

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Christi A. Grimm
Principal Deputy Inspector General**

**July 2020
A-06-17-04003**

Office of Inspector General

<https://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Report in Brief

Date: July 2020

Report No. A-06-17-04003

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



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. CMS 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 Texas complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings from January through December 2016.

How OIG Did This Audit

We reviewed Texas' compliance with waiver requirements, including beneficiary death reporting and review; consumer rights complaint tracking; and tracking of allegations of abuse, neglect, and exploitation.

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

What OIG Found

Texas did not ensure that all beneficiary deaths were reported and reviewed; that all complaints not closed within 10 days were tracked; and that all allegations of abuse, neglect, and exploitation were entered into the Human Services Enterprise Administration Reporting and Tracking (HEART) system. Texas had a procedure to detect unreported deaths but was not following it, did not have a system in place to track complaints not closed within 10 days, and did not have procedures to ensure that allegations were entered into the HEART system.

What OIG Recommends and Texas Comments

We recommend that Texas (1) ensure that procedures are followed to detect unreported deaths; (2) implement a system to ensure that it can track complaints not closed within 10 days; and (3) implement procedures to ensure that investigations of abuse, neglect, and exploitation are entered in the HEART system.

In written comments on our draft report, Texas concurred with our findings and recommendations and described actions that it has taken or plans to take to address them. These actions include increasing the frequency of comparing deaths reported by the provider to death reports from the CARE system, implementing a new system to monitor unreported deaths, and issuing violations and administrative penalties for failure to report deaths.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Audit	1
Objective	1
Background	1
Developmental Disabilities Assistance and Bill of Rights Act of 2000	1
Medicaid Home and Community-Based Services Waiver	2
Critical Incident Reporting and Monitoring	2
How We Conducted This Audit	3
FINDINGS	4
The State Agency Did Not Ensure That All Beneficiary Deaths Were Reported and Reviewed	4
The State Agency Did Not Ensure That All Complaints Not Closed Within 10 Days Were Tracked	5
The State Agency Did Not Ensure That All Abuse, Neglect, and Exploitation Cases Were Entered Into the Health and Human Services Enterprise Administration Reporting and Tracking System.....	6
RECOMMENDATIONS	6
STATE AGENCY COMMENTS	6
APPENDICES	
A: Audit Scope and Methodology	7
B: Related Office of Inspector General Reports.....	9
C: Federal Waiver and State Requirements.....	10
D: State Agency Comments	12

INTRODUCTION

WHY WE 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.¹ This request was made in response to nationwide media coverage of deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors.

In Texas, individuals with developmental disabilities may reside in a variety of residential settings, including an individual's own home or family home, a host home or companion care setting, or a three- or four-person group home setting. Within community-based settings, provider types include, but are not limited to, group-home workers, care coordinators, and family members responsible for the care of beneficiaries (collectively known as community-based providers).

OBJECTIVE

Our objective was to determine whether the Texas Health and Human Services Commission (State agency) complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings from January through December 2016 (audit period).

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 attributable to a mental or physical impairment or a combination of both, evident before age 22, and likely to continue indefinitely. The disability results in substantial limitations in three or more major life areas, defined as 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-based providers that serve individuals with developmental disabilities. Further, these providers must meet minimum standards to ensure that the care they provide does not involve abuse, neglect, sexual exploitation, or violations of legal and human rights (the Disabilities Act § 109(a)(3)).

¹ See Appendix B for a list of related work.

² P.L. No. 106-402 (Oct. 30, 2000).

Medicaid Home and Community-Based Services Waiver

The Social Security Act (the Act) authorizes the Medicaid Home and Community-Based Services (HCBS) waiver program (the Act § 1915(c)). The HCBS waiver program permits a State 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. HCBS waiver services complement or supplement the services that are available to beneficiaries 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 HCBS waiver program to address the needs of the HCBS waiver's target population.

