

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CALIFORNIA 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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Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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Report in Brief

Date: September 2021
Report No. A-09-19-02004

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



Why OIG Did This Audit

We have performed audits in multiple 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 (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 California complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in Community Care Facilities (CCFs) from July through December 2017.

How OIG Did This Audit

To determine whether there were unreported critical incidents, we judgmentally selected a sample of 100 medical claims for beneficiaries with developmental disabilities residing in CCFs that included diagnosis codes associated with a high likelihood that a critical incident had occurred. For these claims, we reviewed supporting medical records and regional center documentation, if applicable. We also reviewed 105 critical incidents contained in California's reporting system.

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

What OIG Found

California 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 CCFs. Specifically, California did not ensure that: (1) all critical incidents were reported and (2) all reported critical incidents were reported in a timely manner and followed up on completely to ensure beneficiaries' health and safety. In addition, California did not ensure that reported critical incidents involving the death of a beneficiary were properly reviewed.

California provided various reasons that providers and regional centers (contracted by the State to provide a wide range of services for individuals with developmental disabilities) did not properly report some critical incidents, as well as reasons that reported critical incidents were not always reported in a timely manner and followed up on completely. Because California did not fully comply with Federal and State requirements for reporting and monitoring critical incidents, it did not ensure compliance with safeguard assurances it provided to CMS in the Federal Medicaid waiver, which could impact the health and safety of Medicaid beneficiaries.

What OIG Recommends and California Comments

We recommend that California: (1) provide additional guidance to providers, such as a standard reporting form that includes the types of incidents that are required to be reported, and provide additional training to providers on critical incident identification and reporting; (2) provide additional guidance and training to regional centers for identifying the types of incidents that are required to be reported; (3) perform additional analytical procedures, such as data matches, to identify potential critical incidents that have not been reported and follow up on them as required; (4) improve oversight to ensure that timeliness and followup requirements related to reported critical incidents are met; and (5) ensure that reported critical incidents involving the death of a beneficiary are reviewed by a mortality review committee as appropriate.

California agreed with our first four recommendations, partially agreed with our fifth recommendation (which we revised), and described corrective actions it had taken or planned to take, including providing technical support and training to regional centers and performing additional analysis.

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INTRODUCTION

WHY WE DID THIS AUDIT

We have performed audits in multiple States in response to a congressional request concerning the number of deaths and cases of abuse of residents with developmental disabilities in group homes.¹ This request was made in response to media coverage throughout the country of deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors.

In California, individuals with developmental disabilities may reside in Community Care Facilities (CCFs), such as adult residential facilities, adult residential facilities for persons with special health care needs, residential care facilities for the elderly, group homes, and small family homes. CCFs are licensed to provide 24-hour residential care to children and adults with developmental disabilities who are in need of personal services, supervision, or assistance essential for self-protection or sustaining the activities of daily living.

A Federal Medicaid waiver requires each State to make assurances that necessary safeguards have been taken to protect the health and welfare of beneficiaries. In its waiver, California listed participant safeguards, including operating a critical event or incident reporting and management process. According to State regulations, critical incidents include deaths, certain crimes, missing persons, reasonably suspected neglect, unplanned or unscheduled hospitalizations, reasonably suspected abuse or exploitation, and serious injury or accident.²

OBJECTIVE

Our objective was to determine whether the California Department of Health Care Services (State agency) complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in CCFs from July through December 2017.

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), “developmental disability” means a severe, chronic disability that:

- is attributable to a mental or physical impairment or a combination of both;
- is evident before the age of 22;

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

² Although California refers to critical incidents as “special incidents,” we use the term “critical incidents” in this report.

- is likely to continue indefinitely; and
- results in substantial limitations in three or more major life areas, defined as self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.³

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 disabilities.⁴ 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)).

Medicaid Home and Community-Based Services Waiver

The Social Security Act (the Act) authorizes the Medicaid Home and Community-Based Services Waiver (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 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 waiver’s target population. In the HCBS waiver (*Appendix G-1, Participant Safeguards: Response to Critical Events or Incidents*), a State agency generally states whether it has a critical event or incident reporting system and defines the types of critical events or incidents that are to be reported for review and followup action by an appropriate authority, the individuals and entities that are required to report such events and incidents, and the timelines for reporting.

California’s Home and Community-Based Services Waiver

In California, the State agency and the Department of Developmental Services (DDS) have responsibilities for the HCBS waiver.

Department of Health Care Services

The State agency administers the Medicaid program in California (called Medi-Cal). The State agency funds health care services for about 13 million Medi-Cal beneficiaries and provides home and community-based services to Medicaid beneficiaries with developmental disabilities through the HCBS waiver. The State agency collaborates with other agencies, counties, and partners to provide care for low-income families, children, seniors, and persons with disabilities.

³ P.L. No. 106-402 (Oct. 30, 2000).

⁴ Providers offer a variety of services, including residential care, independent and supported living services, day care and activity programs, respite care, behavior management services, and vocational training.

Department of Developmental Services and Regional Centers

The State agency has an interagency agreement with DDS to operate the HCBS waiver. DDS contracts with regional centers, which are nonprofit corporations, to provide a wide range of services for individuals with developmental disabilities. Regional centers develop, purchase, and manage services for individuals with developmental disabilities and their families. California has 21 regional centers throughout the State, each serving a separate geographic area.

Figure 1 shows the responsibilities of the State agency, DDS, and the regional centers for administering the HCBS waiver.

Figure 1: Administration of the California HCBS Waiver

Department of Health Care Services	Department of Developmental Services	Regional Centers
<ul style="list-style-type: none">Oversees and monitors programmatic and fiscal aspects of the HCBS waiver	<ul style="list-style-type: none">Operates the HCBS waiverOversees and monitors implementation of the HCBS waiver at regional centers	<ul style="list-style-type: none">Assess individuals' eligibility to receive services and help plan, access, coordinate, and monitor services

California's Reporting of Critical Incidents

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 taken to protect the health and welfare of beneficiaries receiving services (42 CFR § 441.302). This waiver assurance requires a 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 waiver, the State agency stated that it has a critical incident reporting system.

Reporting Requirements and Incident Types

California's HCBS waiver and State regulations describe reporting requirements for critical incidents and define the incident types that require a critical incident report (HCBS waiver, Appendix G-1, and California Code of Regulations (CCR), Title 17, § 54327). Categories of incident types include deaths, certain crimes, missing persons, reasonably suspected neglect, unplanned or unscheduled hospitalizations, reasonably suspected abuse or exploitation, and serious injury or accident.

