Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ARKANSAS DID NOT FULLY COMPLY WITH FEDERAL AND STATE REQUIREMENTS FOR REPORTING AND MONITORING CRITICAL INCIDENTS INVOLVING MEDICAID BENEFICIARIES WITH DEVELOPMENTAL DISABILITIES

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A-06-17-01003

Office of Inspector General

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Report in Brief
Date: December 2021
Report No. A-06-17-01003

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Arkansas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities

Why OIG Did This Audit

We have performed audits in several States in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes.

Federal waivers permit States to furnish an array of home and community-based services to Medicaid beneficiaries with developmental disabilities so that they may live in community settings and avoid institutionalization. The Centers for Medicare & Medicaid Services requires States to implement a critical incident reporting system to protect the health and welfare of Medicaid beneficiaries receiving waiver services.

Our objective was to determine whether Arkansas complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings.

How OIG Did This Audit

We compared Medicaid emergency room claims with reported critical incidents to determine whether any critical incidents were unreported. We also analyzed data on critical incidents that occurred during our audit period to determine whether critical incidents were reported and followed up on in a timely manner.

What OIG Found

Arkansas did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings. Specifically, Arkansas did not: (1) ensure that community-based providers properly reported all incidents of suspected adult or child abuse to the appropriate hotline; (2) provide evidence of review and followup action on all incidents of adult or child abuse; and (3) review all deaths of beneficiaries receiving waiver services. These issues occurred because Arkansas did not have controls in place to ensure that incidents of abuse, neglect, or death were reviewed and reported to the appropriate authority. Additionally, Arkansas did not ensure that all incidents involving Medicaid beneficiaries, including incidents of death, were reported because its waiver did not clearly require that incidents that occurred outside of State custody or State facilities be reported. Also, Arkansas did not have adequate internal controls in place to detect unreported incidents.

What OIG Recommends and Arkansas Comments

We recommend that Arkansas: (1) ensure that community-based providers report all suspected adult or child abuse and neglect to the appropriate adult or child abuse hotline; (2) follow waiver guidance for incidents that appear to be abuse that require review and followup; (3) follow waiver guidance to conduct reviews of the deaths of beneficiaries receiving waiver services; (4) consider amending critical incident reporting requirements, including those related to incidents of death, to clearly apply to circumstances in which Arkansas employees or contractors are providing waiver services at a non-State facility or a private home, and a critical incident occurs; and (5) perform analytical procedures, such as data matches, on Medicaid claims data to identify potential critical incidents that have not been reported and investigate as needed. In written comments on our draft report, Arkansas concurred with our first three recommendations and outlined the corrective actions that it has taken or plans to take to address them. Regarding our fourth recommendation, Arkansas stated that all community-based providers are required to report all critical incidents involving waiver beneficiaries. Regarding our fifth recommendation, Arkansas stated that improvements to its current controls allow it to identify potential critical incidents that have not been reported and need investigation.

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INTRODUCTION

WHY WE DID THIS AUDIT

We have performed audits in several States concerning deaths and abuse of people with developmental disabilities living in group homes.[1] Originally these audits were in response to a congressional request that noted serious concerns raised by media outlets about abuse in these homes. On the basis of previous findings, the Office of Inspector General expanded on this work to ensure quality of care and patient safety.

In Arkansas, individuals with developmental disabilities may generally reside in community-based settings such as provider group homes or shared living arrangements (collectively known as "community-based providers") or in private family homes. As required by its Medicaid Home and Community-Based Services (HCBS) Waiver, the Arkansas Department of Human Services (State agency or DHS) has specified types of events—including alleged abuse and neglect—that must be reported to the State agency for review and followup action by an appropriate authority. Arkansas' waiver application refers to these events as "critical events" or "incidents" (critical incidents).

OBJECTIVE

Our objective was to determine whether the State agency complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings.

BACKGROUND

Developmental Disabilities Assistance and Bill of Rights Act of 2000

As defined by the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (the Disabilities Act),[2] "developmental disability" means a severe, chronic disability of an individual that is attributable to a mental impairment, a physical impairment, or a combination of both; is evident before the age of 22 and is likely to continue indefinitely; and results in substantial limitations in three or more major life areas: self-care, receptive and expressive language, learning, mobility, self-determination, capacity for independent living, and economic self-sufficiency.

Federal and State Governments have an obligation to ensure that public funds are provided to residential, institutional, and community providers that serve individuals with developmental

[1] See Appendix B for related Office of Inspector General reports.

[2] P.L. No. 106-402 (Oct. 30, 2000).

disabilities. Furthermore, these providers must meet minimum standards to ensure that the care they provide does not involve abuse or neglect (the Disabilities Act § 109(a)(3)).

Medicaid Home and Community-Based Services Waiver

The Social Security Act (the Act) authorizes the Medicaid HCBS waiver program (the Act § 1915(c)). The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. Waiver services complement or supplement the services that are available to participants through the Medicaid State plan and other Federal, State, and local public programs and the support that families and communities provide. Each State has broad discretion to design its waiver program to address the needs of the waiver's target population.

