



FINDINGS FROM THE 1915(c) WAIVER INCIDENT MANAGEMENT SURVEY: INCIDENT MANAGEMENT SYSTEMS AND PROCESSES

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

Training Objectives

- This training is part one of a three-part presentation based on a national survey completed by states on incident management systems. The survey findings covered in this training focus on the design of state incident management systems and processes. Subsequent trainings will examine other parts of the survey.
- The objectives for this training are as follows:
 - Review federal guidance and reports that underscore the priority of protecting waiver participant health and welfare through effective incident management assurances.
 - Provide an overview of the current landscape of states' HCBS waiver incident management system technologies and processes, including how states respond to, monitor, resolve, and seek to prevent critical incidents.
 - Review findings from a national survey of incident management systems regarding policies and procedures established by states for reporting and resolving incidents.

Introduction to Incident Management

Goals of an Incident Management System

- In the context of this training, an “incident management system” includes all technologies and processes implemented within a state to manage critical incidents.
- According to the 1915(c) Technical Guide, page 225, an incident management system must be able to:
 - Assure that reports of incidents are filed;
 - Track that incidents are investigated in a timely fashion; and
 - Analyze incident data and develop strategies to reduce the risk and likelihood of the occurrence of similar incidents in the future.¹

Health and Welfare in the Social Security Act § 1915(c)

Assuring the health and welfare of waiver participants is the highest priority.

- Under section 1915(c) of the Social Security Act, the state must provide for the health and welfare of individuals served. Waivers must address QIS Appendix G, which outlines assurances to CMS that the state has necessary safeguards to protect the health and welfare of participants receiving services.
- Section 1915(c) also requires states to annually report the following to CMS:
 - Information on the impact of the waiver granted;
 - Types and amounts of medical assistance provided; and
 - Information on the health and welfare of participants.
- Several reports and audits indicate that states face challenges in adequately identifying and investigating incidents, as well as preventing incidents from occurring.
- CMS seeks to continually improve the 1915(c) HCBS waiver program by providing state guidance, analyzing and sharing state practices, and providing ongoing technical support and assistance.

2014 Revised §1915(c) Waiver Guidance

- On March 12, 2014, CMS issued an Informational Bulletin on “Modifications to Quality Measurements and Reporting in § 1915(c) Home and Community-Based Waivers”. This document:
 - Revised the guidance on quality assurances related to health and welfare in recognition of the importance of tracking services to prevent future incidents of abuse, neglect, and exploitation;
 - Modified the assurance and sub-assurances related to health and welfare to allow for more extensive tracking of incidents “to benefit the individual receiving services by using data to prevent future incidents”; and
 - Established the following assurance: “The state demonstrates it has designed and implemented an effective system for assuring waiver participant health and welfare.” ²

2014 Revised § 1915(c) Waiver Guidance – Continued

- The guidance also created four new sub-assurances that require states to:
 - Demonstrate on an ongoing basis how it identifies, addresses, and seeks to prevent instances of abuse, neglect or exploitation, and unexplained death;
 - Demonstrate that an incident management system is in place and effectively resolves reported incidents and prevents further similar incidents to the extent possible;
 - Demonstrates that policies and procedures for the use of and prohibition of restrictive interventions (including restraints and seclusion) are followed; and
 - Establishes overall health care standards and monitors those standards based on the responsibility of the service provider as established in the approved waiver.

Summary of HHS-OIG Report Findings

- In 2016, the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) released several reports on their review of states' compliance with federal or state requirements regarding critical incident reporting.
- The HHS-OIG found that several states did not comply with federal waiver and state requirements for reporting and monitoring critical incidents involving HCBS waiver individuals. ^{3,4,5}
 - Critical incidents were not reported correctly;
 - Adequate training to identify appropriate action steps for reported critical incidents or reports of abuse or neglect was not provided to state staff;
 - Appropriate data sets to trend and track critical incidents were not accessible to staff; and
 - Critical incidents were not clearly defined, making it difficult to identify potential abuse or neglect.

Summary of CMS Audit Findings

In 2016, CMS conducted three state audits based in part or in whole on concerns regarding health and welfare and negative media coverage on abuse, neglect or exploitation issues.

- CMS found these states had not been meeting their 1915(c) waiver assurances, similar to findings reported by the OIG.
 - In two cases, for the incidents of concern, tracking and trending were not present.
 - In at least two of the states, staffing at appropriate levels was identified as an issue.
- For more detail on the CMS audits and recommendations resulting from these findings, refer to the HCBS Quality 201 training:
<http://www.nasuad.org/sites/nasuad/files/Final%20Quality%20201.pdf>
- Please note that CMS is currently working with states and state associations to update the performance measures from the training cited above.

Summary of GAO Report Findings

In January 2018, the United States Government Accountability Office (GAO) released a report on a study of 48 states that covered assisted living services.⁶

- The GAO found large inconsistencies between states in their definition of a critical incident and their system's ability to report, track, and collect information on critical incidents that have occurred.
- States also varied in their oversight methods as well as the type of information they were reviewing as part of this oversight.
- CMS conducts oversight using annual state reports for each HCBS waiver; however, almost half of the states had limitations in their data reflected in 372 reports.

The GAO recommended that requiring states to report information on incidents (e.g., type and severity of incidents, number of incidents, etc.) will strengthen the effectiveness of state and federal oversight.

Summary of Recommendations from Reports

Findings from the HHS-OIG, GAO reports, and CMS audits highlight the need for states to:

- Conduct additional oversight regarding the administration and operation of their incident management systems;
- Provide clarity and transparency on the operation and collection of information from their incident management systems;
- Standardize definitions and processes for:
 - Responding to incidents; and
 - Annual reporting requirements for HCBS waivers.
- Implement promising practices and performance improvements that help maximize resources and improve current incident management systems.

CMS Guidance on Incident Management

- In April 2018, CMS discussed key elements of a successful incident management system on a Medicaid State Technical Assistance call. Notes from this call can be found here:
<https://www.medicaid.gov/sites/default/files/2019-12/incident-management-101.pdf>
- To gain a baseline understanding of how states implement their incident management systems, CMS administered a 8-state pilot survey between May and June 2018. Results from this survey were shared at the 2018 Home and Community-Based Services conference:
http://www.advancingstates.org/sites/nasuad/files/12%20-%20CMS_Managing_Incident_Mgmt_508.pdf
- In June 2019, CMS launched a national Incident Management Survey to states that operate 1915(c) waivers. The results of the survey are discussed in the following slides.

