

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**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



Christi A. Grimm  
Principal Deputy Inspector General

March 2020  
A-07-18-06081

# *Office of Inspector General*

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## Report in Brief

Date: March 2020

Report No. A-07-18-06081

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



### Why OIG Did This Audit

We are performing reviews 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 members with developmental disabilities so that they may live in community settings and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) requires States to implement a critical incident reporting system to protect the health and welfare of the Medicaid members (as Medicaid beneficiaries are referred to in Iowa) receiving waiver services.

Our objective was to determine whether Iowa complied with Federal and State requirements for reporting and monitoring major incidents involving Medicaid members with developmental disabilities from January 2014 through December 2017.

### How OIG Did This Audit

We judgmentally selected and reviewed 817 medical claims for 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 system.

## Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities

### What OIG Found

Iowa did not fully comply with Federal and State requirements for reporting and monitoring major incidents involving Medicaid members with developmental disabilities. Specifically, Iowa did not ensure that community-based providers reported all major incidents to the State; ensure that community-based providers documented the resolution of reported major incidents to prevent or diminish the probability of future occurrences; review Critical Incident Reports to determine trends, problems, and issues in service delivery; ensure that community-based providers reported all member deaths to the State; and report all known major incidents to CMS.

### What OIG Recommends and Iowa's Comments

We made procedural recommendations to Iowa, including that it work with community-based providers on how to identify and report all major incidents and to ensure that they appropriately document resolution of major incidents. We also recommended that Iowa perform trend analysis that identifies patterns and trends to assess the health and safety of members and 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; ensure that community-based providers report to the State all member deaths; include all major incidents reported by Medicaid Managed Care Organizations in Iowa's reports to CMS; and develop and implement internal controls adequate to ensure full compliance with Federal and State requirements.

Iowa concurred with our recommendations and described the actions that it had taken or planned to take to address them.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

The Office of Inspector General (OIG) is conducting a series of audits in several States (Appendix B) in response to a congressional request concerning deaths and abuse of people with developmental disabilities living in group homes. This request was made in response to media coverage throughout the country on deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors.

In Iowa, individuals with developmental disabilities may reside in community-based settings such as group homes, shared living arrangements, and private family homes.

### OBJECTIVE

Our objective was to determine whether the Iowa Department of Human Services, Iowa Medicaid Enterprise (State agency), complied with Federal and State requirements for reporting and monitoring major incidents involving developmentally disabled members who resided in community-based settings.<sup>1</sup>

### BACKGROUND

#### Developmental Disabilities Assistance and Bill of Rights Act of 2000

As defined by the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (the Disabilities Act), “developmental disability” means a severe, chronic disability of an individual.<sup>2</sup> The disability of the individual 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. The 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.

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, and violations of legal and human rights (the Disabilities Act § 109(a)(3)).

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<sup>1</sup> Because most of the policies and guidelines the State agency uses to administer this program refer to its beneficiaries as “members,” this report will follow suit.

<sup>2</sup> The Developmental Disabilities Assistance and Bill of Rights Act of 2000, P.L. No. 106-402 (Oct. 30, 2000).

## Medicaid Home and Community-Based Services Waiver

The Social Security Act (the Act) authorizes the Medicaid Home and Community-Based Services 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. Waiver services complement and 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 to individuals. Each State has broad discretion to design its HCBS waiver program to address the needs of the HCBS waiver program'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 participant safeguards have been taken to protect the health and welfare of the members receiving services (42 CFR § 441.302(a)). This HCBS waiver assurance requires the State to 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*).

Iowa currently 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 our audit to the Brain Injury (BI) and Intellectual Disability (ID) waivers, which between them cover the majority of the members who are receiving services under Iowa's HCBS waiver. 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.<sup>3</sup> 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*).

## Iowa Medicaid and Managed Care Organizations

The State agency administered the Iowa HCBS waiver programs on a fee-for-service (FFS) basis from January 1, 2014, through March 31, 2016, a timeframe that fell within our audit period.<sup>4</sup> FFS is a payment model in which doctors and other healthcare providers are paid for each

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<sup>3</sup> During the period of this audit, 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 that have an intellectual disability, or both an intellectual disability and a physical disability, as having developmental disabilities.

<sup>4</sup> Our audit period was January 1, 2014, to December 31, 2017. See also "How We Conducted This Audit" and Appendix A.



service performed, such as tests and office visits. Services are not bundled; they are paid for separately.

Effective April 1, 2016, the State agency transitioned most Iowa Medicaid members to 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 healthcare services, including physical, behavioral, and long-term-care services and support.<sup>5</sup> Effective April 1, 2016, the Iowa HCBS BI and ID waiver programs are also administered by MCOs on behalf of the State agency.<sup>6</sup>

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, healthcare services to enrollees on a fixed prepayment basis; and (3) is responsible for the availability, accessibility, and quality of the healthcare services provided or arranged.<sup>7</sup>

Three MCOs managed the Iowa HCBS waiver programs from IA Health Link's inception on April 1, 2016, through November 30, 2017: UnitedHealthcare Community Plan of the River Valley, Inc., AmeriHealth Caritas Iowa (AmeriHealth), and Amerigroup Iowa, Inc. Effective November 30, 2017, AmeriHealth withdrew from its participation as an MCO.<sup>8</sup>

During our audit period, the Iowa BI and ID HCBS waiver programs served 16,056 members. After the transition to MCOs, the majority of the HCBS members were enrolled in one of the MCOs.<sup>9</sup>

### **Critical Incident Reporting for Community-Based Providers**

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

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<sup>5</sup> See "About Iowa Medicaid," at <https://dhs.iowa.gov/ime/about>. Accessed on Dec. 31, 2019.

<sup>6</sup> 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.

<sup>7</sup> Iowa Code section 514B.1 and Iowa Administrative Code 441, chapter 73.1.

<sup>8</sup> See "AmeriHealth Caritas to Withdraw from the IA Health Link Program," at <https://myemail.constantcontact.com/Medicaid-e-News--Transition-Updates.html?soid=1123163422953&aid=fRJZi8m7Qj0>. Accessed on Dec. 31, 2019.

<sup>9</sup> BI and ID waiver April 1, 2016, waivers: *Brief Waiver Description*.

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

- 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 as defined by Iowa Code section 232.69,<sup>10</sup>
- requires a report of dependent adult abuse as defined by 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.<sup>11</sup>

The HCBS waivers further 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)). These community-based providers are required to report to the State agency or to the MCO for members enrolled in managed care. An example of a Critical Incident Report that was in effect for the first portion of our audit period appears as Appendix C.<sup>12</sup> For this audit, we focused on major incidents that were required to be reported during our audit period.

When a major incident occurs or a staff member becomes aware of a major incident, an incident report is to be entered into the Iowa Medicaid Provider Access (IMPA) system. The report must

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<sup>10</sup> 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 Iowa's permanent laws enacted by the Iowa General Assembly. The Iowa Administrative Code contains the administrative rules adopted and administered by executive branch agencies to implement state law and policy.

<sup>11</sup> While the definition of major incident is generally similar across the BI and ID waivers that apply to our audit period, there are some differences in language across the applicable waivers. Specifically, the BI waiver also identifies, as a major incident, a prescription medication error or a pattern of medication errors resulting in certain types of medical care or death. Additionally, the BI waiver with an effective date of October 1, 2014, does not identify, as a major incident, an occurrence that results in a member's location being unknown by community-based provider staff who are assigned protective oversight of that member.

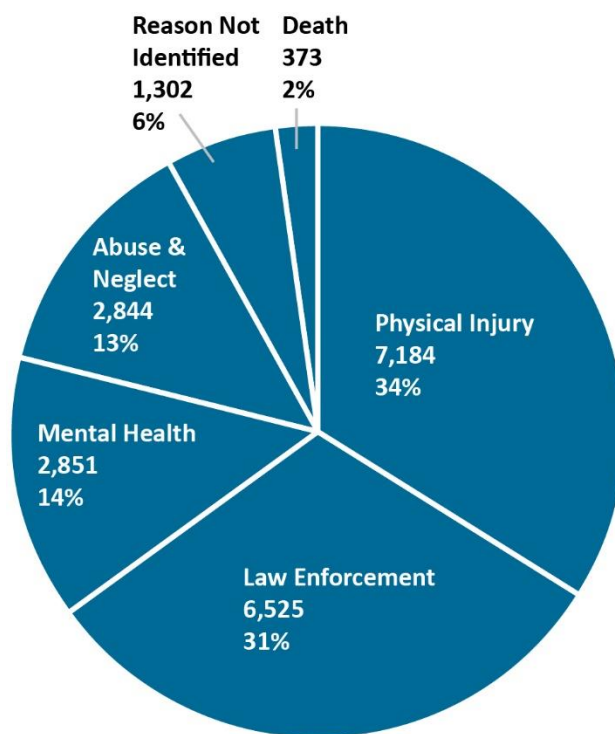
<sup>12</sup> The example Critical Incident Report in Appendix C is for illustrative purposes only. During our audit period, the State agency implemented a redesigned Critical Incident Report. The required data did not substantially change from one version to the next.

