMAHS verified that the 372 report is produced out of NJMMIS, which has been certified by CMS as meeting all of CMS's requirements as to record retention.</p>	<p>Title 47: Public Records of the New Jersey Permanent Statutes is the statute that governs the process by which State and local agencies make, maintain, and manage public records. New Jersey Administrative Code 15:3 Subchapter 2 addresses the Records Retention requirements.</p>	<p>The GQ Records Retention Schedule is not scheduled for review by the State Records Committee until its meeting in February 2008. At that time, DACS's retention schedule will be formally reviewed and should be accepted. As long as the schedule complies with regulations, the review and approval is a formality. We shall receive a signed copy of the approved schedule for our permanent files.</p>	<p>Annually</p>	<p>Updated as needed</p>
	<p>DACS, through the Offices of Community Choice Options and the Care Management sites, maintains participant records onsite for three years after the case has closed and then in the State archives for four years at which point, they may be marked for disposal.</p>	<p>The files for each participant, which are maintain at the care management site, include Monitoring Notes that document Care Manager Monthly Contacts and Quarterly Visits with the participant, a Plan of Care, and verification of service provision with providers.</p>	<p>During a quality assurance survey visit, files are reviewed to assure service verification is documented. If missing form the file, a deficiency is cited in the follow-up letter and remediation must be addressed in the Corrective Action Plan.</p>	<p>As Needed</p>	<p>Feb-08</p>
	<p>DACS maintains a Home and Community-Based Services (HCBS) website, which was designed so the Care Manager can set up non-traditional services only with providers that have been approved by the Division. The Care Manager enters an Individual Service Agreement (ISA) onto the website to authorize monthly payment amounts to each provider for every service to be delivered to a particular participant. The authorization includes the number of units, frequency, amount and cost. The HCBS System feeds s this authorized information to the fiscal agency, Public Partnership Limited (PPL). If a provider bills for a service that is not authorized or nor more than the monthly -authorized amount, the fiscal agent does not pay the provider.</p>	<p>The State has developed a system to ensure that rate information entered into the HCBS system by the Care Manager for non-traditional service providers is accurate. Through a data support system developed by UNISYS, quarterly reports are run that indicate overspending for service codes by client by county. If overspending is identified, the report is given the the GQ County Liaison staff, who work with the care management agencies to resolve any over billing or errors.</p>	<p>Ultimately, the Care Manager corrects the ISA and payments on the HCBS are monitored to reflect change. Also responsible are Public Partnerships LLC (PPL), a private for-profit entity whose Financial Management Services were procured through the Department of Treasury, Division of Purchase and Property, according to the requirements of N.J.A.C. 17:12. Unisys enrolled PPL as a Medicaid Provider.</p>	<p>Quarterly</p>	<p>Effective no later than May 2008, the HCBS will incorporate a Rate Table. This table will link each service to a specified rate, which will eliminate the need for monitoring rate information entered into the HCBS. The Rate table will block the care manager's ability to input an authorized service amount that exceeds the allowable rate.</p>
	<p>The GQ staff is in constant communication with other State staff from Medicaid and other DACS Offices/Units to address any financial irregularities on a scheduled (Interdepartmental/Interdivisional meetings six times a year) and as needed basis.</p>	<p>For non-traditional Waiver Services, PPL (Public Partnerships LLC) produces a monthly report to address invoices that do not match authorizations regarding units, rate or frequency (financial irregularities). The claims are in a pending status and no provider can be paid until the issue is resolved. PPL sends the report each month to the county care coordinator for review and resolution of either the claim or the ISA. The issues are determined largely to be mistakes in data entry or communication rather than a fraudulent attempt to receive reimbursement that exceeds allowable amounts. A copy of a pending report that identifies the consumer by number, the service provided, units of service, submitted rate per unit, the service start and end dates, service code (identified on the report as Medical d No., Provider Name, Provider EIN, and a message that states why the claim was pending.</p>	<p>If the situation persists where a provider is identified as continually submitting inappropriate invoices, the DACS Director of Provider Relations is available to investigate. In addition, appropriate ISAs are always an agenda item at the four times a year Care Coordinator/Care Management Supervisor meetings and the six Regional Care Management meetings.</p>	<p>Monthly</p>	<p>Process will be updated as needed</p>
	<p>For traditional Waiver Services, billed through Unisys, DACS relies on the SURS reports that have been custom-made to address over-billing. The reports are sent electronically on a quarterly basis and identify any participant whose total claims have exceeded \$1,300 a month for two consecutive months. These reports cover an 18-month time frame and so there is a continual update of the information. Any questions regarding interpretation of the report are directed to the SURS unit in Medicaid.</p>	<p>The Waiver/Policy Administrator and Staff in the Data Management Unit review the reports and provide the Supervisor of the GQ with the names of individuals that are still active, and for whom the overbilling seems chronic. The problems are discussed with Care Managers as they are discovered. The files of these individuals are reviewed during the quality assurance surveys. Individual training about the issue is provided directly at that time to the Care Manager. The issue is also addressed globally in the Exit Interview and covered in future trainings for the Care Managers, Care Management Supervisors and Care Coordinators.</p>	<p>The DACS has hired three additional GQ County Liaisons, who will report for work on February 16, 2008, thereby doubling its current County Liaison staff. DACS has also hired three fiscal analysts, two of whom will report for work in early February. The new professional analysts will enable OCP to review the SURS reports in more depth and identify problem trends at care management sites or with Care Managers and/or providers and report these findings to the County Liaisons. The Liaisons will then address the chronic situations in depth with the Care Managers and take whatever actions are necessary to resolve the problem.</p>	<p>Quarterly</p>	<p>Ongoing</p>

## New Jersey Department of Human Services

### *Division of Developmental Disabilities (DDD)*

New Jersey's Division of Developmental Disabilities (Division) is committed to, complying with waiver assurances, ensuring the health and safety of people receiving services, implementing promising practices, and offering the highest quality services that promote choice and control in people's everyday lives. DDD continuously strives to improve the quality of services and supports through:

- Guidance from people who receive services and supports and their families
- Recommendations from the Quality Management Steering Committee, and
- Collaboration with all partners – advocates, providers, administrative entities, and the community.

The Division will integrate the MFP demonstration into its existing 1915(c) HCBS waiver. The MFP program will incorporate, at a minimum, the same level of quality assurance and improvement activities required in Appendix H of the existing 1915(c) HCBS waiver. This document provides a brief overview of The Division of Developmental Disabilities Quality Management Strategy.

### **Current System Overview and Activities**

The Divisions current system includes the critical processes, structures and operational features necessary to meet the CMS Assurances related to, Monitoring and Responsibilities, Data Management Reports, Report Frequency and the plan for developing and implementing automated processes and reports over the next three years. Each activity is chosen to provide evidence that compliance with each assurance is demonstrated. Evidence is developed from qualitative and quantitative data from record reviews, participant feedback surveys, participant or provider interviews, NJ's Unusual Incident Reporting Management System (UIRMS), Complaint/Grievance database, paid claims and other sources. In 2006 the Division formed the **Office of Quality Management and Planning OQMP** by joining the Offices of Planning and Quality Improvement. Additionally the Office of Risk Management (ORM) was formed. The OQM&P is responsible for analyzing patterns and trends to discover problems or deficiencies. Data on remediation and quality improvement efforts will be collected and analyzed by the OQM&P and provided to Division leadership and management for the purpose of setting goals, assigning resources and guiding policy. DDD Leadership is supported by the Quality Management Steering Committee established through the Real Choice Systems Change grant, awarded in 2004, This Committee was created to advise, support and assist in the design and implementation of the DDD quality management system. Audit processes for oversight by the Single State Agency (Medicaid) are planned as part of the Quality Strategy.

DDD's existing Waiver Monitoring activities collect data both on paper and electronically, Quality, IT, Waiver, and Regional Staffs are working in collaboration to develop and implement IT applications to track timeliness and approval of Level of Care Determinations, Annual Plan development, and plan modification required by changing needs of an individual, annual re-determinations, Medicaid eligibility monitoring and all assurances of CMS's Interim Procedural Guidance. Family, Consumer and Provider feedback is obtained through the Quality Management Steering Committee for incorporation into the Quality Management Strategy. Data

and information from the following: DHS' Office of Program Integrity and Accountability units; Unusual Incident Report Management System (UIRMS), Office of Licensing (OOL), Budget Office and Special Response Unit (SRU), information from complaints and grievances, and participant/family satisfaction will be used to monitor provider compliance with standards and to assess participant Health, Safety and Freedom from Exploitation.