Regional Center Responsibilities

The HCBS waiver and State regulations state that a provider is required to report to its regional center a critical incident within 24 hours of learning about the incident and must submit a written report within 48 hours (HCBS waiver, Appendix G-1, and 17 CCR § 54327). The regional center has local-level responsibility for evaluation, examination, and followup of critical incident reports. Upon receiving a critical incident report, the regional center reviews the report to verify that the beneficiary is safe and reports the incident to licensing, investigative, or protective services agencies, as appropriate.

The regional center enters the initial information from the critical incident report into SANDIS (the computer system used for tracking critical incidents) and transmits the critical incident report to DDS (within 2 working days of learning of the incident). The regional center is required to: (1) pursue followup activities until there is a satisfactory resolution of the immediate issue and mitigation of future risk to beneficiaries, (2) update the report with required information in SANDIS as needed (within 30 working days following the initial report), and (3) close the critical incident report when all required information and followup activities are completed and entered into SANDIS.

Department of Developmental Services and State Agency Responsibilities

DDS conducts daily reviews of the critical incident reports that regional centers submit in SANDIS. These reviews are intended to ensure regulatory compliance and also to ensure that proper notifications have been made to legally required entities and that appropriate followup activities are occurring. DDS follows up with regional centers as needed. DDS's independent contractor, Mission Analytics, uses SANDIS data to identify trends in critical incidents and reports the trends to DDS and the regional centers.

State agency and DDS executives serve on the Quality Management Executive Committee, which meets quarterly to review data and trend analysis prepared by Mission Analytics as part of the overall oversight of the HCBS waiver, regional centers, and critical incident reports. In addition, both the State agency and DDS exercise oversight of the waiver through Biennial Collaborative onsite HCBS waiver monitoring reviews at the 21 regional centers. Several components of the reviews address risk management activities, including critical incident reporting. Specifically, the State agency and DDS review compliance with reporting, meeting mandated timelines, and appropriate and complete followup activities for a sample of 10 critical incident reports for HCBS waiver participants. The State agency may also perform additional focused onsite reviews of reported critical incidents when it is deemed necessary.⁵

⁵ As of October 2020, the State agency had not found it necessary to perform any focused, onsite reviews at the regional centers to evaluate reported critical incidents.

HOW WE CONDUCTED THIS AUDIT

From July 1 through December 31, 2017 (audit period), 20,340 Medicaid beneficiaries with developmental disabilities resided in CCFs for all or a portion of this period. To determine whether there were unreported critical incidents during our audit period, we identified 4,731 emergency-room medical claims with high-risk diagnosis codes that the State agency paid on behalf of Medicaid beneficiaries.⁶ We removed claims with corresponding critical incident reports, resulting in 3,495 claims without a critical incident report, and selected a judgmental sample of 100 claims. To determine whether each claim represented an unreported critical incident, we reviewed supporting medical records and regional center documentation, if applicable.⁷ In addition, we provided to DDS those claims we considered to be associated with unreported critical incidents for its review and comments. We also compared identifying information (e.g., beneficiary name and date of birth) for the 20,340 Medicaid beneficiaries with the Social Security Administration's Death Master file and identified a list of beneficiaries who died during our audit period. We then compared this list of beneficiaries with critical incident reports to determine whether any deaths occurred during our audit period that were not reported to the State agency as a critical incident.

DDS received 3,624 critical incident reports involving 2,655 of the 20,340 Medicaid beneficiaries with developmental disabilities. We reviewed documentation for 105 critical incidents to determine whether the State agency, DDS, and regional centers complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents.

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 describes our audit scope and methodology. Appendix C contains details on the Federal waiver and State requirements relevant to our findings.

⁶ High-risk diagnosis codes are those diagnosis codes we determined have a high probability of indicating that a critical incident occurred.

⁷ For six claims, providers could not locate the medical records. Therefore, we reviewed 94 sampled claims.

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 CCFs. Specifically, the State agency did not ensure that: (1) all critical incidents were reported and (2) all reported critical incidents were reported in a timely manner and followed up on completely to ensure beneficiaries' health and safety. In addition, the State agency did not ensure that reported critical incidents involving the death of a beneficiary were properly reviewed.

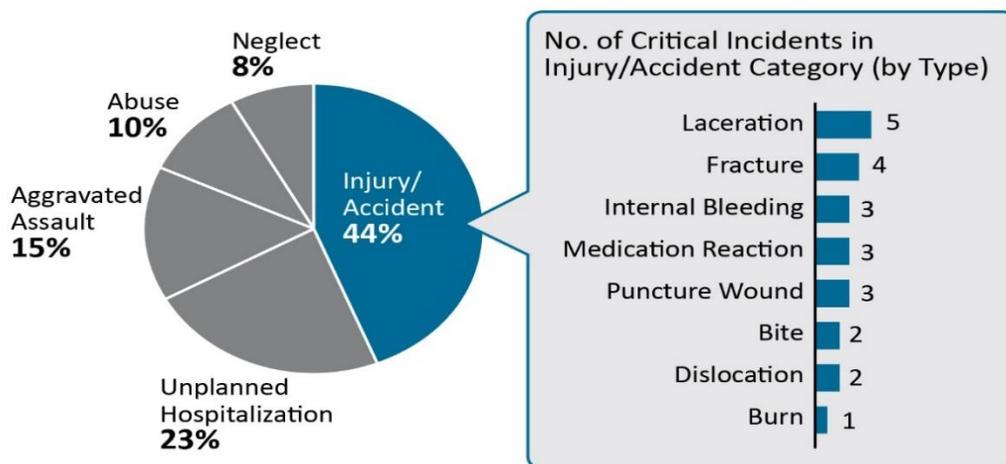
The State agency, through DDS officials, provided various reasons that providers and regional centers did not properly report some critical incidents, as well as reasons that reported critical incidents were not always reported in a timely manner and followed up on completely. Because the State agency did not fully comply with Federal and State requirements for reporting and monitoring critical incidents, it did not ensure compliance with safeguard assurances it provided to CMS in the HCBS waiver, which could impact the health and safety of Medicaid beneficiaries.

THE STATE AGENCY DID NOT ENSURE THAT ALL CRITICAL INCIDENTS WERE REPORTED

Providers in California are required to report critical incidents involving Medicaid beneficiaries with developmental disabilities to the regional centers, which in turn must report those critical incidents to DDS (HCBS waiver, Appendix G-1(b)). Critical incidents include those involving reasonably suspected abuse or exploitation (e.g., physical or sexual abuse); reasonably suspected neglect (e.g., failure to provide medical care for physical and mental health needs); a serious injury or accident (e.g., bites that break the skin and require medical treatment beyond first aid); unplanned or unscheduled hospitalization for certain conditions; the death of any beneficiary; and incidents when the beneficiary is a victim of certain crimes (HCBS waiver, Appendix G-1(b); 17 CCR § 54327).