Incident Management Survey Background and Methodology

Survey Background

- In July 2019, CMS issued a survey to the 47 states that operate 1915(c) waivers, requesting information on their approach to administering incident management systems.
- The goal of the survey was to obtain a comprehensive understanding of how states organize their incident management system to best respond, resolve, monitor, and prevent critical incidents for their waiver programs.
- Additionally, this assessment has helped CMS compile common challenges and promising practices regarding critical incident management to disseminate to states.

Survey Methodology

- The survey consisted of 146 questions across 8 sections:
 1. Systems
 2. Reporting
 3. Incident Resolution
 4. Quality Improvement
 5. Collaboration
 6. Training
 7. Prevention
 8. Mitigation of Fraud, Waste, and Abuse (FWA)

Survey Methodology - Continued

- This survey was provided through a web-based platform with some survey logic (e.g., skip patterns). Based on a state's individual waiver criteria, the respondent may not have answered some of the questions in this survey.
- Survey findings are based on an analysis of survey responses received from 45 states:
 - States self-reported their data.
 - States submitted responses for each unique incident management system for their 1915(c) waivers.

State Interviews Overview

- CMS conducted interviews with 5 states to gain a more in-depth understanding of their incident management systems from October 2019 to January 2020.
- CMS selected these 5 states for interviews based on promising practices demonstrated in their survey responses.

Incident Management Survey and Interview Findings

General Survey Findings

- CMS received 101 survey responses, representing 101 unique incident management systems across 45 states and 237 waivers.
 - To account for the varying systems, states submitted a unique survey response for each incident management system in their state. As a result, states often submitted multiple but unique surveys.
- Findings are presented in terms of numbers of unique state systems to mirror the structure of survey responses.

Table 1: General Survey Results

<i>General Survey Results</i>			
Survey Responses			
<i>Total # Survey Responses Received</i>		101	
Survey Response Rates by Level			
	<i>Target Number of Participants</i>	<i>Number of Respondents</i>	<i>Response Rate</i>
<i>States</i>	47	45	96%
<i>HCBS Waiver Programs</i>	252	237	94%

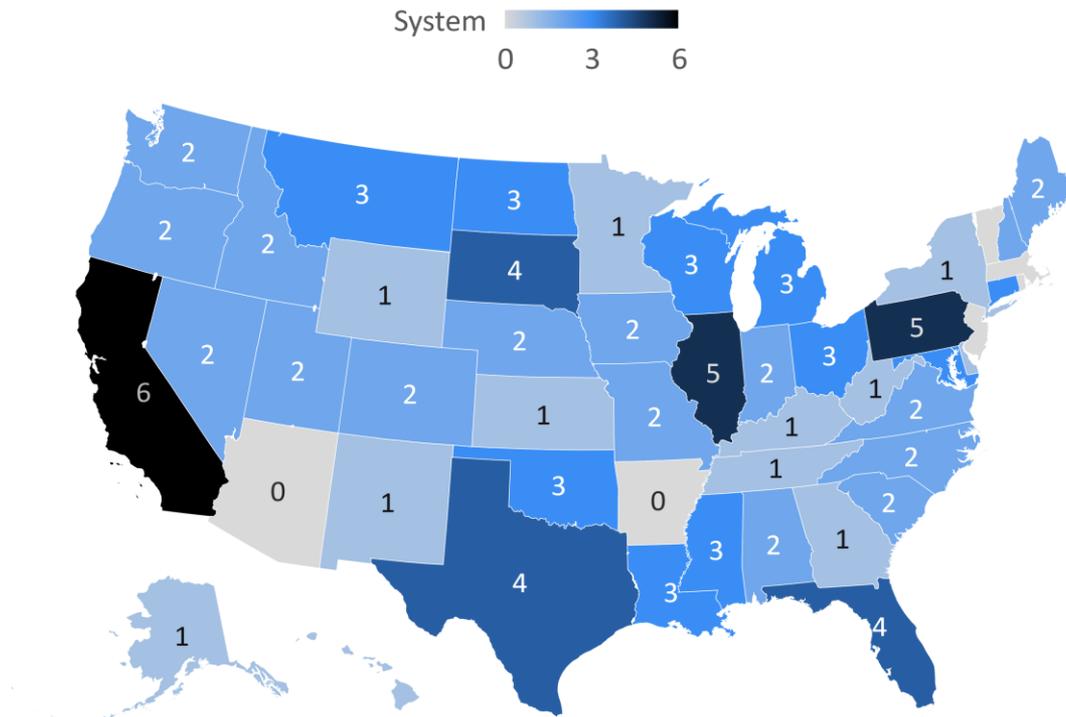
Overview of Findings

- Survey results and interview findings show that the states with more advanced incident management systems consider incident management as a cohesive system rather than siloed processes and activities.
- States are working towards adopting strategies and solutions that support a more comprehensive approach towards managing incidents by:
 - Identifying and addressing the different priorities of the state, whether legislative, or based on state population needs; and
 - Aligning technologies and policies and procedures so that they work in conjunction with one another.

Number of Incident Management Systems Implemented Within a State

- 32 of 45 surveyed states (71 percent) operate more than one system.

Figure 1: Number of Systems Implemented Within a State*



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*Grey states (states labeled with a zero) either did not provide a survey in time for the creation of this training or currently do not operate 1915(c)

Population Types

States often develop differing systems and processes in response to varying waiver program designs and population needs.

- 62 of 101 systems (61 percent) serve only one of the following distinct waiver populations:
 - Aged or Disabled (AD), or Both – General¹
 - Aged or Disabled, or Both – Specific Recognized Subgroups²
 - Intellectual Disability or Developmental Disability (ID/DD), or Both³
 - Mental Illness⁴
- **Example:** One state operates two incident management systems with one pertaining to AD waivers and the other pertaining to ID/DD waivers. This state reported that certification and licensure is different for various provider types. Therefore, referrals and investigations are handled differently for different waiver recipient populations.

