DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION III
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JAN 17 2020

Report Number: A-03-17-00202

Ms. Teresa D. Miller
Secretary
Department of Human Services
P.O. Box 2675
Harrisburg, PA 17105-2675

Dear Ms. Miller:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary. The HHS action official will make final determination as to actions taken on all matters reported.

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If you have any questions or comments about this report, please do not hesitate to contact Charles Hubbs, Assistant Regional Inspector General for Audit Services, at (202) 815-1540 or through email at Charles.Hubbs@oig.hhs.gov. Please refer to report number A-03-17-00202 in all correspondence.

Sincerely,

Nicole Freda

Nicole Freda
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Glaze
Acting Director
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PENNSYLVANIA 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

January 2020
A-03-17-00202

Office of Inspector General

https://oig.hhs.gov

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: January 2020
Report No. A-03-17-00202

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

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

Why OIG Did This Audit

We have performed audits in several States in response to a congressional request concerning deaths and abuse of people with developmental disabilities living 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 the community and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) requires States to implement an incident reporting system to protect the health and welfare of the Medicaid beneficiaries receiving waiver services.

Our objective was to determine whether Pennsylvania complied with Federal waiver and State requirements related to 24-hour reportable incidents that involve Medicaid beneficiaries with developmental disabilities residing in community-based settings.

How OIG Did This Audit

Our audit covered 2015 and 2016. We reviewed medical claims for beneficiaries residing in community-based settings who had acute-care hospital stays and emergency room visits with diagnosis codes that we determined to be indicative of high risk for suspected abuse or neglect. We also reviewed 24-hour reportable incident reports that were submitted to Pennsylvania's incident reporting system.

What OIG Found

Pennsylvania did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring 24-hour reportable incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings. Specifically, Pennsylvania did not (1) ensure that community-based providers reported thousands of 24-hour reportable incidents within required timeframes, (2) ensure that community-based providers and county and regional investigators analyzed and investigated all beneficiary deaths, and (3) ensure that community-based providers referred all suspicious deaths to law enforcement.

Pennsylvania did not have adequate controls to detect unreported 24-hour reportable incidents and did not have controls in place to ensure that all beneficiary deaths were investigated and that all suspicious deaths were referred to law enforcement. Therefore, Pennsylvania did not fulfill participant safeguard assurances it gave to CMS to ensure the health, welfare, and safety of the 18,770 Medicaid beneficiaries with developmental disabilities covered by the Medicaid waiver in our audit.

What OIG Recommends and Pennsylvania Comments

We recommend that Pennsylvania improve its controls regarding the reporting and monitoring of 24-hour reportable incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. We made specific recommendations for these controls.

Pennsylvania concurred with six of our seven recommendations and described corrective actions that it plans to take or has already taken, but it did not concur with our recommendation that it record the 24-hour reportable incidents noted in our report. Instead, Pennsylvania stated that it plans to focus on recording unreported emergency room visits and hospital stays that contain diagnoses indicative of high risk for suspected abuse or neglect and take remedial action as appropriate. We agree that Pennsylvania should prioritize recording unreported incidents that contain diagnoses indicative of high risk for suspected abuse or neglect but maintain that all unreported 24-hour reportable incidents must be reported.

The full report can be found at https://oig.hhs.gov/oas/reports/region3/31700202.asp.

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INTRODUCTION

WHY WE DID THIS AUDIT

We have performed audits in several States[1] in response to a congressional request concerning deaths and abuse of people with developmental disabilities living in group homes. This request was made following nation-wide media coverage of deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors.

In Pennsylvania, individuals with developmental disabilities may reside in community-based settings such as group homes, shared living arrangements, and private family homes (collectively known as "community-based providers"). As required by its Medicaid Home and Community-Based Services (HCBS) Waiver, the Pennsylvania Department of Human Services (State agency) has specified types of events—including alleged abuse and neglect—that must be reported to the State agency for review and followup action by an appropriate authority. Pennsylvania's waiver application contains two categories that must be reported to the State agency within 24 hours of incident occurrence (collectively referred to in this report as "24-hour reportable incidents"). The waiver application further categorizes these events as either "critical incidents" or "incidents."

OBJECTIVE

Our objective was to determine whether the State agency complied with Federal Medicaid waiver and State requirements for reporting and monitoring 24-hour reportable incidents that involve Medicaid beneficiaries with developmental disabilities residing in community-based settings.

BACKGROUND

Developmental Disabilities Assistance and Bill of Rights Act of 2000

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

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

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

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

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

Pennsylvania currently has several HCBS waiver programs for people with developmental disabilities. This audit includes only those beneficiaries covered by the consolidated waiver program.[3]

States must give certain assurances to the Centers for Medicare & Medicaid Services (CMS) to receive approval for an HCBS waiver, including that necessary safeguards have been taken to protect the health and welfare of the beneficiaries receiving services (42 CFR § 441.302). This waiver assurance requires the State to give 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 consolidated waiver, Appendix G-1). In its consolidated waiver and its own regulations, the State agency stated that it has a critical event or incident reporting system.

The State agency retains authority over the administration and implementation of the consolidated waiver program. Within the State agency, the Office of Developmental Programs (ODP) is responsible for developing and distributing policies, procedures, and rules related to consolidated waiver operations and for coordinating with other State and local agencies.

During 2015 and 2016, Pennsylvania claimed $4.1 billion ($2.2 billion Federal share) to provide 18,770 individuals with needed comprehensive support services under the consolidated waiver.

[3] During our audit period, the consolidated waiver population consisted of beneficiaries with intellectual disabilities, which is a subset of developmental disabilities. After our audit period, the consolidated waiver's eligibility criteria was expanded to include certain beneficiaries with other developmental disabilities. For the purposes of this report, we refer to beneficiaries who have an intellectual disability, or both an intellectual disability and a physical disability, as having developmental disabilities.

Community-Based Providers' Reporting Requirements for 24-Hour Reportable Incidents

The HCBS waiver states that the State agency must specify types of critical events or incidents, including alleged abuse, neglect, and exploitation, that must be reported for review and followup action by an appropriate authority (HCBS consolidated waiver, Appendix G-1(b)). Pennsylvania's consolidated waiver application contains two categories, "critical incidents" or "incidents," that must be reported to the State agency within 24 hours of occurrence.[4] Examples of critical incidents include abuse, neglect, death, and certain emergency room visits and hospitalizations. Examples of incidents include missing persons, fire, law enforcement activity, and all non-critical-incident emergency room visits and hospitalizations. Both critical incidents and incidents must be reported in the State agency's incident reporting system,[5] but there are different investigation requirements for critical incidents and incidents.

The consolidated waiver specifies that community-based providers must report both critical incidents and incidents to the State agency within 24 hours of their occurrence or discovery.[6] Community-based providers must complete incident reports[7] for all 24-hour reportable incidents. These finalized incident reports must correctly categorize the 24-hour reportable incident; indicate if proper safeguards were in place; indicate if any necessary corrective action either has taken or will take place; and indicate if critical incidents of abuse, neglect, or exploitation were reported to the proper authority as required by Pennsylvania law[8] (HCBS consolidated waiver, Appendix G-1(d)).

In addition, critical incidents must also be investigated by an ODP-certified investigator in accordance with established timelines and standards. When an ODP-certified investigator completes the investigation, he or she enters the summary into the State agency's incident

[4] The consolidated waiver and State regulations also include a category of incidents that must be reported within 72 hours. However, we limited our review to only those incidents that must be reported within 24 hours of occurrence. When we use the term "incident" in this report, we are referring only to those incidents that must be reported within 24 hours of occurrence.

[5] Before 2016, the State agency's incident reporting system was the Home and Community Services Information System (HCSIS). On January 4, 2016, the State agency transitioned to the Enterprise Incident Management (EIM) system. The State agency maintains separate databases for HCSIS incidents and EIM incidents. We analyzed data from both systems and refer to the systems collectively as "the incident reporting system."

[6] State regulations at 55 Pennsylvania Code section 6000.922 also specify categories that must be reported in the State agency's incident reporting system within 24 hours after occurrence.

[7] These reports are known as "incident reports" regardless of whether the event is a critical incident or an incident.

[8] Incident reports include a conclusion section in which investigators document whether the 24-hour reportable incident resulted from abuse or neglect or whether there were additional referrals to adult or child protective services. Detail must also be provided that describes exactly what happened during the incident, including all relevant details prior to, during, and after the incident.

reporting system, and the provider then completes and finalizes the report within 30 days of the occurrence of the critical incident (HCBS consolidated waiver, Appendix G-1(d)).

