

**Department of Health and Human Services
OFFICE OF
INSPECTOR GENERAL**

**IOWA IMPLEMENTED
MOST OF OUR PRIOR AUDIT
RECOMMENDATIONS AND GENERALLY
COMPLIED WITH FEDERAL AND STATE
REQUIREMENTS FOR REPORTING AND
MONITORING MAJOR INCIDENTS**

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**November 2022
A-07-21-06105**

Office of Inspector General

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Report in Brief

Date: November 2022

Report No. A-07-21-06105

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



Why OIG Did This Audit

We are performing this audit in several States in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes. This request was made after nationwide media coverage on deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors.

In our previous audit in Iowa, we found that the State did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring those incidents. Our previous audit report contained nine recommendations, and we performed this followup audit to determine whether Iowa implemented these recommendations.

Our objectives were to determine whether Iowa: (1) implemented the recommendations from our prior audit and (2) complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents.

How OIG Did This Audit

We reviewed claims for 1,115 emergency room visits for Medicaid members with developmental disabilities whose claims included diagnoses associated with a high likelihood that a major incident had occurred. We also reviewed Critical Incident Reports contained in Iowa's reporting systems.

Iowa Implemented Most of Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Major Incidents

What OIG Found

Iowa implemented the nine recommendations from our prior audit and generally complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid members with developmental disabilities residing in group homes. However, Iowa's corrective actions for one recommendation in our prior audit were not completely effective in addressing the associated finding. Iowa did not ensure that community-based providers properly reported all major incidents involving members in waiver programs to the State. Although Iowa achieved significant progress since our prior audit, its internal controls did not ensure that providers properly reported all major incidents, because the State did not periodically update the diagnosis code list it used to identify Medicaid claims involving major incidents.

What OIG Recommends and Iowa Comments

We recommend that Iowa continue to strengthen internal controls to ensure full compliance with Federal and State requirements, to include periodically updating the list of diagnosis codes used when reviewing the Medicaid emergency room claims data to ensure that all Critical Incident Reports for major incidents were submitted as required.

Iowa concurred with our findings, agreed with our recommendation, described corrective actions that it had taken or planned to take, and projected the completion dates for the corrective actions. Iowa said that it would audit and update its list of emergency room claim codes to include all the codes that we identified as high-risk diagnosis codes, and that it would review and update this list annually. In addition, Iowa said that to ensure that emergency room visits are more thoroughly evaluated for potential major incidents, it would expand the existing monthly comparison of the primary diagnosis codes on emergency room claims to include the secondary diagnosis codes. Furthermore, Iowa stated that to ensure the adequacy of internal controls for accurately capturing all major data elements, it would update the online Critical Incident Report form and corresponding data extraction methodology. Finally, Iowa said that to ensure that all major incidents are reported and appropriately resolved in a timely manner, it was in the process of developing a centralized technical solution for critical incident reporting of all major incidents involving Medicaid members.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Office of Inspector General (OIG) previously conducted an audit of the Iowa Department of Human Services, Iowa Medicaid Enterprise's (State agency's) compliance with requirements related to major incidents involving Medicaid beneficiaries with developmental disabilities in Iowa.¹ This was part of a series of audits that we are performing in several States in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes.² This request was made after nationwide media coverage on deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors.

In our previous audit in Iowa, we found that the State agency did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring those incidents. Our previous audit report contained nine recommendations, and we performed this followup audit to determine whether the State agency implemented these recommendations.

OBJECTIVES

Our objectives were to determine whether the State agency: (1) implemented the recommendations from our prior audit and (2) complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents.

BACKGROUND

Developmental Disabilities Assistance and Bill of Rights Act of 2000

As defined by section 102(8)(A) of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (the Disabilities Act), "developmental disability" means a severe, chronic disability of an individual.³ A developmental disability is attributable to a mental or physical impairment or a combination of both, must be evident before the age of 22, and is likely to continue indefinitely. In addition, a developmental disability results in substantial limitations in three or more major life areas, including self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

¹ The Department of Health and Human Services, Office of Inspector General, *Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities* (A-07-18-06081), Mar. 27, 2020. Available at <https://oig.hhs.gov/oas/reports/region7/71806081.pdf>.

² See Appendix B for related work.

³ The Developmental Disabilities Assistance and Bill of Rights Act of 2000, P.L. No. 106-402 (Oct. 30, 2000).

Federal and State Governments have an obligation to ensure that public funds are provided to residential, institutional, and community-based providers (which we will discuss in greater detail later in this report) that serve individuals with developmental disabilities. Further, these providers must meet minimum standards to ensure that the care they provide does not involve abuse, neglect, sexual exploitation, or violations of legal and human rights (the Disabilities Act § 109(a)(3)(B)(i)).

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 HCBS waiver program permits a State to furnish an array of services that assists members to live in the community and avoid institutionalization.⁴ Waiver services complement or supplement the services that are available through the Medicaid State plan and other Federal, State, and local public programs as well as the supports 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.

States must provide certain assurances to the Centers for Medicare & Medicaid Services (CMS) to receive approval for HCBS waivers, including that necessary safeguards are in place to protect the health and welfare of the members receiving services (42 CFR § 441.302(a)). A State must provide specific information regarding its plan or process related to member safeguards, which includes whether the State operates a critical event or incident reporting and management process (HCBS waivers, Appendix G-1: *Response to Critical Events or Incidents*).

As of the time of our audit, Iowa has seven HCBS waiver programs that provide service funding and individualized supports to maintain eligible members in their own homes or communities; these members would otherwise require care in a medical institution. We limited this followup audit to the Brain Injury (BI) and Intellectual Disability (ID) waivers, as those were the waivers that we reviewed during our previous audit in Iowa. The BI waiver offers services to those who have been diagnosed with a brain injury because of an accident or illness (HCBS waivers, Appendix B-1: *Specification of the Waiver Target Group(s)*). The ID waiver provides services for members who have been diagnosed with developmental disabilities.⁵ Both waivers offer various services, including adult daycare services, home and vehicle modification, supported community living, supported employment, and transportation (HCBS waivers: *Brief Waiver Description*).

⁴ Although the HCBS waiver refers to “beneficiaries,” most of the policies and procedures that the State agency uses to administer this program refers to its beneficiaries as “members.” For that reason, this report will refer to “members.”

⁵ During our audit period, the target subgroup for Iowa's ID waiver was individuals with intellectual disabilities, which is a subset of developmental disabilities. Developmental disabilities are severe chronic disabilities that can be intellectual, physical, or both intellectual and physical. For the purposes of this report, we refer to members who have an intellectual disability, or both an intellectual disability and a physical disability, as having developmental disabilities.

