Maryland On-site Review Summary Report

I. Executive Summary

The Health and Welfare Special Review Team (H&W SRT) conducted a 5-day focused on-site review of Maryland's Medicaid Home and Community-Based Services (HCBS) waiver programs from July 29 through August 2, 2019. The on-site review included multiple meetings with state directors and staff responsible for the administration and operation of Maryland's eight 1915(c) waivers including staff from the Maryland Department of Health (MDH), and its sub-agencies Behavioral Health Administration (BHA) and the Developmental Disabilities Administration (DDA). The H&W SRT also held meetings with representatives from Maryland's licensing entity, the Office of Health Care Quality (OHCQ), protective services entities, HCBS ombudsman, coordination of community service (CCS) providers, supports planners, case managers, providers, participants and other stakeholders. The focus of these meetings was to gain a better understanding of how the state's process for reporting, investigating and resolving critical incidents operate in practice, and how health and welfare is assured for HCBS waiver participants in Maryland through the lens of these stakeholders. This on-site review was conducted as part of a national initiative to provide individualized technical assistance to states on maximizing the health and welfare of Medicaid beneficiaries, and to identify both promising practices and challenges to be addressed.

The MDH is the single state agency and retains administrative authority in overseeing Maryland's eight 1915(c) waiver programs. Additionally, DDA is the operating agency for four of these waiver programs. To address this, the H&W SRT divided into two groups. Team A focused on the Brain Injury and Community Pathways Waiver Programs operated by DDA and Team B focused on the Home and Community-Based (HCB) Options Waiver Program operated by MDH.

During the on-site review, the H&W SRT identified a number of strengths and promising practices, along with challenges, which are listed here and summarized more fully later in the report, along with recommendations for the state's consideration.

<u>Strengths and Promising Practices for Assuring Health and Welfare</u>

A. Planned activities to transition all waiver programs into the state's Long-Term Services and Supports (LTSS) tracking system
B. Comprehensive process for conducting mortality reviews of the deaths of individuals with intellectual/developmental disabilities
C. Tracking and following up on critical incident reports involving individuals enrolled in the Community Options waiver program
D. Some DDA providers exceed state requirements for incident reporting
E. Evidence of cross-agency collaboration between MDH and DDA
F. DDA policy requirement for each provider to have a standing critical incident review committee

<u>Challenges in Assuring Health and Welfare</u>

A. Inconsistency in assisted living providers reporting incidents and lack of training resources for these providers

B. Lack of a standardized training curriculum for providers conducting critical incident investigations for DDA Waivers
C. Inconsistent involvement by adult protective services, depending on the waiver program associated with the critical incident allegations

Recommendations

The state should

A. Develop and disseminate training material for assisted living facilities to enhance consistency in reporting critical incidents to the state. The state should also consider a standard critical incident form for all providers.
B. Train DDA providers on documentation requirements for critical incident investigations.
C. Collaborate across agencies to ensure consistent involvement by adult protective services across all waiver programs.
D. Systematically address participant education about identifying and reporting abuse, neglect, and exploitation.
E. Pursue the inclusion of participant focused outcomes as a key element of the critical incident report that will be housed in the LTSS tracking system.
F. Ensure that critical investigations conducted by OHCQ align with policies and procedures across all waiver programs.
G. Explore strategies to use and trend data to inform and enhance a more robust provider training process for direct support staff.
H. Expand the mortality review committee to all waivers.

Overall, Maryland demonstrated that it has a system for addressing, tracking, trending and analyzing critical incidents, and that stakeholders are aware of how to respond to a critical incident.

II. Background

Before the on-site visit, the H&W SRT reviewed waiver program documents and other material from the public domain related to the health and welfare assurance of individuals receiving HCBS waiver services in Maryland. Table 1 lists the eight Maryland waiver programs that were reviewed prior to the visit, in addition to each waiver's expiration date, operating agency and target population.

