

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MASSACHUSETTS IMPLEMENTED
OUR PRIOR AUDIT
RECOMMENDATIONS AND
GENERALLY COMPLIED WITH
FEDERAL AND STATE
REQUIREMENTS FOR REPORTING
AND MONITORING CRITICAL
INCIDENTS**

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April 2022
A-01-20-00003

Office of Inspector General

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Report in Brief

Date: April 2022

Report No. A-01-20-00003

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



Why OIG Did This Audit

OIG previously conducted an audit of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes and found that Massachusetts did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents. The report contained five recommendations.

Our objectives were to determine whether Massachusetts implemented the recommendations from our prior audit and complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents.

How OIG Did This Audit

We reviewed Massachusetts' system for reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities during our audit period, July 2018 through June 2019. To determine whether the five recommendations from the prior OIG report were implemented, we reviewed correspondence from Centers for Medicare & Medicaid Services (CMS) and supporting documentation provided by the State. To determine whether the actions taken by Massachusetts effectively addressed our previous findings, we reviewed 147 emergency room claims from April 2019 to June 2019 for 128 beneficiaries residing in group homes who were diagnosed with conditions that we determined to be indicative of high risk for suspected abuse or neglect.

Massachusetts Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents

What OIG Found

Massachusetts implemented the five recommendations from our prior audit and generally complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes. However, the corrective actions for one recommendation in our prior audit were not effective in addressing one of our previous findings. Specifically, Massachusetts did not ensure all reasonable suspicions of abuse or neglect were reported to the Disabled Persons Protection Commission (DPPC). One possible reason that this issue occurred is because the Massachusetts Department of Developmental Services (DDS) and group home staff were only required to take mandated reporter training on reporting reasonable suspicions of abuse and neglect (a corrective action) once rather than periodically.

Because Massachusetts did not ensure that all reasonable suspicions of abuse or neglect were reported, it did not fulfill all of the participant safeguard assurances it provided to CMS in the Medicaid Home and Community-Based Services Intensive Supports waiver along with the State requirements incorporated under the waiver.

What OIG Recommends and Massachusetts Comments

We recommend that Massachusetts: (1) continue to coordinate with DDS and DPPC to ensure that all reasonable suspicions of abuse and neglect are properly identified, reported, and investigated as needed and (2) require periodic training for DDS and group home staff on reporting reasonable suspicions of abuse and neglect.

In written comments on our draft report, Massachusetts concurred with both of our recommendations and described the actions that it has taken or planned to take to implement them, including holding meetings between DDS and DPPC to review the updated DDS training curriculum on the proper reporting and identification of all reasonable suspicions of abuse and neglect and the addition of annual mandated reporter training for DDS and group home staff.

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INTRODUCTION

WHY WE DID THIS AUDIT

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

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

OBJECTIVES

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

BACKGROUND

Developmental Disabilities Assistance and Bill of Rights Act of 2000

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

¹ The Department of Health and Human Services, Office of Inspector General, *Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries* (A-01-14-00008), July 2016. Available at <https://www.oig.hhs.gov/oas/reports/region1/11400008.pdf>.

² See Appendix B for related work.

³ P.L. No. 106-402 (Oct. 30, 2000).

Federal and State Governments have an obligation to ensure that public funds are provided to residential, institutional, and community providers that serve developmentally disabled individuals. Further, these providers must meet minimum standards to ensure the care they provide does not involve abuse, neglect, sexual exploitation, or violations of legal and human rights (the Disabilities Act § 109(a)(3)(B)(i)).

Medicaid Home and Community-Based Services Waiver

The Social Security Act (the Act) authorizes the Medicaid Home and Community-Based Services Intensive Supports waiver (HCBS waiver) program (the Act § 1915(c)).⁴ The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. Waiver services complement or supplement the services that are available to beneficiaries—through the Medicaid State plan and other Federal, State, and local public programs—and the support that families and communities provide. Each State has broad discretion to design its waiver program to address the needs of the waiver’s target population.

The State agency administers Massachusetts’ HCBS waiver. The Massachusetts Department of Developmental Services (DDS), which is a separate agency, implements portions of this waiver through an interdepartmental service agreement (ISA) with the State agency. The HCBS waiver program supports individuals who require comprehensive support services based on the severity of their functional, behavioral, or medical impairments. These individuals reside either in an out-of-home setting, such as a group home with 24-hour support, or in their family home with additional in-home support and supervision.