Providers and regional centers did not report to the State agency through DDS all critical incidents involving beneficiaries with developmental disabilities. Specifically, of 94 judgmentally selected claims without a critical incident report, 52 were associated with incidents that should have been reported as critical incidents. (See Figure 2 on the following page for the categories of critical incidents that were not reported to DDS and Appendix D for the number of claims associated with unreported critical incidents in each category and the corresponding high-risk diagnosis codes.) In addition, our analysis of the Social Security Administration's Death Master file identified one death that was not reported as a critical incident.

Figure 2: The Injury/Accident Category Represented 44 Percent of All Unreported Critical Incidents



Example of an Unreported Critical Incident

A 46-year-old female living in an adult residential facility was taken to a hospital emergency room by the caregiver. The beneficiary’s medical records showed that she fell over her walker, which resulted in a nasal fracture. The beneficiary had previously been seen twice at the hospital for falls requiring CT (computed tomography) scans of her head. The fall over the walker was witnessed by the beneficiary’s caretaker and was reported to the regional center, but the regional center did not report the critical incident to DDS.

Officials from Mission Analytics, DDS’s independent contractor, stated that they perform analytical procedures on Medicaid claims data quarterly to identify unreported hospitalizations that may be considered critical incidents. However, DDS does not perform analytical procedures on Medicaid claims data to identify all categories of unreported critical incidents. Analytical procedures, such as performing a data match between claims containing potential high-risk diagnosis codes and critical incident reports, could identify beneficiaries who may have experienced critical incidents that were not reported.

DDS officials provided reasons that a provider or a regional center might not report a critical incident, including:

- the provider or regional center, or both, had no knowledge of the incident;
- the provider failed to submit a critical incident report or submitted an incomplete critical incident report to the regional center; and
- the regional center incorrectly classified the incident report as a nonreportable incident type, which would not have received the same amount of followup as a reportable incident type and would not have been transmitted to DDS for review.

When providers and regional centers do not report critical incidents, DDS cannot investigate and take appropriate action to protect the health and welfare of Medicaid beneficiaries with developmental disabilities.

THE STATE AGENCY DID NOT ENSURE THAT ALL REPORTED CRITICAL INCIDENTS WERE REPORTED IN A TIMELY MANNER AND FOLLOWED UP ON COMPLETELY

The State agency did not ensure that all reported critical incidents were reported in a timely manner and followed up on completely to ensure beneficiaries' health and safety. Specifically, the State agency and DDS did not ensure that: (1) providers and regional centers met timeliness requirements for reporting critical incidents or updating critical incident reports, (2) regional centers met followup requirements for all reported critical incidents to ensure beneficiaries' health and safety, and (3) reported critical incidents involving the death of a beneficiary were properly reviewed.

The State Agency and Department of Developmental Services Did Not Ensure That Providers and Regional Centers Met Timeliness Requirements for Reporting Critical Incidents and Updating Critical Incident Reports

Providers that furnish services to beneficiaries are required to report critical incidents to regional centers within 24 hours after learning that an incident has occurred (HCBS waiver, Appendix G-1(b)). The initial report may be by telephone; however, a written report with specified information must be submitted to the regional center within 48 hours of learning of the incident. The regional center has local-level responsibility for evaluation, examination, and followup of critical incidents (HCBS waiver, Appendix G-1(d)). Specifically, upon receiving a critical incident report, a regional center is required to: (1) enter the initial information into SANDIS and transmit the critical incident report to DDS within 2 working days of learning of the incident, (2) add required information to the initial critical incident report within 30 working days following initial reporting, and (3) update the critical incident report as needed. In addition, the regional center should close the critical incident report when all required followup activities are completed and information is entered into SANDIS.

The State agency and DDS did not ensure that providers and regional centers met timeliness requirements for reporting critical incidents or updating critical incident reports. Specifically, for 18 of the 105 critical incidents that we reviewed, the providers did not send a written report to the regional center within 48 hours of learning of the incident.⁸ For 11 of the 105 critical

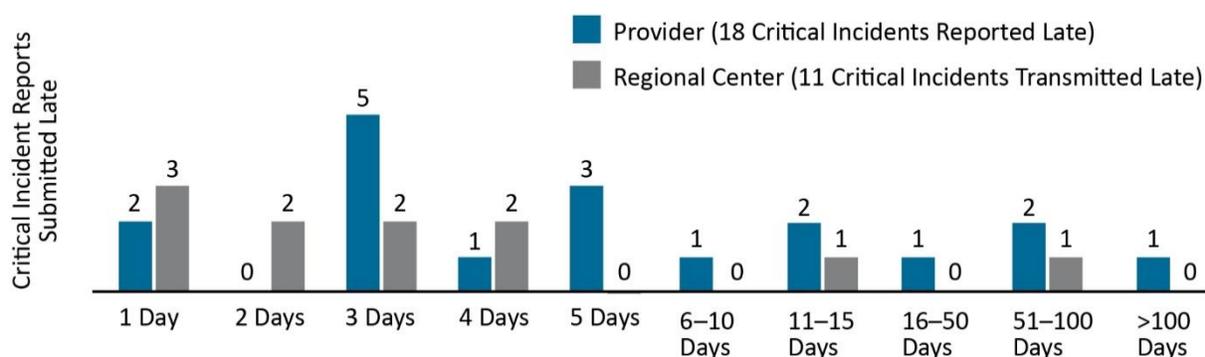
⁸ To determine whether a provider submitted a written report within 48 hours of learning of the incident, we started the 48-hour clock at midnight on the night that the provider learned of the incident. We considered each 24-hour period after the first 48-hour period to be 1 day.

incidents, the regional center did not enter initial information into SANDIS and transmit the critical incident report to DDS within 2 working days of learning of the incident.⁹

For example, on Monday, July 24, 2017, a critical incident occurred, and the provider learned of the incident that day. On Tuesday, July 25, 2017, the provider initially reported the critical incident via email to the regional center and indicated it would send the written report soon. The written report was received by the regional center on Monday, July 31, 2017 (5 days late). The regional center entered initial information into SANDIS and transmitted the critical incident report to DDS on Wednesday, August 2, 2017, which was 4 working days late (i.e., 4 days after the date the regional center was initially notified via email when taking into account the 2 allowable days to transmit the critical incident report to DDS and the weekend days July 29 and July 30, 2017).

See Figure 3 for additional information on the reporting delays.

