



# HCBS Quality 201

## *Quality in the HCBS Waiver – Health and Welfare*



Division of Long Term Services and Supports  
Disabled and Elderly Health Programs Group  
Center for Medicaid and CHIP Services  
August 2017

# Training Objectives

- This training is part one of a two-part presentation.
  - HCBS Quality 101: Quality in the 1915(c) Home and Community-Based Services (HCBS) Waiver
    - Provide an overview of Federal requirements related to Quality Improvement Programs (QIPs) in 1915(c) waiver applications.
    - Discuss overall findings noted by CMS after analyzing multiple performance measures submitted in the 1915(c) waiver applications.
  - HCBS Quality 201: Quality in the HCBS Waiver – Health and Welfare
    - Discuss recommendations from OIG’s 2016 Health and Welfare audits.
    - Discuss Health and Welfare related findings from CMS site visits.
    - Provide CMS’ recommended performance measures for the Health and Welfare Quality Improvement System (QIS) sub-assurances to improve the existing QIS.

# Overview

- **OIG will discuss:**
  - Current efforts and existing audit results regarding states' adherence to health and welfare requirements in the Northeast corridor.
  - Recommendations regarding their findings from their existing audit results.
- **CMS will discuss:**
  - Additional areas of concern regarding health and welfare assurances in multiple states.
  - Recommendations regarding their findings.
- **The following items will be highlighted from appendix G from an analysis of the performance measures specific to appendix G, QIS health and welfare**
  - Commonly submitted performance measures and corresponding key findings.
  - Recommended performance measures and considerations.



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*HHS OIG Findings*



# CMS Site Visit Findings

- In calendar year 2016 CMS conducted 3 site visits based in part or in whole on concerns regarding Health and Welfare.
- In the same calendar year CMS followed up with another state on abuse/neglect/exploitation issues that were covered in a major news market.
- A common theme emerging from these instances is states not following their 1915(c) waiver requirements.

# CMS Site Visit Findings

- CMS findings generally indicated that the state had set up the right Quality Improvement System (QIS) in the approved waiver but that the state had difficulty adhering to the assurances as specified in the QIS in the waiver.
- In two of the cases in particular, the tracking and trending of Unusual Incidents were not present for the incidents that were of concern.
- In one of the cases, media coverage of critical incidents revealed statistics that were inconsistent with the SMA's 372 reports and Evidentiary Report.
- In at least two of the states the ability to staff at appropriate levels was identified as an issue.

# CMS Site Visit Findings & Recommendations

- The state should review the requirements set in the state's QIS in the approved waiver:
  - Annually when the 372 is prepared; and,
  - At the end of 3 years in the waiver cycle when the Evidentiary Report is prepared.
- States should look closely at incident reports and findings when a single provider renders both residential and day services.
- If QIS staff are housed in the same facility as a provider, the state should set measurements to ensure the QIS staff remain independent.

# CMS Site Visit Findings & Recommendations

- Determine the burden of proof standard the state will use in determining the substantiation of an allegation.
- There are generally 3 burden of proof standards.
  - Preponderance of evidence – the probability that the incident occurred as a result of the alleged/suspected abuse/neglect and/or exploitation is more than 50%
  - Clear and convincing – the probability that the incident occurred as a result of the alleged/suspected abuse, neglect and/or exploitation is greater than 85%. This measure is often used in Civil Court.
  - Beyond a reasonable doubt - the probability that the incident occurred as a result of the alleged/suspected abuse, neglect and/or exploitation is greater than 99%. This measure is used in criminal prosecutions.

# CMS Site Visit Findings & Recommendations

- Where the SMA is not the operating agency, look closely at the QIS activities of both the SMA and the operating agency and ensure that the findings for each entity are reconciled and any inconsistencies identified are addressed.
- Ensure coordination between the state's licensing/credentialing entity, investigative entity and QIS entity.
- If there are allegations of abuse, neglect or exploitation and staff are reporting that they are having difficulty getting medical treatment/examination for the individual, require the provider to ensure an examination/treatment is rendered.

# CMS Site Visit Findings & Recommendations

- Where the agency staff is signing off on Unusual Incident findings internal to the agency make all attempts to ensure the independent investigative entity sees and makes record of the injury.
- Where the state is serving a unique cohort of individuals in a waiver, ensure that they are identified and that tracking and trending is done specific to this group and compared to the general trends identified for individuals served in the waiver.
- Ensure that as the state writes corrective action, the actions are sequenced in a manner that build on the previous action.
- Ensure that the state has outcome measures that assess whether the proposed action has ameliorated the targeted concern.



