Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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A-09-17-02006

Office of Inspector General

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

Report in Brief
Date: June 2019
Report No. A-09-17-02006

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

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

Why OIG Did This Review

We have performed reviews in several States in response to a congressional request concerning the number of deaths and cases of abuse of residents with developmental disabilities in group homes.

Federal waivers permit States to furnish an array of home and community-based services to Medicaid beneficiaries with developmental disabilities so that they may live in community settings and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) requires States to implement a critical incident reporting system to protect the health and welfare of Medicaid beneficiaries receiving waiver services.

Our objective was to determine whether Alaska complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings from July 2014 through June 2016.

How OIG Did This Review

We judgmentally selected and reviewed 303 medical claims for beneficiaries residing in community-based settings whose claims included diagnosis codes associated with a high likelihood that a critical incident had occurred. We also reviewed critical incident reports contained in Alaska's reporting system.

What OIG Found

Alaska did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Specifically, Alaska did not ensure that community-based providers reported all critical incidents to the State. For the 303 judgmentally selected claims, 68 percent (205 claims) were not reported to Alaska as critical incidents. Alaska officials provided various reasons why a community-based provider may not properly report a critical incident to the State, including that the provider is unaware of the incident, fears retaliation by the employer, or has a general misunderstanding of the reporting requirements.

Alaska did not have a process, such as performing analytical procedures on Medicaid claims data, to determine whether there were unreported critical incidents. Alaska cannot investigate and take appropriate action to protect the health and welfare of Medicaid beneficiaries with developmental disabilities when community-based providers do not report critical incidents. As a result of not ensuring that providers reported all critical incidents, Alaska did not ensure proper responses to critical incidents or events as outlined in the safeguard assurances it provided to CMS in the Federal Medicaid waivers.

What OIG Recommends and Alaska Comments

We recommend that Alaska (1) work with community-based providers on processes to identify and report all critical incidents and (2) perform analytical procedures, such as data matches, on Medicaid claims data to identify potential critical incidents that have not been reported and investigate as needed.

Although Alaska did not concur or nonconcur with our recommendations, Alaska stated that, based on our finding, it had initiated corrective actions to (1) implement additional training to increase providers' ability to identify and report all incidents that meet reporting requirements and (2) establish data-mining processes with analytical procedures, such as data matches, using Medicaid claims data to identify potential unreported critical incidents for further investigation.

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INTRODUCTION

WHY WE DID THIS REVIEW

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

In Alaska, individuals with developmental disabilities may reside in community-based settings, such as group homes, shared living arrangements, and private family homes. Within community-based settings, provider types include but are not limited to group-home workers, care coordinators, and family members responsible for the care of beneficiaries (collectively known as community-based providers).

OBJECTIVE

Our objective was to determine whether the Alaska Department of Health and Social Services (State agency) complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings from July 2014 through June 2016 (audit period).

BACKGROUND

Developmental Disabilities Assistance and Bill of Rights Act of 2000

As defined by the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (the Disabilities Act),[2] "developmental disability" means a severe, chronic disability of an individual. 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, defined as self-care, receptive and expressive language, learning, mobility, self-determination, capacity for independent living, and economic self-sufficiency.

Federal and State Governments have an obligation to ensure that public funds are provided to residential, institutional, and community-based providers that serve individuals with developmental disabilities. Further, these providers must meet minimum standards to ensure

[1] See Appendix B for related work.

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

that the care they provide does not involve abuse, neglect, sexual exploitation, or violations of legal and human rights (the Disabilities Act § 109(a)(3)).

Medicaid Home and Community-Based Services Waiver

The Social Security Act (the Act) authorizes the Medicaid Home and Community-Based Services Waiver (HCBS waiver) program (the Act § 1915(c)). The program permits a State to furnish an array of home and community-based services to Medicaid beneficiaries with developmental disabilities so that they may live in community settings and avoid institutionalization. Waiver services complement or supplement the services that are available to beneficiaries through the Medicaid State plan and other Federal, State, and local public programs and the support that families and communities provide. Each State has broad discretion to design its waiver program to address the needs of the waiver's target population.