The State agency exercises administrative discretion in the administration and supervision of the HCBS waiver. The State agency delegated routine functions necessary for the operation of the HCBS waiver to the operating agency, the Texas Department of Aging and Disability Services (DADS).³ The HCBS waiver program in Texas provided services to 26,964 Medicaid beneficiaries during our audit period.

States must provide 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(b)). In its waiver, the State agency stated that it has a critical event or incident reporting system.

Critical Incident Reporting and Monitoring

Texas' HCBS waiver specifies multiple reporting and monitoring requirements depending on the type of critical event or incident involving HCBS waiver participants.

Community-based providers are required to report monthly the number of critical incidents, defined in the HCBS waiver as medication errors, serious injuries, or restraint-related use or injury, in the Client Assignment and Registration (CARE) system. The reporting of critical incidents to the CARE system is reviewed as part of annual certification monitoring by DADS Regulatory Services (HCBS waiver, Appendix G-1(b) and (d)).

Community-based provider personnel, local authority staff, individuals, legally authorized representatives, and financial management services agencies are provided the Texas Department of Family and Protective Services' (DFPS's) toll-free telephone number in writing

³ HCBS waiver, Appendix A: Waiver Administration and Operation. In addition, although waiver requirements did not change, DADS was integrated with the State agency and operates under the authority of the State agency, effective September 1, 2016.

and are required by the HCBS waiver and Texas law⁴ to report to DFPS immediately, but not later than 1 hour after having knowledge or suspicion that an individual has been or is being abused, neglected, or exploited (HCBS waiver, Appendix G-1(b)). DFPS is statutorily responsible to review, investigate, and respond to these reports.⁵ Additionally, DFPS notifies the DADS Consumer Rights and Services (CRS) unit of any reports it received alleging abuse, neglect, or exploitation. CRS enters the abuse, neglect, and exploitation allegation information into the Health and Human Services Enterprise Administration Reporting and Tracking (HEART) system (HCBS waiver, Appendix G-1(e)).⁶

Complaints regarding incidents or concerns that do not meet the definition of abuse, neglect, or exploitation, or the definition of critical incidents, are reported directly to CRS. Each complaint is assigned to a rights representative for followup investigation. CRS has a goal of complaint resolution and closure of the complaint case within 10 days of receipt of the complaint. CRS tracks complaint data and each complaint that has not been closed within the 10 days after receipt receives followup. Once followup activities are completed, the complaint case is considered closed (HCBS waiver, Appendix G-1(d)).

Community-based providers must also report the death of an individual to DADS by the end of the next business day following the death of the individual or the provider's knowledge of the death. DADS Regulatory Services reviews all deaths to ensure appropriate followup (HCBS waiver, Appendix G-1(b) and (e)).

HOW WE CONDUCTED THIS AUDIT

We obtained the beneficiary assignment schedule from CARE, which contains beneficiary status information including client identification, dates of service, service location, and date of death. We also obtained a record of the deaths reviewed by DADS Regulatory Services. We compared the beneficiaries with a discharge status of death to the record of deaths reviewed by DADS Regulatory Services.

We obtained a record of all CRS complaints. We selected and reviewed a judgmental sample of complaints not closed within the goal of 10 days. We asked State program officials how they tracked cases open for more than 10 days for followup as required by the HCBS waiver. We also asked State agency program officials to review complaint documentation and identify any reasons for delay in closing cases within the 10-day goal.

⁴ Texas Administrative Code Title 40, chapter 9, subchapter D, § 9.178(j)(3).

⁵ Texas Human Resources Code Chapter 48, Investigations and Protective Services for Elderly Persons and Persons with Disabilities, Subchapter F, Investigations of Abuse, Neglect, or Exploitation of Individuals Receiving Services From Certain Providers.

⁶ The HEART system is used by CRS to store complaint information and investigation results.

We reviewed a report from the HEART system and supporting documentation provided by CRS to determine whether a judgmental sample of DFPS cases was entered into the HEART system. For cases not entered into HEART, we asked program officials to explain (1) why the case information was not entered into the system and (2) the purpose of communicating the information to CRS.

