Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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

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Report in Brief
Date: December 2023
Report No. A-01-21-00001

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

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

Why OIG Did This Audit

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

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

How OIG Did This Audit

We reviewed Connecticut's system for reporting and monitoring of critical incidents involving Medicaid enrollees with developmental disabilities during our audit period, January 2020 through December 2020. To determine whether the four recommendations from the prior OIG report were implemented, we reviewed correspondence from CMS and supporting documentation provided by the State. We limited our review to 163 incidents of potential abuse and neglect during the audit period for 138 enrollees between the ages of 18 and 59 who resided in group homes. We also reviewed 57 potential critical incidents involving 51 Medicaid enrollees between the ages of 18 and 59 who resided in group homes.

What OIG Found

Connecticut implemented the four recommendations from our prior audit and generally complied with Federal and State requirements for reporting and monitoring abuse, neglect, and critical incidents involving Medicaid enrollees with developmental disabilities residing in group homes. However, the corrective actions for two recommendations in our prior audit were not effective in addressing one of our previous findings. Specifically, Connecticut did not ensure that group homes reported all incidents involving potential abuse and neglect to DDS. These issues occurred because: (1) Connecticut group homes experienced significant staff hiring and retention problems, and (2) the State agency and DDS did not implement new analytical procedures to detect incidents involving potential abuse and neglect during our audit period.

What OIG Recommends and Connecticut Comments

We recommend that the State agency continue to coordinate with DDS to : (1) provide training for staff of DDS and private group homes on how to monitor and report reasonable suspicions of abuse and neglect, especially in light of the significant staff hiring and retention problems in Connecticut group homes, and (2) use the new analytical procedures to identify potential cases of abuse or neglect involving Medicaid enrollees with developmental disabilities that incurred injuries and are treated in hospital emergency room settings.

In written comments on our draft report, Connecticut concurred with our recommendations and described the actions it has taken or plans to take to address them.

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INTRODUCTION

WHY WE DID THIS AUDIT

The Office of Inspector General (OIG) previously conducted an audit of the Connecticut Department of Social Services' (State agency's) compliance with requirements related to critical incidents involving people enrolled in Medicaid (Medicaid enrollees) with developmental disabilities in Connecticut.[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 Connecticut, 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 four 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 abuse, neglect, and 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.

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[1] U.S. Department of Health and Human Services, Office of Inspector General, *Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries* (A-01-14-00002), May 2016.

[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 Waiver (HCBS waiver) program (the Act § 1915(c)). The program permits a State to furnish an array of home and community-based services that assists Medicaid enrollees to live in the community and avoid institutionalization. Waiver services complement or supplement the services enrollees receive—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 Connecticut's HCBS waiver program. The Department of Developmental Services (DDS) implements portions of this waiver through a memorandum of understanding (MOU) with the State agency.[4] That waiver program provided 2,255 individuals with comprehensive support services during our audit period.

States must provide certain assurances to the Centers for Medicare & Medicaid Services (CMS) to receive approval for an HCBS waiver, including that necessary safeguards are in place to protect the health and welfare of the enrollees receiving services (42 CFR § 441.302). A State must provide specific information regarding its plan or process related to patient safeguards, including 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 assured that it has a critical event or incident reporting system that relies on DDS policies and procedures. DDS established certain policies and procedures that require coordination with other State agencies, including the Office of Protection and Advocacy for Persons with Disabilities (OPA), that have responsibility for responding to potential abuse and neglect allegations and critical incidents for developmentally disabled individuals (DDS Procedures I.F.PO.001, *Abuse and Neglect*, I.F.PR.001, *Abuse and Neglect/Allegations: Reporting and Intake Processes,* and I.D.PR.009, *Incident Reporting*).

[4] This document was in effect for the HCBS waiver period beginning Oct. 1, 2018.