DDD employs a full time CCW Monitor who audits a random sample of records monthly for level of care determination, timeliness/appropriateness of service plan implementation and other compliance standards. Case Managers currently monitor services for compliance with the annual service plan. OQM&P monitors Employment and Day Services for compliance with existing standards. The Quality Management Steering Committee reviews DDD information and data and annually submits recommendations through the OQM&P to the Assistant Commissioner of the Division of Developmental Disabilities for consideration. NJ DDD is committed to creating a transparent process in which data is communicated through its website to consumers, families, providers, advocates and other stakeholders.

### ***Office of Risk Management (ORM)***

The Office of Risk Management provides DDD with information to assist in the timely identification of issues important for optimal service delivery as well as routine review and analysis of incidents of abuse, neglect and exploitation, follow up on investigations and promotion of best practices and continual improvement; all of which are indicators of quality of life and are important to individuals and their families. ORM Currently collaborates with the Critical Incident Management Unit (CIMU), the Special Response Unit (SRU) and the Office of Licensing (OOL). Currently ORM key functions are:

- Review data, analyze, and provide summaries of problem remediation,
- Identify areas of weakness and improvement,
- Produces ad hoc reports and recommendations moving towards a more proactive system approach,

### ***National Core Indicators (NCI)***

In July of 2007, The Division joined the National Core Indicators Project (NCI) a collaboration of 28 participating states and the NASDDDS member state agencies and the Humans Service Research Institute (HSRI) with the goal of developing a systematic approach to performance outcome measurements. Through this project participating states pool their resources and knowledge to create performance monitoring systems, identify common performance indicators, work out comparable data collection strategies and share results. The OQM&P is responsible for the NCI Project and during fiscal year 08

- Conduct of 500 interviews
- Conduct interviews with transitioning individuals, in accordance with NJ's Olmstead Plan "Path to Progress"
- Complete 3000 mail surveys
- Complete provider surveys
- Develop information sharing strategies by June 2009

### ***Day Program Quality Reviews***

In January 2008 The Division of Developmental Disabilities implemented a Day Program Supported Employment Review process to monitor compliance with the Day Program and Supported Employment Standards. Annually Regional and OQM&P staffs will review 20% of all day program and supported employment service contracted agency sites. Review findings and information will be shared with Provider Agency. Information will be aggregated and analyzed for trends to promote systems improvement with reports made available through the Divisions Website for all stakeholders.

### ***Office of Program integrity and Accountability (OPIA)***

OPIA has direct responsibility for incident investigations, licensing of human services programs and facilities and ensuring fiscal and program accountability of community programs and departmental units. The units within OPIA are; Unusual Incident Report Management System (UIRMS), Office of Licensing (OOL), Budget Office and Special Response Unit (SRU) OPIA has a unique role in DHS in that it verifies and validates, independently, activities and operations required and carried out by various departmental units. The OPIA is the entity that certifies DHS compliance with various state and federal regulations and independently investigates or conducts reviews of abuse, neglect and fatalities, as well as financial and program audits. The Office of Licensing is the licensing and regulatory authority that regulates programs serving persons with mental illness, developmental disabilities and traumatic brain injuries. Through its licensing and regulatory process, the Office of Licensing supports the provision of a safe environment in which DHS consumers receive services. Reviews are conducted annually, with unannounced visits to agencies as necessary. Agencies are required to submit a plan of correction to the licensing office regarding deficiencies identified through the licensing review. The Department partners with the Division to take appropriate action in situations where a plan of correction is found to be unacceptable.

### ***Olmstead***

New Jersey's Olmstead plan "Path to Progress" (Plan) outlines the process of transitioning individuals from developmental centers to the community. Supporting the transition to the community requires a quality management system that ensures a continued focus on quality of services and supports that result in chosen outcomes for people receiving services. OQM&P has specific oversight of the Quality Review Process for all individuals transitioned to the community. The system is continually assessed, reviewed and improved to ensure that it is providing what is needed by all who are served by it. Toward this end, DDD organized an Implementation and Planning Advisory Council (Council) to work closely with the Division's leadership. The Council includes service recipients and their families, service providers, Division leadership and members of the broader community. The primary responsibility of the Council is to assure the benchmarks set forth in the plan are met and continue to meet the needs of individuals with developmental disabilities through ongoing review and feedback. The quality management strategies designed to assess whether or not the system is meeting the needs of its customers relies on data that is generated by multiple sources including individuals, families, advocates, providers and other stakeholders. These multiple sources feed the work of the Council.

The information in the following tables presents the processes for monitoring evidence of compliance with assurances for Level of Care, Service Plan, Qualified Providers, Health and Welfare, Administrative Authority and Financial Accountability. The Quality Management System of quality assurance and improvement activities utilized for MFP demonstration participants will be the same as that provided under DDD's 1915(c) HCB waivers. Changes to the Quality Management Strategy will be made in accordance with CMS requirements, recommendations and guidance as a result of the waiver evidentiary process.

*Framework: Participant Access (Indicates process pending CMS Evidentiary)*

<b>Level of Care approval) Assurance Requirement</b>	<b>Monitoring Activity (WHAT)</b>	<b>Monitoring Responsibilities (WHO)</b>	<b>Data</b>	<b>Management Reports</b>	<b>Frequency</b>	<b>Plan (Timeline, milestones)</b>
An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	Waiver Audit of Regional Office and field records by sampling.	Community Care Waiver Auditor <i>Case Manager Supervisor</i>	Regional and Agency files and records	CCW Consumer Review form (maintained in waiver auditor's Central Office file).	Quarterly Reports	<i>By January 2009, DDD will begin a system of quarterly reports aggregating and analyzing the two tiers of oversight for timeliness and appropriateness of reviews of LOC</i>
Enrolled participants are reevaluated at least annually or as specified in the approved waiver.	Waiver Audit of Regional Office and field records by sampling	Waiver Auditor	Regional and Agency files and records. Recertification document embedded in Plan of Care/IHP.	CCW Consumer Review form, (Part B, Section 3) Pre-Admission Assessment and Re-Evaluation.	Monthly sampling which continues on an ongoing basis	Monthly notification to Regional Administrator via email and/or IOC. Regional Administrator response to Waiver Auditor with corrective action noted. Response filed.
	Waiver recertification notification and follow up process	Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), Institutional Service Section (ISS)	ISS consumer files, fiscal information (e.g. bank accounts, earnings, assets) disability documentation (for individuals not covered by SSSI of SSDI)	Letter of confirmation re. final determination of eligibility status	Annual (per individual)	ISS office contacts the DDD Regional Fiscal Waiver staff re. necessary follow up.

The process and instruments described in the approved waiver are applied to determine LOC	Waiver Audit of Regional Office and field records	Waiver Auditor	Regional and Agency files and records.	CCW Consumer Review form (Part B, section 3) Pre-Admission Assessment Re-Evaluation and (Part B, section 2) CCW Eligibility. Recertification document is embedded in the Plan of Care/IHP document.	Monthly sampling which continues on an ongoing basis	Monthly notification to Regional Administrator via email and/or IOC. Regional Administrator response to Waiver Auditor with corrective action noted. Response filed.
	Job Application and interview process- Satisfaction of Qualified Mental Retardation Professional (QMRP) requirement	Personnel	Job Description, Job Application Degree, Resume	Personnel file, Personnel Management Information System (PMIS) Record, Human Resource Information System (HRIS)	Ad Hoc (Per request)	
The state monitors level of care decisions and takes action to address inappropriate level of care determinations	Waiver Audit of Regional Office and field records	Waiver Auditor	Regional and Agency files.	CCW Consumer Review form.	Monthly sampling which continues on an ongoing basis	Monthly notification to Regional Administrator via email and/or IOC. Regional Administrator response to Waiver Auditor with corrective action noted. Response filed.