1. This includes: Aged, Disabled (Physical), Disabled (Other)
2. This includes: Brain Injury, HIV/AIDS, Medically Fragile, Technology Dependent
3. This includes: Autism, Developmental Disability, Intellectual Disability
4. This includes: Mental Illness, Emotional Disability

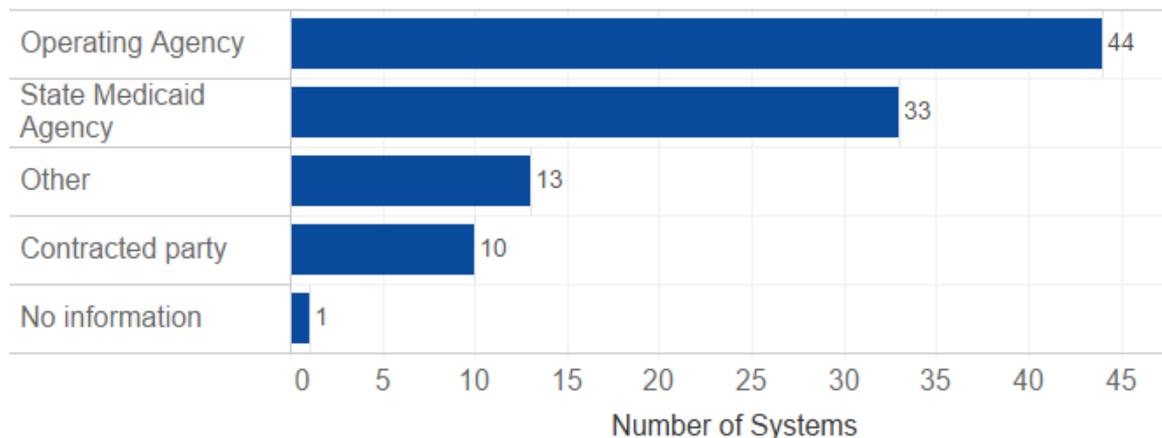
Incident Management Oversight

Most states' incident management systems are operated/managed by the Operating Agency (OA) or the State Medicaid Agency (SMA).

- 44 of 101 surveyed incident management systems (44 percent) are managed by the OA and 33 of 101 systems (33 percent) are managed by the SMA.
- States that selected “Other” indicate that more than one agency was responsible for managing their system (e.g., SMA and an MCO).

Figure 2: Entity that Operates the Incident Management System

Sys-1. Which entity operates/manages the system?

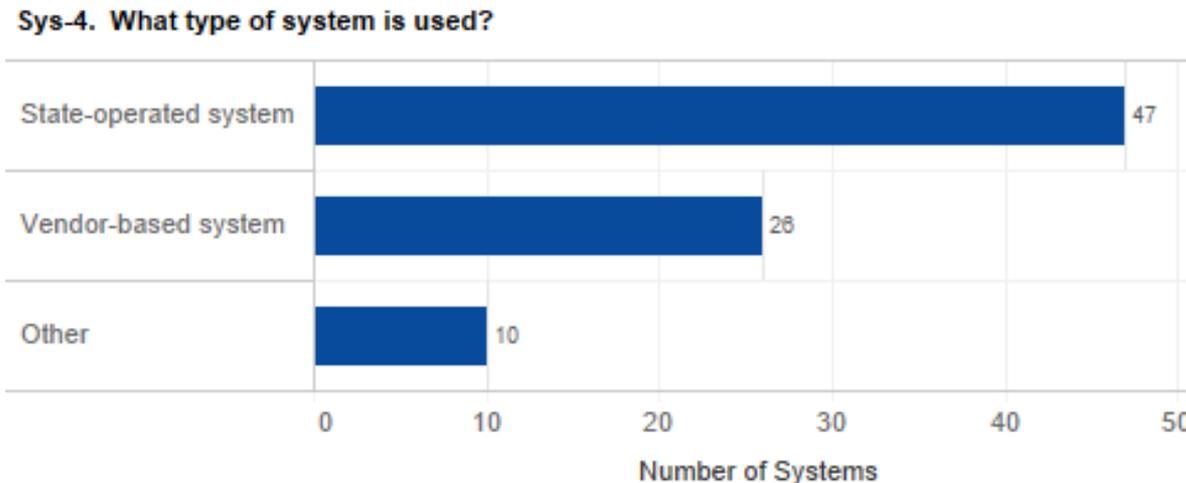


System Type

States are more likely to develop their electronic incident management systems rather than purchase vendor-based systems.

- 47 of 83 electronic incident management systems (57 percent) use a state-operated system.
- “Other” systems most commonly include a decentralized system where critical incident reports are emailed among agencies.

Figure 3: System Type

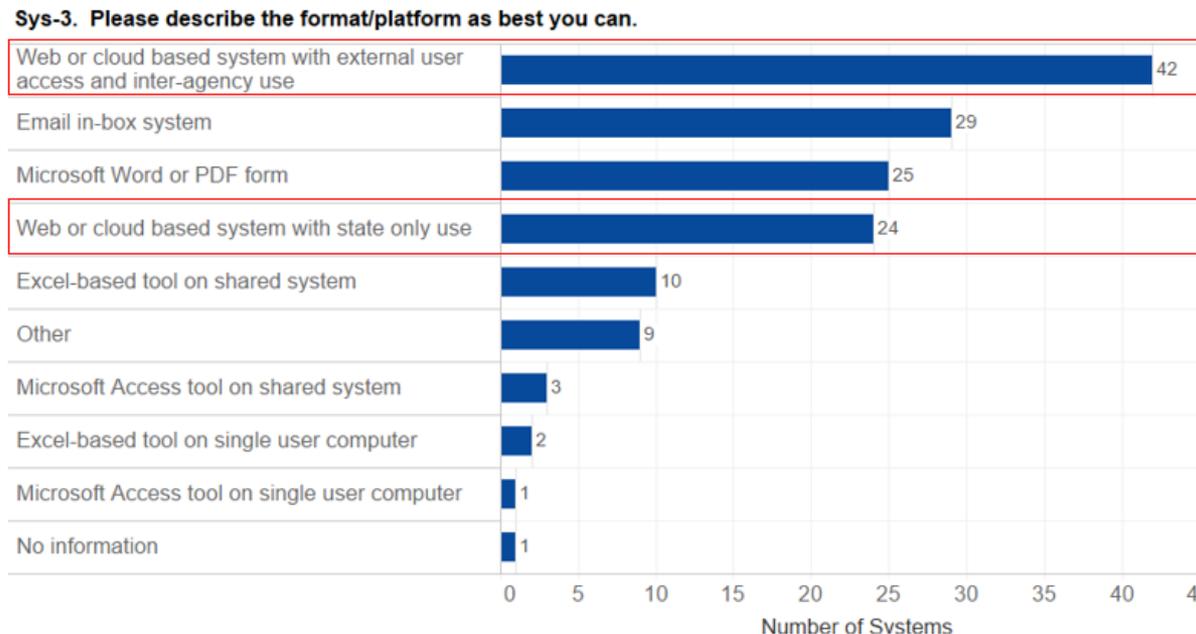


Incident Management Platforms Used by States

Most states have adopted a web- or cloud-based platform for their incident management systems.