Iowa Medicaid and Managed Care Organizations

The State agency administers the Iowa HCBS waiver programs by contracting with a managed care program called IA Health Link. This program is administered by contracted Medicaid Managed Care Organizations (MCOs) that provide members with coverage for comprehensive health care services, including physical, behavioral, and long-term-care services and support. The Iowa HCBS BI and ID waiver programs are also administered by MCOs on behalf of the State agency.⁶

The State agency defines an MCO as an entity that: (1) is under contract to provide services to Medicaid members; (2) provides, either directly or through arrangements with others, health care services to enrollees on a fixed prepayment basis; and (3) is responsible for the availability, accessibility, and quality of the health care services provided or arranged.^{7, 8}

Two MCOs managed the Iowa HCBS waiver programs during our audit period: Amerigroup Iowa, Inc. (Amerigroup), and Iowa Total Care.

During our audit period, the Iowa BI and ID HCBS waiver programs served 14,216 members. The majority of these HCBS members were enrolled in one of the MCOs.⁹

Critical Incident Reporting for Community-Based Providers

The HCBS waivers state that the State agency must specify the 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 waivers, Appendix G: *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, § (b)).

The HCBS waivers group critical incidents into two categories: major incidents and minor incidents. A major incident generally means an occurrence involving a member during service provision that:

⁶ The approved effective date of the BI and ID waivers that enable MCOs to perform waiver operational and administrative functions on behalf of the State agency is April 1, 2016.

⁷ Iowa Code section 514B.1 and Iowa Administrative Code 441, chapter 73.1.

⁸ This report cites to both the Iowa Code and the Iowa Administrative Code. These are two different bodies of Iowa law and rules. The Iowa Code contains all of the State's permanent laws passed by the Iowa General Assembly and signed by the Governor. The Iowa Administrative Code contains the administrative rules adopted by Iowa's State agencies.

⁹ If the member was not enrolled in an MCO, then the member received services from the State agency under the Iowa HCBS waiver programs on a fee-for-service (FFS) basis. FFS is a payment model in which doctors and other health care providers are paid for each service performed, such as tests and office visits.

- results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital,
- results in the death of any person,
- requires emergency mental health treatment for the member,
- requires the intervention of law enforcement,
- requires a report of child abuse according to Iowa Code section 232.69,
- requires a report of dependent adult abuse according to Iowa Code section 235B.3, or
- results in a member's location being unknown by community-based provider staff who are assigned protective oversight of that member.

The HCBS waivers state that community-based providers are required to submit Critical Incident Reports within 24 hours of the major incident (HCBS waivers, Appendix G: *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, § (b)). Community-based providers are required to report to the State agency or to the MCO for members enrolled in managed care. For this audit, we focused on major incidents that were required to be reported during our audit period.

According to the HCBS waivers, when a major incident occurs, “[b]y the end of the next calendar day after the incident, the staff member who observed or first became aware of the incident shall . . . report as much information as is known about the incident” to the member’s MCO or, for members not enrolled with an MCO, to the State agency (HCBS waivers, Appendix G: *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, § (d)(2)). Accordingly, a Critical Incident Report is entered into the Iowa Medicaid Provider Access (IMPA) system or, for MCO members, into the appropriate MCO’s Major Incident Management (MMIM) system. The Critical Incident Report must include the name of the member involved, the date and time that the incident occurred, a description of the incident, the names of the staff present or who responded after becoming aware of the incident, the action the community-based provider took to manage the incident, and the resolution of or followup to the incident (HCBS waivers, Appendix G: *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, § (d)(3)).

The HCBS waivers also state that the MCOs must maintain policies and procedures that address incident reporting (HCBS waivers, Appendix G: *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, § (d)). Iowa Total Care’s policies and procedures include this provision: “Major Incidents will be reported by the end of the next calendar day following the incident.” Amerigroup’s policies and procedures state that Amerigroup will ensure that providers “are required to report adverse incidents to [Amerigroup] immediately but within

twenty-four (24) hours of when the incident occurred or, if it occurred outside the hours of direct supervision, when the [provider] first learned of the incident.” These policies and procedures also state: “The associate involved in, notified of, observing or first discovering the incident is responsible for initiating the Critical Incident reporting before the end of the working day. Reports should include a clear, concise, objective description of the incident. The electronic Critical Incident Form [is] located on the Amerigroup Provider website at <https://providers.amerigroup.com/ia/pages/critical-incidents.aspx>.”

Major (but not minor) incidents must be reported to the State agency’s Iowa Medicaid Enterprise Unit, through the IMPA system, or to the appropriate MCO, through the MMIM system (HCBS waivers, Appendix G-1: *Response to Critical Events or Incidents*, § (b)). (Separately from these reporting systems, anyone may report suspected abuse or neglect to the State-wide abuse reporting hotline, which is also operated by the State agency.)

The State agency groups reported incidents into seven categories: medication error, missing, death, mental health, abuse and neglect, law enforcement, and physical injury.¹⁰ Only major incidents are required to be reported, but some minor incidents do get reported through the IMPA and MMIM systems.

As part of the State agency’s quality assurance policies and procedures for HCBS waivers, all major incidents are to be monitored and remediated by the HCBS Incident Reporting Specialist and HCBS specialists, who are State agency employees or contractors. On a quarterly basis, a Quality Assurance committee, also comprised of State agency staff, reviews data collected on incidents and analyzes the data to determine trends, problems, and issues in service delivery and to recommend any policy changes (HCBS waivers, Appendix G: *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, § (b)).

Findings From Our Prior Audit

Our prior audit found that the State agency did not fully comply with Federal and State requirements for reporting and monitoring major incidents involving members with developmental disabilities who resided in community-based settings. Specifically, the State agency did not:

- ensure that community-based providers reported all major incidents to the State agency;
- ensure that community-based providers documented the resolution of reported major incidents to prevent or diminish future occurrences;
- analyze Critical Incident Reports to determine trends, problems, and issues in service delivery;

¹⁰ The category for each reported incident is selected by the individual who submits the Critical Incident Report.

- ensure that community-based providers reported all member deaths to the State agency; and
- report all known major incidents to CMS.

After issuance of our prior report and as part of our coordination with the State agency for the current audit, the State agency submitted to us its Corrective Action Plan (CAP), which described corrective actions that it had taken or planned to take in response to our prior report's findings.

HOW WE CONDUCTED THIS AUDIT

To determine whether the State agency implemented the nine recommendations from the prior OIG report, we reviewed correspondence from CMS and supporting documentation, to include the CAP, provided by the State agency for the period July 1, 2020, through June 30, 2021.