States must provide certain assurances to the Centers for Medicare & Medicaid Services (CMS) to receive approval for the HCBS waiver, including that necessary safeguards are in place to protect the health and welfare of the beneficiaries receiving services (42 CFR § 441.302). A State must provide specific information regarding its plan or process related to patient safeguards, which includes whether the State operates a critical event or incident reporting system (HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*). In its HCBS waiver, the State agency stated that it has a critical event or incident reporting system and that DDS has responsibility for the oversight of its incident reporting system.

Critical Incident Reporting for Group Homes

The HCBS waiver and DDS policies and procedures require group homes to report critical incidents to DDS through the Home and Community Services Information System (HCSIS), which is an internet-based incident reporting and management system. The HCBS waiver states that incidents must be classified by the level of DDS review, either “minor” or “major.” Deaths, physical and sexual assaults, suicide attempts, certain unplanned hospitalizations, near

⁴ The HCBS Intensive Supports waiver was known as the HCBS Adult Residential waiver before July 1, 2013.

drowning, missing persons, and injuries are examples of critical incidents requiring a major level of review. Suspected verbal or emotional abuse, theft, and property damage are examples of critical incidents requiring a minor level of review (HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), “State Critical Event or Incident Reporting Requirements”). In addition, the HCBS waiver states that group homes must report for each incident the immediate action steps taken to protect the beneficiary and the followup action steps taken to remediate or resolve reported issues. DDS staff must also review and approve the action steps before an incident is closed. Furthermore, monthly management reports are sent to DDS area, regional, and central offices so that DDS staff can track patterns and trends to make service improvements and verify that appropriate followup actions have been taken (HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b) and G-1(d), “State Critical Event or Incident Reporting Requirements” and “Responsibility for Review of and Response to Critical Events or Incidents”).

For critical incidents that involve suspected abuse or neglect, the HCBS waiver and State regulations also require mandated reporters, which include staff of DDS and group homes, to report the incidents directly to the Disabled Persons Protection Commission (DPPC) through a 24-hour hotline.^{5, 6} DPPC is the independent agency in Massachusetts responsible for screening and investigating or referring for investigation all instances of abuse and neglect for persons with disabilities between the ages of 18 and 59. The standard for reporting suspected abuse and neglect is “reasonable cause to believe” (115 Code of Massachusetts Regulations § 9.06).⁷

Findings From Our Prior OIG Audit

Our prior audit found that the State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities. Specifically, the State agency did not ensure that:

- group homes reported all critical incidents to DDS (15 percent unreported),

⁵ A mandated reporter is any: physician; medical intern; hospital personnel engaged in the examination, care, or treatment of persons; medical examiner; dentist; psychologist; nurse; chiropractor; podiatrist; osteopath; public or private school teacher; educational administrator; guidance or family counselor; day care worker; probation officer; social worker; foster parent; police officer; or person employed by a State agency within the Executive Office of Health and Human Services as defined by section 16 of chapter 6a or employed by a private agency providing services to disabled persons, who in his or her professional capacity shall have reasonable cause to believe that a disabled person is suffering from a reportable condition (Massachusetts General Laws, pt. I, Title II, ch. 19c, *Disabled Persons Protection Commission*).

⁶ DPPC, which was created in 1987 by Massachusetts General Laws, ch. 19c, reviews all complaints and, if necessary, assigns investigation responsibility to itself, DDS, or other State agencies.

⁷ The DPPC Mandated Reporter Fact Sheet defines a reasonable cause to believe as a standard that is less than “probable cause” but more than a nonspecific suspicion, “hunch,” or gut feeling. If a mandated reporter cannot decide whether to report a situation, the DPPC Mandated Reporter Fact Sheet states that it is better to err on the side of reporting and make the report.

- DDS obtained and analyzed data on all critical incidents,
- group homes identified appropriate action steps in all incident reports that could prevent similar critical incidents (29 percent unidentified), and
- DDS always reported all reasonable suspicions of abuse or neglect to DPPC (58 percent unreported).

HOW WE CONDUCTED THIS AUDIT

We reviewed the State agency’s system for reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in group homes during our audit period, July 1, 2018, through June 30, 2019.

To determine whether the five recommendations from the prior OIG report were implemented, we reviewed correspondence from CMS and supporting documentation provided by the State agency.