Table 1. Waiver Programs Reviewed

Waiver Name and Number	Expiration Date	Operating Agency	Target Population
Home and Community Based Options (0265) – "HCB Options" (Merge of Older Adults & Living at Home Waivers)	June 2021	Maryland Department of Health	Participants who are 65 years and older or who are 18-64 with a disability
Medical Day Care Services (0645)	June 2021	Office of Health Services	Participants who are 65 years and older or who are 16-64 with a disability

Waiver Name and Number	Expiration Date	Operating Agency	Target Population
Model Waiver for Medically Fragile Children (40118)	June 2023	Office of Health Services	Medically fragile children under the age of 22
Brain Injury Waiver (40198)	June 2026	Behavioral Health Administration	Participants with brain injury aged 22 years and older
Community Pathways (0023)	June 2023	Developmental Disabilities Administration	Participants with a developmental disability
Family Supports Waiver (1466) (New in 2018)	December 2022	Developmental Disabilities Administration	Participants aged birth-21 years with a developmental disability
Community Supports Waiver (1506) (New in 2018)	December 2022	Developmental Disabilities Administration	Participants with a developmental disability
Waiver for Children with Autism Spectrum Disorder (0339)	June 2024	Maryland State Department of Education - Division of Special Education/Early Intervention Services	Children aged 1-21 years who have autism spectrum disorder

Based on its review of the preliminary information, the H&W SRT focused on the Brain Injury and Community Pathways waiver programs operated by DDA in addition to the Home and Community Based (HCB) Options Waiver Program operated by MDH. These waivers were selected because they have different operating agencies and waiver populations. By reviewing these waivers, CMS had the opportunity to gain a more holistic view of the state's health and welfare initiatives across the programs. Additionally, the Community Pathways waiver was selected because it had an active corrective action plan.

The **HCB Options Waiver Program** provides services to approximately 4,000 individuals residing in assisted living facilities. Critical incidents are reported and tracked through the submission of Reportable Events (RE) entered into LTSSMaryland, the state's long-term care services and supports electronic tracking system. Supports planners, local health department nurse monitors and MDH staff enter REs submitted by participants or any individual concerned with a participant's health and safety. LTSSMaryland contains general information about the participant, service data from the Medicaid Management Information System (MMIS), and a narrative section to track participant focused outcomes, actions that were taken and status of reportable events. REs are closed once an intervention and action plan has been implemented and documented. MDH staff review and monitor RE reports entered into LTSSMaryland to ensure that incidents are addressed.

The **Community Pathways Waiver Program** serves approximately 15,000 individuals and the **Brain Injury Waiver Program** serves approximately 90 individuals. Both waiver programs use the Provider Consumer Information System 2 (PCIS2) system to report and track critical incidents. Waiver providers are required to enter incident information into the system as soon as they become aware an incident occurred and assign a category type, at which time the report is elevated to the state's Regional Office. Support coordinators are also notified once an incident is submitted which allows them to begin their care coordination process. The provider is required to conduct an internal investigation, and develop a plan to prevent similar incidents from occurring and to assure the health and safety of the participant, which the Regional Office reviews.

Maryland On-site Review

The H&W SRT conducted the on-site visit over a five-day period July 29- August 2, 2019 and met with various state staff, stakeholders, advocates, providers and participants. The following topics were covered in addition to reviewing a sample of critical incident reports.

- State Medicaid Agency's oversight of the waiver programs and the critical incident management systems and processes
- Maryland's mortality review process
- Critical incident reporting process (from both the provider and participant perspectives)

Joint meetings were held with protective services entities, protection and advocacy entity representatives, the HCBS ombudsman and other stakeholders to understand how the entities work together to assure the health and welfare of participants for the various waivers.

III. State Strengths and Promising Practices for Assuring the Health and Welfare

The following is an overview of the state's strengths and promising practices identified by the H&W SRT regarding the design or practice of assuring the health and welfare of HCBS participants in Maryland.

A. **Planning activities to shift all waiver programs into the state's LTSS tracking system**

Following the success and strength of the LTSS tracking system, Maryland continues to carry out activities to transition the remaining waiver programs into the tracking system. This will assist the state with achieving its goal of aligning and streamlining the operation of waiver programs operated across agencies. This may also improve the state's ability to use data for trending and systemic improvement.