During our audit period, the Developmental Disabilities Services (DDS) division within the State agency administered Arkansas' HCBS waiver program. From July 2014 through June 2016 (audit period), Arkansas provided comprehensive support services to 4,346 individuals under the waiver. The DDS Quality Assurance Unit (QA Unit) ultimately oversees or performs much of the monitoring of the HCBS waiver. The QA Unit transferred from DDS to the newly created Division of Provider Services and Quality Assurance within the State agency in October 2017.[3]

States must give certain assurances to the Centers for Medicare & Medicaid Services (CMS) to receive approval for an HCBS waiver, including that necessary safeguards have been undertaken to protect the health and welfare of the beneficiaries receiving services (42 CFR § 441.302). This waiver assurance requires the State to provide specific information regarding its plan or process related to participant safeguards, which includes whether the State operates a critical event or incident reporting system (HCBS waiver, Appendix G-1). In its HCBS waiver and its own policies and procedures referenced under the waiver, the State agency stated that it has a critical event or incident reporting system.

Group homes that are owned and operated by waiver-certified providers must meet all the applicable State and Federal laws and regulations (HCBS waiver, Appendix C-2). In Arkansas, approximately 5 percent of the HCBS waiver beneficiaries lived in a group home setting during our audit period. Therefore, a majority of waiver beneficiaries were receiving services in private family homes, shared living arrangements, or day facilities. State agency employees or contractors perform waiver services provided in private family homes.

Critical Incident Reporting for Community-Based Providers

Arkansas' HCBS waiver states that the State agency must specify types of critical incidents, including abuse and neglect, that must be reported for review and followup action by an appropriate authority (HCBS waiver, Appendix G-1 (b)). The HCBS waiver also states that when

[3] The DDS QA Unit has had 100-percent staff turnover since its transfer to the Division of Provider Services and Quality Assurance.

a DDS QA staff member receives reports of certain critical incidents (defined as death, elopement, allegation of rape or severe abuse, arrest, or a natural disaster), he or she should prepare a synopsis, notify designated, pertinent upper management, and follow up as necessary, based on the circumstances surrounding the event (HCBS waiver, Appendix G-1 (d)). State agency policies specifically incorporated under the HCBS waiver further require that if a critical incident involves alleged, suspected, and witnessed adult abuse, maltreatment, or child maltreatment or severe maltreatment, the person making the report must also immediately report the incident to the appropriate adult or child abuse hotline (DHS Policy 1090 section 1090.6.1, and DDS Service Policy 3004-I section B(2)).

DDS QA Unit staff maintain an incident reporting system (IRIS) and tracks, on a monthly basis, the number of incidents that are reported. Incidents are tracked according to type of incident (critical incidents as well as other incidents such as theft). The HCBS waiver states that the DDS QA Unit must ensure that 100 percent of all incident reports received that appear to be abuse or neglect are reported to the applicable Arkansas protective agency. The HCBS waiver also states that the DDS QA Unit staff will maintain oversight by performing followup, as necessary, as indicated by the circumstances surrounding the incident and by conducting a review of the deaths of beneficiaries receiving waiver services. In the event State agency employees or contractors fail to notify proper authorities, such as the Adult Protective Services Hotline or Child Abuse Hotline, the DDS QA Investigator will ensure that the notifications are made immediately (HCBS waiver, Appendix G-1(d) and (e) and Appendix G: *Participant Safeguards*).

HOW WE CONDUCTED THIS AUDIT

We identified 6,640 incidents involving waiver beneficiaries from July 2014 through June 2016 (audit period). State agency employees or contractors classified 583 of these incidents as suspected abuse and neglect and 88 as a death. We reviewed all 583 incidents of suspected abuse and neglect. Of these 583 incidents of suspected abuse and neglect, State agency employees or contractors reported 513 incidents to authorities. We selected a sample of 51 of the 513 incidents reported to authorities through the Adult Protective Services Hotline or Child Abuse Hotline to determine the followup action taken by the DDS QA Unit. We reviewed all 88 incidents of death during our audit period. We requested evidence of followup by the State agency for 23 of the 88 incidents of death that did not have a death date listed in the State agency records to determine whether the State agency reviewed deaths of beneficiaries receiving waiver services. The State agency maintained records of these incidents in the IRIS system.

We obtained 2,366 emergency room claims from the Arkansas Medicaid Management Information System (MMIS) that the State agency paid on behalf of Medicaid beneficiaries with developmental disabilities covered by the HCBS waiver during our audit period. We analyzed the claims data and identified 346 claims associated with 142 diagnosis codes that we

determined were associated with a high likelihood that a critical incident had occurred.[4] We then compared these 346 claims with the State agency's reported 6,640 incidents and determined that potential critical incidents associated with 121 claims were not reported to the State agency.

Of the 121 claims, we judgmentally selected 31 claims for further review to determine whether each claim represented a critical incident. This additional review included requesting the medical records to support the claim or asking the community-based provider to review the claim and determine whether it was for a critical incident.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology. Appendix D contains details on the Federal waiver and State requirements relevant to our findings.