To determine whether the corrective actions taken by the State agency effectively addressed our previous findings of noncompliance and whether the State agency complied with Federal and State requirements for reporting and monitoring critical incidents, we obtained 3,657 emergency room claims that the State agency paid on behalf of Medicaid beneficiaries with developmental disabilities residing in group homes from July 2018 through June 2019.⁸ We limited our review to all 147 emergency room claims with service dates from April 2019 to June 2019 for 128 beneficiaries between the ages of 18 and 59 who resided in group homes. The 147 emergency room claims were comprised of 142 hospital emergency room visits.⁹ The beneficiaries were diagnosed with at least 1 of 93 conditions that we determined to be indicative of high risk for suspected abuse or neglect.¹⁰ We first determined that the 142 emergency room visits met the definition of a critical incident and then determined whether the group homes reported to DDS the 142 critical incidents.

Further, we reviewed incident reports submitted by the group homes to DDS to determine whether action steps to protect beneficiaries and remediate reported issues were properly

⁸ We obtained the claims data from the Transformed Medicaid Statistical Information System (T-MSIS). CMS requires States to submit files and data elements in the T-MSIS, which provides a national Medicaid data repository that, among other functions, supports program management, financial management, and program integrity.

⁹ Some emergency room visits were associated with more than one Medicaid claim.

¹⁰ These conditions were indicative of “high risk” because they are associated with diagnosis codes that indicate an increased risk of abuse or neglect. These diagnosis codes include certain medical services, head injuries, bodily injuries, car and other accidents, and safety issues.

identified. Finally, we determined whether critical incidents involving reasonable suspicion of abuse or neglect should have been reported to DPPC.

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.

FINDINGS

The State agency implemented the five recommendations from our prior audit and generally complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes.¹¹ However, the State agency's corrective actions for one recommendation in our prior audit were not effective in addressing one of our previous findings. Specifically, the State agency did not ensure that all reasonable suspicions of abuse or neglect were reported to DPPC. One possible reason that this issue occurred is because DDS and group home staff were only required to take mandated reporter training on reporting reasonable suspicions of abuse and neglect (a corrective action) once rather than periodically. As a result, the State agency did not fulfill all of the participant safeguard assurances it provided to CMS in its HCBS waiver and the State requirements incorporated under the waiver.

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

The State agency addressed four of our five prior audit recommendations through a number of corrective actions implemented by DDS. These corrective actions effectively addressed our previous findings related to these four prior audit recommendations and significantly improved compliance with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents. A description of our recommendations and the corrective actions implemented by DDS are as follows:

Prior Recommendation: Work with DDS to develop and provide training for staff of DDS and group homes on how to identify and report critical incidents and reasonable suspicions of abuse or neglect

DDS developed and provided multiple training sessions and resources for staff of DDS and group homes on how to identify and report critical incidents and reasonable suspicions of

¹¹ The previous OIG report contained five recommendations that CMS determined were implemented and resolved as of December 15, 2016.

abuse or neglect. Specifically, these resources included revised mandated reporter training and fact sheets that outlined the standard for reporting critical incidents and reasonable suspicions of abuse or neglect. In addition, DDS provided guidance to its managers that outlined their responsibilities to review incidents and included specific questions that DDS staff must answer to address high-risk incidents during the monthly trigger report process.¹² Specifically, the questions assist DDS in determining whether an incident was reported to DPPC and, if not, whether the group home should have reported it.

Prior Recommendation: Work with DDS to develop a data-exchange agreement and related analytical procedures to ensure DDS access to the Medicaid claims data contained in Massachusetts' Medicaid Management Information System so it can detect unreported critical incidents

DDS developed a data-exchange agreement with the State agency to obtain access to the Medicaid claims data and implemented a data match to detect unreported critical incidents.

Group homes reported 132 (93 percent) of 142 critical incidents treated in hospital emergency rooms but did not report the remaining 10 (7 percent) critical incidents. Accordingly, the percentage of unreported critical incidents decreased from 15 percent in our prior audit to 7 percent, which represents a significant improvement.

Prior Recommendation: Work with DDS to develop and provide training for staff of DDS and group homes to ensure that action steps are identified in the incident reports to prevent similar critical incidents

DDS provided guidance to its management staff on how to conduct a thorough review of incidents in the incident reporting system and to ensure all immediate and long-term action steps are identified and taken.

