Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SOUTH CAROLINA DID NOT FULLY COMPLY WITH REQUIREMENTS FOR REPORTING AND MONITORING CRITICAL EVENTS INVOLVING MEDICAID BENEFICIARIES WITH DEVELOPMENTAL DISABILITIES

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Inspector General

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Office of Inspector General

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Report in Brief
Date: April 2022
Report No. A-04-18-07078

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

South Carolina Did Not Fully Comply With Requirements for Reporting and Monitoring Critical Events Involving Medicaid Beneficiaries With Developmental Disabilities

Why OIG Did This Audit

We have performed audits in several States in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes. This request was made in response to nationwide media coverage of deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors.

Our objective was to determine whether South Carolina complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical events involving Medicaid beneficiaries with developmental disabilities residing in community-based settings.

How OIG Did This Audit

We reviewed South Carolina's compliance with Intellectually Disabled and Related Disabilities (IDRD) waiver requirements for reporting and monitoring critical events during our audit period. South Carolina provided comprehensive support services to 8,156 individuals with developmental disabilities who were enrolled in the IDRD waiver program. We limited our review to 7,161 beneficiaries who were at least 18 years old as of January 1, 2015.

What OIG Found

South Carolina did not fully comply with requirements for reporting and monitoring critical events involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Specifically, South Carolina did not ensure that providers: (1) reported all critical incidents, (2) reported within 24 hours or the next business day all critical events, or (3) always submitted the results of their internal reviews within 10 working days. The detailed findings are listed in the body of the report.

What OIG Recommends and South Carolina Comments

We recommend that South Carolina work with the Department of Disabilities and Special Needs (DDSN) to: (1) ensure that providers follow the reporting requirements for critical events, (2) provide training to providers on recognizing and reporting critical incidents according to reporting requirements, (3) perform analytical procedures such as data matches on Medicaid claims data to identify any unreported critical incidents and investigate as needed, and (4) ensure that providers submit all incident reports to DDSN through the Incident Management System within 24 hours of an incident or the next business day. The detailed recommendations are listed in the body of the report.

In written comments on our draft report, South Carolina concurred with our recommendations and described the corrective actions that it has taken or plans to take to address them. These actions include but are not limited to: (1) revising its policies, procedures, and protocols to provide assurance that incidents will be reported as required; (2) continuing to strengthen and reinforce training with contracted provider agencies to identify and prevent allegations of abuse, neglect, and exploitation and critical incidents; and (3) working with data analytics staff to develop a dashboard of claims data to inform incident detection and reporting efforts.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

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

In South Carolina, individuals with intellectual and developmental disabilities may reside in community-based settings such as community training homes (CTHs), supervised or supported living apartments, or community residential care facilities.

OBJECTIVE

Our objective was to determine whether the South Carolina Department of Health and Human Services (State agency) complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical events involving Medicaid beneficiaries with developmental disabilities residing in community-based settings.[2]

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 (Disabilities Act),[3] "developmental disability" means a severe, chronic disability of an individual attributable to a mental or physical impairment or a combination of both that is evident before age 22 and likely to continue indefinitely. The disability results in substantial limitations in three or more major life areas including: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

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

[1] See Appendix B for a list of related work.

[2] Critical events include: critical incidents; incidents of abuse, neglect, or exploitation (ANE); and deaths. A critical incident is an unusual, unfavorable occurrence that: (1) is not consistent with routine operations; (2) has harmful or otherwise negative effects involving people with disabilities, employees, or property; and (3) occurs in a South Carolina Department of Disabilities and Special Needs (DDSN) Regional Center, in a Disabilities and Special Needs board facility, in other service provider facilities, or during the provision of waiver case management services.

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

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

Medicaid Home and Community-Based Services Waiver

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

The South Carolina Department of Disabilities and Special Needs (DDSN) operates three HCBS waiver programs on behalf of the State agency.[4] However, we limited our audit to the Intellectually Disabled and Related Disabilities (IDRD) waiver.

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

Critical Event Reporting

The HCBS waiver says that the State agency must specify types of critical events that must be reported for review and followup action by an appropriate authority (HCBS waiver, Appendix G-1(b)). DDSN has a web-based Incident Management System (IMS) for reviewing the critical events that providers report. The IMS contains three different reporting modules: critical incident; abuse, neglect, and exploitation (ANE); and death.[5]

[4] The State agency and DDSN have a Memorandum of Agreement (MOA) to ensure an understanding between agencies regarding the operation and administration of the Intellectually Disabled and Related Disabilities waiver. The MOA specifies that DDSN will operate the waiver under the oversight of the State agency. Furthermore, the State agency and DDSN have a waiver service contract to outline the requirements and responsibilities for the provision of waiver services by DDSN (HCBS waiver, Appendix A: Waiver Administration and Operation).

[5] DDSN Directive 100-09-DD states that allegations of ANE are not considered critical incidents.

Critical Incident Reporting

The HCBS waiver and DDSN Directive 100-09-DD define a critical incident as an unusual, unfavorable occurrence that: (1) is not consistent with routine operations; (2) has harmful or otherwise negative effects involving people with disabilities, employees, or property; and (3) occurs in a DDSN Regional Center, in a Disabilities and Special Needs board facility, in other service provider facilities, or during the provision of waiver case management services. In addition to the HCBS waiver, DDSN Directive 100-09-DD addresses critical incident reporting.

Providers are required to report a critical incident to DDSN using the IMS within 24 hours or the next business day of the incident. A provider must then complete an internal review of the incident and submit it to DDSN within 10 working days. DDSN policies require the provider, upon completion of the internal review, to notify the participant or responsible party or both of the outcome of the review.

DDSN provides 28 categories from which providers can select when reporting critical incidents. Table 1 summarizes the number of reported critical incidents by category from January 1, 2015, through June 30, 2017.

Table 1: Number of Critical Incidents by Category Reported in the Incident Management System From January 1, 2015, Through June 30, 2017

Critical Incident Category	Number of Critical Incidents
Major Medical	736
Unplanned Hospital Admission Totaling Three or More Overnight Stays	600
Other	324
Law Enforcement	298
Aggression or Assault	292
Injury	286
Motor Vehicle	175
Fall	173
Suicidal Ideation	146
Assault With Injury	130
Fire	118
Elopement	110
Choking	96
Aggression	81
Sexual Assault or Aggression	75
Criminal Arrest	75
Communicable Disease	75

Critical Incident Category	Number of Critical Incidents
Assault Without Injury	61
Accident	55
Theft or Misuse of Money	51
Theft or Misuse of Property	47
Medication Error	46
Property Damage (Natural or Unusual)	44
Firearm, Weapon, or Explosive	24
Illegal Substance	21
Restraint	21
Malicious Use of Profane or Disrespectful Language to Consumer	16
Medical Treatment (Prescribed or Recommended) Not Followed	11
Total	**4,187**

Abuse, Neglect, and Exploitation Reporting

Providers are required to report an allegation of ANE to DDSN using the IMS within 24 hours of an incident or the next business day. Furthermore, mandated reporters, which include providers, have the duty to report an allegation of ANE to the South Carolina Department of Social Services' (DSS's) Adult Protective Services (APS) and State or local law enforcement within 24 hours of an incident or the next business day.[6] DDSN works closely with DSS and local law enforcement regarding critical incidents and ANE allegations, as applicable.