The Senior and Disabilities Services division within the State agency administers Alaska's HCBS waiver program. The HCBS waiver program in Alaska planned to provide up to 1,706 individuals with needed comprehensive support services during our audit period.[3]

States must provide certain assurances to the Centers for Medicare & Medicaid Services (CMS) to receive approval for an HCBS waiver, including that necessary safeguards have been undertaken to protect the health and welfare of the beneficiaries receiving services (42 CFR § 441.302). This waiver assurance requires the State to provide specific information regarding its plan or process related to participant safeguards, which includes whether the State operates a critical event or incident reporting system (HCBS waiver, Appendix G-1). In its two waivers and its own regulations, the State agency stated that it has a critical event or incident reporting system.

Critical Incident Reporting for Community-Based Providers

Alaska's HCBS waivers and State agency regulations define a critical incident as any unplanned event in which a beneficiary was injured and required medical attention. Examples of critical incidents include (1) beneficiary behavior that results in harm to the beneficiary or others, (2) misuse of restrictive interventions,[4] (3) a medication error resulting in the need for evaluation by or consultation with medical personnel, or (4) death of a beneficiary. The HCBS waivers and State agency regulations further state that community-based providers must report to the State agency a critical incident involving a beneficiary for whom services are

[3] Alaska operates two HCBS waivers that cover individuals with developmental disabilities: The Adults with Physical and Developmental Disabilities waiver planned to serve up to 106 individuals per year, and the People with Intellectual and Developmental Disabilities waiver planned to serve up to 1,600 individuals per year.

[4] Restrictive interventions include interrupting or preventing a challenging or dangerous behavior that is physically harmful to the beneficiary or others (HCBS waiver, Appendix G-2). Examples of misuse of restrictive interventions include seclusion, prone restraint, or chemical restraint; these interventions cannot be used (Alaska Administrative Code (AAC), Title 7, § 130.229(b)(2)).

provided under a service plan no later than 24 hours or 1 business day after observing or learning of the critical incident. The provider is required to file a Critical Incident Report with the State agency using the designated web portal, mail, email, fax, or phone, or by reporting in person to the State agency's Central Intake Unit.

Effective January 2015, the State agency implemented the Harmony Data System (Harmony), a central database to collect and record intake reports from community-based providers.[5] Intake reports may include requests for new services, general informational inquiries, and Critical Incident Reports. Once recorded, the State agency is responsible for reviewing the intake reports and investigating if necessary. During our audit period, Harmony recorded 11,038 intake reports.

HOW WE CONDUCTED THIS REVIEW

We obtained 59,026 medical claims[6] from the Alaska Medicaid Management Information System (MMIS) that the State agency paid on behalf of 1,628 Medicaid beneficiaries with developmental disabilities covered by the HCBS waivers from July 2014 through June 2016. We analyzed the claims data and identified 618 diagnosis codes associated with a high likelihood that a critical incident occurred.[7] We identified 3,135 claims that contained at least 1 of these 618 diagnosis codes. (We considered these claims to be indicative of a critical incident.) We then compared these 3,135 claims with Harmony data and identified 2,555 claims associated with potential critical incidents that may not have been reported to the State agency.

Of the 2,555 claims, we judgmentally selected 303 claims for further review to determine whether each claim represented an unreported critical incident. This additional review included requesting the medical records to support the claim or asking the State agency to review the claim and determine whether it was for an unreported critical incident. We also reviewed critical incident reports contained in Alaska's reporting system.

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

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

[5] Data from the prior intake-reporting system were transferred to Harmony when it was implemented.

[6] These medical claims were from various settings, such as clinics, hospitals, and emergency rooms.

[7] These diagnosis codes, such as codes for head injuries, bodily injuries, sexual trauma, and neglect (e.g., bed sores and dehydration), indicate an increased likelihood of abuse or neglect.

FINDING

The State agency did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Specifically, the State agency did not ensure that community-based providers reported all critical incidents to the State agency. State agency officials provided various reasons why a community-based provider may not report a critical incident to the State agency, including that the provider is unaware of the incident, fears retaliation by the employer, or has a general misunderstanding of the reporting requirements.