FINDINGS

The State agency did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings. Specifically, the State agency did not:

- ensure that community-based providers properly reported all incidents of suspected adult or child abuse to the appropriate hotline,
- provide evidence of review and followup action on incidents of adult or child abuse, and
- review all deaths of beneficiaries who received waiver services.

The State agency did not have controls in place to ensure that incidents of abuse, neglect, or death were reviewed and reported to the appropriate authority. As a result, the State agency did not fulfill various participant safeguard assurances it gave to CMS in its HCBS waiver.

Additionally, the State agency did not ensure that all incidents involving Medicaid beneficiaries, including incidents of death, were reported because its waiver did not clearly require that incidents that occurred outside of State agency custody or State agency facilities be reported.

[4] Appendix C contains a list of the high-risk diagnosis codes associated with unreported critical incidents and the number of claims and beneficiaries associated with each code. These diagnosis codes, such as codes for head injuries, bodily injuries, sexual trauma, and neglect (e.g., bed sores and dehydration), indicate an increased likelihood of abuse or neglect.

Also, the State agency did not have adequate internal controls in place to detect unreported incidents.

THE STATE AGENCY DID NOT ENSURE THAT COMMUNITY-BASED PROVIDERS PROPERLY REPORTED ALL INCIDENTS OF ADULT OR CHILD ABUSE OR NEGLECT TO THE APPROPRIATE HOTLINE

Community-based providers in Arkansas are required to report to the State agency critical incidents involving Medicaid beneficiaries with developmental disabilities (HCBS waiver, Appendix G-1 (b)). State agency policies specifically incorporated under the HCBS waiver further require that if the critical incident involves suspected adult abuse, maltreatment (which we refer to as "neglect"), or child maltreatment or severe maltreatment, the person making the report must also immediately report the incident to the appropriate adult or child abuse hotline (DHS Policy 1090 section 1090.6.1 and DDS Service Policy 3004-I sections (4) and B(2)).

Community-based providers did not report all incidents of suspected adult or child abuse to the appropriate hotline. Specifically, we identified 583 incident reports for waiver beneficiaries that were reported to the State agency as suspected abuse or neglect. Of these 583 abuse and neglect incidents, State agency staff or contractors reported 513 to the adult or child abuse hotline but did not report 70 incidents to the adult or child abuse hotline. Although community-based providers reported most incidents of suspected abuse and neglect to the appropriate hotline, the HCBS waiver and State agency policies under the waiver require that all of these incidents be reported.

The State agency did not have internal controls in place to ensure that all incidents of suspected abuse and neglect were reported to the adult or child abuse hotline. As a result, the proper authority could not investigate and take appropriate action to protect the health and safety of Medicaid beneficiaries with developmental disabilities. In addition, the State agency did not fully comply with all safeguard assurances it provided to CMS in the HCBS waiver.

THE STATE AGENCY DID NOT PROVIDE EVIDENCE OF REVIEW AND FOLLOWUP ACTION ON INCIDENTS OF ADULT OR CHILD ABUSE

The HCBS waiver states that the DDS QA Unit ensures that 100 percent of incidents that appear to involve abuse or neglect are reported to the applicable Arkansas protective agency. The HCBS waiver also states that when a DDS QA staff member receives a report of a certain critical incident (defined as a death, elopement, allegation of rape or severe abuse, arrest, or natural disaster), he or she should prepare a synopsis, notify designated, pertinent upper management staff and follow up as necessary, based on the circumstances surrounding the event (HCBS waiver, Appendix G-1 (d)).[5]

[5] The State agency did not classify reported incidents of abuse by the severity of abuse. The State agency classified reported incidents of abuse as suspected abuse or suspected abuse by staff.

We selected a sample of 51 of the 513 incidents of adult or child abuse reported to authorities to determine the followup action taken by the DDS QA Unit. For our sample of 51 incidents of adult or child abuse reported to authorities, we were unable to determine whether the DDS QA Unit reviewed these incidents and provided followup. State agency officials stated that in October 2017, the DDS QA Unit was transferred to the newly created Division of Provider Services and Quality Assurance. The officials added that they could not locate any investigative or other files that would support followup by the DDS QA Unit.

As a result, we were unable to determine whether the State agency fully complied with all safeguard assurances it provided to CMS in the HCBS waiver to ensure the health and welfare of Medicaid beneficiaries.

THE STATE AGENCY DID NOT REVIEW ALL DEATHS OF BENEFICIARIES WHO HAD BEEN RECEIVING WAIVER SERVICES

The HCBS waiver states that when the DDS QA Unit receives an incident report regarding a death, that information is shared with the Division of Medical Services (DMS) Quality Assurance section, and DDS maintains oversight of critical events by conducting reviews of the deaths of persons who had been receiving waiver services. The HCBS waiver states that DDS Policy 3018, Mortality Review of Deaths of Persons Receiving Alternative Community Services Waiver Services, describes the procedures for reviewing the circumstances surrounding the death of an individual (HCBS waiver, Appendix G-1(d) and (e)). DDS Policy 3018 defines a record as "the written or electronic file containing information pertaining to the individual, including relevant facts, dates, and actions taken related to the individual" and states that a preliminary review of a death will occur to designate the death as expected, unexpected, or unexplained.