B. **Comprehensive process for conducting mortality reviews of the deaths of individuals with developmental/intellectual disabilities**

Maryland has a comprehensive process for conducting mortality reviews of the deaths of individuals with developmental/intellectual disabilities, including those enrolled in waivers operated by DDA. Maryland's Mortality Review Committee meets four times yearly to review cases, identify patterns and trends, and make recommendations that are included in an annual report disseminated to OHCQ and DDA.

C. **Tracking and following up on critical incident reports involving individuals enrolled in the Community Options waiver program**

MDH clearly demonstrated that staff are tracking and following up on critical incident reports involving individuals enrolled in the Community Options waiver program. Support planners are required to conduct monthly contacts and meet face to face quarterly with participants. During those visits, they confirm that participants understand their rights and know how to report any health and safety issues.

D. **Some DDA providers exceed state requirements for incident reporting**

DDA has some providers that have implemented higher standards than the state requires by securing their own training for investigators of critical incidents and providing staff training on critical incident reporting more often than is required by the state. This is reflective of providers that operate in multiple states. It was reported that the provider will implement a system based on the highest rigor of the states they operate in.

E. **Evidence of cross-agency collaboration between the MDH and its sub-agencies, BHA and DDA**

Based on discussions with DDA, BHA and MDH leadership, it is evident that steps have been taken to improve the communication and coordination of the agencies involved in operating the waivers. Changes about the process the two agencies experienced when under the CMS Corrective Action Plan were discussed. DDA, BHA and MDH leadership recognize that ongoing, dedicated efforts are essential and the H&W SRT encourages the continuation of this cross-agency collaboration.

F. **DDA policy requirement for each provider to have a standing critical incident review committee**

The DDA policy requirement for each provider to have a standing committee that regularly reviews critical incidents to identify opportunities for systemic improvement is a strength that the state is encouraged to replicate across agencies.

IV. Challenges in Assuring Health and Welfare

The following is an overview of the challenges identified by the H&W SRT regarding the design or practice related to assuring the health and welfare of HCBS waiver participants in Maryland.

A. **Inconsistency in assisted living providers reporting incidents**

At the time of the visit, there were 1,520 assisted living providers in the state, of which 480 provided services to HCBS waiver participants. In the sample of assisted living facility providers interviewed, 50% were unaware of the requirement to report critical incidents to MDH. In response to questions posed during the interview with assisted living providers for the Community Options waiver program, half of the six providers reported that they were not aware of the requirement to submit critical incident reports to the MDH. Based on the face to face interviews with the providers, it appeared that all were tracking this information, including steps taken in response to critical incidents, but did not follow through with reporting these incidents to the MDH. It appeared that these

providers expected that the critical incident information would be reviewed during an OHCQ audit. In addition, the team heard from multiple providers that they use their own critical incident form. This may be why some providers do not know that incidents should be reported to the state. Using a standardized form that would be completed when there is a critical incident would help to standardize this process. Providers also expressed a concern about lack of training resources for their direct support staff. Developing standard online training would provide easy access to information and promote consistency.

B. **Lack of a standardized training curriculum for providers conducting critical incident investigations for DDA Waivers**

DDA has a comprehensive and well-structured Policy on Reportable Incidents and Investigations (PORII) which includes expectations for providers to conduct their own investigations of critical incidents. However, there is no required training that investigators must complete related to critical incidents. DDA indicated that the development of a standardized curriculum for provider investigators is underway and the H&W SRT strongly encourages the completion of that process.

C. **Inconsistent involvement by Adult Protective Services (APS) depending on the waiver program associated with the critical incident allegations**

Information gathered during the on-site review identified inconsistent involvement by APS depending on the waiver program associated with the critical incident allegation. The H&W SRT found that APS was consistently involved in allegations of abuse, neglect and exploitation for the Community Options program, but all indications point to APS declining investigative involvement for participants in the DDA operated programs, even though providers consistently follow requirements to report allegations to APS. Maryland is encouraged to collaborate at the agency level to identify improvements in this area.