**Plan of Care**

*Framework: Participant Centered Service Planning and Delivery, Participant Rights and Responsibilities,*

*Participant Outcomes and Satisfaction (Indicates process pending CMS Evidentiary approval)*

<b>Assurance Requirement</b>	<b>Monitoring Activity (WHAT)</b>	<b>Monitoring Responsibilities (WHO)</b>	<b>Data</b>	<b>Management Reports</b>	<b>Frequency</b>	<b>Plan (Timeline, milestones)</b>
Plans of Care address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means.	<i>Case Management Supervisors review monthly five percent sampling of plans of care document all participants' needs and goals were addressed, all issues are identified; and participants are afforded choices between/among waiver services and providers.</i>	Case Manager	Consumer and provider interviews; Case manager progress notes; Review of progress of current goals; Review of medical evaluations. Provider of service monthly progress reports. Prior Individual Habilitation Plans.	Individual Habilitation Plan	<i>By January 2009 DDD will develop quarterly reports that aggregate data from both tiers by region and identify issues for remediation. The status of the remediation will be tracked on a quarterly basis through reports generated by the electronic system</i>	IHP is modified as needed throughout the year as goals are met or as service providers change to adjust for changing consumer needs.
		Case Manager Supervisor				
		Waiver Auditor	Plan of Care/IHP document (confirmation of participation and of determination of service need)	CCW Consumer Review form, Part D, Section 4, numbers 5 and 6.	Monthly notification to Regional Administrator via email and/or IOC. Regional Administrator response to Waiver Auditor with corrective action noted. Response filed.	
Waiver Audit of Regional Office and field records			Assessment documents as appropriate (e.g. Adaptive Behavior Summary (ABS)	Licensure Inspection Report		Follow up by OOL requiring 30 day plan of correction for noted deficiencies.
		Special Response Unit	Assessment documents as appropriate (e.g. Adaptive Behavior Summary (ABS) IHP, medical records, monthly reports, critical incident log, UIR, staffing	Investigation Report (Unusual Incident Reporting Management System, Files) Formal SRU letter		
Licensing						

	Inspection where applicable		IHP and Unusual Incident Report, Medical Reports, Agency Logs	titled Summary of Findings re. completion of investigation to provider, agency and OOL, DDD Regional Administrator and guardian if applicable	Annual per agency/provider	Current 60 day investigative timeline. Where appropriate based on findings, OOL requires a plan of correction in 30 days DDD Office of Quality Management follows up with agency where appropriate regarding resolution of concerns.
	Special Response Investigation where applicable				Per investigation as appropriate	Monthly notification to Regional Administrator via email and/or IOC. Regional Administrator response to Waiver Auditor with corrective action noted. Response filed.
State monitors POC development in accordance with its policies and procedures and takes appropriate action when it identifies inadequacies in the development of POCs	Waiver Audit of Regional Office and field records	Waiver Auditor	IHP (confirmation of participation and of determination of service need) Assessment documents as appropriate (e.g. Adaptive Behavior Summary (ABS))	CCW Consumer Review form, Part D, Section 4, numbers 5 and 6.	Monthly sampling which continues on an ongoing basis	30 day plan of correction for noted deficiencies
	Licensing Inspection where applicable	Office of Licensing	IHP, medical records, monthly reports, critical incident log, UIR, staffing	Licensure Inspection Report  Investigation Report (Unusual Incident Reporting Management	Annual per agency/provider	

System, Files)

Service Plans are updated/revised when warranted by changes in the waiver participant's needs.

Waiver Audit of Regional Office and field records

Waiver Auditor

IHP (confirmation of participation and of determination of service need)

CCW Consumer Review form, Part D, Section 4, numbers 3a and 3b.

Monthly sampling which continues on an ongoing basis

Monthly notification to Regional Administrator via email and/or IOC. Regional Administrator response to Waiver Auditor with corrective action noted. Response filed.

Licensing Inspection as appropriate

DHS, Office of Licensing (OOL)

IHP, medical records, monthly reports, critical incident log, UIR, staffing

Licensure Inspection Report

Annual

Case Manager

Review of Provider Progress Notes, Interviews with consumers and provider staff

Provider Progress Notes, Interdisciplinary Team (IDT) meeting minutes

Modified IHP

As needed throughout the IHP year

Services are specified by type, amount, duration, scope, and frequency and are delivered in accordance with the POC.

Waiver Audit of Regional Office and field records

Waiver Auditor

IHP (confirmation of participation and of determination of service need).

CCW Consumer Review form, Part E Section 5, Individual Supports and Part F, Section 6, Habilitation.

Monthly sampling which continues on an ongoing basis

Monthly notification to Reg. Admin. via email and/or IOC. Reg. Admin response to Waiver Auditor with corrective action noted. Response filed.

Licensing

Office of

IHP, medical records,

	Inspection as appropriate	Licensing (OOL)	monthly reports, critical incident log, UIR, staffing	Licensure Inspection Report	Annual	
	Special Response Unit Investigation where appropriate	Special Response Unit (SRU)	IHP and Unusual Incident Report, Medical Reports, Agency Logs	Formal SRU letter titled Summary of Findings re. completion of investigation to provider, agency and OOL, DDD Regional Administrator and guardian if applicable	As required upon completion of investigation	Corrective action as necessary per OOL communication to provider/agency
	Review of proposed goals and objectives. IDT meeting to develop IHP	Case Manager	proposed goals and objectives, assessment tools as appropriate	IHP, Modified IHP	No less than annual	
	Review of provider monthly progress reports, case management visit to residential or day program site	Case Manager	Monthly provider progress reports, interviews with consumer and service providers	Case Management Progress note	Monthly or quarterly per residential type and individual situation	
Participants are afforded choice between waiver services and institutional care, and between/among waiver services and providers.	Development of IHP and signing of Freedom of Choice Form	Case Manager	Consumer interviews, monthly provider reports, on site visits	IHP Document, Progress Notes	Annually No less than quarterly	IHP is modified when services or service providers are changed at the request of the individual
	Waiver Audit of Regional Office	Waiver Auditor	IHP (confirmation of participation and of	CCW Consumer Review form: B	Monthly sampling	Monthly notification to

and field records		determination of service need)	Section 3, 1c Verification of Freedom of Choice; and D Section 4, 7a IHP case manager's progress notes. Freedom of Choice form. IHP/Plan of Care document.	which continues on an ongoing basis	Regional Administrator via email and/or IOC. Regional Administrator response to Waiver Auditor with corrective action noted. Response filed.
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<i>Day Program Quality Review</i>	DDD OFFICE OF Quality Management and Planning (OQM&P) Staff	<i>Day Program review results</i>	<i>Quarterly Review Report</i>	<i>Quarterly</i>	
			<i>Annual ATS Review Report.</i>	<i>Annual</i>	<i>20% of all agency sites reviewed annually starting in January 2008</i>
Licensing Inspection as appropriate	OOL	Your Rights as a Consumer of the Division of Developmental Disabilities (N.J.S.A.30:6D-1-12) Division #35 is used as a guiding source	Licensure Inspection Report		

**Qualified Providers approval)**

*Framework: Provider Capacity and Capabilities (Indicates process pending CMS Evidentiary*

**Assurance**

**Monitoring**

**Monitoring**

**Data**

**Management**

**Frequency**

**Plan**

<b>Requirement</b>	<b>Activity (WHAT)</b>	<b>Responsibilities (WHO)</b>	<b>Reports</b>	<b>(Timeline, milestones)</b>		
State verifies on a periodic basis, that providers meet required licensing and/or certification standards and adhere to other state standards.	Licensing Inspections as appropriate	OOL	Agency and provider records, physical layout of residential placements, staff interviews.	Licensure Inspection Report	Annually	Action taken may be full, provisional, suspended or termination of licensure. Plan of correction is required within 30 days of notification of concerns/deficiencies.
	Waiver Audit of Regional Office and field records	Waiver Auditor	Agency and Provider records	CCW Consumer Review form, Part E Section 5, Individual Supports.	Monthly sampling which continues on an ongoing basis	Monthly notification to Regional Administrator via email and/or IOC. Regional Administrator response to Waiver Auditor with corrective action noted. Response filed.
	Special Response Unit Investigations as appropriate	Special Response Unit	Unusual Incident Reports (UIR), Follow up Reports, Agency and Provider Records. Any additional records and interview sources.	Unusual Incident Follow up Reports Formal SRU letter titled Summary of Findings re. completion of investigation to provider, agency and OOL, DDD Regional Administrator and guardian if applicable	As needed per investigation.	Ongoing as a part of an investigation.
		OQM&P Staff review			Quarterly	