Incidents, however, do not require an investigation by an ODP-certified investigator. The consolidated waiver states that incidents are subject to review by ODP and an administrative entity.[9] Table 1 on the following page shows the types and number of incidents recorded in the incident reporting system[10] during calendar years (CYs) 2015 and 2016 (audit period).

The waiver generally classifies beneficiary deaths as critical incidents, which must be reported within 24 hours of occurrence or discovery, investigated by an ODP-certified investigator in accordance with ODP's established timelines and standards, and entered as an incident in the incident reporting system. In addition, State regulations at 55 Pennsylvania Code section 6000.922(a)(2) require all deaths to be reported within 24 hours, while 55 Pennsylvania Code section 6000.925 indicates that the death of an individual receiving services from a provider must be investigated by the provider and ODP or by the Pennsylvania Department of Health with county participation as requested by ODP.

In addition to these requirements, the Pennsylvania Adult Protective Services Act, which applies to adults between the ages of 18 and 59, and the Pennsylvania Older Adults Protective Services Act, which applies to adults ages 60 and older, specify that when deaths are suspicious, the community-based provider must immediately make an oral report to appropriate law enforcement officials. Within 48 hours of making the oral report, the community-based provider must submit a written report to appropriate law enforcement officials.[11]

[9] An administrative entity is a county mental health or intellectual disability program or a nongovernmental entity that has a signed agreement with ODP to perform operations and administrative functions related to the consolidated waiver.

[10] This table contains every incident type that a provider can report in the incident reporting system. This includes both critical incidents and incidents. The incident reporting system does not distinguish between critical incidents and incidents in its listing of primary incident types.

[11] Pennsylvania Adult Protective Services Act § 501(b); Pennsylvania Older Adults Protective Services Act § 701(b).

Table 1: Number and Type of Incidents Reported in the Incident Reporting System for Calendar Years 2015 and 2016

Primary Incident Type*	Number of Incidents
Emergency Room Visit	24,149
Medication Error	22,226
Individual To Individual Abuse	10,650
Hospitalization	8,160
Neglect	6,369
Restraint	5,279
Abuse	5,273
Optionally Reportable Event	3,581
Law Enforcement Activity	2,958
Injury Requiring Treatment Beyond First Aid	2,524
Psychiatric Hospitalization	2,098
Misuse of Funds	1,536
Rights Violation	1,215
Death	654
Missing Person	469
Emergency Closure	141
Fire	66
Reportable Disease	53
Suicide Attempt	43
Total	**97,444**

***** Incidents also have secondary incident types; however, they are categorized in this table according to primary incident type. The provider determines the primary incident type for reporting purposes; for each primary incident type, the incident reporting system automatically generates a list of options from which the provider selects the secondary incident type.

HOW WE CONDUCTED THIS AUDIT

We extracted from the Pennsylvania Medicaid Management Information System (MMIS) claim records for 28,627 emergency room visits and 5,709 acute-care hospital stays that the State agency paid on behalf of Medicaid beneficiaries with developmental disabilities who were eligible for the consolidated waiver and had a claim during CYs 2015 and 2016. We compared these 28,627 emergency room visits and 5,709 acute-care hospital stays to the incident reporting system databases to determine if these visits and stays were reported to the State agency as 24-hour reportable incidents.[12]

To determine whether community-based providers reported these 24-hour reportable incidents to the State agency, we also reviewed 1,162 emergency room visits and 510

[12] Emergency room visits and acute-care hospital stays can be either critical incidents or incidents depending on the circumstances. However, in either case, all emergency room visits and acute-care hospital stays must be reported in the State agency's incident reporting system within 24 hours of their occurrence.

acute-care hospital stays with at least 1 of 97 diagnosis codes that we determined to be indicative of high risk for suspected abuse or neglect. We also reviewed incident reports that were submitted to the State agency through the State agency's incident reporting system to determine if the State agency followed Federal and State requirements regarding 24-hour reportable incident reporting and monitoring.

To determine whether community-based providers analyzed and investigated all beneficiary deaths, we judgmentally sampled 13 of the 654 beneficiaries who had an incident report during our audit period with the primary incident type listed as death. We reviewed the critical incident reports surrounding the 13 deaths and compared that information to hospital medical records. For those 13 beneficiaries, we also reviewed any previous 24-hour reportable incidents that were reported in the incident reporting system.

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 details of our audit scope and methodology. Appendix C contains details about the Federal waiver and State requirements.

FINDINGS

The State agency did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring 24-hour reportable incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings. Specifically, the State agency did not:

- ensure that community-based providers reported all 24-hour reportable incidents to the State agency within required timeframes,
- ensure that community-based providers and county and regional investigators analyzed and investigated all beneficiary deaths, and
- ensure that community-based providers referred all suspicious deaths to law enforcement.

The State agency did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring 24-hour reportable incidents because it did not have adequate internal controls in place to detect unreported 24-hour reportable incidents and did not have controls in place to ensure that all beneficiary deaths were investigated and that all suspicious deaths were referred to law enforcement. Therefore, the State agency did not fulfill various participant safeguard assurances it gave to CMS in its consolidated waiver. The State agency

also failed to demonstrate that it ensured the health, welfare, and safety of the 18,770 Medicaid beneficiaries with developmental disabilities covered by the consolidated waiver.

COMMUNITY-BASED PROVIDERS DID NOT REPORT THOUSANDS OF 24-HOUR REPORTABLE INCIDENTS TO THE STATE AGENCY

Community-based providers in Pennsylvania are required to report to the State agency 24-hour reportable incidents involving Medicaid beneficiaries with developmental disabilities (HCBS consolidated waiver, Appendix G-1(b)). As part of its oversight, the State agency is required to compile 24-hour reportable incident data and analyze these data to identify patterns and trends to prevent reoccurrences of 24-hour reportable incidents (Appendix G-1(e); Appendix G: Quality Improvement: Health and Welfare; Appendix H). All emergency room visits and acute-care hospital stays are either critical incidents or incidents depending on the circumstances[13] surrounding the visits or stays and must be reported in the State agency's incident reporting system within 24 hours of their occurrence.

Unreported Emergency Room Visits

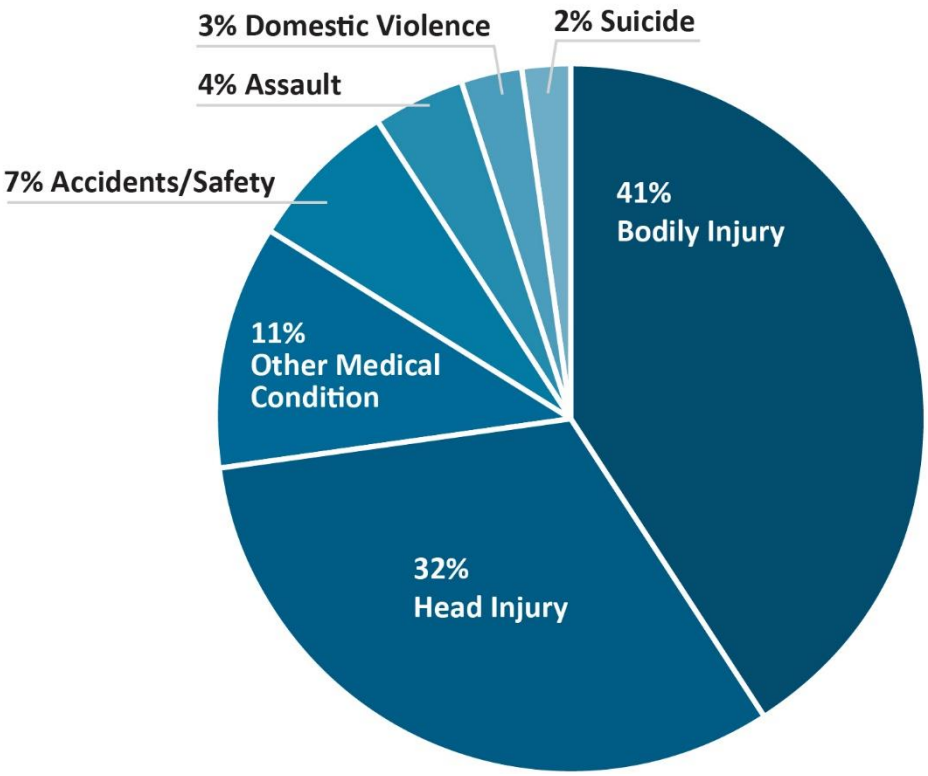
Community-based providers did not report to the State agency all 24-hour reportable incidents involving emergency room visits for Medicaid beneficiaries with developmental disabilities covered by the consolidated waiver. By comparing Medicaid claims for emergency room visits to the emergency room visits reported in the State agency's incident reporting system, we determined that 18,880 emergency room visits were not reported.