Providers reported five types of ANE incidents to DDSN. Table 2 (on the following page) summarizes by ANE type the number of incidents reported from January 1, 2015, through June 30, 2017.

[6] Mandated reporters are defined as professional staff, employees, and volunteer or contracted provider agencies having a legal responsibility under State law to report suspected ANE to State investigative agencies.

Table 2: Number of Incidents of ANE by Type Reported in the Incident Management System From January 1, 2015, Through June 30, 2017

ANE Type	Number of Incidents
Physical Abuse	539
Neglect	297
Psychological Abuse	213
Exploitation	85
Sexual Abuse	41
Total	**1,175***

* Providers categorized some incidents of ANE as more than one type. However, providers reported exactly 1,098 unique ANE incidents.

DDSN Directive 534-02-DD addresses the procedure for preventing and reporting ANE incidents. The directive establishes the reporting requirements under State law and also identifies DDSN's and its contracted provider agencies' legal responsibilities for reporting ANE incidents.

Death Reporting

Providers must report the death of an individual using the IMS as soon as possible but no later than 24 hours after the incident or the next business day. DDSN Directive 505-02-DD addresses the death or impending death of a person receiving services from DDSN. During our audit period, 137 beneficiaries died.

HOW WE CONDUCTED THIS AUDIT

We reviewed the State agency's compliance with IDRD waiver requirements for reporting and monitoring critical events during our audit period. The State agency provided comprehensive support services from January 1, 2015, through June 30, 2017 (audit period), to 8,156 individuals with developmental disabilities who were enrolled in the IDRD waiver program. We limited our review to the 7,161 beneficiaries who were at least 18 years old at the beginning of our audit period.

We extracted from the South Carolina Medicaid Management Information System (MMIS) the claim records for all emergency room visits that the State agency paid on behalf of Medicaid beneficiaries with developmental disabilities who were at least 18 years old residing in community-based settings during our audit period. We determined that 1,019 emergency room visits met the State agency's definition of a "critical incident." We then compared these 1,019 emergency room visits to the list of critical events in the IMS to determine whether providers reported the emergency room visits as critical incidents to the State agency.

We also reviewed a sample of 326 critical events that providers submitted to DDSN through the IMS to determine whether they submitted internal reviews and reports in a timely manner.

This sample included all of the critical events from the five providers that had the most critical events during our audit period.

In addition, we reviewed 137 beneficiary deaths to determine whether:

- providers reported deaths to the South Carolina Law Enforcement Division (SLED) and
- any deaths were potentially due to neglect.

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

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

FINDINGS

The State agency did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical events involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Specifically, the State agency did not ensure that:

- providers reported all critical incidents,
- providers reported within 24 hours or the next business day all critical events,
- providers always submitted the results of their internal reviews within 10 working days,
- one beneficiary death was reported to SLED, or
- it developed and implemented strategies to prevent future incidents of neglect that resulted in beneficiary deaths.

These issues occurred because:

- Providers did not always report an incident, nor did DDSN have a process, such as performing analytical procedures on Medicaid claims data, to determine whether any critical incidents remained unreported.

- Some staff members either were confused about which entity they should first contact to report an incident or might not have reported an incident to supervisors after making a report to the State investigative agency, which could delay the submission of a report through the IMS.

- Some staff members experienced delays in obtaining the information needed to complete their internal reviews.

- The DDSN Incident Management Coordinator (IMC) determined that SLED had no record in its database concerning the beneficiary's death, even though the provider stated in the initial death report that it had notified SLED of the death.

- DDSN took no further measures to develop and implement strategies and policies to prevent incidents of neglect that resulted in beneficiary deaths.

As a result, the State agency did not fulfill participant safeguard assurances that it provided to CMS in the HCBS waiver. Specifically, the State agency did not demonstrate that it had an adequate system to ensure the health, welfare, and safety of the Medicaid beneficiaries with developmental disabilities covered by the Medicaid waiver.

THE STATE AGENCY DID NOT ENSURE THAT PROVIDERS REPORTED ALL CRITICAL INCIDENTS

Providers must report all critical incidents, except vehicle accidents and vandalism, using the IMS within 24 hours of the incident or the next business day. DDSN Directive 100-09-DD directs providers on determining whether a particular event should be considered a critical incident. It states, "when in doubt, then report."

Some providers did not report to DDSN all critical incidents involving beneficiaries with developmental disabilities. Specifically, of the 1,019 emergency room visits with a primary diagnosis code that met South Carolina's definition of a critical incident, providers reported 737 of the incidents (72 percent) but did not report the remaining 282 (28 percent) to DDSN.

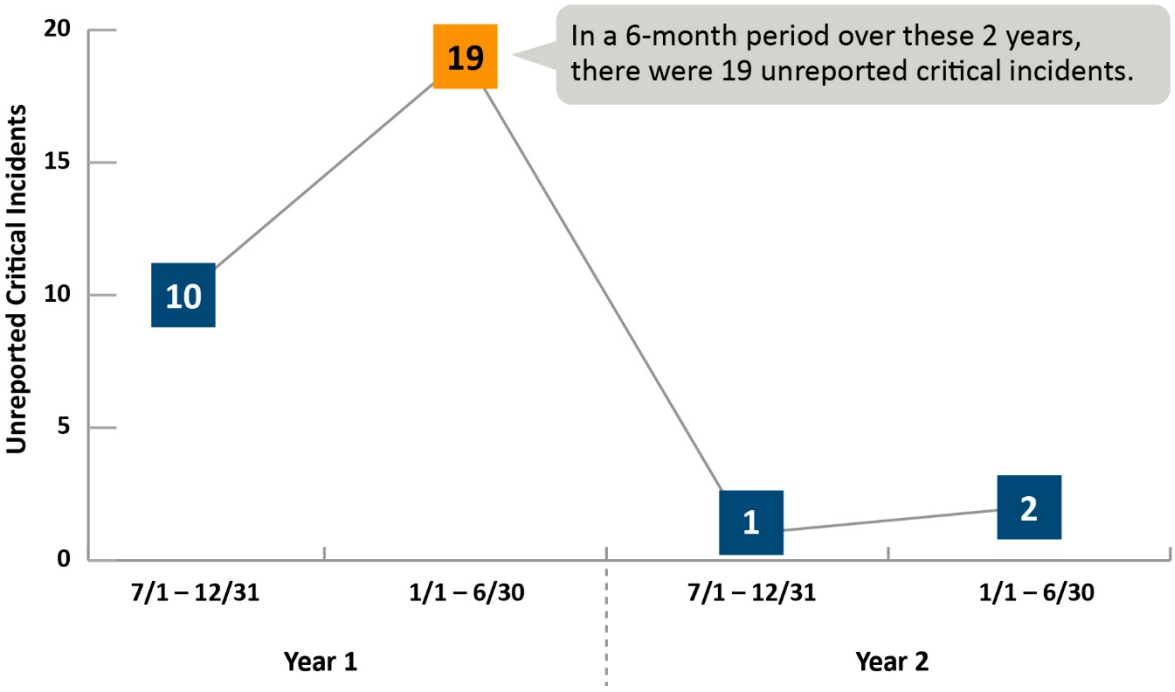
State agency officials said that providers did not recognize incidents that met the reporting requirement and did not report such incidents. In addition, DDSN did not have a process, such as performing analytical procedures on Medicaid claims data (for example, data matches between Medicaid claims and critical incident reports), to determine whether any critical incidents remained unreported.

