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

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Office of Inspector General

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EXECUTIVE SUMMARY

The Massachusetts Executive Office of Health and Human Services, Office of Medicaid, did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries residing in group homes.

WHY WE DID THIS REVIEW

We are performing reviews in several States in response to a congressional request concerning the number of deaths and cases of abuse of developmentally disabled residents of group homes. This request was made in response to media coverage throughout the country on deaths of developmentally disabled individuals involving abuse, neglect, or medical errors.

The objective of this review was to determine whether the Massachusetts Executive Office of Health and Human Services, Office of Medicaid (State agency), complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries residing in group homes from January 2012 through June 2014.

BACKGROUND

Developmentally disabled individuals have chronic mental or physical impairments that must be evident by the age of 22. Residential, institutional, and community providers that serve developmentally disabled individuals must meet minimum standards to ensure the care they provide is free from abuse, neglect, sexual exploitation, and violations of legal and human rights. The State agency administers the Medicaid Home and Community-Based Services Intensive Supports waiver (HCBS waiver). This waiver contains safeguards that the State agency established to ensure the health and welfare of waiver participants. The Massachusetts Department of Developmental Services (DDS) implements portions of this waiver, including the safeguard provisions, through an interdepartmental service agreement with the State agency. The HCBS waiver and DDS policies and procedures require providers to report critical incidents to DDS through a Web-based incident reporting system. Furthermore, the HCBS waiver and State regulations require DDS and all other mandated reporters to report all critical incidents that involve suspected abuse or neglect directly to the Disabled Persons Protection Commission (DPPC). The standard for reporting suspected abuse and neglect is any situation in which there is a reasonable suspicion to believe abuse or neglect exists.

We limited our review to 769 emergency room claims for 334 beneficiaries aged 18 through 59 who were residing in group homes. These beneficiaries had 587 hospital emergency room visits and were diagnosed with at least 1 of 149 conditions that we determined to be indicative of a high risk for suspected abuse or neglect.

WHAT WE FOUND

The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries.

Specifically, the State agency did not ensure that:

- group homes reported all critical incidents to DDS (15 percent unreported),
- DDS obtained and analyzed data on all critical incidents,
- appropriate action steps were identified 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).

The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents because group home staff did not always follow procedures for reporting critical incidents. In addition, the staff of DDS and group homes lacked adequate training to identify appropriate action steps for all reported critical incidents and to correctly identify and report reasonable suspicions of abuse or neglect. Furthermore, DDS did not have access to the relevant Medicaid claims data, and DDS policies and procedures did not establish clear definitions and examples of potential abuse or neglect that should be reported.

The State agency did not adequately safeguard 146 out of 334 developmentally disabled Medicaid beneficiaries because the DDS system of reporting and monitoring critical incidents did not work as expected.

In addition, we noted another issue that while outside the scope of our review is worthy of the State agency's attention. This issue involves the failure of hospital-based mandated reporters to report to DPPC all critical incidents with reasonable suspicion of abuse or neglect.

WHAT WE RECOMMEND

We recommend that the State agency:

- 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,
- 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,
- 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,

- 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, and

- 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.

DEPARTMENT OF DEVELOPMENTAL SERVICES COMMENTS AND OUR RESPONSE

In written comments on our draft report, DDS agreed with our second finding but disagreed with the other findings. DDS also did not agree with our conclusion that the State agency did not adequately safeguard 146 developmentally disabled Medicaid beneficiaries. However, DDS generally agreed with all five of the recommendations that we made to the State agency and stated that it is committed to protecting the health and welfare of beneficiaries receiving services who have intellectual and developmental disabilities.

We have reviewed DDS's comments on our draft report and maintain that our findings are valid.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency agreed with all five of the report's recommendations. The State agency also agreed with our second finding. However, it disagreed with our first, third, and fourth findings. Specifically, the State agency stated that it disagrees with aspects of the methodology we used to determine certain findings and the broad characterization that Massachusetts is not "in compliance with Federal and State requirements" for incident reporting.

We maintain that the State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries. Therefore, the State agency failed to adequately protect 146 of the 334 beneficiaries included in our review.

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INTRODUCTION

WHY WE DID THIS REVIEW

We are performing reviews in several States[1] in response to a congressional request concerning the number of deaths and cases of abuse of developmentally disabled residents of group homes. This request was made in response to media coverage throughout the country on deaths of developmentally disabled individuals involving abuse, neglect, or medical errors.

OBJECTIVE

Our objective was to determine whether the Massachusetts Executive Office of Health and Human Services, Office of Medicaid (State agency), complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries residing in group homes from January 2012 through June 2014.

BACKGROUND

Developmental Disabilities Assistance and Bill of Rights Act of 2000

As defined by the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (the Disabilities Act),[2] "developmental disability" means a severe, chronic disability of an individual. The disability of the individual is attributable to a mental or physical impairment or a combination of both; must be evident before the age of 22; and is likely to continue indefinitely. The disability results in substantial limitations in three or more major life areas, including self-care, receptive and expressive language, learning, mobility, self-determination, capacity for independent living, and economic self-sufficiency.

Federal and State Governments have an obligation to ensure that public funds are provided to residential, institutional, and community 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, and violations of legal and human rights (the Disabilities Act § 109(a)(3)).

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[1] U.S. Department of Health and Human Services, Office of Inspector General, *Review of Intermediate Care Facilities in New York with High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries* (A-02-14-01011), September 2015, and *Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries* (A-01-14-00002), May 2016. Available at http://oig.hhs.gov/oas/reports/region2/21401011.pdf and http://oig.hhs.gov/oas/reports/region1/11400002.pdf. The State of Maine is also currently under review.

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

Medicaid Home and Community-Based Services Waiver

The Social Security Act (the Act) authorizes the Medicaid Home and Community-Based Services Intensive Supports waiver (HCBS waiver) program (the Act § 1915(c)).[3] The program permits a State to furnish an array of home and community-based services that assists Medicaid beneficiaries to live in the community and avoid institutionalization. Waiver services complement or supplement the services that are available to participants 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) 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. 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 have been taken to protect the health and welfare of the beneficiaries receiving services (42 CFR § 441.302). This waiver assurance requires States to 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 waiver, the State agency stated that it has a critical event or incident reporting system that relies on DDS policies and procedures. DDS established certain policies and procedures, which require coordination with other State agencies, including the Disabled Persons Protection Commission (DPPC),[4] that have responsibility for responding to critical incidents for developmentally disabled individuals (DDS memorandum to DDS employees and provider personnel, July 22, 2009).

Critical Incident Reporting for Group Homes

The ISA between the State agency and DDS defines an "incident" as "any significant injury, medical, or behavioral/psychiatric event involving an individual Participant and/or any other event that involves harm or potential risk of harm to, or caused by, a Participant...." The HCBS waiver states that incidents are classified as requiring either a minor or major level of review. Deaths, physical and sexual assaults, suicide attempts, unplanned hospitalizations, near 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

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

[4] DPPC, which was created in 1987 by Massachusetts General Law chapter 19c, is the independent agency 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.

critical incidents requiring a minor level of review. The HCBS waiver and DDS policies and procedures require group homes to report critical incidents to DDS through the Home Community Services Information System (HCSIS), which is a Web-based incident reporting and management system. A major incident must be reported in the HCSIS within 1 business day, and a minor incident must be reported within 3 business days.

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 DPPC through a 24-hour hotline. The standard for reporting suspected abuse and neglect is "reasonable cause to believe" (115 Code of Massachusetts Regulations section 9.15). According to DPPC guidance and training materials, this standard means that mandated reporters need only a "mere suspicion" that abuse or neglect was committed against a person with a disability to file a report.

HOW WE CONDUCTED THIS REVIEW

We extracted 2,964 emergency room claims from the Massachusetts Medicaid Management Information System (MMIS) that the State agency paid on behalf of developmentally disabled Medicaid beneficiaries residing in group homes from January 2012 through June 2014. We limited our review to 769 emergency room claims for 334 beneficiaries between the ages of 18 and 59 residing in group homes who had 587 hospital emergency room visits[5] and were diagnosed with at least 1 of 149 conditions that we determined to be indicative of high risk for suspected abuse or neglect.[6]

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

Appendix A contains details of our audit scope and methodology. Appendix B contains details on the Federal waiver and State requirements relevant to our findings. Appendix C contains a description of the 149 diagnosis codes we reviewed and details of the types of injuries sustained by the 334 beneficiaries who went to the emergency room.

FINDINGS

The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically, the State agency did not ensure that:

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[5] Some emergency room visits had more than one Medicaid claim.

[6] 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.

- group homes reported all critical incidents to DDS (15 percent unreported),
- DDS obtained and analyzed data on all critical incidents,
- appropriate action steps were identified 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).

The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents because group home staff did not always follow procedures for reporting critical incidents. In addition, the staff of DDS and group homes lacked adequate training to identify appropriate action steps for all reported critical incidents and to correctly identify and report reasonable suspicions of abuse or neglect. Furthermore, DDS did not have access to the relevant Medicaid claims data, and DDS policies and procedures did not establish clear definitions and examples of potential abuse or neglect that should be reported.

The State agency did not adequately safeguard 146 out of 334 developmentally disabled Medicaid beneficiaries because the DDS system of reporting and monitoring critical incidents did not work as expected.

In addition, we noted another issue that while outside the scope of our review is worthy of the State agency's attention. This issue involves the failure of hospital-based mandated reporters to report to DPPC all critical incidents with reasonable suspicion of abuse or neglect.

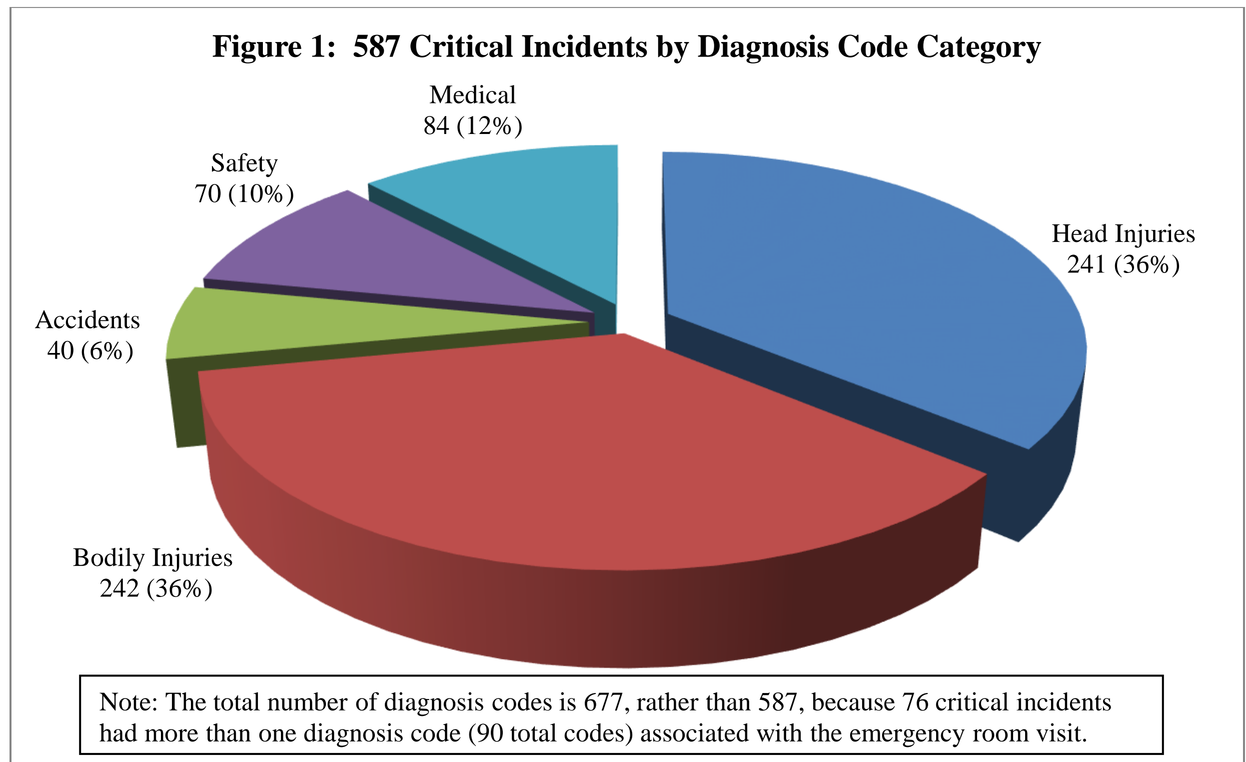
GROUP HOMES DID NOT REPORT ALL CRITICAL INCIDENTS TO THE DEPARTMENT OF DEVELOPMENTAL SERVICES

Group homes in Massachusetts are required to use the HCSIS to report critical incidents involving developmentally disabled Medicaid beneficiaries. Unplanned hospitalizations are considered critical incidents (HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements"). Unplanned hospitalizations include emergency room visits, medical hospitalizations, psychiatric hospitalizations, and emergency services psychiatric evaluations (*HCSIS Incident Management Training Participant Guide*, page 5). Therefore, all of the 587 emergency room visits provided to 334 developmentally disabled Medicaid beneficiaries met the DDS definition of a "critical incident."

Group homes did not report to DDS all critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically, group homes reported 499 (85 percent) of the 587 critical incidents treated in hospital emergency rooms. However, group homes did not report to DDS the remaining 88 (15 percent) critical incidents. Figure 1 contains the details of the 587 critical incidents by diagnosis code category.