Of the 1,162 claims that included diagnoses indicative of high risk for suspected abuse or neglect, community-based providers failed to report 307. Figure 1 on the following page shows these 307 unreported emergency room visits by diagnosis code category.[14]

[13] See Appendix C for the circumstances that dictate whether an emergency room visit or acute-care hospital stay is a critical incident or an incident.

[14] Appendix D contains descriptions of the 61 diagnosis codes associated with unreported emergency room visits.

Figure 1: High-Risk Diagnosis Code Categories in Unreported Emergency Room Visits



State agency officials stated that the State agency relies on community-based providers to report 24-hour reportable incidents. Current controls to detect unreported 24-hour reportable incidents consist of State agency visits and annual provider monitoring by administrative entities. However, these controls did not detect the 18,880 emergency room visits that we found were not reported, and State agency officials did not indicate that the State agency had any other controls to ensure that community-based providers report 24-hour reportable incidents within 24 hours. Because the State agency did not detect that these 24-hour reportable incidents had not been reported, it was not always able to take prompt action to protect beneficiaries' health, safety, and rights.

A Representative Example of Emergency Room Visits Not Reported by the Community-Based Provider

A beneficiary with developmental disabilities who lived alone in an apartment but had 24-hour home-care services was admitted to an emergency room twice. The first emergency room visit was not reported within 24 hours of the incident, and the second emergency room visit was not reported at all.

The medical record from the first emergency room visit documented that the beneficiary called 911 and stated that she wanted to commit suicide. The beneficiary was brought to the emergency room, where the medical record noted self-inflicted facial lacerations that the beneficiary said resulted from a

suicide attempt. The medical record also documented that the beneficiary was pinching her arm and stabbing a pencil into her chest. The emergency room physician diagnosed the beneficiary with a suicide attempt and suicidal ideation.

Even though the home-care services provider was at the hospital, the home-care services provider waited 63 days to report the emergency room visit. The incident report stated only that the beneficiary was admitted, treated, and discharged home. The incident report did not contain any explanation for what occurred before, during, and after the beneficiary was taken to the emergency room. A State agency reviewer concluded that the incident report should have included an explanation for the delay in reporting the emergency room visit and that home-care services provider should have taken corrective action to ensure that all staff understood the requirements for reporting 24-hour reportable incidents within required timeframes.

Twelve days after the first emergency room visit was reported, the beneficiary was admitted to the emergency room again for a suicide attempt. The second emergency room visit was not reported in the incident reporting system.

Because both of the emergency room visits met the State agency's definition of a 24-hour reportable incident, the community-based provider should have reported each in the State's incident reporting system within 24 hours of occurrence. Because of the delay in reporting the first emergency room visit, the State agency could not review it in a timely manner and ensure prompt corrective actions were taken. Because the second emergency room visit was not reported, the State agency could not review it and ensure prompt corrective actions were taken or identify patterns of beneficiary care.

Unreported Acute-Care Hospital Stays

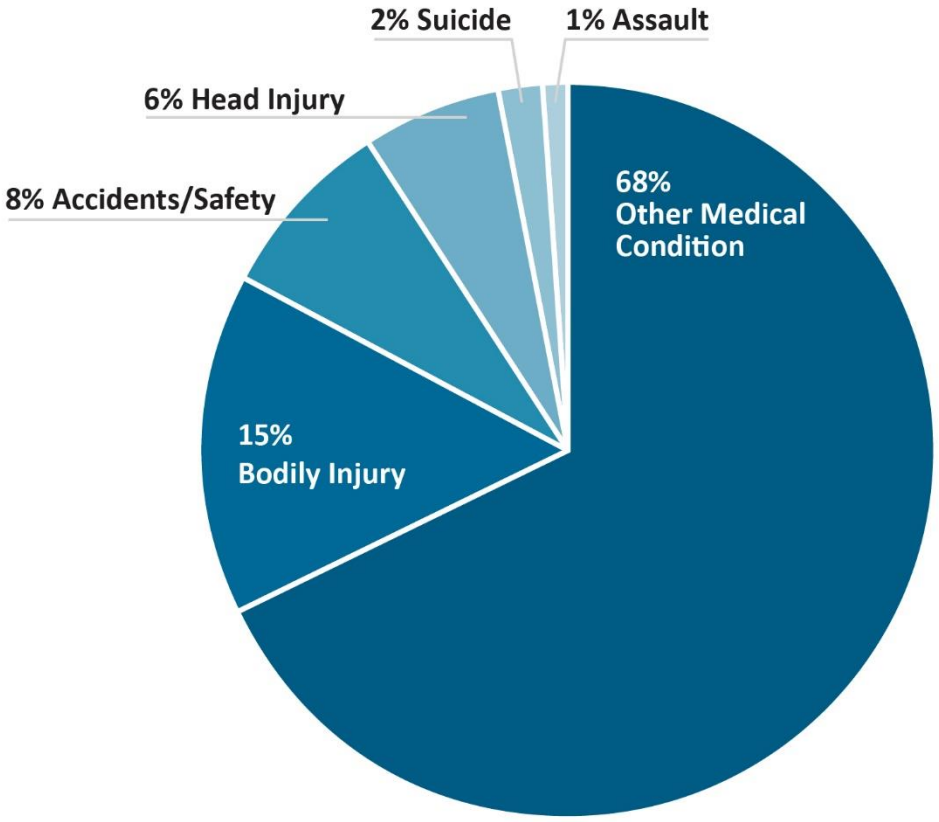
Community-based providers did not report to the State agency all 24-hour reportable incidents involving acute-care hospital stays for Medicaid beneficiaries with developmental disabilities. By comparing Medicaid claims for acute-care hospital stays to the acute-care hospital stays reported in the incident reporting system, we determined that 2,078 stays had not been reported. [15]

To determine if the most serious acute-care hospital stays were being reported, we selected acute-care hospital stay claims with at least 1 of 97 diagnosis codes that we determined to be indicative of high risk for suspected abuse or neglect. Of the 510 stays that included diagnoses

[15] OIG has developed *A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect*, A-01-19-00502. The guide explains OIG's approach to using claims data to identify incidents of potential abuse or neglect and also provides technical information to support OIG's private and public sector partners with analyzing their own claims data to help combat abuse and neglect.

indicative of high risk for suspected abuse or neglect, community-based providers failed to report 167. Figure 2 shows these 167 unreported acute-care hospital stays by diagnosis code category.[16]

Figure 2: High-Risk Diagnosis Code Categories in Unreported Acute-Care Hospital Stays



State agency officials stated that the State agency relies on community-based providers to report 24-hour reportable incidents. Current controls to detect unreported 24-hour reportable incidents consist of State agency visits and annual provider monitoring by administrative entities. However, these controls did not detect the 2,078 acute-care hospital stays that we found had not been reported, and the State agency officials did not indicate that the State agency had any other controls to ensure that community-based providers report 24-hour reportable incidents within 24 hours. Because the State agency did not detect that these 24-hour reportable incidents had not been reported, it was not always able to take prompt action to protect beneficiaries' health, safety, and rights.

[16] Appendix E contains descriptions of the 32 diagnosis codes associated with unreported acute-care hospital stays.

A Representative Example of Acute-Care Hospital Stays Not Reported by the Community-Based Provider

A beneficiary with developmental disabilities had two unreported acute-care hospital stays following a reported critical incident of abuse.

The two hospital stays took place at two different hospitals on two consecutive days. During the first hospital stay, the beneficiary was diagnosed with dehydration, and during the second hospital stay, the beneficiary was diagnosed with bedsores and recurrent dislocation of the pelvis.