Connecticut Protection and Advocacy System

Connecticut Public Act No. 16-66, sections 47 through 49, abolished the OPA.[5] OPA's investigatory responsibilities were transferred to the DDS Abuse Investigation Division (AID)[6] and Disability Rights Connecticut (DRCT) became the State advocacy entity for individuals with disabilities. DRCT is a nonprofit organization with a mission to advocate for the human, civil, and legal rights of people with disabilities in Connecticut. Although DRCT is an advocacy entity, under Federal law as the State's Protection and Advocacy system, it has the authority to investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.[7]

Abuse, Neglect, and Critical Incident Reporting for Group Homes

DDS procedures referenced under the HCBS waiver for group homes and other facilities define "abuse" as the "willful infliction by a caregiver of physical pain or injury, or the willful deprivation of services necessary to the physical safety of an individual" and "neglect" as the failure by a caregiver to provide an individual with the services necessary to maintain such individual's physical health, mental health and safety. This definition of neglect includes DDS staff, DDS qualified providers' staff, and Community Companion Homes licensees in cases of programmatic neglect through action or inaction to provide an individual with the services necessary to maintain physical health, mental health, and safety.[8]

The HCBS waiver and incorporated DDS procedures for group homes and other facilities define a "critical incident" to include severe injuries requiring an inpatient hospital stay or vehicle

[5] Effective July 1, 2017. However, OPA was still mentioned in the HCBS waiver and policies and procedures incorporated under the waiver that were in place in 2020 during our followup audit period.

[6] The HCBS waiver during our followup audit period continued to identify the OPA as the agency responsible for monitoring the protection and advocacy of the rights of developmentally disabled persons aged 18 through 59 residing in Connecticut. DDS officials informed us that the renewal for the 2018 waiver was initiated prior to the final pieces of OPA being disbanded fell into place. We confirmed the current waiver was revised, and all references to OPA Patient Safeguard were replaced with DDS.

[7] Section 143 of the Disabilities Act.

[8] Connecticut General Statutes define abuse as "(A) the willful infliction by an employee of physical pain or injury, financial exploitation, psychological abuse or verbal abuse; (B) the willful deprivation of services necessary to the physical and mental health and safety of an individual who receives services or funding from the department; or (C) sexual abuse (§ 17a-247a(1))" and neglect as "the failure by an employee, through action or inaction, to provide an individual who receives services or funding from the department with the services necessary to maintain such individual's physical and mental health and safety (§ 17a-247a(8))."

accidents involving moderate to severe injuries, along with other types of incidents.[9] Critical incidents must be reported immediately to the beneficiary's family and/or guardian and to the DDS regional director or a designee. DDS established a system of reporting and monitoring critical incidents. This system seeks to manage and reduce overall risk and provides a standardized process for reporting, documenting, and following up on selected types of incidents, including those caused by injury, restraint, and medication errors (DDS Procedure I.D. PR.009, *Incident Reporting*). These procedures also require DDS staff to follow up on critical incidents to ensure that corrective actions have been taken and critical incidents have been resolved. DDS requires group homes to use the DDS incident report, Form 255, to report incidents, and DDS is supposed to enter the data from these forms into its incident reporting system.[10]

Findings From Our Prior Audit

Our prior audit found that the State agency did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes from January 2012 through June 2014. Specifically, the State agency did not ensure that:

- group homes reported all critical incidents involving potential abuse and neglect to DDS,
- DDS recorded all critical incidents reported by group homes,
- group homes always reported incidents at the correct severity level,
- DDS collected and reviewed all data on critical incidents, and
- DDS always reported reasonable suspicions of abuse or neglect.

[9] We noted in our prior report that DDS revised its critical incident reporting policy to narrow the definition of a critical incident. The DDS policy in effect during the period covered by our prior audit defined a "severe injury" as an injury that requires treatment at an emergency room or admission to a hospital. We further noted in our prior report that only 6 of the 176 critical incidents that we reviewed in our prior audit would have been required to be reported under DDS's new definition of a severe injury. As a result, we expected DDS's new definition to significantly reduce the number of critical incidents that group homes are required to report. We referred this issue to State officials for their future followup and action, as we believe incidents in which developmentally disabled beneficiaries require treatment at an emergency room may also potentially need to be reported under the Federal Medicaid waiver and State requirements.