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 C 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 residing in community-based settings. Specifically, the State agency did not ensure that all beneficiary deaths were reported and reviewed; that all complaints not closed within 10 days after receipt were tracked; and that all allegations of abuse, neglect, and exploitation were entered into the HEART system.⁷ The State agency had a procedure to detect unreported deaths but was not following it, did not have a system in place to track complaints not closed within 10 days, and did not have procedures to ensure that allegations were entered into the HEART system. The failure to identify unreported deaths increases the risk that conditions affecting the health, safety, and welfare of HCBS waiver participants could go undetected; the failure to track complaints not closed within 10 days prevents CRS from meeting its goal for complaint resolution and closure; and the failure to enter all allegations into the HEART system could result in duplication of investigative efforts by CRS and DFPS.

THE STATE AGENCY DID NOT ENSURE THAT ALL BENEFICIARY DEATHS WERE REPORTED AND REVIEWED

Twenty of the 350 beneficiary deaths in 2016 went unreported for more than 30 days. Ten of these deaths had not been reported or reviewed by DADS Regulatory Services before the start of our audit. In Texas, community-based providers are required to report the death of an individual to DADS by the end of the next business day following either the death of the

⁷ DFPS reports allegations of abuse, neglect, or exploitation to CRS so it can enter those allegations into the HEART system to prevent duplication of investigations.

individual or the provider's knowledge of the death. The HCBS waiver requires DADS Regulatory Services to review all deaths.⁸

State agency officials explained that their past procedure had been to search the CARE assignment schedule once a month for discharges due to death and compare that information to the deaths reported by community-based providers. However, State agency officials also explained that they were not following this procedure during our audit period. Beneficiary deaths not reviewed in a timely manner increase the risk that conditions affecting the health, safety, and welfare of waiver participants go undetected.

THE STATE AGENCY DID NOT ENSURE THAT ALL COMPLAINTS NOT CLOSED WITHIN 10 DAYS WERE TRACKED

CRS did not track complaints that were not closed within 10 days after receipt. The HCBS waiver states that CRS has a goal of complaint resolution and closure of the complaint case within 10 days of receipt of the complaint. The HCBS waiver also states that CRS tracks complaint data by Medicaid provider and that CRS follows up on each complaint not closed within 10 days after receipt (HCBS waiver, Appendix G-1(d)). State officials explained that they did not have the ability to track complaints not closed within 10 days. Of the 4,374 complaint cases, we identified 410 cases that were not closed within 10 days. We then judgmentally selected 30 of those CRS complaints and reviewed the documentation.

The HCBS waiver states that complaints might not be closed within the first 10 days because of a delay in contacting the involved parties due to incorrect contact information, or the triaging of cases, which may delay resolution of less urgent issues.⁹ However, for 13 of the 30 complaint cases, no reason for the delay was noted. For the other 17 cases, there were explanations for the delay, such as waiting on documentation, a call to be returned, or the results of another department's investigation. However, based on the complaint documentation we reviewed, we did not identify any adverse impact on the health, safety, and welfare of these HCBS waiver participants due to lack of tracking or delay in complaint resolution.

⁸ Texas Administrative Code Title 40, chapter 9, subchapter D, § 9.178(w), and HCBS waiver, Appendix G-1(b) and (e).

⁹ HCBS waiver, Appendix G-1(d).

THE STATE AGENCY DID NOT ENSURE THAT ALL ABUSE, NEGLECT, AND EXPLOITATION CASES WERE ENTERED INTO THE HEALTH AND HUMAN SERVICES ENTERPRISE ADMINISTRATION REPORTING AND TRACKING SYSTEM

The HCBS waiver requires that DFPS notify CRS of any reports DFPS has received alleging abuse, neglect, or exploitation and that CRS enter the allegations¹⁰ into the HEART system (HCBS waiver, Appendix G-1(e)).