We reviewed 132 incident reports submitted by the group homes to DDS and determined that 126 (95 percent) either properly identified action steps to protect beneficiaries and remediate reported issues or did not warrant an action step because of the nature of the situation. For the remaining six (5 percent), we determined that the action steps were inadequate because they only addressed treating the injury instead of protections for the individual or because the group homes did not identify any action steps in the incident report. Accordingly, the

¹² A trigger report is a risk-management tool that uses incident data to identify potential risks of harm to beneficiaries and to trigger intervention. Specifically, DDS area offices receive monthly trigger reports, which identify beneficiaries who have experienced a threshold number of incidents. Examples of these thresholds include three unplanned hospitalizations, including emergency room visits within 6 months or a single unexpected hospitalization for certain serious or potentially preventable events, such as medication errors, suicide attempts, or dehydration. DDS area office staff are required to perform a focused review on all incidents identified in the trigger reports to ensure that appropriate action has been taken to protect the health and welfare of participants. In 2018, DDS added questions to the review regarding DPPC reporting (DDS Guidance: "Trigger Reporting," 2019 Overview and "Massachusetts Department of Developmental Services: Monthly Individual Risk Trigger Report, Guide for Individual Risk Trigger Review," Updated 2017).

percentage of incident reports submitted by group homes that did not identify action steps to protect beneficiaries and remediate reported issues decreased from 29 percent in our prior audit to 5 percent, which represents a significant improvement.

Prior Recommendation: Work with DDS to update DDS policies and procedures so they clearly define and provide examples of potential abuse or neglect that must be reported

DDS updated its policies and procedures to define and provide examples of potential abuse or neglect that must be reported in accordance with reporting standards. The updated policies and procedures are covered in the revised mandated reporter training, fact sheets, and regional training copresented by DDS and DPPC to DDS and provider staff. We reviewed the revised mandated reporter training and fact sheets and determined that they clearly defined and provided examples of potential abuse or neglect that must be reported. The purpose of these revisions was to clarify the reporting requirements for group homes and DDS staff.

THE STATE AGENCY’S CORRECTIVE ACTIONS DID NOT EFFECTIVELY ADDRESS FINDINGS RELATED TO ONE OF OUR FIVE PRIOR AUDIT RECOMMENDATIONS

The State agency’s corrective actions were not effective in addressing findings related to one of our five prior audit recommendations. Even though the State agency implemented corrective actions in response to our recommendation below from our prior audit, it did not fully comply with the Federal Medicaid waiver and State requirements to ensure that all reasonable suspicions of abuse or neglect were reported to DPPC. Specifically, the percentage of these unreported critical incidents to DPPC only decreased by approximately 3.8 percent, from 58.3 percent in our prior audit to 54.5 percent in our followup audit.

Prior Recommendation: Coordinate with DDS and DPPC to ensure that any potential cases of abuse or neglect that are identified as a result of new analytical procedures are investigated as needed

Federal Medicaid Waiver and State Requirements

Both DDS and DPPC are responsible for reporting and responding to complaints of abuse, neglect, or exploitation, and all allegations of abuse or neglect must be reported to DPPC. DPPC receives and reviews all reports and makes the determination as to whether a reported event meets the criteria to require an investigation. As a result of our prior audit, DDS and DPPC developed mandated reporter training and required it for all staff who work with beneficiaries in provider agencies and State-operated services (HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), G-1(d), and G-1(e), “State Critical Event or Incident Reporting Requirements,” “Responsibility for Review of and Response to Critical Events or Incidents,” and “Responsibility for Oversight of Critical Incidents and Events”). The ISA between the State agency and DDS also states that it is DDS’s responsibility to ensure that all alleged instances of abuse or neglect are reported to DPPC. The ISA also requires DDS

to conduct ongoing training, in conjunction with State agency staff, as necessary, for DDS staff regarding relevant State agency and DDS policies, procedures, and program regulations.