[10] Form 255s are completed and submitted electronically to the appropriate regional email box (each region has its own email address specific to collecting incident reports). Providers may also fax their 255s or mail them; Upon receipt of a 255 form, the region has a designated staff person that then enters the information in the DDS computer system and forwards an electronic copy to the appropriate staff, which usually includes the case manager and resource manager.

Our prior report included four recommendations to address these findings.

HOW WE CONDUCTED THIS AUDIT

We reviewed the system that the State agency had in place during our audit period (calendar year 2020) for reporting and monitoring critical incidents and potential incidents of abuse and neglect involving Medicaid enrollees with developmental disabilities who resided in group homes. To determine whether the four recommendations from our prior audit report were implemented, we reviewed correspondence between CMS and the State agency and supporting documentation provided by the State agency.

We limited our review to 163 incidents of potential abuse and neglect with service dates from January 2020 through December 2020 for 138 enrollees between the ages of 18 and 59 who resided in group homes. The enrollees were diagnosed with at least 1 of 73 diagnosis codes that we determined to be indicative of high risk for suspected abuse or neglect.[11] We also reviewed 57 potential critical incidents involving 51 Medicaid enrollees between the ages of 18 and 59 who resided in group homes. The enrollees were diagnosed with at least one of seven diagnosis codes that we determined to be indicative of high risk for potential critical incidents.[12]

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 four recommendations from our prior audit and generally complied with Federal Medicaid waiver and State requirements for reporting and monitoring abuse, neglect, and critical incidents.[13] In addition, the corrective actions implemented in response to two of the four recommendations were effective in addressing the related findings. However, the corrective actions for two recommendations in our prior audit were not effective

[11] These diagnosis codes were indicative of "high risk" for potential abuse or neglect because they are associated with broken bones, bruises and cuts, and unknown injuries. See Figure 1 for further "high risk" category descriptions.

[12] These diagnosis codes were indicative of "high risk" for potential critical incidents because they are associated with inpatient stays involving severe injuries and vehicle accidents involving moderate to severe injuries.

[13] The previous OIG report contained four recommendations that CMS determined were implemented and resolved as of September 30, 2021.

in addressing one of our previous findings. Specifically, the State agency did not ensure that group homes reported all incidents involving potential abuse and neglect to DDS. Group homes did not report all incidents because of significant staff hiring and retention problems. In addition, the State agency and DDS did not implement new analytical procedures to detect incidents involving potential abuse and neglect during our audit period.[14]

As a result, the State agency did not fulfill all participant safeguard assurances it provided to CMS in its Federal Medicaid waiver and State requirements incorporated under the waiver.

THE STATE AGENCY'S CORRECTIVE ACTIONS IMPLEMENTED IN RESPONSE TO TWO OF OUR FOUR PRIOR AUDIT RECOMMENDATIONS EFFECTIVELY ADDRESSED RELATED FINDINGS

The State agency addressed two of our four prior audit recommendations by implementing a number of corrective actions implemented by the State agency and DDS. These corrective actions effectively addressed our previous findings related to these two prior audit recommendations and significantly improved compliance with Federal Medicaid waiver and State requirements for reporting and monitoring potential abuse, neglect, and critical incidents. The following sections describe our prior recommendations and the corrective actions that the State agency took to implement them.

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 Connecticut's Medicaid Management Information System (MMIS) to detect unreported and unrecorded critical incidents

In April 2020, DDS developed a data-exchange agreement with the State agency that allowed DDS access to the Medicaid claims data contained in Connecticut's MMIS to detect unreported and critical incidents. DDS also worked on implementing related analytical procedures that involved a data match that included 45,871 diagnosis codes to detect unreported and unrecorded critical incidents in hospital inpatient admission settings.[15, 16]

We evaluated Connecticut's MMIS claims data for calendar year 2020 claims and identified 57 hospital outpatient and inpatient claims that potentially met Connecticut's definition of a critical incident. DDS reviewed the related medical records and determined that 3 of the 57

[14] After our audit period, DDS implemented new analytical procedures to identify sexual assaults involving Medicaid enrollees with developmental disabilities that required treatment in an emergency room setting. However, DDS acknowledged that they have not begun implementing new analytical procedures to identify other incidents of potential abuse and neglect involving Medicaid enrollees with developmental disabilities that incurred injuries and are treated in hospital emergency room settings.