When providers do not report critical incidents, DDSN cannot ensure that proper steps are taken to protect the health and safety of Medicaid beneficiaries with developmental disabilities.

Example of Critical Incidents Not Reported by Providers

Providers did not report to DDSN critical incidents involving a developmentally disabled beneficiary with a history of bipolar and schizophrenia disorders and suicidal ideations. This beneficiary had 36 emergency room visits within a 2-year period that resulted from behaviors that were suicidal in nature and involved ingesting foreign objects that were often sharp, metal objects. The providers reported 4 of those incidents; however, they failed to report the remaining 32. Figure 1 illustrates the timing of those incidents.

Figure 1: Number of Unreported Critical Incidents for One Beneficiary Within a 2-Year Period



These incidents occurred within a 2-year period. But because the providers did not report all of the incidents, DDSN did not know the effect that the incidents had on the health and well-being of this individual. Furthermore, given this beneficiary's history of ingesting dangerous objects, the beneficiary's continued ability to access these objects raises concerns.

Additionally, three of the four critical incidents that the provider reported were in the "Other" category when the "Suicidal Ideation" category might have been more suitable. Because the incident was not reported in the "Suicidal Ideation" category, the number of incidents that potentially should have been reported in

this category was understated. Using the "Other" category provides DDSN with less precise information about the types of critical incidents that occurred. For example, a DDSN trend analysis on the number of incidents reported in the "Suicidal Ideation" category would produce less serious results if providers had categorized incidents of "Suicidal Ideation" in the "Other" category.

Furthermore, in each of these three critical incident reports, which occurred during a 4-month period, the provider indicated that the incidents were repeat occurrences. In addition, these critical incident reports required that the provider explain the quality assurance actions the provider took to prevent occurrence of a similar incident. For each of the three responses in the critical incident reports, the provider used identical language—including the same misspellings, typos, and grammatical errors (Figure 2 on the following page). Therefore, the provider and DDSN were aware through these reports that the provider had taken identical, ineffective measures to prevent reoccurrences instead of considering alternative measures to prevent those incidents from reoccurring. Critical incident reports for this beneficiary stated that "[t]he Management team will meet to see if CTH II is the proper placement for . . ." the beneficiary (Figure 2).[7] However, based on the reoccurring suicidal incidents, management may have needed to move the beneficiary to a residential setting that provided more oversight. In addition, the provider and DDSN were aware through these reports that the provider used verbatim language, which may indicate that the provider pasted the language into the three reports without having previously taken the corrective management and quality assurance actions that it had planned to take to prevent occurrence of another, similar incident.

[7] A beneficiary who resides in a CTH II lives in a home-like environment in the community under the supervision of qualified and trained staff members. Staff members provide care, supervision, and skills-training according to individualized needs as reflected in the person-centered service plan. No more than four people live in each residence.

Figure 2: Excerpt From One of the Three Verbatim Critical Incident Reports for a Single Beneficiary During a 4-Month Period

Management Action Taken:
A CTM is being scheduled to include the service coordinator and natural supports to determine any increased service delivery needs that may benefit [redacted].

Is this incident a repeat occurrence with this consumer? Y

What quality assurance actions were taken to prevent the occurrence of an incident/event like this?
The Management team will meet to see if CTH II is the proper placement for [redacted] *at this time.* [redacted] *room is search for any harmful item on each shif and documented in his daily progress notes.* [redacted] *also receives a body check on all shift and documented in his daily progress note.*

THE STATE AGENCY DID NOT ENSURE THAT PROVIDERS REPORTED ALL CRITICAL EVENTS WITHIN THE REQUIRED TIME LIMITS

Providers must submit a report of an ANE allegation using the IMS within 24 hours or the next business day (DDSN Directive 534-02-DD). In addition, providers must submit an initial death report form located in the death reporting function of the IMS as soon as possible, but no later than 24 hours of a death or the next business day (DDSN Directive 505-02-DD).

Providers did not always report ANE allegations or deaths to DDSN in a timely manner. Of the 326 critical events that we reviewed, 4 providers did not report 9 of these incidents within 24 hours of the incident or the next business day. The incidents included eight ANEs and one death, and the providers submitted the reports ranging from 1 to 14 business days after the due date. One provider submitted six of the nine late reports. According to DDSN officials, during our audit period this provider had already been through a corrective action plan process as a result of its late submissions.[8]

State agency officials said that providers did not always report the incidents within 24 hours of an incident or the next business day because, although staff members were aware of the requirement to report allegations of ANEs to a State investigative agency, staff members were sometimes confused about which entity (DSS, SLED, or local law enforcement) they should first call to report an incident. State agency officials also told us that staff members might not have reported the incidents to their supervisors after making a report to the State investigative agency, thereby delaying the submission of a report through the IMS. Furthermore, DDSN's controls for timeliness did not include progressive sanctions against providers that consistently

[8] DDSN requires that providers submit a written Plan of Correction to address compliance deficiencies and follow up to ensure successful remediation and implementation. Failure to comply and correct deficiencies may result in the imposition of sanctions by DDSN.

submit late reports.[9] However, DDSN officials stated that they plan to issue official finding reports and require Plans of Correction from providers that file late reports. If a provider subject to these measures does not become compliant, DDSN will use progressive sanctions to compel compliance.