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**QIS G Health and Welfare:  
Performance Measure Findings and  
Recommendations**



# QIS G Health and Welfare: *Overview*

## Overview

- QIS G measures how the Medicaid Agency ensures participant health and welfare.
- This QIS is a special focus for CMS. Refer to CMS DLTSS presentation during 2016 NASUAD HCBS Conference, titled “[1915c Waiver Quality Requirements: Health and Welfare](#)”

# QIS G Health and Welfare: *Findings of Performance Measure Analysis*

- Measures report whether:
  - Critical incidents are identified and reported
  - In some cases, whether individual remediation has taken place.
- Measures currently do not identify:
  - Whether any trending analysis is taking place in the state.
  - Whether follow-up actions are taken on a systemic basis to prevent future incidents, such as proper reporting and investigation, as well as educating individuals and families.
  - Whether the states make referrals to Adult Protective Services (APS) or Child Protective Services (CPS).
- Although states must continue to remediate problem areas, CMS requires reporting on individual activities only in the instances of **substantiated abuse, neglect and/or exploitation**.

# QIS G Health and Welfare: *Commonly Used Performance Measures*

- Based on our review of applications, the following are the most commonly used performance measures by states:

## Health and Welfare Assurance:

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

## Subassurance (a)

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

Percent of substantiated critical incidents where appropriate follow-up (safety plans, corrective action plans, provider sanctions, etc.) was completed.

## Subassurance (b)

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

Percent of critical incidents reported within the required timeframe.

# QIS G Health and Welfare: *Commonly Used Performance Measures*

## Health and Welfare Assurance:

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

## Subassurance (c)

The state policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Percent of unauthorized incidents of restrictive interventions that were appropriately reported.

## Subassurance (d)

The state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

Percent of waiver individuals receiving age-appropriate preventive health care.

# QIS G Health and Welfare:

## *Recommended Performance Measures for Subassurance a*

### QIS G, subassurance a:

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

### Recommended List of Performance Measures

- **PM 1:** Percent of waiver individuals (or families / legal guardians) who *received information* on how to report abuse, neglect, exploitation and unexplained death.
- **PM 2:** Percent of abuse, neglect, exploitation and unexplained death incidents *reported* within the required timeframe.
- **PM 3:** Percent of abuse, neglect, exploitation and unexplained death incidents *reviewed/ investigated* within the required timeframe.
- **PM 4:** Percent of substantiated abuse, neglect, exploitation and unexplained death incidents where *required / recommended follow-up* (safety plans, corrective action plans, provider sanctions, etc.) was completed.
- **PM 5:** Percent of substantiated abuse, neglect, exploitation and unexplained death incidents that were *referred* to appropriate investigative entities (e.g., Law Enforcement, APS / CPS) for follow-up.

# QIS G Health and Welfare:

## *Recommended Performance Measures for Subassurance b*

### QIS G, subassurance b:

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

### Recommended List of Performance Measures

- **PM 1:** Percent of critical incidents where root cause was identified.
- **PM 2:** Percent of critical incident trends where systemic intervention was implemented.
- **PM 3:** Percent reduction in critical incidents with shared root causes / trends as a result of a systemic intervention.
  - Many states have methods in place for identifying the root causes of critical incidents. However, it is not always evident if states have adopted a process for trend analysis or systemic interventions.
  - Use of PMs 1-2 allows states to not only identify but also further update systems to prevent future incidents and demonstrate an appropriate trending of systemic interventions.

# QIS G Health and Welfare: *Recommended Performance Measures for Subassurance d*

## QIS G, subassurance c:

*The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.*

### **Recommended List of Performance Measures**

- **PM 1:** Percent of unapproved restrictive interventions with a prevention plan developed as a result of the incident.

*If the state allows restrictive interventions:*

- **PM 2:** Percent of restrictive interventions that followed state policies and procedures, as specified in the approved waiver.
- **PM 3:** Percent reduction of restrictive interventions.

# QIS G Health and Welfare: *Recommended Performance Measures for Subassurance c*

## QIS G, subassurance d:

*The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

### **Recommended List of Performance Measures**

- **PM 1:** Percent of waiver individuals receiving an annual physical by provider type.
- **PM 2:** Percent of waiver individuals receiving an annual dental check-up by provider type.
- Beyond annual physicals and dental check-ups, states may include additional performance measures that are specifically required for certain diagnoses or conditions highly prevalent in the waiver population (e.g. diabetes, convulsive disorders, HIV, etc.).

