"People helping people help themselves"

Michael R. Pence, Governor
State of Indiana

Division of Disability and Rehabilitative Services
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To: Division of Disability and Rehabilitative Services Waiver Providers
From: Shelly Thomas, Assistant Director, Bureau of Quality Improvement Services
Re: Reviews conducted by BQIS
Date: October 31, 2013

The Bureau of Quality Improvement Services (BQIS) has refocused our approach in conducting compliance reviews and complaint investigations. The primary focus of these activities is to assess consumer outcomes and safety as well as compliance with 460 IAC Article 6. All requirements outlined in 460 IAC Article 6, the DDRS' Waiver Manual, DDRS' approved Home and Community Based Services (HCBS) Waiver applications, as well as all state and federal regulations are still important and required. Below are detailed descriptions of the approach BQIS will utilize.

Revised Version of Compliance Evaluation Review Tool (CERT)
On November 1, 2013, BQIS will implement a revised version of the Compliance Evaluation and Review Tool (CERT) for provider compliance reviews. Independent of accreditation status, all new providers will be reviewed with this tool within 12 months of their initial approval as a Home and Community Based Services (HCBS) Waiver Provider. All existing providers approved to deliver services under the FSW and/or CIHW receive provider compliance reviews (with the CERT) that take into account their accreditation status and covered services. Providers with some accredited services, but not all, will have the non-accredited services reviewed using this tool. Providers that are fully accredited are exempt from a CERT review.

In addition to the streamlined tool, BQIS is amending its approach in conducting these reviews:

- Providers will continue to be held accountable to 460 IAC Article 6 requirements as well as requirements outlined in the approved CMS Waiver Applications and corrective action plans (CAPs) will be required for standards not met.
- If the provider's policies do not align with DDRS policies, then the item will be cited in the review; however, a formal CAP will not be required.
- CAPs are only required when 460 IAC Article 6 standards are not met.
- Providers will be given two validation attempts instead of one.
- The risk area in the Provider Re-Approval Profile will be based on CAPs required instead of the number of citations.

The updated version of the CERT is available on the BQIS webpage (http://www.in.gov/fssa/ddrs/2635.htm).

Complaint Citations

Complaints will have three categories of citations:

1. Substantiated, CAP Required (these would be cases that require formal corrective action through the complaint investigation process).
2. Substantiated, CAP NOT Required (these would be cases that may not be directly tied to consumer outcomes, e.g., documentation, etc., or cases where the provider implements corrective action during the information gathering stage of the review).
3. Unsubstantiated (allegation not supported).

BQIS is amending its approach in conducting these investigations:

- Citations will be based on 460 IAC Article 6, Indiana Code, requirements outlined in the approved CMS Waiver Applications, DDRS Waiver Manual, DDRS Provider Agreement and/or Federal Regulations and supported with any applicable DDRS policy.
- Identifying a lack of files or documents in the home, may or may not be captured as a negative finding:
    1. If the documents pertain to program implementation (e.g., risk plans, behavior plans, tracking sheets for ISP goals and objectives, or behavioral documentation), AND are required to be in the home, and are not, then we would cite as a finding. We would still request that the provider place these documents in the home ASAP.
        - If the provider can produce this information from the office within 24 hours, then no CAP is required.
        - If the provider cannot produce this information, then a CAP is required.
    2. If the documents do not pertain to program implementation, even if required to be in the home, (e.g., monitoring in the home, policies, training, etc.) AND are not in the home, we will request the documents from the office.
        - If the provider can produce this information from the office, then it will not be cited and a CAP will not be required.
        - If the provider cannot produce this information within 24 hours, then it will be cited but a CAP will not be required.
- If a provider has repeated minor issues where a CAP was not required, BQIS will elevate the specific issue and require a formal CAP.
- If an issue is corrected during an investigation, it will be cited, but would not require a CAP since the issue had been corrected.
- If not directly related to program implementation or consumer health and welfare, additional findings will not be cited (e.g., documentation issues such as title of the trainer, etc.).
- Discontinue citing providers for not following their own internal policies but communicate the discrepancy to the provider.
- To encourage collaboration, surveyors will communicate with the provider throughout the CAP process. This may include having conversations about the best approach to address the situation and providing recommendations when requested.
- The risk area in the Provider Re-Approval Profile will be based on CAPs required instead of the number of issues substantiated.

In addition to a refocused approach to conducting these activities, BQIS has also developed an appeal process for citations and CAP denials. Surveyors will collaborate with Providers through the review process but a Provider may also seek a formal decision from BQIS by utilizing the appeal process outlined below.

BQIS REVIEW APPEAL PROCESS

Appeal of Citations

- Appeals must be submitted in writing to the BQIS Director within 7 business days of the date the Findings Report was issued.
- The appeal must include:
    1. Basis for the citation appeal; and
    2. Supporting documentation or evidence
- Supporting documentation must be submitted with the appeal request or the appeal will not be considered.
- BQIS will issue appeal decisions to the provider within 10 business days of receipt.
- If the appeal is disallowed, the provider must submit a Corrective Action Plan (CAP) for the appealed citation within 5 business days from BQIS notification of such.
- If the appeal is allowed, the citation will be removed and a revised report issued along with the appeal decision.

Appeal of Corrective Action Plan (CAP) Denials

- Appeals must be submitted in writing to the BQIS Director within 7 business days of the date the CAP Denial was issued.
- The appeal must include:
    1. Basis for the CAP Denial appeal; and
    2. Supporting documentation or evidence
- Supporting documentation must be submitted with the appeal request or the appeal will not be considered.
- BQIS will issue appeal decisions to the provider within 10 business days of receipt.
- If the appeal is disallowed, the provider must re-submit a CAP for the appealed CAP within 5 business days from BQIS notification of such.
- If the appeal is allowed, the CAP will be accepted and a revised report issued along with the appeal decision.