Less than two weeks before these unreported acute-care hospital stays, the beneficiary was released from the hospital after a reported 24-day hospitalization. The medical record for this 24-day hospitalization stated that the beneficiary's mother pushed the beneficiary, who was in a wheelchair, to a park and left the beneficiary there unattended for 5 days. According to the medical record, law enforcement found the beneficiary covered by a tarp, leaves, and sticks and bound so that the beneficiary could not communicate. Law enforcement brought the beneficiary to the hospital, where he was diagnosed with adult nutritional neglect and assault (criminal neglect). The medical record also documented that the beneficiary's mother had previously attempted to drown him by leaving him in a bathtub with the water running.

Because both of the unreported acute-care hospital stays met the State agency's definition of a 24-hour reportable incident, the community-based provider should have reported each acute-care hospital stay in the incident reporting system within 24 hours of occurrence. However, because the acute-care hospital stays were not reported, the State agency could not record or investigate them and could not implement possible corrective actions and identify patterns of beneficiary care.

THE STATE AGENCY DID NOT ENSURE THAT COMMUNITY-BASED PROVIDERS AND COUNTY AND REGIONAL INVESTIGATORS ANALYZED AND INVESTIGATED ALL BENEFICIARY DEATHS

The death of a beneficiary covered by the consolidated waiver is generally a critical incident and must therefore be reported in the incident reporting system and investigated. (HCBS consolidated waiver, Appendix G(b)). In addition, State regulations at 55 Pennsylvania Code section 6000.922(a)(2) requires all deaths to be reported within 24 hours, and 55 Pennsylvania Code section 6000.925 indicates that deaths must be investigated when an individual is receiving services from a provider.

Of the 13 beneficiary deaths in our judgmental sample, 1 involved potential abuse or neglect. For this case, the community-based provider's investigation originally determined that the beneficiary's death did not involve abuse or neglect. However, the initial investigation was

based on incomplete information. The State agency reopened the investigation after reviewing the case at our request.

In addition, community-based providers and county and regional investigators did not investigate a significant number of deaths: community-based providers did not investigate 80 deaths, and county and regional investigators did not investigate 94 deaths. (See Table 2.) We also found differences between the results of provider investigations and the results of county and regional investigations. Additionally, many community-based provider and county or regional investigations left the conclusion section of the incident report blank.

Table 2: Analysis of Death Investigations

Results of Investigations Into Beneficiary Death	Provider Investigation	County or Regional Investigation
Neglect	11	12
Abuse and Neglect	1	1
No Abuse or Neglect	510	240
Conclusion Blank	52	307
No Investigation	80	94
Total	**654**	**654**

If a community-based provider investigation or county or regional investigation concludes that deaths did not involve abuse or neglect based on incomplete information or if an investigator does not document conclusions on incident reports, there is a possibility that beneficiary deaths involving abuse or neglect could be overlooked and not referred to law enforcement in accordance with the Pennsylvania law.[17] For the beneficiary death in our sample that may have involved abuse or neglect, had the initial investigation taken into account the beneficiary's previous 24-hour reportable incidents we describe below, the investigation might have come to a different conclusion and the community-based provider might have referred the case to law enforcement.

The Incomplete Investigation Into a Beneficiary Death

A community-based provider reported the death of a beneficiary with a developmental disability. The beneficiary had two wound care clinic visits and five reported 24-hour reportable incidents in the 3-month period before the beneficiary's death.

In February, 3 months before the beneficiary's death, the beneficiary was seen by a hospital's outpatient wound care clinic for surgical evaluation of multiple bed sores as well as a stage IV pressure ulcer. In the medical record, the attending physician expressed "significant concerns with this patient in the

[17] Pennsylvania Adult Protective Services Act § 501(b); Pennsylvania Older Adults Protective Services Act § 701(b).

environment that she is currently living in, due to multiple pressure ulcer development. [The beneficiary] is in a group home and appears to need more skilled nursing care than is able to be provided through [the group home]."

The following month, in March, the beneficiary had a second wound care clinic visit. In the medical record, the attending physician noted that "based on the patient's current health status and present living conditions, I feel that [the beneficiary's] health issues are becoming overly difficult for non-skilled nursing caregivers to be able to provide. It is my recommendation that [the beneficiary] be considered for placement in a skilled nursing facility."

In addition to these wound care clinic visits, this beneficiary also had five 24-hour reportable incidents that were reported in the incident reporting system in the 3 months before the beneficiary's death.

Specifically, in February, the beneficiary had two reported 24-hour reportable incidents:

- an (undetermined) injury requiring treatment beyond first aid and
- a failure by the group home to provide needed care.

In March, the beneficiary had three reported 24-hour reportable incidents:

- a hospital stay,
- a failure by the group home to provide needed care, and
- an emergency room visit.

Separate provider investigations of these 24-hour reportable incidents confirmed neglect in the "failure to provide needed care" 24-hour reportable incidents.

In April, the community-based provider reported the death of the beneficiary. The provider investigated the death to determine if the beneficiary received timely and adequate care before death but did not document a conclusion to its investigation. A regional investigation concluded that the death was "not confirmed for abuse or neglect."[18]

Investigations for this death did not take into account the beneficiary's previously reported 24-hour reportable incidents. If the investigators had

[18] The State agency noted that a conclusion of "not confirmed for abuse or neglect" is an assertion that the critical incident is not a founded case of abuse or neglect.

considered previous 24-hour reportable incidents, medical history, and doctor's notes, they may have decided that this case resulted from abuse or neglect, which would have triggered an additional investigation into the group home. While reviewing this case at our request, the State agency discovered evidence that warranted reopening the investigation into the beneficiary's death.

THE STATE AGENCY DID NOT ENSURE THAT PROVIDER EMPLOYEES AND ADMINISTRATORS REFERRED ALL SUSPICIOUS DEATHS TO LAW ENFORCEMENT

In addition to the provider's requirement to report deaths to the State agency, Pennsylvania requires a provider's employee or administrator who has reasonable cause to suspect that a death is suspicious to immediately contact law enforcement officials to make an oral report. Within 48 hours of making the oral report, the employee and the administrator must submit a joint written report to appropriate law enforcement officials (Pennsylvania Adult Protective Services Act § 501(b); Pennsylvania Older Adults Protective Services Act § 701 (b)).

Of the 13 death cases in our judgmental sample that met the criteria for referral to law enforcement, 2 cases were not referred. One case had provider and regional investigations that confirmed neglect, but law enforcement officials and the Office of the Attorney General were not notified as required by Pennsylvania law.[19] Therefore, neither the district attorney nor the Attorney General investigated the death. After we asked about the case, the State agency reported the death to the district attorney's office. For the other case, the State agency reopened its investigation after reviewing the case at our request.

A Representative Example of a Suspicious Death Not Reported to Law Enforcement

A beneficiary died after being removed from life support. The written description of the critical incident in the incident reporting system stated that the beneficiary was eating lunch and began choking. The cause of death on the death certificate was anoxic brain injury, cardiorespiratory arrest, and aspiration with upper respiratory obstruction. A provider investigation concluded that the beneficiary's death was the result of neglect. The State agency agreed with this determination and confirmed that the beneficiary's care was not managed properly.

The regional investigator stated that she communicated directly with a provider quality improvement manager who expanded the provider investigation summary to document more information on the circumstances surrounding the critical incident. According to this expanded summary, the beneficiary grabbed

[19] ACT 28/26 (Pennsylvania Statutes, Title 18, section 2713), requires the State agency to report abuse or neglect of a care-dependent person to the Office of the Attorney General or local law enforcement. Under ACT 28/26, the Attorney General and district attorneys have the authority to investigate the alleged abuse or neglect.

a plate of pureed grilled cheese and began eating very quickly while the staff member's back was turned. The beneficiary's individual service plan stated that the beneficiary was to have direct staff supervision while eating. The beneficiary was also to eat slowly and have sips of water every three bites because the beneficiary was at risk for choking. The expanded summary stated that it appeared that there was insufficient direction regarding foods that may be less than ideal for pureeing.

Both the provider investigation and the regional investigation confirmed neglect. However, neither law enforcement nor the district attorney's office was contacted regarding the case. Because this case was not referred to law enforcement for further review and investigation, the State agency did not ensure that other Medicaid beneficiaries with developmental disabilities were adequately protected from similar future 24-hour reportable incidents involving neglect by this community-based provider.

As a result of our questioning why the case was not referred to the district attorney's office, the State agency referred this case to law enforcement in July 2018. The State agency referral indicated that the provider was suspected of neglecting an individual in its care, which resulted in the individual's death.