	Review of new Provider Applications	and score application, complete and score provider interview	Qualified Provider List (Family Support Website)	Qualified Provider Updates to Olmstead Project Director		DDD Office of Housing and Resource Development staff will assume responsibility upon implementation of single qualifying process
State monitors non-licensed/non-certified providers to assure adherence to waiver requirements	Waiver Audit of Regional Office and field records	Waiver Auditor	Agency and Provider records	CCW Consumer Review form, Part F Section 6, Habilitation.	Monthly sampling which continues on an ongoing basis	Monthly notification to Reg. Admin via email and/or IOC. Reg. Admin response to Waiver Auditor with corrective action noted. Response filed. Ongoing, currently investigation timeline is 60 days. Follow up with OOL and DDD as necessitated by findings.
	Special Response Unit Investigations where appropriate	Special Response Unit	Unusual Incident Reports, Follow up Reports, Agency and Provider Records. Any additional records and interview sources	Unusual Incident Follow up Reports Formal SRU letter titled Summary of Findings re. completion of investigation to provider, agency and OOL, DDD Regional Administrator and guardian if applicable	Investigations on a case by case basis per allegation	
	Day Program Reviews to assure compliance with DDD Standards	OQM&P Staff	Q-Shared Drive, Day Program Folder,	Agency Review Report (to Agency and	At time of Review	Implement revised Day Program Review process is proposed and will be

	for Adult Day Programs		“Reviews Data Set” Excel	Regional ATS Coordinator)		implemented contingent upon provider input. This new Implemented Review/Report process should be implemented by January 2, 2008
				Annual ATS Review Report	Annual	Plan of Correction must be submitted within 60 days of receipt of LIR & letter of notification
State identifies and rectifies situations where providers do not meet requirements.	Licensing Inspections as appropriate	DHS, Office Of Licensing (OOL)	Agency and provider records, physical layout of residential placements, staff interviews.	Licensure Inspection Report , and accompanying cover letter with potential Provisional Licensure, Suspension of License, Termination of Licensure, Plan of Correction notification	Annually	
		Waiver Auditor				
	Waiver Audit of Regional Office and field records		Agency and Provider records	CCW Consumer Review form, Part E Section 5, Individual Supports.	Monthly sampling which continues on an ongoing basis	Monthly notification to Regional Administrator via email and/or IOC. Regional Administrator response to Waiver Auditor with corrective action noted. Response filed.
	Special Response Unit Investigations as appropriate	DHS, Special Response Unit (SRU)	Unusual Incident Reports, Follow up Reports, Agency and	Unusual Incident Follow up Reports	As needed per investigation.	Currently Investigations are

<p>Response to SRU summary letter of findings where required.</p>	<p>DHS, OOL</p>	<p>Provider Records. Any additional records and interview sources.</p>	<p>Formal SRU letter titled Summary of Findings re. completion of investigation to provider, agency and OOL, DDD Regional Administrator and guardian if applicable</p>	<p>As needed per findings</p>	<p>completed within 60 days. The function of investigating unusual incidents is ongoing.</p>
		<p>Formal SRU letter titled Summary of Findings re. completion of investigation to provider, agency and OOL, DDD Regional Administrator and guardian if applicable</p>	<p>Provisional Licensure, Suspension of License, Termination of Licensure, Plan of Correction notification</p>		<p>Ongoing. If issues are identified in findings appropriate action is taken. Generally a response remediating the concern or a plan of correction is the initial step in follow up.</p>
<p>Review New Provider Applications</p>	<p>DDD Office of Management and Planning (OQP&amp;P) Staff review and score application, complete and score provider interview</p>	<p>Qualified Provider List (Family Support Website)</p>	<p>Qualified Provider Updates to Olmstead Project Director</p>	<p>Quarterly</p>	<p><i>Quarterly Report from</i></p>
<p><i>The Office of</i></p>	<p><i>OPIA</i></p>				

*Program Integrity and Accountability (OPIA) has developed a risk management system that will aggregate, analyze and provide summaries of problem remediation to ensure the health and safety of waiver participants*

*Referrals, UIRs, UIR follow-up reports, case management notes, OOL reports*

*Process pending approval by CMS Evidentiary review. OPIA Quality Indicators Report*

*OPIA- (CIMU) that provides trending information through the aggregation of incidents by region, type, investigative assignment and findings.*

*By October 2008, CIMU will generate quarterly reports to DDD, OOL and SRU that provides trending information through the aggregation of incidents.*

*By July 2009, DHS will create a data field in the UIRMS system that allows for the entry and querying of final actions taken.*

*By October 2009, CIMU will add to the quarterly reports described above the information regarding actions taken in response to findings.*

State implements its policies and procedures for verifying that training is provided in accordance with state requirements and the approved waiver.

Training of Pre-Service modules.

DDD Regional Training Coordinators. Regional and Statewide Training Advisory Committees.

Lead training agencies on a monthly basis submit documents re: registration, attendance,

CCW Consumer Review form: Part E Section 5, Individual Supports; and Part F , Section 6, Habilitation.

Monthly Reports and meeting minutes

Training required within 120 days of employment. Corrective action as recommended by DDD Regional Training Coordinator

			cancellations, failures and “no-shows”.	Meeting minutes from the Advisory Committee’s review of training data.	Annual	and/or Advisory Committee.
Annual Inspection as appropriate	DHS Office Of Licensing inspectors	Staff Training Records			Annual	Plan of Correction due within 30 days
Special Response Investigation as appropriate	DHS, Special Response Unit	Unusual Incident Reports, Follow up Reports, Agency and Provider Records. Any additional records and interview		Licensure Inspection Report	As needed per investigation.	Corrective action required where appropriate per follow up from OOL.
				Unusual Incident Follow up Reports Formal SRU letter titled Summary of Findings re. completion of investigation to provider, agency and OOL, DDD Regional Administrator and guardian if applicable	Ongoing. Agencies submit verification of training annually	Follow up communications to provider/agency to assist in complying with regulation.
Danielle’s Law Training Certification	DDD Office of Quality Management and Planning	Agency Policy procedure re. Danielle’s Law trng. Agency Letter verifying training completed.		Database		

**Health and Welfare**

*Framework: Participant Safeguard*

*Participant Outcomes and Satisfaction*

*(Indicates process pending CMS Evidentiary approval)*

**Assurance Requirement**

**Monitoring Activity (WHAT)**

**Monitoring Responsibilities**

**Data**

**Management Reports**

**Frequency**

**Plan (Timeline,**

		<b>(WHO)</b>				<b>milestones)</b>
State, on an on-going basis, identifies and addresses and seeks to prevent instances of abuse, neglect and exploitation.	Case Management Onsite Visits	Case Manager	Interview with consumer, Skill Development Home Program Monthly Report, Provider Agency Program Monthly Report	Progress Notes Unusual Incident Report (UIR)	Monthly or quarterly per residential type and individual situation	UIR generated as necessary
	Annual Inspection, Unannounced Visits, Inspection on a more frequent basis Participation in Early Alert program as appropriate	DHS, Office Of Licensing	Unusual Incidents, Incident Follow up Reports, Agency Files and records, complaints that don't arise to UIR level, Interviews, SRU Investigation Report	Licensure Inspection Report, Letters of Action announcing sanctions, Unusual Incident Report, Incident Follow up Report.	Annual and per incident/report	Plan of Correction (e.g. additional training, retraining of staff, physical corrections to residence, increased supervision/staffing) to suspension, revocation of licensure,
	Special Response Investigations where necessary	DHS, Special Response Unit	Unusual Incident Reports, Follow up Reports, Agency and Provider Records. Any additional records and interview	Unusual Incident Follow up Reports Formal SRU letter titled Summary of Findings re. completion of investigation to provider, agency and OOL, DDD Regional Administrator	As needed per investigation.	OOL requested corrective action plan from agency if necessary within 30 days.  30 day follow up reports until the case is closed.
	Review of Administrative Investigations of	DHS, Critical Incident Management Unit			Weekly	

Unusual Incidents by Provider Agencies where necessary			and guardian if applicable	
Routine review, routing and assignment of investigations to SRU, CIMU, OOL, DDD and tracking thereof.	DHS, Critical Incident Management Unit	Provider Agency Investigative Reports	Addendum caselist (includes updated status report)	Daily Daily Daily (Monthly Summary)
		Unusual Incidents and Follow up Reports	Bureau of Guardianship UIR alert	Weekly
			SRU potential case list	Weekly
			Correction Report insuring data integrity	
Review of potential Danielle's Law violations	DHS, Danielle's Law Review Panel		Grid Query (i.e. SRU potential case list, CIMU potential case list, OOL potential case list, and the DDD potential case list)	Monthly
		UIR and Follow up Reports, Interviews and Investigations	Summary of Reviews	