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.

Major (but not minor) incidents are required to be reported to the State agency's Iowa Medicaid Enterprise Unit, through the IMPA system (HCBS waivers, Appendix G-1: *Response to Critical Events or Incidents*, § (b)). Suspected abuse or neglect is reported to the State-wide abuse reporting hotline, which is also operated by the State agency.

The State agency groups reported incidents into six categories.<sup>13</sup> Figure 1 identifies the number of reported incidents for our audit period by category. Only major incidents are required, but some minor incidents do get reported in the IMPA system.

**Figure 1: Category and Number of Critical Incidents Reported in Our Audit Period**



Note: There were 20,381 reported critical incidents. Figure 1 reflects an additional 698 critical incidents because some incidents were reported with multiple categories.

As part of the State agency's quality assurance policies and procedures for HCBS waivers, all incidents are to be monitored and remediated by the HCBS Incident Reporting Specialist and

<sup>13</sup> The category for each report is selected by the individual who submits it.

HCBS specialists, who are State agency employees or contractors. On a quarterly basis, a Quality Assurance committee, also composed of State agency staff, reviews data collected on incidents and analyzes the data to determine trends, problems, and issues in service delivery and recommend any policy changes (HCBS waivers, Appendix G: *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, § (b)).

## HOW WE CONDUCTED THIS AUDIT

The State agency provided services to 16,056 members with developmental disabilities who were enrolled in the BI or ID HCBS waiver programs for all or part of the period January 1, 2014, to December 31, 2017 (our audit period). The State agency provided Critical Incident Reports detailing 20,381 incidents (both major and minor) associated with these members that were reported during our audit period. (See Figure 1 on the previous page.) We reviewed the documentation that the State agency provided to us as support for the followup that it performed on 59 members, each of whom was the subject of 15 or more reported major incidents.

Because the State agency's transition to Medicaid managed care occurred during our audit period, services provided to the 16,056 members were paid on both an FFS basis and by the MCOs. We obtained and analyzed Medicaid claims data for emergency room visits paid for on behalf of these members. Using medical diagnoses or conditions listed on the State agency's Critical Incident Report form (Appendix C) 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 these emergency room visits, we identified claims for 2,572 emergency room visits for 1,528 members (of the 16,056) whose claims data showed at least 1 of the 15 high-risk diagnoses but for whom a major incident was not reported.
- Of the 2,572 claims, we selected a nonstatistical sample of 817 medical claims for the State agency to review to determine whether the incidents were reported and whether each met the definition of a major incident.

In addition, we compared claims data in the State agency's Medicaid Management Information System (MMIS) to the incidents reported to the State agency's IMPA system to determine whether all major incidents that occurred during our audit period had been reported to the State agency.<sup>14</sup> We also reviewed 95 Critical Incident Reports submitted by community-based providers to determine whether each report had a completed "Resolution" section.

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<sup>14</sup> 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 beneficiaries and services.

Furthermore, we analyzed eligibility lists provided to us by the State agency to identify members who died during our audit period. We identified members whose deaths were not reported by comparing the list of deceased members to Critical Incident Reports. We reviewed 11 of the State agency's HCBS Quality Assurance Oversight quarterly reports on Quality Improvement Activities and Outcomes to identify what analysis and trends the State agency had reported to CMS during our audit period.

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 D contains details on the Federal and State requirements relevant to our findings.

## FINDINGS

The State agency did not fully comply with Federal and State requirements for reporting and monitoring major incidents involving developmentally disabled members 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 the probability of future occurrences;
- review Critical Incident Reports to determine trends, problems, and issues in service delivery;
- ensure that community-based providers reported all member deaths to the State agency; and
- report all known major incidents to CMS.

The State agency's internal controls were not adequate to ensure that community-based providers (1) reported all major incidents and member deaths, (2) consistently documented the resolution of reported major incidents, and (3) analyzed and acted on trends regarding members with multiple reported major incidents. Accordingly, the State agency did not fulfill various participant safeguard assurances that it provided to CMS in its Medicaid HCBS waivers to ensure the health, welfare, and safety of the 16,056 members with developmental disabilities covered by the BI and ID waivers. Because many major incidents were not reported to the State agency, the State agency was not able to fully ensure the health and safety of members

receiving waiver services. Preventing, detecting, and combating abuse requires the State agency and the community-based providers to fulfill all of their responsibilities.

## THE STATE AGENCY DID NOT ENSURE THAT COMMUNITY-BASED PROVIDERS REPORTED ALL MAJOR INCIDENTS TO THE STATE AGENCY

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)),<sup>15</sup> and Iowa Code § 232.69. Major incidents must be reported within 24 hours of witnessing or discovering that an incident has occurred.

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. See Table 1.

**Table 1: Potentially Unreported Incidents**

<b>High-Risk Diagnosis</b>	<b>Claim Count</b>	<b>Member Count</b>
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
<b>Total</b>	<b>2,572</b>	<b>1,917</b>

<sup>15</sup> As of April 2016, community-based providers must report major incidents to the member's MCO or, for members not enrolled with an MCO, the State agency. See HCBS April 2016 waivers, Appendix G: *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, §(d) and Iowa Administrative Code 441, chapter 77.25(3)(2).

Note: The 2,572 claims were for 1,528 members. Table 1 reflects an additional 389 members because some members had incidents in more than 1 category.

Community-based providers did not report all major incidents involving BI and ID members. Based on the State agency's review of the 817 medical records that we 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 summarizes our findings.

**Table 2: Unreported Emergency Room Visits**

	<b>Total Reviewed</b>	<b>Not Reported</b>	<b>Percent</b>
FFS	205	139	68%
MCO	612	538	88%
<b>Total</b>	<b>817</b>	<b>677</b>	<b>83%</b>

#### **Examples of Major Incidents Not Reported by Community-Based Providers**

A community-based provider did not report to the State agency a major incident involving a member who slipped and fractured the base of the skull, for which the member received treatment at a hospital. Because a fracture meets the State agency's definition of a "major incident," the community-based provider should have reported the incident.

Another community-based provider did not report to the State agency a major incident involving a member who was taken to the emergency room after the member drank lotion and shampoo and ate a detergent pod in an apparent suicide attempt. Because this event resulted in emergency mental health treatment, it meets the State agency's definition of a "major incident," and the community-based provider should have reported the incident.

#### **THE STATE AGENCY DID NOT ENSURE THAT COMMUNITY-BASED PROVIDERS DOCUMENTED RESOLUTION OF REPORTED MAJOR INCIDENTS TO PREVENT OR DIMINISH FUTURE OCCURRENCES**

Community-based providers are required to report major incidents when they occur or when a staff member becomes aware of them. State requirements direct community-based providers to report the resolution of or followup to a major incident (Iowa Administrative Code 441,

chapter 77.25(3)(3)). Specifically, in the “Incident-specific Resolution” section of the Critical Incident Report (as shown in the example on the third page of Appendix C), community-based providers are to describe the course of action taken; provide additional information if certain conditions or issues contributed to the incident, such as proposed plans, self-corrective actions, or measures needed to prevent or diminish future occurrences; and describe specifically how these self-corrective actions will prevent or diminish the probability of future occurrences or, if no changes are required, how the major incident was isolated with a minimal probability of recurrence.

Furthermore, State requirements state that when complete information about the incident is not available at the time of the initial report, the provider must submit followup reports until the case manager is satisfied with the incident resolution and followup (Iowa Administrative Code 441, chapter 77.25(3)(4)).

Community-based providers did not always document the resolution of major incidents, as instructed on the Critical Incident Report form and in accordance with Iowa Administrative Code 441, to identify incident-specific resolutions that would prevent or diminish future occurrences.

Twenty-two of the 95 Critical Incident Reports we reviewed did not have a completed “Incident-specific Resolution” section (23.2 percent). Table 3 summarizes these findings.