Because the providers did not submit nine reports within the specified timeframes, DDSN could not take the appropriate actions to protect the safety and well-being of developmentally disabled individuals. Furthermore, DDSN could have delayed any corrective actions against individuals involved in the incidents, resulting in providers continuing to place the health and well-being of developmentally disabled individuals at risk of further critical events.

THE STATE AGENCY DID NOT ENSURE THAT PROVIDERS ALWAYS SUBMITTED THE RESULTS OF THEIR INTERNAL REVIEWS WITHIN 10 WORKING DAYS

Providers must conduct an internal (management or administrative) review and submit the results to DDSN within 10 working days of a critical event or discovery of an event.[10] Providers must conduct a management review of all critical incidents and deaths, and they must conduct either an administrative or a management review of every ANE allegation (DDSN Directives 100-09-DD, 505-02-DD, and 534-02-DD).

The State agency did not ensure that providers submitted to DDSN the results of 8 of 326 internal reviews (2.5 percent) within the required timeframe. Of the 326 incidents that we reviewed, providers submitted the results of their corresponding internal reviews for 318 incidents to DDSN within 10 working days as required by DDSN directives. However, providers did not in a timely manner submit the results of their internal reviews for the remaining eight, which consisted of two critical incidents, two ANE incidents, and four deaths. Instead, the providers submitted the results of their internal reviews between 1 and 25 working days after the due dates.

According to DDSN officials, most providers have one or two designated people who submit reports to DDSN through the IMS. Some providers submitted reports late because their staff members experienced delays in obtaining the information needed to complete their internal reviews. Although DDSN has a full-time IMC who tracks when reports are due, according to a DDSN official an IMC contacts the providers only after a report is late.

[9] DDSN may impose a penalty when a provider fails to comply with certain performance requirements and fails to correct identified deficiencies. These penalties become progressively worse if a provider continues not to comply.

[10] During a management review, which is conducted when SLED or a local law enforcement agency accepts a case for investigation, reviewers are not permitted to collect witness statements or interview witnesses. Staff members can write a statement to share with the State investigative agency but cannot share the information with providers during an active investigation. However, during an administrative review, reviewers are permitted to collect statements and interview witnesses as long as they do not interfere with the investigation of the allegation of ANE.

As a result of delays in submitting results of the internal reviews, providers may have continued to place the health and well-being of developmentally disabled individuals at risk of further critical incidents, ANE incidents, or death. For example, a delay could result in a staff member remaining employed after that member, based on the results of the internal review, should have been put on administrative leave or terminated.

THE STATE AGENCY DID NOT ENSURE THAT ONE BENEFICIARY DEATH WAS REPORTED TO THE SOUTH CAROLINA LAW ENFORCEMENT DIVISION

In addition to the requirement that providers submit an initial death report form into the IMS as soon as possible but no later than 24 hours after an incident or the next business day, DDSN Directive 505-02-DD states that a facility administrator, executive director, chief executive officer (CEO), or a designee must immediately call SLED to report the death. Furthermore, the HCBS Waiver, Appendix G-1(e) states that the Vulnerable Adult Fatalities (VAF) Review Office of SLED will investigate a vulnerable adult death involving abuse, physical trauma, or sexual trauma, as well as a death that is suspicious or questionable.

The State agency did not ensure that all beneficiary deaths were reported to SLED. Of the 137 death reports that we reviewed, 1 of those deaths (0.7 percent) was not reported to SLED for investigation. According to the initial death report, the provider stated that it had notified SLED of the beneficiary's death. However, based on an email exchange between the DDSN IMC and a SLED official, the SLED official stated that SLED received no calls and had no record in its database concerning the beneficiary's death. According to DDSN, it appeared based on available evidence that the IMC began researching the issue. However, the research process was interrupted because the IMC had to take emergency leave, and DDSN did not have backup staff members to continue working where the IMC left off. Also, according to DDSN, the IMC is no longer employed by DDSN, and access to additional records for researching the issue is limited.

Because the death of the developmentally disabled individual was not reported to SLED, SLED was unable to investigate the cause of death. If a cause of death is not investigated, beneficiary health and safety could be at risk.

THE STATE AGENCY DID NOT DEVELOP AND IMPLEMENT STRATEGIES TO PREVENT FUTURE INCIDENTS OF NEGLECT THAT RESULTED IN BENEFICIARY DEATHS

If a death is unexpected or suspicious in nature, the facility administrator, executive director, CEO, or a designee must immediately call the DDSN district director or a designee and SLED. "Immediately" is defined as within 2 hours of the death. The DDSN district director will then notify the associate State director of operations and the State director. Providers must report a beneficiary's death to DDSN using the IMS as soon as possible, no later than 24 hours after the death or the next business day. If there is any reason to believe that abuse or neglect may have occurred, the provider also needs to complete a corresponding ANE report in the IMS (DDSN Directive 505-02-DD). Furthermore, as DDSN identifies ANE incidents and unexplained deaths,

the provider should take action to protect the health and welfare of the beneficiaries. DDSN collects data, analyzes it for trends, and develops and implements strategies to prevent future incidents (HCBS Waiver, Appendix G(b)(i), *Participant Safeguards, Quality Improvement: Health and Welfare*).

Of the 137 beneficiary death reports that we reviewed, 7 beneficiary deaths (5 percent) were attributable to staff member neglect. The providers reported these deaths to SLED on the death report, and SLED investigated them; however, DDSN took no further measures to develop and implement strategies and policies to prevent similar deaths from occurring.

The following are examples of beneficiary deaths that were due to neglect:

Examples of Beneficiary Deaths That Were Due to Neglect

Example 1: In 2016, a 54-year old beneficiary was having breakfast (sausage patty, eggs, and biscuit) that a staff member served the beneficiary in regular form. The staff member asked the beneficiary to let them cut the sausage patty into pieces, but the beneficiary declined. The staff member noticed that the beneficiary appeared to be in distress and performed the Heimlich maneuver until a small piece of sausage came out of the beneficiary's mouth. Staff members performed cardiopulmonary resuscitation (CPR) until emergency medical service (EMS) personnel arrived. EMS transported the beneficiary to the hospital and the hospital's medical staff placed the beneficiary on a ventilator. The beneficiary died 6 days later.

Per the recommendation on a 2013 Swallowing Disorders Consultation completed by a DDSN Dysphagia and Gastroesophageal Reflux Disease Consultant, staff members should have ensured that they cut all foods into small, bite-sized pieces for the beneficiary and provided cues to slow the eating pace during meals. Furthermore, in 2013 and 2014 the provider completed a Swallowing Disorder Checklist for the beneficiary, which must be updated annually, but the provider did not complete the checklist in 2015. Both the 2013 and 2014 checklists identified that the beneficiary coughed consistently during meals, gagged sometimes while eating, ate at a fast pace, overfilled the mouth, and swallowed without adequately chewing.