**Administrative Authority**

*Framework: System Performance*

*(Indicates process pending CMS Evidentiary approval)*

<b>Assurance Requirement</b>	<b>Monitoring Activity (WHAT)</b>	<b>Monitoring Responsibilities (WHO)</b>	<b>Data</b>	<b>Management Reports</b>	<b>Frequency</b>	<b>Plan (Timeline, milestones)</b>
Medicaid Agency or operating agency conducts routine, on-going oversight of the waiver program.	Expenditure Oversight	DHS, Division of Medical Assistance and Health Services, Research Unit	DDD CMS claims reports	Management and Administrative Reporting System (MARS) Reports	Monthly	Annual MARS expenditure report (Initial and lag) to be utilized in the HCFA-372 annual initial and lag reports
	Licensing Inspections as required	DHS, Office of Licensing	Provider records, reports, consumer plans of care, medical records, etc.	Licensure Inspection Report	Annually	Licensure, provisional licensure (appropriate plan of correction to return to full licensure to be submitted within 30 days of notification) or licensure revocation.
	Review of Unusual Incident, Abuse, Neglect and Exploitation as reported	DHS, Critical Incident Management Unit (CIMU)	Provider Agency Investigative Reports Unusual Incident Reports and Follow up Reports	Correction Report insuring data integrity Grid Query (i.e. SRU potential case list, CIMU potential case list, OOL potential case list, and the	As Necessary	Requested corrective action plan from agency if necessary within 30 days.
					As Necessary	

Rate Setting for waiver services	DHS, Bureau of Rate Setting	Service contracts, expenditure reports, attendance records	DDD potential case list)	Bureau of Rate Setting Amended Cost Report Rate Calculation	Weekly
Review of Waiver eligibility	DHS, DMAHS, Institutional Service Section	Consumer Disability Reports/Documents	correspondence to DMAHS and approvals. Final Rate Report/	Schedules, Rate Recommendation	
			Individual letter of certification.		

**Financial Accountability**  
*approval)*

*(Indicates process pending CMS Evidentiary*

<b>Assurance Requirement</b>	<b>Monitoring Activity (WHAT)</b>	<b>Monitoring Responsibilities (WHO)</b>	<b>Data</b>	<b>Management Reports</b>	<b>Frequency</b>	<b>Plan (Timeline, milestones)</b>
State financial oversight exists to assure that claims are coded and paid in accordance with the reimbursement methodology specified in the approved waiver.	Monitor the accuracy of attendance records and expenditure reports.	Provider management staff attest, through online certification or signature	Online attendance records and expenditure reports.	Expenditure reports.	Monthly	
	Review of provider and DDD case file records to insure that	DDD waiver monitor.	Provider and consumer records and	Individual Habilitation Plan, CCW Consumer	Monthly sampling which continues on an ongoing basis	Monthly notification to Reg. Admin via email and/or IOC. Reg.

individuals receiving waiver services are in need of the services, maintain eligibility, and receive the services as documented in their individual service plans.		files	Review sheet		Admin response to Waiver Auditor with corrective action noted. Response filed.
Review to ensure that federal claim rates have been appropriately calculated.	DDD Fiscal office	Cost report rates.	An analysis of exceptionally high and low individual provider rates by Fiscal Year.	When setting rates Monthly.	
Identify individuals who are deceased, insuring that claims cease as of the date of death.	DDD Fiscal office	Unusual Incident Reports (UIR)		Annual	
Contract audits for select agencies.	Department of Human Services Office of Audit (OOA)	Provider fiscal records	Contract audits	Annual or as necessary	
Calculate final Community Care Waiver (CCW) rates.	DDD	Include OOA contract audit findings.	Cost Rate Reports for review by DHS Bureau of Rate Setting	Annual	
Single audit (section P7.06 of the Contract Policy Manual) performed in accordance with federal	Provider agency/licensed accounting firm	DDDs/DHS final reports of expenditure (ROE). Single audit by a licensed	DDD/DHS final ROE.  Audit by a licensed accounting firm.		If audit shows a necessary disallowance the agency must met with DDD Fiscal Office Representative and

<p>OMB circular A-133 and Department policy by a licensed accounting firm to ascertain that the financial statements fairly represent the financial position of the organization including a review of the DDD/DHS final Report of Expenditures (ROE) as mandated by section P2.01 of the Contract Policy Manual.</p>	<p>DDD Fiscal office</p>	<p>accounting firm.</p> <p>Provider attendance and ROE.</p>	<p>Fiscal office creates reports that identify patterns and variances in reported attendance data to detect errors and omissions.</p>	<p>Ad Hoc (based on unusual rates (more than twice or less than half of rate).</p> <p>Intermittent</p>	<p>contract is adjusted accordingly.</p>
<p>Review posted provider attendance and reports of expenditure (ROE) data in the DDD systems to correct potential errors and omissions.</p>	<p>DDD Fiscal and IT</p>	<p>Match DDD eligibility files (one component of the claim file) to DMAHS eligibility files.</p>	<p>Ad Hoc queries</p>	<p>Currently a minimum of monthly</p>	<p>Reconciliation of discrepancies.</p>
<p>Reconciliation of apparent discrepancies.</p>	<p>DDD Fiscal and IT Unit</p>	<p>Consumer Information System; Waiver Eligibility File; Consumer Service Recording.</p>	<p>Missing Attendance Report</p>	<p>Weekly</p>	
<p>Review of billing to ensure eligibility resulting in the Generation of a pre-</p>			<p>Pre-Claim Reports to remove</p>		

claim report to finalize billing.

Unisys, Fiscal Agent for the Medicaid system

HIPPA 837-P DDD claim report

duplicative or contradictory billing which results in a finalized HIPPA 837-P DDD claim report. Note: only the HIPPA 837-P report is saved. CCW Claim Summary Report

Weekly

Weekly

On line to DDD for review and response.

DDD IT Unit

Screening of billing report through exception edits that remove contradictory or unauthorized claims

HIPPA 837-P,, Program records, DDD and DMAHS consumer eligibility records

HIPPA 835-P UNISYS remittance file identifying the disposition of each claim

Corrected Claim Report submitted if there are corrections

Review and investigate denied claims and resubmit with corrections.



### ***Quality Management Strategy Initiatives***

In addition to the new 1915c waiver application Appendix H requirements, the following is also part of the New Jersey MFP Quality Management Strategy:

- Risk assessment and mitigation process for MFP participants (1915 c waiver assurance # iv. Health and Welfare);
- An emergency back-up system; and
- Incident report management system which includes discovery, remediation, and improvement procedures

***Self Directed Services*** DDD will develop a process by June 2009 to assure the ongoing quality and improvement of supports and services to individual who self-direct their services. The current Self-Directed Services record makes information accessible electronically to a Fiscal Intermediary and to a contracted Support Coordination entity. Staff in the Regional Offices and the Office of Quality Improvement can also access the record. This application allows the individual/ family to create a service plan online for their Individual Budget allocation. The electronic record stores data on plan content, review and approval. Additionally it permits for the documentation of other required data to be tracked and aggregated.

***Case Management and Regional Operations Redesign*** DDD has begun the Redesign of their Regional System, as a component of building and strengthening community infrastructure which includes case management services. Redesign seeks to improve the quality and the responsiveness of services through restructuring caseloads, implementing IT improvements developments. Case management role will change from that of caretaker to that of support and assurances, identifying systemic issues and focusing on the needs of the individual.

A significant effort within Redesign is the development of four Regional Quality Improvement Units. These Units are proposed to sustain the delivery of quality service and supports through the provision of technical assistance and training to service providers (which include the community care providers). Additionally it is planned these units will review and monitor day activities and programming in the community, develop/review continuous quality improvement systems, and implement all aspects of quality improvement services and supports.

***Assurances*** The Division is currently working to put in place policies and procedures to ensure that New Jersey's 1915(c) HCBS Waiver meets CMS required assurances. The Division is improving its processes of discovery, remediation and improvement to assure the health and welfare of participants by monitoring: a) level of care determinations; b) individual plans and services delivery; c) provider qualifications; d) participant health and welfare; e) financial oversight and; f) administrative oversight of the waiver. All problems identified through these discovery processes will be addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. The State's single state Medicaid Agency, Department of Human Services, will conduct reviews of waiver operations, in accordance with interagency agreements.

