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## Financial Services Monitoring

### Financial Quality Assurance Unit Monitoring QA Process Review

* A statistically valid sample is pulled for each regional area based on the combined number of completed financial applications and reviews that were processed for each region in an annual time period.
* The 12-month QA Monitoring Schedule is available on the QA intranet site. If dates or number of reviews change from original release at the beginning of the monitoring year, which is distributed in a MB, the updated information can be found on the [QA intranet site](http://adsaweb.dshs.wa.gov/hcs/QA/);
* An Entrance Conference letter is sent at the start of an areas’ QA Process Review period.
* Monitoring occurs at headquarters.
* An Exit Conference is conducted via MS TEAMS at the completion of the review.
* The region has 30 calendar days to make required corrections.
* ALTSA QA staff conducts a 30-day review to document remediation.
* Issues identified in the 30-day QA Review as not fully remediated must be corrected within 30 calendar days for the 60-day QA Review.
* ALTSA QA staff conduct a 60-day review and document remediation.
* ALTSA QA staff complete the Regional Final Report which is a summary of all QA Unit findings for that Region.
* Questions below the expected proficiency level will need to be addressed in the area’s Proficiency Improvement Plan (PIP).
* QA Unit Manager completes the statewide Final Report which is a summary of all QA Unit findings for the annual review for all Regions.

### Sampling

* A statistically valid sample will be used for each region.
* The number of QA reviews being completed will be based on the combined number of applications and reviews that were processed for each Region per year.

##### Sampling example:

* 292 applications + 1,427 reviews in Month Y for Region X = 1,719
* 1,719 applications/reviews x 12 months = 20,628
* Statistically valid sample for Region X = 378

This sampling process would be repeated for each region.

### Monitoring Schedule

A QA monitoring schedule will be distributed by MB prior to the annual monitoring cycle. The schedule will include the following activities:

Each Region’s QA Process Review cycle and timelines (initial, 30-day and 60-day Reviews)

Entrance and Exit Conference dates

Final Report due dates

### Entrance Conferences

The Entrance Conference email is sent prior to monitoring each regional area and provides information about:

1. The monitoring processes
   1. Expectations
   2. Philosophy
   3. Changes to the QA process review, tool or questions from the previous year
2. Monitoring
   1. Schedule
   2. QA questions
3. Regional Reports
4. Exit Conference
5. 30-day Response QA questions
6. Remediation
7. Non-Concur Request Process
8. Proficiency Improvement Plan (PIP)

### Exit Conferences for each Region

1. Exit Conferences are optional. The QA lead will ask the Regional Administrator if they wish to have a QA Exit Conference at the time the office is notified of their upcoming initial review. If a QA Exit Conference is requested, the conference will be conducted through MS Teams by the QA Lead and the QA Unit Manager with the following staff who may be attending via MS Teams or phone:
   1. HQ staff, including the Chief of Field Operations, Chief of LTC Financial Eligibility & Policy, and
   2. Regional Management and line staff at the discretion of the management team.
2. The QA Unit presents the following in power point format:
   1. The Proficiency Improvement Plan (PIP) activities from the previous year for the area being reviewed and for the current year for HQ.
   2. What QA reviewed.
   3. QA questions that met or exceeded proficiency.
   4. QA questions that did not meet expected proficiency.
   5. Why proficiency was not met.
   6. Remediation, Non-Concur Request, PIP process, and
   7. 30-day due dates.

### 30-Day and 60-Day Reviews

Full remediation is required on **all** QA findings at the individual level that do not meet 100% proficiency.

1. All QA findings that require remediation must be completed within 30 calendar days. Remediation documentation completed by the field is analyzed by the ALTSA QA staff at the 30-day review.
2. Any outstanding QA findings after the 30-day review are identified on the “Cases Requiring Action” report and those remediation are expected to be completed by the 60-day due date. ALTSA QA staff are available to the Region to offer assistance on any outstanding issues.
3. Remediation documentation completed by the field will be analyzed by the ALTSA QA staff at the 60-day review.
4. All QA findings that are still outstanding after the 60-day review will be reviewed with the Social & Health Program Manager (SHPM) or Regional Representative who will be expected to have the QA finding fully remediated. The SHPM or Regional Representative will need to inform the Financial QA Program Manager when the finding is fully remediated so that final analysis can be completed.
5. Remediation completed after the 60-day due date will be documented as to why the remediation was not made within the time frame allotted and how much time past the due date remediation occurred. Remediation time frames will be included in the Final Regional Report.
6. All issues that cannot be resolved will be forwarded to the Executive Management team for action.

## Non-Concur Request Committee

The intent of the Non-Concur Committee is to interpret policy, make decisions on non-concur requests, and make recommendations if policy is not clear.