Group homes did not always report critical incidents to DDS because group home staff did not follow reporting procedures. In response to our findings, DDS officials stated that a reminder had already been sent to all providers regarding the requirement to report all unplanned hospital visits, including emergency room visits.

Figure 1: 587 Critical Incidents by Diagnosis Code Category



Note: The total number of diagnosis codes is 677, rather than 587, because 76 critical incidents had more than one diagnosis code (90 total codes) associated with the emergency room visit.

An Example of a Group Home's Unreported Critical Incident

A group home did not report to DDS a critical incident involving a resident with a diagnosis of developmental disabilities. This resident suffered a second-degree burn on his right shoulder that required treatment at a local hospital's emergency room. The injury was noticed by the group home's aide while assisting the resident who was taking a shower. The resident's medical records noted that the aide stated the cause of the injury was unknown and that the resident could not describe how he received the injury.

Because the injury met the DDS definition of a "critical incident," the group home should have reported the incident through the HCSIS.

THE DEPARTMENT OF DEVELOPMENTAL SERVICES DID NOT REVIEW AND ANALYZE DATA ON ALL CRITICAL INCIDENTS

DDS is responsible for overseeing the reporting of and response to critical incidents. This oversight includes the review of all incident data on a systemwide basis. DDS staff review and analyze specific incidents, incident types, and risk categories on a periodic basis. In addition, the

DDS central office disseminates "trigger" reports based on incidents that meet certain thresholds to each DDS area office monthly. The trigger reports serve as an additional safeguard to ensure that the area offices are aware of, have taken appropriate actions in response to, and have followed up on potential patterns and trends for the individuals they support (HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(e), "Responsibility for Oversight of Critical Incidents and Events"). The ISA between the State agency and DDS also states that DDS must ensure that all incidents are reported, tracked in the HCSIS, and reviewed by DDS staff.

DDS did not review and analyze all data on critical incidents. Specifically, DDS only reviewed and analyzed the incidents that were reported by the group homes in the HCSIS. In this regard, DDS did not have a way to obtain and analyze all data regarding critical incidents from the State agency.[7] Accordingly, DDS could not analyze relevant Medicaid claims data for injuries that required emergency room visits or hospital admissions—key elements to detect whether beneficiaries were involved with critical incidents and whether those incidents were reported and investigated within required timeframes.

If DDS had access to the relevant Medicaid claims data as contained in the Massachusetts MMIS, it could have performed a data match similar to the one we performed. Because it could not, DDS was unable to detect the 88 critical incidents that group homes did not report.

GROUP HOMES DID NOT IDENTIFY APPROPRIATE ACTION STEPS IN ALL INCIDENT REPORTS TO PREVENT SIMILAR CRITICAL INCIDENTS

Providers, including group homes, must submit incident reports to DDS when the critical incidents occur. Unplanned hospitalizations require a major level of review and must be reported in the HCSIS within 1 business day of the incident (HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements"). The initial report is reviewed by DDS staff to ensure that immediate actions have been taken to protect the individual, and the final report must also detail any additional action steps that will be taken beyond those already identified to protect the individual. The incident report cannot be finalized until both the provider and DDS agree on the appropriate action steps for the incident (HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(d), "Responsibility for Review of and Response to Critical Events or Incidents"). The ISA states that DDS shall receive the incident reports from providers and follow up with the providers and beneficiaries about the causes and results of the incidents and actions to be taken to prevent similar incidents.

We reviewed a judgmental sample of 162 incident reports submitted by the group homes to DDS and determined that 115 (71 percent) either properly identified action steps to prevent similar critical incidents from happening again or did not warrant an action step because of the nature of

[7] DDS officials stated that they had only limited access to Medicaid claims data and that they will consult with the State agency to determine the optimal manner to obtain the relevant data so DDS can perform a data check against the incident reporting system.

the situation.[8] However, for the remaining 47 (29 percent), we determined that the action steps were not appropriate 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. This occurred because the State agency did not ensure that staff of DDS and group homes had sufficient training to identify appropriate action steps in the incident reports for all reported critical incidents.

An Example of Action Steps That Did Not Address the Prevention of Similar Critical Incidents

A group home did not identify appropriate action steps for an incident involving a resident with a history of schizophrenia and mood disorder. This resident was hit in the head with a metal chair by another resident and suffered a concussion and abrasions to the face that required treatment at a local hospital's emergency room. The medical records noted that the resident may have also briefly lost consciousness. The action steps detailed in the incident report submitted by the group home only addressed the resident's concussion symptoms. Specifically, the incident report stated that the group home staff would report any changes in condition to the agency nurse, monitor the resident closely, and follow up with the resident's primary care physician. The DDS Area Office finalized the incident report without any modifications to the group home's action steps.

Because this injury met the DDS definition of a "critical incident," the group home should have identified additional action steps to protect the individual. Action steps in similar critical incidents that we reviewed included increased supervision, staff retraining, and review of current behavioral plans and safety protocols.

THE DEPARTMENT OF DEVELOPMENTAL SERVICES DID NOT ALWAYS REPORT REASONABLE SUSPICIONS OF ABUSE OR NEGLECT

All alleged instances 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 (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"). 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.

Staff of DDS and group homes, as mandated reporters, must file a report with DPPC if there is reasonable cause to believe that serious physical or emotional injury resulted from an act or omission of care by a service provider or caretaker (115 Code of Massachusetts Regulations,

[8] We requested from DDS the hardcopy incident reports submitted by group homes for 200 emergency room visits and summary information from the incident reports for the remaining 387 emergency room visits. Because of timeliness concerns, we only reviewed the action steps for the 162 incident reports that were obtained from DDS (out of the 200 we requested). See Appendix A for further details on our methodology.

section 9.15). Furthermore, both DPPC and DDS guidance explain that the standard for reporting suspected abuse or neglect is any situation in which there is a reasonable suspicion to believe that abuse or neglect exists. To meet this standard, mandated reporters only need a "mere suspicion" that abuse or neglect has been committed against a person with a disability (DPPC training manual entitled "Protect, Report, Preserve: Abuse Against Persons With Disabilities," January 2012; DDS memorandum to DDS employees and provider personnel, July 22, 2009).

Of the 587 critical incidents involving developmentally disabled Medicaid beneficiaries during the period of our review, 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. Figure 2 shows these 73 critical incidents by types of mandated reporters.

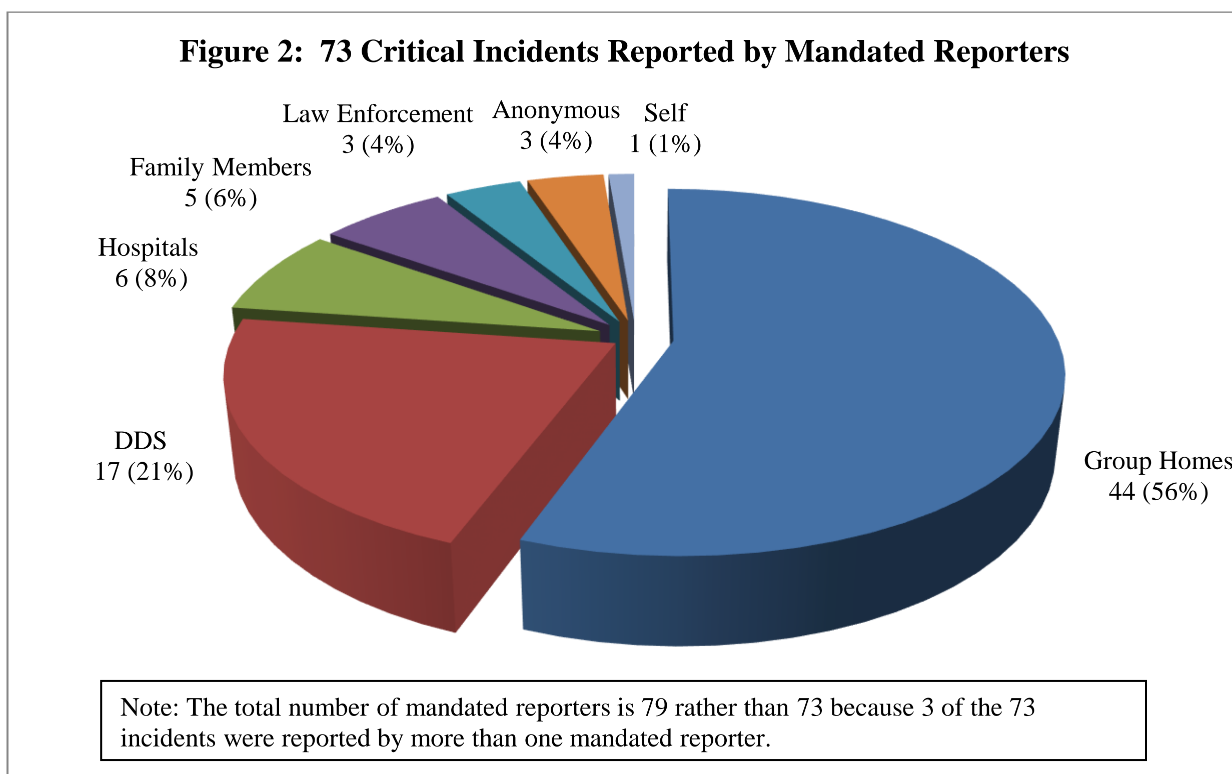


Figure 2: 73 Critical Incidents Reported by Mandated Reporters

Note: The total number of mandated reporters is 79 rather than 73 because 3 of the 73 incidents were reported by more than one mandated reporter.

We reported to DPPC the 514 unreported critical incidents we identified during the period of our review. 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 (Table). 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" threshold regarding whether a suspicion of abuse or neglect exists as required.

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

DPPC Opinion	Number of Critical Incidents
Critical Incidents Should Have Been Reported	102
Critical Incidents Did Not Have To Be Reported	240
Not Enough Information To Make Determination	172

DPPC officials said they were in the process of reviewing the critical incidents that they said should have been reported as incidents with reasonable suspicion of abuse or neglect. Of the 20 incidents that DPPC has reviewed to date, it has opened 6 investigations. It determined that further investigation was not warranted for 14 incidents because the residents were safe from harm and all appropriate services were provided.[9] DPPC officials stated they planned to review the remaining unreported critical incidents to determine whether additional actions are necessary to protect developmentally disabled group home residents from potential harm.

DDS did not report suspected cases of abuse or neglect to DPPC because staff of DDS and group homes lacked adequate training to ensure that they could properly identify and report reasonable suspicions of abuse or neglect. In addition, DDS policies and procedures did not provide clear definitions and examples of potential abuse or neglect that DDS staff could refer to if needed. DDS officials stated that they would work with DPPC to establish clear criteria regarding what needs to be reported to be DPPC and that DDS would conduct extensive statewide training for all DDS and provider staff after clearer criteria have been established.

An Example of the Department of Developmental Services Not Reporting a Critical Incident That Had Reasonable Suspicion of Abuse or Neglect

Staff of DDS or the group home did not report to DPPC either of two separate critical incidents that occurred in December 2013 and April 2014 involving a resident with a history of oppositional defiance disorder and seizures. This resident suffered head lacerations that required treatment at a local hospital's emergency room. The medical records noted that the resident was injured while being restrained by the group home's aides. The resident cut her head on a bed headboard during the first incident and on a chair during the second incident. In each case, the group home submitted an incident report to DDS, but neither DDS staff nor group home staff filed a report with DPPC.[10]

Because these injuries met the DDS definition of a "critical incident" and DPPC officials stated that there was reasonable evidence to suspect abuse or neglect,

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[9] After the draft report was issued, the State agency obtained an updated figure from DPPC. Specifically, DPPC confirmed that 8 investigations were opened out of 108 total incidents that it reviewed. See the State agency's comments and our response for further details.

[10] Appendix D contains a more detailed example of an unreported critical incident with reasonable suspicion of abuse or neglect.

DDS should have reported the incidents immediately to DPPC. On the basis of the information we provided, DPPC subsequently opened investigations of both incidents.

Hospital-Based Mandated Reporters Did Not Report All Critical Incidents to the Disabled Persons Protection Commission

This issue was outside the scope of our review; however, it is significant and worthy of the State agency's attention.

Mandated reporters include any physician, medical intern, nurse, or hospital personnel engaged in the examination, care, or treatment of a disabled person who they have reasonable cause to believe is suffering from a reportable condition. A reportable condition is an act or omission of care that results in serious physical or emotional injury to a disabled person and must be reported to DPPC immediately upon a mandated reporter becoming aware of such a condition (Massachusetts General Laws, Part I, Title II, Chapter 19c, *Disabled Persons Protection Commission*).[11]

During the period of our review, there were 587 emergency room visits at 63 hospitals by 334 developmentally disabled Medicaid beneficiaries. Hospital-based mandated reporters reported only six of these incidents as potential abuse or neglect of a developmentally disabled Medicaid beneficiary.[12]

An Example of a Hospital's Unreported Critical Incident

A hospital did not report to DPPC a critical incident involving a group home resident with a history of autism. This resident had an open wound on the buttocks. The hospital's emergency room diagnosed the resident with a pressure ulcer (bed sore) and determined that the wound was infected and had spread to the surrounding areas. The hospital staff was concerned that the resident had developed gangrene, which would have required extensive surgery and reconstruction that were beyond the hospital's capabilities. Therefore, the resident was transferred to another hospital. The second hospital also did not report the incident to DPPC.

Because DPPC officials stated that there was reasonable cause to suspect abuse or neglect of this resident, the hospitals' physicians, nurses, or other hospital personnel, as well as any other mandated reporter aware of this condition, should have reported this incident to DPPC. Based on the information that we provided, DPPC decided to request additional information from the group home, DDS, and hospitals regarding this incident. After reviewing the additional information, it

[11] Appendix B contains a complete list of mandated reporters.