To determine whether the corrective actions taken by the State agency effectively addressed our previous findings of noncompliance and whether the State agency complied with Federal and State requirements for reporting and monitoring critical incidents, we obtained and analyzed Medicaid claims data from the State agency's Medicaid Management Information System (MMIS).¹¹ Using medical diagnoses or conditions listed on the State agency's Critical Incident Report form and our own analysis of major incidents as described in the claims data, we developed a list of 15 diagnoses that we classified as high-risk diagnoses because they were likely to indicate that a major incident had occurred. This list appears in Table 1 later in this report. We used this list of high-risk diagnoses to perform the following steps:

- From the Medicaid claims data associated with emergency room visits, we identified claims for 1,115 emergency room visits for members (of the 14,216 members) for which claims data showed at least 1 of the 15 high-risk diagnoses but for which a major incident was potentially not reported.
- Of the 1,115 claims, we attempted to locate a Critical Incident Report in the IMPA or MMIM system. If we were unable to locate a Critical Incident Report, we provided a list of the relevant claims to the State agency, so that it could determine whether the incidents were reported and whether each met the definition of a major incident.

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

¹¹ The MMIS is a computerized payment and information reporting system that the State agency uses to process and pay Medicaid claims and to manage information about Medicaid members and services.

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

FINDINGS

The State agency implemented the nine recommendations from our prior audit and generally complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid members with developmental disabilities residing in group homes.¹² However, the State agency's corrective actions for one recommendation in our prior audit were not completely effective in addressing the associated finding. Although the State agency made changes to its internal controls as recommended, those changes did not ensure that community-based providers properly reported all major incidents involving members in the BI and ID waiver programs to the State agency. Specifically, the State agency's controls were not completely effective because the State agency did not periodically update the diagnosis code list that it used to identify major incident claims. As a result, the State agency did not fulfill all of the participant safeguard assurances it provided to CMS in its HCBS waivers and the State requirements incorporated under the waivers.

THE STATE AGENCY'S CORRECTIVE ACTIONS EFFECTIVELY ADDRESSED FINDINGS RELATED TO EIGHT OF OUR NINE PRIOR AUDIT RECOMMENDATIONS

The State agency addressed our nine prior audit recommendations through a number of corrective actions that it had implemented and described in its CAP. These corrective actions effectively addressed our previous findings related to eight of the nine prior audit recommendations and significantly improved compliance with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents. A description of our recommendations and the corrective actions that the State agency implemented (and described in its CAP) are as follows:

Prior Recommendation: Train community-based providers on how to identify and report all major incidents

The State agency notified community-based providers and case managers of the definition of a "major incident" and updated its training to educate providers. On April 16, 2020, the State agency issued Informational Letter 2128-MC-FFS, which notified providers and case managers of the definition of a "major incident" and explained the circumstances under which an incident must be reported on a Critical Incident Report. In addition, the State agency updated training to include information about major incidents and the circumstances under which they need to be reported. This training became available to community-based providers, online, on December 20, 2020.

¹² The previous OIG report contained nine recommendations that CMS determined were implemented and resolved as of October 30, 2020.

Prior Recommendation: Train community-based providers on how to ensure that they appropriately document the resolution of major incidents, including the completion of the “Resolution” sections of the Critical Incident Report form, to prevent or diminish the probability of future occurrences

The State agency updated its policies and procedures to ensure proper documentation of the “Resolution” sections of the Critical Incident Report. The State agency said that it updated its policies to include a followup review on all Critical Incident Reports received that do not include a resolution; the State agency added that it updated this policy to ensure proper documentation of a resolution. In addition, the State agency updated the training it provides to community-based providers to include information on how to appropriately document the resolution of major incidents, including the completion of the “Resolution” sections of the Critical Incident Report form. This training became available to community-based providers, online, on December 20, 2020.

Prior Recommendation: Perform trend analysis that identifies patterns and trends to assess the health and safety of members and to determine whether changes need to be made for service implementation or whether staff training is needed to prevent recurrences of major incidents and to reduce the number or severity of incidents

The State agency updated its policies and procedures to address the performance of trend analyses. Specifically, the State agency said that it updated its policies and procedures to include a requirement for a monthly analysis of submitted Critical Incident Reports to identify any trends related to specific members in the preceding 12 months. If a trend is identified, a complaint is opened and a Complaint Specialist follows up with the relevant community-based providers.

Prior Recommendation: Ensure that community-based providers report to the State agency all member deaths

The State agency updated its policies and procedures to address the reporting of all member deaths. According to the CAP, the updated process requires State agency staff to retrieve information on all member deaths from the MMIS monthly to verify that a Critical Incident Report has been received. If a Critical Incident Report has not been received, State agency staff contact the provider, case manager, or MCO to request it. Member deaths and the relevant Critical Incident Reports are logged monthly. In addition, the State agency updated training for community-based providers to include information about major incidents and the circumstances under which they need to be reported, as in the case of a death. This training became available to community-based providers, online, on December 20, 2020.

Prior Recommendation: Include all major incidents reported by Medicaid managed care organizations in the State agency's reports to CMS

The State agency updated its policies and procedures to ensure that all critical incidents are reported to CMS. According to the CAP, a comprehensive critical incident reporting system has been developed to ensure that all major incidents reported by MCOs will in turn be reported to CMS. The MCOs have developed a process to ensure that all incidents are reported to the State agency monthly and, in turn, that the State agency reports all incidents to CMS.

Prior Recommendation: Develop and implement internal controls adequate to ensure full compliance with Federal and State requirements, including a Critical Incident Report review checklist for use by the State agency's Incident Reporting Specialist and Home and Community-Based Services Specialist that includes completing the "Resolution" sections

The State agency updated its policies, procedures, and database to ensure that the "Resolution" sections of each Critical Incident Report are completed as required. Specifically, the State agency said that it had created a checklist for use by the State agency's Incident Reporting Specialist and HCBS Specialist, and that this checklist includes a section with instructions on completing the "Resolution" sections of the Critical Incident Report. In addition, the State updated its incident database to ensure that the "Resolution" sections are included on all submitted Critical Incident Reports.

Prior Recommendation: Develop and implement internal controls adequate to ensure full compliance with Federal and State requirements, including a periodic comparison of member deaths as reported by the community-based providers with the member eligibility list to ensure the most accurate possible accounting of deceased members

The State agency updated its policies and procedures to ensure a more accurate accounting of deceased members. According to the CAP, the updated process requires State agency staff to retrieve information on all member deaths from the MMIS monthly to verify that a Critical Incident Report has been received. If a Critical Incident Report has not been received, one is requested from the case manager. In addition, the State agency maintains a log of all member deaths.

Prior Recommendation: Develop and implement internal controls adequate to ensure full compliance with Federal and State requirements, including enhancements to the State agency's Iowa Medicaid Provider Access system to minimize the need for staff to employ workarounds when inputting information regarding major incidents

The State agency updated its IMPA system so that Critical Incident Reports can be submitted through that system. Specifically, the State agency executed various enhancements in the IMPA system to minimize the need for staff to employ workarounds when inputting information regarding major incidents.