**24-Hour Back Up System** The Division has an existing emergency back up system /after hour on-call system. On-call is a system of responding to emergency issues that begin after the office is closed. Issues that begin while the office is open are not considered issues for on-call. On-call will transition any unresolved issues to the appropriate worker once the office re-opens. The on-call answering service is in operation from 5pm to 9am during the workweek and 24 hours a day on weekends, holidays and for those periods when offices are closed due to inclement weather or other events. The main number in each regional office is the emergency number. The answering service monitors all incoming call to the main office after hours. Should a caller identify an emergency situation, the service is to contact the on-call worker immediately. Each DDD region assigns staff to be “On-Call” to cover the non business hours and accept all service recipients’ emergency calls.” The On-Call employee must have at least one year case management experience. If the matter cannot be resolved, or if the situation merits supervisory or administrative attention, the On-Call employee must contact supervisory/administrative personnel. The on-call worker is then responsible to respond to the situation taking any actions advised by supervisory/administrative personnel. The DDD on-call worker is then responsible to write a report regarding the matter and actions taken in response. Division contracted provider agencies also have their own 24 hour on-call procedures.

The Division will develop a process to track the number and type of participant requests for emergency assistance, timeliness of responses to consumer calls, the number of transitioned individuals who re-enter institutions or nursing homes, and the reasons for returning to the institution by January 2009. The aggregated information will aid policy decisions, resource allocation and quality improvement activities.

**Incident Management** Current initiatives within the ORM are:

- Develop a system to aggregate data, analyze, and provide summaries of problem remediation by December 2008,
- Identify trends and/ or areas of improvement,
- Produce reports and recommendations for the reduction and/or mitigation of risk, moving towards  
a more proactive system approach, specific focus on the development of processes related to individual risk.
- Collaborate with the Department of Human Services through regular meetings with the offices responsible for monitoring, investigating, and resolving allegations of abuse, neglect, or exploitation. Respectively: the Office of Critical Incident Management Unit (CIMU), the Special Response Unit (SRU) and the Office of Licensing (OOL).

**Risk Assessment** The risk assessment will identify the participant’s individual health care needs and all supports needed in order for them to safely transition to and remain in the community. Risk assessments will be completed for 100% of MFP Participants. Risk factors will be documented in the assessment (currently the ABS, and risk assessment worksheet in development and will be completed by December 2008). The process will be as follows:

1. The IDT will discuss the risk and the supports needed to mitigate the risk.
2. Potential risks, the supports needed to mitigate them, who will provide the supports and services, and how, will be clearly documented in the Risk Assessment Worksheet.

3. Information from the Risk assessment Worksheet will be included in the Service Plan.
4. The Service Plan will be monitored for the effectiveness of the services provided in mitigating risk and for any changes that may potentially place the individual at greater risk.
5. When changes occur, the cycle will begin again

**Satisfaction Surveys** Individuals participating in *the MFP Demonstration* may have the added benefit of an enhanced monitoring during their transition period. As part of NJ's Olmstead Quality Process during the first 12 months following an individual's transition to the community, regional and developmental center staffs visit the individual at 30, 60, 90, and 180 days intervals. Participant-specific information is gathered to guide decisions about needed modifications to plans of care, to mitigate/ameliorate issues, inform infrastructure decisions. In addition, MFP individuals will participate in the Quality Of Life Surveys.

## **Attachment # 2 to Appendix H**

### ***Roles and Responsibilities***

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#### **DDD Central Office Responsibilities:**

- *Ensure individuals access to services*
- *Monitor health and safety*
- *System oversight*
- *Financial auditing*
- *Quality improvement initiatives*
- *Incident report trend analysis*
- *Mortality review*
- *Data management*
- *Rules and regulation implementation*
- *Constituent input*
- *Waiver and Medicaid compliance*
- *Training standards*
- *Correcting oversight*
- *Collaborations with other system partners (OOL,SRU,CIMU, Auditing)*

#### **Regional Responsibilities:**

- *Health and Safety monitoring*
- *Reviews regional performance outcomes and trends*
- *Review data to determine waiver assurances*
- *Monitor progress on remediation plans*
- *Contracted provider management*
- *Incident report collection and review*
- *Corrective action monitoring*
- *Approves remediation plans*
- *Incident management and reviews*
- *Mortality reviews*

- *Case management*
- *Fiscal management*
- *Collaboration with central office*

### **DDD Quality Management Steering Committee**

- *Study and analyze DDD data and information to recommend improvement to DDD Leadership*
- *Establish performance indicators that need to be assessed in the system*
- *Review and approves the OQM&P Annual Plan and Report*
- *Review statewide performance outcomes, trends and patterns.*
- *Recommend quality improvement actions based on the review of information*
- *Evaluate the effectiveness DDD quality improvement activities*

### **Olmstead Implementation and Advisory Council**

- *Review reports on benchmarks*
- *Make recommendations for improvements based on data*
- *Conduct consumer focus groups*
- *Conduct public meetings*
- *Recommend policy actions*
- *Monthly/quarterly meetings to review the implementation plan.*
- *Ongoing work groups to based on the response*

**The Quality Management Strategy for the waiver is:**

**LOC - QUALITY FRAMEWORK:**

*The State demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with care provided in a hospital, NJ, or ICF/MR.*

*Assurance - 1: An evaluation for level of care is provided to all applicants for whom there is reasonable indication that services may be needed in the future.*

<b>Monitoring</b>	<b>Who</b>	<b>DATA</b>	<b>Frequency</b>	<b>Plan</b>
<p>DDS receives and processes the referrals for CRPD and TBI Waiver and utilizes an Oracle database tracking system to capture waiver enrollment trends and compliance with timeframes.</p> <p>Data analysis is presented and discussed at the Total Quality Management Team (TQMT) Meetings. TQMT is comprised of representation from the Dept. of Health and Senior Services (DHSS) – Office of Community Choice Options (OCCO), DDS, and DMAHS.</p> <p>DHSS/OCCO conducts the initial LOC assessments for 100% of the applicants for whom there is reasonable indication that services may be needed in the future.</p> <p>DHSS/OCCO reviews a random sample of initial LOC approvals for quality control on a monthly basis. The data is compiled, analyzed, and reviewed for trends. As deficiencies and area for improvement are identified, training focusing on deficient areas will be arranged for DHSS staff. Results of the review are reported quarterly to DDS during the TQMT meeting.</p>	<p>DDS</p> <p>DDS and TQMT members</p> <p>DHSS - OCCO</p> <p>DHSS - OCCO</p>	<p>Data is entered into the Oracle database. Waiver specific reports are generated capturing the number of waiver referrals, enrollments, denials, terminations, and length of time for financial and initial LOC eligibility determination. Data is presented at the quarterly Total Quality Management Team (TQMT Meetings).</p> <p>DHSS/OCCO – Statewide Quarterly Audit Report for each of the HCBS Waivers.</p>	<p>At a minimum, on a quarterly basis, reports are produced from the Oracle Database. Data obtained from the Oracle database is aggregated, presented and discussed at TQMT quarterly meetings.</p> <p>Report is generated quarterly and incorporated into the TQMT Meeting minutes.</p> <p>Quarterly – TQMT Meetings</p>	<p>Oracle Database: Ongoing activity</p> <p>TQMT Meetings: Quarterly;</p> <p>In 2006, OCCO initiated quarterly reports to analyze the LOC Audit outcomes; however the data was aggregated across all waiver programs. OCCO is revising their report format and sampling size to capture waiver specific data using a statistically valid sample size. Anticipated completion is 6/30/08.</p>



**The Quality Management Strategy for the waiver is:**

<b>LEVEL OF CARE (LOC) – Quality Framework</b>				
<i>Assurance - 3: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.</i>				
<b>Monitoring</b>	<b>Who</b>	<b>DATA</b>	<b>Frequency</b>	<b>Plan</b>
DHSS supervisory staff reviews the initial LOC documents to ensure that the process and instruments described in the approved waiver are applied in determining LOC. The tool used for the initial LOC (Pre-Admission Screening), is the Minimum Data Set-Home Care (MDS-HC).	DHSS	LOC Audit Outcomes – Quarterly Reports; generated by DHSS-OCCO.	Quarterly	OCCO is revising their report format and sampling size to capture waiver specific data using a statistically valid sample size. Anticipated completion is 6/30/08.
DDS Support staff reviews initial LOC determination packet from DHSS to ensure all required documents are provided to Case Management Site.		DHSS/OCCO – MDS-HC form included in the Initial LOC determination paperwork submitted to DDS.	Ongoing – each Initial LOC determination.	
LOC reevaluations are performed by the CMs using the CP-CM-1 form and are required to review and sign the form. DDS/RR must review LOC re-evaluations within 20-working days of receiving them for approval. Areas of deficiency are reported on the CMDR. Data analysis is presented and discussed at the Total Quality Management Team (TQMT) Meetings.	CM DDS/RR			
Case Management Trainings are conducted at least annually and technical assistance is provided as needed throughout the year. Trainings include information that review the what information constitutes a complete and timely reevaluation	DDS – supervisory staff	CMDR Report Forms	Quarterly	See Assurance 1 for remediation plan for the CMDR.
	DDS/RR DDS staff	Sign in sheets and agenda	At least annually.	10/1/08 DDS will revise the CM Manual to include an instruction guide for the LOC reevaluation process and documentation requirements.

