



1915c Waiver Quality Requirements: Health and Welfare

*Division of Long-Term Services & Supports
Disabled and Elderly Health Programs Group, CMS
and the Administration on Community Living*

History

- 1915(c) of the Social Security Act enacted through OBRA 1981
 - Required six assurances of applicant states
 - State Medicaid Agency retains administrative authority
 - Determination that participants meet institutional levels of care
 - Person centered service plans are reviewed at least annually
 - Providers are qualified
 - Health and welfare of beneficiaries is protected, and
 - Financial integrity of payments is assured

History, continued

- In 2003, GAO issued a report that was critical of CMS oversight of waivers
 - In response, CMS convened State Associations to develop recommendations for ongoing monitoring
 - The assurances were used as the statutory basis to require performance measure collection and reporting by states to demonstrate waiver compliance
 - Major iterations of the waiver template were distributed in 2005, 2009 and 2014 to incorporate these requirements

2009 Version

- The waiver template disseminated in 2009 added the required sub assurances for each of the six statutory assurances
 - States were required to track and report on at least one performance measure for each sub-assurance

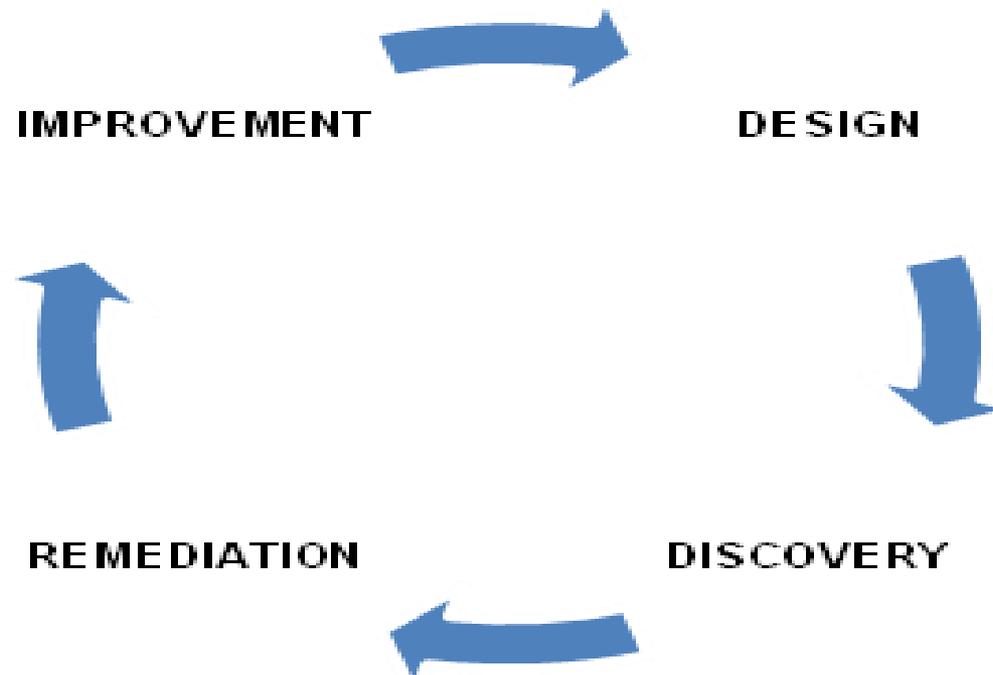
2014 Version

- Quality Workgroup formed in Autumn 2011
- Representatives:
 - CMS Central & Regional Offices
 - State Associations (NAMMD, NASUAD, NASDDDS)
 - 11 States, representing
 - Medicaid Agencies, ID/DD & Aged/Disabled Operating Agencies
 - National Quality Enterprise (logistics & consulting to CMS)

Quality Workgroup, con't

- Met 18 times
 - Between October 2011 and March 2013
- Additional smaller workgroup meetings between full workgroup meetings
- Workgroup recommended changes in sub-assurances and threshold of compliance
- Internal CMS review process remained intact

No Change in CQI Life Cycle Expectations



Evidence Collection & Analysis Requirements

- No change
- Collect and analyze “Discovery” data as specified in the approved waiver
 - Frequency of data collection & analysis can vary by Performance Measure (PM)

Evidence Collection, Analysis & Reporting Requirements

- Submit Evidence Report to CMS
 - Evidence for each PM specified in waiver application
 - For waivers approved for 5 years:
 - Evidence submitted 21 months prior to expiration
 - Minimum of 3 years of evidence
 - For waivers approved for 3 years (some new waivers)
 - Evidence submitted 15 months prior to expiration
 - 18 months of evidence

Evidence Collection, Analysis & Reporting Requirements

- CMS reviews the quality reports on the annual 372 reports and the Evidence report.
 - CMS reviews the state's statistical analysis of the performance measures for each sub-assurance.
 - This review allows CMS to evaluate:
 - the health of the overall quality system, and
 - the state's success in administering each individual assurance and sub-assurance, and
 - the areas the state will need to focus on for improvement in the subsequent waiver cycle.