THE STATE AGENCY'S CORRECTIVE ACTIONS ONLY PARTIALLY ADDRESSED FINDINGS RELATED TO ONE OF OUR NINE PRIOR AUDIT RECOMMENDATIONS

The State agency's corrective actions were not completely effective in addressing findings related to one of our nine prior audit recommendations. Even though the State agency implemented corrective actions in response to our recommendation below from our prior audit, it did not fully comply with the Federal Medicaid waiver and State requirements to ensure that all reasonable suspicions of abuse or neglect were properly reported to the State agency. Although we noted significant improvement in the percentage of critical incidents reported to the State agency from the previous audit period (17 percent) to the current audit period (63 percent), 37 percent of critical incidents were still not properly reported to the State agency.

Prior Recommendation: Develop and implement internal controls adequate to ensure full compliance with Federal and State requirements, including a periodic comparison of Medicaid emergency room claims data with Critical Incident Reports submitted by community-based providers to verify that all Critical Incident Reports for major incidents were submitted as required

As a result of our prior audit, the State agency took steps, to include updating its policies and procedures as well as its training, to ensure that all major incidents are reported. According to the CAP, the State agency created a workgroup, which included officials from both MCOs, to address the reporting of major incidents. On April 16, 2020, the State agency issued Informational Letter 2128-MC-FFS, which notified providers and case managers of the definition of a "major incident" and explained the circumstances under which an incident must be reported on a Critical Incident Report. The State agency informed us that it compares emergency room claims to submitted Critical Incident Reports on a monthly basis. If the State agency determines that a Critical Incident Report was not submitted, then it asks the relevant case manager to submit a report for the claim in question. In addition, the State agency updated training to include information about major incidents and the circumstances under which they must be reported. This training became available to community-based providers, online, on December 20, 2020.

Community-based providers in Iowa are required to report to the State agency, or to the MCO for members enrolled in managed care, major incidents involving Medicaid members with developmental disabilities in accordance with the HCBS waivers (HCBS waivers, Appendix G: *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, § (b), and Iowa Administrative Code 441, chapter 77.25(3)(b)). Major incidents must be reported by the staff member who observed or first became aware of the incident (HCBS waivers, Appendix G: *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, § (d)(2)).

Prior Audit and Corrective Actions

In our prior audit, we determined that community-based providers did not report all major incidents involving BI and ID members. We reviewed claims with at least 1 of the 15 high-risk diagnoses that did not have an incident reported for that member with the same date as an emergency room visit. We identified 2,572 emergency room claims for 1,528 members who had a diagnosis that would potentially meet the State agency's definition of a major—and therefore reportable—incident. Table 1 breaks out these unreported major incidents by high-risk diagnosis.

Table 1: Potentially Unreported Incidents – Previous Audit

High-Risk Diagnosis	Claim Count	Member Count
Accident	188	168
Acute alcoholic intoxication	8	6
Burn	38	34
Collision	122	105
Contact with a knife	4	4
Drowning	1	1
Fall	784	546
Fracture	480	331
Homicidal and/or suicidal ideations	481	318
Pneumonitis due to inhalation of food	50	33
Poisoning	182	170
Sexual/physical abuse or rape	23	21
Trauma	4	4
Unspecified injury of head	183	155
Violent behavior	24	21
Total	2,572	1,917

Note: The 2,572 claims were for 1,528 members. Table 1 identifies 1,917 members because some members had incidents in more than 1 category.

Community-based providers did not report all major incidents involving members in the BI and ID waiver programs. Based on the State agency's review of the 817 medical records that we judgmentally selected from the 2,572 potentially unreported incidents, we identified 677 emergency room visits for 534 members that community-based providers were required to report to the State agency but did not. Table 2 on the following page summarizes our findings, differentiated by whether members received services on a fee-for-service (FFS) basis or were enrolled in an MCO.

Table 2: Unreported Emergency Room Visits – Previous Audit

	Total Reviewed	Not Reported	Percent
Fee-for-service	205	139	68%
Managed care organization	612	538	88%
Total	817	677	83%

Of the 817 critical incidents that we reviewed involving Medicaid members with developmental disabilities, 140 (17 percent) were reported to the State agency as potential incidents of abuse or neglect. However, the remaining 677 critical incidents (83 percent) were not reported to the State agency.

Current Audit

In our current audit, we determined that community-based providers did not properly report all major incidents involving members in the BI and ID waiver programs. Of the 1,115 critical incidents that we reviewed involving Medicaid members with developmental disabilities, 408 (37 percent) were not properly reported to the State agency. The HCBS waivers state that community-based providers must distribute a completed Critical Incident Report within 24 hours of the major incident (HCBS waivers, Appendix G: *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, § (b)). However, all but 3 of the 408 associated Critical Incident Reports had been created: (1) after we began our audit work and (2) an average of 349 days after the dates of the incidents. The remaining three major incidents did not have associated Critical Incident Reports.

We developed this finding after reviewing claims with at least 1 of the 15 high-risk diagnoses that did not have an incident reported for that member with the same date as an emergency room visit. We identified 1,115 emergency room claims for 728 members who had a diagnosis that would potentially meet the State agency’s definition of a major—and therefore reportable—incident. Table 3 on the following page breaks out these major incidents by high-risk diagnosis.

Table 3: Potentially Unreported Incidents – Current Audit

High-Risk Diagnosis	Claim Count	Member Count
Accident	44	42
Acute alcoholic intoxication	2	2
Burn	10	9
Collision	7	7
Contact with a knife	4	4
Drowning	0	0
Fall	208	187
Fracture	154	146
Homicidal and/or suicidal ideations	403	206
Pneumonitis due to inhalation of food	17	16
Poisoning	33	30
Sexual/physical abuse or rape	6	6
Trauma	38	32
Unspecified injury of head	161	153
Violent behavior	28	27
Total	1,115	867

Note: The 1,115 claims were for 728 members. Table 3 identifies 867 members because some members had incidents in more than 1 category.

Of the 1,115 emergency room claims that involved Medicaid members with developmental disabilities, we determined that 551 either had an associated Critical Incident Report that was identified in the State agency's IMPA system or in an MCO's MMIM system or did not require a report. The State agency reviewed the claims and provided Critical Incident Reports for 561 of the remaining 564 claims but did not provide Critical Incident Reports for the other 3 claims. For 156 of the 561 Critical Incident Reports, the State agency either provided us with a Critical Incident Report or informed us that the incident in question did not meet the definition of a major incident.

However, 405 of the 561 Critical Incident Reports were created after the start of our current audit, and remained unreported until we requested the reports for this audit. For example, one of the Critical Incident Reports had an incident date of July 18, 2020, but the Critical Incident Report was not created until December 15, 2021—a total of 515 days after the incident had occurred. For the 405 Critical Incident Reports, the average length of time between the dates of the incidents and the dates that the Critical Incident Reports were created was 349 days. The shortest length of time between when the incident took place and when the Critical Incident Report was created for any of these 405 Critical Incident Reports was 167 days; the longest length of time was 565 days.