- 66 of 101 systems (65 percent) feature web- or cloud-based technology.

Figure 4: Distribution of State Incident Management System Electronic Platforms*



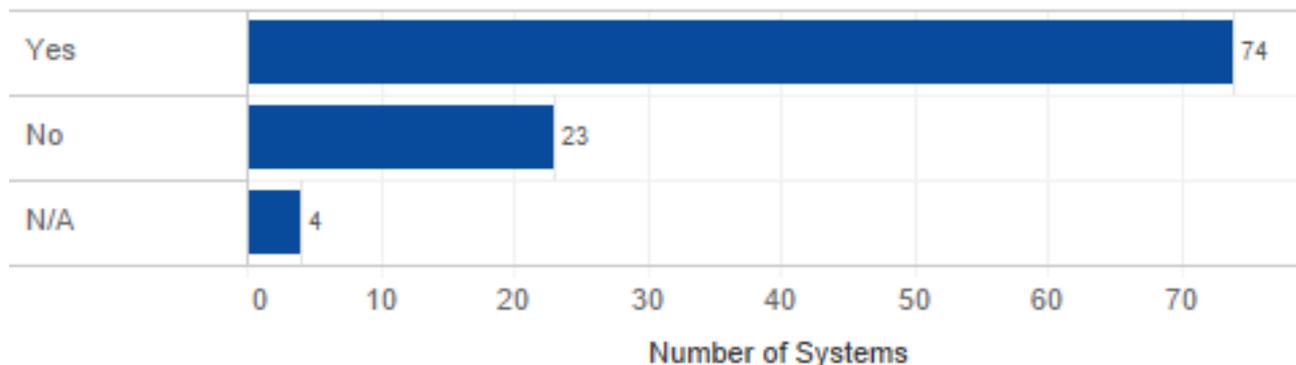
Incident Risk Identification

Though most states identify incidents by risk, definitions for critical incidents vary.

- According to survey responses, 74 of 101 systems (73 percent) identify incidents by risk (i.e., critical vs. non-critical) and 23 of 101 systems (23 percent) do not.

Figure 5: Incident Risk Identification

Rep-1. Does the state identify incidents by risk level?



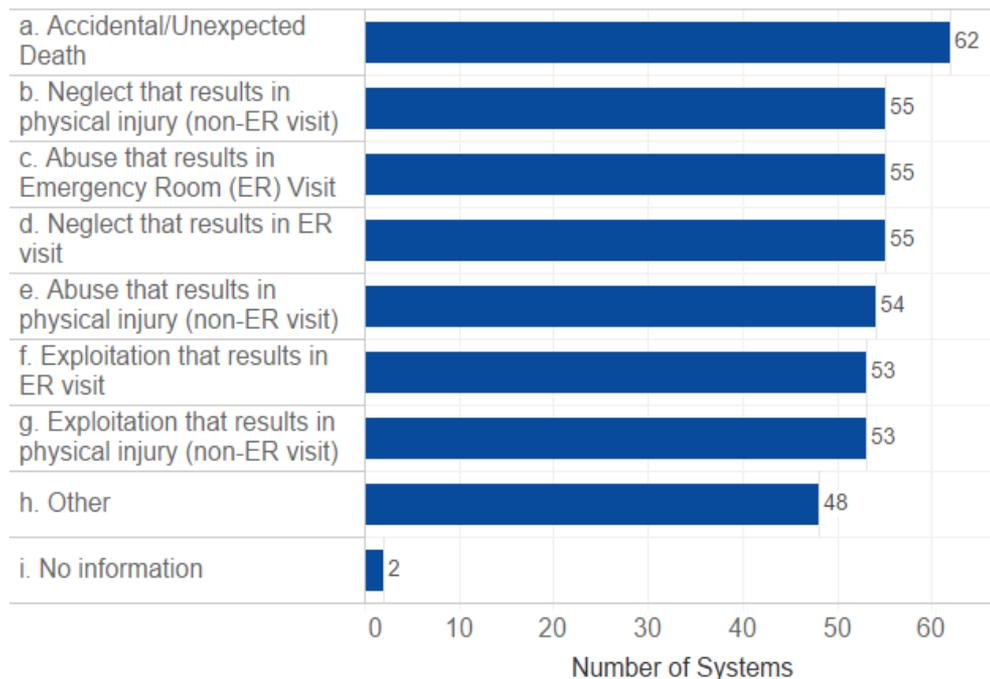
Critical Incident Definitions

States most commonly selected all available options within the survey to define critical incidents.

- 49 of the 74 systems that identified incidents by risk (66 percent) included definitions a-g as a “critical incident”.
- Of the 49 systems that included a-g in their definition of “critical incident”, 29 systems (59 percent) provided an “Other” definition (options a-h).

Figure 6: State Definition of Critical Incidents*

Rep-2. How does the state define an incident as a “critical” incident?



27 *Note: For this question, states had the option of selecting multiple answer choices. As a result, total response counts do not sum up to 101 systems.

Other Critical Incident Definitions

States also identified “Other” definitions of critical incidents in the survey.

- 48 of 74 systems (64 percent) provided “Other” definitions of critical incidents.
- “Other” definitions often fell in multiple categories and therefore the system counts for each definition type should be interpreted independently.

Table 2: “Other” Critical Incident Definitions Identified by States

Definition Type	# of Systems
Medication error	19
Use of restraints	17
Mental health treatment/ psychological injury	16
Criminal activity/ law enforcement intervention	14
Sexual abuse	14
Missing person/ elopement	12
General risk to health and welfare	12
Natural disaster/ environmental danger	9
Suicide or suicide attempt	8
Financial exploitation/ misappropriation	8
Falls	5
Homelessness	3