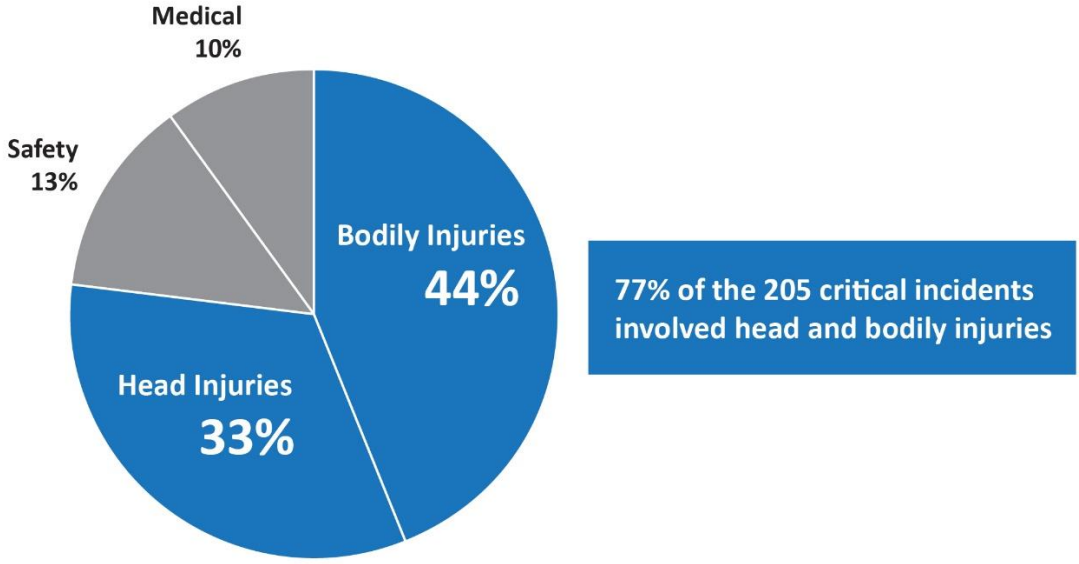
The State agency did not have a process, such as performing analytical procedures on Medicaid claims data, to determine whether there were unreported critical incidents. As a result of not ensuring that providers reported all critical incidents, the State agency did not ensure proper responses to critical incidents or events as outlined in the safeguard assurances it provided to CMS in the HCBS waivers.

COMMUNITY-BASED PROVIDERS DID NOT REPORT ALL CRITICAL INCIDENTS TO THE STATE AGENCY

Community-based providers in Alaska are required to report to the State agency all critical incidents involving Medicaid beneficiaries with developmental disabilities. Critical incidents that must be reported to the State agency include (1) an accident, injury, or other unexpected event that affected a beneficiary's health, safety, or welfare to the extent that evaluation by or consultation with medical personnel was needed; and (2) the death of a beneficiary (HCBS waiver, Appendix G-1(b)). In addition, a provider must report to the State agency, on a form provided by the State agency, a critical incident involving a beneficiary not later than 24 hours or 1 business day after observing or learning of the critical incident (7 AAC § 130.224(a)).

Community-based providers did not report to the State agency all critical incidents involving beneficiaries with developmental disabilities. Specifically, for the 303 judgmentally selected claims, 68 percent (205 claims) were not reported to the State agency as critical incidents. The figure on the following page contains details of the 205 claims with critical incidents, organized by diagnosis code category. Appendix D contains a list of the high-risk diagnosis codes associated with unreported critical incidents and the number of claims and the number of beneficiaries associated with each code.

Figure: Diagnoses Associated With the 205 Critical Incidents, by Diagnosis Code Category



State agency officials provided various reasons why a community-based provider may not properly report a critical incident to the State agency, including that the provider is unaware of the incident, fears retaliation by the employer, or has a general misunderstanding of the reporting requirements.

The State agency did not have a process, such as performing analytical procedures on Medicaid claims data, to determine whether there were unreported critical incidents. The State agency cannot investigate and take appropriate action to protect the health and welfare of Medicaid beneficiaries with developmental disabilities when community-based providers do not report critical incidents. As a result of not ensuring that providers reported all critical incidents, the State agency did not ensure proper responses to critical incidents or events as outlined in the safeguard assurances it provided to CMS in the HCBS waivers.

Example of a Critical Incident Not Reported by a Community-Based Provider
A community-based provider did not report to the State agency a critical incident involving a beneficiary with developmental disabilities. This beneficiary, who was 20 years old on the date of service, suffered hand, facial, and chest pain as well as contusions and bruises that required treatment at a local hospital's emergency room. X-rays were taken and were negative for broken bones. The beneficiary's medical records noted that the beneficiary got into an altercation with a housemate, in which punching and kicking were involved. Because the beneficiary's injury met the State agency's definition of a critical incident, the community-based provider should have reported the incident to the State agency's Central Intake Unit.