THE STATE AGENCY DID NOT HAVE ADEQUATE CONTROLS TO ENSURE COMPLIANCE WITH FEDERAL MEDICAID WAIVER AND STATE REQUIREMENTS

The State agency did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring 24-hour reportable incidents because internal controls were not sufficient to ensure that providers reported all 24-hour reportable incidents. The State agency relies on community-based providers to report all 24-hour reportable incidents in the incident reporting system.

The State agency's only controls for detecting unreported 24-hour reportable incidents were quarterly support coordinator[20] visits for each beneficiary covered by the consolidated waiver, annual State agency licensing inspections, and annual administrative entity provider-monitoring activities.

During their visits, support coordinators and State agency officials should review event logs to determine if all 24-hour reportable incidents have been reported. However, not all community-based providers have event logs, and the support coordinators and State agency licensing personnel did not disclose any steps the State agency or the providers had taken to identify 24-hour reportable incidents that may not have been logged. Additionally, administrative entities conduct annual provider-monitoring activities that review a sample of

[20] Support coordinators are employed by Supports Coordination Organizations that have contracts with the State agency. Each support coordinator works to locate, coordinate, and monitor needed services and supports for waiver participants.

individual records at each provider. As part of the record review, the administrative entities determine whether all 24-hour reportable incidents have been reported. However, this control did not detect the 18,880 emergency room visit claims and 2,078 acute-care hospital stay claims that we found had not been reported.

Current controls only address identifying 24-hour reportable incidents after they have gone unreported. The State agency officials did not indicate that the State agency had any other controls to ensure that community-based providers report all 24-hour reportable incidents within 24 hours of their occurrence.

One control that would improve the percentage of 24-hour reportable incidents that are reported would be the State agency's conducting a routine reconciliation of the 24-hour reportable incidents in the incident reporting system with Medicaid claims data in MMIS. A routine reconciliation would allow the State agency to identify claims that should have been reported as 24-hour reportable incidents. Such a reconciliation might also provide the State agency with information about patterns of reporting behavior and beneficiary care at community-based providers.

The State agency also did not have controls in place to ensure that all beneficiary deaths were investigated. Nor were there controls in place to ensure that the State agency referred all suspicious deaths to law enforcement.

Accordingly, the State agency did not fulfill numerous participant safeguard assurances it gave to CMS to ensure the health, welfare, and safety of the Medicaid beneficiaries with developmental disabilities covered by the consolidated waiver (18,770 for the audit period) (42 CFR § 441.302(a)).

RECOMMENDATIONS

We recommend that the Pennsylvania Department of Human Services improve its controls regarding the reporting and monitoring of 24-hour reportable incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Specifically, we recommend that the Pennsylvania Department of Human Services:

- record the unreported 24-hour reportable incidents noted in this report;
- work with community-based providers on how to identify and report all 24-hour reportable incidents;
- work with community-based providers to ensure that all community-based providers' staff understand the requirements for reporting 24-hour reportable incidents within required timeframes;

- develop a policy to periodically match Medicaid emergency room visit and acute-care hospital stay claims to 24-hour reportable incidents recorded in the incident reporting system;

- work with community-based providers to ensure that administrative reviews and investigations are conducted and reported appropriately and consider all previous 24-hour reportable incidents related to the beneficiary;

- ensure community-based providers analyze, investigate, and report to the State all beneficiary deaths; and

- send a written report of death to law enforcement or the district attorney's office when a death is determined to be suspicious or when abuse or neglect is suspected.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency did not concur with our first recommendation but concurred with the remaining six recommendations. The State agency outlined the corrective actions that it has taken and plans to take to address those six recommendations.

The State agency did not concur with our recommendation that the State agency record the unreported 24-hour reportable incidents noted in this report. Although it said that it understood the basis for the recommendation, it stated that adopting the recommendation would require significant effort and resource investment and would have minimal impact on health and safety outcomes for current waiver participants. The State agency further noted that, given the amount of time since the incidents occurred, it is unlikely that the State agency would be able to perform critical investigative activities, such as locating witnesses and gathering the documentary evidence necessary to determine whether abuse or neglect had occurred.

Instead, the State agency stated that it plans to focus its efforts on recording all unreported emergency room visits and hospital stays that had diagnoses indicative of high risk for suspected abuse or neglect and take remedial action as appropriate. The State agency began this process after we brought the issue to its attention.

The State agency stated that it analyzed several high-risk incidents that we identified as unreported and found that these high-risk incidents had been reported. According to the State agency, these incidents appeared to us to be unreported because the date of the incident and the date of the claim were not an exact match. The State agency also indicated that some claims for emergency room visits did not meet the criteria for required reporting because the incidents did not occur during the provision of a provider-delivered service in accordance with 55 Pa. Code section 6000.911. Additionally, the State agency noted that it found that some claims identified as unreported emergency room visits occurred at treatment facilities located at the same service location as an emergency room but were not emergencies that were

required to be reported. For these reasons, the State agency requested that we reconsider the characterization of our finding that thousands of incidents were unreported.

In its comments, the State agency also noted an inaccuracy in the draft report that we corrected. The State agency's comments are included in their entirety as Appendix F.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that the facts of our report are valid. We agree that the State agency should prioritize recording the unreported 24-hour reportable incidents that contain diagnoses indicative of high risk for suspected abuse or neglect. However, we maintain that all unreported 24-hour reportable incidents must be reported to establish an accurate beneficiary history, which may indicate that changes to a beneficiary's care setting are necessary.

We acknowledge that some of the 18,800 unreported emergency room visits could have been followup visits, assessments, and visits to the emergency room in lieu of visits to a primary care provider. However, all 18,800 were coded as emergency room visits, and the State agency did not determine how many of the coded emergency room visits may have been miscategorized. We also acknowledge that, under certain limited circumstances the incident date and claim date may not have been an exact match, and therefore some of the 24-hour reportable incidents that we classified as unreported may have been reported. However, the State agency did not provide evidence as to how many of these 24-hour reportable incidents were reported on a date other than the emergency room claim date. Therefore, we have not changed the characterization of our finding that thousands of incidents were unreported.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

During CYs 2015 and 2016, the State agency provided consolidated waiver services to 18,770 Medicaid beneficiaries with developmental disabilities and received 97,444 incident reports involving these 18,770 beneficiaries from community-based providers and other mandated reporters. Of the 18,770 beneficiaries, 14,099 had at least one 24-hour reportable incident recorded. MMIS claim records showed that the State agency paid for a total of 28,627 emergency room visits and 5,709 acute-care hospital stays on behalf of Medicaid beneficiaries with developmental disabilities who were eligible for the consolidated waiver during CYs 2015 and 2016. For this same period, the State agency conducted 16,140 critical incident investigations on behalf of beneficiaries covered by the consolidated waiver.

We selected 1 of 97 diagnosis codes that we determined to be indicative of high risk for suspected abuse or neglect and reviewed 1,162 emergency room visits and 510 acute-care hospital stays that contained at least one of those diagnosis codes.

In performing our audit, we established reasonable assurance that the claims data contained in the MMIS were accurate. We did not review the overall internal control structure of the State agency. We limited our internal control review to obtaining an understanding of the State agency's policies and procedures related to 24-hour reportable incidents.

We performed our fieldwork at the State agency office in Harrisburg, Pennsylvania.