We therefore concluded that a total of 408 emergency room claims (i.e., the 405 claims for which Critical Incident Reports were created after the start of this audit (and therefore not in a timely manner) plus the 3 claims (of the 564) for which the State agency did not provide a Critical Incident Report) were not properly reported to the State agency. Table 4 summarizes our findings, differentiated by whether members received services on an FFS basis or were enrolled in an MCO.

Table 4: Results of Potentially Unreported Emergency Room Visits – Current Audit

	Total Reviewed	Not Properly Reported	Percent
Fee-for-service	6	0	0%
Managed care organization	1,109	408	37%
Total	1,115	408	37%

The 408 emergency room claims that were not properly reported to the State agency represented 37 percent of the total number of claims that we reviewed for the current audit.

The State agency achieved significant progress in reporting potential incidents of abuse or neglect, but its internal controls were not adequate to ensure that community-based providers properly reported all major incidents. Specifically, the State agency used a diagnosis code list, which was derived from information we furnished at the end of our prior audit (i.e., in the late summer of 2019; footnote 1), to identify major incident claims that should be reported, but it did not update that list to ensure that all relevant diagnosis codes were being identified, nor did the State agency examine diagnosis codes (other than the primary diagnosis code on the claim). As a result, the State agency did not identify in a timely manner a significant percentage of major incidents that required a Critical Incident Report.

Accordingly, the State agency did not completely fulfill all of the participant safeguard assurances that it provided to CMS in its HCBS waivers and the State requirements incorporated under the waiver. Because some major incidents went unreported to the State agency or the MCOs for a significant period of time, the State agency was not fully able to ensure the health, welfare, and safety of those members with developmental disabilities who were enrolled in the BI and ID waiver programs. Some of these members, all belonging to a vulnerable population, were thus placed at an increased risk that neither their MCO nor the State agency was even aware of the members' emergency room visits and, potentially, of the high-risk diagnoses (as reflected in the claims data) associated with those visits. Preventing, detecting, and combating abuse requires the State agency and the community-based providers to fulfill all of their responsibilities.

RECOMMENDATION

We recommend that the Iowa Department of Human Services, Iowa Medicaid Enterprise, continue to strengthen internal controls to ensure full compliance with Federal and State requirements, to include periodically updating the list of diagnosis codes used when reviewing the Medicaid emergency room claims data to ensure that all Critical Incident Reports for major incidents were submitted as required.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our findings, agreed with our recommendation, and described corrective actions that it had taken or planned to take. Specifically, the State agency said that although it conducts monthly comparisons of emergency room claims to submitted Critical Incident Reports for Medicaid members with developmental disabilities, “the emergency room claims codes originally identified as likely to meet the definition of a major incident have not been updated since the previous audit.” Accordingly, the State agency stated that, to immediately ensure that the list of claims codes is current and relevant for comparison, it would audit the list of claim codes used for comparison; update the list to match the current emergency room claim codes and to include all the codes that we identified as high-risk diagnosis codes; and create an annual review and update process of this list.

In addition, the State agency said that to ensure that emergency room visits are more thoroughly evaluated for potential major incidents, it would expand the existing monthly comparison of the primary diagnosis codes on emergency room claims to include the secondary diagnosis codes. In this regard, the State agency said that it had been examining only the primary claim code, “which was not adequate in detecting unreported major incidents.”

Furthermore, the State agency stated that to ensure the adequacy of internal controls for accurately capturing all major data elements, it would update the online Critical Incident Report form and corresponding data extraction methodology. Finally, the State agency said that to ensure that all major incidents are reported and appropriately resolved in a timely manner, it was in the process of developing a centralized technical solution for critical incident reporting of all major incidents involving Medicaid members.

The State agency projected a completion date of June 30, 2023, for the technical solution described just above. For all other corrective actions, the State agency projected completion by the end of 2022 or earlier.

The State agency’s comments appear in their entirety as Appendix D.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed the State agency's system for reporting and monitoring of critical incidents involving members who participated in the BI and ID HCBS waiver program during our audit period (July 1, 2020, through June 30, 2021).

The State agency provided services to 14,216 members with developmental disabilities who were enrolled in the BI or ID HCBS waiver programs for all or part of our audit period. During this period, the State agency received 4,701 Critical Incident Reports from community-based providers, involving 4,135 members. Of the 14,216 members, 2,681 had 11,135 Medicaid claims for emergency room services for all diagnosis codes.

Services provided to the 14,216 members were paid mostly by the MCOs, although some were paid on an FFS basis (footnote 9). To determine whether the corrective actions taken by the State agency effectively addressed our previous findings of noncompliance and whether the State agency complied with Federal and State requirements for reporting and monitoring critical incidents, we obtained and analyzed Medicaid claims data for emergency room visits that the State agency paid on behalf of these members. We used the State agency's own definitions of medical diagnoses or conditions that are representative of a major incident to identify 15 high-risk diagnoses (Table 1 earlier in this report).

In performing our audit, we established reasonable assurance that the claims data we received from the State agency were accurate. We did not review the overall internal control structure of the State agency. We obtained an understanding of the State agency's policies and procedures related to critical incident reporting, analysis, and followup actions. We also identified the State agency's controls for ensuring that the community-based providers reported all major incidents involving members in the BI and ID waiver programs and tested those controls to determine whether they were effective.

We performed audit work from September 2021 through September 2022.

METHODOLOGY

To accomplish our audit objectives, we took the following steps:

- We reviewed applicable Federal and State requirements and the Federal HCBS waiver.
- We reviewed correspondence between CMS and State agency officials to determine whether the State agency implemented the nine recommendations from our prior report and to gain an understanding of the corrective actions implemented to address our prior audit recommendations.

- We held discussions with State agency officials and reviewed supporting documentation, to include the CAP, to determine whether the State agency had implemented our prior audit recommendations.
- We interviewed State agency officials and reviewed the State agency's policies for reporting, processing, and managing critical incidents to gain an understanding of the mandatory reporting of major incidents involving members with developmental disabilities.
- We obtained from the State agency eligibility information on 14,216 members with developmental disabilities who resided in community-based settings for all or part of our audit period.
- We obtained from the State agency 4,701 Critical Incident Reports (associated with 4,135 members with developmental disabilities) for incidents that took place during our audit period.
- We obtained claims data from the Iowa MMIS for 11,135 emergency room visits that took place during our audit period, for 2,681 members with developmental disabilities.
- Using medical diagnoses or conditions listed on the State agency's Critical Incident Report form and our own analysis of major incidents as described in the claims data, we developed a list of 15 diagnoses that we classified as high-risk diagnoses because they were likely to indicate that a major incident had occurred.
- From the Medicaid claims data associated with these emergency room visits, we identified claims for 1,115 emergency room visits for members (of the 14,216 members) for which claims data showed at least 1 of the 15 high-risk diagnoses.
- Of the 1,115 claims, we attempted to locate a Critical Incident Report in the IMPA or MMIM system. If we were unable to locate a Critical Incident Report, we provided a list of the relevant claims to the State agency, so that it could determine whether the incidents were reported and whether each met the definition of a major incident.
- We discussed the results of our audit with State agency officials on April 28, 2022.