RECOMMENDATIONS

We recommend that the State agency:

- work with community-based providers on processes to identify and report all critical incidents and

- perform analytical procedures, such as data matches, on Medicaid claims data to identify potential critical incidents that have not been reported and investigate as needed.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency did not concur or nonconcur with our recommendations. However, the State agency said that, based on our finding, it had initiated corrective actions to (1) implement additional central intake reporting training to increase providers' ability to identify and report all incidents that meet reporting requirements and (2) establish data-mining processes with analytical procedures, such as data matches, using Medicaid claims data to identify potential unreported critical incidents for further investigation.

The State agency's comments appear in their entirety as Appendix E.

STATE AGENCY COMMENTS

The State agency proposed two changes to our report.

First, the State agency said that it does not dispute that 205 critical incidents were not reported by community-based providers. However, it stated that we were unable to establish whether those providers were aware of the critical incidents (as required by Alaska regulations, 7 AAC § 130.224). The State agency said that if a provider is not involved with or aware of a critical incident, the provider is not obligated to report it. The State agency also said that it is misleading for our report to state that community-based providers did not report 68 percent of the 303 judgmentally selected claims without acknowledging that we did not verify whether each of the incidents was known to a provider. The State agency provided an example outlining when a provider might not be aware of a critical incident and proposed amended language for our report.

Second, the State agency requested that we remove doctors and add other provider types to the list of provider types shown in our report as community-based providers:

- The State agency said that doctors are not providers in community-based settings; rather, when they are performing their professional duties, if they have reasonable cause to believe a vulnerable adult suffers from undue influence, abandonment, exploitation, abuse, neglect, or self-neglect, (i.e., maltreatment), they "shall report that

incident to the State's central intake." The State agency said that the reporting obligations under State regulations do not extend to doctors and that because not all critical incidents rise to the level of maltreatment, doctors are not obligated to report such incidents.

- The State agency commented that the list of provider types is not inclusive of all Alaska-certified HCBS providers. The State agency said that, in addition to group-home workers and caseworkers (called care coordinators in Alaska), there are also workers in the service areas of family home and day habilitation, in-home supports, and supported living, among others. Further, the State agency said that family members may act in the capacity of a "provider/worker" when they have a signed order from the court granting them authority to work as a paid provider. The State agency commented that physician services are not furnished in community-based settings, as defined in the State's HCBS waiver regulations (7 AAC § 130.220(k)–(r)).

The State agency said that if its proposed amendments to the language in our report are implemented, it concurs with our report. However, it said that if the proposed changes are not made, it partially concurs with our report as written.

OFFICE OF INSPECTOR GENERAL RESPONSE

We updated our report to address the State agency's comments as appropriate.

Regarding the State agency's comments on unreported critical incidents, the scope of our review was not intended to identify whether a community-based provider was aware of an unreported critical incident. This report highlights that critical incidents are not being reported and, as stated in the report, State agency officials provided various reasons why a community-based provider may not properly report a critical incident to the State agency, including that the provider is unaware of the incident, fears retaliation by the employer, or has a general misunderstanding of the reporting requirements.

Although we recognize that not all critical incidents we identified in our review rise to the level of maltreatment, ensuring that these incidents are reported is beneficial. The example that the State agency provided, on its own, may not require additional intervention to ensure the health and safety of the individual. However, if the same individual has multiple accidents involving public transportation or in other unsupervised areas, additional intervention may be warranted to ensure the health and safety of the individual. Without accurate reporting of critical incidents, the State agency has limited information to ensure that it can satisfy the waiver assurances related to beneficiary health and safety.

Regarding the State agency's comments on the provider types shown in our report, we revised our report to refer to caseworkers as "care coordinators" and removed doctors from the list of community-based providers. However, we did not add the State agency's other provider types because our list was not intended to be all-inclusive.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From July 2014 through June 2016, 1,628 Medicaid beneficiaries with developmental disabilities covered by Alaska's HCBS waivers received medical services. During this period, the State agency received from community-based providers 11,038 intake reports involving 1,261 of the 1,628 Medicaid beneficiaries. We obtained and analyzed 59,026 medical claims that the State agency paid on behalf of the 1,628 Medicaid beneficiaries and identified 618 diagnosis codes associated with a high likelihood that a critical incident occurred. We identified 3,135 claims that contained at least 1 of these 618 diagnosis codes. (We considered these claims to be indicative of a critical incident.) We then compared these 3,135 claims with Harmony data and identified 2,555 claims associated with potential critical incidents that may not have been reported to the State agency.

Our objective did not require an understanding of all of the State agency's internal controls. We limited our internal control review to obtaining an understanding of the State agency's policies and procedures related to its critical incident reporting and monitoring.