METHODOLOGY

To accomplish our audit objective, we:

- reviewed applicable Federal waiver and State requirements;
- held discussions with CMS officials to gain an understanding of the HCBS waiver for beneficiaries with developmental disabilities residing in community-based settings;
- held discussions with officials from various Pennsylvania agencies to gain an understanding of Pennsylvania's policies and procedures related to the mandatory reporting of potential abuse and neglect of beneficiaries with developmental disabilities;
- obtained from the State agency a computer-generated file of eligibility information on all 18,770 Medicaid beneficiaries with developmental disabilities covered by the consolidated waiver and residing in community-based settings during 2015 and 2016;
- obtained from MMIS a computer-generated file containing claims for emergency room visits and acute-care hospital stays during CYs 2015 and 2016 for Medicaid beneficiaries with developmental disabilities covered by the consolidated waiver;

- obtained from the incident reporting system database 97,444 incident reports from CYs 2015 and 2016 submitted on behalf of beneficiaries covered by the consolidated waiver;

- obtained from the incident reporting system databases 16,140 investigation reports of 24-hour reportable incidents from CYs 2015 and 2016 submitted on behalf of beneficiaries covered by the consolidated waiver;

- matched the MMIS medical claims data (28,627 emergency room visits) for beneficiaries covered by the consolidated waiver to the incident reporting system databases to determine which claims for emergency room visits did not have corresponding 24-hour reportable incidents reported in the incident reporting system;

- matched the MMIS medical claims data (5,709 acute-care hospital stays) for beneficiaries covered by the consolidated waiver to the incident reporting system databases to determine which claims for acute-care hospital stays did not have corresponding 24-hour reportable incidents reported in the incident reporting system;

- identified 1,162 emergency room visit claims that had 1 or more of the 97 diagnosis codes indicative of high risk for potential abuse or neglect (Appendix D);

- identified 510 acute-care hospital stay claims that had 1 or more of the 97 diagnosis codes indicative of high risk for potential abuse or neglect (Appendix E);

- contacted hospitals and obtained and reviewed hospital medical records for 52 judgmentally selected beneficiary emergency room visits and 12 judgmentally selected acute-care hospital stays associated with 1 or more of the 97 diagnosis codes that indicated an increased risk of abuse or neglect;

- reviewed incident reporting system data for 654 critical incidents involving beneficiary deaths and specifically reviewed incident reports and other supporting documentation for 13 judgmentally sampled critical incidents involving beneficiary deaths to determine if the State agency followed Federal waiver and State requirements regarding critical incident reporting for critical incidents involving beneficiary deaths; and

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

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect	A-01-19-00502	7/23/2019
Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-09-17-02006	6/10/2019
Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight	Joint Report	1/17/2018
Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-01-16-00001	8/9/2017
Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00008	7/13/2016
Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00002	5/25/2016
Review of Intermediate Care Facilities in New York With High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries	A-02-14-01011	9/28/2015

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,[21] 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 its 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 consolidated waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements"

This section of the waiver states that the entities required to report 24-hour reportable incidents are identified and defined in the ODP Bulletin and regulations, and that these entities include employees, contracted agents and volunteers for waiver service providers, administrative entities, and ODP staff.

Participating beneficiaries and their families must notify the provider or support coordinator, when they feel it is appropriate, regarding any health and safety concerns related to a service or support received. ODP requires reporting of 24-hour reportable incidents in the incident reporting system whether the person who witnessed or first discovered the 24-hour reportable incident is an employee, contractor, or volunteer. To facilitate reporting, there are toll-free phone and email options for reporting of 24-hour reportable incidents by volunteers, families, or other community members.

This section of the waiver also defines both critical incidents and incidents. It states that the following are critical incidents:

- abuse;
- death;

[21] Three different versions of the consolidated waiver were in effect during the period of this audit. Any material differences between these waivers are noted in this report.

- emergency room visit resulting from unexplained injury, staff-to-individual injury, injury resulting from individual-to-individual abuse, or injury resulting from restraint;
- hospitalization resulting from accidental injury, unexplained injury, staff-to-individual injury, injury resulting from individual-to-individual abuse, or injury resulting from restraint;
- individual-to-individual sexual abuse;
- injury requiring treatment beyond first aid resulting from staff-to-individual injury, individual-to-individual abuse, or restraint;
- misuse of funds;
- neglect; and
- rights violation.

The following are incidents:

- suicide attempt;
- emergency room visit that does not involve unexplained injury, staff-to-individual injury, injury resulting from individual-to-individual abuse, or injury resulting from restraint;
- hospitalization that does not involve accidental injury, unexplained injury, staff-to-individual injury, injury resulting from individual-to-individual abuse, or injury resulting from restraint;
- psychiatric hospitalization;
- individual-to-individual abuse that does not involve sexual abuse;
- missing person;
- injury requiring treatment beyond first aid that does not involve staff-to-individual injury and that is not the result of individual-to-individual abuse;
- disease that is reportable to the Department of Health;
- fire;
- law enforcement activity; and
- emergency closure of a facility or home.

The HCBS consolidated 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"

This section of the waiver states that ODP receives and evaluates reports on each type of critical incident. When a critical incident is recognized or discovered, the provider must take prompt action to protect the beneficiary and must file an incident report in the incident reporting system within 24 hours. ODP reviews beneficiary records through the administrative entity, which is required to ensure that the provider files an incident report and takes appropriate action if a critical incident has not been reported. ODP also requires providers to separate victims from alleged perpetrators when the victim's health and safety are jeopardized. Separation may include reassigning, suspending, or terminating the alleged perpetrator.

This section of the waiver also provides details about ODP's policy on incident management and investigations.

According to the waiver, ODP policy on incident management states that the administrative entity and ODP regional office must evaluate incident reports within 24 hours of submission to ensure that the provider took prompt action to protect the beneficiary's health, safety, and rights; the provider notified the beneficiary's family of the critical incident within 24 hours unless otherwise indicated in the individual support plan; and the provider initiated an investigation by assigning the case to a certified investigator. The provider may also be required to meet other notification requirements related to the Older Adults Protective Services Act and Child Protective Services Law.

This section of the waiver also states that ODP certifies its investigators and requires that only those certified by ODP conduct investigations of critical incidents. ODP requires certified investigators to participate in 4 days of training in investigatory procedures. ODP only certifies investigators who successfully complete the training and pass a final examination. Investigators must be recertified every 3 years.

When a certified investigator completes an investigation, he or she enters the summary in the incident reporting system. The provider then completes and finalizes the report within 30 days of the critical incident, and the incident reporting system sends an electronic alert notifying ODP and the administrative entity of the finalized report.

The administrative entity evaluates all finalized reports within 30 days and approves the report if it meets certain requirements related to the protection of the participant's health, safety, and rights through proper resolution of the critical incident. After resolution of the critical incident, the administrative entity will continue to work with and monitor the provider to ensure appropriate adherence to the established policies. ODP staff evaluates approved reports within 30 days and, if satisfactory, closes the incident report.

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

Appendix G: *Participant Safeguards, Quality Improvement: Health and Welfare*, and Appendix H: *Quality Improvement Strategy*

These sections of the waiver state that the State agency is responsible for the oversight of and response to critical incidents and events. This oversight includes the collection and compilation of reported 24-hour reportable incidents. Specifically, the State agency should analyze aggregate incident data to develop reports that identify patterns and trends to prevent reoccurrences of 24-hour reportable incidents.

The HCBS consolidated waiver, Appendix G, *Participant Safeguards*, *Quality Improvement: Health and Welfare*, (a)(i), "Methods for Discovery: Health and Welfare," (a) "Sub-Assurances"

This section of the waiver states that the State agency must demonstrate on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death.[22] The State agency must review deaths to determine the number and percentage of deaths by cause of death, and determine the number and percent of deaths examined according to State protocols.

PENNSYLVANIA STATUTES

Older Adults Protective Services Act (Act 79 of 1987, P.L. 381) Chapter 7, "Reporting Suspected Abuse by Employees," codified at 35 P.S. §§ 10225.101-10225.5102

For participating beneficiaries age 60 and older, Pennsylvania's Older Adults Protective Services Act specifies that a provider's employee or administrator who has reasonable cause to suspect that a beneficiary is the victim of sexual abuse, serious physical injury or serious bodily injury, or that a death is suspicious, must immediately contact appropriate law enforcement officials to make an oral report. Within 48 hours of making the oral report, the provider's employee and administrator must submit a written report to appropriate law enforcement officials.

Adult Protective Services Act (Act 10 of 2010, P.L. 484) Chapter 5, "Reporting Suspected Abuse by Employees," codified at 35 P.S. §§ 10210.101-10210.704

For participating beneficiaries between the ages of 18 and 59, this act mandates that a provider's employee or administrator who has reasonable cause to suspect that a beneficiary is the victim of sexual abuse, serious injury, or serious bodily injury, or has reasonable cause to suspect that a death is suspicious, must immediately contact the appropriate law enforcement officials to make an oral report. Within 48 hours of making the oral report, the provider's employee and administrator must submit a joint written report to appropriate law enforcement officials.

[22] The version of the consolidated waiver effective through July 22, 2015, states that the State agency, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect, and exploitation.

ACT 28/26 (Pennsylvania Statutes, Title 18, section 2713)

This statute requires the State agency to report abuse or neglect of a care-dependent person to the Office of the Attorney General or to local law enforcement.