Figure 3: Number of Critical Incident Reports Submitted Late by Providers and Regional Centers (by Number of Days Late)



In addition, for the 105 critical incidents we reviewed, the regional center did not update SANDIS with required information for 6 of the critical incidents after it had initially transmitted the critical incident reports to DDS. Updates that were not made included: (1) followup with Adult Protective Services in instances of suspected financial abuse and an incident of failure to protect and (2) confirmation of the discharge date for an unplanned hospitalization (17 CCR § 54327.1(c)(16)). Finally, the reports for 45 critical incidents were not closed after required information entry and followup were completed.

State agency and DDS oversight did not ensure timely reporting of critical incidents or updating and closing of critical incident reports. DDS’s daily review of critical incident report transmissions did not ensure compliance with requirements and completion of followup

⁹ To determine whether the regional center entered initial information into SANDIS and transmitted the critical incident report to DDS within 2 working days, we counted day 1 as the working day after the regional center learned of the incident, day 2 as the next working day, etc. For this audit, we considered a report late if the regional center entered the information into SANDIS after 2 working days (not counting nonworking days).

activities. DDS officials said these issues were caused by provider and case worker error. Without timely reporting of a critical incident or updating and closing of a critical incident report, the State agency and DDS cannot ensure there is a satisfactory resolution of the immediate issue or mitigate future risks to the beneficiary.

The Department of Developmental Services Implemented a Process To Review and Close Critical Incidents

In the first SANDIS dataset of reported critical incidents we received, many of the critical incidents were not closed (more than 900). (According to the HCBS waiver, the regional center should close the critical incident report when all required information is entered into SANDIS and followup activities are completed.) After DDS investigated the high number of unclosed critical incidents, DDS requested that the regional centers review reported critical incidents that were not closed, confirm that entry of required information and followup were completed, and close the incidents. In March 2019, we obtained an updated dataset from which we made our sample selection, and there were approximately 489 open critical incidents. In November 2019, we requested another updated dataset, and approximately 305 critical incidents were still open. During our fieldwork, DDS implemented a process in which it runs a monthly report of open critical incidents and sends the report to the regional centers for review and followup.

The State Agency and Department of Developmental Services Did Not Ensure That Regional Centers Met Followup Requirements for All Reported Critical Incidents To Ensure Beneficiaries' Health and Safety

Regional centers have local-level responsibility for evaluation, examination, and followup of critical incidents (HCBS waiver, Appendix G-1(d)). Specifically, upon receiving a critical incident report, a regional center is required to: (1) review medical records and coroner reports to ensure that appropriate medical attention was sought or given; (2) report the incident to licensing, investigative, or protective services agencies, as appropriate;¹⁰ (3) conduct onsite and chart review activities to gather and report initial and followup critical incident information; and (4) coordinate with other agencies (e.g., licensing, protective services, law enforcement agencies, coroners, and the long-term care ombudsman) to gather and review the results of their investigations and use this information to prevent the recurrence of similar problems.

¹⁰ Licensing, investigative, or protective service agencies include Adult Protective Services, the California Department of Social Services' Community Care Licensing (CCL), local ombudsmen, and law enforcement. The beneficiaries in our finding resided in licensed CCFs, which are required to report critical incidents to CCL (22 CCR § 80061).

The State agency and DDS did not ensure that regional centers met followup requirements for all reported critical incidents. Specifically, for the 105 critical incidents we reviewed, regional centers did not meet followup requirements for 8 critical incidents, as follows:

- For four critical incidents, regional centers did not review medical records or coroner reports to verify that appropriate medical attention was sought.
- For three critical incidents, regional centers did not ensure that the incidents were reported to the appropriate licensing agency.
- For one critical incident, the regional center did not conduct onsite or chart review activities to gather and report initial and followup information or engage in activities to protect the beneficiary's health and welfare and prevent future incidents.

Example of a Critical Incident Not Reported to the Appropriate Licensing Agency

An 80-year-old male, with a risk of choking, living in an adult residential facility was found unconscious by a caretaker, who called 911. The beneficiary was taken to the emergency room and admitted to the hospital with a diagnosis of aspiration pneumonia. His condition worsened, and 5 days later the beneficiary died. This incident was not reported to Community Care Licensing.

State agency and DDS oversight did not ensure that regional centers properly followed up on the eight reported critical incidents. DDS's daily review of critical incident report transmissions did not ensure compliance with requirements, notification to agencies, and completion of followup activities. DDS officials did not provide a detailed explanation for why the incidents were not followed up on. Without thorough oversight, evaluation, examination, and followup of a critical incident, the State agency and DDS cannot ensure there is a satisfactory resolution of the immediate issue or mitigate future risks to the beneficiary.

The State Agency and Department of Developmental Services Did Not Ensure That Reported Critical Incidents Involving the Death of a Beneficiary Were Reviewed by a Mortality Review Committee

DDS has overall State-level responsibility for planning, coordinating, and overseeing implementation of the State's risk mitigation and management system for persons with developmental disabilities, of which training and education is a component (HCBS waiver, Appendix G-1(c)). Further, DDS carries out these responsibilities in part by: (1) developing and maintaining a statewide mortality review system that includes development and maintenance of a statewide database of all persons who have died and (2) conducting studies to educate and inform the service system to improve quality-of-life outcomes for participants (HCBS waiver, Appendix G-1(e)). Each regional center is responsible for establishing a risk management, assessment, and planning committee, which develops the regional center's risk management and mitigation plan to address, among other things, a process for reviewing medical records

and coroner reports, as appropriate, associated with critical incidents to ensure that appropriate medical attention was sought or given (17 CCR §§ 54327.2(a) and 54327.2(b)(5)). According to the *California Home and Community-based Waiver Primer and Policy Manual*, mortality reviews and studies occur at the regional center and State levels. A regional center's risk management and mitigation plan outlines that a mortality review committee reviews each beneficiary death.

The State agency and DDS did not ensure that 4 of 10 reported critical incidents involving the death of a beneficiary were reviewed by a mortality review committee. The four critical incidents were all reported by one regional center, and the stated objective of the mortality review committee at this regional center was to review every beneficiary's death to determine whether: (1) appropriate medical attention was sought or given before a beneficiary's death and (2) there were any concerns identified with the beneficiary's living environment before death.

Example of a Critical Incident Involving the Death of a Beneficiary Not Reviewed by a Mortality Review Committee

A 61-year-old, legally blind, nonverbal female living in an adult residential facility was taken to the emergency room and admitted for sepsis. Beneficiary records showed that she weighed less than 90 pounds at the annual care planning meeting just 5 months before her death. The death certificate listed the cause of death as aspiration pneumonia, failure to thrive, and Down syndrome. This death was not reviewed by a mortality review committee.