**Table 3: Resolution of Reported Incidents**

	Total Reviewed	No Resolution	Percent
FFS	25	8	32%
MCO	70	14	20%
<b>Total</b>	<b>95</b>	<b>22</b>	<b>23%</b>

**Example of a Major Incident for Which  
a Resolution Was Not Identified**

A member who lived alone in an apartment was taken to the emergency room by the police after a community-based provider’s staff member visited the member at the individual’s home. The staff member said that the member was being uncooperative and had broken into the medicine dispenser. The member referred to being upset the day before and punching a wall; the member now complained of wrist pain. The member also spoke of angry, suicidal, and homicidal feelings, and spoke of wanting to kill the family because, the member thought, they did not like the member.

The member’s medical record revealed a history of overdose and a long history of mental illness. The member asked the emergency room nurse to call the



community-based provider to arrange for someone to stay with the member for a few nights.

The Critical Incident Report did not document any incident-specific resolution describing actions that would diminish the probability of future occurrences of this nature.

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### **THE STATE AGENCY DID NOT ANALYZE CRITICAL INCIDENT REPORTS TO DETERMINE TRENDS, PROBLEMS, AND ISSUES IN SERVICE DELIVERY, BUT THE MANAGED CARE ORGANIZATIONS' ANALYSES WERE FULLY COMPLIANT**

The HCBS waivers state that as part of the quality assurance policies and procedures for HCBS waivers, all incidents will be monitored by the HCBS specialist (of the State agency staff) (HCBS waivers, Appendix G: *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, § (b)). The waivers add that on a quarterly basis, a Quality Assurance committee, also composed of State agency staff, reviews data collected on incidents and analyzes the data to determine trends, problems, and issues in service delivery and to make recommendations of any policy changes (HCBS waivers, Appendix G: *Participant Safeguards*, Appendix G-1: *Response to Critical Events or Incidents*, § (b)).

The HCBS waivers state that the State agency must 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 as specified in the approved waivers (HCBS waivers, Appendix G, *Participant Safeguards*, *Quality Improvement: Health and Welfare*, § (a), “Methods for Discovery: Health and Welfare,” subsection (i), “Sub-Assurances”).

As part of our audit, we identified 1,164 incidents for 59 members, each of whom was the subject of 15 or more reported incidents (1 member had 43 incidents reported) during our audit period. The State agency did not perform an analysis of the reported major incidents associated with 27 of the 59 members (46 percent) to determine trends, problems, and issues in the delivery of services by the relevant community-based providers.

We also identified members with claims paid by MCOs and who were the subject of 15 or more reported major incidents during our 4-year audit period. We identified 497 MCO-reported major incidents for 25 members, each of whom was the subject of 15 or more reported incidents (1 member had 40 incidents reported) during our audit period. The MCOs reviewed and analyzed the major incidents associated with all 25 members. For several of the incidents, the MCOs opened quality-of-care reviews and provided training to both the facility staff involved and the member. In addition, as part of these analyses, the MCOs noted that they had reviewed several of the community-based providers. As a result, four community-based providers were put on corrective action plans, eight received training, and four were referred to

Iowa's Medicaid Fraud Control Unit (MFCU).<sup>16</sup> For members who were the subject of 15 or more reported incidents, Table 4 compares the percentages of analyses conducted by the State agency (under the FFS payment model) with the percentages of analyses conducted by the MCOs after the transition.

**Table 4: Properly Performed Analyses of Members With Multiple Incidents**

	Total Reviewed	Analysis Performed	Percent
FFS	59	32	54%
MCO	25	25	100%
<b>Total</b>	<b>84</b>	<b>57</b>	<b>68%</b>

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**Example of a Member With 15 or More Incidents**

A member had 18 reported major incidents in a 10-month period from 2015 through early 2016. Of the 18 incidents, 11 were reported because law enforcement was involved, 3 were reported for abuse or neglect, 3 were reported because of a mental health issue, and 1 was reported because of a physical injury.

Despite the occurrence of the incidents in a relatively short timeframe, the State agency did not analyze these major incidents to determine trends, problems, and issues in the delivery of services.

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**THE STATE AGENCY DID NOT ENSURE THAT COMMUNITY-BASED PROVIDERS REPORTED ALL MEMBER DEATHS TO THE STATE AGENCY**

State requirements state that community-based providers must report every death of an adult with developmental disabilities, regardless of cause, within 24 hours of witnessing or discovering a death (HCBS waivers, Appendix G).

The Critical Incident Report (Appendix C) has a "Death" section in which the community-based provider enters information about the apparent cause of death, the location, and a narrative of all pertinent information of the events surrounding the member's death. When complete information about the incident is not available at the time of the initial report, the community-based provider must submit one or more followup reports within 5 business days (Iowa Department of Human Services, Home and Community-Based Services (HCBS) Provider Manual). The community-based provider then reports its investigation findings and resolution of the incident in the IMPA system within 30 calendar days of the initial report.

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<sup>16</sup> A MFCU within a State investigates and prosecutes Medicaid provider fraud, as well as patient abuse or neglect in healthcare facilities. In Iowa, the MFCU is part of the Department of Inspections and Appeals.

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 of members covered under the HCBS waiver. The State agency also has a performance measure to report the number and percentage of unexplained, suspicious, and untimely deaths (HCBS waivers, Appendix G, subsection (a)(i)(a)).

The State agency did not ensure that community-based providers reported all member deaths. Of the 444 BI and ID member deaths during our audit period, community-based providers did not report 95 deaths (21 percent) to the State agency; see Table 5.

**Table 5: Unreported Deaths**

	Total Deaths	Not Reported	Percent
FFS	244	34	14%
MCO	200	61	31%
<b>Totals</b>	<b>444</b>	<b>95</b>	<b>21%</b>

Additionally, the State agency did not identify or review all member deaths to determine whether the incident was responded to and resolved appropriately, as required by the HCBS waivers, Appendix G, subsections (a)(i)(a) and (b). Because all member deaths were not reported, the State agency's analysis and reporting of aggregated data to address and seek prevention of unexplained deaths were incomplete and thus inaccurate.

#### **THE STATE AGENCY DID NOT REPORT ALL KNOWN MAJOR INCIDENTS TO CMS**

According to the HCBS waivers, Appendix G, *Participant Safeguards, Quality Improvement: Health and Welfare*, section (a), "Methods for Discovery: Health and Welfare," subsection (i) "Sub-Assurances," the State agency is to demonstrate on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death (HCBS waivers, Appendix G, *Participant Safeguards, Quality Improvement: Health and Welfare*, § (a), "Methods for Discovery: Health and Welfare," subsection (i), "Sub-Assurances"). The State agency identified three performance measures, among others, to assess compliance with these assurances:

- number, percent, and frequency of major incidents, by type;
- the number and percent of major incidents that were reported within required timeframes; and
- the number and percent of unexplained, suspicious, or untimely deaths.<sup>17</sup>

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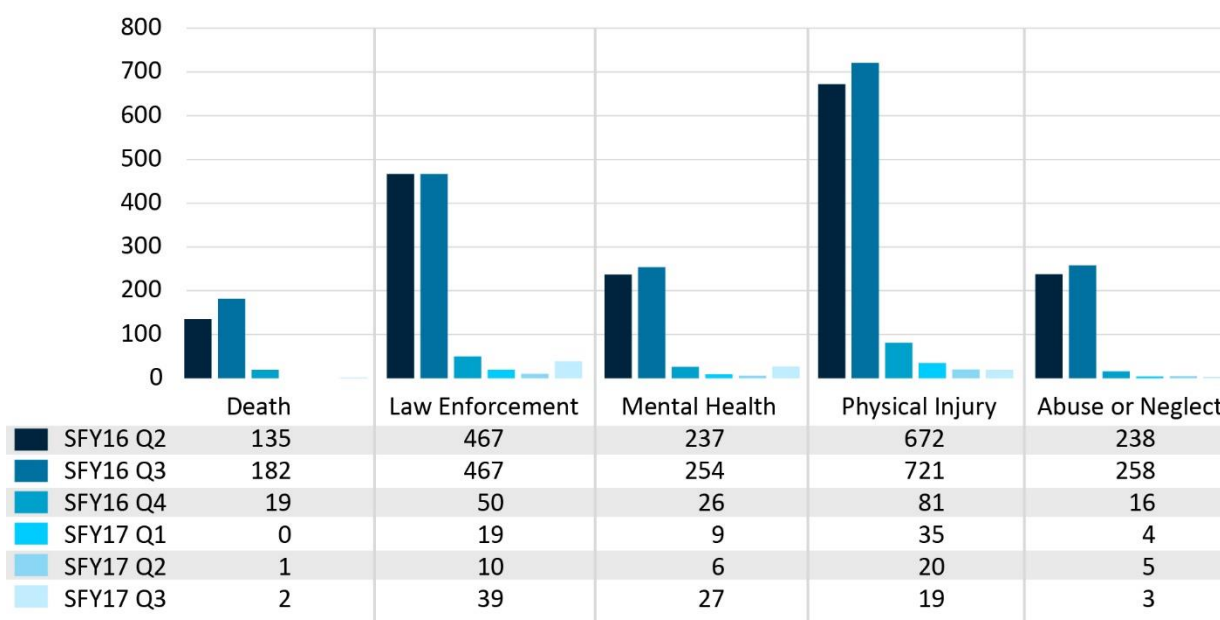
<sup>17</sup> As of April 2016, several of these performance measures were identified to assess compliance with the sub-assurance that the State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible (HCBS April 2016 waivers, Appendix G, subsection (a)(i)(b)).