[12] Three additional incidents were reported to DPPC anonymously and may have been reported by hospital-based mandated reporters.

determined that a new investigation was not warranted. However, DPPC could not make this determination initially because it was unaware of the incident.

CAUSES OF NONCOMPLIANCE WITH FEDERAL WAIVER AND STATE REQUIREMENTS

On the basis of our discussions with State agency and DDS officials, we determined the State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents because:

- group homes did not always report critical incidents to DDS because group home staff did not follow reporting procedures,
- staff of DDS and group homes lacked the training to identify appropriate action steps in the incident reports for all reported critical incidents and to identify and report reasonable suspicions of abuse or neglect,
- DDS did not have access to the relevant Medicaid claims data so it could not comply with some participant safeguard provisions of the HCBS waiver, and
- DDS policies and procedures did not establish clear definitions and provide examples of potential abuse or neglect that should be reported.

The State agency did not adequately safeguard 146 out of 334 developmentally disabled Medicaid beneficiaries because the DDS system of reporting and monitoring critical incidents did not work as expected.[13]

RECOMMENDATIONS

We recommend that the State agency:

- 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,
- 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' MMIS so it can detect unreported critical incidents,

[13] There were 334 Medicaid beneficiaries involved with 587 critical incidents. Of the 334 Medicaid beneficiaries, 188 were involved in 387 critical incidents that met the Federal waiver and State requirements for reporting and monitoring critical incidents. However, 146 Medicaid beneficiaries were involved in 200 critical incidents that were not reported to the appropriate State agency, did not have appropriate action steps identified in the incident reports, or both.

- 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,

- 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, and

- 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.

DEPARTMENT OF DEVELOPMENTAL SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, DDS agreed with our second finding but disagreed with our first, third, and fourth findings. DDS also did not agree with our conclusion that the State agency did not adequately safeguard 146 developmentally disabled Medicaid beneficiaries.

However, DDS generally agreed with all five of the recommendations that we issued to the State agency and stated that it is committed to protecting the health and welfare of individuals with intellectual and developmental disabilities who are beneficiaries receiving services. We appreciate DDS's agreement to:

- provide additional training to DDS and group home staff to ensure that critical incidents are reported in accordance with Federal waiver and State requirements,

- obtain access to Medicaid claims data and to develop appropriate analytics,

- provide additional training regarding appropriate action steps to prevent the reoccurrence of similar incidents, and

- collaborate with DPPC to clarify policy and procedures so that they more clearly define abuse or neglect reporting criteria.

We maintain that the State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries. Below is a summary of DDS's comments on the findings it did not agree with and our response to those comments.

GROUP HOMES DID NOT REPORT ALL CRITICAL INCIDENTS TO THE DEPARTMENT OF DEVELOPMENTAL SERVICES

Department of Developmental Services Comments

DDS said that our finding that group homes reported 85 percent of all critical incidents to DDS is a broad finding that is unsupported by the scope and duration of the audit period. DDS also stated that the 85-percent compliance rate does not indicate a failure to comply with Federal

standards, although any failure to report should be addressed. DDS supported this position by referencing the guidance "CMS Modifications to Quality Measures and Reporting in § 1915(c) Home and Community Based Waivers," dated March 12, 2014 (CMS guidance). The CMS guidance states that "an assurance is not considered met if a performance measure for any sub-assurance stays below 86 percent for three or more consecutive years regardless of whether a performance improvement project has been implemented unless the measure has had steady improvement over the years and the State and CMS agree that performance is likely to exceed 85 percent the following year."

DDS further stated that it:

> …reviewed the 15 percent of hospital visits that went unreported through the critical incident system, and found that in at least some of the instances where an incident was not reported, the incident occurred when a resident was with family or otherwise not within the care of group home staff. In these cases, the injury or emergency room visit occurred outside the scope of the group home's reporting requirement, and thus should not be characterized as a failure to report in HCSIS.

DDS said it is concerned about any unreported emergency hospital visits and that the report's reference to such instances of nonreporting as "clerical errors" is inaccurate to the extent that family members or others who are not group home staff have not reported an incident.

Office of Inspector General Response

We disagree with DDS's assertion that the State needed an 85-percent compliance rate to comply with Federal standards. The State agency detailed the participant safeguards policies and procedures it adopted in Appendix G of the HCBS waiver, which includes reporting all critical incidents in the HCSIS. Additionally, the ISA between the State agency and DDS requires all critical incidents to be reported in the HCSIS. Our audit examined the State's compliance with these policies and procedures for participant safeguards.

Furthermore, DDS cited the CMS guidance dated March 12, 2014, as evidence that it did not fail to comply with Federal requirements. The CMS guidance was not applicable to the program during our audit period. The guidance only applies to waiver applications and renewals submitted after June 1, 2014. The State submitted the applicable HCBS waiver renewals on June 20, 2011, and June 19, 2013, which were effective on July 1, 2010, and July 1, 2013. We recognize that the CMS guidance addresses modifications to the quality assurances, including performance measures that need to be met and reported to CMS during the HCBS waiver application renewal process. Additionally, the guidance provides specific procedures for how CMS Regional Offices determine whether a State's waiver program is meeting the assurances. That determination and the associated remediation provisions did not apply during our audit.

However, even if the percentage of reported critical incidents had been a defined performance measure applicable during our audit period, the CMS guidance pertains to the HCBS waiver application renewal process and not the ongoing operation of the participant safeguards that the

State has established to protect beneficiaries covered by the HCBS waiver. In fact, the CMS guidance clarifies that States must continue to remediate issues but only have to report the remediation to CMS when the measure is at or below 85 percent.[14] Nonetheless, we commend DDS for acknowledging that any failure to report critical incidents should be addressed. We agree that critical incident reporting is essential to ensure the health and welfare of developmentally disabled Medicaid beneficiaries.

However, we disagree with DDS's assertion that injuries or ER visits that occurred outside of the group home should not be characterized as a failure to report in the HCSIS. The HCBS waiver, as well as State requirements and guidance, does not differentiate the reporting responsibilities based on the location of the critical incident. The HCBS waiver states that providers must report incidents when they occur, and service coordinators must report incidents when they learn about them if they have not already been reported (HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements"). We noted that 89 percent of the 88 unreported incidents occurred in or near the group home, and the remaining incidents occurred in a transport van traveling to or from the group home (3 percent), at a day program (3 percent), at another medical facility (3 percent), at a work program (1 percent), or at family home (1 percent). In fact, we identified only 1 of the 88 unreported incidents that occurred when a resident was visiting with family. We did, however, note that at least three unreported incidents occurred at a group home, but in each case a family member transported the resident to the hospital after discovering an injury or illness. In addition, we found several incidents that occurred in a location other than the group home and were properly reported in the HCSIS when staff became aware of the incidents.

Finally, we attributed this finding to "clerical errors" because the group home staff members were informed of their reporting responsibilities but still failed to enter the incidents into the HCSIS. We revised the draft report in order to be more specific and clarify that the group home staff did not always follow reporting procedures.

GROUP HOMES DID NOT IDENTIFY APPROPRIATE ACTION STEPS IN ALL INCIDENT REPORTS TO PREVENT SIMILAR CRITICAL INCIDENTS

Department of Developmental Services Comments

DDS disagreed with our finding that the State agency did not ensure that appropriate action steps were identified in all incident reports that could prevent similar critical incidents (29 percent unidentified). DDS said it reviewed the action steps for the 47 incidents identified in the report as not appropriate and agreed that 7 "should have had additional steps taken." However, DDS determined that the remaining 40 incidents did not require any further action beyond the immediate action taken. Specifically:

- Twenty-five incidents required no further action based on the nature of incident. As an example of an incident not requiring further action, DDS asserted that for 1 of the 25

[14] The CMS guidance also clarified that the remediation for all substantiated instances of abuse, neglect, or exploitation must continue to be reported to CMS.

critical incidents, the resident was brought to the emergency room for pneumonia and then taken for a followup visit with the resident's primary care physician.

- Seven incidents were reported to DPPC for screening and investigation, which in effect meant that additional actions needed to be pursued.

- DDS's review of additional materials, such as notes in the client record, risk management plans, and behavior plans, indicated that "additional actions" were taken for eight incidents.

Office of Inspector General Response

We disagree with DDS's assertion that 40 of the 47 critical incidents did not require further action for the following reasons:

- DDS is correct in its assertion that for 1 of 25 critical incidents the resident was brought to the emergency room for pneumonia. We also identified 22 additional incidents in our judgmental sample in which a resident was treated for pneumonia, but we determined that the illness was due to the resident's underlying medical conditions and that it was not reasonable to assume action steps could be taken to prevent the illness from occurring again. These 22 incidents were not counted as critical incidents that required further action. However, in the incident cited by DDS, we identified additional circumstances that required further action. Specifically, the medical records state that the resident also had unexplained bruising on her leg, which the group home staff member stated was from frequent falls. At the very least, an action step to address the injuries that resulted from the resident's falls at the group home would have been appropriate in this case.[15] We also noted that the medical record indicated that the resident stated the bruising was the result of being kicked and not from a fall. This fact was not included in the incident report submitted to DDS by the group home, and the incident was not reported to DPPC.[16] DDS did not identify the nature of the remaining 24 incidents that it said did not require further action, so we cannot respond to each specific incident. However, we maintain the validity of our findings.

- We disagree that the reporting of the seven incidents to DPPC represents an appropriate action step to prevent similar critical incidents. The requirements to report suspected cases of abuse or neglect to DPPC and to identify appropriate action steps in the incident reports are distinct participant safeguards. If DPPC reviews a reported critical incident and determines that the incident does not meet its investigation criteria for abuse or neglect, there is no assurance that the group home or any other party will take action to prevent similar incidents from occurring again. Appropriate action steps are implemented, in part, to prevent similar incidents from occurring again.

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[15] HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(d), "Responsibility for Review of and Response to Critical Events or Incidents."

[16] We reported this critical incident to DPPC, and DPPC officials stated that it should have been reported as an incident with reasonable suspicion of abuse or neglect.

- Our finding is that the appropriate action steps to prevent the reoccurrence of similar incidents were not properly identified in the incident report, as required by the HCBS waiver. The fact that action steps may or may not have been taken for the eight incidents that DDS identified in its comments is not relevant to our finding.

THE DEPARTMENT OF DEVELOPMENTAL SERVICES DID NOT ALWAYS REPORT REASONABLE SUSPICIONS OF ABUSE OR NEGLECT

Department of Developmental Services Comments

DDS disagreed with our finding that the State agency did not ensure that DDS always reports reasonable suspicions of abuse or neglect to DPPC. Specifically:

- DDS stated that the report repeatedly describes the standard for reporting suspected abuse as "reasonable suspicion" or "mere suspicion." DDS said that "only a mere suspicion" is adopted from the DPPC Web site and "oversimplifies and misconstrues the legal standard for mandated reporting."

- DDS disagreed with our methodology employed to reach this finding. DDS summarized DPPC's conclusions based on its review of 515 incidents: 102 (20 percent) should have been reported to DPPC, 239 (46 percent) should not have been reported, and 173 (34 percent) lacked sufficient information to offer an opinion. DDS stated that our conclusion based on DPPC's review "rests solely on a one-person review of two- to five-sentence summaries with no access to other available information" and that our methodology is "insufficient to support such a conclusory finding that DDS/vendors have failed to safeguard group home residents." DDS further stated that DPPC staff acknowledged that the limited information made available from which to draw the conclusion was insufficient.

- DDS disagreed with our calculation that 58 percent of incidents were not reported by staff of DDS and group homes. DDS stated that this calculation is inconsistent with other calculations in the report, which compared the number of incidents reported to DPPC with the total number. DDS further said "the result of the analysis conducted by DPPC was that 20 percent of the total incidents should have been reported to DPPC, not 58 percent." DDS urged us to use the 587 critical incidents reviewed as the denominator to determine that 17 percent of incidents were not reported by staff of DDS and group homes.

- DDS said that DPPC has opened investigations on only 6 of the 20 incidents that it has reviewed. DDS stated that the fact that DPPC's review of additional information resulted in smaller percentage of reportable incidents underscores the fundamental flaw in our audit methodology.

Office of Inspector General Response

We maintain that the State agency did not ensure DDS always reports reasonable suspicions of abuse or neglect to DPPC for the following reasons:

- Our assertion that reporting requirements only require a "mere suspicion" was not solely adopted from the DPPC Web site. The training manual entitled "Protect, Report, Preserve: Abuse Against Persons with Disabilities," January 2012, states: "A reportable condition meets the standard of a 'reasonable cause to believe' abuse or neglect has occurred. Mandated reporters only require a 'mere suspicion' that abuse or neglect may have occurred." This manual was published by DPPC and given to us by DDS after our request for all training manuals and guidance DDS had given to DDS and group home staff. We also discussed the "mere suspicion" guidance with DPPC officials. The officials explained that this guidance is provided to make it clear that the "reasonable cause to believe" threshold is extremely low. During an interview, DPPC officials further explained that the guidance is meant to convey the message that "if you have to stop and think whether abuse or neglect has occurred, report it." We noted that this guidance is consistent with the DDS memorandum, July 22, 2009, to DDS employees and provider personnel, which explains that there are clearly many cases that could be considered abuse or neglect and that DDS prefers the over-reporting of potentially abusive conditions or incidents because it has a zero tolerance policy for these issues.