We performed our fieldwork from June 2017 through September 2018, which included site visits to the State agency's office in Anchorage, Alaska.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal waiver and State requirements;
- held discussions with CMS officials to gain an understanding of Alaska's HCBS waivers for beneficiaries with developmental disabilities residing in community-based settings;
- held discussions with State agency officials to gain an understanding of State policies and controls related to reporting critical incidents involving beneficiaries with developmental disabilities;
- obtained from the State agency a computer-generated file of information for all Medicaid beneficiaries with developmental disabilities residing in community-based settings during the audit period;
- obtained from the MMIS a computer-generated file containing 59,026 medical claims;
- reconciled the MMIS claims data with the Alaska Medicaid eligibility records to verify the accuracy of these data;

- obtained from the State agency's Harmony system a computer-generated file of information related to 11,038 intake reports for Medicaid beneficiaries residing in community-based settings during our audit period;

- identified 3,135 claims that contained 1 or more of the 618 diagnosis codes that were indicative of a critical incident;

- compared the 11,038 intake reports with the 3,135 claims containing high-risk diagnosis codes and identified 2,555 claims that may not have been reported as critical incidents to the State agency;

- judgmentally selected for further review 303 of the 2,555 claims that may not have been reported as critical incidents to the State agency to determine whether each claim represented an unreported critical incident;[8]

- reviewed medical records supporting each claim or asked the State agency to determine whether the claim was associated with an unreported critical incident;

- analyzed medical claims and reported incident data that matched reported critical incidents to determine whether the State agency followed its own procedures for reporting and monitoring critical incidents; and

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

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

[8] We judgmentally selected claims that included certain diagnosis codes, such as those related to physical and sexual abuse, as well as those related to fractures, contusions, and open wounds.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Joint Report: Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight	Joint Report[9]	1/17/2018
Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-01-16-00001	8/9/2017
Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00008	7/13/2016
Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00002	5/25/2016
Review of Intermediate Care Facilities in New York With High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries	A-02-14-01011	9/28/2015

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

APPENDIX C: FEDERAL WAIVER AND STATE REQUIREMENTS

MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER

States must provide certain assurances to CMS to receive approval for an HCBS waiver, including that necessary safeguards have been taken to protect the health and welfare of the beneficiaries of the service (42 CFR § 441.302). The State agency must provide CMS with information regarding these participant safeguards in the HCBS waiver, Appendix G, *Participant Safeguards*. A State must provide assurances regarding three main categories of safeguards:

- response to critical events or incidents (including alleged abuse, neglect, and exploitation);
- safeguards concerning restraints and restrictive interventions; and
- medication management and administration.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements," requires all providers to report critical incidents. Within 24 hours or 1 business day of observing or learning of an incident involving a participant for whom services are provided under a service plan, the provider is required to file a Critical Incident Report. For medication errors, the timeframe must be met only when the error results in the need for medical intervention; all other medical errors must be reviewed and documented by the provider on a quarterly basis and submitted to the State agency upon request.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(e), "Responsibility for Oversight of Critical Events or Incidents," states that the State agency maintains an incident report database to track incidents and to monitor technical assistance and dispositions, including requests for additional information regarding incidents and completions of critical incident improvement plans. For research and analysis purposes, the State agency develops monthly reports summarizing incident data and analyzes cumulative incident report data as a risk management method to identify prevalence and patterns of adverse events in the participant population, to evaluate the effectiveness of technical assistance interventions, and to identify areas for quality improvement in both the State agency and provider agency operations.

ALASKA ADMINISTRATIVE CODE

The AAC, Title 7, chapter 130, *Home and Community-Based Waiver Services; Nursing Facility and ICF/IID Level of Care,* section 224, "Critical incident reporting," subsection (a), states: "A provider shall report to the department, on a form provided by the department, a critical incident involving a recipient not later than one business day after observing or learning of the critical incident."