All allegations of abuse, neglect, and exploitation were not entered into the HEART system. Of the 3,866 allegations of abuse, neglect, or exploitation during our audit period, we selected a judgmental sample of 28 cases to determine whether DFPS notified CRS of the cases. Of the 28 cases reviewed, 14 were not entered into the HEART system. DFPS did not send these cases to CRS, and there were no procedures in place to ensure that DFPS notified CRS of all reports of abuse, neglect, or exploitation. Because DFPS investigates allegations of abuse, neglect, and exploitation, failure to enter the allegations into the HEART system could result in a duplicate investigation by CRS if it also receives the complaint.

RECOMMENDATIONS

We recommend that the Texas Health and Human Services Commission:

- ensure that procedures are followed to detect unreported deaths;
- implement a system to ensure that it can track complaints not closed within 10 days; and
- implement procedures to ensure that investigations of abuse, neglect, and exploitation are entered in the HEART system database.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings and recommendations and described actions that it has taken or plans to take to address them. These actions include increasing the frequency of comparing deaths reported by the provider to death reports from the CARE system, implementing a new system to monitor unreported deaths, and issuing violations and administrative penalties for failure to report deaths. The State agency's comments are included in their entirety as Appendix D.

¹⁰ DFPS information such as case number, client name, provider, type of complaint, and status of case is entered into the HEART system.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed the State's compliance with waiver requirements for reporting and monitoring critical incidents for calendar year 2016. During this period, a total of 26,964 Medicaid beneficiaries with developmental disabilities were covered by Texas' HCBS waiver.

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 November 2017 through November 2019, which included site visits to the State agency's office in Austin, Texas.

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 policies and controls related to reporting and monitoring critical incidents involving beneficiaries with developmental disabilities;
- obtained from the State agency computer-generated reports containing all beneficiary death information, DFPS cases, and complaints for Medicaid beneficiaries with developmental disabilities residing in community-based settings during the audit period;
- compared the beneficiaries with a discharge status of death to the record of deaths reviewed by DADS Regulatory Services;
- selected a judgmental sample of 30 CRS complaint cases not closed within 10 days to determine whether tracking and followup activities were completed;
- selected a judgmental sample of 28 DFPS cases of confirmed abuse, neglect, or exploitation and compared those cases to cases entered in the HEART system; and
- discussed the results of our review 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.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities</i>	<u>A-07-18-06081</u>	3/27/2020
<i>Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-03-17-00202</u>	1/17/2020
<i>Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-09-17-02006</u>	6/11/2019
<i>Joint Report: Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight</i>	<u>Joint Report*</u>	1/17/2018
<i>Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-01-16-00001</u>	8/9/2017
<i>Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	<u>A-01-14-00008</u>	7/13/2016
<i>Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	<u>A-01-14-00002</u>	5/25/2016
<i>Review of Intermediate Care Facilities in New York With High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries</i>	<u>A-02-14-01011</u>	9/28/2015

* This report was jointly prepared by the U.S. Department of Health and Human Services' Office of Inspector General, Administration for Community Living, and Office for Civil Rights.

APPENDIX C: 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, neglect, and exploitation);
- 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” and (e) “Responsibility for Oversight of Critical Incidents and Events,” requires the HCBS provider to report the death of an individual to DADS Regulatory Services by the end of the next business day following the death of the individual or the HCBS provider’s knowledge of the death. DADS Regulatory Services reviews all deaths to ensure appropriate followup by DADS or by the DFPS.

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,” states that:

The DADS Consumer Rights and Services has a goal of complaint resolution and closure of the complaint case within 10 days of receipt of the complaint The DADS Consumer Rights and Services department tracks complaint data by HC[B]S Medicaid provider agreement and each complaint that has not been closed within the 10 days after receipt receives follow-up. One reason why a case might not be closed within the first 10 days includes a delay in contacting the involved parties due to incorrect contact information. Another is that the triaging of cases, which ensures that the most urgent issues are addressed quickly, may delay resolution of less urgent issues. Once follow-up activities are completed, the complaint case is closed.