[15] We confirmed that the 40 high-risk diagnosis codes identified in our prior report are included in the 45,871 diagnosis codes.

[16] The new analytical procedures were implemented in four phases from 2018 through 2020.

incidents (5 percent) met the DDS definition of a critical incident.[17] However, the group homes did not report the three critical incidents to DDS.[18] DDS officials informed us they did not detect these unreported critical incidents because DDS was in the process of finalizing its data match program. We verified that the new data match includes the diagnosis codes related to the unreported critical incidents. Therefore, if DDS had fully implemented the new data match program during the audit period, the program would have detected the three unreported and unrecorded critical incidents during its monthly review process.[19]

Prior Recommendation: Work with DDS to update DDS policies and procedures to 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 abuse and neglect training, PowerPoint training slides, and videos presented by DDS to DDS and provider group staff. We reviewed the revised policies, procedures, and training and determined that they clearly defined and provided examples of potential abuse or neglect that must be reported. The purpose of the revised policies and procedures was to clarify the reporting requirements for group homes and DDS staff.

THE STATE AGENCY'S CORRECTIVE ACTIONS IMPLEMENTED IN RESPONSE TO TWO OF OUR FOUR PRIOR AUDIT RECOMMENDATIONS WERE ONLY PARTIALLY EFFECTIVE IN ADDRESSING A RELATED FINDING

The State agency's corrective actions were partially effective in addressing findings related to two of our four prior audit recommendations. The State agency ensured DDS implemented corrective actions in response to our prior audit's recommendations. However, it did not fully comply with the Federal Medicaid waiver and State requirements to ensure that group homes reported all abuse and neglect incidents to DDS. Specifically, we concluded that 9 percent of potential incidents of abuse and neglect were not reported by group homes to DDS.

[17] At our request, DDS made the determination of whether an emergency room visit represented a critical incident. The HCBS waiver and incorporated DDS procedures for group homes and other facilities define a "critical incident" to include severe injuries requiring an inpatient stay or vehicle accidents involving moderate to severe injuries, along with other types of incidents.

[18] DDS obtained incident reports from the group homes that failed to report the three critical incidents. They determined that no further action was necessary for two of the critical incidents and referred the other incident to the Abuse Investigation Division. All three critical incidents involved severe injuries requiring treatment in an inpatient setting.

[19] In February 2021, Connecticut officials informed us that they fully implemented their data match program for the 45,871 diagnosis codes to detect unreported and unrecorded critical incidents in inpatient hospital settings.

Prior Recommendations: 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, and coordinate with DDS and OPA 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

Any employee of DDS or a provider agency must immediately intervene on a developmentally disabled individual's behalf in any abuse or neglect situation and must report the incident immediately (HCBS waiver, Appendix G, Participant Safeguards, G-1(b), State Critical Event or Incident Reporting Requirements). DDS and provider employees are mandated reporters, and any employee who has witnessed or has reasonable cause to suspect or believe that there has been abuse or neglect of a developmentally disabled person shall immediately make a verbal report, or cause such report to be made, to the appropriate agency (DDS Procedure I.F.PR.001, *Abuse and Neglect Allegations*, D.1.a "Implementation").

The verbal report is transcribed by the receiving agency and is forwarded to the DDS Division of Investigations via fax or secure electronic transmission (HCBS waiver, Appendix G, Participant Safeguards, G-1(b), State Critical Event or Incident Reporting Requirements). The Protection and Advocacy Abuse Investigation Division of DDS also receives reports of abuse or neglect (DDS Procedures No. I.F.PR.001, D.2 "Notification – Supervisors and Administrators," and No. I.F.PR.005, D. "Implementation") if the individual is between 18 and 59 years of age (HCBS waiver, Appendix G, Participant Safeguards, G-1(d), Responsibility for Review of and Response to Critical Events or Incidents).