PENNSYLVANIA REQUIREMENTS REGARDING REPORTABLE INCIDENTS

55 Pa. Code § 6000.921, Categories of incidents

This section of the Pennsylvania Code states that there are different categories of incidents that must be reported in the incident reporting system. There are categories of incidents that must be reported within 24 hours and other categories of incidents that must be reported within 72 hours. For the incidents that require reporting within 24 hours, the first section of the incident report must be completed in the incident reporting system within 24 hours of the incident's occurrence. This first section includes individual and provider demographics, incident categorization, actions taken to protect the health and safety of the beneficiary, and a description of the incident. The final section of the incident report includes additional information about the incident, any required investigation, and any corrective actions taken. The final section must be completed within 30 days of recognition or discovery of the incident.

This section also states that providers, support coordination entities, counties, and ODP must be vigilant in reporting to law enforcement any incident in which there is a suspected crime.

55 Pa. Code § 6000.922, Incidents to be reported within 24 hours, and § 6000.931, Multiple categories and sequences

These sections list the categories of incidents to be reported within 24 hours, define each category, and provide a suggested sequence for reporting incidents that can be classified as belonging in multiple categories. Section 6000.931 also states that if a death, hospitalization, psychiatric hospitalization, emergency room visit, or injury requiring treatment beyond first aid is the result of a medication error or the use of a restraint, a report is to be initiated within 24 hours using the corresponding primary category.

55 Pa. Code § 6000.925, Categories of incidents to be investigated

This section identifies reportable incidents to be investigated by the provider, the county, and ODP.

APPENDIX D: UNREPORTED EMERGENCY ROOM VISIT DIAGNOSIS CODES

Category	Diagnosis Code	Description
Accidents/Safety		
	9331	Foreign body in larynx
	9661	Poisoning by hydantoin derivatives
	9691	Poisoning by phenothiazine tranquilizers
	9712	Poisoning by sympathomimetics
	9752	Poisoning by skeletal muscle relaxants
	9778	Poisoning by drugs or medicinal substance
	9779	Poisoning by other unspecified drug or medicinal substance
	9941	Drowning and nonfatal submersion
	E9108	Other accidental drowning or submersion
	T184XXA	Foreign body in colon, initial encounter
	T192XXA	Foreign body vulva or vagina, initial encounter
	T5692XA	Toxic effect of unspecified metal, intentional self-harm, initial encounter
	V714	Observation following other accident (car)
Bodily Injury		
	9592	Injury to shoulder and upper arm
	9597	Injury to knee, leg, ankle, foot
	70722	Pressure ulcer stage II
	70723	Pressure ulcer stage III
	70724	Pressure ulcer stage IV
	80701	Closed fracture to hip
	81000	Closed fracture to unspecified part of clavicle
	81342	Closed fracture radius distal end
	81500	Closed fracture to hand
	81601	Closed fracture to fingers
	82525	Fractured toes
	92320	Contusion of hand
	92401	Contusion to hip
	92411	Contusion of knee
	92420	Contusion of foot
	95919	Injury to the trunk
	L89153	Pressure ulcer of sacral region, stage 3
	L89323	Pressure ulcer of left buttock, stage 3
Domestic Violence		
	99581	Adult physical abuse
	99583	Adult sexual abuse

Category	Diagnosis Code	Description
	E9682	Assault by striking by blunt or thrown object
	E9688	Assault by other specified means
	E9804	Poisoning by other specified drugs and medicinal substances, undetermined whether accidentally or purposely inflicted
	E9889	Injury by unspecified means, undetermined whether accidentally or purposely inflicted
	T7411XA	Adult physical abuse, confirmed, initial encounter
	T7611XA	Adult physical abuse, suspected, initial encounter
	T7621XA	Adult sexual abuse, suspected, initial encounter
Head Injury		
	920	Contusion to face, scalp or neck
	8730	Open wound to scalp
	9100	Abrasion/friction burn to head
	87342	Open wound to forehead
	87343	Open wound to lip
	87344	Open wound to jaw
	87349	Open wound to face and other sites
	95901	Head injury, unspecified
	95909	Injury of face or neck
Other Medical Conditions		
	5070	Pneumonitis due to inhalation of food or vomitus
	79902	Hypoxemia—lack of oxygen
Suicide		
	E9503	Suicide and self-inflicted poisoning by tranquilizers and other psychotropic agents
	E9588	Suicide and self-inflicted injury by other specified means
	T1491	Suicide attempt
	X781XXA	Intentional self-harm by knife, initial encounter
Assault		
	E9600	Unarmed fight or brawl
	Y00XXXA	Assault by blunt object initial encounter
	Y040XXA	Assault by unarmed brawl or fight, initial encounter
	Y041XXA	Assault by human bite, initial encounter
	Y042XXA	Accidental striking against or bumped into by another person, initial encounter
	Y048XXA	Assault by other bodily force, initial encounter

APPENDIX E: UNREPORTED ACUTE-CARE HOSPITAL STAY DIAGNOSIS CODES

Category	Diagnosis Code	Diagnosis Description
Accidents/Safety		
	9331	Foreign body in larynx
	9351	Foreign body in esophagus
	9941	Drowning and nonfatal submersion
	99584	Adult neglect (nutritional)
	E9108	Other accidental drowning or submersion
	T184XXA	Foreign body in colon, initial encounter
	T421X2A	Poisoning by iminostilbenes, intentional self-harm, initial encounter
	T426X2D	Poisoning by other antiepileptic and sedative-hypnotic drugs, intentional self-harm, subsequent encounter
	T43222A	Poisoning by selective serotonin reuptake inhibitors, intentional self-harm, initial encounter
	T43592A	Poisoning by other antipsychotics and neuroleptics, intentional self-harm, initial encounter
	T56892A	Toxic effect of other metals, intentional self-harm, initial encounter
	Y0703	Male partner, perpetrator of maltreatment and neglect
Bodily Injury		
	9597	Injury to knee, leg, ankle, foot
	70722	Pressure ulcer stage II
	70723	Pressure ulcer stage III
	70724	pressure ulcer stage IV
	80701	Closed fracture to hip
	81000	Closed fracture to unspecified part of clavicle
	82525	Fractured toes
	L89153	Pressure ulcer of sacral region, stage 3
	L89323	Pressure ulcer of left buttock, stage 3
	S61451A	Open bite of right hand, initial encounter
Head Injury		
	920	Contusion to face, scalp or neck
	9100	Abrasion/friction burn to head
	95901	Head injury, unspecified
Other Medical Condition		
	5070	Pneumonitis due to inhalation of food or vomitus
	79902	Hypoxemia—lack of oxygen

Category	Diagnosis Code	Diagnosis Description
Suicide		
	E9504	Suicide and self-inflicted poisoning by other specified drugs and medicinal substances
	E9588	Suicide and self-inflicted injury by other specified means
	X76XXXS	Intentional self-harm by smoke, fire and flames, subsequent encounter
Assault		
	E9684	Assault by criminal neglect
	T7601XA	Adult neglect or abandonment, suspected, initial encounter

APPENDIX F: STATE AGENCY COMMENTS

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
OCT 18 2019

Ms. Nicole Freda
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region III
801 Market Street, Suite 8500
Philadelphia, Pennsylvania 19107

Dear Ms. Freda:

The Department of Human Services (OHS) has received the draft report number A-03-17-00202 titled "Pennsylvania Did Not Fully Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities". The objective of this audit was to determine whether the Pennsylvania Department of Human Services (State agency) complied with Federal Medicaid waiver and State requirements for reporting and monitoring 24-hour reportable incidents that involve Medicaid beneficiaries with developmental disabilities residing in community-based settings.

We first want to comment on a couple of items in the report before responding to the individual recommendations.

We noted one statement in the draft report that isn't completely accurate, and we wanted to bring this to your attention:

The last full paragraph on page 15 of the draft report states: "The State agency's only control for detecting unreported 24-hour reportable incidents consisted of 3 State agency visits each quarter or 12 visits each year for each beneficiary covered by the consolidated waiver. During these visits, State agency officials review event logs to determine if all 24-hour reportable incidents have been reported." Supports Coordination Organizations are the entities that conduct the quarterly visits and review event logs to determine if all 24-hour reportable incidents have been reported. The State agency conducts annual licensing inspections where event logs and other on-site documentation (e.g. medical records, medical visit or discharge summaries, daily progress notes, event logs, etc.) are reviewed to detect unreported critical incidents.