We identified 88 waiver beneficiaries with an incident report of death during our audit period. Of these 88 beneficiaries, 23 did not have a death date listed in the State agency records. We requested evidence of followup by the State agency for the 23 unrecorded deaths. The State agency could not provide evidence that these 23 deaths underwent preliminary review.

These reporting errors occurred because the State agency did not have internal controls in place to ensure that all incidents of death were reviewed and the date of death was recorded in the State system. As a result, the State agency cannot identify issues and take appropriate action to protect the health and welfare of other beneficiaries.

THE STATE AGENCY DID NOT HAVE WAIVER REQUIREMENTS TO FULLY PROTECT THE HEALTH AND WELFARE OF MEDICAID BENEFICIARIES RECEIVING SERVICES OUTSIDE OF STATE AGENCY FACILITIES

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements," and DHS policy 1090 specify the types of critical events or incidents (including alleged abuse or neglect) that the State requires to be reported for review and followup action by an appropriate authority

required to report such events. Section b(5)(a) of the waiver and DHS policy 1090 specifically include death as a reportable event.

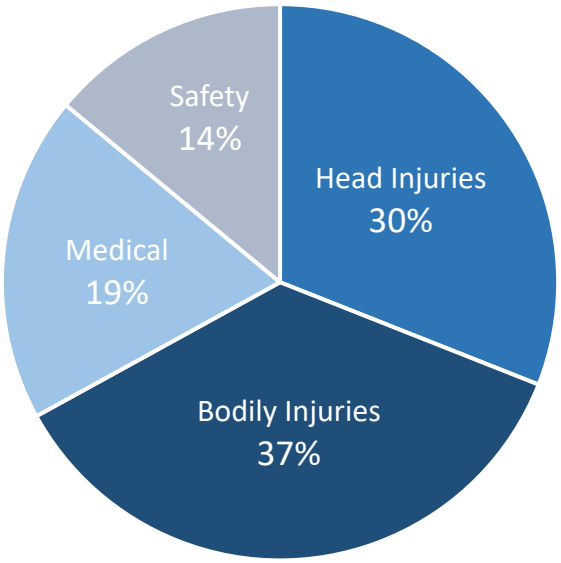
The requirement to report critical incidents including deaths under the HCBS waiver and DHS policy 1090 does not apply to individuals other than State agency employees or contractors. DHS policy 1090, which is specifically incorporated under the HCBS waiver, generally defines critical incidents as incidents involving beneficiaries: (1) in State agency custody; (2) at a State agency office, institution, or facility; or (3) caused or done by an on-duty State agency employee. This policy defines State agency custody as "a legal custody order or circumstances in which a person is subject to actual care and control of DHS, such as persons residing in Human Development Centers or other [State agency] facilities."

In addition, the HCBS waiver and DHS policy 1090 are unclear as to whether the reporting requirement applies to State agency employees or contractors who are providing waiver services when the critical incident occurs at a non-State facility or a private home.

Thirty-five percent (121 of 346) of emergency room claims indicative of critical incidents were not reported to the State agency through IRIS. However, we determined that most of the 121 incidents occurred while the beneficiary was at a private family home and/or with a family member or legal guardian, so it appeared that they were not explicitly required to be reported under the HCBS waiver and applicable State policy referenced under the waiver.[6] The Figure (next page) summarizes by diagnosis code category the incidents associated with the 121 emergency room claims.

[6] Group homes that are owned and operated by waiver-certified providers must meet all the applicable State and Federal laws and regulations (HCBS waiver, Appendix C-2). In Arkansas, approximately 5 percent of the HCBS waiver beneficiaries lived in a group home setting during our audit period. Therefore, a majority of waiver beneficiaries were receiving services in private family homes, shared living arrangements, or day facilities.

Figure: The 121 Incidents by Diagnosis Code Category



Additionally, each of 79 waiver beneficiaries had a date of death on record with the State during our audit period. Of these 79 beneficiaries, 16 percent (13 of 79) of the beneficiaries' deaths were not reported to the State through IRIS. However, we could not determine where the deaths occurred.

As a result of not ensuring that all incidents that signified potential harm to Medicaid beneficiaries under the HCBS waiver were reported and responded to, the State agency may not have ensured that the health and welfare of Medicaid waiver beneficiaries were protected.

RECOMMENDATIONS

We recommend that the Arkansas Department of Human Services:

- ensure that community-based providers report all suspected adult or child abuse and neglect to the appropriate adult or child abuse hotline;

- follow waiver guidance for incidents that appear to be abuse that require review and followup;

- follow waiver guidance to conduct reviews of the deaths of beneficiaries receiving waiver services;

- consider amending critical incident reporting requirements, including those related to incidents of death, to clearly apply to circumstances in which State agency employees or contractors are providing waiver services at a non-State facility or a private home, and a critical incident occurs; and

- perform analytical procedures, such as data matches, on Medicaid claims data to identify potential critical incidents that have not been reported and investigate as needed.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our first three recommendations but did not concur with our fourth and fifth recommendations.