The provider terminated the two staff members involved in the incident.

Example 2: A staff member was supposed to check on a 40-year old beneficiary every 15 minutes. The accountability log showed that the staff member checked on the beneficiary every 15 minutes between 9 a.m. and 9 p.m. However, the staff member stated that he had last checked on the beneficiary at approximately 8 p.m. The final death report stated that this discrepancy most

likely signified that the staff member prefilled the log and did not check on the beneficiary for nearly an hour. At approximately 9 p.m., the staff member on the next shift checked and found the beneficiary unresponsive. That staff member performed CPR until EMS personnel arrived, at which point the beneficiary was already deceased. The coroner's report said the coroner was unable to determine the cause or manner of death. The provider terminated the staff member for not following proper procedures. According to an investigator at SLED, the investigation did not result in a criminal finding.

By not developing and implementing strategies and processes to prevent future incidents, such as by increasing DDSN's oversight of providers with high numbers of ANE incidents, DDSN is placing the safety of developmentally disabled beneficiaries at risk.

RECOMMENDATIONS

We recommend that the South Carolina Department of Health and Human Services work with the Department of Disabilities and Special Needs to:

- ensure that providers follow the reporting requirements for critical events;
- provide training to providers on recognizing and reporting critical incidents according to reporting requirements;
- perform analytical procedures, such as data matches, on Medicaid claims data to identify any unreported critical incidents, and investigate as needed;
- ensure that providers submit all incident reports to DDSN through the IMS within 24 hours of an incident or the next business day;
- impose sanctions on providers to compel compliance with timely reporting requirements for allegations of ANE and deaths;
- require that the IMC contact providers before the results of internal reviews are due to ensure that providers submit such results within required timeframes;
- ensure that backup staff members are available to work on incident management activities whenever the primary IMC is unavailable; and
- develop and implement strategies and processes to prevent future ANE incidents and unexplained beneficiary deaths.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

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

In response to our recommendation to ensure that providers follow the reporting requirements for critical events, the State agency said that DDSN had identified 42 providers that had unreported critical incidents from 2020 through 2021 and issued them corrective action plans, which providers have fully addressed. In addition, the State agency said that DDSN is revising its policies, procedures, and protocols to provide assurance that incidents will be reported as required.

In response to our recommendation to provide training to providers on recognizing and reporting critical incidents according to reporting requirements, the State agency said that DDSN continues to strengthen and reinforce training with contracted provider agencies to identify and prevent allegations of ANE and critical incidents.

In response to our recommendation to perform analytical procedures on Medicaid claims data to identify any unreported critical incidents, and investigate as needed, the State agency said that it and DDSN are working with data analytics staff to develop a dashboard of claims data to inform incident detection and reporting efforts, and are exploring technology to integrate claims monitoring within the IMS. In addition, the State agency said that it and DDSN will start providing ongoing trend analysis of data to indicate the need for systemic improvements and conducting monthly risk management meetings to cover at-risk list process and systemic improvement activities.

In response to our recommendation to ensure that providers submit all incident reports to DDSN through the IMS within 24 hours of an incident or the next business day, the State agency said that DDSN now requires that each provider's risk management committee review the provider's systemic analysis of its data for individual report types and compliance with timely reporting requirements on a quarterly, instead of annual, basis.

In response to our recommendation to impose sanctions on providers to compel compliance with timely reporting requirements for allegations of ANE and deaths, the State agency said that it and DDSN will develop a matrix of progressive sanctions based on the percentage of incident management reports that fail to meet reporting requirements, including requirements for a corrective action plan to ensure future compliance.

In response to our recommendation to require that the IMC contact providers before the results of internal reviews are due to ensure that providers submit such results within required timeframes, the State agency said that it is working with providers to improve timely reporting through feedback from DDSN.

In response to our recommendation to ensure that backup staff members are available to work on incident management activities whenever the primary IMC is unavailable, the State agency said that DDSN changed staffing patterns to ensure that backup staff are available to work on incident management activities when the primary IMC is not available.

In response to our recommendation to develop and implement strategies and processes to prevent future ANE incidents and unexplained beneficiary deaths, the State agency said that DDSN is: (1) developing a singular incident management directive with clear definitions of incidents of neglect to improve providers' recognition of these incidents, (2) exploring other methods for increased oversight of incident management, and (3) developing a comprehensive quality improvement strategy.

We believe the corrective actions described by the State agency will improve its reporting of critical incidents and prevent future ANE incidents and unexplained beneficiary deaths.

The State agency's comments are included in their entirety as Appendix D.

OTHER MATTERS

The State agency did not ensure that providers categorized critical incidents appropriately. Specifically, many providers selected a category that did not best reflect an incident as described in a report.

DDSN Directive 100-09-DD states that providers must include brief descriptions of incidents in their initial reports. Providers must include details to ensure that any reviewer would have a good understanding of the incidents that took place. Furthermore, DDSN officials stated that providers must categorize incidents when reporting them to DDSN and can choose from a total of 28 categories of critical incidents.

Providers frequently selected the "Other" category when, based on the description of an incident, another category may have been more appropriate. Providers reported 324 critical incidents in the "Other" category, which ranked third highest out of 28 categories of critical incidents. Of the 324 critical incidents reported in the "Other" category for our audit period, we reviewed 271. Providers could have more accurately reported at least 76 of these 271 critical incidents in one of the following categories:

- Suicidal Ideation (51)[11]

[11] One provider reported 26 of these 51 incidents.

- Motor Vehicle (19)[12]

- Medication Error (6)

In addition, 54 of the 271 critical incidents (20 percent) in the "Other" category involved bed bugs. However, no category existed specifically for a bed bug or pest incident.

Inappropriately categorized critical incidents may make it more difficult for DDSN to analyze and track trends to identify problems and take appropriate action to reduce the risk of critical incidents. Furthermore, by not adding new categories when trends reveal emerging critical incidents outside of established categories, DDSN may not be able to address providers' pervasive bed bug problems.

[12] This category involved two motor vehicle accidents. Every individual who was involved in the accidents should be counted as a separate incident.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed the State agency's compliance with waiver requirements for reporting and monitoring critical events that occurred from January 1, 2015, through June 30, 2017 (audit period). During this period, 8,156 Medicaid beneficiaries with developmental disabilities were covered by South Carolina's HCBS waiver. We limited our review to the 7,161 beneficiaries who were at least 18 years old as of January 1, 2015.

We extracted from the South Carolina MMIS the claim records of all emergency room visits that the State agency paid on behalf of Medicaid beneficiaries with developmental disabilities who were at least 18 years old and residing in community-based settings during our audit period. We determined that 1,019 emergency room visits met the State agency's definition of a "critical incident." We then compared these 1,019 emergency room visits to the list of critical events in the IMS to determine whether providers reported the emergency room visits as critical events to the State agency.