The Quality Management Strategy for the waiver is:

**Plan of Care (POC) - QUALITY FRAMEWORK:**

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

*Assurance – 1 and 2: Service plans address all participants’ assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means. AND The state monitors service plan development in accordance with its policies and procedures.*

Monitoring	Who	DATA	Frequency	Plan
<p>CM prepares an initial POC based on the original assessment completed by DHSS/OCCO, which has components to evaluate the health and safety risk factors of the participant. The CM also completes an individual evaluation during the initial home visit with waiver participant factoring in areas such as participant and caregiver preferences and goals; physician recommendations; consultation with any formal supporters; and the participant’s medical and social needs.</p> <p>CM Supervisor reviews and signs POC after CM completion to assure participant involvement with POC development, appropriate services and health and safety risk factors are addressed. DDS/RR will not approve/sign-off on POC with CM supervisor signature.</p>	<p>CM CM - Supervisor</p>	<p>Care Plans (CP-11 form)</p>	<p>On-going (every 6-months for participants receiving PDN services and annually for non-PDN participants).</p>	<p>11-19-07 the CMDR analysis was revised to capture data by waiver program rather than the former method of aggregating the ACCAP, TBI, and CRPD waivers. The new format of reporting the data was presented at the 3/5/08 TQMT Quarterly Meeting.</p> <p>The CMDR is under revision to support the data collection to establish trends on the timeliness and compliance with established reassessment policies and procedures. Anticipated completion is 4/30/08.</p> <p>By 7/1/08, DDS will develop a systemic report to inform DDS/RR of the analysis completed on the CMDR by individual CM sites and serve as a mechanism for tracking CM site deficiencies.</p> <p>By 8/1/08, DDS will complete and implement a database to identify specific quality improvement areas from the information obtained on the CMDR and initiate CM trainings accordingly.</p> <p>By 10/1/08, DDS will revise the CM Manual to include an instruction guide for the completion of the LOC reevaluation and POC forms (CP-CM-1 and CP-11).</p>





**The Quality Management Strategy for the waiver is:**

<b>PLANOF CARE (POC) – Quality Framework</b>				
<i>Assurance – 5: Participants are afforded choice between waiver services and institutional care; and between/among waivers services and providers</i>				
<b>Monitoring</b>	<b>Who</b>	<b>DATA</b>	<b>Frequency</b>	<b>Plan</b>
Institutional vs. community based services option is fully explained by the DDS/RR during initial waiver screening visit and again by the DHSS/OCCO representative during the initial LOC evaluation. The DDS coordinator reviews the waiver packet and documents receipt of the Choice of Care Form (CP-6) into Oracle database. A participant’s file is not forwarded to CM agency until all documents are received. The amount of time between referral to DHSS/OCCO and receipt of documents is analyzed and reported on the TQMT quarterly report.	DDS/RR DHSS – OCCO DDS coordinator TQMT	Oracle database Initial LOC determination packet Choice of Care Form (CP-6)	ongoing	Waiver referral packets are not forwarded to CM agency for implementation of waiver services until receipt of CP-6.
Waiver participant’s signature on the POC confirms his/her desire to remain on the waiver and continuing receiving community services. POC and monthly monitoring notes should confirm that the CM discussed with the participant the care options available to them.	DDS/RR CM CM - Supervisor	POC re-assessments TQMT – CMDR data form CM monitoring notes	Annually TQMT data is reviewed quarterly	CMDR forms are being revised to better capture this information. See previous remediation for timeline of revisions.
DDS/RR reviews the POC to verify/confirm that a waiver participant was afforded choice between/among waiver services and providers. There is an area on the POC for the participant to document his/her agreement/disagreement with POC; participation in the development and selections of service providers.	DDS/RR CM- Supervisors TQMT	POC CM Monitoring Notes TQMT – CMDR data form	Annually (PDN cases 6-months)	Upon request CM are provided with a list of approved Medicaid providers. Paid claims may be reviewed to confirm provider selection. Trends will be documented in the CMDR database (upon completion) and documented in the TQMT quarterly report.

**The Quality Management Strategy for the waiver is:**

**Qualified Providers - QUALITY FRAMEWORK:**

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

*Assurance – 1: 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.*

<b>Monitoring</b>	<b>Who</b>	<b>DATA</b>	<b>Frequency</b>	<b>Plan</b>
<p>Unisys has a provider unit that reviews new and revised provider applications to verify that licensure and certification have been met prior to granting approval for Medicaid provider status. In 2006, DMAHS and Unisys completed a re-enrollment process of all qualified traditional providers. Providers of home health services must also complete a “Statement of Intent” form confirming they’ve contacted DDS and have an understanding of services available under the waivers.</p>	<p>Unisys Provider Enrollment Unit</p> <p>DMAHS Provider Enrollment Unit</p> <p>DDS Admin. staff</p>	<p>Written confirmation received from Unisys that provider was assigned a provider number</p>	<p>On-going</p>	<p>By 7/1/08, DDS will confirm the licensure and certification of CM providing services to waiver participants.</p>
<p>DDD – Office of Licensing inspects and licenses Community Residential Service Providers that provide residential services for the TBI waiver participants. Copies of the licensure inspection visit are provided to DDS, Licensing monitors those agencies that are required to submit corrective action plans for deficiencies noted during inspection.</p>	<p>DDD Licensing Unit</p> <p>DDS</p>	<p>Licensing reports</p>	<p>Annually or as needed</p>	
<p>DDS has a MOU with 4 Accreditation Agencies to audit and accredit Home Care providers such as PCA, adult companion, respite providers, and PDN agencies. DDS conducts follow-up with any provider found to have deficiencies and notifies DMAHS accordingly.</p>	<p>JCAHO CHAP CHAC NHAC</p>	<p>Accrediting agencies’ annual reports.</p>	<p>Annually or as corrective action plans are received</p>	<p>A tracking database is use to assure that all accreditation reports are received. Any reports of suspected fraud are forward to DMAHS’ Bureau of Program Integrity for investigation.</p>

**The Quality Management Strategy for the waiver is:**

**Qualified Providers - QUALITY FRAMEWORK:**

*Assurance – 2: The State monitors non-licensed/non-certified providers to assure adherence to waiver requirements.*

<b>Monitoring</b>	<b>Who</b>	<b>DATA</b>	<b>Frequency</b>	<b>Plan</b>
Providers of environmental/vehicular modifications and personal emergency response system (PERS) are non-traditional providers and are reimbursed by DDS' fiscal intermediary, Community Access unlimited (CAU). These providers are monitored by case managers as per established DDS written protocols. Licensed contractor must be used for environmental modifications and participant must obtain appropriate permits for the work. Once work is completed an authorization for payment is completed for the fiscal intermediary.	DDS CAU	Database of non-traditional providers; CM service request documentation – environmental medications must be provided by licensed contractor	As needed	By 7/1/08, DDS will develop a current listing and obtain signed agreements of approved providers of PERS services.

**Qualified Providers - QUALITY FRAMEWORK:**

*Assurance – 3: The State implements it policies and procedures for verifying that training is provided in accordance with State requirements and the approved waiver.*

<b>Monitoring</b>	<b>Who</b>	<b>DATA</b>	<b>Frequency</b>	<b>Plan</b>
DDS has a CM Operational Manual that is used to train staff at new CM agencies, new CMs and to be used as a daily reference of their responsibilities to the participant and DDS. DDS provides trainings for CM agencies and other provider agencies on waiver requirements and services.	DDS CM	Sign-in sheets Agendas Tracking database (to be developed)	On-going	Maintain a file of sign-in sheets and agendas of all provider trainings and track in database.  Continue to review technical assistance training and Accrediting Reports to determine trends, statewide or geographically and make recommendations to staff for follow-up.
DDS will continue to provider CM trainings as quality improvement areas are identified from the TQMT	DDS	Tracking database to be developed	Quarterly	By 7/1/08, DDS will develop a systemic report to inform DDS Representatives of the analysis completed on the CMDR by individual case management sites. By 8/1/08 complete database to identify quality improvement areas for trainings.