The State agency outlined the corrective actions that it has taken and plans to take to address the first three recommendations. These actions include monitoring all community-based providers to improve compliance with provider incident reporting requirements; providing additional training to providers on incident reporting; performing a monthly review to ensure that all incident reports have been appropriately reviewed; performing a review of all deaths of beneficiaries who were receiving developmental disability waiver services, which includes a death match to identify beneficiary deaths that may not have been reported; and performing a review of the specific circumstances of the deaths that are designated as unexplained or unexpected.

Regarding our fourth recommendation, the State agency stated that all community-based providers and the State agency are required to report all critical incidents involving waiver beneficiaries that occur while receiving waiver services, including waiver services that are received in a private home or non-State facility.

Regarding our fifth recommendation, the State agency stated that, as an alternative, the improvements to current controls allow the State agency to identify potential critical incidents that have not been reported and need investigation. The State agency said that care coordinators are required to follow up with each beneficiary after a visit to an emergency room or discharge from a hospital or inpatient psychiatric unit and must provide a quarterly report on this activity to the State agency to review for compliance with incident reporting requirements.

The State agency's comments appear in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding our fourth recommendation, after we issued our draft report the State agency provided a copy of its current Provider-Led Arkansas Shared Savings Entity (PASSE) Provider Agreement, which addresses critical incident reporting involving waiver beneficiaries, and stated that these requirements do not limit reporting to specific locations in which an incident may occur. We acknowledge that these State agency requirements may not limit reporting to specific locations. However, there is still some ambiguity, since neither the PASSE Provider Agreement nor the waiver's critical incident reporting requirements that applied to our audit

explicitly state that incidents that occur in a private home or non-State facility must be reported. Thus, we still recommend amending these requirements to be explicit, and therefore clearer, that they apply to circumstances in which State agency employees or contractors are providing waiver services at a non-State facility or a private home, and a critical incident occurs.

Regarding our fifth recommendation, we have not performed a review of the State agency's improvements to current controls that allow it to identify potential critical incidents. However, we acknowledge that the State agency's improvements to current controls may address our recommendation.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From July 2014 through June 2016, the State agency provided waiver services to 4,346 Medicaid beneficiaries with developmental disabilities. During this period, the State agency reported 6,640 incidents for waiver beneficiaries. The State agency employees or contractors classified 583 of these incidents as suspected abuse and neglect and 88 as a death. We obtained and analyzed 2,366 emergency room claims that the State agency paid on behalf of waiver beneficiaries and identified 142 diagnosis codes associated with a high likelihood that a critical incident had occurred. We identified 346 claims that contained at least 1 of these diagnosis codes. (We considered these claims to be indicative of a critical incident.) We then compared these 346 claims with the State agency's reported 6,640 incidents and identified 121 claims associated with potential critical incidents that were not reported to the State agency.

Our objective did not require an understanding of all the State agency's internal controls. We limited our internal control review to obtaining an understanding of the State agency's policies and procedures related to its critical incident reporting and monitoring.

We performed our audit work from May 2017 through May 2021.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal waiver and State requirements;
- held discussions with State agency officials to gain an understanding of State agency policies and controls related to reporting critical incidents involving beneficiaries with developmental disabilities;
- obtained from the State agency a file of all Medicaid beneficiaries with developmental disabilities residing in community-based settings during our audit period;
- obtained from the MMIS a file containing 2,366 emergency room medical claims;
- obtained from the State agency's IRIS system a computer-generated file of incident report data, which included 6,640 incidents associated with Medicaid beneficiaries residing in community-based settings during our audit period;
- identified 583 incidents classified as suspected abuse and neglect and 88 incidents classified as a death during our audit period;

- identified 513 of the 583 incidents of suspected abuse and neglect that were reported to authorities by State agency employees or contractors;

- judgmentally selected 51 of the 513 incidents of adult or child abuse reported to authorities to determine the followup action taken by the DDS QA Unit;

- identified 23 beneficiaries from the 88 incidents of death that did not have a death date listed in the State agency records and requested evidence of followup by the State agency for the 23 unrecorded deaths;

- identified 346 claims that contained 1 of the 142 diagnosis codes that were indicative of a critical incident;

- compared incident report data with the 346 claims containing high-risk diagnosis codes and identified 121 claims that may not have been reported as critical incidents to the State agency;

- judgmentally selected for further review 31 of the 121 claims that may not have been reported as critical incidents to the State agency to determine whether each claim represented an unreported critical incident;[7]

- reviewed medical records for the 31 judgmentally selected claims or asked the community-based provider to determine whether the claim was associated with an unreported critical incident; and