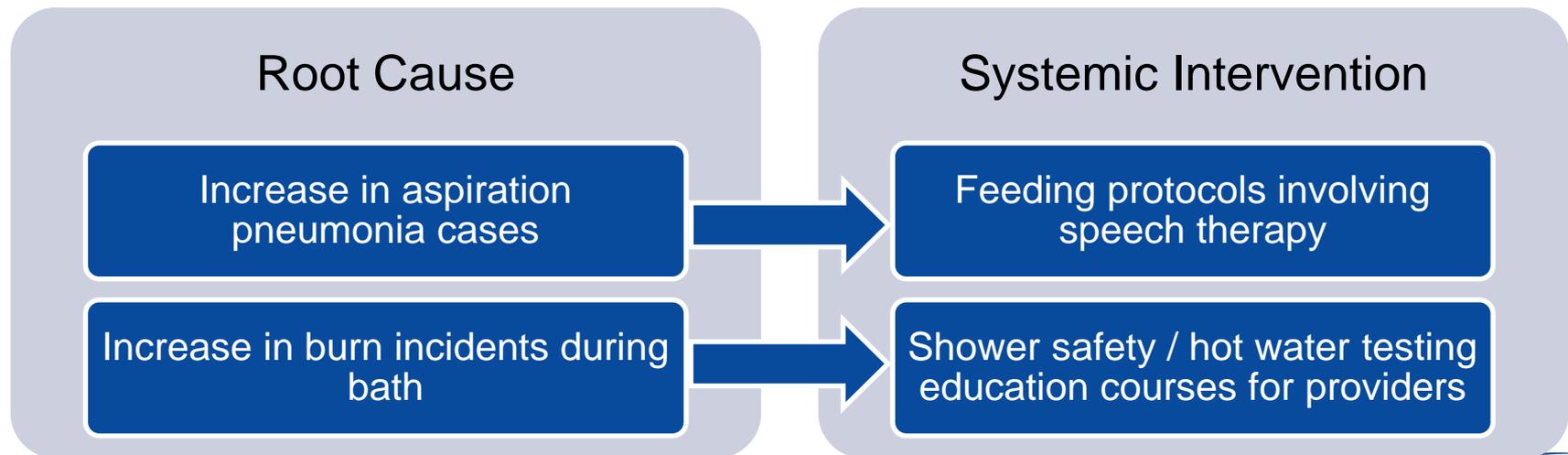
# QIS G Health and Welfare: *Recommended Performance Measures for Subassurance c*

## QIS G, subassurance d:

*The State establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.*

### **Recommended List of Performance Measures**

- States' performance measures in this subassurance could be specific, systemic recommendations for the performance measures based on root cause analysis results. For example:



# Key Takeaways From HCBS Quality 201

- OIG's recommendations can be cross-walked to the March 14, 2014 quality IB (Informational Bulletin) constructed by CMS, NAMD, NASDDD, NASUAD, and 11 representatives from 15 states.
- As states develop further QIS they can develop more outcome-based measures.
- It is important for states to conduct trend analysis on allegations and findings of abuse, neglect, exploitation and unexplained death.
- If the outcome-based PMs that show systemic interventions do not lend themselves to the 86% measurement, CMS will work with states to identify the measurement of success.

# Summary

- We reviewed the measures states use to report on 1915(c) Appendix G, QIS Health and Welfare and recommended a list of performance measures states can consider as alternatives.
- States are encouraged to think creatively about performance measures and desired outcomes.

# Additional Resources

- Refer to below website for other CMS HCBS related training topics.

<https://www.medicare.gov/medicaid/hcbs/training/index.html>

# Questions & Answers

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# For Further Information

**For questions contact:**

**[HCBS@cms.hhs.gov](mailto:HCBS@cms.hhs.gov)**



# US HHS/OIG Audits of State Compliance With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities





# OIG Mission Statement

The Office of Inspector General's (OIG) mission is to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.





# About The OIG

- OIG has a responsibility to independently report to both the Secretary of HHS and Congress on program and management problems and recommendations to correct them.
- OIG's work is carried out through a nationwide network of regional offices that perform audits, investigations, evaluations, and other mission-related functions.



# Independence





# Why We Did These Audits

## Congressional interest:

- Requested a review of deaths and cases of abuse of individuals with developmental disabilities residing in group homes.
- Prompted by series of articles published by the Hartford Courant and CNN regarding abuse and neglect of individuals residing in group homes.





# OIG Response

- Agreed to audits in CT, MA, and NY and issue reports to the respective States.
- Expanded work to include ME.
- Reviews focused on Medicaid beneficiaries.
  - Federal criteria
    - HCBS Waiver, Appendix G, Participant Safeguards
  - Data matching





# OIG Audit Objective

Determine if Medicaid State agencies complied with Federal waiver and State requirements on reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes from January 2012 through June 2014.





# Background

Several State departments involved with monitoring and reporting critical incidents:

- Medicaid State agency
- State service providing agency (DDS)
- State protective service agency (APS)
- Federally designate Protection and Advocacy agency (P&A)





# Background

- The Social Security Act section 1915 (c) authorized the Medicaid Home and Community-Based Services Comprehensive Supports (HCBS) waiver program.
- The HCBS waiver services are provided in order to avoid higher cost medical settings including hospitals, nursing facilities, and intermediate care facilities.
- The HCBS waiver, Appendix G, *Participant Safeguards* contains the safeguards the State agencies adopt concerning the reporting and monitoring of critical incidents involving developmentally disabled beneficiaries.