We also reviewed a sample of 326 critical events that providers submitted to DDSN through the IMS to determine whether they submitted internal reviews and reports in a timely manner. This sample included all of the critical events from the five providers that had the highest number of critical events during our audit period.

In addition, we reviewed 137 beneficiary deaths to determine whether:

- providers reported deaths to SLED and
- any deaths were potentially due to neglect.

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

We performed our audit work from August 2018 through December 2021.

METHODOLOGY

To accomplish our audit objective, we:

- reviewed applicable Federal and State requirements and the Federal HCBS waiver;

- held discussions with State agency and DDSN officials to gain an understanding of the State agency's policies and procedures related to reporting and monitoring critical events involving beneficiaries with developmental disabilities;

- obtained a computer-generated file from the State agency of 8,156 Medicaid beneficiaries with developmental disabilities residing in community-based settings during our audit period;

- extracted from the 8,156 Medicaid beneficiaries 7,161 who were at least 18 years old on January 1, 2015;

- obtained a computer-generated file of claims data from MMIS for emergency room visits during our audit period for Medicaid beneficiaries with developmental disabilities who were at least 18 years old as of January 1, 2015;

- obtained critical incident, ANE incident, and death information from the IMS;

- identified 1,019 emergency room visits from MMIS that met the State agency's definition of a critical incident;

- compared the IMS data to the MMIS data to determine whether any of the 1,019 emergency room visits were not reported to the State agency;

- reviewed 326 critical events to determine whether providers:

    - reported the incidents within 24 hours of the incident or the next business day and

    - submitted internal reviews to the DDSN within 10 working days;

- reviewed 137 death reports to determine whether providers reported all beneficiary deaths to SLED and whether any deaths were potentially attributable to provider negligence;

- reviewed 271 summary reports for critical incidents reported to DDSN using the "Other" category to determine the details of each incident that took place; 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.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Arkansas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-06-17-01003	12/22/2021
California Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-09-19-02004	9/22/2021
Louisiana Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-06-17-02005	5/5/2021
New York Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-02-17-01026	2/16/2021
Texas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-06-17-04003	7/9/2020
Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities	A-07-18-06081	3/27/2020
Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-03-17-00202	1/17/2020
Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-09-17-02006	6/11/2019
Joint Report: Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight	Joint Report*	1/17/2018
Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-01-16-00001	8/9/2017
Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00008	7/13/2016

Report Title	Report Number	Date Issued
Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00002	5/25/2016
Review of Intermediate Care Facilities in New York With High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries	A-02-14-01011	9/28/2015
[*]This report was jointly prepared by the Department of Health and Human Services, Office of Inspector General; the Administration for Community Living; and the Office for Civil Rights.		

APPENDIX C: FEDERAL WAIVER AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS AND MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER

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

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

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, in G-1(b): "State Critical Event or Incident Reporting Requirements" states that a critical incident is an unusual, unfavorable occurrence that: (1) is not consistent with routine operations; (2) has harmful or otherwise negative effects involving people with disabilities, employees, or property; and (3) occurs in a DDSN Regional Center, in a Disabilities and Special Needs Board facility, in other service provider facilities, or during the provision of waiver case management services. A report to the operating agency is required within 24 hours of a critical incident or the next business day.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, in G-1(b): "State Critical Event or Incident Reporting Requirements" states that the South Carolina Omnibus Adult Protection Act requires reporting and investigating a suspected ANE of vulnerable adults (age 18 and over) to APS and SLED or to local law enforcement. Mandated reporters must report suspected ANE allegations within 24 hours of an incident or the next business day after its discovery.[13]

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, in G-1(d): "Responsibility for Review of and Response to Critical Events or Incidents" requires that the service provider make an initial report of an incident within 24 hours or the next business day. The provider must then complete an internal review of the incident within 10 working days. An internal review is submitted to DDSN for acceptance by the Statewide IMC.

[13] Mandated reporters are defined as professional staff, employees, and volunteer or contracted provider agencies having a legal responsibility under State law to report suspected ANE allegations to State investigative agencies.

The HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, in G-1(e): "Responsibility for Oversight of Critical Incidents and Events" states that the VAF Review Office of SLED will investigate all deaths involving abuse, physical, and sexual trauma, as well as suspicious and questionable deaths of vulnerable adults. The State Vulnerable Adult Investigations Unit will also review the involvement that various agencies may have had with the person prior to death.

STATE REQUIREMENTS

DDSN Directive 100-09-DD, Critical Incident Reporting states the following:

- When determining whether a particular event should be considered a critical incident, the best guidance is "when in doubt, then report."

- Providers are to report all critical incidents, except vehicle accidents and vandalism, using the IMS within 24 hours of an incident or the next business day.

    - The initial report should include a brief description of the incident.

    - The report should provide sufficient details to ensure that any authorized reviewer would have a good understanding of the incident, parties involved, and outside medical or law enforcement intervention.

- Providers will conduct internal management reviews of all critical incidents. Providers must submit results of all reviews to the IMS within 10 working days of an incident or when staff members first became aware of the incident.

- On a regular basis, DDSN quality management staff will review critical incidents, analyze data for trends, and recommend changes in policy, practice, or training that may reduce the risk of such incidents occurring in the future.

DDSN Directive 534-02-DD, Procedures for Preventing and Reporting Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or Disabilities and Special Needs Board or Contracted Service Provider states the following:

- Providers must submit a report of the ANE allegation using the IMS within 24 hours of the incident or on the next business day after the discovery of a suspected ANE.

- Providers must conduct an administrative review when: (1) an intermediate care facility for individuals with intellectual disabilities (ICF/IID) (community or DDSN regional center) resident is allegedly abused, including when that resident is attending a day program, or (2) when SLED vets the case to the long-term care ombudsman.

During the administrative review process, reviewers are permitted to interview witnesses and collect witness statements as long as they do not interfere with the investigation of an allegation of ANE conducted by a State investigative agency.

Providers must report the results of an administrative review for improper conduct toward a consumer (non-ICF/IID) to the DDSN Director of Quality Management within 10 working days, excluding State and Federal holidays.

- Providers must conduct a management review when: (1) an alleged abuse occurs while a consumer resides in any other home operated or contracted by DDSN, or (2) an alleged abuse occurs when a consumer is under the direct supervision of an agency employee or contracted employee.

  During a management review process, which is conducted when SLED or local law enforcement accepts a case for investigation, reviewers are not permitted to interview the consumer or staff members and cannot collect witness statements.

  A provider must complete a management review and report the results thereof to the DDSN Director of Quality Management within 10 working days, excluding State and Federal holidays, of a discovery of an ANE incident by the provider.