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:

The Department of Family and Protective Services notifies the DADS Consumer Rights and Services unit of any reports received alleging abuse, neglect, or exploitation. The DADS Consumer Rights and Services department enters the abuse, neglect, and exploitation allegation information into the Health and Human Services Enterprise Administration Reporting and Tracking System database.

STATE REQUIREMENT

Texas Administrative Code Title 40, chapter 9, subchapter D, section 9.178(w) requires the program provider to report the death of an individual to DADS Regulatory Services and the service coordinator by the end of the next business day following the death or the program provider’s learning of the death.

APPENDIX D: STATE AGENCY COMMENTS



TEXAS
Health and Human
Services

Texas Health and Human Services Commission

Phil Wilson
Executive Commissioner

May 26, 2020

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Office of Inspector General, Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Re: Number A-06-17-04003

Dear Ms. Wheeler:

The Texas Health and Human Services Commission (HHSC) received a draft audit report entitled "*Texas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities*" from the U.S. Department of Health and Human Services Office of Inspector General. The cover letter, dated March 24, 2020, requested that HHSC provide written comments, including a statement of concurrence or nonconcurrence with each recommendation and the reasons for our non-concurrence or the status of actions taken or planned in response to report recommendations for which we concur.

I appreciate the opportunity to respond. Please find the attached HHSC management response which (a) includes comments related to the content of the findings and recommendations and (b) detailed actions HHSC has completed or planned.

Should you need additional information or have any questions, Jose Garcia, Office of Audit and Compliance Interim Deputy Director, serves as lead staff on this matter and can be reached by phone at 512-927-7454 or by email at jose.garcia@hhsc.state.tx.us.

Sincerely,

A handwritten signature in cursive script that reads "Phil Wilson".

Phil Wilson

P.O. Box 13247 • Austin, Texas 78711-3247 • 512-424-6500 • hhs.texas.gov

Texas Health and Human Services Commission (HHSC)
Management Response to the
U.S. Department of Health and Human Services Office of Inspector General
Draft Report dated March 24, 2020 - A-06-17-04003

***"Texas Did Not Fully Comply with Federal and State Requirements for
Reporting and Monitoring Critical Incidents Involving Medicaid
Beneficiaries with Developmental Disabilities"***

Summary of the Management Response

The Texas Health and Human Services Commission (HHSC) concurs with the issues and associated recommendations and is taking appropriate actions necessary to fully address each of the issues identified in the report.

Management Response Recommendation 1

Recommendation 1: HHSC ensure that procedures are followed to detect unreported deaths.

Statement of Concurrence or Nonconcurrence

HHSC concurs with this recommendation.

Actions Taken and/or Planned

Home and Community-based Services (HCS) program providers are required by HHSC rules at Texas Administrative Code, Title 40, §9.178(r) to report the death of an individual to HHSC by the end of the next business day after the program provider becomes aware of the death.

A program provider reports a death to HHSC by submitting Form 8493 to the Waiver Survey and Certification (WSC) unit in Long-term Care Regulatory (LTCR). In addition to submitting this form, a program provider is required to enter the death into ID CARE, place the individual on permanent discharge, and in accordance with 40 TAC §9.178(t), report the death as a critical incident.

To better ensure that unreported deaths are detected, WSC will take the following actions:

First Action: Effective May 31, 2020, WSC will, on a monthly basis, compare the deaths reported by Form 8493 with the death report entered into ID CARE. Currently this comparison is made on a quarterly basis.

Second Action: Effective August 2018, if WSC identifies a discrepancy between a report made by Form 8493 and by a death report entered in ID CARE, WSC will contact the program provider by phone and email to inform the provider of the discrepancy and require the provider to correct the discrepancy.

Third Action: Effective August 2018, if WSC determines from comparing reports that a program provider did *not* report a death in accordance with HHSC rules, WSC issues a violation, as appropriate, during the next survey of the provider.

Fourth Action: If WSC determines through the normal survey process that a program provider did not report a death as required, WSC will issue a violation of §9.178(r). If WSC determines that a program provider failed to enter a death in ID CARE as a critical incident, WSC will issue a violation of §9.178(t). This action is not new and remains in effect.