# Background

States frequently define critical incidents as including (but not limited to) incidents involving a severe injury that requires treatment in an emergency room or an inpatient admission.





# How We Conducted Audits in CT, MA, and ME

Reviewed emergency room claims and critical incident reports for treatment of group home residents who received at least 1 of 40 diagnosis codes indicative of potential abuse or neglect:

- 400 emergency room claims in CT
  - 800 emergency room claims in MA
  - 100 emergency room claims and 20,000 critical incident reports in ME
- ❖ Some ER visits had more than one Medicaid claim for reimbursement.





# Results of Audits in CT, MA, and ME

- The State agencies did not comply with Federal waiver and State requirements on reporting and monitoring critical incidents.
- State agencies did not ensure that:
  - All critical incidents were reported.
  - All critical incidents were reported correctly.
  - All reported critical incidents were recorded.
  - All critical incident data was analyzed to detect unreported incidents.





# Example of an Unreported Critical Incident

- A group home did not report a critical incident involving a resident who suffered from Down syndrome and dementia:
  - The resident wore a helmet for protection.
  - The resident required one-on-one supervision while walking.
  - The resident had an unwitnessed fall in the group home’s kitchen, which was followed by a period of unconsciousness.
  - The resident was evaluated for head trauma with a CAT scan by hospital emergency room staff.
- The group home should have reported the incident immediately because these injuries met the definitions of a “critical incident” and a “severe injury.”





# Causes

- The State agencies did not adequately safeguard Medicaid beneficiaries with developmental disabilities because the agencies lacked:
  - Training to correctly identify and report critical incidents.
  - Policies and procedures that established clear definitions and examples of potential abuse and neglect.
  - Access to Medicaid claims data.





# Recommendations

- We made several recommendations to the Medicaid State agencies including:
  - Develop and provide training for State and group home staff on how to identify and report critical incidents and reasonable suspicions of abuse and neglect.
  - Work with DDS to update their policies and procedures to clearly define and provide examples of potential abuse and neglect that must be reported.
  - Provide DDS with access to Medicaid claims data.





# Related Problem: Mandated Reporters

Hospital-based mandated reporters did not report all critical incidents to appropriate State officials:

- CT hospitals reported only 1 instance of potential abuse or neglect out of 300 emergency room visits reviewed.
- MA hospitals reported only 6 instances of potential abuse or neglect out of 600 emergency room visits reviewed.
- ME hospitals did not report any instances of potential abuse or neglect out of 100 emergency room visits reviewed.





# Mandated Reporters: Example

- A hospital did not report a critical incident involving a group home resident who suffered a lacerated scalp and fractured cervical spine:
  - Group home staff attributed the resident's injuries to falling down a flight of stairs.
  - The resident's medical history indicated that his clavicle appeared to have been fractured in a prior incident.
- State officials indicated they would have accepted a referral for this incident if one had been made.





# Results of Audit in NY

## *Review of Intermediate Care Facilities in New York With High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries (A-02-14-01011)*

- Issued in September 2015.
- Found the vast majority of ER visits they reviewed resulted from circumstances associated with the Medicaid beneficiaries' underlying medical conditions – not from neglect or abuse.
- Accordingly, the report contained no recommendations.





# Inter-Agency Work Group

- Created to address problems found during OIG audits.
- Provide multiple perspectives and depth of expertise across knowledge areas.
- Members include representatives from:
  - US HHS/OIG
  - US HHS/OCR
  - US HHS/ACL
  - US DOJ/CRT





# Inter-Agency Work Group

Developing a set of model practices that provide States with a roadmap for how to implement better health and safety practices many of which are already required in the Act 1915(c) Medicaid HCBS Waiver, Appendix G.





# Model Practices: A Roadmap for States

Model practices contain four primary elements:

- Incident Management and Investigation Program
- Quality Assurance Program
- Mortality Review Program
- Incident Management Audit Program





# Model Practices: A Roadmap for States

## Key Goals of the Model Standards:

- Identify specific and systemic issues.
- Investigate specific and systemic issues when appropriate.
- Remedy specific incidents and systemic issues.
- Ensure transparency to all stakeholders.
- Meaningful oversight at State and Federal level.





# Inter-Agency Work Group

## Coordination and Outreach

- Coordination with CMS:
  - Provided CMS with draft of model practices for discussion.
- Outreach to national organizations:
  - National Association of States United for Aging and Disabilities
  - National Association of State Directors of Developmental Disabilities Services
  - National Association of State Mental Health Program Directors





# Questions?

# Questions?