DDS officials said the regional center did not have its mortality review committee review the deaths of the four beneficiaries because the regional center's clerk did not schedule a meeting for the mortality review committee after receiving the beneficiaries' death certificates. If reported deaths are not reviewed by a mortality review committee, the State agency and DDS cannot verify that appropriate medical attention was sought and given directly before a beneficiary's death and that there were no concerns identified with the beneficiary's living environment before death. When such concerns are identified, the health and welfare of other beneficiaries in the same living environment need to be investigated.

RECOMMENDATIONS

We recommend that the California Department of Health Care Services, in coordination with the Department of Developmental Services:

- provide additional guidance to providers, such as a standard reporting form that includes the types of incidents that are required to be reported, and provide additional training to providers on critical incident identification and reporting;
- provide additional guidance and training to regional centers for identifying the types of incidents that are required to be reported;

- perform additional analytical procedures, such as data matches, to identify potential critical incidents that have not been reported and follow up on them as required;
- improve oversight to ensure that timeliness and followup requirements related to reported critical incidents are met; and
- ensure that reported critical incidents involving the death of a beneficiary are reviewed by a mortality review committee as appropriate.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency and DDS agreed with our first four recommendations, partially agreed with our fifth recommendation, and described actions that they had taken or planned to take to implement our recommendations. The State agency's comments appear as Appendix E.¹¹

After reviewing the State agency's comments, we revised our fifth recommendation.

STATE AGENCY COMMENTS

The State agency had the following comments on our five recommendations:

First recommendation. The State agency said that technical support and training to regional centers on critical incident identification and reporting is ongoing, and in turn, regional centers are training and supporting providers. The State agency also said that work is currently under way within DDS to identify desired changes, such as exploring the use of a standard reporting format.

Second recommendation. The State agency said that its response to the first recommendation addresses DDS's current activity to identify changes and update training and support for stakeholders.

Third recommendation. The State agency said since January 2020, DDS has been collecting and analyzing Medi-Cal claims data for Medicaid beneficiaries who received treatment from a hospital for conditions possibly related to incidents of suspected abuse and neglect. The State agency also said that regional centers must review the claims data and determine whether a critical incident report is required to be submitted. In addition, the State agency said that, specific to mortality events, DDS compares death certificate data in the California Comprehensive Master Death File with mortality data from critical incident reports. The State agency said that this data analysis identifies individuals who have died and for whom a

¹¹ The State agency included multiple attachments to support actions that it had taken or planned to take to implement our recommendations. Although the attachments are not included as appendices in our final report, we reviewed these documents and will provide the State agency's comments in their entirety to CMS.

mortality critical incident report has not been received by DDS. Finally, the State agency said that DDS staff contact regional centers to confirm an identified individual's status and request a mortality critical incident report be submitted, as necessary.

Fourth recommendation. The State agency said that DDS is providing additional monthly reports about outcomes and timeliness to regional centers for review. For example, the State agency said that DDS began providing a monthly report to regional centers that includes data regarding critical incident reports with incident dates more than 90 days before the reporting month, which remain open without an identified outcome. In addition, the State agency said that DDS: (1) provides support and technical assistance to regional centers with compliance issues and utilizes data to analyze the variables impacting timeliness (e.g., specific vendors or vendor categories and internal regional center processes) and (2) reviews critical incident reports daily and evaluates them for specific information, such as whether the most appropriate incident type was selected.

Fifth recommendation. The State agency partially agreed with our recommendation (as it was written in our draft report) and said that Title 17 regulations do not require *all* deaths to be reviewed by a regional center mortality review committee. The State agency said that upon learning of our finding, DDS followed up with the regional center that failed to conduct mortality reviews according to its risk mitigation and management plan for all reported critical incidents involving deaths and that the regional center took immediate corrective action to address the clerical error that caused the lapse in reviews. The State agency described other actions taken by DDS to address risk management activities and current practices at the regional centers, including their mortality review elements.

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding our fifth recommendation, we agree that Title 17 regulations do not require *all* deaths to be reviewed by a regional center's mortality review committee. However, each regional center is responsible for establishing a risk management, assessment, and planning committee, which develops the regional center's risk management and mitigation plan to address, among other things, a process for reviewing medical records and coroner reports, as appropriate, associated with critical incidents to ensure that appropriate medical attention was sought or given (17 CCR §§ 54327.2(a) and 54327.2(b)(5)). This particular regional center's risk management and mitigation plan states that a mortality review committee reviews each beneficiary death. We revised our fifth recommendation to reflect that reported critical incidents involving the death of a beneficiary should be reviewed as appropriate.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From July 1 through December 31, 2017 (audit period), 20,340 Medicaid beneficiaries with developmental disabilities resided in CCFs for all or a portion of this period. We obtained and analyzed 13,817 emergency-room medical claims that the State agency paid on behalf of the 20,340 Medicaid beneficiaries and identified 787 diagnosis codes associated with a high likelihood that a critical incident had occurred. We identified 4,731 claims that contained at least 1 of these 787 diagnosis codes. (We considered these claims to be indicative of a critical incident.) From the 4,731 claims, we removed claims with corresponding critical incident reports, resulting in 3,495 claims without a critical incident report.

DDS received 3,624 critical incident reports involving 2,655 of the 20,340 Medicaid beneficiaries with developmental disabilities. We reviewed documentation for 105 critical incidents to determine whether the State agency, DDS, and regional centers complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents.

Our objective did not require an understanding of all of 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 fieldwork at the State agency's office and DDS's office in Sacramento, California, and conducted site visits at five regional centers located throughout California.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal waiver and State requirements;
- held discussions with CMS officials to gain an understanding of California's HCBS waiver for beneficiaries with developmental disabilities and California's critical incident monitoring and reporting process;
- held discussions with DDS officials to gain an understanding of the policies and procedures related to reporting critical incidents involving beneficiaries with developmental disabilities;
- obtained from the State agency a computer-generated file of information for all Medicaid beneficiaries with developmental disabilities residing in a CCF at some point during our audit period (California Medi-Cal eligibility file);