VI. H&W SRT Recommendations and Next Steps for Maryland

CMS appreciates the state's participation in the H&W SRT and provides the following recommendations that would enhance the state's ability to safeguard health and welfare.

A. **Development and dissemination of assisted living facility training materials and reporting forms to enhance consistency in reporting critical incidents to the state**

Standardized training and material provided by the state would support providers and improve the overall training provided to paid caregivers in assisted living facilities. Multiple assisted living providers indicated they find their own provider training information for their caregivers. Some providers conduct Google searches looking for information to include in the training and others use resources from other jobs they have had. The state should consider a standard critical incident form for all providers on all waivers. The H&W SRT heard from multiple assisted living providers for the Community Options waiver program that they use their own critical incident form. This may be why some providers do not know that incidents should be reported to the state (noted in Challenges above).

B. **Enhanced DDA provider trainings that target the documentation and description sections within critical incident reports**

Current reporting reviewed from the PCIS2 system showed answers from providers to be vague, incomplete and/or not germane to the element of the investigative report. The timing of migration to the LTSS tracking system presents an ideal opportunity to refresh training for providers regarding complete and detailed critical incident documentation.

C. **Cross-agency collaboration to ensure consistent involvement by adult protective services across all waiver programs**

Information gathered during the on-site review points to inconsistent involvement by APS, depending on the waiver program associated with the critical incident allegation. Cross-agency collaboration has the benefit of providing a standardized APS response to critical incidents impacting HCBS waiver participants. The state may wish should consider developing a memorandum of agreement in coordination with APS to help build the relationship and define expectations.

D. **Systematic training approach to educate participants and families about identifying and reporting abuse, neglect, and exploitation**

During the joint meeting with multiple DDA stakeholders and oversight entities, individuals and families expressed little to no knowledge of how to report or obtain support for a critical incident. However, discussions with participants during provider visits confirmed that individuals are aware of their rights and who they can ask for help if they feel unsafe. DDA acknowledged during the visit that this was a revelation to them, and it presents a motivation to explore ways to better educate individuals and families about identifying and reporting abuse, neglect and exploitation. The state should also consider developing a participant handbook to educate individuals and families about identifying and reporting abuse, neglect and exploitation. The H&W SRT recommends that MDH and DDA pursue this as a systemic improvement, including using the annual service plan meeting and other opportunities to educate individuals and families by explaining how to report or obtain support for critical incidents. which is distinct from a general discussion of participants' rights and responsibilities. The state could reach out to or states or the state associations and request examples of other states' handbooks.

E. **Inclusion of participant focused outcomes as a key element of the critical incident report to be housed in the LTSS tracking system**

The critical incident reports from the DDA PCIS2 systems have ample required elements, but there currently is not clear documentation on outcomes tied to the completion of the investigation for the participant. There is an opportunity within the LTSS tracking system migration to improve this documentation so there is a full picture regarding the critical incident reporting process from beginning to end.

F. **Ensure that critical incident investigations conducted by OHCQ align with policies and procedures across all waiver programs**

OHCQ has a dual role focused on both licensing and investigations of critical incidents, with their own definitions of incidents and response times for beginning an investigation.

Aligned policies and procedures have the potential to improve the state's ability to monitor response and resolution timeframes across the state.

G. **Utilize trend data to inform and enhance the provider training process for health and welfare, including for direct support staff**

The information gathered during the on-site review demonstrates that MDH and DDA are tracking and trending data from the critical incident management processes. This information could be used to inform provider training.

H. **Expansion of the mortality review committee to include all waivers**

Maryland has a comprehensive process for conducting mortality reviews of the deaths of individuals with developmental/intellectual disabilities, including those enrolled in waivers operated by DDA. However, this committee does not review deaths of individuals enrolled in the Community Options waiver programs or other waivers serving older adults. While deaths of older adults are evaluated via the Reportable Events process, no trend analysis is conducted. The H&W SRT encourages Maryland to consider including all waiver programs in their mortality review process, whether it be by a single committee or through separate oversight bodies. Additional mortality data across all programs will improve health and safety outcomes, particularly among the groups not currently studied.