- discussed the results of our audit with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[7] We judgmentally selected claims that included certain diagnosis codes, such as those related to physical and sexual abuse as well as those related to fractures, contusions, and open wounds.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
California Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-09-19-02004	9/22/2021
Louisiana Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-06-17-02005	5/5/2021
New York Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-02-17-01026	2/16/2021
Texas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-06-17-04003	7/9/2020
Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities	A-07-18-06081	3/27/2020
Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-03-17-00202	1/17/2020
A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect	A-01-19-00502	7/23/2019
Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-09-17-02006	6/11/2019
Joint Report: Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight	Joint Report[8]	1/17/2018
Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-01-16-00001	8/9/2017
Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00008	7/13/2016
Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00002	5/25/2016

[8] This report was jointly prepared by the Department of Health and Human Services, Office of Inspector General; Administration for Community Living; and Office for Civil Rights.

APPENDIX C: DIAGNOSIS CODES ASSOCIATED WITH UNREPORTED CRITICAL INCIDENTS

Category	Diagnosis Code	Description	No. of Claims	No. of Beneficiaries
Head Injuries				
1	7842	Swelling, mass, or lump in head and neck	1	1
2	8730	Open wound of scalp, without mention of complication	2	2
3	87342	Open wound of forehead, without mention of complication	4	4
4	87343	Open wound of lip, without mention of complication	1	1
5	87344	Open wound of jaw, without mention of complication	1	1
6	87349	Open wound of other and multiple sites of face, without mention of complication	1	1
7	9100	Abrasion or friction burn of face, neck, and scalp except eye, without mention of infection	1	1
8	920	Contusion of face, scalp, and neck except eye(s)	8	8
9	95901	Head injury, unspecified	6	6
10	R220	Localized swelling, mass and lump, head	1	1
11	S0003XA	Contusion of scalp, initial encounter	1	1
12	S0101XA	Laceration without foreign body of scalp, initial encounter	1	1
13	S0101XD	Laceration without foreign body of scalp, subsequent encounter	1	1
14	S0121XA	Laceration without foreign body of nose, initial encounter	1	1
15	S060X0A	Concussion without loss of consciousness, initial encounter	1	1
16	S0990XA	Unspecified injury of head, initial encounter	5	5
Category Subtotals			**36**	**36**

Category	Diagnosis Code	Description	No. of Claims	No. of Beneficiaries
Bodily Injuries				
1	81200	Closed fracture of unspecified part of upper end of humerus	1	1
2	81209	Other closed fracture of upper end of humerus	1	1
3	82380	Closed fracture of unspecified part of tibia alone	1	1
4	8248	Unspecified fracture of ankle, closed	2	2
5	83104	Closed dislocation of acromioclavicular (joint)	1	1
6	83500	Closed dislocation of hip, unspecified site	1	1
7	8363	Dislocation of patella, closed	2	2
8	8820	Open wound of hand except finger(s) alone, without mention of complication	3	3
9	8821	Open wound of hand except finger(s) alone, complicated	1	1
10	8830	Open wound of finger(s), without mention of complication	1	1
11	8910	Open wound of knee, leg (except thigh), and ankle, without mention of complication	2	2
12	8920	Open wound of foot except toe(s) alone, without mention of complication	2	2
13	8930	Open wound of toe(s), without mention of complication	2	2
14	9221	Contusion of chest wall	1	1
15	92311	Contusion of elbow	1	1
16	92320	Contusion of hand(s)	2	2
17	92401	Contusion of hip	1	1
18	92421	Contusion of ankle	1	1
19	9243	Contusion of toe	2	2
20	9245	Contusion of unspecified part of lower limb	1	1
21	S20219A	Contusion of unspecified front wall of thorax, initial encounter	1	1
22	S301XXS	Contusion of abdominal wall, sequela	1	1

Category	Diagnosis Code	Description	No. of Claims	No. of Beneficiaries
23	S40012A	Contusion of left shoulder, initial encounter	1	1
24	S52502A	Unspecified fracture of the lower end of left radius, initial encounter for closed fracture	1	1
25	S60212A	Contusion of left wrist, initial encounter	1	1
26	S60221A	Contusion of right hand, initial encounter	1	1
27	S61242A	Puncture wound with foreign body of right middle finger without damage to nail, initial encounter	1	1
28	S61411A	Laceration without foreign body of right hand, initial encounter	1	1
29	S7002XA	Contusion of left hip, initial encounter	1	1
30	S71111A	Laceration without foreign body, right thigh, initial encounter	1	1
31	S73101A	Unspecified sprain of right hip, initial encounter	1	1
32	S81802A	Unspecified open wound, left lower leg, initial encounter	1	1
33	S82201A	Unspecified fracture of shaft of right tibia, initial encounter for closed fracture	1	1
34	S83005A	Unspecified dislocation of left patella, initial encounter	1	1
35	S90121A	Contusion of right lesser toe(s) without damage to nail, initial encounter	1	1
36	S92411A	Displaced fracture of proximal phalanx of right great toe, initial encounter for closed fracture	1	1
Category Subtotals			**45**	**45**
Medical				
1	485	Bronchopneumonia, organism unspecified	1	1
2	486	Pneumonia, organism unspecified	12	11
3	J151	Pneumonia due to Pseudomonas	1	1
4	J189	Pneumonia, unspecified organism	9	9