- We maintain that our audit methodology was reliable and sufficient to support our findings. Our methodology relied on the professional judgement of DPPC to make the determination of whether a critical incident should have been reported with reasonable suspicion of abuse or neglect. We discussed DDS's concerns about our methodology with DPPC, and DPPC officials agreed that it was the best way to conduct our review. At no time did DPPC officials indicate that the information we presented to them was insufficient to draw a conclusion in all cases.

  While it is true that DPPC officials stated that there was not enough information to determine whether 172 of the 514 unreported incidents should have been reported, they determined that there was sufficient information to make a determination for the remaining 342 incidents. We reviewed many of these incidents with DPPC officials, and they identified incidents that met the "reasonable cause to believe" threshold. The reporting threshold only requires a question of whether abuse or neglect may have occurred, not 100-percent confirmation that it occurred. DDS is correct in its assertion that we provided summaries from the medical records for DPPC to review. However, we also made it clear to both DPPC and DDS officials on multiple occasions that all medical records were available for their review. Given the fact that we obtained thousands of pages of medical records containing sensitive information during our review, we made the decision, with agreement from DPPC, to only provide the records that were specifically requested. Neither agency requested any of these records during our review.

  Finally, in DDS's preliminary written response to our findings, dated June 30, 2015, DDS stated that it reviewed the 102 incidents that DPPC determined should have been reported

as incidents with reasonable suspicion of abuse or neglect and agreed 60 of the 102 incidents should have been reported. DDS stated that its "determination was not conclusive as to whether the facts known to the mandated reporter(s) at the time the incident occurred were sufficient to provide reasonable cause, but an acknowledgment that the fact patterns may have constituted conditions that should have been reported to DPPC." DDS also noted that a number of the unreported incidents were classified as incidents of self-injury, peer-to-peer altercations, injuries during restraint, and repetitive injuries (e.g., instances of foreign body ingestion or falls during a seizure). DDS acknowledged that "these types of incidents may at-times present staff with a 'gray area' of what triggers a suspicion that abuse exists that, therefore, needs to be reported." While we recognize that the reporting of potential abuse or neglect does rely on some level of personal judgement, we made the decision to rely on the determinations made by DPPC because it is the independent screening agency in Massachusetts. Therefore, based on our communications with DPPC officials and DPPC's expertise in reviewing reported incidents of potential abuse and neglect, we maintain that our findings are valid.

- The two percentages referenced by DDS present different information. The lower percentage of 17 percent preferred by DDS details the additional critical incidents that should have been reported to DPPC compared to the total number of critical incidents in our population. The higher percentage of 58 percent from our report details the unreported critical incidents that met the "reasonable cause to believe" threshold compared to all unreported and reported incidents that met this threshold.[17] The calculation of the lower percentage does not present an apples-to-apples comparison because the numerator in the calculation is based on the "reasonable cause to believe threshold" for reporting suspicions of abuse and neglect to DPPC and the denominator is based on the standard for reporting critical incidents to DDS (unplanned hospitalizations). The purpose of using the higher percentage in the report is not to manipulate the data or mislead the reader. Rather, it is to highlight the fact that a large number of incidents that should have been reported to DPPC with reasonable suspicion of abuse and neglect were not. Regardless of the percentage used to present our finding, we maintain that our finding is valid.

- The requirement for reporting an incident with reasonable suspicion of abuse and neglect to DPPC and the DPPC standards for conducting an investigation are separate and distinct. Therefore, the fact that DPPC determined a reported incident did not warrant an investigation has no correlation to whether or not the incident should have been reported by a mandated reporter. Nevertheless, in contrast to DDS's assertion, the fact that DPPC opened investigations in 6 out of the 20 (30 percent) unreported incidents that it has reviewed to date supports our conclusion that the State agency did not adequately safeguard all developmentally disabled Medicaid beneficiaries.

[17] Our calculation assumes all reported incidents met the "reasonable cause to believe" threshold. We are confident in this assumption, because any incident that a mandated reporter believes should be reported meets the threshold by definition.

THE STATE AGENCY DID NOT ADEQUATELY SAFEGUARD BENEFICIARIES

Department of Developmental Services Comments

DDS disagreed with our conclusion that the State agency did not adequately safeguard 146 of the 334 developmentally disabled Medicaid beneficiaries because the DDS system of reporting and monitoring critical incidents did not work as expected. Specifically, DDS stated that the absence of an incident report does not represent a failure to safeguard individuals because other documentation may have demonstrated that action to safeguard beneficiaries had been taken. Additionally, DDS stated that "the reporting of unplanned hospital visits via the HCSIS system represents just one reporting category in the Department's comprehensive incident reporting system, which itself is just one component of the Department's multi-tiered quality assurance system."

Office of Inspector General Response

We maintain that our conclusion is valid. The participant safeguards outlined in the HCBS waiver, including the critical incident reporting system and the requirement to report potential cases of abuse or neglect to DPPC, are designed to protect the health and welfare of the developmentally disabled Medicaid beneficiaries residing in group homes. If these safeguards are not working as designed, the beneficiaries are at risk. Furthermore, it is not safe to assume the beneficiaries whose critical incidents were not reported in the HCSIS were protected by some other mechanism. The participant safeguards depend on close coordination between DDS and DPPC, and any discrepancies between the two agencies regarding the abuse or neglect reporting criteria also potentially endangers the beneficiaries.

REQUESTED CHANGES TO THE DRAFT REPORT

Department of Developmental Services Comments

DDS requested several additional changes to the draft report, including the report title, conclusions, and the reference to certain percentages. These changes were based on DDS's comments on the findings it did not agree with.

Office of Inspector General Response

We did not accept DDS's requested changes to our draft report because of the reasons stated above in our responses to DDS's comments. Because we maintain the validity of the findings, recommendations, and conclusion, we declined to make any additional changes to the draft report.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed with all five of the report's recommendations. Specifically, the State agency stated that it is committed to continuous quality improvement and will undertake all of the recommendations in the report. The State agency also agreed with our second finding. However, it disagreed with our first, third, and fourth findings. Specifically, the State agency stated that it disagrees with aspects of the methodology we used to determine certain findings and the broad characterization that Massachusetts is not "in compliance with Federal and State requirements" for incident reporting. The State agency also requested that we revise the title of the report.

We maintain that the State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries. Therefore, the State agency failed to adequately protect 146 of the 334 beneficiaries included in our review. Below is a summary of the State agency's comments on the findings it did not agree with and our response to those comments.

GROUP HOMES DID NOT REPORT ALL CRITICAL INCIDENTS TO THE DEPARTMENT OF DEVELOPMENTAL SERVICES

State Agency Comments

The State agency stated that our characterization that 15 percent of critical incidents were unreported is inaccurate. The State agency said that we reviewed only certain types of emergency room visits to see if critical incidents were reported and that it is inaccurate to extrapolate that finding to conclude that 15 percent of all types of critical incidents were not properly reported.

Additionally, the State agency stated that it does not concur with our broad conclusion for this finding that Massachusetts was not in compliance with Federal and State requirements for critical incidents, as this implies that during the period reviewed, the standard was 100 percent compliance. The State agency further stated that current CMS guidance, issued in March of 2014, sets a threshold of 85 percent or greater for compliance, or not less than 85 percent for 3 consecutive years for noncompliance. The State agency also said that "although this standard was not in effect during the full audit period, in the absence of any alternative guidance at the time, the current CMS standard is the best indication of Federal expectations."

Office of Inspector General Response

Our finding is that group homes did not report all critical incidents to DDS. This finding is based on the review of all Medicaid claims for beneficiaries covered by the HCBS waiver during the audit period that we determined to be high risk. Our audit methodology did not involve statistical sampling, and we did not extrapolate findings to beneficiaries or incidents not included in our review. Furthermore, our report describes in detail that we limited our review to 334 beneficiaries residing in group homes who had 769 Medicaid claims consisting of 587 hospital

emergency room visits with at least one diagnosis code that we determined to be indicative of a high risk for suspected abuse or neglect. We maintain that our review of this population supports our finding.

As discussed in our response to DDS's comments, we disagree with the State agency's assertion that the State needed an 85 percent compliance rate to comply with Federal standards. The State agency detailed the participant safeguards policies and procedures it adopted in Appendix G of the HCBS waiver, which includes reporting all critical incidents in the HCSIS. Additionally, the ISA between the State agency and DDS also requires all critical incidents to be reported in the HCSIS. Our audit examined the State's compliance with these policies and procedures for participant safeguards.

Furthermore, the State agency cited the CMS guidance dated March 12, 2014, as evidence that it did not fail to comply with Federal requirements. The CMS guidance was not applicable to the program during our audit period. The guidance only applies to waiver applications and renewals submitted after June 1, 2014. The State submitted the applicable HCBS waiver renewals on June 20, 2011, and June 19, 2013, which were effective on July 1, 2010, and July 1, 2013.

The State agency also stated that the current CMS guidance is the best indication of Federal expectations during our audit period, because there was not any alternative guidance at the time. We strongly disagree with the State agency's assertion. The CMS guidance clarifies that, before the issuance of the current guidance, States had to submit the remediation for any performance measures with less than 100-percent compliance during the waiver renewal process.

Additionally, we noted that the State agency incorrectly asserted that the threshold for compliance described in the CMS guidance is 85 percent or greater. The CMS guidance clearly states that States must continue to remediate issues but only have to report the remediation to CMS when the measure is 85 percent or lower. However, regardless of whether the threshold for reporting the remediation to CMS is met, the CMS guidance maintains that States must continue to remediate any performance measures with less than 100-percent compliance.

For these reasons, we determined that the State agency's noncompliance with the performance of participant safeguards is not acceptable. This is an important distinction to make, because the purpose of the safeguards is to protect the safety and well-being of developmentally disabled Medicaid beneficiaries. Accordingly, we maintain that the State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents.

GROUP HOMES DID NOT IDENTIFY APPROPRIATE ACTION STEPS IN ALL INCIDENT REPORTS TO PREVENT SIMILAR CRITICAL INCIDENTS

State Agency Comments

The State agency disagreed with the finding that 47 of the 162 (29 percent) critical incidents reviewed did not document appropriate action steps. The State agency explained that DDS conducted a review of these 47 critical incidents and found that only 7 of them, or 4.3 percent of the 162 critical incidents referenced by OIG, did not adequately document action steps.

Office of Inspector General Response

As discussed in detail in our response to DDS's comments, we disagree with DDS's assertion that 40 of the 47 critical incidents did not require further action. We, therefore, continue to maintain the validity of our finding.

THE DEPARTMENT OF DEVELOPMENTAL SERVICES DID NOT ALWAYS REPORT REASONABLE SUSPICIONS OF ABUSE OR NEGLECT

State Agency Comments

The State agency stated that it strongly disagrees with the methodology utilized in this finding and believes that the methodology exaggerated our findings of noncompliance. Specifically:

- The State agency stated that it does not believe that our methodology for determining whether an incident should have been reported for reasonable suspicion of abuse and neglect was sound. Specifically, the State agency said that we drafted two- to five-sentence summaries of medical records and then had DPPC staff determine whether the summaries constituted incidents that should have been reported. The State agency also said that, at the time of the audit, DPPC expressed that the summaries were insufficient to base any conclusions on but proceeded with the review at our request. The State agency also maintained that DPPC noted that it had no input into this approach and that DPPC "rendered an opinion based upon limited information and not through its normal intake process." The State agency referenced a statement from DPPC that was addressed to DDS and included with its comments to the draft report.

- The State agency stated that DPPC opened a total of eight investigations of the 102 unreported incidents as possibly appropriate for investigation. The State agency also stated that the findings of the subsequent review by DPPC underscore the likelihood that the majority of the 102 incidents may not have risen to the level in which an individual would have developed a reasonable suspicion of abuse or neglect from the totality of information available to them.

- The State agency stated that it disagrees with the calculation used to determine that there was a total of 58 percent unreported incidents. Specifically, the State agency maintained that the calculation should be based on the total number of unreported incidents over a denominator of "total number of reviewed incidents" (587), rather than a denominator of "total number of incidents that DPPC determined should have been reported based on OIG created summaries" (175). The State agency further stated that the result would be a decrease in the percentage of unreported incidents from 58 percent to 17 percent. The State agency added that the Center for Developmental Disabilities Evaluation and Research at the University of Massachusetts Medical School, an entity independent of DDS or the State agency, confirmed that the calculation proposed by DDS, in which the denominator is "total number of reviewed incidents," would be a more valid means for determining the level of compliance.

Office of Inspector General Response

We maintain that our audit methodology was reliable and sufficient to support our finding that DDS did not always report reasonable suspicions of abuse and neglect for the following reasons:

- As discussed in our response to DDS's comments, DPPC never expressed concerns with our audit methodology, nor did it indicate that the information we presented was insufficient to draw a conclusion in all cases. In fact, DPPC officials stated that there was enough information to determine that 102 of the 514 unreported incidents should have been reported as incidents with reasonable suspicion of abuse or neglect.

  Moreover, at the beginning of our audit we met on January 12, 2015, with DPPC officials to review a judgmentally selected sample of 26 critical incidents that were not reported to DPPC as incidents with reasonable suspicion of abuse and neglect. These incidents included beneficiaries who were physically assaulted by other residents, suffered injuries while being restrained by group home staff, given the incorrect medication by group home staff, or suffered injuries from unknown origins. DPPC officials stated that they believed all 26 incidents met the "reasonable cause to believe" threshold and should have been reported for suspected abuse and neglect. DPPC officials also stated that they were surprised so many incidents involving injuries were unreported, given the amount of training DPPC provided to the community. Based on the results of this meeting, we decided on the audit methodology we used to develop our audit finding.