- obtained from California’s Medicaid Management Information System (MMIS) a file containing 13,817 emergency-room medical claims from both fee-for-service and managed-care programs;
- reconciled the MMIS claims data with records in the California Medi-Cal eligibility file to verify the accuracy of these data;
- identified 787 diagnosis codes within the MMIS claims data associated with a high likelihood that a critical incident had occurred;
- identified 4,731 emergency-room medical claims that contained 1 or more of the 787 diagnosis codes that were indicative of a critical incident;
- obtained from SANDIS a file containing information related to 3,624 critical incident reports for Medicaid beneficiaries residing in CCFs during our audit period (the SANDIS dataset);
- compared the 3,624 critical incident reports with the 4,731 emergency-room medical claims containing high-risk diagnosis codes and identified 3,495 claims that did not have a corresponding critical incident report;
- judgmentally selected a sample of 100 of the 3,495 claims to determine whether they were associated with critical incidents not reported to DDS;¹²
- reviewed supporting medical records and regional center documentation, if applicable, to determine whether each claim represented an unreported critical incident and provided to DDS those claims we considered to be unreported critical incidents for its review and comments;¹³
- compared identifying information (e.g., beneficiary name and date of birth) for the 20,340 Medicaid beneficiaries from the California Medi-Cal eligibility records with the Social Security Administration’s Death Master file to identify a list of beneficiaries who died during our audit period and then compared this list of beneficiaries with the reported critical incidents;
- visited 5 judgmentally selected regional centers to: (1) gain an understanding of their policies and procedures related to critical incident reporting and monitoring and (2) review critical incident documentation for 105 critical incidents to determine

¹² For six claims, providers could not locate the medical records. Therefore, we reviewed 94 sampled claims, which were associated with 20 regional centers.

¹³ We reviewed documentation for 37 claims at 5 judgmentally selected regional centers that we visited.

whether each regional center, DDS, and the State agency followed Federal and State requirements regarding critical incident reporting and monitoring; and

- discussed the results of our audit with State agency and DDS 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>Louisiana Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-06-17-02005</u>	5/5/2021
<i>New York Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-02-17-01026</u>	2/16/2021
<i>Texas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-06-17-04003</u>	7/9/2020
<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> ¹⁴	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

¹⁴ 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: 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*, section (b), “State Critical Event or Incident Reporting Requirements,” states that incident reporting is just one component of the Statewide Risk Mitigation and Management System, designed to enhance consumers’ health, safety, and well-being and to implement preventative strategies and interventions to mitigate such risks. The system is a coordinated effort among numerous agencies, including regional centers; the State’s independent risk management contractor; the State’s Quality Management Executive Committee (consisting of executive-level personnel from both the State agency and DDS, who review data and trends identified through multiple discovery activities); DDS; and various licensing and protective service agencies.

The system also requires the following types of events to be reported as critical incidents for review and followup action:¹⁵

- Reasonably suspected abuse/exploitation including physical, sexual, fiduciary, emotional/mental, or physical/chemical restraint.
- Reasonably suspected neglect including failure to provide medical care for physical and mental health needs, prevent malnutrition or dehydration, protect from health and safety hazards, assist in personal hygiene or the provision of food, clothing or shelter or exercise the degree of care that a reasonable person would exercise in the position of having the care and custody of an elder or a dependent adult.

¹⁵ The text in the following list is directly quoted from the HCBS waiver.

- A serious injury/accident including lacerations requiring sutures or staples, puncture wounds requiring medical treatment beyond first aid; fractures, dislocations, bites that break the skin and require medical treatment beyond first aid, internal bleeding requiring medical treatment beyond first aid, any medications errors, medication reactions that require medical treatment beyond first aid, or burns that require medical treatment beyond first aid.
- Any unplanned or unscheduled hospitalization due to the following conditions: respiratory illness, including but not limited to asthma, tuberculosis, and chronic obstructive pulmonary disease; seizure-related; cardiac-related, including but not limited to, congestive heart failure, hypertension and angina; internal infections, including but not limited to, ear, nose and throat, GI, kidney, dental, pelvic, or urinary tract; diabetes including diabetes-related complications; wound/skin care, including but not limited, to cellulitis and decubitus; nutritional deficiencies, including but not limited, to anemia and dehydration; or involuntary psychiatric admission.
- Deaths, regardless of cause.
- The consumer is a victim of a crime including the following: robbery, including theft using a firearm, knife, or cutting instrument or other dangerous weapons or methods which force or threaten a victim; aggravated assault, including a physical attack on a victim using hands, fist, feet or a firearm, knife or cutting instrument or other dangerous weapon; larceny, including the unlawful taking, carrying, leading, or riding away of property, except for motor vehicles, from the possession or constructive possession of another person; burglary, including forcible entry; unlawful non-forcible entry; and, attempted forcible entry of a structure to commit a felony or theft therein; or rape, including rape and attempts to commit rape.

The HCBS waiver, Appendix G-1(b), further states that providers will report to the regional center a critical incident within 24 hours of learning about the incident and submit a written report within 48 hours. The regional center will review the report, enter the preliminary information in SANDIS (the computer system used for critical incident tracking), transmit the critical incident report to DDS (within 2 working days of learning of the incident), and pursue followup activities until there is a satisfactory resolution of the immediate issue and mitigation of future risk to beneficiaries. The regional center will update the information in SANDIS as needed, within 30 working days following the initial report, and the regional center should close the critical incident report when all required information and followup activities are completed and entered into SANDIS (HCBS waiver, Appendix G-1(d)).

The HCBS waiver, Appendix G-1(e), "Responsibility for Oversight of Critical Events or Incidents," states that DDS has overall State-level responsibility for planning, coordinating, and overseeing the implementation of the Statewide Risk Mitigation and Management System for all

individuals with developmental disabilities, including those who are waiver participants. The State agency is the single State agency for the HCBS waiver, and DDS is the operating agency for the waiver. The State agency and DDS exercise oversight of the waiver through Biennial Collaborative onsite HCBS waiver monitoring reviews at the 21 regional centers.

STATE REGULATIONS

State regulations restate the critical incident requirements outlined in the HCBS waiver and which information is required when reporting a critical incident (17 CCR §§ 54327 and 54327.1).