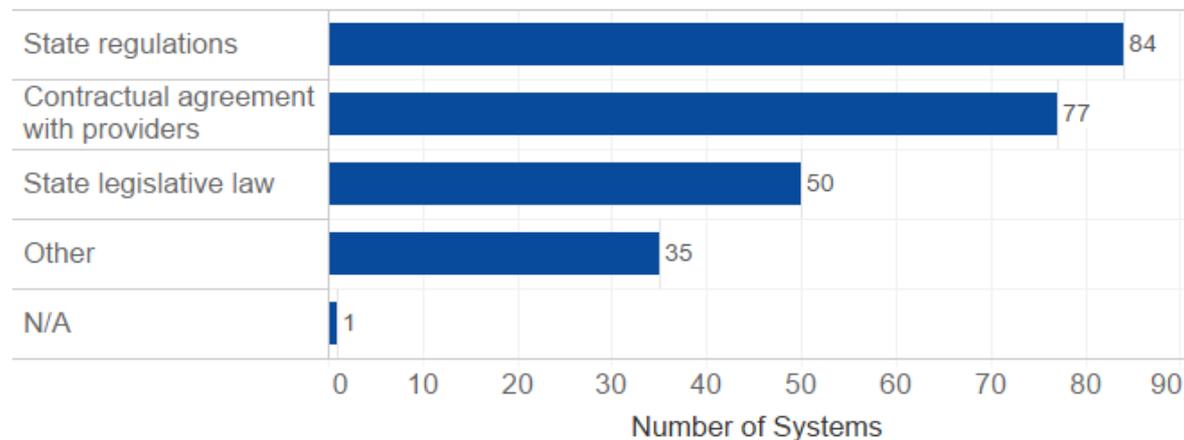
Protocols Requiring Incident Reporting

States often rely on regulations and provider contracts to define the requirements for incident reporting.

- 84 of 101 systems (83 percent) reported using state regulations to require incident reporting, while 77 of 101 systems (76 percent) stated using contractual agreements with providers.

Figure 7: Authority Requiring Incident Reporting*

Rep-5. Which of the following does the state use to require incident reporting?

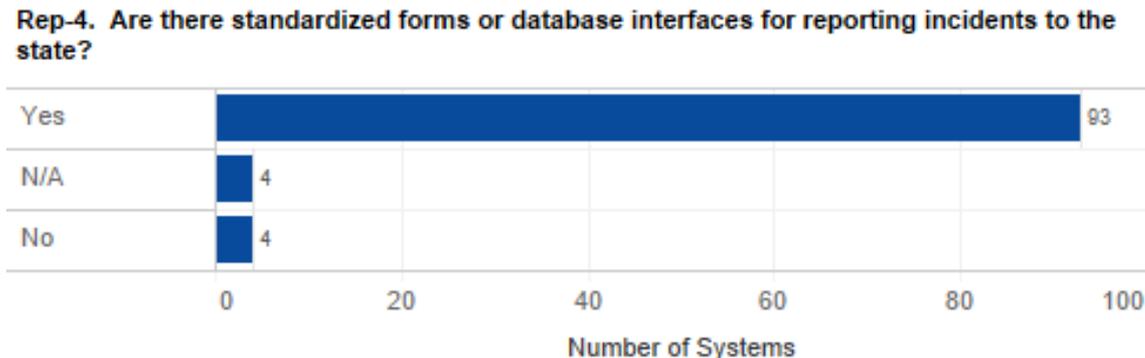


Standardized Reporting Forms

Most systems use a standardized form for reporting incidents.

- 93 of 101 systems (92 percent) use standardized forms or database interfaces for reporting incidents to the state.
- Standardized forms are beneficial as they expedite the review of incidents and confirm that required information is reported.

Figure 8: Standardized Forms for Reporting Incidents

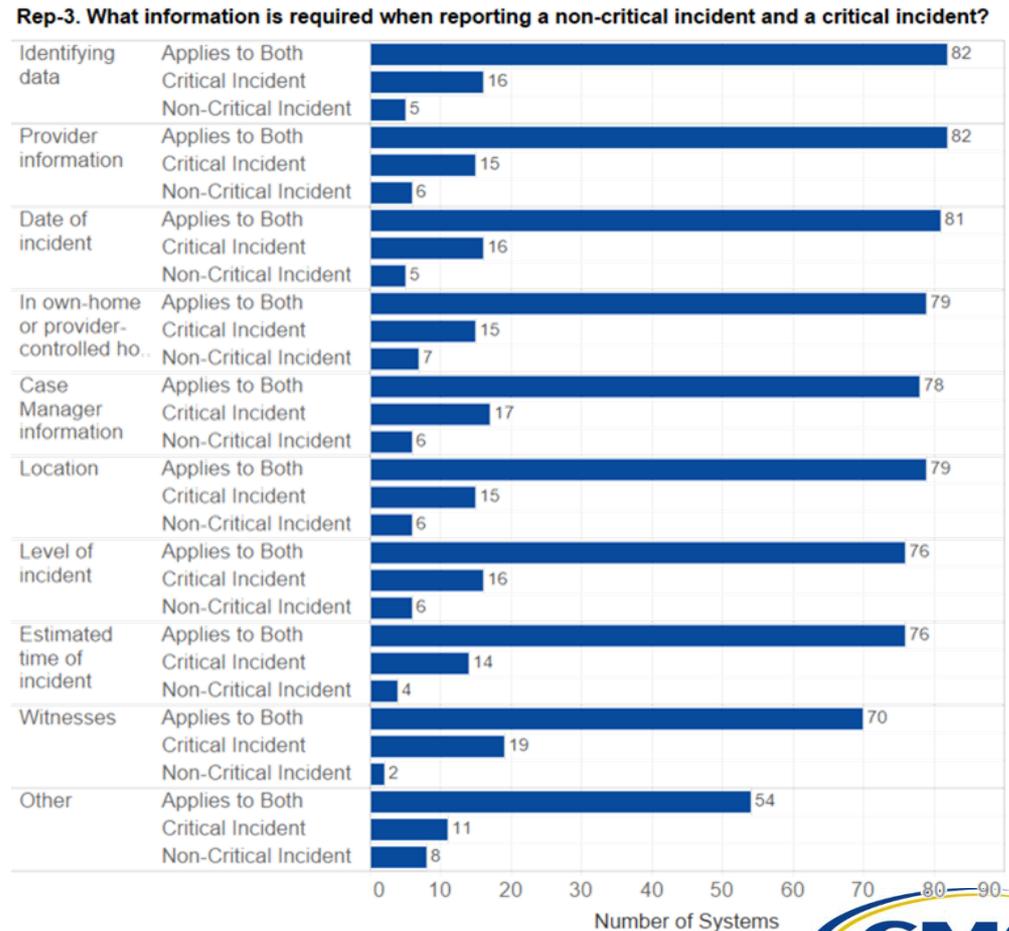


Reporting Information

Most incident management systems collect the same data for non-critical and critical incidents.