DDSN Directive 505-02-DD, Death or Impending Death of Persons Receiving Services from DDSN, states the following:

- Providers must submit an initial death report form located in the death reporting function of the IMS as soon as possible, but no later than 24 hours after an incident or the next business day.

- Facility administrators, executive directors, CEOs, or a designee must immediately call SLED to report a death if the death was unexpected or suspicious in nature.

- A provider's management must conduct an internal review of every death and submit results of the review to DDSN within 10 working days of a death.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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January 10, 2022

Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
61 Forsyth Street SW Suite 3T41
Atlanta, GA 30303

Report Number: A-04-18-07078

Dear Ms. Pilcher,

Enclosed is the state response to the draft report *South Carolina Did Not Fully Comply With Requirements for Reporting and Monitoring Critical Events Involving Medicaid Beneficiaries with Developmental Disabilities*. These written comments include statements of concurrence or nonconcurrence with each recommendation. The South Carolina Department of Health and Human Services (SCDHHS) considers the health and welfare of all Health Connections Medicaid members to be of utmost importance. In the state's response, SCDHHS has outlined multiple proactive steps that have been taken to address potential findings prior to issuance of the draft report. The state continues to enforce corrective actions to ensure that requirements for monitoring critical events are met.

Sincerely,

Robert M. Kerr
Director

Enclosure

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

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Jan. 10, 2022

South Carolina Department of Health and Human Services (SCDHHS)

State Response to Draft Report

Report Number: A-04-18-07078
Report: South Carolina Did Not Fully Comply With Requirements for Reporting and Monitoring Critical Events Involving Medicaid Beneficiaries With Developmental Disabilities.

SCDHHS has taken multiple approaches to address management of reporting for critical incidents and instances of abuse, neglect, and exploitation. The agency issued a corrective action plan to the South Carolina Department of Disabilities and Special Needs (SCDDSN) in June of 2021, to support remediation and ensure compliance with performance measures and operating requirements. In addition, SCDHHS incorporated many of these corrective actions in the waiver renewal application for the Intellectual Disabilities/Related Disabilities waiver and will incorporate these in waiver renewals and amendments being submitted in the near future. SCDHHS is actively working with SCDDSN to redesign waiver programs and provider billing processes. These efforts will result in a shift in responsibilities to focus SCDDN's efforts on monitoring and programmatic oversight, rather than administrative functions of billing and claims payment.

Summary of Findings and State Response

The performance audit included review of 7,161 beneficiaries who were at least 18 years of age at the beginning of the audit period who received comprehensive support services from Jan. 1, 2015, through June 30, 2017. Findings indicated that the state did not fully comply with federal Medicaid waiver and state requirements in the following areas:

- Providers reported all critical incidents
  - Of the 1,019 emergency room visits with a primary diagnosis code that met South Carolina's definition of a critical incident, providers reported 72% to SCDDSN
- Providers reported within 24 hours or the next business day all critical events
  - Of the 326 critical events reviewed, four providers did not report nine of the incidents (2.8%) within 24 hours of the event or the next business day.
- Providers always submitted the results of their internal reviews within 10 working days
  - Of the 326 internal reviews, eight reports (2.5%) were not submitted within 10 working days.
- One beneficiary death was reported to the South Carolina Law Enforcement Division (SLED)

    - Of the 137 death reports that were reviewed, one of those deaths (0.7%) was not reported to SLED.
- It developed and implemented strategies to prevent future incidents of neglect that resulted in beneficiary deaths
    - Of the 137 beneficiary death reports reviewed, seven beneficiary deaths (5%) were attributable to staff member neglect.

The South Carolina Department of Health and Human Services (SCDHHS) provides administrative oversight to SCDDSN as the designated waiver operator for three home and community based waivers. Upon review of draft findings during the course of the Office of Inspector General (OIG) audit, SCDHHS took steps to advise SCDDSN of formal corrective actions required to maintain compliance with waiver assurances in June 2021. SCDHHS and SCDDSN have worked collaboratively in an ongoing effort to monitor corrective actions and their impact on the anticipated findings of the OIG audit. These corrective actions are included in the response to the OIG report recommendations noted below.

Recommendation 1

SCDHHS work with SCDDSN to ensure that providers follow the reporting requirements for critical events.

State Response: SCDHHS concurs with this recommendation.

Corrective Actions: At the instruction of SCDHHS, SCDDSN addressed actions to ensure that providers follow the reporting requirements for critical events. From 2020-2021, 42 providers were identified as having unreported critical incidents and corrective actions plans were issued for all 42 providers. Remediation occurred from Sept 16, 2020-April 21, 2021, and per SCDDSN's report, all 42 providers identified have fully remediated. All corrective action plans related to the OIG audit were closed as of May 19, 2021. In addition, organizational policies, procedures, and protocols are being revised to provide assurance that incidents will be reported as required. All materials must align with the approved SCDDSN abuse, neglect and exploitation (ANE), critical incident and general event report (GER) reporting requirements, in accordance with SCDDSN directives. SCDHHS and SCDDSN are revising all incident management directives to reflect one comprehensive incident management directive.

Recommendation 2

SCDHHS work with SCDDSN to provide training to providers on recognizing and reporting critical incidents according to reporting requirements.

State Response: SCDHHS concurs with this recommendation.

Corrective Actions: As part of corrective actions issued by SCDHHS, SCDDSN continues to work with contracted provider agencies to strengthen and reinforce training to identify and prevent allegations of ANE and CI. SCDDSN currently uses a mandated statewide curriculum for training that was developed by the University of South Carolina Children's Law Center and the South Carolina Adult Protection Coordinating Council, along with a competency test that is required at the conclusion of the training. Participants must score a minimum of 80% on the

competency test, or they must be re-trained. SCDDSN intends to provide training for providers on quality management investigations of critical incidents and ANE with a one-two-year roll-out timeline. Training was conducted for state-level staff July 27 – 29, 2021, on quality management investigations of critical incidents and ANE.

In addition, SCDDSN is currently in the process of working with SLED to identify reporting-related training issues and information that callers need to have readily available when making a report. SLED and SCDDSN are also currently working on the process for how reports will be handled when they are not accepted for investigation. As these important issues are resolved, SCDDSN will revise the provider training curriculum.

Recommendation 3

SCDHHS work with SCDDSN to perform analytical procedures, such as data matches, on Medicaid claims data to identify any unreported critical incidents and investigate as needed.

State Response: SCDHHS concurs with this recommendation.