  We also note that DDS officials previously agreed in their preliminary written response to our findings, dated June 30, 2015, that 60 of the 102 unreported incidents should have been reported as incidents with reasonable suspicion of abuse or neglect. DDS acknowledged that a number of the unreported incidents were classified as incidents of self-injury, peer-to-peer altercations, injuries during restraint, and repetitive injuries.

- As discussed in our response to DDS's comments, the requirement for reporting an incident with reasonable suspicion of abuse and neglect to DPPC and the DPPC standards for conducting an investigation are separate and distinct. Therefore, the fact that DPPC determined a reported incident did not warrant an investigation has no correlation to whether the incident should have been reported by a mandated reporter. In addition, the fact that DPPC opened investigations based on the unreported incidents that it has reviewed to date supports our conclusion that the State agency did not adequately safeguard all developmentally disabled Medicaid beneficiaries.

  At the time of issuance of the draft report, DPPC officials stated that they opened investigations on 6 of the first 20 unreported incidents that it reviewed. We have confirmed with DPPC officials that they opened 2 additional investigations on the next 88 unreported incidents that it reviewed. Of the 108 incidents reviewed in total, DPPC opened 8 investigations and conducted 58 desk reviews and 29 followup reviews (through additional records or telephone calls). In addition, 12 followup reviews remain

open at the time of the release of this report, and DPPC officials said it believes 1 incident may have already been investigated under a different name for the beneficiary.

It is appropriate for us to comment on DPPC's final actions because the State agency attempted to impugn our audit findings on the basis of the number of final actions. We find it troubling that DPPC opened 6 investigations of the first 20 unreported incidents that it reviewed, but it only opened 2 additional investigations on the next 88 unreported incidents it reviewed after our draft report was issued to DDS. We find the disparity in DPPC's result inexplicable, given the vulnerability of the developmentally disabled Medicaid beneficiaries included in our review and the consistent nature of the unreported critical incidents we discovered and reported to DPPC.

- As discussed in our response to DDS's comments, the two percentages referenced by DDS present different information. The lower percentage of 17 percent preferred by DDS is the additional critical incidents that should have been reported to DPPC compared to the total number of critical incidents in our population. The higher percentage of 58 percent from our report is the unreported critical incidents that met the "reasonable cause to believe" threshold compared to all unreported and reported incidents that met this threshold. Regardless of the percentage used to present our finding, we maintain that the State agency did not adequately safeguard 146 of the 334 developmentally disabled Medicaid beneficiaries included in our review.

COLLABORATION WITH THE DISABLED PERSONS PROTECTION COMMISSION

State Agency Comments

The State agency agreed with our recommendation to coordinate with DDS and DPPC to ensure any potential cases of abuse and neglect that are identified as a result of new analytical procedures are investigated as needed. The State agency stated that it has already started additional collaboration with DDS and DPPC. However, the State agency restated that it disagrees with the characterization of our findings on overall reporting of abuse and neglect and certain methodologies that were used to reach those findings.

Moreover, the State agency stated that it shares our commitment to improving public systems that serve the most vulnerable and also reiterated its commitment to protecting the health and welfare of individuals with intellectual and developmental disabilities who participate in and receive services through the HCBS waivers.

The State agency also submitted a statement from DPPC that was addressed to DDS. DPPC stated that it has a long history of working together successfully and cooperatively with DDS and that it will continue to do so to improve the understanding of mandated reporting requirements for both the DDS community and particularly for medical professionals in hospitals. DPPC also described its role in our audit.

Office of Inspector General Response

We maintain that our audit methodology was reliable and sufficient to support our audit results. Because we maintain the validity of the findings, recommendations, and conclusion, we declined to make any additional changes to the draft report, including its title.

We acknowledge the State agency's agreement to implement our recommendations in order to ensure that developmentally disabled Medicaid beneficiaries are adequately safeguarded. Specifically, we acknowledge that the State agency has agreed to:

- work on the development of a refresher training and webinar regarding incident reporting;
- execute a data-sharing agreement with DDS and engage in collaborative work to test procedures and create a process for ongoing exchange of information and for developing appropriate analytics;
- send out advisories from DDS to DDS staff and providers regarding the documentation of action steps and incorporating this information into the webinar and training materials under development for DDS staff and providers;
- continue to collaborate with DDS on its policies and procedures, particularly so that they clearly define and provide examples of potential abuse or neglect that must be reported; and
- initiate additional collaboration between DDS and DPPC to ensure any potential cases of abuse and neglect that are identified as a result of new analytical procedures are investigated as needed.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

DDS provided services to 5,982 developmentally disabled Medicaid beneficiaries residing in group homes from January 1, 2012, through June 30, 2014. Of the 5,982 beneficiaries, 691 had 2,964 claims representing 1,879 emergency room visits for all diagnosis codes. We limited our review to 334 beneficiaries residing in group homes who had 769 emergency room claims consisting of 587 hospital emergency room visits that included 915 medical services and were diagnosed with at least 1 of 149 conditions that we determined to be indicative of a high risk for suspected abuse or neglect.

In performing our review, we established reasonable assurance that the claims data contained in the MMIS were accurate. We did not review the overall internal control structure of DDS. We limited our internal control review to obtaining an understanding of DDS's policies and procedures related to critical incidents.

We performed our fieldwork at DPPC offices in Braintree, Massachusetts, and DDS offices in Boston, Massachusetts, from October 2014 through July 2015.

METHODOLOGY

To accomplish our audit objective, we:

- reviewed applicable Federal waiver and State requirements;

- held discussions with CMS officials to gain an understanding of the HCBS waiver for developmentally disabled beneficiaries residing in group homes;

- held discussions with officials from various State agencies to gain an understanding of State policies and controls as they relate to the mandatory reporting of potential abuse and neglect of developmentally disabled beneficiaries;

- obtained a computer-generated file from DDS of information on all 5,982 Medicaid developmentally disabled individuals residing in group homes from January 1, 2012, through June 30, 2014;

- extracted a computer-generated file from MMIS containing claims for 1,879 emergency room visits that included 3,313 medical services for developmentally disabled Medicaid beneficiaries for the period January 1, 2012, through June 30, 2014;

- reviewed and reconciled the MMIS claims data to the Massachusetts Medicaid eligibility records;

- evaluated claims for 1,879 emergency room visits to determine the 149 diagnosis codes with diagnoses that indicated an increased risk of abuse or neglect;

- reviewed and analyzed the 769 Medicaid claims that contained at least 1 of the 149 diagnosis codes for the 334 developmentally disabled Medicaid beneficiaries between the ages of 18 and 59 who resided in group homes in Massachusetts and who had 587 emergency room visits[18] during our audit period;

- requested and reviewed the medical records for the 587 emergency room visits;

- obtained from DPPC officials lists of all reported potential abuse or neglect of developmentally disabled Medicaid beneficiaries during our audit period and compared this list to the MMIS data and emergency room medical records to determine which of the 587 emergency room visits were not reported to DPPC;

- provided a list of the unreported emergency room visits and a summary of the related medical records to DPPC officials to determine whether the visits should have been reported to DPPC and what actions DPPC officials planned for each unreported visit;

- requested from DDS the incident reports submitted by group homes for 200 judgmentally selected emergency room visits and requested summary information from the incident reports for the remaining 387 emergency room visits;

- compared the incident report documentation to the MMIS data and medical records to determine which of the 587 emergency room visits were not reported to DDS;

- reviewed a judgmental sample of the 162 incident reports that were obtained from DDS (out of the 200 reports we requested) and determined whether the action steps identified in the incident reports appropriately addressed the prevention of similar critical incidents;

- contacted the hospitals that provided services to developmentally disabled Medicaid beneficiaries during 30 judgmentally selected emergency room visits to determine whether the hospitals reported these visits to Massachusetts and, if so, which State agency they contacted and, if not, why; and

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

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

[18] Some emergency room visits had more than one Medicaid claim.

APPENDIX B: FEDERAL WAIVER AND STATE REQUIREMENTS

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

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

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements," states that DDS uses a Web-based incident reporting system, which provides invaluable incident information regarding individual incidents, immediate and long-range actions, and aggregate information that informs analyses of patterns and trends. The HCBS waiver also states that providers must report incidents when they occur and service coordinators must report incidents when they learn about them if they have not already been reported. Incidents are classified as requiring either a minor or major level of review. Deaths, physical and sexual assaults, suicide attempts, unplanned hospitalizations, near drowning, missing persons, and injuries are examples of incidents requiring a major level of review. Suspected verbal or emotional abuse, theft, and property damage are examples of incidents requiring a minor level of review. In addition, the HCSIS is an integrated "event" system and, as such, medication occurrences and uses of restraint are also reported.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements" requires that all alleged instances of abuse or neglect are reported to DPPC. DPPC is the independent State agency responsible for screening and investigating or referring for investigation all allegations of abuse or neglect for individuals with disabilities between the ages of 18 and 59. Mandated reporters, as well as individuals and families, report suspected cases of abuse or neglect directly to DPPC. DPPC reviews all reports, then determines and assigns responsibility for the investigation.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(d), "Responsibility for Review of and Response to Critical Events or Incidents," states that there are two distinct processes for reporting incidents: one for incidents (classified as minor or major) and one for reporting of suspected instances of abuse or neglect. A reported incident may also be the subject of an investigation, but investigation processes are different and carried out by different entities.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(d), "Responsibility for Review of and Response to Critical Events or Incidents," states that minor and major incidents are reported by the staff person observing or discovering the incident. A major incident is immediately reported orally to the service coordinator in the area office. The incident is entered into the electronic Web-based system. A major incident must be reported within 1 business day, a minor incident within 3 business days. The initial report is reviewed by the service coordinator to assure that immediate actions have been taken to protect the individual. A final report is submitted by the provider and includes any additional action steps that will be taken beyond those already identified. Both minor and major incident reports are reviewed by the service coordinator. Major incidents are escalated to the regional level for review. The final report, which includes action steps, must be agreed upon by both the provider and DDS. If DDS does not concur with the action steps, the report is sent back to the provider for additional action. Incident reports are considered closed only after there is consensus among the parties as to the action steps taken. A similar process is in place for response to medication occurrences and uses of restraint.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(d), "Responsibility for Review of and Response to Critical Events or Incidents," states that incidents that rise to the level of a reportable event, i.e., allegation of abuse or neglect, potentially subject to investigation, are 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. It then refers the case to the appropriate agency for investigation. DPPC can decide to conduct the investigation itself, refer the case to the DDS Investigations Unit for investigation, or refer the case to law enforcement entities, as the circumstances require. All reports of abuse or neglect are processed by trained, experienced staff. When deemed necessary, immediate protective services are put into place to ensure that the individual is safe while the investigation is completed.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(e), "Responsibility for Oversight of Critical Incidents and Events," states that the State agency retains administrative authority for the HCBS waiver, although the subagency DDS has responsibility for oversight of the critical incidents system. The responsibility for overseeing the reporting of and response to critical incidents rests with DDS as the operating agency for the waiver.

The ISA between the State agency and DDS states that DDS will ensure that all incidents are reported, tracked in an electronic Web-based system, and reviewed by DDS staff. In addition, DDS will receive incident reports from waiver providers and follow up about the causes and results of the incidents and actions to be taken to prevent similar incidents.

Title 115, CMR, section 9.15, states that a DDS or group home employee must file a complaint with DPPC if they have reasonable cause to believe that serious physical or emotional injury resulted from an act or omission by a service provider or caretaker. Furthermore, Title 115, CMR, section 9.16, states that all incidents involving individuals served by the program that result in physical injury requiring medical treatment beyond routine medical treatment must be reported by the program.

Title 118, CMR, section 2.02, explains that a "reasonable cause to believe" is the threshold that creates a suspicion that abuse exists. Title 118, CMR, section 3.03, states that a mandated reporter is required to report suspected abuse to DPPC.

Massachusetts General Laws, Part I, title II, chapter 19c, *Disabled Persons Protection Commission*, defines a mandated reporter as 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.

A DDS memorandum, dated July 22, 2009, to DDS employees and provider personnel states that all cases of abuse and mistreatment must be reported through DPPC. In addition, the memorandum explains that there are clearly many cases that could be considered abuse or neglect and that DDS prefers the overreporting of potentially abusive conditions or incidents because it has a zero tolerance policy for these issues.

The training manual entitled "Protect, Report, Preserve: Abuse Against Persons with Disabilities," January 2012, which was published by DPPC and is used by DDS, states that mandated reporters are required by law to report suspected conditions or abuse and neglect to DPPC when a reportable condition exists. A reportable condition meets the standard of a "reasonable cause to believe" abuse or neglect has occurred. Mandated reporters only require a "mere suspicion" that abuse or neglect may have occurred.