Staff of DDS and group homes are mandated to report an incident to DPPC if there is reasonable cause to believe that a reportable condition exists. Reportable conditions are generally defined as an incident, condition or occurrence of abuse, abuse per se, assault, sexual abuse, financial exploitation, or mistreatment as defined by 115 Code of Massachusetts Regulations § 5.05 (115 Code of Massachusetts Regulations §§ 9.02 and 9.06(2)).¹³ A reportable condition must be orally reported to DPPC immediately upon a mandated reporter becoming aware of such a condition and in writing within 48 hours after the oral report (Massachusetts General Laws, part I, Title II, chapter 19c, *Disabled Persons Protection Commission* § 10). The “reasonable cause to believe” standard is further defined as a threshold function of judgment triggered by a presentation of facts either directly observed or obtained from reliable sources that creates a suspicion that abuse exists (118 Code of Massachusetts Regulations § 2.02). Moreover, both DPPC and DDS guidance explain that the standard for reporting suspected abuse or neglect is any situation in which there is a reasonable cause to believe that an individual has been injured, harmed, mistreated, exposed to risk, or been subjected to inhumane treatment due to the actions, inactions, or negligence of a caregiver or provider. A report to DPPC should also be made if an individual with a disability supported by DDS has died, regardless of whether or not abuse or neglect is suspected (DPPC Mandated Reporter Fact Sheet, “When should an incident be reported to DPPC” and DDS mandated reporter training materials).

Prior Audit and Corrective Actions

In our prior audit, we determined that DDS did not report all reasonable suspicions of abuse or neglect to DPPC. Of the 587 critical incidents that occurred during our audit period involving Medicaid beneficiaries with developmental disabilities, 73 (12 percent) were reported to DPPC as potential incidents of abuse or neglect. However, the remaining 514 (88 percent) were not reported to DPPC.

We reported to DPPC the 514 unreported critical incidents we identified that occurred during our audit period. DPPC officials stated that they believed that 102 of the unreported incidents (20 percent) should have been reported as incidents with reasonable suspicion of abuse or neglect. In addition, DPPC officials stated that 240 incidents (47 percent) did not have to be reported, and that they did not have enough information to determine whether the remaining 172 incidents (33 percent) should have been reported. Therefore, we determined that staff of DDS and group homes did not report 58 percent of the 175 incidents (73 critical incidents reported to DPPC plus 102 additional critical incidents that should have been reported) that met the “reasonable cause to believe” standard regarding whether a suspicion of abuse or

¹³ Massachusetts General Laws, part I, Title II, chapter 19c, Disabled Persons Protection Commission § 1, “Reportable condition” is defined as a serious physical or emotional injury resulting from abuse, including unconsented to sexual activity.

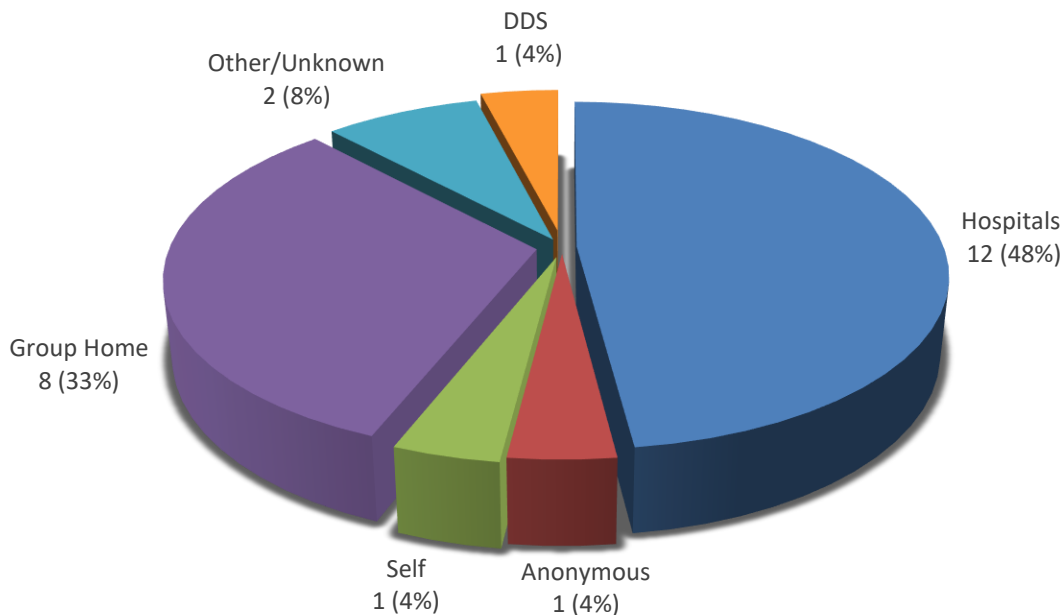
neglect exists as required. Accordingly, we recommended that the State agency coordinate with DDS and DPPC to ensure that any potential cases of abuse or neglect that are identified as a result of new analytical procedures are investigated as needed.