In accordance with assurances contained in the HCBS waiver, staff of all DDS operated, funded, or licensed facilities and programs must immediately report all critical incidents to the individual's family and/or guardian and appropriate DDS regional director or designee via telephone. An incident report form must be faxed to the DDS Regional Director's Office. The form should be forwarded to the appropriate DDS region in the usual process within 5 business days (HCBS waiver, Appendix G, Participant Safeguards, G-1(b), State Critical Event or Incident Reporting Requirements). DDS procedures define a "severe injury" as an injury that requires a hospital admission (DDS Procedure I.D.PR.009, *Incident Reporting,* (C) "Definitions").

Prior Audit and Corrective Actions

In our prior audit, we determined that group homes did not report critical incidents involving potential abuse and neglect involving developmentally disabled Medicaid beneficiaries to DDS. Specifically, of the 310 emergency room visits by 245 developmentally disabled Medicaid beneficiaries, 176 visits met DDS's definition in effect at the time of a critical incident because they included a severe injury. However, group homes did not report 24 (14 percent) of the critical incidents to DDS. In addition, although group homes reported 152 of the 176 critical incidents to DDS during the period of our prior audit, DDS did not report 151 (99 percent) of the

152 to OPA as potential incidents of abuse or neglect involving developmentally disabled Medicaid beneficiaries.

The State agency did not comply with Federal and State requirements for reporting and monitoring critical incidents because staff at DDS and group homes lacked the training to correctly identify and report critical incidents and reasonable suspicions of abuse or neglect. Further, DDS did not have a way to obtain all data regarding critical events and incidents involving potential abuse and neglect from the State agency. As a result, DDS could not review relevant Medicaid claims data for injuries that required hospital admission or emergency room treatment—key elements to detect whether beneficiaries were involved with critical incidents and incidents involving potential abuse and neglect.

Therefore, we recommended that the State agency: (1) work with DDS to develop and provide training for staff of DDS and group homes on how to identify and report reasonable suspicions of abuse, neglect, and critical incidents; and (2) coordinate with DDS 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 first prior recommendation, DDS developed and provided multiple training sessions to staff of DDS and private group homes on how to identify and report reasonable suspicions of abuse or neglect and critical incidents. The training specified that all mandated reporters must report suspected abuse or neglect. The training also provided specific examples of what constitutes abuse and neglect and provided helpful tips for completing the DDS abuse and neglect incident reporting forms.

DDS also made the revised training available to all 712 private group homes.[20] We further found that DDS monitored the efficacy of private group homes abuse, neglect, and critical incident training by conducting a random sample of 156 of the 712 private group homes (22 percent). Of the 156 private group homes, DDS found that 152 (97 percent) met the abuse, neglect, and critical incident training requirements.[21] This represents a significant improvement from the prior audit that found that DDS did not offer any training on critical incident reporting to Connecticut's 961 public or private group homes.

In response to our second prior recommendation, DDS developed a data-exchange agreement with the State agency that allowed DDS to access Connecticut's MMIS hospital admission and emergency room treatment claims data. Prior to and during our audit period, DDS used the

[20] DDS allowed the private group homes to use their own curriculum or a third party to provide training to their staff. However, they must incorporate a DDS abuse and neglect curriculum template into their individualized curriculum.

[21] One group home closed and, therefore, was not rated. DDS found that the three remaining private group homes did not meet the abuse, neglect, and critical incident training requirements. The three group homes that did not meet the training requirement were required to submit an immediate corrective action plan to DDS, which were subsequently accepted by DDS.