* + - 1. The Non-Concur Committee consists of the following members:
         1. Chief of LTC Financial Eligibility & Policy.
         2. Financial QA Program Manager.
         3. Members of the LTC Financial Eligibility & Policy Unit; and
         4. The QA Regional contact representing the field
      2. Non-Concur Committee Process
         1. Prior to submitting a non-concur request the SHPM/field representative would need to determine if the finding in question has been previously heard by the Non-Concur Committee and thus a precedent-setting decision was made.
         2. For Non-Concur requests that may be taken to the Non-Concur Committee, the regional office documents the requested change in the Review Cycle Notes (RCN), using “QA Non-Concur” drop down. The ALTSA QA staff will review the requests.
         3. The ALTSA QA staff review the issue and make corrections if a process review error has been made. Consultation with the LTC Financial Eligibility & Policy Unit may occur if needed for clarification.
         4. The ALTSA QA staff review prior decisions by the Non-Concur Committee. If the issue is the same, the ALTSA QA staff will make the change based on the Non-Concur Committee’s prior decision. These issues are not forwarded to the committee.
         5. Issues not corrected by the ALTSA QA staff, or which have not had a previous decision are forwarded to the Non-Concur Committee and documented in the SharePoint database.
         6. The ALTSA QA staff sets up the non-Concur meetings with at least a one-week advanced notice of the meeting date according to the QA calendar. The meeting notice will include a write-up of the Non-Concur Request. The ALTSA QA staff invites the appropriate HQ staff to the meetings.
         7. The Non-Concur Committee:

Reviews the non-concur request documentation.

Hears the field QA contact’s analysis.

Hears the ALTSA QA staff’s analysis; and

Makes a final decision based on policy

* + - * 1. If a decision cannot be made within the Non-Concur Committee, the QA Unit Manager will have it addressed at the Executive Management level whose decision is final.
        2. If the Non-Concur Request is approved, the ALTSA QA staff will change the “no” to a “yes” or “N/A”. If the change is not approved, the field QA contact will ensure the corrections are made. The ALTSA QA staff documents the decision in the RCN.
        3. The QA Unit Manager documents the decision in the SharePoint database.
        4. If changes to policy are recommended, the Chief of LTC Financial Eligibility & Policy will identify who will be responsible for follow-up and response to, or completion of, the recommended policy change.
        5. At the end of the review cycle, the QA Unit Manager, and the Chief of LTC Financial Eligibility & Policy review the Non-Concur Requests for possible impact on the next review cycle.

## Final Local Report Summary and Cover Letter

1. After the 60-day review, the ALTSA QA staff prepares the “Final Report Summary” which includes:
   1. Attachments of the local reports, and
   2. The Proficiency Improvement Plan template
2. The Financial Policy unit Office Chief reviews the PIP and upon approving the PIP forwards the PIP to the Deputy Director of Field Operation for signature.
3. The Final Report is due to the Regional Administrators within 30 calendar days after completion of the 60-day review.

## 

## Proficiency Improvement Plan (PIP) for Financial Services Monitoring

A PIP outlines a plan for addressing items that do not meet proficiency. The proficiency threshold will be specified in the QA Exit Conference. Both HCS HQ and the Regions are responsible for developing and implementing a PIP.

1. Regional action is required for PIP development (based on initial findings). A Regional PIP is not required for the current QA Unit review cycle:
   1. When proficiency is reached on all QA questions.
   2. When HCS HQ is conducting the PIP on a QA question that does not meet statewide proficiency.
2. Regions will use the PIP template provided for all questions below the expected proficiency level.
3. HQ will identify items that need to be addressed at a statewide level and develop a HQ PIP if necessary. Information about the HQ PIP status will be maintained on the QA intranet site.
4. Regions are required to address all other items that did not meet proficiency except those items being addressed in the HQ PIP. Items being addressed by HCS HQ may also be addressed on a local PIP if the Region wants to focus on improving local proficiency. The Region will support and reinforce strategies to increase proficiency and supervisors will continue to work with individual staff to increase proficiency in identified areas.
5. QA Unit Manager, ALTSA QA staff, and other HQ staff are available to assist in development and revision of the PIP.
6. The PIP is due to the ALTSA QA staff within 30 calendar days from the date the Final Report summary was emailed. ALTSA QA staff tracks the time frame, follows up and offer assistance, if not received on time.
7. HQ Review and Approval
   1. When the PIP is received, the ALTSA QA staff, QA Unit Manager and HCS Chief of Financial Eligibility & Policy jointly review the plan. The field representative is contacted by email if there are recommended changes. If changes are needed, the revised document is reviewed and approved.
8. Reporting Progress
   1. Regions
      1. Progress reporting is unique to each item within the PIP and unique to each Region.
      2. The Region completes the “Progress Reporting Section” and sends it to the Financial QA Program Manager, when due, with a copy to the QA Unit Manager. If the progress report is not received on time, the ALTSA QA staff will follow-up with the field and notify Executive Management if necessary.
   2. HQ
      1. Upon review of the progress report the ALTSA QA staff or other management staff may share other ideas or strategies for quality improvement.
      2. The QA Unit Manager reports the HQ PIP status on an “as needed” basis and at least quarterly to Executive Management at a regularly scheduled Office Chief meeting.