Under the provisions of the HCBS waivers, the State agency must perform a 100-percent review of major incidents on a regular basis. In addition, the State agency reports the number of major incidents to CMS.

We reviewed 11 of the State agency’s HCBS Quality Assurance Oversight quarterly reports on Quality Improvement Activities and Outcomes to identify what analysis and trends the State agency had reported to CMS during our audit period.

Before the April 1, 2016, effective date of the transition that added most Iowa Medicaid members to IA Health Link—and that therefore added Medicaid managed care plans to the HCBS waivers—the State agency reported to CMS only the major incidents associated with members whose services were being paid on an FFS basis. After that transition, the State agency did not report to CMS the major incidents associated with former FFS members whose services were now being paid by the MCOs. Data that the State agency reported to CMS are presented in Figure 2:

**Figure 2: Number of Major Incidents by Type<sup>18</sup>**



The data reported to CMS showed a declining number of major incidents. The dramatic decline in the number of major incidents reported was not caused by a decrease in the number of major incidents, but rather by a failure to report to CMS major incidents associated with members who were enrolled in MCOs.

<sup>18</sup> Source: the State agency’s quarterly report, *Number of Incidents by Type, SFY17 Q3 (January—March 2017)*.

State agency officials acknowledged that for several reporting quarters during the transition to Medicaid managed care, the State agency did not report all known major incidents to CMS. These officials said that during this period, the State agency was not receiving this information from the MCOs. State agency officials added that they believe that that State agency is now reporting to CMS all major incidents that the community-based providers (those still operating on an FFS basis, as well as those operating with the MCOs) are reporting.

## **THE STATE AGENCY DID NOT HAVE ADEQUATE CONTROLS TO ENSURE COMPLIANCE WITH FEDERAL AND STATE REQUIREMENTS**

The State agency's internal controls were not adequate to ensure that community-based providers (1) reported all major incidents and member deaths, (2) consistently documented the resolution of reported major incidents, and (3) analyzed and acted on trends regarding members with multiple reported major incidents. In the absence of necessary controls, such as procedures governing the performance of data matches and other methods of analysis, the State agency relied too extensively on community-based providers to report the appropriate information related to major incidents involving members.

Furthermore, the State agency did not have policies and procedures in place to conduct data matches (such as the one we performed or those addressed in our guidance entitled "A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect" A-01-19-00502, issued July 23, 2019). Specifically, the State agency did not conduct data matches to compare major incidents reported by community-based providers and relevant Medicaid claims data available in its MMIS. Data matches of this nature, periodically executed, would have permitted the State agency to identify instances in which major incidents had not been reported and to analyze causes and consequences of those instances.

In addition, the State agency lacked adequate internal controls to ensure that it reported all major incidents to CMS. State agency officials said that for several reporting periods during the transition to Medicaid managed care, the State agency did not receive information from the MCOs on a timely basis. These officials added that it took some time for the State agency to develop and implement a process to receive the information in a timely manner for reporting.

System limitations also affected the State agency's ability to comply fully with Federal waiver and State requirements. State agency officials told us during our audit work that the State agency's IMPA system would not accept a Critical Incident Report on a member who was in a "closed" status.<sup>19</sup> As a result, case managers had to ensure that a Critical Incident Report was submitted in the system before changing the member's status to "closed."

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<sup>19</sup> A member's status in the IMPA system may be changed to "closed" for a variety of reasons, such as the member's death or disenrollment from Medicaid coverage.

State agency officials also acknowledged the need for the community-based providers to obtain additional training on critical incident reporting and followup.

Accordingly, the State agency did not fulfill numerous participant safeguard assurances that it provided to CMS in its Medicaid HCBS waivers to ensure the health, welfare, and safety of the 16,056 Medicaid members with developmental disabilities covered by the two HCBS waivers we reviewed. Because many major incidents were not reported to the State agency, the State agency was not able to fully ensure the health and safety of members receiving waiver services. Preventing, detecting, and combating abuse requires the State agency and the community-based providers to fulfill all of their responsibilities.

## **RECOMMENDATIONS**

We recommend that the Iowa Department of Human Services, Iowa Medicaid Enterprise:

- train community-based providers on how to identify and report all major incidents;
- 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;
- perform trend analysis that identifies patterns and trends to assess the health and safety of members and 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;
- ensure that community-based providers report to the State agency all member deaths;
- include all major incidents reported by MCOs in the State agency’s reports to CMS; and
- 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,
  - a Critical Incident Report review checklist for use by the State agency’s Incident Reporting Specialist and HCBS specialist that includes completing the “Resolution” sections,

- 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, and
- enhancements to the State agency's IMPA system to minimize the need for staff to employ workarounds when inputting information regarding major incidents.

### **STATE AGENCY COMMENTS**

In written comments on our draft report, the State agency concurred with our recommendations and described the actions that it had taken or planned to take to address them. These actions include the revision of the definition of "major incident" in the Iowa Administrative Code; the development of processes for analysis of Critical Incident Reports, monthly reviews of member deaths and followup procedures, critical incident reporting, and claims review; the development of critical incident report review checklists; and updated procedures, desk guides, and provider training. The State agency's comments appear in their entirety as Appendix E.

### **OTHER MATTERS**

During our audit, we identified an additional 46 deaths of individuals who received services under the BI or ID HCBS waiver but who were at the times of their deaths residing in a medical institution or residential facility and therefore are no longer eligible members of an HCBS waiver. According to State agency officials, the individuals' deaths should have been reported to the Iowa Department of Inspections and Appeals (DIA). However, the medical institution or residential facility did not report any of these 46 deaths to DIA. DIA staff confirmed to us that DIA had not been notified of any of these 46 deaths prior to OIG notifying it.

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

The State agency provided services to 16,056 members with developmental disabilities who were enrolled in the BI or ID HCBS waiver programs for all or part of the period January 1, 2014, through December 31, 2017. During this period, the State agency received 20,381 Critical Incident Reports from community-based providers involving 6,631 members. Of the 16,056 members, 7,136 had 27,764 Medicaid claims for emergency room services for all diagnosis codes.

Because the State agency's transition to Medicaid managed care occurred during our audit period, services provided to the 16,056 members were paid on both an FFS basis and by the MCOs. We obtained and analyzed Medicaid claims data for emergency room visits paid for 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 limited our internal control review to obtaining an understanding of the State agency's policies and procedures related to critical incident reporting, analysis, and followup actions.

We performed audit work, which included contacting the State agency in Des Moines, Iowa, from January 2017 to August 2019.

### **METHODOLOGY**

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

- We reviewed applicable Federal and State requirements and the Federal HCBS waiver.
- 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 16,056 members with developmental disabilities who resided in community-based settings for all or part of the period January 1, 2014, through December 31, 2017.



- We obtained from the State agency 20,381 Critical Incident Reports (associated with 6,631 members with developmental disabilities) for incidents that took place from January 1, 2014, through December 31, 2017.
- We obtained claims data from the Iowa MMIS for 27,764 emergency room visits that took place from January 1, 2014, through December 31, 2017, for 7,136 members with developmental disabilities.
- We compared MMIS claims data and medical records to data in the State agency's IMPA system to identify emergency room visits by members that were not reported to the State agency.
- We evaluated claims for 2,572 emergency room visits (involving 1,528 members) for which claims data showed at least 1 of the 15 high-risk diagnoses but for which a major incident was not reported.
- We selected a nonstatistical sample of 817 medical claims (associated with the 2,572 emergency room visits) for the State agency to review to determine whether the incidents were reported and whether each met the definition of a major incident.
- We selected 95 Critical Incident Reports submitted by community-based providers (Table 3 on report page 10) to determine whether each incident report had a completed "Resolution" section.
- We identified 59 members with claims paid on an FFS basis and who were the subject of 15 or more reported major incidents during our audit period. We identified 1,164 major incidents associated with these 59 members and evaluated them to determine whether the State agency had determined trends, problems, and issues in the delivery of services by the relevant community-based providers.
- We identified 25 members with claims paid by MCOs and who were the subject of 15 or more reported major incidents during our audit period. We identified 497 major incidents reported to the MCOs for these 25 members and evaluated them to determine whether the MCOs had determined trends, problems, and issues in the delivery of services by the relevant community-based providers.
- We analyzed eligibility listings (provided to us in a spreadsheet by the State agency) to identify members who died during our audit period. We identified members whose deaths were not reported by comparing the list of deceased members with Critical Incident Reports.