- States most frequently cited collecting identifying data, provider information, and the date of incident.
- “Other” data collected by incident management systems include treatment/remediation efforts provided and agencies and/or individuals who have been notified of the incident.

Figure 9: Required Reporting Information*



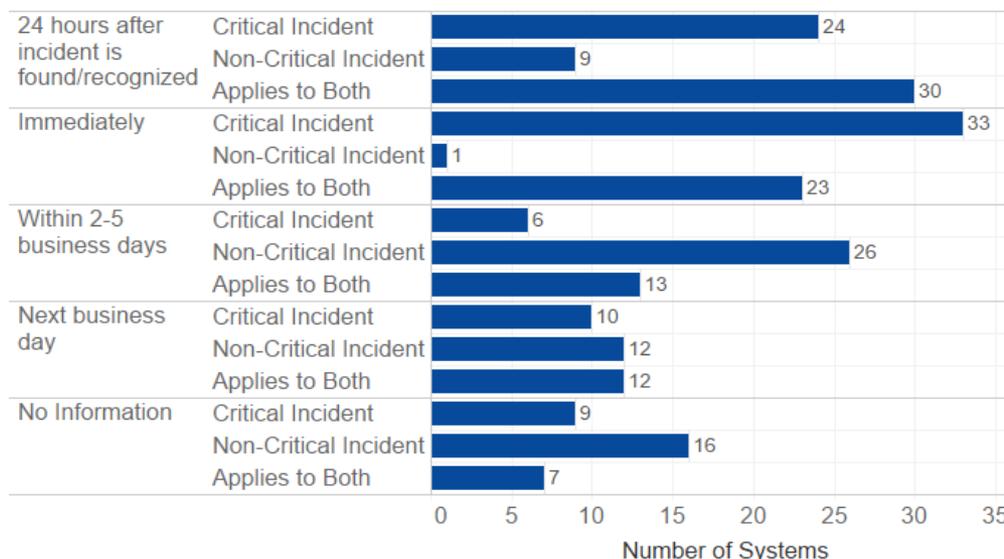
Reporting Timelines

The majority of systems report critical incidents immediately or report critical incidents in a more aggressive timeframe than non-critical incidents.

- The most common reporting timeframe for critical incidents were “immediately” and within “24 hours after incident is found/recognized” while for non-critical incidents, “within 2-5 business days” was most common.

Figure 10: Reporting Timelines*

Rep-7. What is the timeliness standard for reporting incidents?



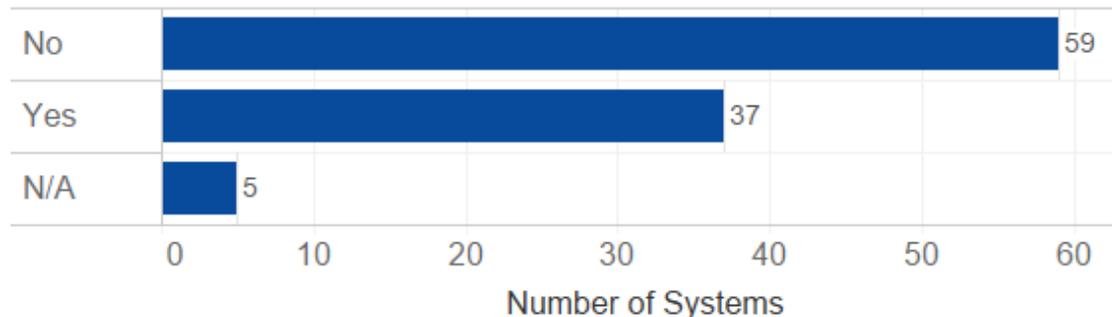
Incident Triaging

A majority of state systems do not conduct investigations on all reported incidents, allowing the state to prioritize incidents based on nature or severity.

- Survey results illustrate that 59 of 101 systems (58 percent) do not perform investigations on all reported incidents. States reported that they relied on the nature and severity of the incident to determine which incidents to investigate.

Figure 11: Investigations on Reported Incidents

IR-4. Is an investigation performed on all incidents reported?



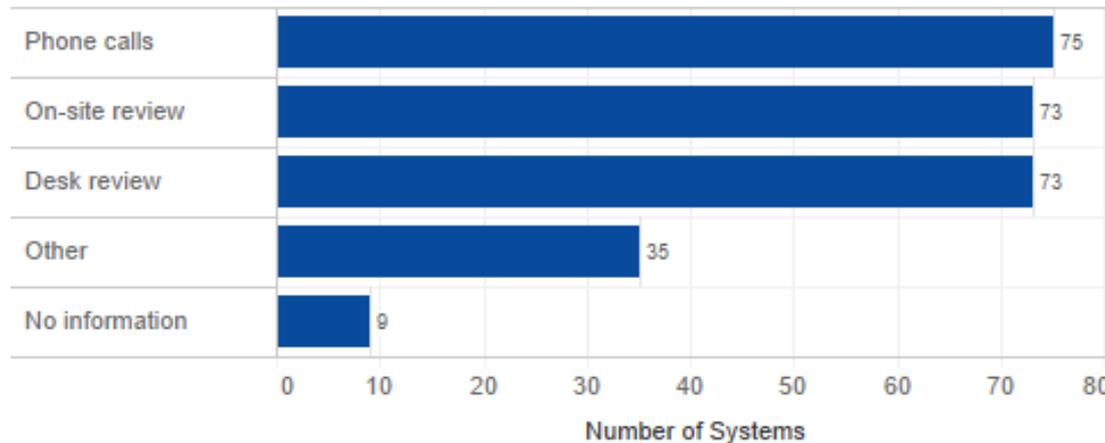
Investigation Methods

States often rely on multiple methods for conducting investigations.

- Most states' systems use a combination of desk reviews, on-site reviews, and/or phone calls to conduct investigations.
 - States frequently cited conducting meetings with provider(s) and with individuals as the most common methods used to investigate incidents.
- Only 12 of 101 systems (12 percent) use one primary method to conduct investigations.

Figure 12: Investigation Methods*

IR-6. How are investigations performed?