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>Maine Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents</i>	<u>A-01-20-00007</u>	6/6/2022
<i>Massachusetts Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents</i>	<u>A-01-20-00003</u>	4/25/2022
<i>South Carolina Did Not Fully Comply With Requirements for Reporting and Monitoring Critical Events Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-04-18-07078</u>	4/1/2022
<i>Arkansas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-06-17-01003</u>	12/22/2021
<i>California Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-09-19-02004</u>	9/22/2021
<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

Report Title	Report Number	Date Issued
<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>A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect</i>	<u>A-01-19-00502</u>	7/23/2019
<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>Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight</i>	<u>Joint Report</u>	1/9/2018
<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

APPENDIX C: FEDERAL WAIVER AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS AND MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVERS

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 members receiving services under this waiver (42 CFR § 441.302(a)). 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 the restraints and restrictive interventions; and
- medication management and administration.

The HCBS waiver for the BI waiver program, Appendix G, *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, section (b), “State Critical Event or Incident Reporting Requirements,” states:

‘major incidents’ are defined as an occurrence involving a participant during service provision that: (1) results in a physical injury to or by the participant that requires a physician’s treatment or admission to a hospital; (2) results in the death of any person; (3) requires emergency mental health treatment for the participant; (4) requires the intervention of law enforcement; (5) requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; (6) constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph “1,” “2,” or “3”; or (7) involves a participant’s location being unknown by provider staff who are assigned protective oversight.

The corresponding section of the HCBS waiver for the ID waiver program contains similar language. These sections of the HCBS waivers for both the BI and ID programs also contain requirements for critical incident reporting.

The HCBS waivers for both the BI and ID waiver programs, Appendix G, *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, section (b), “State Critical Event or Incident Reporting Requirements,” define child abuse. These provisions cite to Iowa Code

section 232.68 and state that child abuse may include any of the following types of acts of willful or negligent acts or omissions:¹³

- a. any nonaccidental physical injury;
- b. any mental injury to a child's intellectual or psychological capacity;
- c. the commission of a sexual offense with or to a child pursuant as defined in the Iowa Code;
- d. the failure on the part of a person responsible for the care of a child to provide for the adequate food, shelter, clothing, or other care necessary for the child's health and welfare; and
- e. the presence of an illegal drug in a child's body as a direct act or omission of the person responsible for the child or manufactured a dangerous substance in the presence of the child.

The HCBS waivers for both the BI and ID waiver programs, Appendix G, *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, section (b), "State Critical Event or Incident Reporting Requirements," define dependent adult abuse. These provisions cite to Iowa Code section 235B.2 and state that dependent adult abuse includes any of the following types of acts of willful or negligent acts or omissions:

- a. physical injury or unreasonable confinement, unreasonable punishment, or assault of a dependent adult;
- b. the commission of a sexual offense or sexual exploitation as defined in the [Iowa Code];
- c. exploitation of a dependent adult; and
- d. the deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a dependent adult's life or health.

The HCBS waiver for the ID waiver program, Appendix G, *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, section (d), "Responsibility for Review of and Response to Critical Events or Incidents," states that the State of Iowa, Bureau of Long-Term Care:

meets bi-weekly to review major incident reports of child and dependent adult abuse and member deaths that have been reported through the major incident reporting process. DHS [the Department of Human Services] reviews and

¹³ Different versions of Iowa Code 232.68 were in effect during our audit period. Differences between these versions did not have a bearing on our findings.

requests information from the case manager, community-based case manager or HCBS Specialist for follow through and resolution of the abuse allegation and member deaths. Requests for information are forwarded to the case manager or community-based case manager to verify any needed changes and confirm that follow-up has occurred with the member (i.e., changes to a plan of care or the safety or risk plan as necessary). If additional information or actions are required of a provider, the HCBS Specialist works directly with the provider to ensure that performance issues identified in the incident report are addressed. The HCBS Specialist uses the provider's Self-Assessment as the foundation of the review to assure that accuracy in the Self-Assessment and to identify any corrective actions that may be required. The HCBS Specialist generates a report of findings within thirty days of the completion of any review requiring corrective actions.

DHS implemented a web-based major incident reporting system September 1, 2009, that significantly enhanced the State's ability to track and trend the discovery, remediation, and improvement of the major incident reporting process. Revisions have been made to the system based on data collection and feedback from users, further enhancing the process.

The HCBS waiver for the BI waiver program has a corresponding section for "Responsibility for Review of and Response to Critical Events or Incidents" that includes information for that program on critical incident reporting and followup.

The HCBS waiver for the BI waiver program, Appendix G, *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, section (e), "Responsibility for Oversight of Critical Incidents and Events," states that DHS "has oversight for monitoring incidents that affect all waiver members. An HCBS Quality Assurance and Technical Assistance Unit reviews all critical incident reports as soon as they are reported to DHS. All critical incidents are tracked in a critical incident database that tracks the date of the event, the specific waiver the member is enrolled in, the provider (if applicable), and the nature of the event, and follow up provided."

The HCBS waiver for the ID waiver program has a corresponding section (e) for "Responsibility for Oversight of Critical Incidents and Events," which states that the State agency's HCBS Quality Oversight Unit reviews all critical incident reports but which otherwise has the same language as that quoted just above for the BI waiver program.

The waivers add that the State agency's HCBS Quality Assurance committee meets (biweekly for both the BI and ID waiver programs) to review the data tracked in the critical incident database and decide whether policy changes or additional training are needed. Data are compiled and analyzed in an attempt to prevent future instances through the identification of system- and provider-specific training needs and individual service plan revisions.

The HCBS waivers for both the BI and ID waiver programs, Appendix G, *Participant Safeguards*, *Quality Improvement: Health and Welfare*, section (a), "Methods for Discovery: Health and

Welfare,” subsection (i), “Sub-Assurances,” require the State agency to demonstrate on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death. The waivers also require the State agency to perform a 100-percent review of major incidents and determine on an ongoing basis the number and percentage of major incidents reported within required timeframes.¹⁴

STATE REQUIREMENTS¹⁵

Iowa Code section 135B.1(3) states:

‘Hospital’ means a place which is devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment or care over a period exceeding twenty-four hours of two or more nonrelated individuals suffering from illness, injury, or deformity, or a place which is devoted primarily to the rendering over a period exceeding twenty-four hours of obstetrical or other medical or nursing care for two or more nonrelated individuals, or any institution, place, building or agency in which any accommodation is primarily maintained, furnished or offered for the care over a period exceeding twenty-four hours of two or more nonrelated aged or infirm persons requiring or receiving chronic or convalescent care; and shall include sanatoriums or other related institutions within the meaning of this chapter.