- We reviewed 11 of the State agency's HCBS Quality Assurance Oversight quarterly reports on Quality Improvement Activities and Outcomes to identify what analysis and trends the State agency had reported to CMS during our audit period.
- We discussed the results of our audit with State agency officials on August 14, 2019.

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>Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<a href="#">A-03-17-00202</a>	1/17/2020
<i>Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<a href="#">A-09-17-02006</a>	6/11/2019
<i>Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight</i>	<a href="#">Joint Report</a>	1/9/2018
<i>Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries with Developmental Disabilities</i>	<a href="#">A-01-16-00001</a>	8/9/2017
<i>Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	<a href="#">A-01-14-00008</a>	7/13/2016
<i>Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	<a href="#">A-01-14-00002</a>	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>	<a href="#">A-02-14-01011</a>	9/28/2015
<i>A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect</i>	<a href="#">A-01-19-00502</a>	7/23/2019

## APPENDIX C: EXAMPLE OF A CRITICAL INCIDENT REPORT

Page 1

### IOWA MEDICAID CRITICAL INCIDENT REPORT

<b>(Please note: Select <u>Completed</u> ONLY when all investigative activities are complete and resolution activities have been implemented. Otherwise submit an initial report.)</b> Report Status: <input type="checkbox"/> Initial <input type="checkbox"/> Completed		
<b>Reporting Party</b>	National Provider Identifier _____ Provider (Name or Agency) _____ Provider Address _____ City _____ State _____ Zip _____ County _____ Phone # _____ Fax # _____ Reporter Name (Last) _____ (First) _____ (MI) _____ (Title) _____ (Email) _____	
<b>Medicaid Member</b>	<div style="display: flex; justify-content: space-between;"> <div style="width: 65%;">           Medicaid No: _____ Name: (Last) _____ (First) _____ (MI) _____            Address _____ City _____            State _____ Zip _____ County _____            Date of Birth: _____ Member's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female            Case Manager Name: (Last) _____ (First) _____ (Email) _____         </div> <div style="width: 30%;">           HCBS Waiver: <input type="checkbox"/> Aids/HIV  <input type="checkbox"/> Ill &amp; Handicapped <input type="checkbox"/> Brain Injury  <input type="checkbox"/> Physical Disability <input type="checkbox"/> Elderly  <input type="checkbox"/> Children's Mental Health  <input type="checkbox"/> Intellectually Disabled (formerly MR)            State Plan: _____ Grants: _____  <input type="checkbox"/> Habilitation <input type="checkbox"/> MFP         </div> </div>	
<b>Incident Information</b>	Date of Incident: _____ Time of Incident: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> unknown The Incident Was: <input type="checkbox"/> discovered <input type="checkbox"/> witnessed First staff person to learn of the incident: (Name) _____ (Title) _____ <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 30%;">           Location where incident occurred: (select one)  <input type="checkbox"/> <b>Member's Home</b>  <input type="checkbox"/> private residence/household – living alone  <input type="checkbox"/> private residence/household – living with relatives  <input type="checkbox"/> private residence/household – living with unrelated persons  <input type="checkbox"/> community supervised living  <input type="checkbox"/> RCF  <input type="checkbox"/> RCF/MR  <input type="checkbox"/> RCF/PMI  <input type="checkbox"/> assisted living  <input type="checkbox"/> other _____         </div> <div style="width: 30%;"> <input type="checkbox"/> <b>Community</b>  <input type="checkbox"/> community job  <input type="checkbox"/> school  <input type="checkbox"/> day program  <input type="checkbox"/> work activity  <input type="checkbox"/> homeless/shelter/street  <input type="checkbox"/> vehicle  <input type="checkbox"/> shopping  <input type="checkbox"/> dining  <input type="checkbox"/> recreating  <input type="checkbox"/> other _____         </div> <div style="width: 30%;"> <input type="checkbox"/> <b>Other Location</b>  <input type="checkbox"/> state MHI  <input type="checkbox"/> state resource center  <input type="checkbox"/> correctional facility / jail  <input type="checkbox"/> foster care/family life home  <input type="checkbox"/> ICF / nursing facility  <input type="checkbox"/> ICF/MR  <input type="checkbox"/> ICF/PMI  <input type="checkbox"/> hospital / medical clinic  <input type="checkbox"/> other _____         </div> </div> <div style="margin-top: 10px;">           Other People Present (Provide name of person, initials if a member, and their relationship to the member)            1. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____            2. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____            3. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____            4. _____ <input type="checkbox"/> other member <input type="checkbox"/> staff <input type="checkbox"/> family <input type="checkbox"/> roommate <input type="checkbox"/> neighbor <input type="checkbox"/> other, specify _____         </div> <div style="margin-top: 10px;">           Services: (select one)  <input type="checkbox"/> Services were not being provided.  <input type="checkbox"/> Service being provided at the time of the incident: W code _____ Service Name _____         </div> <div style="margin-top: 10px;">           Describe the incident, including <b>Who, What, When, Where, and How</b>. (Describe any preceding circumstances, resulting harm to people, property damage, and any other relevant information. Include what was observed or heard. Attach additional pages if needed)         </div>	
<b>Immediate Resolution</b>	Date of Immediate Resolution: _____ Type of Immediate Resolution: (select <b>all</b> that apply) <input type="checkbox"/> resolved by case manager <input type="checkbox"/> resolved by provider staff <input type="checkbox"/> in-patient hospitalization (medical unit) <input type="checkbox"/> resolved by natural supports <input type="checkbox"/> incarceration <input type="checkbox"/> resolved by outside entity <input type="checkbox"/> emergency room treatment <input type="checkbox"/> out-patient mental health <input type="checkbox"/> treatment by a health care professional <input type="checkbox"/> in-patient hospitalization (mental health unit) Describe the actions taken after the incident occurred to secure the member's safety.   <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div>Guardian: <input type="checkbox"/> yes <input type="checkbox"/> no</div> <div>Guardian notified: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> attempted, unable to reach</div> </div>	

470-4698 (Rev 5/10)

(MAIL) Provider Correspondence, PO Box 36450, Des Moines, IA 50315 (FAX) 515-725-1360