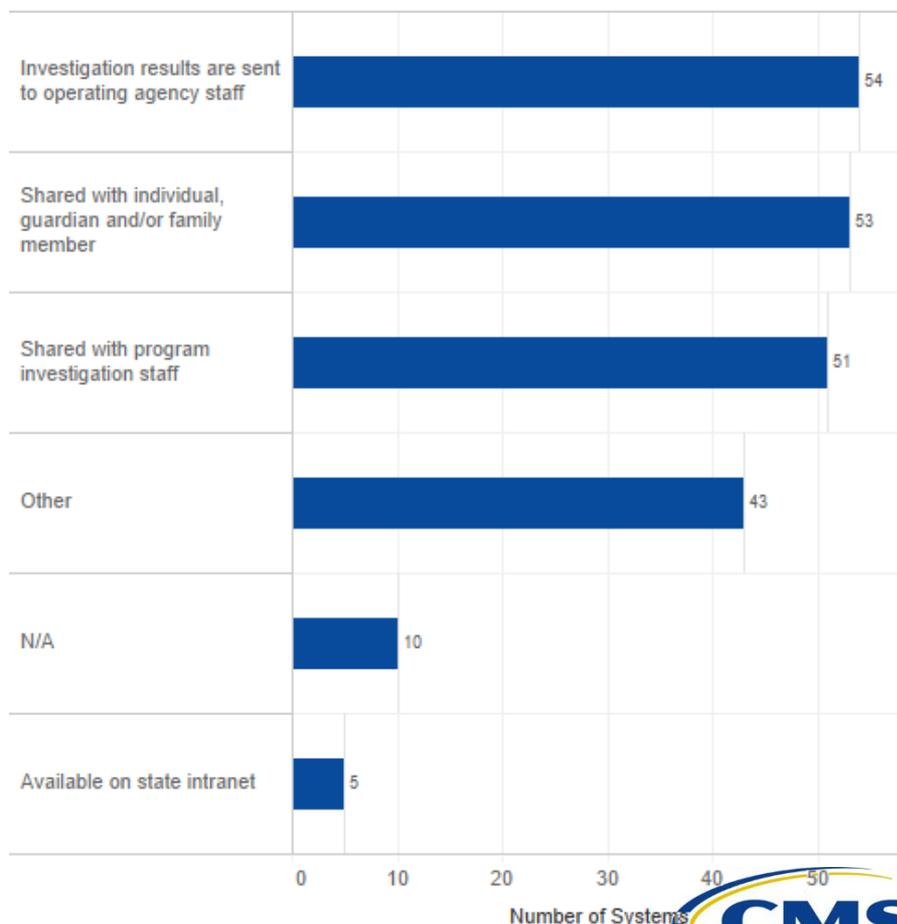
Investigation Result Sharing

Once investigations are conducted, states share results with a variety of individuals and stakeholders.

- Most states reported that investigation results were sent to OA staff, shared with participants, guardians, and/or family members, or shared with program investigation staff.

Figure 13: Communicating Investigation Results*

IR-20. How are the results of the investigation communicated?



Investigation Result Sharing with Other Entities

Though many states cited the lack of communication within and across state agencies as a barrier to incident resolution, survey results demonstrate that states are attempting to share investigation findings with other entities.

- 46 of 101 systems (46 percent) share investigation results with other branches of the SMA.
- 60 of 101 systems (59 percent) share results with provider agencies.

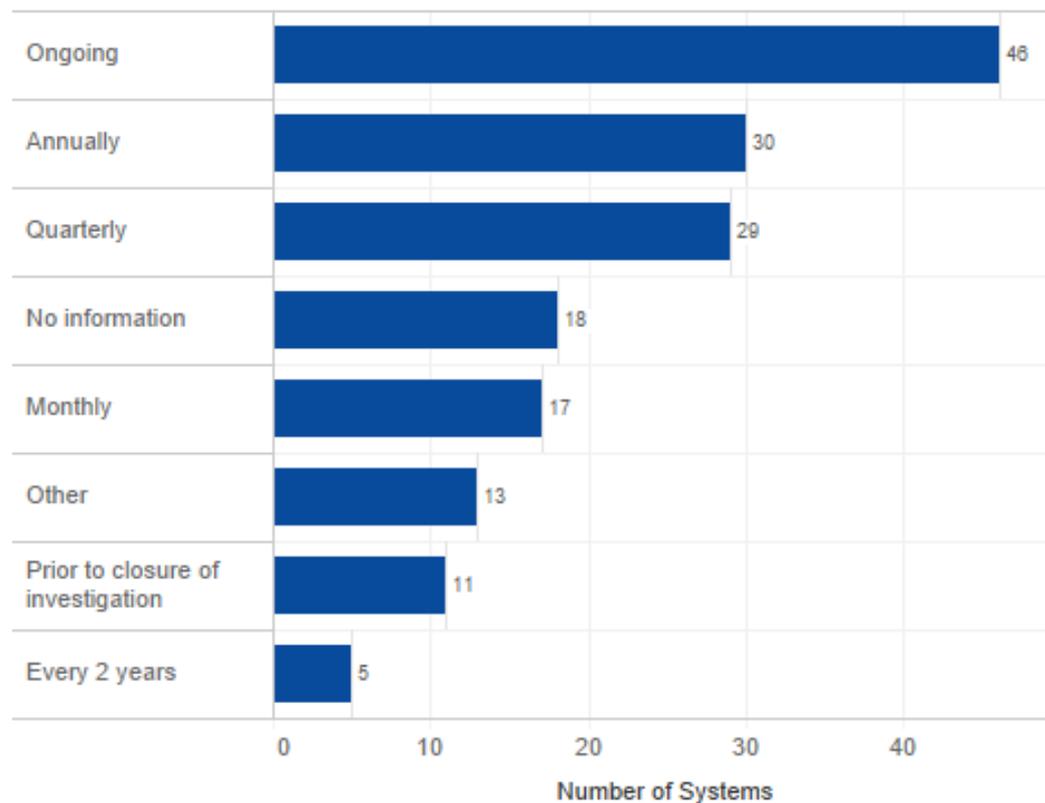
Investigation Audits

States routinely conduct audits of the investigation and/or incident resolution process to determine the efficiency and efficacy of the process.

- Survey responses indicate that states mostly conduct audits on an ongoing basis, but also incorporate routine audit checks (e.g., annually, quarterly, etc.)

Figure 14: Frequency of Audits*

IR-25. How often are audits on investigation/incident resolution processes conducted?