## Public Benefit Specialist Supervisor Monitoring

The Financial QA process reviews completed by Supervisors in the Regional HCS offices are very important because they ensure that we are following Financial Eligibility Requirements and that quality work is being completed by field staff. Public Benefit Specialist Supervisor QA process reviews help identify training, staff performance and policy issues. Financial QA process reviews completed by Supervisors are mandated to be completed in the QA Monitor Tool only.

Public Benefit Specialist Supervisors have the following quality assurance and improvement responsibilities:

1. Monitoring Results – Supervisors will use the “Reviewed Cases with Questions Requiring Action” report to ensure that corrections identified by the QA Unit have been completed.
2. Supervisor QA Monitoring – Supervisors must inform their staff of the QA monitoring process and expectations. Supervisors monitor that their staff are:
   1. Correctly determining benefits that are issued.
   2. Processing all case actions in a timely manner.
   3. Following department policies and procedures.
   4. Required verifications are received and/or documented.
3. Supervisory Monitoring of New and Experienced staff:
   1. New Public Benefit Specialists (PBS) staff and experienced PBS new to long-term care (LTC) eligibility:
      1. After an initial mentoring period when the PBS is assisted with case actions as they occur, 25%-100% of all case actions will be reviewed based on their learning level until the new worker demonstrates the ability to accurately determine financial eligibility.
   2. Experienced staff (processed Applications and/or Reviews):
      1. Experienced staff is defined as staff that are authorized to process applications and/or eligibility reviews issuing a Medicaid benefit.
      2. Three (3) full case reviews per worker(s) per year when the worker(s) have completed at least 3 full case actions in a calendar year.
      3. Use of the QA Monitor tool is required, and QA process reviews completed in the QA Monitor Tool will count toward the annual Supervisory reviews of three per year, per worker.

## Authority for Policies and Procedures

[Section 1915 (k) of the Social Security Act #17](http://www.ssa.gov/OP_Home/ssact/title19/1915.htm): Authorizes the Community First Choice (CFC) State Plan Amendment and requires that the State of Washington have a formal system in place for monitoring the quality standards outlined in the SPA and that all problems identified by monitoring are addressed.

[Section 1915 (c) of the Social Security Act #17](http://www.ssa.gov/OP_Home/ssact/title19/1915.htm): Authorizes the COPES Waiver and requires that the State of Washington have a formal system in place for monitoring the quality standards outlined in the waiver and that all problems identified by monitoring are addressed.

[RCW 74.39A.050](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.39A.050): Requires DSHS to implement a LTC care QI system that focuses on consumer satisfaction and positive outcomes for consumers. This statute outlines 15 QA principles consistent with federal laws and regulation.

[RCW 74.39A.090](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.39A.090): Requires DSHS to monitor the degree and quality of case management services provided to elderly and disabled clients by AAA.

[RCW 74.39A.095](http://apps.leg.wa.gov/RCW/default.aspx?cite=74.39A.095): Specifies the minimum elements that must be included in AAA oversight of care being provided to clients.

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**PROFICIENCY IMPROVEMENT PLAN**

**DATE:**

|  |  |  |
| --- | --- | --- |
| **PIP Development Coordinator** | **Phone & Email** | **PSA/Region/RCS Program** |
|  |  |  |
| **QA SME/Representative** | **Phone & Email** | **Date PIP Due to HQ Approver** |
|  |  |  |
| **HQ Approver Printed Name** | **HQ Approver’s Signature** | **HQ Approver Signature Date** |
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| --- | --- | --- | --- |
| **PIP Results Tracking** | | | |
| QA Question(s)/# | Target Completion Date | Results Review Date | Next Steps or Completion Date |
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| **P**  **L**  **A**  **N** | **QA Question (s)/ #** | **No Response(s)** | **Root Cause Analysis** | | | **Proficiency Expected** | **Proficiency Achieved** |
|  |  |  | | |  |  |
| **D**  **O** | **Intervention/Counter measure** | | | | **Who Acts** | **Target Completion Date** | |
|  | | | |  |  | |
| **C**  **H**  **E**  **C**  **K** | **Proposed Success Measure** | | **Who Acts** | **Review Date** | **Results of Success Measure** | | |
|  | |  |  |  | | |
| **A**  **C**  **T** | **Next Steps/Changes to be made** | | **Who Acts** | | **Describe Next Steps** | | |
| *Check the box below that best describes the status of this plan.*  *A.*  Proficiency not met, need to reanalyze/change process  B.  Proficiency not met, continue intervention in place  C.  Proficiency not met, need to try a different intervention strategy  D.  Proficiency met or exceeded, no further revisions required | |  | |  | | |