## IOWA MEDICAID CRITICAL INCIDENT REPORT

<b>Physical Injury</b>  <input type="checkbox"/>	<b>(Please note: Complete the Circumstances section and Physical Injury Type before completing the Injury due to: section.)</b>		
	<b>Circumstances:</b> (select one) Physical injury occurred <input type="checkbox"/> to the member <input type="checkbox"/> by the member to another individual.  <b>Physical Injury Type:</b> Physical injury requiring physician's treatment or admission to a hospital. (select all that apply) <input type="checkbox"/> burn <input type="checkbox"/> dislocation <input type="checkbox"/> sprain <input type="checkbox"/> allergic reaction <input type="checkbox"/> concussion <input type="checkbox"/> contusion / bruise <input type="checkbox"/> human/animal bite <input type="checkbox"/> abrasion <input type="checkbox"/> laceration <input type="checkbox"/> puncture wound <input type="checkbox"/> fracture <input type="checkbox"/> electric shock <input type="checkbox"/> eye emergency <input type="checkbox"/> loss/tearing of body part <input type="checkbox"/> loss of consciousness <input type="checkbox"/> poisoning/toxin ingestion <input type="checkbox"/> other _____  <input type="checkbox"/> Mechanical restraint <input type="checkbox"/> mechanical restraint for behaviors <input type="checkbox"/> removal of mobility aids <input type="checkbox"/> impair sensory capabilities <input type="checkbox"/> other; describe _____  <input type="checkbox"/> Personal harm <input type="checkbox"/> aggressive behavior <input type="checkbox"/> self-mutilation / self injurious behavior <input type="checkbox"/> suicide attempt <input type="checkbox"/> PICA behavior / ingestion of harmful substance <input type="checkbox"/> accidental fall <input type="checkbox"/> aspiration / choking <input type="checkbox"/> seizure <input type="checkbox"/> vehicular accident <input type="checkbox"/> assault <input type="checkbox"/> other; describe _____  <input type="checkbox"/> Medication variance by staff <input type="checkbox"/> wrong dosage <input type="checkbox"/> wrong medication <input type="checkbox"/> wrong time <input type="checkbox"/> documentation error <input type="checkbox"/> unauthorized administration <input type="checkbox"/> missed dosage <input type="checkbox"/> other; describe _____  <input type="checkbox"/> Physical / manual restraint <input type="checkbox"/> movement inhibited <input type="checkbox"/> take down <input type="checkbox"/> prone restraint <input type="checkbox"/> other; describe _____  <input type="checkbox"/> Environmental condition <input type="checkbox"/> fire <input type="checkbox"/> tornado / storm <input type="checkbox"/> flooding <input type="checkbox"/> unsafe/ unhealthy physical environment <input type="checkbox"/> social environment <input type="checkbox"/> other; describe _____  <input type="checkbox"/> Medication variance by member <input type="checkbox"/> wrong dosage <input type="checkbox"/> wrong medication <input type="checkbox"/> wrong time <input type="checkbox"/> unauthorized administration <input type="checkbox"/> missed dosage <input type="checkbox"/> other; describe _____		
<b>Death</b>  <input type="checkbox"/>	<b>Apparent cause of death:</b> (select one) <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide / violence <input type="checkbox"/> terminal illness / natural causes <input type="checkbox"/> physical injury condition / situation <input type="checkbox"/> other; describe _____  <input type="checkbox"/> Death of person other than member: Name _____ Relationship to member: _____  Specifically, what were the circumstances surrounding death? _____		
	<b>Member's location at time of death:</b> (select one) <input type="checkbox"/> member's legal residence <input type="checkbox"/> community <input type="checkbox"/> community job <input type="checkbox"/> school <input type="checkbox"/> crisis stabilization <input type="checkbox"/> day program <input type="checkbox"/> work activity <input type="checkbox"/> state facility <input type="checkbox"/> hospital / clinic <input type="checkbox"/> hospice <input type="checkbox"/> other; describe _____  <b>Physical address where the member died:</b> Address: _____ City: _____ State _____ Zip _____ <b>Physical illnesses/conditions were:</b> <input type="checkbox"/> diagnosed prior to death <input type="checkbox"/> discovered at time of death <input type="checkbox"/> unknown  <b>Complete if known:</b> Was an autopsy requested? <input type="checkbox"/> Yes <input type="checkbox"/> No Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No Was there a DNR order? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Mental Health</b>  <input type="checkbox"/>	<b>Emergency mental health treatment due to:</b> (select <b>all</b> that apply) <input type="checkbox"/> condition / situation identified under physical injury <input type="checkbox"/> condition / situation identified under law enforcement <input type="checkbox"/> suicidal ideation <input type="checkbox"/> self injurious / self mutilation behavior without physical injury <input type="checkbox"/> aggressive behavior toward another without physical injury <input type="checkbox"/> other; describe _____		
<b>Law Enforcement</b>  <input type="checkbox"/>	<b>Intervention of law enforcement for:</b> (indicate whether the member was the victim or perpetrator and select all that apply) <input type="checkbox"/> illegal sexual behavior; <input type="checkbox"/> possession of illegal / hazardous substances; <input type="checkbox"/> inappropriate sexual advances; <input type="checkbox"/> aggressive behavior; <input type="checkbox"/> victim <input type="checkbox"/> perpetrator <input type="checkbox"/> victim <input type="checkbox"/> perpetrator <input type="checkbox"/> victim <input type="checkbox"/> perpetrator <input type="checkbox"/> victim <input type="checkbox"/> perpetrator <input type="checkbox"/> illegal acts; <input type="checkbox"/> property damage; <input type="checkbox"/> provoking incident; <input type="checkbox"/> other; describe _____ <input type="checkbox"/> victim <input type="checkbox"/> perpetrator <input type="checkbox"/> victim <input type="checkbox"/> perpetrator <input type="checkbox"/> victim <input type="checkbox"/> perpetrator <input type="checkbox"/> victim <input type="checkbox"/> perpetrator		
<b>Abuse Report or Restriction</b>  <input type="checkbox"/>	<b>Please specify member's involvement:</b> Member was the <input type="checkbox"/> victim <input type="checkbox"/> perpetrator		<b>Report of suspected dependent adult abuse:</b> (select all that apply) <input type="checkbox"/> physical injury <input type="checkbox"/> sexual abuse <input type="checkbox"/> self-denial of critical care <input type="checkbox"/> exploitation <input type="checkbox"/> denial of critical care
	<b>Report of suspected child abuse:</b> (select all that apply) <input type="checkbox"/> physical injury <input type="checkbox"/> mental injury <input type="checkbox"/> sexual abuse <input type="checkbox"/> denial of critical care <input type="checkbox"/> presence of illegal drugs <input type="checkbox"/> manufacture or possession of a dangerous substance <input type="checkbox"/> cohabitation with a registered sex offender		<b>Restriction or confinement:</b> (select all that apply) <input type="checkbox"/> arrest <input type="checkbox"/> as identified under physical injury <input type="checkbox"/> PRN meds for behavior <input type="checkbox"/> exclusionary timeout <input type="checkbox"/> seclusion / isolation <input type="checkbox"/> rights violation <input type="checkbox"/> cruel punishment
<b>Location Unk</b>  <input type="checkbox"/>	Member's location is unknown by provider responsible for protective oversight. Please describe: _____		

## IOWA MEDICAID CRITICAL INCIDENT REPORT

Incident-specific Resolutions	
<b>Staff Review</b> <input type="checkbox"/>	<p><b>(Please note: Complete the Staff Review section only if staff issues contributed to the incident.)</b></p> <p>Review staff: (select <b>all</b> that apply)</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> increase number of staff  <input type="checkbox"/> increase staff hour  <input type="checkbox"/> improve team building  <input type="checkbox"/> increase supervision of staff </div> <div> <input type="checkbox"/> disciplinary action  <input type="checkbox"/> change staff  <input type="checkbox"/> terminate staff  <input type="checkbox"/> other, describe: _____ </div> </div> <p>Provide staff training on: (select <b>all</b> that apply)</p> <div> <input type="checkbox"/> rights  <input type="checkbox"/> individual needs  <input type="checkbox"/> behavioral needs  <input type="checkbox"/> positive and supportive relationships  <input type="checkbox"/> communication with member, family and/or other staff  <input type="checkbox"/> staff trained / retrained on equipment use  <input type="checkbox"/> other, describe: _____ </div> <p><input type="checkbox"/> Resolution following staffing review / training. Describe specifically how action(s) will prevent or diminish the probability of future occurrence(s). _____</p> <p><input type="checkbox"/> No staffing changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence. _____</p>
<b>Member Review</b> <input type="checkbox"/>	<p><b>(Please note: Complete the Member Review section only if member issues contributed to the incident.)</b></p> <p>Review member: (select <b>all</b> that apply)</p> <div> <input type="checkbox"/> treatment plan reviewed and/or revised due to behavioral issues  <input type="checkbox"/> treatment plan reviewed and/or revised due to reflect member's goals  <input type="checkbox"/> treatment plan reviewed and/or revised due to cognitive abilities  <input type="checkbox"/> treatment plan reviewed and/or revised due to communication needs  <input type="checkbox"/> treatment plan reviewed and/or revised due to physical abilities  <input type="checkbox"/> treatment plan reviewed and/or revised due to level of need and support  <input type="checkbox"/> treatment plan reviewed and/or revised due to medical / health status, including medication review  <input type="checkbox"/> treatment plan reviewed and/or revised due to unidentified risk or safety issues; safety plan reviewed / modified  <input type="checkbox"/> other, describe: _____ </div> <p><input type="checkbox"/> Resolution following member review. Describe specifically how revision(s) will prevent or diminish the probability of future occurrence(s). _____</p> <p><input type="checkbox"/> Treatment plan reviewed and no changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence. _____</p>
<b>Equip &amp; Supplies Review</b> <input type="checkbox"/>	<p><b>(Please note: Complete the Equipment &amp; Supplies Review section only if their presence, absence and/or condition contributed to the incident.)</b></p> <p>Review of equipment and / or supplies: (select <b>all</b> that apply)</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> necessary equipment needs to be repaired  <input type="checkbox"/> necessary equipment needs to be purchased </div> <div> <input type="checkbox"/> necessary equipment needs to be replaced  <input type="checkbox"/> other, describe: _____ </div> </div> <p><input type="checkbox"/> Resolution following equipment and supplies review. Describe specifically how this review(s) will prevent or diminish the probability of future occurrence(s). _____</p> <p><input type="checkbox"/> Equipment and supplies reviewed and no changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence. _____</p>
<b>Environ Review</b> <input type="checkbox"/>	<p><b>(Please note: Complete the Environment Review section only if the identified condition or circumstance contributed to the incident.)</b></p> <p>Review of environment: (select <b>all</b> that apply)</p> <div> <input type="checkbox"/> member's physical environment evaluated, and modified if necessary, for safety issues  <input type="checkbox"/> member's physical environment evaluated, and modified if necessary, to increase accessibility  <input type="checkbox"/> member's interpersonal relationships within their environment evaluated, and accommodated / modified if necessary, for safety reasons  <input type="checkbox"/> other, describe: _____ </div> <p><input type="checkbox"/> Resolution following environmental review. Describe specifically how action(s) will prevent or diminish the probability of future occurrence(s). _____</p> <p><input type="checkbox"/> Environment reviewed and no changes required. Describe how this adverse incident was isolated with a minimal probability of a reoccurrence. _____</p>