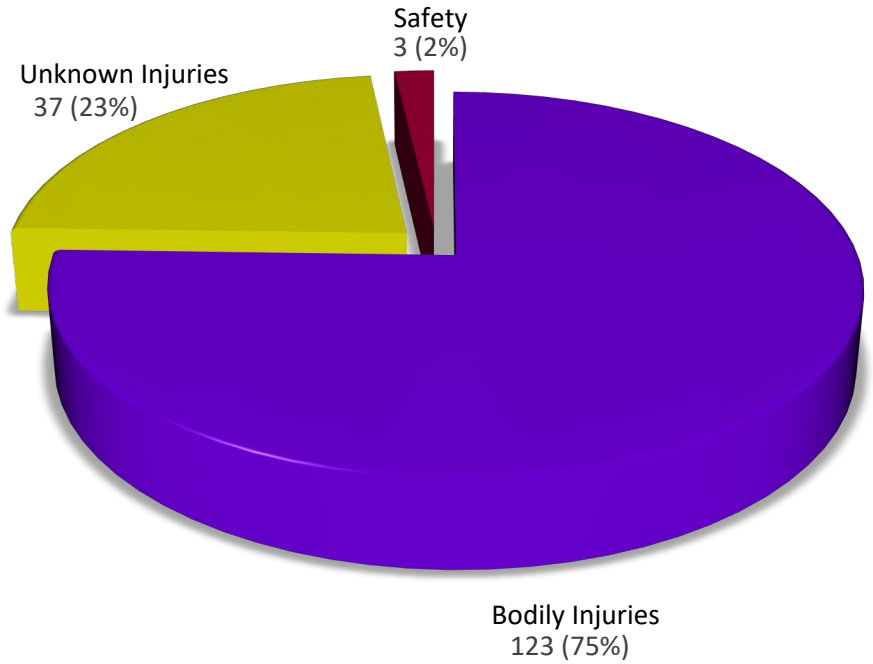
State agency's MMIS data to develop related analytical procedures to identify critical incidents involving potential cases of abuse or neglect.

Current Audit

In our current audit, we identified the State agency partially: (1) implemented our recommendations from our prior report, and (2) complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents. Specifically, the State agency's critical incident training and new analytical efforts were generally effective in reducing unreported critical incidents. Accordingly, the number of unreported critical incidents by group homes to DDS decreased from 24 in our prior audit to 3 in our current audit, which represents a significant improvement.

However, we determined that the State agency and DDS's new training and analytical efforts did not ensure that all reasonable suspicions of abuse and neglect were reported to DDS. Of 1,813 incidents of potential abuse and neglect that occurred from January 2020 through December 2020 involving Medicaid enrollees with developmental disabilities, 1,650 (91 percent) were reported to DDS as incidents of potential abuse and neglect. However, the remaining 163 incidents of potential abuse and neglect (9 percent) were not reported to DDS. Figure 1 summarizes the 163 incidents of potential abuse and neglect in the following categories: (1) bodily injuries involving incidents such as broken bones, burns, human bite marks, and internal injuries; (2) injuries of unknown origin; and (3) safety issues such as poisonings.

Figure 1: 163 Cases of Potential Abuse or Neglect



We interviewed officials from 11 of the 45 group homes that did not report potential abuse or neglect instances to DDS.[22] Officials from the 11 group homes informed us that they experienced hiring and retention problems in 2020 that resulted in significant training challenges related to the identification and reporting of abuse and neglect training. Furthermore, all agreed that some of their direct staff participated in care of their enrollees without completing abuse or neglect training.[23] Four officials stated that new employees did not stay employed by the group homes long enough to complete required training. Finally, one official stated administrative staff that filled in for absent direct care staff were not trained in abuse and neglect reporting requirements.

We reported to the State agency and DDS officials the 163 incidents of potential abuse and neglect. Both the State agency and DDS officials stated they believed all 163 incidents of potential abuse and neglect should have been reported based on DDS's revised abuse and neglect policies, training, and training examples. In addition, DDS officials determined the group homes experienced hiring and retention problems that also contributed to the significant training challenges.[24] Therefore, we determined that staff of DDS and private group homes did not report 163 of the 1,813 incidents of potential abuse and neglect as required by the assurances noted in the HCBS waiver.

The 163 (9 percent) incidents of potential abuse and neglect show that this remains an area that needs improvement. Therefore, even though the State agency implemented some corrective actions in response to our prior report's recommendations, it did not fully comply with the Federal Medicaid waiver and State requirements for reporting and monitoring potential incidents of abuse and neglect involving Medicaid enrollees with developmental disabilities residing in group homes.