APPENDIX D: DIAGNOSIS CODES ASSOCIATED WITH UNREPORTED CRITICAL INCIDENTS[10]

Category	Diagnosis Code	Description	No. of Claims	No. of Beneficiaries
Head Injuries				
1	850.9	Concussion—not otherwise specified (NOS)	1	1
2	851	Cerebral cortex contusion	2	1
3	870	Laceration of the eyelid skin/periocular	1	1
4	873	Open wound of scalp	2	1
5	873.4	Open wound of face NOS	1	1
6	873.42	Open wound of forehead	7	4
7	873.43	Open wound of lip	3	1
8	873.44	Open wound of jaw	2	1
9	873.52	Open wound forehead—complicated	2	1
10	873.8	Open wound of head—not elsewhere classifiable (NEC)	1	1
11	873.9	Open wound head NEC—complicated	1	1
12	920	Contusion face/scalp/neck	12	4
13	959.01	Head injury, unspecified	14	7
14	959.09	Injury, face and neck	3	2
15	R22.0	Localized swelling, mass and lump, head	2	2
16	R22.1	Localized swelling, mass and lump, neck	4	2
17	S00.81XA	Abrasion of other part of head, initial encounter	2	2
18	S00.91XA	Abrasion of unspecified part of head, initial encounter	2	2
19	S01.01XA	Laceration without foreign body of scalp, initial encounter	2	1
20	S01.23XA	Puncture wound without foreign body of nose, initial encounter	1	1
21	S01.81XA	Laceration without foreign body of other part of head, initial encounter	2	1

[10] Diagnosis codes and descriptions are taken from the *International Classification of Diseases, Ninth Revision, Clinical Modification;* and *International Classification of Diseases, Tenth Revision, Clinical Modification* (which took effect on October 1, 2015).

Category	Diagnosis Code	Description	No. of Claims	No. of Beneficiaries
22	S01.91XA	Laceration without foreign body of unspecified part of head, initial encounter	1	1
23	S05.12XA	Contusion of eyeball and orbital tissues, left eye, initial encounter	2	1
24	S06.0X0A	Concussion without loss of consciousness, initial encounter	2	1
25	S06.0X0D	Concussion without loss of consciousness, subsequent encounter	2	1
26	S08.0XXA	Avulsion of scalp, initial encounter	1	1
27	S09.90XA	Unspecified injury of head, initial encounter	5	2
Category Subtotal			**80**	**45**
Bodily Injuries				
1	805.6	Fracture sacrum/coccyx—closed	2	1
2	812	Fracture up end humerus NOS (unspecified)—closed	1	1
3	812.03	Fracture of greater tuberosity of the humerus—closed	5	1
4	812.21	Fracture humerus shaft—closed	3	1
5	813.05	Fracture radius head—closed	4	1
6	813.42	Fracture distal radius NEC (other)—closed	1	1
7	813.81	Fracture radius NOS—closed	2	1
8	816.12	Fracture distal phalanx, hand—open	1	1
9	822	Fracture patella—closed	1	1
10	823.2	Fracture shaft tibia—closed	6	2
11	823.21	Fracture shaft fibula—closed	1	1
12	824.2	Fracture lateral malleolus—closed	1	1
13	824.8	Fracture ankle NOS—closed	7	1
14	831	Dislocated shoulder NOS—closed	4	1
15	881.01	Open wound of elbow	2	1
16	891	Open wound knee/leg/ankle	3	1
17	922.1	Contusion of chest wall	6	2
18	922.4	Contusion genital organs	2	1
19	923.03	Contusion of upper arm	1	1
20	923.1	Contusion of forearm	1	1
21	923.11	Contusion of elbow	1	1

Category	Diagnosis Code	Description	No. of Claims	No. of Beneficiaries
22	923.21	Contusion of wrist	1	1
23	924.11	Contusion of knee	1	1
24	924.9	Contusion NOS	1	1
25	927.3	Crushing injury finger	3	2
26	959.11	Other injury chest wall	2	1
27	959.19	Other injury of other sites of the trunk	2	2
28	959.2	Shoulder/upper arm injury NOS	3	2
29	959.5	Finger injury NOS	1	1
30	959.7	Lower leg injury NOS	1	1
31	S20.20XA	Contusion of thorax, unspecified, initial encounter	2	2
32	S20.212A	Contusion of left front wall of thorax, initial encounter	1	1
33	S29.9XXA	Unspecified injury of thorax, initial encounter	2	1
34	S30.1XXA	Contusion of abdominal wall, initial encounter	1	1
35	S39.92XA	Unspecified injury of lower back, initial encounter	1	1
36	S42.201A	Unspecified fracture of upper end of right humerus, initial encounter	3	1
37	S42.291A	Other displaced fracture of upper end of right humerus, initial encounter for closed fracture	2	1
38	S42.321A	Displaced transverse fracture shaft of humerus, right arm, initial encounter	2	1
39	S43.101A	Unspecified dislocation of right acromioclavicular joint, initial encounter	2	1
40	S49.92XA	Unspecified injury of left shoulder and upper arm, initial encounter	1	1
41	S52.122A	Displaced fracture of head of left radius, initial encounter for closed fracture	3	1
42	S52.125D	Nondisplaced fracture of head of left radius, subsequent encounter for closed fracture with routine healing	1	1
43	S52.135A	Nondisplaced fracture of neck of left radius, initial encounter for closed fracture	1	1