(MAIL) Provider Correspondence, PO Box 36450, Des Moines, IA 50315 (FAX) 515-725-1360

## APPENDIX D: 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,<sup>20</sup> including that necessary safeguards have been taken to protect the health and welfare of the members of the service (42 CFR § 441.302(a)). The State agency must provide CMS with information regarding these participant safeguards in 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 incident means an occurrence involving a member of services that results in physical injury to or by the member that requires a physician’s treatments or admission, results in someone’s death, requires emergency mental health treatment for the member, requires the intervention of law enforcements, requires a report of child abuse pursuant to Iowa Code or a report of dependent adult abuse pursuant to Iowa Code, or constitutes a prescriptions medication error or a pattern of medication result[ing] in hospitalization or death.

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:

- a. any non-accidental physical injury;

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<sup>20</sup> Different versions of the BI and ID waivers were in effect during the period of this audit. Any material differences between these waivers are noted in this report.



- 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 biweekly to review critical incident reports of child and dependent adult abuse and member deaths that have been reported through the critical incident reporting process. The Department [of Human Services] reviews, and if needed, requests information for follow through and resolution of the abuse allegation and member deaths from the case manager or HCBS Specialist. Follow through may include changes to a plan of care or the safety or risk plan. If additional information or actions are required of a provider, the HCBS Specialist will work with the provider to assure any performance issues that are identified in the incident report [are] addressed.

The waiver program implemented a web-based critical incident reporting system September 1, 2009 that significantly enhanced the ability to track and trend the discovery, remediation and improvement processes of the critical incident reporting system. Revisions have been made to the system based on data collection and feedback from users, further enhancing the incident reporting 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 waivers for both the BI and ID waiver programs, 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 the Iowa Department of Human Services “has oversight for monitoring incidents that affect waiver participants. There is a HCBS quality assurance team that reviews all critical incident reports as soon as they are reported to the Department. All critical incidents are tracked in a critical incident database. This database tracks the date of the event, the specific waiver the member participates in, the provider (if applicable), and the nature of the event and follow up that was provided.”

The waivers add that the State agency’s HCBS Quality Assurance committee meets (monthly for the BI waiver program and biweekly for the ID waiver program) 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 treatment planning 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”) requires 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 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 perform a 100-percent review<sup>21</sup> of major incidents and determine on an ongoing basis the number and percentage of major incidents reported within required timeframes.

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<sup>21</sup> As of April 2016, MCOs were responsible for data collection and generation for this review.

## STATE REQUIREMENTS

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(7) 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 sixteen hours or less in a 24-hour period to two or more persons with a functional impairment on a regularly scheduled, contractual basis.

Iowa Code section 232.68.2(a) defines child abuse.

Iowa Code sections 232.69, 235B.3(2), and 235E.2 define the types of community-based providers who 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 it has occurred.

Iowa Code sections 235B.2 and 235B.3 provide definitions and requirements regarding the reporting of dependent adult abuse. These provisions give DIA the responsibility for the

evaluation and disposition of dependent adult abuse cases and the reporting of those dispositions to the Iowa Department of Human Services.

Iowa Code section 249A.29(2) states that the State agency “shall conduct criminal and child and dependent adult abuse records checks of the person in this state and may conduct these checks in other states.”

Iowa Code section 514B.1.6 defines health maintenance organizations as any person who:

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

Iowa Administrative Code 441, chapter 77.25(249A), states that “To 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.”

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 as defined by Iowa Code section 232.69 or a report of dependent adult abuse as defined by 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 organizations, member, and minor incident as follows:

‘Managed care organization’ means an entity that (1) is under contract with the department 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 medical assistance 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 sub rule.

Iowa Administrative Code 441, chapter 77.25(3)(4), states with respect to critical incident reporting, “[w]hen 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)(4)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.”



Kim Reynolds, Governor

Adam Gregg, Lt. Governor

Kelly Garcia, Director

Patrick J. Cogley  
 Regional Inspector General for Audit Services  
 HHS-OIG-Office of Audit Services  
 Region VII  
 601 East 12<sup>th</sup> Street, Room 0429  
 Kansas City, MO 64106

RE: *Iowa Did Not Comply with Federal and State Requirements for Major Incidents Involving Medicaid Members with Developmental Disabilities, Draft Report, A-07-18-06081*

Dear Mr. Cogley:

Enclosed please find comments from the Iowa Department of Human Services (DHS) on the January 23, 2020, Draft Report concerning Office of Inspector General's (OIG) review of critical incidents for home and community-based service members with developmental disabilities.

DHS appreciates the opportunity to respond to the draft report and provide additional comments to be included in the Final Report. DHS strives to administer its programs in compliance with applicable Federal and State law, regulations, and other policies. DHS is committed to working with CMS to resolve the issues identified in this audit review and are appreciative of the hard work your staff has undertaken relative to this audit.

Questions about the enclosed response can be addressed to:

Jody Lane-Molnari, Executive Officer II  
 Division of Fiscal Management  
 Iowa Department of Human Services  
 Hoover State Office Building, 1<sup>st</sup> Floor SW  
 1305 E Walnut Street  
 Des Moines, IA 50319-0114

**Email:** [janemo@dhs.state.ia.us](mailto:janemo@dhs.state.ia.us)

**Phone:** 515-281-6027

Sincerely,

/s/  
 Michael Randol  
 Medicaid Director

enclosure

cc: Dan Bittner, Audit Manager  
 Dustin Litwiler, Senior Auditor

**IOWA DEPARTMENT OF HUMAN SERVICES  
RESPONSE TO OIG DRAFT REPORT:**

***Iowa Did Not Comply with Federal and State Requirements for Major Incidents  
Involving Medicaid Members with Developmental Disabilities  
Draft Report, A-07-18-06081***

**Background**

As defined by the Developmental Disabilities Assistance and Bill of Rights Act of 2000, “developmental disability” means a severe, chronic disability of an individual. The disability of the individual 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. The disability results in substantial limitations in three or more major life areas, including selfcare, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

Federal and State Governments have an obligation to ensure that public funds are provided to residential, institutional, and community-based providers that serve individuals with developmental disabilities. Further, these providers must meet minimum standards to ensure that the care they provide does not involve abuse, neglect, sexual exploitation, and violations of legal and human rights.

The Social Security Act authorizes the Medicaid Home and Community-Based Services Waiver program. The HCBS waiver program permits a State to furnish an array of services that assists members to live in the community and avoid institutionalization. Waiver services complement and 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 to individuals. Each State has broad discretion to design its HCBS waiver program to address the needs of the HCBS waiver program’s target population.

States must provide certain assurances to the Centers for Medicare & Medicaid Services to receive approval for HCBS waivers, including that necessary participant safeguards have been taken to protect the health and welfare of the members receiving services. This HCBS waiver assurance requires the State to 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).

Iowa currently 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. OIG limited the audit to the Brain Injury (BI) and Intellectual Disability (ID) waivers, which between them cover the majority of the members who are receiving services under Iowa’s HCBS waiver. The BI waiver offers services to those who have been diagnosed with a brain injury because of an accident or illness. The ID waiver provides services for members who have been diagnosed with developmental disabilities. Both waivers offer various services, including adult daycare

services, home and vehicle modification, supported community living, supported employment, and transportation.

DHS administered the Iowa HCBS waiver programs on a fee-for-service (FFS) basis from January 1, 2014, through March 31, 2016, a timeframe that fell within the audit period. FFS is a payment model in which doctors and other healthcare providers are paid for each service performed, such as tests and office visits. Services are not bundled; they are paid for separately.

Effective April 1, 2016, DHS transitioned most Iowa Medicaid members to 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 healthcare services, including physical, behavioral, and long-term-care services and support. Effective April 1, 2016, the Iowa HCBS BI and ID waiver programs are also administered by MCOs on behalf of DHS.