Fifth Action: If WSC is notified by Provider Investigations (PI) of the death of an individual, WSC will conduct an on-site survey of the program provider to determine if the program provider reported the death as required. If WSC determines that the program provider did not report the death as required, WSC will issue a violation of §9.178(r). If WSC determines that program provider failed to enter the death in ID CARE as a critical incident in ID CARE, WSC will issue a violation of §9.178(t). This action is not new and remains in effect.

Sixth Action: WSC will develop and implement a new system to monitor unreported deaths by August 31, 2020. If WSC determines from the monitoring that a program provider has violated a rule, WSC will issue a violation, as appropriate, during the next survey of the program provider. The monitoring system will ensure that program providers are held accountable for failing to report a death of an individual in accordance with HHSC rules.

Seventh Action: WSC will begin enforcing administrative penalties in the HCS program in September 2020 in accordance with rules that have recently been adopted by HHSC. The rules allow HHSC to impose an administrative penalty against a program provider for a violation issued during a survey.

WSC also will continue to track the date that a death is reported by submission of form 8493, as well as the date HHSC completes its death review.

This tracking activity is a performance measure in the Regulatory Services Division's business plan, which requires LTCR to review *all* provider reported deaths within 60 days. WSC will continue to review and monitor all deaths received within 60 days after being notified by the program provider.

Responsible Manager

Alyssa Naugle, Director of Waiver Survey and Certification

Responsible Party for Providing Status Updates

Alyssa Naugle, Director of Waiver Survey and Certification

Target Implementation Date

September 1, 2020

Management Response to Recommendation 2

Recommendation 2: HHSC implement a system to ensure that it can track complaints not closed within 10 days.

Statement of Concurrence or Nonconcurrence

HHSC concurs with this recommendation.

Actions Taken and/or Planned

The Intellectual and Developmental Disabilities (IDD) Ombudsman will, by May 31, 2020, run a monthly report in the Health and Human Services Enterprise Administration Reporting and Tracking System database to identify complaints open longer than 10 days. The manager will review each complaint in the report to determine and document the reason the complaint was not closed within 10 days after it was received and take action as

necessary to address any issues identified. Any actions taken will be documented.

Responsible Manager

Amanda Woodall, Managing IDD Ombudsman

Responsible Party for Providing Status Updates

Amanda Woodall, Managing IDD Ombudsman

Target Implementation Date

May 31, 2020

Management Response to Recommendation 3

Recommendation 3: HHSC implement procedures to ensure that investigations of abuse, neglect, and exploitation are entered in the HEART system database.

Statement of Concurrence or Nonconcurrence

HHSC concurs with this recommendation.

Actions Taken and/or Planned

The Department of Family and Protective Services enters abuse, neglect and exploitation intakes into the Information Management Protecting Adults and Children in Texas (IMPACT) system. Provider Investigations (PI) emails intakes related to HCS to the IDD Ombudsman, and the IDD Ombudsman enters each intake into the HHS Enterprise Administrative and Report Tracking (HEART) system. PI and the IDD Ombudsman will collaborate to reconcile abuse, neglect, and exploitation intakes, annually, using reports generated from the IMPACT and HEART systems. If HHSC determines that all intakes were not sent to the IDD Ombudsman, PI will send the IDD Ombudsman the missing intakes. The IDD Ombudsman will enter those intakes in HEART.

The first reconciliation of these reports will be completed by September 30, 2020. In February 2019, the IDD Ombudsman notified PI that the IDD Ombudsman's unit's name and email address changed to ensure intakes are sent to the correct mailbox.

Responsible Manager

Rebecca "Susie" Weirether, Policy Manager Provider Investigations
Amanda Woodall, Managing IDD Ombudsman

Responsible Party for Providing Status Updates

Rebecca "Susie" Weirether, Policy Manager Provider Investigations
Amanda Woodall, Managing IDD Ombudsman

Target Implementation Date

September 30, 2020