The Quality Management Strategy for the waiver is:

**Health and Welfare - QUALITY FRAMEWORK:**

*The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation.*

*Assurance – 1: The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation.*

Monitoring	Who	DATA	Frequency	Plan
<p><b>On an annual basis, participants are provided with information as to whom they can report allegations of abuse, neglect, or exploitation and a document is signed confirming receipt of information. CM continually monitors the participant’s health and welfare with monthly contacts and takes prompt remediation actions when needed. CM document incidents of alleged abuse, neglect or exploitation and are required to report the alleged incident to DDS within 72 hours. DDS/RR review reports and is responsible for ensuring that appropriate intervention is initiated and incident is resolved. All reports/and follow-up is documented into a database. Semi-annually, the TQMT reviews all complaint reports to ensure that incidents were thoroughly investigated and that all necessary recommendations were implemented.</b></p>	<p>CM CM – supervisors DDS/RR DDS Admin.</p>	<p>Critical Incident Report Tracking database and semi-annual reports. TQMT Minutes</p>	<p>Ongoing reporting and review.  Semi-annually</p>	<p>Critical Incident Reports and Investigation/Resolution Monitoring Records are compiled in electronic file. An electronic data base is now used to track reports, ensure timely follow-up, and detect trends that will assist in the monitoring of the H/W of participants.</p> <p>By 5/1/08, DDS will initiate discussion with Adult Protective Services (APS) about the H/W assurance for waiver participants and inquire as to the potential information APS is permitted to share with DDS.</p> <p>By 5/1/08, DDS will initiate discussion Division of Youth and Family Services about the health and welfare assurance for waiver participants and begin developing a formalized process between the two Divisions.</p>
<p><b>Allegations of abuse, neglect, exploitation in a DDD-licensed TBI-community residential setting are reported to DDD for investigation and resolution. DDD tracks and monitors these incidents. DDS is</b></p>	<p>CRS DDD- Unusual Incident Report Mgmt. System</p>	<p>DDD – UIRMS Reports Tracking database and semi-annual reports. TQMT Minutes</p>	<p>Monthly On-going Monthly</p>	<p>By 7/1/08, DDS will obtain access and training on the UIRMS so that information can be obtained and tracked by DDS of the status and resolution of incidents reported to DDD.</p>

**The Quality Management Strategy for the waiver is:**

<p>provided with a copy of the initial report. DDS tracks these incidents and include in the report presented to TQMT semi-annually.</p>	<p>DDS/RR DDS – Admin.</p>			
<p align="center"><b><u>Administrative Authority - QUALITY FRAMEWORK:</u></b> <i>The State demonstrates that it retains ultimate administrative authority over the waiver program and that its administration of the waiver program is consistent with the approved waiver application.</i></p>				
<p><i>Assurance – 1: 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 contracted entities.</i></p>				
Monitoring	Who	DATA	Frequency	Plan
<p>At the TQMT meeting, reports re: DHSS LOC review, CM LOC reevaluation, CM POC reassessments, Abuse/Neglect/Exploitation and Incident Reports, Fair Hearing Requests, and Accreditation Reports are reviewed and any recommendations are implemented and reported on at the next TQMT meeting. DHSS/OCCO and DMAHS – Quality Management Unit (DMAHS/QMU) responsible for the oversight of waiver are represented on the TQMT.</p> <p>DMAHS/QMU is developing an Oversight and Monitoring Work Plan and working with DDS to formalize the oversight process.</p>	<p>DDS-Admin staff</p> <p>DHSS-OCCO</p> <p>DMAHS - QMU</p>	<p>DHSS Quarterly LOC Audits</p> <p>CMDR reports</p> <p>Abuse/Neglect/Exploitation Reports</p> <p>Accreditation Reports</p> <p>Fair Hearing Reports</p> <p>To be determined</p>	<p>At a minimum, quarterly basis to the TQMT</p> <p>To be determined</p>	<p>4/8/08 DDS met with DMAHS/QMU to review the Oversight and Monitoring Work Plan. Monthly meetings will be held to discuss waiver specific information and implementation of any QMU requested remediation.</p>

**The Quality Management Strategy for the waiver is:**

**Financial Accountability - QUALITY FRAMEWORK:**

*The State demonstrates that it has designed and implemented an adequate system for assuring financial accountability of the waiver program.*

*Assurance – 1: State financial oversight exists to assure that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver.*

<b>Monitoring</b>	<b>Who</b>	<b>DATA</b>	<b>Frequency</b>	<b>Plan</b>
Review of HCFA-372 report to identify any trends or service utilization issues, as well as cost-neutrality of the waiver	DMAHS DDS	HCFA-372 Reports	Annually	Annual review by DDS and DMAHS of waiver cost neutrality is an on-going basis.
Maintaining a DDS staff liaison with DMAHS fiscal agent, Unisys.	DDS Data Coord. Unisys	Special reports, claims payment resolution, mass adjustments, off system payments, claims payment edit enhancements	On-going	Continue staff assignment as Unisys liaison.
Comparison of POC and paid claims	DDS	MARS Reports	On-going	DDS/RR use the MARS reports during frequent POC reviews at the CM sites and will provide copies to CM upon request.
Use of the Decision Support System (DDS) to create unique ad-hoc reports within parameters set by the DDS staff requesting the report.	DMAHS DDS Unisys	Ad-Hoc Reports	On-going	A database is maintained that captures the report requester, type of report (provider, participant, or financial), and the outcome of the report.
Post-payment surveillance utilization review (SURS) of paid waiver claims.	DDS DMAHS	Paid claims analysis by DMAHS/SURS Unit SURS Reports for DDS	On-going	March 2008, DDS initiated meeting with DMAHS/SURS Unit to re-establish the claims analysis for waiver clients. Discussion was held on the waiver programs and service requirements/limitations. Monthly meetings will be held to review SURS reports and take necessary action.

# TRANSITION PLAN

Consumer Name: \_\_\_\_\_ Date of NF Admission \_\_\_\_\_

Dates of Previous NF admissions & discharges: \_\_\_\_\_

## Consumer's Goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## Cultural Concepts/Personal preferences to be considered:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## Desired Outcomes – Maintenance, Independence, Rehabilitation, Prevention or Other

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## Consumer strengths/desires/responsibilities to achieve goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## Consumer's support system to achieve goals:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Consumer Name:** \_\_\_\_\_

**Services and Supports needed for transition:**

Service Needed	Frequency	Number of Units	Cost per Unit	Total Cost

**Justification for waiver service costs that exceed \$2,841 a month:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Consumer Risk Factors:** Factors that, if not addressed, might pose a high threat to an individual's health and welfare. These include: (a) health risk (medical conditions that require continuing care and treatment); (b) behavioral risk (behaviors or conditions that might cause harm to the person or others); and, (c) personal safety risk (e.g., safe evacuation).

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Backup Plan(s) to address Risk Factors:** Provision for alternative arrangements for the delivery of services that are critical to participant well being in the event that the provider responsible for furnishing the services fails to or is unable to deliver them.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Transition Team Members, Phone number and responsibilities:**

Name	Phone number	Responsibilities

**Consumer Name:** \_\_\_\_\_

<b>Consumer Choices</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>
1. I have been advised and understand that I may choose to remain in the nursing facility or move to a community setting to receive home and community-based services.			
2. I voluntarily choose to return to the community to receive home and community-based services.			
3. I have been advised about the Global Options (GO) Program and services..			
4. I voluntarily agree to participate in the GO Program.			
5. I have been advised of the potential risk factors identified in this transition Plan if I leave the nursing facility to return to a community setting with services through the GO Program.			
6. I understand and accept the potential risk factors if I leave the nursing facility to return to a community setting.			
7. I was a member of the Transition Team that planned my discharge from the Nursing facility to the community.			
8. I helped develop this Transition Plan and the Plan of Care.			
9. I had the freedom to choose my services under the GO Program.			
10. I had the freedom to choose the providers of my services based on available providers. I am aware that I may not receive the providers I have chosen.			
11. I agree with this Transition Plan and the Plan of Care.			
12. I was advised that the amount, frequency, and continuation of services depend upon the availability of state and federal funds.			
13. I am aware that I may have a cost share for Assisted Living/Adult Family Care.			

**Anticipated Date of discharge:** \_\_\_\_\_

Consumer: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Actual Date of Discharge & Destination:** \_\_\_\_\_