DHS 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, healthcare services to enrollees on a fixed prepayment basis; and (3) is responsible for the availability, accessibility, and quality of the healthcare services provided or arranged.

Three MCOs managed the Iowa HCBS waiver programs from IA Health Link's inception on April 1, 2016, through November 30, 2017: UnitedHealthcare Community Plan of the River Valley, Inc., AmeriHealth Caritas Iowa (AmeriHealth), and Amerigroup Iowa, Inc. Effective November 30, 2017, AmeriHealth withdrew from its participation as an MCO.

The HCBS waivers state that DHS must specify types of critical events or incidents, including alleged abuse, neglect, and exploitation that must be reported for review and follow-up action by an appropriate authority. The HCBS waivers group critical incidents into two categories: major incidents and minor incidents.

The HCBS waivers further state that community-based providers are required to submit Critical Incident Reports within 24 hours of the major incident. These community based providers are required to report to DHS or to the MCO for members enrolled in managed care. For this audit, OIG focused on major incidents that were required to be reported during the audit period.

During the audit period, the Iowa BI and ID HCBS waiver programs served 16,056 members. After the transition to MCOs, the majority of the HCBS members were enrolled in one of the MCOs.

## **OIG Findings and Recommendations**

DHS did not fully comply with Federal and State requirements for reporting and monitoring major incidents involving developmentally disabled members who resided in community-based settings. Specifically, DHS did not:

- ensure that community-based providers reported all major incidents to DHS;



- ensure that community-based providers documented the resolution of reported major incidents to prevent or diminish the probability of future occurrences;
- review Critical Incident Reports to determine trends, problems, and issues in service delivery;
- ensure that community-based providers reported all member deaths to DHS; and
- report all known major incidents to CMS.

DHS' internal controls were not adequate to ensure that community-based providers (1) reported all major incidents and member deaths, (2) consistently documented the resolution of reported major incidents, and (3) analyzed and acted on trends regarding members with multiple reported major incidents. Accordingly, DHS did not fulfill various participant safeguard assurances that it provided to CMS in its Medicaid HCBS waivers to ensure the health, welfare, and safety of the 16,056 members with developmental disabilities covered by the BI and ID waivers. Because many major incidents were not reported, DHS was not able to fully ensure the health and safety of members receiving waiver services. Preventing, detecting, and combating abuse requires DHS and the community-based providers to fulfill all of their responsibilities.

OIG recommends that DHS, Iowa Medicaid Enterprise:

- train community-based providers on how to identify and report all major incidents;
- 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;
- perform trend analysis that identifies patterns and trends to assess the health and safety of members and 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;
- ensure that community-based providers report to DHS all member deaths;
- include all major incidents reported by MCOs in DHS reports to CMS; and
- 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,
  - a Critical Incident Report review checklist for use by DHS' Incident Reporting Specialist and HCBS specialist that includes completing the "Resolution" sections,
  - 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, and

- enhancements to DHS' IMPA system to minimize the need for staff to employ workarounds when inputting information regarding major incidents.

## **DHS Response and Corrective Actions**

### **OIG Recommendation #1 – Training community-based providers on how to identify and report all major incidents.**

DHS Concur: Iowa Administrative Code currently defines a major incident as “an occurrence involving a consumer during service provision.” The definition does not require providers to submit a Critical Incident report for incidents that do not occur during service provision. Members are able to receive 24 hour services or hourly services. In cases where the member receives hourly services, the community-based provider is required to submit a Critical Incident report only if the incident occurs during service provision or if the member reports the incident to staff. Iowa Medicaid Enterprise (IME) will update Iowa Administrative Code to change the definition of a major incident to “an incident involving a member enrolled in waiver services.” IME has also implemented a process to analyze incident reports, as well as Emergency Room (ER) claims to ensure all ER claims that meet the definition of a major incident are reported. IME will complete a collaborative training with HCBS providers regarding the updated Iowa Administrative Code and reporting requirements.

### **OIG Recommendation #2 – Training community-based providers on documenting resolution of major incidents.**

DHS Concur: IME recognizes there were Critical Incident Reports missing a resolution. In some cases the resolution was documented in ISIS and not on the incident report. IME has implemented a plan to follow up on all Critical Incident reports received that do not include a resolution to ensure a resolution is documented. In addition, properly reporting the resolution on a Critical Incident report will be included in the Incident Report training for HCBS waiver providers.

### **OIG Recommendation #3 – Perform trend analysis to assess the health and safety of members.**

DHS Concur: IME recognizes there were members with multiple incidents that did not have trend analysis completed. IME has implemented a process to analyze Critical Incident reports, as well as Emergency Room (ER) claims to ensure all ER claims identifying a defined major critical incident are reported. In addition, data trends by provider, as well as by individual will be reviewed to identify ongoing problems. Issues identified will result in a targeted review requiring a corrective action plan as needed. The Incident and Complaint specialist will complete this analysis monthly and complete follow up with providers or case managers on any members that have multiple incidents of a similar type.

**OIG Recommendation #4 – Ensure community-based providers report all member deaths to DHS.**

DHS Concur: IME recognizes there were member deaths that were not reported. During the OIG audit it was identified that if a member's service line in the ISIS system was ended prior to the Critical Incident report being submitted, the system would not allow the report to be submitted. IME has implemented a process to pull all member deaths from MMIS on a monthly basis and ensure an incident report has been received. If an incident report has not been received, contact will be made with the provider, case manager, or MCO to request the Critical Incident report. A log will be maintained of member deaths on a monthly basis. A copy of the incident report will be logged and maintained in OnBase. HCBS is currently working on a process to ensure that deaths of members no longer receiving HCBS services are reported to the Department of Inspection and Appeals (DIA).

**OIG Recommendation #5 – Include all major incidents reported by MCOs to CMS.**

DHS Concur: A comprehensive Critical Incident reporting process has been developed to ensure all MCO Incidents will be reported to CMS. IME receives the critical incident reporting file on a monthly basis. MCO data files are reviewed and missing information is requested from the MCO. HCBS combines the MCO critical incident files with the fee-for-service (FFS) incident files. While the MCO tracks and trends on an individual basis, the HCBS unit tracks and trends on a provider basis. Issues identified through the tracking and trending of MCO and FFS incident reports will be used for provider specific technical assistance, as well as be addressed in the HCBS provider critical incident training.

**OIG Recommendation #6 – Develop and implement internal controls to ensure full compliance with Federal and state requirements.**

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

DHS Concur: A comprehensive claims review process has been developed to match claims to Critical Incident reports based on diagnosis code provided by the Office of Inspector General (OIG) during the audit. The data is collected and analyzed on a monthly basis. In cases where a critical incident report should have been submitted but was not, the Incident and Complaint specialist reaches out to the case manager and requests a completed critical incident report. If the occurrence happened during direct service provision the provider is asked to complete the critical incident report. Follow up occurs until the critical incident report is received.

A Critical Incident report review checklist for use by the State agency's Incident Reporting Specialist and HCBS specialist that includes completing the "Resolution" sections

DHS Concur: A quality improvement plan is currently in development for the critical incident and complaint process. A checklist will be developed to ensure that incident reports include all required components. In addition, data tracking has been developed in response to the OIG review to ensure that data requested throughout the audit will be available for future reviews. Operational procedures and desk guides have been updated and will continue to be updated throughout the implementation of the quality improvement plan.

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

DHS Concur: IME recognizes there were member deaths that were not reported. During the OIG audit it was identified that if a member's service line in the ISIS system was ended prior to the Critical Incident report being submitted, the system would not allow the report to be submitted. IME has implemented a process to pull all member deaths from MMIS on a monthly basis and ensure an incident report has been received. If an incident report has not been received, contact will be made with the provider, case manager, or MCO to request the Critical Incident report. A log will be maintained of member deaths on a monthly basis. A copy of the incident report will be logged and maintained in OnBase. HCBS is currently working on a process to ensure that deaths of members no longer receiving HCBS services are reported to the Department of Inspection and Appeals (DIA).

Enhancements to DHS' IMPA system to minimize the need for staff to employ workarounds when inputting information regarding major incidents

DHS Concur: IME has implemented a process to pull all member deaths from MMIS on a monthly basis and ensure an incident report has been received. If an incident report has not been received, contact will be made with the provider, case manager, or MCO to request the Critical Incident report. A log will be maintained of member deaths on a monthly basis. A copy of the incident report will be logged and maintained in OnBase. HCBS is currently working on a process to ensure that deaths of members no longer receiving HCBS services are reported to the Department of Inspection and Appeals (DIA). IME will work with the systems department to discuss the availability of modifying IMPA to allow reporting after a member has been closed due to death in MMIS.