APPENDIX C: INJURY CATEGORY STATISTICS

	Diagnosis Code	Description	Number of Diagnosis Codes	Number of ER Visits	Number of Beneficiaries
Head Injuries					
1	7842	Swelling, mass, or lump in head and neck	1	12	11
2	80101	Closed fracture of base of skull	1	1	1
3	802	Fracture of face bones	3	7	7
4	850	Concussion	2	4	4
5	85220	Subarachnoid subdural and extradural hemorrhage	1	1	1
6	85400	Intracranial injury of other and unspecified nature	1	1	1
7	870	Open wound of ocular adnexa	3	8	8
8	8714	Open wound of eyeball—Unspecified laceration of eye	1	1	1
9	872	Open wound of ear	2	2	2
10	873	Other open wound of head	12	77	70
11	9100	Abrasion or friction burn of face, neck, and scalp except eye	1	9	8
12	920	Contusion of face, scalp, and neck except eye	1	29	26
13	921	Contusion of eyes and adnexa	3	4	4
14	959	Injury other and unspecified—Head injury	2	85	73
		Subtotal	**34**	**241**	**217**
Bodily Injuries					
1	805	Fracture of vertebral column	3	4	4
2	807	Fracture of ribs, sternum, and trachea	2	3	3
3	8088	Fracture of pelvis, closed	1	1	1
4	81003	Fracture of acromial end of clavicle, closed	1	1	1
5	812	Fracture of humerus	4	7	7
6	813	Fracture of radius and ulna	3	5	5
7	81400	Closed fracture of carpal bone, unspecified	1	1	1
8	815	Fracture of metacarpal bone(s)	3	5	5
9	816	Fracture of one or more phalanges of hand	3	8	8
10	8208	Fracture of neck of femur, closed	1	1	1
11	821	Fracture of other and unspecified parts of femur	2	2	2
12	8220	Closed fracture of patella	1	2	2
13	823	Fracture of tibia and fibula	3	6	5
14	824	Fracture of ankle	4	11	10
15	825	Fracture of one or more tarsal and metatarsal bones	4	12	11
16	8260	Closed fracture of one or more phalanges of foot	1	6	5
17	83402	Dislocation of interphalangeal (joint), hand, closed	1	1	1
18	83500	Dislocation of hip, unspecified site, closed	1	1	1
19	8363	Dislocation of patella, closed	1	1	1
20	8770	Open wound of buttock	1	1	1
21	8782	Open wound of scrotum and testes	1	1	1
22	879	Open wound of other and unspecified sites, except limbs	2	2	2
23	88003	Open wound of upper arm	1	1	1
24	881	Open wound of elbow, forearm, and wrist	3	10	10
25	8820	Open wound of hand except finger(s) alone	1	9	8
26	8830	Open wound of finger(s)	1	5	5
27	8910	Open wound of knee, leg [except thigh], and ankle	1	4	4

	Diagnosis Code	Description	Number of Diagnosis Codes	Number of ER Visits	Number of Beneficiaries
28	892	Open wound of foot except toe(s) alone	2	3	3
29	8930	Open wound of toe(s)	1	4	3
30	9160	Abrasion or friction burn of hip, thigh, leg, and ankle	1	3	2
31	922	Contusion of trunk	4	11	11
32	923	Contusion of upper limb	7	39	38
33	924	Contusion of lower limb and other and unspecified sites	5	19	19
34	9273	Crushing injury of upper limb—Finger(s)	1	1	1
35	959	Injury other and unspecified—Bodily injury	8	51	46
		Subtotal	**80**	**242**	**229**
Medical					
1	481	Pneumococcal pneumonia	1	1	1
2	4829	Bacterial pneumonia, unspecified	1	1	1
3	485	Bronchopneumonia, organism unspecified	1	1	1
4	486	Pneumonia, organism unspecified	1	67	47
5	4871	Influenza with other respiratory manifestations	1	4	4
6	78001	Coma	1	1	1
7	79902	Hypoxemia	1	4	4
8	9916	Hypothermia	1	5	4
		Subtotal	**8**	**84**	**63**
Accidents					
1	V714	Observation following other accident	1	40	37
		Subtotal	**1**	**40**	**37**
Safety					
1	9331	Foreign body in larynx	1	7	7
2	935	Foreign body in mouth, esophagus, and stomach	3	9	7
3	938	Foreign body in digestive system, unspecified	1	19	9
4	94116	Burn—Erythema [first degree] of scalp	1	1	1
5	94325	Burn—Blisters, epidermal loss [second degree] of shoulder	1	1	1
6	94422	Burn—Blisters, epidermal loss [second degree] of thumbnail	1	1	1
7	94526	Burn—Blisters, epidermal loss [second degree] of thigh	1	1	1
8	9470	Burn of mouth and pharynx	1	2	2
9	965	Poisoning by analgesics, antipyretics, and antirheumatics	3	3	3
10	9663	Poisoning by other and unspecified anticonvulsants	1	3	3
11	967	Poisoning by sedatives and hypnotics	2	5	5
12	9729	Poisoning by agents affecting the cardiovascular system	1	1	1
13	977	Poisoning by unspecified drugs and medicinal substances	2	4	4
14	9858	Toxic effect of other specified metals	1	1	1
15	98989	Toxic effect of other substances, chiefly nonmedicinal	1	1	1
16	99581	Adult physical abuse	2	2	2
17	V6284	Homicidal ideation	1	1	1
18	V6285	Suicidal ideation	1	7	1
19	V715	Observation following alleged rape or seduction	1	1	4
		Subtotal	**26**	**70**	**55**
		133 Beneficiaries with more than 1 diagnosis code			(267)
		76 ER visits with more than 1 diagnosis code		(90)	
		TOTAL	**149**	**587**	**334**

APPENDIX D: CRITICAL INCIDENT DETAILED EXAMPLE

Jane A. Doe was a group home resident with developmental disabilities and a variety of psychiatric disorders, including borderline personality disorder and suicide ideation. One hospital emergency room treated Ms. Doe on 10 separate occasions from May 2013 through May 2014.

According to the medical records of the 10 emergency room visits, Ms. Doe received treatment for ingesting foreign objects during each visit. The records stated that Ms. Doe swallowed batteries, screws, bolts, soda can tabs, plastic beads, a jacket zipper head, and part of a cell phone charger. On one occasion, Ms. Doe required a colonoscopy to extract a screw that she had ingested. Furthermore, hospital staff physically restrained her during some of these emergency room visits because of combative and self-abusive behaviors. The group home reported all of the 10 critical incidents to DDS through the HCSIS, but only 1 of the 10 incidents was reported to DPPC through the 24-hour hotline; this report was submitted by DDS staff. Furthermore, none of these 10 incidents was reported to DPPC by the hospital.

We provided DPPC officials with summaries of Ms. Doe's medical records in March 2015 and further discussed her emergency room visits during a meeting in May 2015. DPPC officials stated that they believed the nine unreported critical incidents should have been reported as incidents with reasonable suspicion of abuse or neglect. The officials expressed concern over the repetitive nature of the incidents and explained that they would review whether there was an omission of care or lack of supervision in these cases and whether Ms. Doe's injuries were preventable. The officials said that they were in the process of reviewing the unreported critical incidents to determine whether additional actions were necessary to protect Ms. Doe from further harm.

Charles D. Baker
Governor

Marylou Sudders
Secretary

Feb. 11, 2016

By Electronic and First Class Mail

Mr. David Lamir
Regional Inspector General for Audit Services
U.S. Department of Health & Human Services
Office of the Inspector General
JFK Federal Building –Room 2425
Boston, MA 02203

Re: Massachusetts Department of Developmental Services Response to Draft Report No.: A-01-14-00008

Dear Mr. Lamir:

The Department hereby responds to the U.S. Department of Health and Human Services, Office of Inspector General's draft report ("the Report") which was forwarded to the Department of Developmental Services ("DDS" or "Department") on January 27, 2016. We appreciate the work that the OIG has done in this review, and appreciate the opportunity to respond to the draft Report.

Massachusetts is a national leader in providing services to individuals with intellectual and developmental disability, and in particular a leader in developing a comprehensive quality assurance system to protect the health and safety of individuals we serve. A key component of that system is our electronic system for the reporting of critical incidents and follow-up actions, referred to as the Home and Community Services Information System ("HCSIS") which Massachusetts implemented in 2006. The HCSIS Incident Reporting System is also instrumental in meeting the "assurances" provided to the Centers for Medicare and Medicaid Services ("CMS") in accordance with its application for approval of the Home and Community Based Services Waivers pursuant to 42 CFR § 441.302. We therefore share your commitment to

protecting the health and welfare of individuals with intellectual and developmental disability who are beneficiaries receiving services.

Massachusetts also has worked for many years in partnership with the Disabled Persons Protection Commission ("DPPC"), the state agency charged pursuant to G.L. ch. 19C with investigating reports of abuse and neglect, to ensure that staff in DDS-funded group homes, and individuals, are trained in the reporting of suspected abuse or mistreatment.

While we strive for 100% compliance in reporting critical incidents and instances of abuse, and agree with portions of the Report that identify areas for improvement, we disagree with the overall characterization in the report that Massachusetts is not "in compliance with federal and state requirements" for incident reporting, and set forth the basis of our disagreement with this finding below. We appreciate in advance your careful consideration of our responses.

DDS Responses to OIG Findings

OIG Finding No. 1: "The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically, the state agency did not ensure that [ ] group homes reported all critical incidents to DDS (15% unreported)" (OIG Report pages *ii*, 4).

DDS Response: The OIG extracted 2,964 emergency room claims from the Massachusetts Medicaid Management Information Systems ("MMIS") for the period from January 2012 through June 2014. The OIG reviewed 769 emergency room claims for 334 Medicaid beneficiaries between the ages of 18 and 59. The OIG further limited their review to 587 hospital emergency room visits for individuals with diagnostic codes of particular injury types. A hospital emergency room visit is one category in the Department's critical incident reporting system for staff to file a critical incident. The OIG finding with respect to the reporting of critical incidents was that "group homes reported 85% of all critical incidents to DDS." (Report at *ii*). OIG's broad finding that DDS failed to comply with Federal waiver and State requirements for reporting critical incidents is unsupported by the scope and duration of the audit period. [1]

While any failure to report should be addressed, the 85% compliance rate does not, as the OIG finding suggests, indicate a failure to comply with federal standards. CMS, the federal agency which overseers the Commonwealth's administration of the Home and Community Based

[1] Reporting of unplanned hospital visits is just one component of the approximately 17 incident categories that providers must report to DDS. OIG's review of just one incident reporting category is insufficient to support a conclusion that DDS has failed to meet its Federal/State incident reporting obligations. DDS reports to CMS on nine separate performance measures within the Health and Welfare waiver assurance – all of which CMS has accepted as acceptable performance measures upon which to base compliance with the overall Health and Welfare assurance. DDS consistently performs above 85% in each of the 9 performance measures. There is no distinct performance measure for unplanned hospital visits, thus OIG's conclusion that DDS does not comply with Federal waiver requirements is not accurate. Finally, DDS's year-by-year review of the 587 unplanned hospitalizations to assess compliance with the requirement to file an incident report indicated 79% compliance for 2012, 84.7% for 2013; and 87% for 2014.

Waiver programs, has indicated that for compliance purposes, "an assurance is not considered met if a performance measure for any sub-assurance stays below 86% for three or more consecutive years regardless of whether a performance improvement project has been implemented unless the measure has had steady improvement over the years and the state and CMS agree that performance is likely to exceed 85% the following year." See CMS Modifications to Quality Measures and Reporting in §1915(c) Home and Community Based Waivers (March 12, 2014).

Further, Massachusetts reviewed the 15% of hospital visits that went unreported through the critical incident system, and found that in at least some of the instances where an incident was not reported, the incident occurred when a resident was with family or otherwise not within the care of group home staff. See DDS Response to Preliminary Findings (June 30, 2015) at p. 2. In these cases, the injury or emergency room visit occurred outside the scope of the group home's reporting requirement, and thus should not be characterized as a failure to report in HCSIS. While the Department shares the OIG's concern about any unreported emergency hospital visits, we believe that the Report's reference to such instances of non-reporting as "clerical errors" is inaccurate to the extent that family members (or other non-group home staff) have not reported an incident, and should be removed from the Report.[2]

OIG Recommendation:

- Work with DDS Staff to develop and provide training for staff of DDS and group homes on how to identify and report critical incidents and reasonable suspicion of abuse or neglect . . . (Report at *ii*)

DDS Response to OIG Recommendation: While DDS disagrees with the characterization of its incident reporting system as not in compliance with federal and state requirements, and with the identification of "clerical errors" as a basis of concern, DDS agrees with the OIG recommendation that Massachusetts redouble efforts to retrain staff on the criteria for reporting critical incidents and has initiated such efforts by sending a reminder to all DDS and group home staff to report critical incidents in accordance with established criteria.

OIG Finding No. 2: "The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically,...the state agency did not ensure that DDS obtained and analyzed data on all critical incidents" (Report pages *i*, 5).

OIG Recommendation: The OIG recommended that the Massachusetts Executive Office of Health and Human Services, Office of Medicaid "work with DDS to develop a data-exchange agreement and related analytical procedures to ensure DDS access to the Medicaid claims data contained in the Massachusetts Medicaid Management information Systems so that it can detect unreported critical incidents" (Report at *ii*).

[2] Family members are not required to report critical incidents.

DDS Response to OIG Recommendation: DDS agrees with this and has taken steps to initiate a match with Medicaid claims data, and will collaborate with the Office of Medicaid to develop appropriate analytics.

OIG Finding No. 3: "The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically,...the state agency did not ensure that appropriate action steps were identified in all incident reports that could prevent similar critical incidents (29% unidentified). . ." (OIG Report at *ii, page 6*).

DDS Response: The OIG "reviewed a 'judgmental' sample of 162 incident reports and determined that 115 (71%) either properly identified action steps to prevent similar critical incidents from happening again or did not warrant an action because of the nature of the situation. However, for the remaining 47 (29%), the OIG "determined that the action steps were not appropriate because they only addressed treating the injury instead of protections for the individual because the group home did not address any action steps in the incident report" (Report at 6-7). The identified reason for the deficiency, according to the OIG, was a lack of training in appropriate actions steps.

After receiving the Report, DDS reviewed the 47 incidents where it was asserted that the action steps were not appropriate. HCSIS incident reports contain a section that requires providers to indicate what immediate steps were taken at the time of and immediately after the incident. In all of the 47 incidents, immediate action was taken to address the incident. The HCSIS report also contains another section that asks the provider to indicate whether any "additional action" steps were taken.