Category	Diagnosis Code	Description	No. of Claims	No. of Beneficiaries
44	S52.381A	Bent bone of right radius, initial encounter for closed fracture	1	1
45	S52.521D	Torus fracture lower end of right radius, subsequent encounter for fracture with routine healing	1	1
46	S69.91XA	Unspecified injury of right wrist, hand and finger(s), initial encounter	1	1
47	S73.004A	Unspecified dislocation of right hip, initial encounter	1	1
48	S73.005A	Unspecified dislocation of left hip, initial encounter	2	1
49	S73.005D	Unspecified dislocation of left hip, subsequent encounter	2	1
50	S73.015A	Posterior dislocation of left hip, initial encounter	2	1
51	S73.015D	Posterior dislocation of left hip, subsequent encounter	1	1
52	T14.90	Injury, unspecified	2	2
Category Subtotal			**105**	**59**
Medical				
1	599.7	Hematuria, unspecified	13	7
2	599.71	Gross hematuria	3	1
3	E86.0	Dehydration	1	1
4	R31.9	Hematuria, unspecified	7	3
Category Subtotal			**24**	**12**
Safety				
1	930.9	Foreign body in external eye NOS	1	1
2	931	Foreign body in ear	1	1
3	932	Foreign body in nose	2	1
4	933	Foreign body in pharynx	1	1
5	935.1	Foreign body esophagus	1	1
6	938	Foreign body digestive system NOS	3	2
7	995.59	Other child abuse & neglect	1	1
8	995.81	Adult maltreatment	1	1
9	995.83	Adverse effect NEC—adult sexual abuse	1	1

Category	Diagnosis Code	Description	No. of Claims	No. of Beneficiaries
10	R09.01	Asphyxia	1	1
11	T16.1XXA	Foreign body in right ear, initial encounter	2	2
12	T22.062A	Burn of unspecified degree of left scapular region, initial encounter	1	1
13	T22.069	Burn of unspecified degree of unspecified scapular region, subsequent encounter	1	1
14	T23.271A	Burn of second degree of right wrist, initial encounter	2	1
15	T25.021A	Burn of unspecified degree of right foot, initial encounter	1	1
16	T38.3X1A	Poisoning by insulin and oral hypoglycemic drugs, accidental, initial	1	1
17	T39.012A	Poisoning by aspirin, intentional self-harm	1	1
18	T51.94XA	Toxic effect of unspecified alcohol, undetermined, initial encounter	1	1
19	T76.11XA	Adult physical abuse, suspected, initial encounter	2	2
20	V71.5	Observation following rape	1	1
21	Z04.1	Encounter for exam and observation following transport accident	3	1
22	Z04.41	Encounter for exam and observation following alleged adult rape	2	2
Category Subtotal			**31**	**26**
Subtotal			**240**	**142**
		35 claims with more than 1 selected diagnosis code	(35)	
		58 beneficiaries with more than 1 claim		(58)
TOTAL			**205**	**84**

APPENDIX E: STATE AGENCY COMMENTS

THE STATE of ALASKA
GOVERNOR MICHAEL J. DUNLEAVY

Department of Health and Social Services

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March 15, 2019

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
Office of Inspector General
Department of Health and Human Services
90 – 7th Street, Suite #-650
San Francisco, CA 94103

Dear Ms. Ahlstrand:

RE: Response to OIG report number #A-09-17-02006 received February 19, 2019 for Alaska Department of Health and Social Services, Reporting and Monitoring of Critical Incidents Involving Medicaid Beneficiaries with Developmental Disabilities.

Thank you for the opportunity to review and respond to the draft report by the Office of Inspector General (OIG) regarding their review of Alaska's reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities. Additionally, I would also like to extend my sincere appreciation for the high level of professional courtesy extended to our program staff throughout the audit process.

The Alaska Department of Health and Social Services (AK DHSS) proposes the following amendments to the report. With amendments the agency concurs with the OIG report.