In response to our prior recommendation, DDS collaborated with DPPC to clarify the “reasonable cause to believe” standard for reporting reasonable suspicions of abuse and neglect. Specifically, DDS included clear examples of what must be reported in the revised mandated reporter training and fact sheets. DDS and DPPC also copresented training on the reporting standards to staff of DDS and group homes. In addition, DDS and DPPC executed a data exchange agreement resulting in an exchange of reporting data from DPPC to DDS on a quarterly basis.

Current Audit

In our current audit, we again determined that DDS did not ensure that all reasonable suspicions of abuse or neglect were reported to DPPC. Of 142 critical incidents that occurred from April 2019 to June 2019 involving Medicaid beneficiaries with developmental disabilities, 25 (18 percent) were reported to DPPC as potential incidents of abuse or neglect. However, the remaining 117 critical incidents (82 percent) were not reported to DPPC. Figure 1 shows these 25 critical incidents by types of mandated reporters and other reporters, as categorized by DPPC.

Figure 1: 25 Critical Incidents Reported as Potential Abuse or Neglect



We reported to DPPC the 117 unreported critical incidents we identified, which occurred from April 2019 through June 2019. DPPC officials stated that they believed that 30 of the unreported incidents (21 percent) should have been reported as incidents that met the “reasonable cause to believe” standard for reporting reasonable suspicions of abuse or neglect. In addition, DPPC officials stated that 37 incidents (26 percent) did not have to be reported, and

they did not have enough information to determine whether the remaining 50 incidents (35 percent) should have been reported. (See the Table below.) Based on DPPC’s conclusions, we determined that staff of DDS and group homes did not report 55 percent of the 55 incidents (25 critical incidents reported to DPPC plus 30 additional critical incidents that should have been reported) that met the “reasonable cause to believe” standard regarding whether a suspicion of abuse or neglect exists as required.

Table: DPPC’s Opinion on Whether 117 Critical Incidents Should Have Been Reported As Incidents With Reasonable Suspicion of Abuse or Neglect

DPPC Opinion	Number of Critical Incidents
Critical Incidents Should Have Been Reported	30
Critical Incidents Did Not Have To Be Reported	37
Not Enough Information To Make Determination	50

DDS concurred with DPPC that 9 of 30 critical incidents should have been reported to DPPC and subsequently reported the incidents to DPPC. Specifically, six of the nine unreported incidents should have been reported because they involved a potential omission of care. In addition, DDS determined that two incidents should have been reported because the group homes indicated on the incident report that they either notified or would notify DPPC but did not do so. For the remaining incident, DDS officials said they were concerned that the group home did not submit an incident report. The group home’s management could not provide enough information about the incident to support its decision to not report the incident to DPPC.

DDS did not concur with DPPC that the remaining 21 of 30 critical incidents should have been reported to DPPC. DDS officials stated that they did not feel these critical incidents met the “reasonable cause to believe” standard for reporting reasonable suspicions of abuse or neglect, even though DPPC concluded that these incidents met this reporting standard.

The percentage of unreported critical incidents only decreased by approximately 3.8 percent (from 58.3 percent to 54.5 percent) from our prior audit to our followup audit. We concluded that this decrease did not represent a significant improvement. Therefore, even though the State agency implemented corrective actions in response to our recommendation from our prior audit, it did not fully comply with the Federal and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes.

Accordingly, further coordination between the State agency, DDS, and DPPC is necessary to ensure that all reasonable suspicions of abuse and neglect are properly identified, reported, and investigated as needed. Based on our discussions with the State agency, DDS, and DPPC officials, we determined that one possible reason that the reporting of reasonable suspicions of abuse and neglect did not significantly improve is because DDS only required DDS and group home staff to take the revised mandated reporter training once. Even though DDS collaborated with DPPC to revise the mandated reporting trainings and fact sheets in response to our fourth

prior audit recommendation, staff were not required to retake the training or a refresher course periodically, such as annually or biennially. More frequent trainings or refresher courses will help DDS and group home staff maintain their understanding of the reporting requirements. Further coordination to discuss the frequency of the trainings, as well as any other corrective actions identified by the agencies, will improve compliance with Federal and State requirements.