In reviewing whether the incident report should have included "additional steps," DDS found that seven of the 47, or 14.8 %, should have had additional steps taken. Specifically,

- 40 of the 47 incidents did not require any further action beyond the immediate action taken. Of the 40:
    - 25 required no further action based on the nature of incident. As an example, one incident involved an individual who had pneumonia, was seen at the ER, received treatment and then follow up with the individual's PCP.
    - 7 incidents were reported to DPPC for screening and investigation. In these instances, the reporting of the incident to DPPC in effect represents the additional action that needed to be pursued.
    - 8 incidents involved self-injury or peer to peer altercations where arguably additional action could be taken. However, the agency's review of additional materials such as notes in the client record, as well as risk management and behavior plans, indicated that "additional actions" were in fact taken.

- 7 incidents could have involved additional action steps beyond the immediate actions.

OIG Recommendation

- "[W]ork 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" (Report at *ii*).

DDS Response to OIG Recommendation: The OIG determined that 115 of the 162 sample incident reports either properly identified action steps to prevent similar critical incidents from happening again or did not warrant an action because of the nature of the situation. However, DDS disagrees that additional action steps were appropriate in 40 of the remaining 47 critical incidents filed. Nevertheless, DDS agrees that additional training regarding appropriate action steps to prevent the re-occurrence of similar incidents should occur.

OIG Finding No 4: "The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically,…the state agency did not ensure that DDS always reports reasonable suspicions of abuse or neglect to DPPC" (OIG Report at ii, 7-8).

DDS Response: DDS disputes this Finding for several reasons. First, the Report repeatedly describes the standard for reporting suspected abuse as "reasonable suspicion" or "mere suspicion." According to the DPPC's statute, however, G.L. c. 19C, § 1, "mandated reporters" are required to file reports with DPPC whenever, in their professional capacity, they have "reasonable cause to believe that a disabled person is suffering from a reportable condition (i.e. a serious physical or emotional injury resulting from abuse)."[3] DPPC regulations define ***reasonable cause to believe*** 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." See 118 CMR 2.02.[4]

Putting the standard for reporting aside, DDS disagrees with the methodology employed to reach this Finding. A central finding of OIG's audit, and one on which multiple subsequent findings were based, is that DDS/vendor group homes failed to report up to 102 incidents to DPPC in which there was reasonable cause to believe that abuse or neglect was present. To arrive at this finding, OIG reviewed emergency room records and claims data of 334 individuals who had 587

[3] Abuse, as defined in DPPC regulations, requires an act or omission of a caretaker and is distinguished from acts of self-injury and other instances in which an injury may be incurred by a person with a disability during appropriate care.

[4] OIG's assertion, adopted from the DPPC website, that reporting obligations require "only a mere suspicion" that abuse/neglect was committed (see http://www.mass.gov/dppc/abuse-report/what-is-reportable.html), oversimplifies and misconstrues the legal standard for mandated reporting. DPPC's Advisory Memorandum No.: Legal-406 specifies that "the obligation of the mandated reporter . . . is triggered when the facts known to the mandated reporter would ". . . create a suspicion of . . . abuse . . ." to a reasonable person. In other words, if a reasonable person had known the same facts, these facts would be sufficient to create the suspicion that abuse has occurred." See DPPC Legal Advisory Memorandum No.: Legal-406 (rev. April 30, 2004). Consideration of all the facts *known to the mandated reporter* who directly observed or responded to the incident/injury is critical to a determination of whether a mandated reporter has complied with their reporting obligations.

ER visits that OIG considered indicative of abuse/neglect. OIG audit staff then prepared two-to-five sentence summaries of the ER records and forwarded these to staff at the DPPC who were asked to provide an opinion as to whether DDS/vendor mandated reporters should have reported the injury to DPPC. DPPC's analysis consisted solely of a review of OIG's brief summaries describing the 515 injuries/ER visits that were not reported to DPPC (72 of the 587 ER visits had been reported). Per the OIG, following its review, the DPPC determined that 102 (20%) should have been reported to DPPC; 239 (46%) should not have been reported; and 173 (34%) lacked sufficient information to offer an opinion. As acknowledged by the DPPC, the limited information made available from which to draw the conclusion, was insufficient to support the finding. [5] The process utilized by OIG, in which a single DPPC staff reviewed brief summaries with no further information, is insufficient to appropriately assess whether DDS/vendor employees were fulfilling their obligation(s) as mandated reporters. Whether reasonable cause exists is dependent on the facts in a given case; all relevant information must be considered, including the circumstances of the injury, the medical or behavioral characteristics of the disabled individual, and the plans in place to treat and protect the individual from harm. None of this information was available to DPPC during its review. The OIG's conclusion, therefore, rests solely on a one-person review of two-to-five sentence summaries with no access to other available information. The methodology employed by OIG is insufficient to support such a conclusory finding that DDS/vendors have failed to safeguard group home residents.

However, even assuming that the methodology employed by the OIG to reach DPPC's conclusion was reliable, which DDS contests, the result of the analysis conducted by DPPC was that 20% of the total incidents should have been reported to DPPC, not 58%. Nevertheless, in its draft Report, the OIG compared the total number of unreported cases (102) to the number that DPPC determined should have been reported, i.e. applied a denominator of those incidents where DPPC had determined that there was "reasonable cause" to report. This was inconsistent with calculations in other sections of the report which compared the number reported to DPPC with the total number of incidents, and resulted in the OIG finding of 58% un-reported incidents of abuse.

Massachusetts urges the OIG to employ the appropriate denominator of the 587 critical incidents reviewed (and not ignore the 73 incidents that were reported to DPPC). The result would be that of the 587 incidents reviewed, 17% of the incidents met reasonable cause to report in DPPC's review and were not reported. At minimum, the denominator of the 514 incidents reviewed by DPPC should be used.

Finally, DDS notes that per the OIG Report (OIG Report at 8), DPPC has begun to review the 102 critical incidents that it found should have been reported. Based upon its review to date, DPPC has opened investigations on only 6 of the 20 incidents reviewed. This finding underscores the fundamental flaw in the audit methodology, indicating that when further

[5] During DDS's meeting with DPPC to review the 102 incidents, and in subsequent communications, DPPC acknowledged that the information reviewed on OIG's summaries was limited and did not provide all necessary information concerning the circumstances surrounding an injury/ER visit. DPPC advised DDS that this qualification was shared with OIG when the opinion that these 102 incidents should have been reported was provided.

information is available and reviewed by the agency responsible for making the determination of whether there is reasonable cause or suspicion to believe that abuse may have occurred, a much smaller percentage of incidents should have been reported.

OIG Recommendation: the Massachusetts Executive Office of Health and Human Services, Office of Medicaid should 1) "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," and 2) "coordinate with DDS and DPPC to ensure any potential cases of abuse and neglect that are identified as a result of new analytical procedures are investigated as needed."

DDS Response to OIG Recommendation: Although DDS disagrees with the characterization of the OIG's finding with respect to reporting of abuse and neglect, DDS agrees that continued ongoing collaboration with the DPPC will be undertaken to clarify policies and procedures so that they more clearly define abuse or neglect reporting criteria.

Additional OIG Finding:
The State agency did not adequately safeguard 146 out of 334 developmentally disabled Medicaid beneficiaries because the DDS system of reporting and monitoring critical incidents did not work as expected" (Report at *ii*).

DDS Response: This conclusion is premised upon the OIG's conclusion that 146 Medicaid beneficiaries did not have an incident reported to either DPPC or DDS' HCSIS system, did not have appropriate action steps identified in the incident reports, or both. DDS' review of this data determined that the number of unduplicated individuals who had an incident that was not reported in HCSIS or to DPPC was 75, which represents a much lower percentage (22%). Furthermore, DDS disagrees with the conclusion that the absence of an incident report represents a failure to safeguard an individual since other documentation, e.g. progress notes, behavior plans and risk management plans often demonstrated that action was in-fact taken. Additionally, the reporting of unplanned hospital visits via the HCSIS system represents just one reporting category in the Department's comprehensive incident reporting system, which itself is just one component of the Department's multi-tiered quality assurance system. Indicative of DDS' multi-tiered system is the fact that of the 102 incidents DPPC concluded should have been reported, 89 had a corresponding incident report completed in the HCSIS system where it was reviewed by multiple layers of DDS staff and demonstrates that DDS/vendor staff were cognizant of the incident and were implementing actions to safeguard Department clients. While DDS arrived at a much lower percentage out of the 334, DDS strives for 100% and as stated previously will take appropriate and on-going action(s) to assure that all incidents of unplanned hospital visits get reported by providers in the HCSIS system.

For the reasons described above, the Department of Developmental Services respectfully requests that the OIG make the following changes to the draft Report:

1. Report Title: Change the title of the Report to: "Massachusetts Did Not Report All Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries" or "Massachusetts To Improve Critical Incident Reporting For Incidents Involving

Developmentally Disabled Medicaid Beneficiaries" to more accurately reflect state of compliance;

2. Page *i*: Delete the last sentence: "The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries." For the reasons discussed above, this sentence should be revised to more accurately state: "The State agency did not report all critical incidents involving developmentally disabled Medicaid beneficiaries."

3. Page *ii*, bullet no. 3, Pages *3*, and *6*: Delete "(29 percent unidentified)" and revise findings to eliminate reference to 29% rate of deficient action steps;

4. Page *ii*, bullet no. 4, Page *4*: Delete "(58 percent unreported)" and revise findings to eliminate reference to 58% rate of unreported suspected abuse or neglect;

5. Page *ii*, First full paragraph, first sentence, Page 11: Delete "Federal waiver and" as well as "due to clerical errors"; and

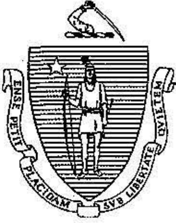
6. Page *ii*, Second full paragraph, Pages 4 and 11: Delete "The State agency did not adequately safeguard 146 out of 334 developmentally disabled Medicaid beneficiaries because the DDS system of reporting and monitoring critical incidents did not work as expected."

Thank you again for your consideration of the Department's responses to your draft report. Department staff are available any time to discuss any questions you may have regarding the Department's responses or should you require additional information.

Very truly yours,

/s/ Elin M. Howe
Elin M. Howe
Commissioner

cc: Joan Senatore, Director of Compliance
MA Office of the Secretary of Health & Human Services



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May 11, 2016

Mr. David Lamir
Regional Inspector General for Audit Services
U.S. Department of Health & Human Services
Office of the Inspector General
JFK Federal Building –Room 2425
Boston, MA 02203

Re: Massachusetts Executive Office of Health and Human Services Response to OIG Report No.: A-01-14-00008

Dear Mr. Lamir:

The Massachusetts Executive Office of Health and Human Services (EOHHS) is writing to respond to the U.S. Department of Health and Human Services, Office of Inspector General's draft report No. A-01-14-00008 ("the Draft Report") dated April 2016. The Draft Report pertains to an OIG review of whether EOHHS complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries residing in group homes from January 2012 through June 2014. We welcome the opportunity to respond to the Draft Report, and greatly appreciate your efforts and willingness to accept input from both EOHHS and its Department of Developmental Services (DDS) in preparing the final report.

Massachusetts is a leader in providing services to individuals with intellectual and developmental disabilities including those who are Medicaid beneficiaries. EOHHS and its agency DDS work closely and collaboratively to ensure quality Home and Community Based Services (HCBS) to this population, and do so with the utmost attention to and concern for the health and welfare of individuals with intellectual and developmental disability receiving services. DDS is recognized as a leader in developing a comprehensive quality assurance system to protect the health and safety of individuals we serve, and EOHHS has leveraged DDS's principles and approaches for the benefit of HCBS populations. Additionally, EOHHS and its agency, DDS have a longstanding relationship with the Disabled Persons Protection Commission ("DPPC"), the

independent state agency charged pursuant to G.L. ch. 19C with investigating allegations of abuse and neglect, to ensure that DDS staff and staff in DDS-funded group homes are trained in reporting suspected abuse or mistreatment.

Massachusetts has an overarching commitment to protecting the health and welfare of individuals with intellectual and developmental disabilities who participate in and receive services through the HCBS waivers.

EOHHS plans to implement the OIG's recommendations for improvement. However, we respectfully disagree with aspects of the methodology OIG used to determine certain findings and the broad characterization in the Draft Report that Massachusetts is not "in compliance with federal and state requirements" for incident reporting. DDS conducted a thorough review of the methodologies used in the Draft Report and expressed concerns about OIG's methodologies. Accordingly, EOHHS concurs with this assessment that certain methodologies used by OIG overstate the level of noncompliance with federal and state requirements for reporting of critical incidents involving developmentally disabled Medicaid beneficiaries. For this reason, EOHHS requests that the OIG revise the title of the report to a more accurate title, such as "Massachusetts Did Not Report All Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries."

Notwithstanding these concerns, EOHHS is committed to continuous quality improvement and will undertake all of the recommendations in the Draft Report.

EOHHS Responses to OIG Recommendations:

OIG Finding No. 1: "The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically, the State agency did not ensure that group homes reported all critical incidents to DDS (15 percent unreported)" (OIG Report pages *ii*, 4).

OIG Recommendation 1: The OIG recommends that EOHHS 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 suspicion of abuse or neglect.