Proposed amendment to cover page language, "For the 303 judgmentally selected claims, community-based providers did not report 68 percent the critical incidents (205) claims to Alaska."

The department does not dispute that 205 critical incidents were not reported by home and community-based providers. However the OIG was not able to establish if the Home and Community Based providers were aware of the critical incident. Alaska regulations, 7 AAC 130.224, state that "A provider shall report to the department, in a format provided by the department, a critical incident involving a recipient not later than one business day after observing or learning of the critical incident." If a provider is not involved or aware of the incident they are not obligated to report the incident. It is misleading to

state that community based providers did not report 68% of the 303 judgmentally selected claims without acknowledging that the OIG did not verify whether each of the incidents were known to a provider.

> For example: John Doe is 23 years old and lives with his parents. He receives supported employment, day habilitation, and care coordination through his support plan. John falls getting off public transportation and cuts his knee. A parent, (unpaid care provider) takes him to the emergency room and he receives a diagnosis of "Contusion – Rt. Knee". This meets the definition of a critical incident report and would be included in the OIG's review. Neither the supported employment provider nor the day habilitation provider was involved in the accident. They would only know about the event if John or his parent/guardian told them of the event. The physician does not suspect maltreatment, therefore is not required to report. The day habilitation provider, supported employment provider, nor the care coordinator would be required to submit a report because they did not know of the incident, yet they would have been counted in the OIG report as failing to report.

AK DHSS proposes the following amended language: For the 303 judgmentally selected claims, 205 critical incidents were not reported to the agency. Alaska critical incident reporting regulations require home and community based providers to report known incidents. Due to data limitations the OIG was not able to verify what percentage of the 205 critical incidents that were not reported were known incidents to home and community based providers, nor what percentage of the 205 critical incidents were maltreatment not reported by physicians.

Proposed amendments to page one language, "Within community-based settings, provider types include *group-home workers, caseworkers, doctors, and family members responsible for the care of beneficiaries (collectively known as community-based providers).*"

The department would like to make two clarifications. First, doctors are not providers in community-based settings. Doctors when they are in the performance of their professional duties, that have reasonable cause to believe a vulnerable adult suffers from undue influence, abandonment, exploitation, abuse, neglect or self-neglect, shall report that incident to the State's central intake (Alaska Statue 47.24.010(1)). AK DHSS critical incident reporting regulations require home and community-based waiver services providers (certified under 7 AAC 130.220) to report all known critical incidents. The reporting obligations under the critical incident regulations (7 AAC 130.224) do not extend to doctors. Not all critical incidents (7 AAC 130.224 (c) (1)) rise to the level of maltreatment, therefore, doctors are not obligated to report those incidents that do not rise to the level of maltreatment.

Second, the list of provider types is not inclusive of all Alaska certified HCBS providers. In addition to group-home workers and caseworkers (called care coordinators in Alaska), there are also workers in the service areas of Family Home Habilitation, Day Habilitation, In-Home Supports, Supported Living, Supported Employment, Respite, Chore, and Environmental Modification. Family members may act in the capacity of a provider/worker when they have a signed order from the court granting them authority to work as a paid provider. Physician services are not furnished in community-based settings, as defined in the State's home and community based waiver regulations (7 AAC 130.220(k)-(r)).

AK DHSS proposes the following amended language: "Within community-based settings, provider types include *group-home, care coordination, family home habilitation, day habilitation, in-home supports, supported living, supported employment, respite, chore, and environmental modification workers and family members responsible for the care of beneficiaries (collectively known as community-based providers). Additional providers of service to beneficiaries include physicians or other licensed health care providers. "*

Based on the findings shared by this audit report, AK DHSS has initiated the following corrective actions:

Additional central intake reporting training to increase providers' (community based providers and physicians) ability to identify and report all incidents that meet reporting requirements.

Establishment of data mining processes with analytical procedures, such as data matches, using Medicaid claims data to identify potential critical incidents that have not been reported for further investigation. The processes will be designed to support a scheduled or periodic assessment of claims data and follow up.

With proposed amendments AK DHSS would concur with the OIG report, however, without the proposed changes the agency partially concurs with the report as written.

Please contact Linnea Osborne at (907) 465-6333 if you have any questions or require additional information.

Sincerely,

Adam Crum
Commissioner

Cc: Donna Steward, Deputy Commissioner
Sana P. Efird, Assistant Commissioner
Deb Etheridge, Acting Director, Division of Senior and Disabilities Services
Linnea Osborne, Accountant V