The ISA between the State agency and DDS states that it is DDS's responsibility to ensure that all alleged instances of abuse or neglect are reported to DPPC. However, the State agency is responsible for the administration of the HCBS waiver. Since neither the State agency nor DDS ensured that all reasonable suspicions of abuse or neglect were reported, the State agency did not fulfill all of the participant safeguard assurances it provided to CMS in its HCBS waiver along with the State requirements incorporated under the HCBS waiver.

RECOMMENDATIONS

We recommend that the Massachusetts Executive Office of Health and Human Services, Office of Medicaid:

- continue to coordinate with DDS and DPPC to ensure that all reasonable suspicions of abuse and neglect are properly identified, reported, and investigated as needed and
- require periodic training for DDS and group home staff on reporting reasonable suspicions of abuse and neglect.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency and DDS concurred with both of our recommendations and described actions that they had taken or planned to take to implement them. Regarding the first recommendation, the State agency stated that DDS has met with DPPC several times and reviewed updates to the DDS training curriculum. The updated DDS training curriculum will help ensure DDS and group home staff are trained to properly identify and report all reasonable suspicions of abuse and neglect. Regarding the second recommendation, the State agency stated that DDS will continue to conduct an in-depth initial training on mandated reporting for DDS and group home staff and also add a required annual training. This requirement will be in effect on June 30, 2022, and providers will be required to attest annually on their compliance with the requirement.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 3,657 emergency room claims that the State agency paid on behalf of Medicaid beneficiaries with developmental disabilities residing in group homes from July 2018 through June 2019. We limited our review to all 147 emergency room claims with service dates from April 2019 to June 2019 for 128 Medicaid beneficiaries between the ages of 18 and 59 who resided in group homes. The 147 emergency room claims were comprised of 142 hospital emergency room visits. The beneficiaries were diagnosed with at least 1 of 93 conditions that we determined to be indicative of high risk for suspected abuse or neglect.

Our audit objective did not require an understanding or assessment of the State agency's or DDS's complete internal control structure. We limited our review of internal controls to obtaining an understanding of DDS's policies and procedures related to the reporting and monitoring of critical incidents.

We conducted our audit from March 2020 through January 2022.

METHODOLOGY

To accomplish our audit objectives, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with CMS officials and reviewed correspondence between CMS and State agency officials to gain an understanding of the corrective actions implemented to address the findings related to our prior audit recommendations;
- held discussions with State agency officials and reviewed supporting documentation to confirm that the prior recommendations were implemented;
- obtained a computer-generated file from DDS of information on all 5,943 Medicaid beneficiaries with developmental disabilities residing in group homes from July 1, 2018, through June 30, 2019;
- extracted from the T-MSIS 3,657 inpatient and outpatient claims for emergency room services provided from July 1, 2018, through June 30, 2019, and that contained revenue code 0450;¹⁴

¹⁴ Revenue code "0450" is described as Emergency Room – General Classification.

- reviewed the T-MSIS claims data and reconciled it to the Massachusetts Medicaid eligibility records to ensure beneficiaries were Medicaid eligible on the date of service;
- evaluated 786 emergency room claims with service dates from April 2019 to June 2019 to determine the diagnosis codes that indicated an increased risk of abuse or neglect;¹⁵
- identified the 147 emergency room claims for 142 hospital emergency room visits that occurred from April 2019 to June 2019 and contained at least 1 of the 93 diagnosis codes that we determined to be indicative of high risk for suspected abuse or neglect;
- determined the 142 emergency room visits met the definition of a critical incident;
- obtained and reviewed the medical records for the 142 critical incidents;
- requested from DDS the incident reports submitted by group homes for 142 critical incidents;
- compared the incident report documentation to the T-MSIS data and medical records to determine which of the 142 critical incidents were not reported to DDS;
- reviewed the action steps identified in the incident reports and determined whether they would address the prevention of similar critical incidents;
- contacted DPPC to confirm whether it was informed of incidents of potential abuse or neglect for all 142 critical incidents;
- provided a list of the unreported emergency room visits and a summary of the related medical records to DPPC officials so that they could determine whether the visits should have been reported to DPPC;
- shared with DDS the 30 unreported incidents that DPPC indicated should have been reported as incidents with reasonable suspicion of abuse or neglect; 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

¹⁵ We reviewed 100 percent of the claims in the last quarter of our audit period because we believed it would account for the improvements in the State agency's data match process as it was implemented.