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Finding one, Community-Based Providers Did Not Report Thousands of 24-Hour Reportable Incidents to the State Agency, on pages 7 through 11 of the draft report includes statements that the auditors determined that 18,880 emergency room visits and 2,078 acute-care hospital stays had not been reported.

We understand that incidents were discovered as not reported; however, following our analysis of the high-risk incidents that were identified as unreported in the draft report, we found that a majority of these incidents were in fact reported but the date of the incident report and the date of the claim were not an exact match. For example, the incident report was dated as July 1, 2015 at 10:00 PM, but the emergency room visit, or hospital stay claim was dated July 2, 2015, because that is when admission or treatment occurred. There were also claims for emergency room visits that did not meet the criteria to require reporting by a provider because the incidents did not occur during the provision of a provider delivered service in accordance with 55 Pa. Code § 6000.911 (b), which states: "the provider is to report all categories of incidents and complete an investigation as necessary whenever services or supports are: (1) Rendered at the provider's site, (2) Provided in a community environment, other than an individual's home, while the individual is the responsibility of an employee, contracted agent or volunteer, or (3) Provided in an individual's own home or the home of his family, while an employee, contracted agent or volunteer is providing services in the home."

In addition, we found that many claims identified as unreported emergency room visits occurred at treatment facilities at the same service location as an emergency room. Such visits were likely scheduled follow-up treatment or assessments resulting from a prior reported incident or a primary care physician visit. For example, a physician may recommend a swallowing study, which is then performed at a service location collocated with an emergency room. Scheduled follow-up treatment and assessments are not considered "emergencies" and not required to be reported in accordance with 55 Pa. Code§ 6000.922 (a) (5), which states "Emergency room visit. The use of a hospital emergency room. This includes situations that are clearly "emergencies" as well as those when an individual is directed to an emergency room in lieu of a visit to the Primary Care Physician (PCP) or as the result of a visit to the PCP. The use of an emergency room by an individual's PCP, in place of the physician's office, is not reportable."

We respectfully request that you reconsider the characterization of this finding given the number of incidents that were not required to be reported and the number of incidents that were reported within the required 24-hour timeframe, but where the 24-hour period spanned two calendar days as described above.

Our responses to the specific recommendations are below:

Office of Inspector General (OIG) Recommendation 1: We recommend that the Pennsylvania Department of Human Services record the unreported 24-hour reportable incidents noted in this report.

Department of Human Services (DHS) Response: OHS does not concur with this recommendation. While we understand the basis for the recommendation, adopting it would require a significant level of effort and resource investment that will have minimal impact on improving health and safety outcomes for current waiver participants. Given the amount of time since the incidents occurred, it is unlikely that we would be able to perform critical investigative activities such as locating witnesses and gathering documentary evidence necessary to make a conclusive determination about whether abuse or neglect occurred and by extension what, if any, corrective actions are necessary. Instead, we intend to focus our efforts on recording all unreported incidents of emergency room visits and hospital stays that contain diagnoses indicative of high-risk for suspected abuse or neglect and take remedial action as appropriate. Please note that we initiated this process as soon as it was brought to our attention by the auditors. As noted above, many of these incidents were in fact reported or did not meet criteria for reporting.

OIG Recommendation 2: We recommend that the Pennsylvania Department of Human Services work with community-based providers on how to identify and report all 24-hour reportable incidents.

DHS Response: OHS concurs with this recommendation. We are revising our incident management policy to align with the recommendations outlined in the OIG, Administration for Community Living, and Office of Civil Rights January 2018 joint report titled "Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight" (Joint Report) and other recognized national best practices. The revised policy emphasizes the need for stronger recognition of reportable incidents by front-line staff and provides detailed definitions of each incident type to minimize confusion about what constitutes a reportable incident. In addition, training to raise awareness of the need to rule out abuse and neglect and ensure reporting to law enforcement, protective service entities, and other oversight entities is under development.

OIG Recommendation 3: We recommend that the Pennsylvania Department of Human Services work with community-based providers to ensure that all community-based providers' staff understand the requirements for reporting 24-hour reportable incidents within required timeframes.

DHS Response: OHS concurs with this recommendation. We are in the process of promulgating regulations that require community-based provider staff to complete annual competency-based training specific to incident recognition, timely reporting of incidents, state protective service laws, and mandatory reporting requirements. We are also working on the development of statewide training in these areas to ensure compliance with the regulations. In addition, community-based providers are required to trend and analyze data related to timeliness and identify improvement strategies to ensure incidents are reported within required timeframes. Incident reporting system-generated reports are available to accomplish these requirements.

OIG Recommendation 4: We recommend that the Pennsylvania Department of Human Services develop a policy to periodically match Medicaid emergency room visit and acute-care hospital stay claims to 24-hour reportable incidents recorded in the incident reporting system.

DHS Response: OHS concurs with this recommendation. We have begun reviewing Medicaid emergency room visit and acute-care hospital stay claims to identify individuals with certain high-risk diagnosis codes such as those associated with pressure ulcers and choking incidents. In addition, we are working to obtain and include Medicare claims data in this analysis, given that many individuals with intellectual disabilities or autism have both Medicare and Medicaid.

Once identified, the findings will be used for targeted interventions, outreach, and training to provider agencies, individuals, and caregivers. OHS has also begun developing protocols and technology enhancements to embed emergency room visit and acute-care hospital claim data into oversight and monitoring activities to better identify unreported incidents.

OIG Recommendation 5: We recommend that the Pennsylvania Department of Human Services work with community-based providers to ensure that administrative reviews and investigations are conducted and reported appropriately and consider all previous 24-hour reportable incidents related to the beneficiary.

DHS Response: DHS concurs with this recommendation. We have enhanced the overall administrative review process for provider investigations to provide guidance and stronger emphasis on the reviewer's obligation to:

- Rule out abuse and neglect for all incidents reviewed;
- Ensure appropriate authorities have been notified; and,
- Develop robust corrective actions that not only prevent a recurrence to the individual beneficiary but prevent recurrence to all individual beneficiaries.

In addition, DHS developed an administrative review manual and continues to enhance the investigator's curriculum to align with nationally recognized best practices and the recommendations outlined in the Joint Report.

OIG Recommendation 6: We recommend that the Pennsylvania Department of Human Services ensure community-based providers analyze, investigate, and report to the State all beneficiary deaths.

DHS Response: DHS concurs with this recommendation. In May 2017, as a result of reviewing other OIG audit reports, we modified policies and the incident reporting system to require investigations for all Home and Community-Based Waiver Services (HCBS) beneficiary deaths. Prior to this change, only deaths that occurred in a provider-operated setting were required to be investigated. In addition, in 2018, OHS enhanced its mortality review process and imbedded this within the incident reporting system. This enables medical staff to more easily analyze the factors that surround

each beneficiary's death, and as appropriate, send a written report to local law enforcement or the Pennsylvania Attorney General's Office when suspicious deaths are discovered, or the death is the result of abuse or neglect. This also enables medical staff to more easily trend beneficiary deaths to identify patterns and develop preventative measures, targeted training, and technical assistance initiatives.

OIG Recommendation 7: We recommend that the Pennsylvania Department of Human Services send a written report of death to law enforcement or the district attorney's office when a death is determined to be suspicious or when abuse or neglect is suspected.

DHS Response: OHS concurs with this recommendation. We recently updated reporting protocols and training to contain a stronger emphasis on notifications to law enforcement when warranted. In addition, in 2018, the incident reporting system was enhanced to include prompts for incident management reviewers to better collect and track follow-up actions planned or being conducted (i.e. notifying law enforcement, licensing entities, the Pennsylvania Department of State, etc.) when abuse or neglect is confirmed or when a death is determined to be suspicious. In addition, protocols were developed to ensure state staff notify the Pennsylvania Attorney General's Office immediately when there is reasonable suspicion of abuse or neglect or when a death is determined to be suspicious. These protocols were developed in conjunction with the Pennsylvania Attorney General's Office's Medicaid Fraud Control Unit.

Thank you for the opportunity to respond to this draft report. If you have any questions or concerns regarding this response, please contact Mr. David R. Bryan, Manager, Audit Resolution Section, Bureau of Financial Operations, at 717-783-7217, or via email at davbryan@pa.gov.

Sincerely,

Carolyn K. Ellison
Deputy Secretary for Administration
Shared Services for Health and Human Services

c: Mr. Charles Hubbs, Assistant Regional Inspector General
Mr. David R. Bryan