Reporting on Remediation

- Revised Requirement
 - Individual Remediation does not have to be reported in Evidence Report
 - **Exception: Substantiated instances of abuse, neglect and exploitation**
 - Expectation that State has a mechanism for measuring its effectiveness in addressing non-performance
 - Mechanism and measurement results are subject to audit by CMS

Health and Welfare Revisions

- Assurance wording revised to focus more broadly on health and welfare
- Four (4) new sub-assurances, with focus on:
 - Abuse, neglect, exploitation & unexplained death
 - Incident management
 - Restrictive interventions
 - Health care standards
- New sub-assurances consistent with Waiver Application, Appendix G - Safeguards

Health and Welfare Revisions

- Previous Assurance: On an ongoing basis the State identifies and seeks to prevent instances of abuse, neglect and exploitation
- Current Assurance: The State demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.

Health and Welfare Subassurance

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

Health and Welfare Revisions

- ii. **Sub-assurance** -- 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

Health and Welfare Revisions

- iii. **Sub-assurance** – State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.

Health and Welfare Revisions

- iv. Sub-assurance** --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

Revised Decision Rule

An assurance is NOT MET if any of the following occur:

1. State did not provide Performance Measure evidence for each sub-assurance (under the given assurance)
2. A Performance Measure for one or more sub-assurances (under the given assurance) is less than 86% in any waiver year

AND

The State has not initiated a Quality Improvement (QI) Project **AND/OR** does not provide acceptable justification for why the QI Project has not been initiated to address the performance issue

Revised Decision Rule, con't

3. A Performance Measure for any sub-assurance (associated with the given assurance) is below 86% for three (3) or more years, regardless of whether a QI Project has been implemented
 - *Exception: Unless there has been steady improvement over the years and CMS and the State agree that performance is likely to exceed 85% the following year*
4. CMS discovers that adequate and appropriate remediation for any Performance Measure associated with any sub-assurance (under the given assurance) did not occur

Revised Decision Rule, con't

In addition, the Health & Welfare Assurance shall be considered NOT MET if:

5. The State did not provide a report on individual remediation for substantiated instances of abuse, neglect and exploitation (*Health & Welfare Sub-assurance ii*)

Implementing the Changes

Changes to be implemented via Waiver Amendment, Renewal or Initial Application

- Short Term - CMS issued an Informational Bulletin in March, 2014
 - All new waivers and renewals submitted after June 1, 2014 must have the new system
- CMS updated the Waiver Application and Technical Guide

Goals

- To establish a framework to ensure quality services
- To improve CMS' ability to effectively monitor state oversight of waivers
- To have sufficient standardization to allow quality comparisons from one waiver to another
- To maximize efficiency and effectiveness of the waiver quality processes

Current Concern

- The Office of the Inspector General has begun a series of audits of Health and Welfare outcomes in waivers in the Northeastern states.
- In two completed reviews OIG asserts that the two states did not comply with Medicaid requirements to protect beneficiaries from abuse and neglect.

Best Practice Ideas From ACL and a Former State Medicaid Director

- Ideas learned from studying various state Adult Protective Service Systems and national experts
- A state has clear definitions of abuse and neglect categorized by severity
- Mandatory abuse reporting laws that reach down to direct service personnel and continual training on what/how to report

Best Practices Continued

- Statewide consistency on how reported cases are triaged with response times tied to severity (a single statewide hotline/call center?)
- Adequate APS caseloads to meet response times for initiating immediate protective actions and then completing investigations tied to required follow-up actions

Best Practices Continued

- APS workers are trained with dual competencies: a) Immediate strategies to keep a person safe along with person-centered listening skills that honor the alleged victim's goals and minimize disruption; and b) technical skills in conducting investigations, interviewing witnesses, collecting evidence, and writing clear and compelling reports

Best Practices Continued

- A state has experts (forensic, etc.) to assist local APS workers with complex cases, e.g., systemic or widespread abuse in particular provider groups where there are multiple victims, etc.
- Medicaid policies require the alleged abuser is separated from the alleged victim pending the investigation

Best Practices Continued

- The state maintains an updated data base of substantiated abuse cases by region, programs, facilities, etc. and conducts analyses regularly to spot trends or systemic issues
- Licensing staff include abuse data in their reviews of programs or facilities

Best Practices Continued

- The state APS system cultivates relationships with DAs/prosecutors willing to process cases even where victims make poor witnesses
- The state has a clear agreement with the state Medicaid Fraud Unit on which cases to refer for criminal prosecution

Best Practices Continued

- If a state sets up an abuse registry, it carefully targets which categories of abuse will be included. Experience in multiple states has shown that due process standards and evidentiary requirements that go along with using a registry to affect the abuser's future employment opportunities will significantly drive down the substantiation rates

Summary

- CMS, State Associations and States have agreed to a stronger focus on Health and Welfare.
- A good incident reporting system that includes investigation processes is vital to supporting Health and Welfare.
- The purpose of the incident reporting system is to effectively resolve incidents and prevent further similar incidents to the extent possible

Questions?

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