Iowa Code section 135C.1(8) defines a “health care facility” as “a residential care facility, a nursing facility, an intermediate care facility for persons with mental illness, or an intermediate care facility for persons with an intellectual disability.”

Iowa Code section 231B.1(3) defines “elder group home” as “a single-family residence that is operated by a person who is providing room, board, and personal care and may provide health-related services to three through five elders who are not related to the person providing the service within the third degree of consanguinity or affinity, and which is staffed by an on-site manager twenty-four hours per day, seven days per week.”

Iowa Code section 231C.3 establishes minimum standards for certification and monitoring of assisted living programs.

Iowa Code section 231D.1 defines “adult day services,” “adult day services program,” and “program” to refer to an organized program providing a variety of health-related care, social services, and other related support services for 16 hours or less in a 24-hour period to two or more persons with a functional impairment on a regularly scheduled, contractual basis.

¹⁴ As of April 2016, MCOs were responsible for data collection and generation for this review.

¹⁵ For the difference between the Iowa Code and the Iowa Administrative Code, see footnote 8.

Iowa Code section 232.68.2(a) defines child abuse (as summarized earlier in this Appendix).

Iowa Code sections 232.69, 235B.3(2), and 235E.2 define the types of community-based providers that must report suspected abuse of children or dependent adults. These provisions specify that reports must be submitted within 24 hours of witnessing abuse or discovering or suspecting that abuse has occurred.

Iowa Code sections 235B.2 and 235B.3 provide definitions and requirements regarding the reporting of dependent adult abuse. These provisions give the Iowa Department of Inspections and Appeals the responsibility for the evaluation and disposition of dependent adult abuse cases and the reporting of those dispositions to DHS.

Iowa Code section 514B.1.6 defines health maintenance organizations (i.e., MCOs) as any entity or person that:

- a. provides either directly or through arrangements with others, health care services to enrollees on a fixed prepayment basis;
- b. provides either directly or through arrangements with other persons for basic health care services; and
- c. is responsible for the availability, accessibility, and quality of the health care services provided or arranged.

Iowa Administrative Code 441, chapter 77.25(249A), states that “[t]o be eligible to participate in the Medicaid program as an approved provider of home- and community-based habilitation services, a provider shall meet the general requirements . . . and shall meet the requirements in the subrules applicable to the individual services being provided.”

Iowa Administrative Code 441, chapter 77.25(1), defines a major incident to mean an occurrence involving a member during service provision that:

1. results in a physical injury to or by the member that requires a physician’s treatment or admission to a hospital;
2. results in the death of any person;
3. requires emergency mental health treatment for the member;
4. requires the intervention of law enforcement;
5. requires a report of child abuse according to Iowa Code section 232.69 or a report of dependent adult abuse according to Iowa Code section 235B.3;

6. constitutes a prescription medication error or a pattern of medication errors that leads to the outcomes in “1,” “2,” or “3” above; or
7. involves a member’s location being unknown by provider staff who are assigned protective oversight of that member.

Iowa Administrative Code 441, chapter 77.25(1), also defines managed care organization, member, and minor incident as follows:

‘Managed care organization’ means an entity that (1) is under contract with [DHS] to provide services to Medicaid recipients and (2) meets the definition of ‘health maintenance organization’ as defined in Iowa Code section 514B.1.

‘Member’ means a person who has been determined to be eligible for Medicaid under [Iowa Administrative Code section] 441, chapter 75.

‘Minor incident’ means an occurrence involving a member during service provision that is not a major incident and that:

1. results in the application of basic first aid;
2. results in bruising;
3. results in seizure activity;
4. results in injury to self, to others, or to property; or
5. constitutes a prescription medication error.

Iowa Administrative Code 441, chapter 77.25(3), defines Incident Management and Reporting as a condition of participation in the Medicaid program. Accordingly, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

Iowa Administrative Code 441, chapter 77.25(3)(b)(4), states with respect to critical incident reporting: “When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up.”

Iowa Administrative Code 441, chapter 77.25(3)(c), defines tracking and analysis. This provision states: “The provider shall track incident data and analyze trends to assess the health and safety of members served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.”

STATE OF IOWA DEPARTMENT OF
Health AND **Human**
 SERVICES

October 12, 2022

James Korn
 Regional Inspector General for Audit Services
 HHS-OIG-Office of Audit Services
 Region VII
 601 East 12th St, Room 0429
 Kansas City MO 64106

RE: Report Number: A-07-21-06105, Iowa Implemented Most of Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Major Incidents

Dear Mr. Korn:

I am writing in response to your September 19, 2022, draft report *Iowa Implemented Most of Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Major Incidents*. Specifically, you have requested the state to review the facts and reasonableness of the recommendation in this report and provide comments including a statement of concurrence or nonconcurrence with the recommendation contained in the draft report. Please see the attached response.

Questions about this response can be addressed to:

Julie Shaw, Executive Officer I
 Office of Chief Operating Officer
 Iowa Department of Human Services
 Hoover State Office Building, 5th Floor
 1305 E Walnut Street
 Des Moines, IA 50319-0114
 Email: jshaw1@dhs.state.ia.us Phone: 515-281-8156

Sincerely,

A handwritten signature in black ink, appearing to read "Elizabeth Matney". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Elizabeth Matney

Medicaid Director

EM: Imm

cc: Jennifer Steenblock, jsteenb@dhs.state.ia.us
Julie Shaw, jshaw1@dhs.state.ia.us
Paula Motsinger, pmotsinger@dhs.state.ia.us
LeAnn Moskowitz, lmoskow@dhs.state.ia.us

STATE OF IOWA DEPARTMENT OF
Health AND **Human**
SERVICES
RESPONSE TO
OFFICE OF INSPECTOR GENERAL
DRAFT REPORT

*IOWA IMPLEMENTED MOST OF OUR
PRIOR AUDIT RECOMMENDATIONS AND
GENERALLY COMPLIED WITH FEDERAL
AND STATE REQUIREMENTS FOR
REPORTING AND MONITORING MAJOR
INCIDENTS*

SEPTEMBER 29, 2022

RESPONSE TO OIG FINDINGS

(AS STATED IN DRAFT REPORT)

WHAT OIG FOUND

OIG found that Iowa implemented eight of the nine recommendations from the prior audit and generally complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid members with developmental disabilities residing in group homes. However, Iowa's corrective actions for one recommendation in the prior audit were not completely effective in addressing the associated finding. Iowa did not ensure that community-based providers properly reported all major incidents involving members in waiver programs to the State. Although Iowa achieved significant progress since the prior audit, internal controls did not ensure that providers properly reported all major incidents, because the State did not periodically update the diagnosis code list it used to identify Medicaid claims involving major incidents.