EOHHS Response to OIG Recommendation 1:
EOHHS agrees with this recommendation. While EOHHS agrees with the recommendation, EOHHS ascertains that the OIG's characterization in OIG Finding 1 that 15% of critical incidents are unreported is inaccurate. The OIG reviewed only certain types of emergency room visits to see if critical incidents were reported. While it is accurate to say that 15% of emergency room visits identified in the sample for the period reviewed were not properly reported as critical incidents, it is inaccurate to extrapolate that finding to conclude that 15% of **all** types of critical incidents were not properly reported.

Additionally, EOHHS does not concur with the OIG's broad conclusion in Finding 1 that Massachusetts was not in compliance with federal and state requirements for critical incidents, as this implies that during the period reviewed, the standard was 100% compliance. During the audit period, CMS calculated the compliance level as the sum of the percentage actually in compliance added to the percentage for which appropriate remediation actions were taken. Current CMS guidance, issued in March of 2014, sets a threshold of 85 percent or greater for compliance, or not less than 85 percent for three consecutive years for noncompliance. Although this standard was not in effect during the full audit period, in the absence of any alternative guidance at the time, the current CMS standard is the best indication of federal expectations. We point this out in order to clarify federal standards; however we strive for the highest possible level of compliance in the interest of the health and safety of the individuals we serve.

Notwithstanding this disagreement regarding OIG Finding 1, EOHHS agrees with OIG Recommendation 1, as EOHHS believes that efforts to develop and provide training for DDS and group home staff on the identification and reporting of critical incidents is valuable. EOHHS is committed to continuous improvement in the quality of its critical incident reporting system. In line with this, several advisories have already been sent out to all providers reminding them of their reporting responsibilities. In addition, a refresher training and webinar are in development and will be released in the near future.

<u>OIG Finding No. 2:</u> "The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically,...the State agency did not ensure that DDS obtained and analyzed data on all critical incidents" (Report pages *i*, 5).

<u>OIG Recommendation 2</u>: The OIG recommends that the Massachusetts Executive Office of Health and Human Services, Office of Medicaid "work with DDS to develop a data-exchange agreement and related analytical procedures to ensure DDS access to the Medicaid claims data contained in the Massachusetts Medicaid Management information Systems so that it can detect unreported critical incidents."

<u>EOHHS Response to OIG Recommendation 2:</u>
EOHHS agrees with this recommendation. Sharing of data, such as the OIG recommends, is a valuable and important check and balance to ensure that critical incidents related to unplanned emergency department use are properly reported. EOHHS and DDS have executed a data-sharing agreement and are engaged in collaborative work to test procedures and create a process for on-going exchange of information, including Medicaid claims data, as well as to develop appropriate analytics.

<u>OIG Finding No. 3:</u> "The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically,...the State agency did not ensure that appropriate action steps were identified in all incident reports that could prevent similar critical incidents (29 percent unidentified)..." (OIG Report at *ii, page 6*).

OIG Recommendation 3: The OIG recommends that the Massachusetts Executive Office of Health and Human Services, Office of Medicaid "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."

EOHHS Response to OIG Recommendation 3:
EOHHS agrees with this recommendation. While EOHHS agrees with the recommendation, EOHHS disagrees with the finding that 47 of the 162 (29%) critical incidents reviewed did not document appropriate action steps. DDS conducted a review of these 47 critical incidents and found that only 7 of them, or 4.3% of the 162 critical incidents referenced by OIG, did not adequately document action steps.

While EOHHS disagrees with the finding, EOHHS agrees that additional training on documenting appropriate action steps to prevent the re-occurrence of similar incidents is a valuable endeavor that should occur. EOHHS is committed to continuous improvement in the quality of its critical incident reporting, including documentation of action steps. In line with this, as referenced in EOHHS response to OIG Recommendation #1, above, DDS has recently sent out advisories to DDS staff and providers and will incorporate this information into a Webinar and training materials under development for DDS staff and providers.

OIG Finding No 4: "The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically,...the State agency did not ensure that DDS always reported reasonable suspicions of abuse or neglect to DPPC (59 percent unreported)" (OIG Report at ii, 7-8).

OIG Recommendation 4: The Massachusetts Executive Office of Health and Human Services, Office of Medicaid should "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."

EOHHS Response to OIG Recommendation 4:
EOHHS agrees with this recommendation. While EOHHS agrees with the recommendation, EOHHS strongly disagrees with the methodology utilized in OIG Finding 4 and believes that the methodology exaggerated OIG's findings of noncompliance. Specifically, EOHHS disagrees with the methodological approach in which OIG audit staff drafted two to five sentence summaries of ER records and then had DPPC staff determine whether the summaries constituted incidents that should have been reported. EOHHS does not believe this is a sound methodology for determining whether an individual on the ground at the time of an incident would have developed—from the totality of information available to them—a reasonable suspicion of abuse or neglect such that a report should have been made to DPPC. Notably, at the time of the audit, DPPC expressed that 2-5 sentence summaries were insufficient to base any conclusions but proceeded with the review at the OIG's request. DPPC noted that this was not an approach they had input into and that they "rendered an opinion based upon limited

information and not through its normal intake process" (see attached letter from DPPC to Commissioner Howe). Additionally, subsequent to the audit, DPPC requested the full incident reports from DDS; based on a review of all the reports, DPPC opened **a total of eight (8) investigations out of the 102 originally identified** as possibly appropriate for investigation. The findings of the subsequent review by DPPC underscore the likelihood that the majority of the 102 incidents may not have risen to the level in which an individual on the ground would have developed a reasonable suspicion of abuse or neglect from the totality of information available to them.[1]

Due to the same methodological concerns, EOHHS also disagrees with the OIG's calculation used to determine that there was a total of 58% unreported incidents. Specifically, EOHHS ascertains that the calculation should be based on the total number of unreported incidents (102) over a denominator 'total number of reviewed incidents' (587), rather than a denominator 'total number of incidents that DPPC determined should have been reported based on OIG created summaries' (175). **The result would be that of the 587 incidents reviewed, 17% of the incidents reviewed met a reasonable cause to report, but were not reported, rather than the OIG finding of 58% unreported incidents based on OIG created summaries.** In furtherance of this position, the Center for Developmental Disabilities Evaluation and Research at the University of Massachusetts Medical School, an entity independent of DDS or EOHHS, confirmed that the calculation proposed by DDS, in which the denominator is 'total number of reviewed incidents' would be a more valid means for determining level of compliance. Ultimately, EOHHS believes that the methodology used, combined with the manner in which overall compliance was calculated, resulted in an inaccurate finding that amplifies the level of noncompliance.

Notwithstanding EOHHS' disagreement with the methodology and calculation used in OIG Finding 4, as noted above, EOHHS agrees with the OIG's Recommendation 4 and will continue to collaborate with DDS on its policies and procedures, and in particular to update policies and procedures so that they clearly define and provide examples of potential abuse or neglect that must be reported. EOHHS is committed to continuous improvement in the quality and utility of its policies and procedures. This work is on-going.

OIG Overall Recommendation: The Massachusetts Executive Office of Health and Human Services, Office of Medicaid should "coordinate with DDS and DPPC to ensure any potential cases of abuse and neglect that are identified as a result of new analytical procedures are investigated as needed."

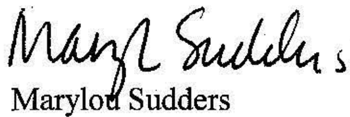
EOHHS Response to OIG Overall Recommendation:
EOHHS agrees with the overall recommendation. Continued ongoing collaboration with the DPPC is a valuable endeavor "to ensure any potential cases of abuse and neglect that

[1] As reflected in the Draft Report (p.16), and as represented by DDS when it provided its comments to the OIG in February 2016, at the time of those comments DPPC had opened investigations on 6 of the 20 incidents that it had reviewed as of that date. Since that time, DPPC has reviewed all 102 unreported incidents and opened investigations on only 8 total.

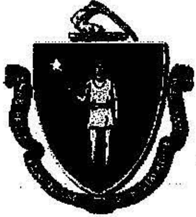
are identified as a result of new analytical procedures are investigated as needed." In line with this belief, EOHHS and DDS have already initiated additional collaboration with DPPC. However, we respectfully wish to restate that EOHHS disagrees with the characterization of the OIG's findings with respect to overall reporting of abuse and neglect and certain methodologies that were used to reach those findings.

In summary, EOHHS shares OIG's commitment to improving public systems that serve the most vulnerable of our populations. Further, EOHHS reiterates its commitment to protecting the health and welfare of individuals with intellectual and developmental disability who participate in and receive services through the HCBS waivers. Thank you for the opportunity to provide input to this Draft Report.

Sincerely,



Marylou Sudders



The Commonwealth of Massachusetts

Disabled Persons Protection Commission

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Via Email

May 10, 2016

Elin Howe
Commissioner
Department of Developmental Services
500 Harrison Avenue
Boston, MA 02118

Re: OIG Draft Audit Report No.: A-01-14-00008

Dear Commissioner Howe:

On behalf of the Disabled Persons Protection Commission ("DPPC"), I am submitting this statement in response to the recommendations made in a draft audit report regarding the recent audit of the Department of Developmental Services ("DDS") critical incident reporting, conducted by the Department of Health and Human Services Office of Inspector General ("OIG"). In addition to expressing DPPC's commitment to working collaboratively with DDS to address some of the recommendations from the OIG audit with regard to reporting requirements, the DPPC would also like to share its assessment of DDS's past and present commitment to the reporting of allegations of abuse of individuals with disabilities in the Commonwealth.

As to DDS's commitment to serving persons with disabilities, I can say that since I assumed leadership of the DPPC over 16 years ago, the DPPC and DDS have fostered and maintained a close and collaborative relationship. DDS and DPPC have a long history of working together successfully and cooperatively to the advantage of the individuals served by DDS and all persons with disabilities. DDS has been a proactive partner in aiding the DPPC in its mission of educating and training mandated reporters of their reporting requirements under M.G.L c. 19C. DDS has been an invaluable collaborator in the Building Partnerships for the Protection of Persons with Disabilities Initiative ("BPI"), a multidisciplinary approach to addressing crimes and abuse against adults with disabilities, which serves as a national model. Much of the BPI's

training and outreach would not be possible without the assistance of DDS, which has volunteered its resources, including staff, facilities, and funds, in support of training and outreach efforts. These training and outreach efforts, have led to substantial increases in reports to the DPPC. The DPPC is confident that this tremendous increase in reporting is based, in no small part, upon its partnership with DDS. For example, between Fiscal Year ("FY") 1994 and FY 2014, the DPPC saw a 173% increase in abuse reports.[1] In FY 2015 alone, the DPPC and its partners have trained 1,018 direct care staff, 858 persons with disabilities, 840 law enforcement officers, and 169 medical personnel.

Pursuant to Massachusetts General Laws Chapter 19C, mandated reporters are required to notify the DPPC upon becoming aware of a reportable condition. A reportable condition is a serious physical or serious emotional injury incurred by a person with a disability and for which there is reasonable suspicion to believe resulted from the act or omission of a caretaker. 118 CMR 2.02. This reporting requirement is inherently subjective and dependent upon the reporter's assessment of the facts known to him or her, including his/her knowledge of the individual with a disability, the nature of the injury, and the circumstances surrounding the manner in which it was incurred, *i.e.*, whether there was reasonable suspicion that the injury resulted from the abusive act or omission of a caretaker.

As you know, the DPPC served an ancillary role in the OIG's audit, reviewing certain data provided by the OIG to render an opinion regarding whether an alleged incident of abuse or neglect should have been reported to the DPPC. DPPC did not provide input regarding the methodology used to assess compliance. However, upon request, a DPPC staff conducted a review with the limitations of the review shared. Assessing abuse allegations that may have occurred years ago is inherently challenging. It is important to note that DPPC rendered an opinion based upon limited information, and not through its normal intake process, which process incorporates the reporter's suspicion with regard to whether the alleged injury resulted from an abusive act or omission of a caretaker. Recognizing this, it is possible that in some of these instances, an accident for example, the mandated reporter did not report the incident to the DPPC because the reporter did not suspect abuse.

The DPPC is aware that as a result of the audit, it was recommended that DDS collaborate with DPPC to clarify policies and procedures so that they more clearly define abuse or neglect reporting criteria, and to collaborate on the development and presentation of training for mandated reports regarding their responsibilities for reporting abuse. This is something that DDS and DPPC have worked on together for many years, but as with any process dependent on human judgment, it will never be perfect. There is always more education and training that needs to be done, and more efforts to be put forth to ensure that the individuals trained demonstrate understanding of their requirements. The work of communicating standards is never done. To that end, DDS and DPPC have already scheduled a meeting to begin the process of addressing these issues.

The DPPC will continue to partner with DDS to improve understanding of mandated reporting requirements for both the DDS community and particularly for medical professionals in hospitals. I know that DDS shares this sentiment and commitment to strengthening our

[1] In FY 1994 the DPPC received 3,366 reports. That number increased to 9,108 reports in FY 2014.

overlapping operations as we continue to work together towards our shared mission of protecting individuals with disabilities in the Commonwealth. While I recognize the audit's finding, in the sense that more can be done to ensure compliance with reporting requirements, I appreciate the efforts that DDS has put forth to assist the DPPC in navigating a complicated system which is dependent upon the vigilance of many.

As an independent agency in the Commonwealth of Massachusetts, the DPPC appreciates any opportunity to benefit from an external review process which seeks to bring attention to the needs of persons with disabilities in the Commonwealth. Education and training with regard to mandated reporting requirements is a critical piece to improving protection of persons with disabilities. As the agency responsible for investigation and remediation of instances of abuse and neglect for persons with disabilities between the ages of 18 and 59, the DPPC is committed to working with DDS, as it has for many years, to provide for the enhanced protection of persons with disabilities.

Very truly yours,

Nancy A. Alterio
Executive Director