Category	Diagnosis Code	Description	No. of Claims	No. of Beneficiaries
Category Subtotals			**23**	**22**
Safety				
1	9331	Foreign body in larynx	2	2
2	94526	Blisters, epidermal loss (second degree) of thigh (any part)	1	1
3	9623	Poisoning by insulins and antidiabetic agents	1	1
4	R45851	Suicidal ideations	7	5
5	T433X2A	Poisoning by phenothiazine antipsychotics and neuroleptics, intentional self-harm, initial encounter	1	1
6	T484X1A	Poisoning by expectorants, accidental (unintentional), initial encounter	1	1
7	V6284	Suicidal ideation	3	3
8	V716	Observation following other inflicted injury	1	1
Category Subtotals			**17**	**15**
Subtotals			**121**	**118**
		Seven beneficiaries with more than one diagnosis code		(7)
TOTALS			**121**	**111**

APPENDIX D: FEDERAL WAIVER AND STATE REQUIREMENTS

MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER

States must provide certain assurances to CMS to receive approval for an HCBS waiver, including that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the service (42 CFR § 441.302). The State agency must provide CMS with information regarding these participant safeguards in the HCBS waiver, Appendix G, *Participant Safeguards*. A State must provide assurances regarding three main categories of safeguards:

- response to critical events or incidents (including alleged abuse or neglect),
- safeguards concerning restraints and restrictive interventions, and
- medication management and administration.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements"

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements," specifies the types of critical events or incidents (including alleged abuse or neglect) that the State requires to be reported for review and followup action by an appropriate authority and the individuals and/or entities that are required to report such events. The waiver states that the DHS Incident Reporting Policy 1090 and DDS Certification Standards for ACS Waiver Services, section 406, describe the requirements for reporting incidents. Those documents require that the following incidents must be reported:

- adult abuse and neglect;
- child maltreatment and severe maltreatment;
- disturbance (meaning any situation in which a State agency client, employee, or member of the general public engage in threatening or disruptive behavior of such a nature that it causes fear of imminent injury or destruction of property);
- serious or significant injuries;
- death;
- threatened or attempted suicide of a person in State agency custody;

- arrest or conviction of a person in State agency custody or a State agency employee while on duty;

- any situation in which the location of any person in State agency custody is unknown and cannot be determined within 2 hours;

- any crime committed at a State agency office, institution, or facility;

- any communicable disease resulting in quarantine or closing of a State agency facility; and

- any condition or event that prevents the delivery of State agency services for more than 2 hours.

This section of the waiver states that failure to report to appropriate hotlines may also be a criminal offense under Arkansas law.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(d), "Responsibility for Review of and Response to Critical Events or Incidents"

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(d), "Responsibility for Review of and Response to Critical Events or Incidents," specifies that when the DDS QA unit receives an incident report regarding a death or a sentinel event, that information is shared with the DMS Quality Assurance section. DDS Policy 3018, Mortality Review of Deaths of Persons Receiving Alternative Community Services Waiver Services, describes the procedures for review of the circumstances surrounding the death of an individual.

Section (d) also states that when DDS QA staff receives a report of a critical incident (defined as death, elopement, allegation of rape or severe abuse, arrest, or natural disaster) they prepare a synopsis and notify designated, pertinent upper management staff. The DDS QA staff perform followup as necessary as dictated by the circumstances surrounding the incident.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(e), "Responsibility for Oversight of Critical Incidents and Events"

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(e), "Responsibility for Oversight of Critical Incidents and Events," states that DDS is responsible for overseeing the reporting of and response to incidents. This section of the waiver further states that DDS Certification Standards for ACS Waiver Services require that all providers report specified incidents or events to the DDS QA Unit. QA Unit staff review each incident within 1 business day of their receipt of a report. The QA Unit staff perform followup as necessary as indicated by the circumstances surrounding the incident. DDS also maintains

oversight of critical events by conducting a review of the deaths of persons receiving waiver services.

ARKANSAS REQUIREMENTS REGARDING REPORTABLE INCIDENTS

Arkansas DHS Service Policy 1090, Incident Response

Incidents that may affect the health and safety of State agency clients, employees, volunteers, visitors, and others on DHS premises or while receiving DHS services, and occurrences that interrupt or prevent the delivery of DHS services, must be reported.

DHS policy 1090 generally defines critical incidents as incidents involving beneficiaries: (1) in State agency custody; (2) at a State agency office, institution, or facility; or (3) caused or done by an on-duty State agency employee.

1090.1.1 DHS Custody: For purposes of this rule, DHS custody includes a legal custody order or circumstances in which a person is subject to actual care and control of DHS, such as persons residing in Human Development Centers or other DHS facilities.

1090.2.1. Any DHS employee or contractor who is aware of facts and circumstances that would cause a reasonable person to suspect that an incident took place must report that incident.