Corrective Actions: SCDHHS issued a request for information (RFI) on Sept. 2, 2021, seeking input regarding a technology solution for incident management, to include information on capabilities of a system to integrate claims data for the purpose of incident detection. SCDHHS is concurrently working with data analytics staff to develop a dashboard of claims data to inform incident detection and reporting efforts. SCDDSN is currently exploring technology that will integrate claims monitoring within the incident management system. SCDDSN is also working to ensure all policy deadlines are met by stakeholders. The state continues to engage with providers to improve compliance with reporting incidents. The topic has been covered extensively in provider counterpart meetings with executive directors, residential and day service directors, case managers and quality management bulletins and is included in periodic incident management reports to the SCDDSN executive staff and commission. SCDDSN will start providing ongoing trend analysis of data to indicate the need for systemic improvements and conduct monthly risk management meetings to cover at-risk list process and systemic improvement activities.

Recommendation 4

SCDHHS work with the SCDDSN to ensure that providers submit all incident reports to SCDDSN through the incident management system (IMS) within 24 hours of an incident or the next business day.

State Response: SCDHHS concurs with this recommendation.

Corrective Actions: Through a set of corrective actions issued by SCDHHS, SCDDSN continues to work with providers to improve compliance with state policies regarding timeliness. The topic has been covered extensively in provider counterpart meetings with executive directors, residential and day service directors, case managers and quality management bulletins; in discussions about contract compliance review results; and, is included in periodic incident management reports to the SCDDSN executive staff and commission.

SCDDSN continues to work with contracted provider agencies to strengthen and reinforce training to identify allegations and prevent incidents of ANE. As an additional measure, SCDDSN requires provider agencies to establish a Risk Management Committee to fully review the provider's systemic processes including the systemic analysis of their data for individual report types and their compliance with timely reporting requirements. In FY19, SCDDSN changed its directive to require provider Risk Management Committees to review this information on a quarterly basis, rather than annually.

SCDHHS' responses to recommendations 1 and 2 further address the state's efforts to ensure providers submit all incident reports to SCDDSN through the IMS within 24 hours of an incident or the next business day.

Recommendation 5

SCDHHS work with SCDDSN to impose sanctions on providers to compel compliance with timely reporting requirements for allegations of ANE and deaths.

State Response: SCDHHS concurs with this recommendation.

Corrective Actions: SCDHHS and SCDDSN will develop a matrix for progressive sanctions, based on the percentage of Incident Management Reports that fail to meet reporting requirements. This matrix will also include requirements for a Plan of Correction to ensure future compliance.

Recommendation 6

SCDHHS work with SCDDSN to require that the Incident Management Coordinator (IMC) contact providers before the results of internal reviews are due to ensure that providers submit such results within required timeframes.

State Response: SCDHHS concurs with this recommendation.

Corrective Actions: The IMC will continue to work with providers to improve timely reporting. This takes the form of providing real-time feedback as incident reports are reviewed in the IMS. The current IMS does not readily support trending in aggregate for this issue. At this time real-time feedback has allowed for individual issues to be remediated. Systemic improvement efforts have focused on this activity until an IMS system that can extract this data in aggregate can be procured.

Recommendation 7

SCDHHS work with SCDDSN to ensure that backup staff members are available to work on incident management activities whenever the primary IMC is unavailable.

State Response: SCDHHS concurs with this recommendation.

Corrective Actions: Changes in SCDDSN staffing patterns have helped ensure back-up staff are available and working on incident management activities in the event the primary IMC is

unable to work for any reason. Requirements to upload notes and keep records of outstanding items (within the system for which appropriate staff have access) have been implemented since the time of the incident cited in the OIG's report. This has greatly improved the ability of SCDDSN to maintain continuity of operations when unexpected circumstances occur that would require back-up staff to continue work in the absence of the IMC.

Each provider must have an incident management representative. The representative may delegate the activities within the organization but will maintain the overall responsibility to ensure completion per applicable laws, regulations, policies, and procedures. In the absence of a designee, the executive director will serve as the incident management representative. The representative must ensure:

- The required actions and activities of point person(s) have been completed;
- Appropriate implementation and monitoring of corrective actions;
- All quality and risk management activities are completed related to incident management, which include, but are not limited to:
    - Monthly monitoring of incident data; and,
    - A trend analysis of incident data at least every three months.
- Administrative reviews are conducted for incidents as appropriate; and,
- Beneficiaries and their families are offered education, training, and information about incident management policies and procedures.

Recommendation 8

SCDHHS work with SCDDSN to develop and implement strategies and processes to prevent future ANE incidents and unexplained beneficiary deaths.

State Response: SCDHHS concurs with this recommendation.

Corrective Actions: Many corrective actions related to incident management reporting improvements will be long-term projects as they require not only policy/practice adjustments but also substantial investment in technology. The state is taking the following actions:

- SCDDSN is developing a singular incident management directive with clear definitions that allow for easy recognition and reporting by providers and other stakeholders. Current incident management directives/instructions are split over multiple documents, which may make reporting confusing for providers.
- SCDDSN is exploring methods for increased oversight of incident management via replicating the claims vs. reports methodology of audits. SCDDSN is currently exploring technology that will integrate claims monitoring within the IMS. SCDHHS is concurrently developing data dashboards for review and analysis of Medicaid claims data.
- SCDDSN is exploring incident management technology that supports a singular incident management directive. After a new SCDDSN incident management directive is complete, SCDDSN will need a technology solution that will support stakeholders' ability to effectively conduct incident management activities. Technology should assist providers in reporting incidents easily and effectively, meeting timeframes established in policy and tracking/implementing corrective actions.

- SCDHHS issued a request for information for a new incident management tracking solution, as described in the state's response to recommendation 3, in September 2021 and is participating in systems demonstrations by potential vendors in advance of a formal procurement action.
- SCDDSN is developing a comprehensive quality improvement (QI) strategy. Central to QI activities is the implementation of conflict free case management, creation of standardized monitoring practices and teaching risk mitigation practices to case management providers. Case management providers are the eyes and the ears of SCDDSN and will be used to increase health and safety protections by conducting meaningful monitoring that leads to actionable protections for waiver participants.
- As corrective actions are completed/implemented, SCDDSN will ensure stakeholders receive appropriate training. SCDDSN is creating training materials related to incident management as policies/procedures are developed.

Other Matters

The state agency did not ensure that providers categorized critical incidents appropriately. Specifically, many providers selected a category that did not best reflect an incident as described in a report.

State Response: SCDHHS concurs with this recommendation.

Corrective Actions: The IMC will continue to work with providers to improve accuracy when choosing incident categories. This will include providing real-time feedback as incident reports are reviewed in the IMS. The current IMS system does not readily support trending in aggregate for this issue. At this time real-time feedback has allowed for individual issues to be remediated. Systemic improvement efforts have focused on this activity until an IMS system that can extract this data in aggregate can be obtained.