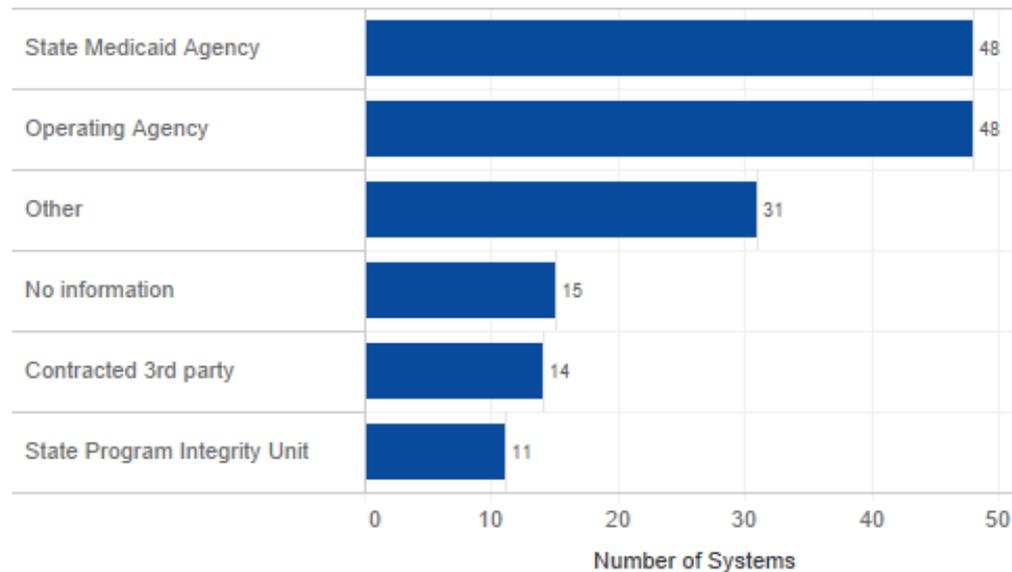
Entity Responsible for Audits

Several entities are often responsible for conducting audits regarding the investigation/incident resolution process.

- States most frequently cited the SMA and the OA to be responsible for conducting audits.

Figure 15: Entity Responsible for Conducting Audits*

IR-24. Who audits the investigation/incident resolution process?



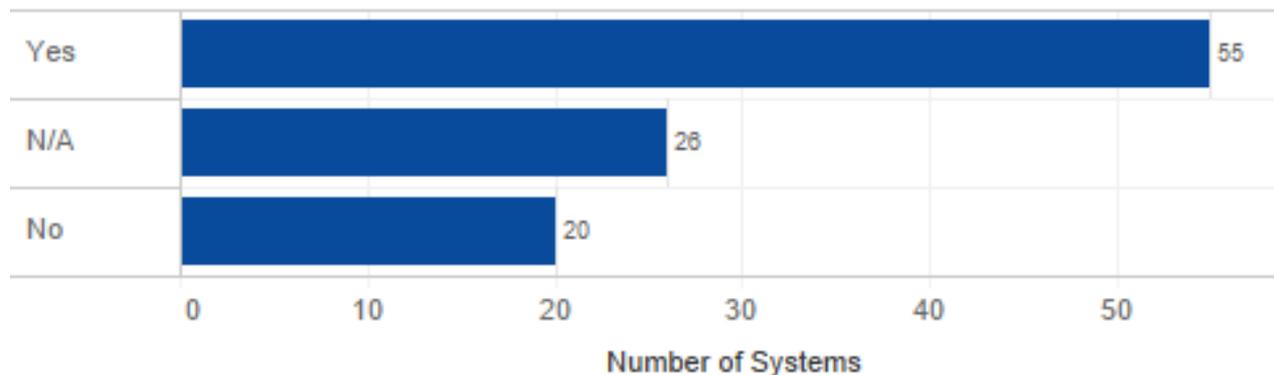
Use of Audits to Identify Unreported Incidents

States have found audits to be a good way to identify unreported incidents.

- 55 of 101 incident management systems (54 percent) reported that audit findings have resulted in identifying incidents that were not reported but should have been.

Figure 16: Audits Resulting in Identifying Unreported Incidents

IR-27. Have state audits resulted in identifying incidents that have not been reported but should have been?



Common Findings Reported by States: Technologies

Common challenges and promising practices highlighted in state survey responses demonstrate the need to streamline incident management system design and implementation.

Areas Highlighted	Challenges	Promising Practices
Technologies	<ul style="list-style-type: none">• Outdated technology platforms, with needed enhancements (e.g., upgrades to support robust reporting)• Manual processes	<ul style="list-style-type: none">• Electronic, web-based, supporting real-time notifications and tracking• System supports the ability to track and trend critical incidents

Common Findings Reported by States: Policies and Procedures

Common challenges and promising practices highlighted in state survey responses demonstrate the need to streamline incident management system design and implementation.

Areas Highlighted	Challenges	Promising Practices
Policies and Procedures	<ul style="list-style-type: none">• Staff turnover or lack of staff to assist with the incident resolution process• Need to support more timely reporting of incidents	<ul style="list-style-type: none">• Clear processes outlined for reporting, including timelines and responsibilities for individuals with access to the reporting system (e.g., State Medicaid Agency/Operating Agency staff, Adult Protective Services, etc.)• Case manager involvement and follow-up• Use of standardized forms to collect information

Common Findings Reported by States: Communication

Common challenges and promising practices highlighted in state survey responses demonstrate the need to streamline incident management system design and implementation.

Areas Highlighted	Challenges	Promising Practices
Communication	<ul style="list-style-type: none">• Lack of communication by the investigative agencies, such as law enforcement or Adult Protective Services• System not linked with other state systems, leading to the systems operating in silos and the need to consolidate information across disparate systems	<ul style="list-style-type: none">• Communication and cooperation between individuals involved in incident resolution, including between the investigative agency and State Medicaid Agency and/or Operating Agency

Summary

- Incident management is a priority for states, as evidenced by the national survey and in-depth interviews with several states.
- There is no standard definition of critical incidents at the national level.
- States have adopted different systems unique to their needs and objectives as well as their different waiver populations. As a result, most states support multiple incident management systems.
- The majority of systems use electronic, web- or cloud-based platforms to report, track, and trend critical incidents. However, some systems still employ alternative platforms such as manual or email-based systems.
- While states try to standardize how incidents are reported, there is still wide variation within and across states.

Upcoming Trainings

- Part 2 of this training series will focus on survey findings relating to quality improvement and incident management prevention.
- Part 3 of this training series will focus on CMS' recommendations for how states can improve their efforts in developing robust incident management systems.

References

1. CMS Disabled and Elderly Health Programs Group. “Application for a 1915(c) home and community-based waiver – instructions, technical guide and review criteria.” January 2015. Available online: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf>
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Questions?

For Further Information

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