WHAT OIG RECOMMENDS

We recommend that Iowa continue to strengthen internal controls to ensure full compliance with Federal and State requirements, to include periodically updating the list of diagnosis codes used when reviewing the Medicaid emergency room claims data to ensure that all CIR for major incidents were submitted as required.

IOWA MEDICAID RESPONSE

Iowa Medicaid concurs with the OIG findings of compliance indicating Iowa has generally complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid members with developmental disabilities residing in group homes. Iowa Medicaid also concurs with the finding that one of the corrective actions was not completely effective in achieving compliance with the OIG recommendation. Iowa Medicaid has developed a Corrective Action Plan (CAP) that identifies that the state will include periodic update of the list of diagnosis codes used for comparison to submitted Critical Incident Reports (CIR) as recommended by OIG. Additionally, the CAP will identify other contributing factors to the shortcomings of the previous corrective actions and solutions going forward.

Prior Recommendation: Train community-based providers on how to identify and report all major incidents.

Iowa Medicaid concurs with the OIG assessment of compliance. In addition to the initial training and outreach efforts described in the OIG findings, training on identifying and reporting major incidents was incorporated into Iowa Medicaid's Competency Based Training (CBT) program as recurring topic. Community-based providers, case managers, and other interested parties can attend a live webinar training on identifying and reporting major incidents and the training can be accessed as a recorded webinar in between the recurring live training dates.

Prior Recommendation: Train community-based providers on how to ensure that they appropriately document the resolution of major incidents, including the completion of the “Resolution” sections of the Critical Incident Report form, to prevent or diminish the probability of future occurrences.

Iowa Medicaid concurs with the OIG assessment of compliance. Additionally, the CBT training program described above addresses appropriate development and documentation of a resolution and that will work to prevent or diminish the probability of future occurrences.

Prior Recommendation: Perform trend analysis that identifies patterns and trends to assess the health and safety of members and to determine whether changes need to be made for service implementation or whether staff training is needed to prevent recurrences of major incidents and to reduce the number or severity of incidents.

Iowa Medicaid concurs with the OIG assessment of compliance.

Prior Recommendation: Ensure that community-based providers report to the State agency all member deaths.

Iowa Medicaid concurs with the OIG assessment of compliance. Additionally, the CBT training program described above addresses the need to report any member deaths as a major incident.

Prior Recommendation: Include all major incidents reported by Medicaid managed care organizations in the State agency’s reports to CMS.

Iowa Medicaid concurs with the OIG assessment of compliance.

Prior Recommendation: Develop and implement internal controls adequate to ensure full compliance with Federal and State requirements, including a Critical Incident Report review checklist for use by the State agency’s Incident Reporting Specialist and Home and Community-Based Services Specialist that includes completing the “Resolution” sections.

Iowa Medicaid concurs with the OIG assessment of compliance.

Prior Recommendation: Develop and implement internal controls adequate to ensure full compliance with Federal and State requirements, including a periodic comparison of member deaths as reported by the community-based providers with the member eligibility list to ensure the most accurate possible accounting of deceased members.

Iowa Medicaid concurs with the OIG assessment of compliance.

Prior Recommendation: Develop and implement internal controls adequate to ensure full compliance with Federal and State requirements, including enhancements to the State agency’s Iowa Medicaid Provider Access system to minimize the need for staff to employ workarounds when inputting information regarding major incidents.

Iowa Medicaid concurs with the OIG assessment of compliance.

Prior Recommendation: Develop and implement internal controls adequate to ensure full compliance with Federal and State requirements, including a periodic comparison of Medicaid emergency room claims data with Critical Incident Reports submitted by community-based providers to verify that all Critical Incident Reports for major incidents were submitted as required.

Iowa Medicaid concurs with the OIG assessment of compliance. Iowa Medicaid will take corrective action as outlined below to address the OIG recommendation to use emergency room claims data as a means of ensuring major incidents are reported as required. While Iowa Medicaid conducts a monthly comparison of emergency room claims to submitted CIR for HCBS waiver and Habilitation members, the emergency room claims codes originally identified as likely to meet the definition of a major incident have not been updated since the previous audit. Additionally, Iowa Medicaid only examines the primary claim code which was not adequate in detecting unreported major incidents. Additionally, Iowa Medicaid identified another factor that contributed to shortfalls in demonstrating compliance with the OIG recommendation in that flaws in the design of the CIR form prevented all submitted CIR from pulling a consolidating tracking list used for the comparison and initially provided to OIG in the audit. When it was discovered that some submitted CIR were not represented on the consolidated list, copies of the completed forms were submitted to OIG for comparison instead. The corrective action plan below identifies how the three identified issues will be addressed by Iowa Medicaid in order to ensure internal controls are adequate in ensure full compliance with Federal and State requirements.

IOWA MEDICAID’S CORRECTIVE ACTION PLAN

Action Steps		
Audit the list of emergency room claim codes used for comparison.	To immediately ensure the list of claims codes are current and relevant for comparison.	By October 31, 2022
Update to match current emergency room claim codes.		
Update to ensure the claim codes include all the codes that OIG identified as high-risk diagnosis in their analysis.		

Create an annual claim code review and update process.	To keep the list of claims codes current and relevant for comparison.	Annually
<p>The state will utilize the 2022 ICD-10 Diagnosis Codes matching the state identified definition of major incident to expand the data query. This will expand the existing monthly comparison of the primary diagnosis codes to include secondary diagnosis.</p> <p>The State will use the E&M CPT codes to ensure we capture emergency room visits.</p> <p>The State will also establish a regularly scheduled review of ICD-10 diagnosis codes and emergency room CPT codes.</p>	To ensure emergency room visits are more thoroughly evaluated for the potential major incidents.	November 30, 2022
<p>The State is in the process of developing a technical solution to update the online critical incident report form and corresponding data extraction methodology.</p> <p>The state is in the process of implementing a major incident process improvement project to improve reporting, identification and remediation of major incidents.</p>	To ensure the adequacy of internal controls for ensuring all major incident data elements are accurately captured in the CIR extraction report.	By December 31, 2022
The State is in the process of developing a technical solution to centralize critical incident reporting for reporting all major incidents for FFS and MCO members.	To allow for more centralized, timely, and flexible access to completed CIR for all Iowa Medicaid HCBS Waiver and Habilitation members to ensure all major incidents are reported and appropriately resolved for the health,	June 30, 2023

	welfare, and safety of members.	
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