APPENDIX D: DIAGNOSIS CODES ASSOCIATED WITH UNREPORTED CRITICAL INCIDENTS

Category	Diagnosis Code	Description	No. of Claims
Abuse			
1	T7421XA	Adult sexual abuse confirmed, initial encounter	1
2	T7491XA	Unspecified adult maltreatment, confirmed, initial encounter	1
3	T7611XA	Adult physical abuse suspected, initial encounter	1
4	T7621XA	Adult sexual abuse suspected, initial encounter	1
5	Y0889XA	Assault by other specified means, initial encounter	1
Category Subtotal			5
Neglect			
1	E43	Unspecified severe protein-calorie malnutrition	1
2	E860	Dehydration	1
3	T189XXA	Foreign body of alimentary tract, part unspecified, initial encounter	1
4	W06XXXA	Fall from bed, initial encounter	1
Category Subtotal			4
Aggravated Assault			
1	S51852A	Open bite of left forearm, initial encounter	1
2	T7411XA	Adult physical abuse, confirmed, initial encounter	1
3	Y040XXA	Assault by unarmed brawl or fight, initial encounter	5
4	Y048XXA	Assault by other bodily force, initial encounter	1
Category Subtotal			8
Injury/Accident			
1	K922	Gastrointestinal hemorrhage, unspecified	3
2	S0101XA	Laceration without foreign body of scalp, initial encounter	2
3	S0181XA	Laceration without foreign body, other part of head, initial encounter	1
4	S022XXA	Fracture of nasal bones, initial encounter for closed fracture	3
5	S0292XA	Unspecified fracture of facial bones, initial encounter for closed fracture	1
6	S31119A	Laceration without foreign body of abdominal wall, unspecified quadrant without penetration into peritoneal cavity, initial encounter	1

Category	Diagnosis Code	Description	No. of Claims
7	S41152A	Open bite of left upper arm, initial encounter	1
8	S43004A	Unspecified dislocation of right shoulder joint, initial encounter	1
9	S51852A	Open bite of left forearm, initial encounter	1
10	S61032A	Puncture wound without foreign body of left thumb without damage to nail, initial encounter	1
11	S61231A	Puncture wound without foreign body of left index finger without damage to nail, initial encounter	1
12	S81011D	Laceration without foreign body, right knee, subsequent encounter	1
13	S91331A	Puncture wound without foreign body, right foot, initial encounter	1
14	S9305XA	Dislocation of left ankle joint, initial encounter	1
15	T23262A	Burn of second degree back of left hand, initial encounter	1
16	T421X1A	Poisoning by iminostilbenes accidental, initial encounter	1
17	T426X1A	Poisoning by other anti-epileptic and sedative-hypnotic drugs accidental, initial encounter	1
18	T43222A	Poisoning by selective serotonin reuptake inhibitors, intentional self-harm, initial encounter	1
Category Subtotal			23
Unplanned Hospitalization			
1	A419	Sepsis, unspecified organism	4
2	D62	Acute posthemorrhagic anemia	1
3	F319	Bipolar disorder, unspecified	1
4	J189	Pneumonia, unspecified organism	2
5	J690	Pneumonitis due to inhalation of food and vomit	1
6	J9600	Acute respiratory failure unspecified whether with hypoxia or hypercapnia	1
7	L03115	Cellulitis of right lower limb	1
8	R6521	Severe sepsis with septic shock	1
Category Subtotal			12
TOTAL			52

APPENDIX E: STATE AGENCY COMMENTS



State of California—Health and Human Services Agency
Department of Health Care Services



July 22, 2021

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

DRAFT AUDIT REPORT RESPONSE

Dear Ms. Ahlstrand:

The Department of Health Care Services (DHCS) hereby submits the enclosed response to the Office of Inspector General (OIG) draft audit report number A-09-19-02004 titled, "California Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities."

In the above audit report, OIG issued five recommendations for DHCS and the Department of Developmental Services (DDS). DHCS and DDS agree with all of OIG's recommendations, except for Recommendation 5, with which DHCS and DDS partially agree, and have prepared corrective action plans for implementation.

DHCS appreciates the work performed by OIG and the opportunity to respond to the draft audit report. If you have any other questions, please contact Internal Audits at (916) 445-0759.

Sincerely,

Will Lightbourne
Director

Enclosure

cc: See Next Page

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Department of Health Care Services

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

Audit Entity: Office of Inspector General

Report Number: A-09-19-02004 (19-26)

Response Type: Draft Audit Report Response

Finding 1: The Department of Health Care Services (DHCS) did not ensure that all critical incidents were reported.

Recommendation 1

DHCS in coordination with Department of Developmental Services (DDS) should provide additional guidance to providers, such as a standard reporting form that includes the types of incidents that are required to be reported, and provide additional training to providers on critical incident identification and reporting.

Agreement: Agrees with Recommendation

Implementation: Will Implement

Implementation Date: 3/1/2021

Implementation Plan:

As described in more detail below in the response to Recommendation 3, in March 2021, the DDS launched the statewide Medi-Cal claims review process. Beginning March 10, 2021 (see Attachment 4 and 5), and each month thereafter, regional centers receive a *Medi-Cal Claims Report*, generated by DDS, consisting of Medi-Cal claims for Medicaid beneficiaries who received treatment from a hospital for conditions possibly related to incidents of suspected abuse and neglect, for which a corresponding Special Incident Report (SIR) was not received by DDS. SIRs are received by the DDS from regional centers via the case management system known as San Diego Information System (SANDIS), and regional centers in turn collect the necessary information from initial and formal written reports from vendor service providers. Technical support and training to regional centers is ongoing (see Attachment 6), and in turn, regional centers are training and supporting providers. Details of the activity are described in subsequent responses, particularly to Recommendation 4.

We view this support and training as interim, however, because DDS also is re-examining reportable incident types for potential changes and associated training for both regional centers and service providers. Work currently is underway within the DDS, with the goal of engaging with other state departments, regional centers and providers,

and community stakeholders to identify desired changes, including exploring the use of a standard reporting format. Following the engagement, formal regulatory amendment to reflect changes in the reporting requirements will be conducted. Training and support for all stakeholders, including regional centers and providers, will be part of the regulatory implementation plan, based upon the updated reporting requirements.

DHCS is in agreement with the approach to achieving resolution to the deficiencies identified in the audit, as indicated above by DDS.

Finding 2: DHCS did not ensure that all reported critical incidents were reported in a timely manner and followed up on completely.

Recommendation 2

DHCS in coordination with DDS should provide additional guidance and training to regional centers for identifying the types of incidents that are required to be reported

Agreement: Agrees with Recommendation

Implementation: Will Implement

Implementation Date: 3/1/2021

Implementation Plan:

Please see our response for Recommendation 1, which addresses DDS current activity to identify changes and update training and support for stakeholders, including the identification of reportable incident types for both regional centers and providers.

Recommendation 3

DHCS in coordination with DDS should perform additional analytical procedures, such as data matches, to identify potential critical incidents that have not been reported and follow up on them as required.

Agreement: Agrees with Recommendation

Implementation: Will Implement

Implementation Date: 3/1/2021

Implementation Plan:

In our commitment to protecting the health and safety of consumers we serve, DDS has undertaken a number of activities. Since January 2020, DDS has been collecting and analyzing Medi-Cal claims data for Medicaid beneficiaries who received treatment from a hospital for conditions possibly related to incidents of suspected abuse and neglect. DDS developed and piloted a claims and review process with three regional centers. Before launching the process statewide in March 2021, DDS conducted multiple training

sessions with regional center leadership and risk management staff on the claims review process.