1090.6.1. If the incident involves adult abuse, neglect, or child maltreatment or severe maltreatment, the employee must also report the incident to the appropriate adult or child abuse hotline immediately. Any employee who is uncertain about whether the incident falls within these categories must notify the appropriate hotline.

Arkansas DDS Administrative Policy 3004-I, Maltreatment Prohibition, Prevention, Reporting, and Investigation

Each facility shall do all that is within its control to prevent occurrences of maltreatment and to report and investigate maltreatment when it occurs. This policy establishes a maltreatment prohibition protocol and defines responsibilities for reporting and investigating alleged, suspected, and witnessed maltreatment of individuals served by DDS.

Compliance with this policy is the responsibility of all facility staff, clients, consultants, volunteers, staff of other agencies serving the client, family members, legal guardians, friends, or other individuals. The following are the policy's reporting standards:

1. All alleged, suspected, and witnessed maltreatment will be immediately reported by all individuals having knowledge of the alleged incident to the on-site administrator.

2. All alleged, suspected, and witnessed maltreatment will be immediately reported to the appropriate abuse reporting hotlines by the on-site administrator. NOTE: Nothing in this policy removes the right and obligation of a mandated reporter to immediately report an incident directly to the appropriate abuse reporting hotline, as well as to the on-site administrator.

3. Reporting shall not be delayed for any type of investigation.

4. Incidents shall be reported in accordance with DHS Policy 1090, Incident Reporting, and the DHS Incident Reporting and Information System (IRIS).

5. Reports of allegations shall also be made by telephone or fax by the on-site administrator/designee to local law enforcement where the facility is located and to the individual's parent/guardian/advocate.

6. Incidents which are not specifically defined in statute as abuse but which have or may have a negative impact on clients shall be reported as noted in item 4 above. An example would be one or more acts of discourteous treatment by an employee, as defined in DHS Policies 1084 and 1085, Minimum Conduct Standards.

Arkansas DDS Administrative Policy 3018, Mortality Review of Deaths of Persons Receiving Alternative Community Services Waiver Services

The intent of the review is to facilitate a better understanding of factors contributing to deaths and to develop enhanced strategies for addressing preventable deaths, developing recommendations for appropriate care, and, ultimately, to prevent the occurrence of future preventable deaths.

During the Preliminary Review, the Review Team will analyze the information regarding a reviewable death to determine whether they will designate the death expected, unexpected, or unexplained. A reviewable death is defined as the death of a person who is receiving waiver services, whose waiver status is in abeyance, or whose waiver status had been closed within 60 days before his or her death.

APPENDIX E: STATE AGENCY COMMENTS

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Office of Security & Compliance

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501-682-8849 · Fax: 501-682-8646 · TDD: 501-682-8933

September 15, 2021

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

Re: Response to Report Number A-06-17-01003

Dear Ms. Wheeler,

The Arkansas Department of Human Services has reviewed the recommendations in the Office of Inspector General draft for Report Number A-06-17-01003 and has the following response.

1) DHS concurs with this recommendation. All community-based providers are being monitored as part of a PASSE effort to improve compliance with provider incident reporting requirements. In coordination with the PASSE, DHS will also provide additional training to providers on incident reporting.

   Note: The PASSE (Provider-Led Arkansas Share Savings Entity) is responsible for organizing and managing delivery of services for Medicaid beneficiaries with specific medical needs which includes developmental and intellectual disabilities.

2) DHS concurs with this recommendation. DDS operational procedures require review and evaluation of incidents defined as reportable. DDS currently performs a monthly review to ensure all incident reports have been appropriately reviewed.

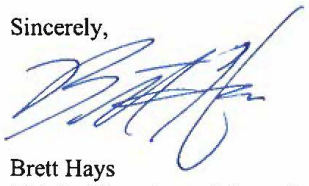
3) DHS concurs with this recommendation. The DDS Mortality Review Subcommittee currently reviews all deaths of members that are receiving developmental disability waiver services. Further, DDS utilizes a death match to identify DDS Waiver benefit member deaths that may have not been reported. DDS also convenes a Mortality Review Committee to review the specific circumstances of the deaths of clients receiving waiver services that are designated as unexplained or unexpected.

4) DHS does not concur with this recommendation. All community-based providers, PASSE's, and the agency are required to report all critical incidents involving waiver beneficiaries that occur while receiving waiver services. This includes waiver services that are received in a private home or non-State facility.

5) DHS does not concur with this recommendation. As an alternative, DDS believes that improvements to current controls allow the agency to identify potential critical incidents that have not been reported and need investigation. PASSE Care Coordinators are required to follow up with members after a visit to an emergency room or discharge from a hospital or inpatient psychiatric unit and must provide a quarterly report on this activity to DHS. DHS will begin reviewing these reports for compliance with incident reporting requirements.

Please contact me if you have any questions about the response or stated corrective action plan.

Sincerely,



Brett Hays
Chief of Security and Compliance
Arkansas Department of Human Services