Based on our discussions with the State agency, DDS officials, and group home providers, we determined that Connecticut group homes did not report potential abuse and neglect because they experienced significant staff hiring and retention problems. In addition, the State agency and DDS did not implement new analytical procedures to detect incidents involving potential abuse and neglect during our audit period. The State agency and DDS officials acknowledged that if they implemented a similar analytical procedure to review hospital emergency room claims, like the hospital inpatient critical incident data match, the new match would have detected the 163 incidents of potential abuse and neglect.[25]

[22] The 11 group homes did not report 93 of the 163 (57 percent) potential instances of abuse and neglect.

[23] In 2020, DDS allowed direct staff 6 months to complete their abuse and neglect training. DDS now requires new staff to complete their abuse and neglect training prior to providing direct care to enrollees.

[24] DDS participates in a national provider workforce survey annually. In 2020, Connecticut DDS reported that group home providers had an annual turnover rate for direct support staff of over 42 percent.

[25] Hospitals billed the 163 incidents of potential abuse and neglect using 73 diagnosis codes. We verified all 73 diagnosis codes are included in the new DDS critical incident analytical procedure involving 45,871 diagnosis codes.

RECOMMENDATIONS

We recommend that the Connecticut Department of Social Services continue to coordinate with the Department of Developmental Services to:

- provide training for staff of DDS and private group homes on how to monitor and report reasonable suspicions of abuse and neglect, especially in light of the significant staff hiring and retention problems in Connecticut group homes; and

- use the new analytical procedures to identify potential cases of abuse or neglect involving Medicaid enrollees with developmental disabilities that incurred injuries and are treated in hospital emergency room settings.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our recommendations and described the actions it has taken or plans to take to address them. The State agency's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

DDS provided services to 2,255 developmentally disabled Medicaid enrollees residing in group homes from January 1, 2020, through December 31, 2020. Of the 2,255 enrollees, 988 had 2,411 claims representing 407 inpatient claims and 2,004 emergency room visits for all diagnosis codes. We limited our audit to 138 enrollees residing in group homes who had 163 incidents of potential abuse and neglect consisting of 162 hospital emergency room visits and were diagnosed with at least 1 of 73 diagnosis codes that we determined to be indicative of high risk for suspected abuse or neglect. We also reviewed 57 potential critical incidents involving 51 Medicaid enrollees with developmental disabilities.

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

We conducted our audit from June 2021 through October 2023.

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 the 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 the State agency of information on all 2,255 Medicaid enrollees with developmental disabilities between the ages of 18 and 59 who resided in group homes from January 1, 2020, through December 31, 2020;
- extracted from the T-MSIS 2,411 inpatient and outpatient claims for emergency room services containing revenue code 0450 provided from January 1, 2020, through December 31, 2020;[26]

[26] Revenue code "0450" is described as Emergency Room – General Classification.

- reviewed the T-MSIS claims data and reconciled it to the Connecticut Medicaid eligibility records to ensure enrollees were Medicaid eligible on the date of service;

- evaluated 2,411 emergency room claims from January 2020 to December 2020 to determine the diagnosis codes that indicated an increased risk of abuse or neglect;

- identified 163 incidents of potential abuse and neglect for 162 hospital emergency room visits that occurred from January 2020 through December 2020 and contained at least 1 of 73 diagnosis codes that were determined to be indicative of high risk for suspected abuse or neglect.

- obtained and reviewed the medical records for the 57 critical incidents;

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

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

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Iowa Implemented Most of Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Major Incidents	A-07-21-06105	11/9/2022
Maine Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents	A-01-20-00007	6/6/2022
Massachusetts Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents	A-01-20-00003	4/25/2022
South Carolina Did Not Fully Comply With Requirements for Reporting and Monitoring Critical Events Involving Medicaid Beneficiaries With Developmental Disabilities	A-04-18-07078	4/1/2022
Arkansas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-06-17-01003	12/22/2021
California Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-09-19-02004	9/22/2021
Louisiana Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-06-17-02005	5/5/2021
New York Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-02-17-01026	2/16/2021
Texas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-06-17-04003	7/9/2020
Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities	A-07-18-06081	3/27/2020
Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-03-17-00202	1/17/2020
A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect	A-01-19-00502	7/23/2019
Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-09-17-02006	6/11/2019
Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight	Joint Report*	1/17/2018

Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-01-16-00001	8/9/2017
Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00008	7/13/2016
Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00002	5/25/2016
Review of Intermediate Care Facilities in New York With High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries	A-02-14-01011	9/28/2015
* This report was jointly prepared by the Department of Health and Human Services' OIG, Administration for Community Living, and Office for Civil Rights		

Ned Lamont
Governor

State of Connecticut
Department of Developmental Services

DDS

Jordan A. Scheff
Commissioner

Elisa F. Velardo
Deputy Commissioner

November 20, 2023

Mr. Curtis Roy
Regional Inspector General for Audit Services
Office of Inspector General
Department of Health and Human Services

In partnership with the Department of Social Services (DSS) as the single state Medicaid agency, the Department of Developmental Services (DDS) is submitting the following comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) draft report *Connecticut Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents*.

The state acknowledges the findings articulated in the draft report and appreciates the opportunity to respond.

OIG identifies two additional recommendations on page 12 of the draft report.

Recommendation #1
Provide training for staff of DDS and private group homes on how to monitor and report reasonable suspicion of abuse and neglect, especially in the light of significant staff hiring and retention problems in Connecticut group homes.

State Response:
The state is in concurrence with this recommendation and recognizes the importance of ongoing training for all staff and provider agencies to ensure reasonable suspicion of abuse and neglect is reported timely and appropriately. Training continues to be a main area of focus to improve and enhance opportunities for learning. The DDS training division has made significant strides in updating the training curriculum for abuse and neglect prevention and reporting and will continually evaluate, improve and update to ensure validity and to meet the changing needs of providers. New DDS employees are required to receive abuse and neglect prevention training before they begin to work directly with individuals. Several providers adopted the same approach and provide the abuse and neglect prevention training on the first day of onboarding to ensure compliance. Training opportunities are also being offered virtually and in-person to ensure ease of access for new provider employees. DDS will continue to work with providers in a collaborative nature and gather their input and feedback for improvements to training and any recommendations for ease of access to training materials. In response to the significant workforce challenges providers are currently facing, the opportunity to hear from providers on how to make materials more accessible is a valuable exchange.

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Recommendation #2

Use the new analytical procedures to identify potential cases of abuse or neglect involving Medicaid enrollees with developmental disabilities that incurred injuries and are treated in hospital emergency room settings.

State Response:

The state is in concurrence with this recommendation but is unable to commit to a timeline associated with implementation at this time. Currently DDS uses a system called Pulselight to review Medicaid claims and identify potential unreported critical incidents or suspected cases of abuse or neglect. The system currently reviews diagnostic trigger codes developed using the DDS definition of critical incidents, which in most cases requires a severe injury with inpatient hospitalization. For all assault and sexual assault trigger codes the claim can occur anywhere, including primary care, walk-in/urgent care or Emergency Room. The recommendation detailed in the draft OIG report would expand the review of Medicaid claims to include all claims within a hospital emergency room setting. The state agrees that Emergency Room visits should be reviewed for certain diagnostic claim codes and is reviewing the capability of Pulselight to implement this change. The state will also need to ensure proper resources are in place to review and conduct the follow up necessary with the new claims being received. DDS is committed to reviewing the feasibility of expanding the system and ensuring the proper follow up resources are in place.

The state would also like to respectfully offer a clarification to page 2 of the draft report under the Medicaid Home and Community-Based Services Waiver. As written, the report notes that the State agency administers Connecticut's HCBS waiver program. This is accurate, however there are ten Medicaid Waivers offered in Connecticut with three operated through DDS. The most expansive waiver operated by DDS, is the Comprehensive Waiver, which includes a community living arrangement residential support (also known as group home). This is the waiver noted in the OIG draft report and provided support to approximately 2,255 individuals during the OIG audit period.

Thank you for the opportunity to review and respond to the OIG draft report. The state, DSS and DDS have the shared goal of protecting and maintaining the health and safety of the individuals we support. It is of the highest importance that the state continually improve on prevention training and implementing safeguards to detect and report any potential cases of abuse, neglect or critical incidents.

Thank you.

Jordan A. Scheff
DDS Commissioner

Andrea Barton Reeves
DSS Commissioner