Regional centers must review the claims data in the reports described above in our response to Recommendation 1 and determine if a SIR is required to be submitted based upon reporting requirements contained in the California Code of Regulations, Title 17. If determined an incident meets regulatory reporting requirements, regional centers must submit a SIR to DDS. When a regional center determines an incident did not meet regulatory reporting requirements, the regional center is required to submit an explanation to DDS describing the reason not reportable (see Attachment 7). Updated *Medi-Cal Claims Report* information is due to DDS by the last day of the reporting month and is submitted to a specific electronic mailbox (sirdatareports@dds.ca.gov). Data from regional centers is reviewed by DDS staff for accuracy and regulatory compliance, and to ascertain the appropriate follow-up action(s) was taken to protect the health and safety of the consumer.

As noted in the response to Recommendation 1, technical support and training to regional centers and providers regarding the *Medi-Cal Claims Report* review process are ongoing. DDS also is re-examining reportable incident types for potential enhancements, with the goal of regulatory updates and subsequent updated training for regional centers, service providers, and other stakeholders.

Lastly, specific to mortality events, DDS engages in annual probabilistic data-matching between mortality SIRs and vital statistics records (see Attachment 8). DDS compares death certificate data in the California Comprehensive Master Death File with mortality data from SIRs for individuals served by DDS. The analysis identifies individuals who have died and for whom a mortality SIR has not been received by DDS. DDS staff in turn contact regional centers to confirm an identified individual's status and request a mortality SIR be submitted, as necessary.

DHCS is in agreement with the approach to achieving resolution to the deficiencies identified in the audit, as indicated above by DDS.

Recommendation 4

DHCS in coordination with DDS should improve oversight to ensure that timeliness and follow up requirements related to reported critical incidents are met.

Agreement: Agrees with Recommendation

Implementation: Will Implement

Implementation Date: 6/1/2020

Implementation Plan:

In December 2018, DDS began providing a monthly *Open SIRs with No Outcomes* report to regional centers (see Attachment 9, 10, and 11). The report includes data regarding SIRs with incident dates more than 90 days prior to the reporting month,

which remain open without an identified outcome. Since DDS has been providing the reports, there has been a positive and intended downward trend in the number of monthly SIRs requiring follow-up by the regional centers. Since 2018, there has been a 96 percent decrease in SIRs open longer than 90 days with no outcomes reported.

Subsequently, in July 2020, DDS began providing two new monthly reports (see Attachment 12 and 13) to regional centers: (1) A *Closed SIRs with No Outcomes* report which includes data regarding SIRs which have been closed without identified outcomes, and (2) An *Abuse/Neglect SIRs with No Protective Agency Notified* report which includes data regarding SIRs alleging suspected consumer neglect or abuse without indicating a protective/ investigative agency was notified. Updated information is due to DDS by the last day of the reporting month. Since July 2020, there has been a positive and intended downward trend in the data in both reports. The number of closed SIRs with no outcomes decreased by 32 percent and the number of suspected abuse/neglect SIRs with no protective agency notified decreased by 73 percent.

DDS analyzes the three reports, identifies trends and notifies individual regional centers of identified issues. DDS provides technical support and training to regional centers specific to issues identified in the reports.

Also in July 2020, DDS began providing two additional reports regarding timeliness: (1) the *Regional Center Summary of SIR Timeliness*, which presents data pertaining to the timely transmission of SIRs by the regional center to DDS within two working days (see Attachment 14), and (2) the *Vendor Summary of SIR Timeliness*, which presents data pertaining to the timely transmission of SIRs by vendors to the regional center within 48 hours of the incident date (see Attachment 15).

The reports inform regional centers' compliance with the regulatory requirements. DDS provides support and technical assistance to regional centers with compliance issues and utilizes data to analyze the variables impacting timeliness (e.g., specific vendors or vendor categories, internal regional center processes, etc.). Since June 2020, there have been a 13-percentage point increase in vendor reporting compliance (from 70 percent to 83 percent) and a 3-percentage point increase for regional centers (from 92 percent to 95 percent). DDS is exploring other methods to improve reporting timelines.

Additionally, DDS staff review SIRs daily and evaluate the following information: (1) whether the most appropriate incident type was selected, (2) whether action was taken to protect the consumer's health and safety, (3) whether the appropriate protective/investigative agencies were notified, and (4) whether safeguards were implemented or preventative actions were taken to mitigate or avoid a recurrence of the incident. In cases of suspected neglect or abuse, regional centers are required to notify a protective/investigative agency. DDS staff ensure the appropriate data fields are checked or identified in the narrative of the SIR. DDS staff contact the regional center if information in the SIR appears to be incomplete or incorrect.

DHCS is in agreement with the approach to achieving resolution to the deficiencies identified in the audit, as indicated above by DDS.

Recommendation 5

DHCS in coordination with DDS should ensure that all reported critical incidents involving the death of a beneficiary are reviewed by a mortality review committee.

Agreement: Partially Agrees with Recommendation

[Note: Title 17 regulations do not require *all* deaths to be reviewed by a regional center *mortality review committee*. The regulations do require regional centers to have a Risk Management and Mitigation Plan that includes the review of medical records and coroner reports (see Attachment 16).]

Implementation: Will Implement

Implementation Date: 1/10/2019

Implementation Plan:

Upon first learning of OIG's findings, DDS followed up with the regional center, which failed to conduct mortality reviews according to its Risk Management and Mitigation Plan for all reported critical incidents involving death to identify the root causes of the failure to perform the review. The regional center took immediate corrective action to address the clerical error, which caused the lapse in reviews.

In fall 2018 and into early January 2019, DDS and risk management contractor, Mission Analytics, held individual meetings with all 21 regional centers and discussed risk management activities and current practices. DDS reviewed each regional center's plans for risk management committees, agendas and meeting documentation to assess compliance with Title 17 requirements. The meetings also included a review and discussion of the risk management committee's role in monitoring the regional center's Risk Management and Mitigation Plan and in reviewing mortalities.

Moving forward, DDS continues meeting with regional centers and the Association of Regional Center Agencies in quarterly meetings to revisit the risk management plans and practices of the regional centers, including their mortality review elements. The issue identified by the OIG in one regional center has been resolved and does not appear to be systemic.

DHCS is in agreement with the approach to achieving resolution to the deficiencies identified in the audit, as indicated above by DDS.