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>South Carolina Did Not Fully Comply With Requirements for Reporting and Monitoring Critical Events Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-04-18-07078</u>	04/01/2022
<i>Arkansas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-06-17-01003</u>	12/22/2021
<i>California Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-09-19-02004</u>	9/22/2021
<i>Louisiana Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-06-17-02005</u>	5/5/2021
<i>New York Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-02-17-01026</u>	2/16/2021
<i>Texas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-06-17-04003</u>	7/9/2020
<i>Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities</i>	<u>A-07-18-06081</u>	3/27/2020
<i>Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-03-17-00202</u>	1/17/2020
<i>A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect</i>	<u>A-01-19-00502</u>	7/23/2019
<i>Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-09-17-02006</u>	6/11/2019
<i>Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight*</i>	<u>Joint Report*</u>	1/17/2018
<i>Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	<u>A-01-16-00001</u>	8/9/2017
<i>Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	<u>A-01-14-00008</u>	7/31/2016

<i>Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	A-01-14-00002	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-02-14-01011	9/28/2015
* This report was jointly prepared by the Department of Health and Human Services' OIG, Administration for Community Living, and Office for Civil Rights.		



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March 11, 2022

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Office of the Inspector General
JFK Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

RE: Response to MA Critical Incident Follow up Audit (A-01-20-00003)

Dear Auditor Roy,

The Executive Office of Health and Human Services (EOHHS), which administers the Massachusetts Medicaid program known as "MassHealth," submits this joint response on behalf of EOHHS and the Department of Development Services (DDS) to the U.S. Department of Health and Human Services, Office of Inspector General's draft report. We value the work the Office of Inspector General (OIG) has completed in this follow-up audit review and appreciate the opportunity to respond to the draft Report.

EOHHS thanks the OIG for highlighting in the draft report the significant efforts DDS has made to improve and enhance its incident management system and the reporting of abuse and neglect since the OIG's initial audit report in July 2016. As noted in the draft report, these efforts have strengthened DDS' system and have led to better health and safety outcomes for the individuals DDS supports.

While acknowledging the progress that has been made, the draft report contains the following two recommendations:

- That EOHHS and DDS should continue to coordinate with the Massachusetts Disabled Persons Protection Commission (DPPC) to ensure that all reasonable suspicions of abuse and neglect are properly identified, reported, and investigated as needed, and
- That DDS should require periodic training for both DDS and group home provider staff on reporting reasonable suspicions of abuse and neglect.

EOHHS and DDS concur with the above two recommendations. Regarding the first recommendation, DDS has met several times with DPPC to make certain there is clear alignment on the identification and reporting of reasonable suspicions of abuse and neglect. The meetings with DPPC have informed

updates to the DDS training curriculum, and DDS has reviewed these changes with DPPC. The resulting updated DDS training curriculum will help ensure DDS and DDS' contracted provider staff are trained to properly identify and report all reasonable suspicions of abuse and neglect.

EOHHS and DDS also concur with the OIG's second recommendation, to require periodic staff training on reporting reasonable suspicions of abuse and neglect. To this end, DDS will continue to conduct an in-depth initial training on mandatory reporting, as well as add a required annual training on mandatory reporting for DDS and DDS group home provider staff. Through these initial and annual trainings, DDS will ensure that DDS and group home provider staff receive the most current version of the training, and that thereafter, they receive an annual training on their reporting duties. This requirement will be in effect on June 30, 2022, and provider agencies will be required to attest annually to their compliance.

Thank you again for the opportunity to respond to the draft report. EOHHS and DDS deeply value the OIG's efforts that support DDS and the DPPC to ensure the health, safety, and welfare of individuals in DDS care. DDS' general compliance and implementation of the OIG's 2016 recommendations combined with its implementation of the recommendations in the draft report will help ensure that Massachusetts maintains its status as a national leader in providing services and supports to individuals with intellectual and developmental disabilities.

Sincerely,



Marylou Sudders

cc:

Alda Rego, Assistant Secretary for Administration and Finance
Amanda Cassel Kraft, Assistant Secretary for MassHealth
Jane Ryder, Commissioner of Department of Developmental Services