

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Christi A. Grimm
Inspector General**

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Office of Inspector General

<https://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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Report in Brief

Date: June 2022

Report No. A-01-20-00007

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



Why OIG Did This Audit

We previously conducted an audit of critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings and found that Maine did not comply with Federal and State requirements for reporting and monitoring critical incidents. The report contained seven recommendations.

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

How OIG Did This Audit

We reviewed the system that Maine had in place during our audit period (calendar year 2019) for reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities. To determine whether the seven recommendations from the prior Office of Inspector General report were implemented, we reviewed correspondence between Centers for Medicare & Medicaid Services (CMS) and Maine and supporting documentation provided by Maine. To determine whether Maine's corrective actions addressed our previous findings, we reviewed 123 emergency room claims with service dates from October 2019 to December 2019 for 89 beneficiaries who were diagnosed with conditions that we determined to be indicative of high risk for suspected abuse or neglect.

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

What OIG Found

Maine implemented the seven recommendations from our prior audit and generally complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities. In addition, the corrective actions implemented in response to five of the seven recommendations were effective in addressing the related findings. However, Maine's corrective actions for two recommendations were not fully implemented by the conclusion of our current audit period and, therefore, were only partially effective in addressing two of our previous findings. We concluded that the corrective actions were not fully effective in addressing these findings because Maine did not ensure that all followup reports were completed by community-based providers within 30 days of each incident and that the Mortality Review Committee conducted a trend analysis based on completed Mortality Review Form aggregate data. As a result, Maine did not fulfill all of the participant safeguard assurances it provided to CMS in the Medicaid Home and Community-Based Services Waiver along with the State requirements incorporated under the waiver.

What OIG Recommends

We recommend that Maine: (1) continue to work with CMS to fully implement the prior recommendation to ensure that followup reports are submitted by community-based providers appropriately and (2) ensure that the Mortality Review Committee reviews Mortality Review Form aggregate data to identify patterns and trends and to make recommendations to improve care.

In written comments on our draft report, Maine agreed with both of our recommendations. Maine stated that it has met the 86-percent standard established by CMS for followup reports submitted within 30 days for 4 consecutive quarters and has hired a coordinator for the Aging and Disability Mortality Review Panel and that appointments of panel members are in progress.

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INTRODUCTION

WHY WE DID THIS AUDIT

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

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

OBJECTIVES

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

BACKGROUND

Developmental Disabilities Assistance and Bill of Rights Act of 2000

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

Federal and State Governments have an obligation to ensure that public funds are provided to residential, institutional, and community providers that serve developmentally disabled

¹ U.S. Department of Health and Human Services, Office of Inspector General, *Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities* (A-01-16-00001), August 2017. Available at <https://www.oig.hhs.gov/oas/reports/region1/11600001.pdf>.

² See Appendix B for related work.

³ P.L. No. 106-402 (Oct. 30, 2000).

individuals. Further, these providers must meet minimum standards to ensure that the care they provide does not involve abuse, neglect, sexual exploitation, or violations of legal and human rights (the Disabilities Act § 109(a)(3)(B)(i)).

Medicaid Home and Community-Based Services Waiver

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

The Office of Aging and Disability Services within the State agency administers Maine’s HCBS waiver program. That waiver program provided 2,802 individuals with comprehensive support services during our audit period.

States must provide certain assurances to the Centers for Medicare & Medicaid Services (CMS) to receive approval for an HCBS waiver, including that necessary safeguards are in place to protect the health and welfare of the beneficiaries receiving services (42 CFR § 441.302). A State must provide specific information regarding its plan or process related to patient safeguards, including whether the State operates a critical event or incident reporting system (HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*). In its HCBS waiver, the State agency asserted that it has a critical event or incident reporting system with policies and procedures that require coordination with other State and local agencies and Disability Rights Maine (DRM), a private nonprofit organization.⁴

Critical Incident Reporting for Community-Based Providers

The HCBS waiver and State agency regulations incorporated under the HCBS waiver define a reportable event (critical incident) as any event that generally falls into one of the following categories: death, suicide attempt, suicide threat, emergency department visit, planned or unplanned hospitalization, medication error, medical treatment provided by emergency medical services, serious injury, lost or missing individuals, physical disasters such as fire, law enforcement intervention, transportation accident, use of emergency restraints, rights

⁴ DRM is Maine’s Protection and Advocacy (P&A) agency. The first P&A program was created by the Developmental Disabilities Assistance and Bill of Rights Act of 1975 (DD Act). The DD Act requires P&A agencies to pursue legal, administrative, and other appropriate remedies to protect and advocate for the rights of individuals with developmental disabilities under all applicable Federal and State laws. The DD Act provided for the governor of each State to designate an entity as the P&A agency and to assure that the P&A agency was, and would remain, independent of any service provider. Most entities designated as P&A agencies are private nonprofit organizations created specifically to conduct P&A programs.

violation, or dangerous situation.⁵ The HCBS waiver and State agency regulations further state that community-based providers must report all critical incidents as soon as possible within 1 business day of the incident into the State agency's Enterprise Information System (EIS) (HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), "State Critical Event or Incident Reporting Requirements," and 14-197 Code of Maine Rules, State agency, chapter 12, § 2).

Community-based providers must also submit to the State agency followup reports of all critical incidents within 30 calendar days of the date of the incident detailing the date and time of the incident, a summary of the circumstances, and any immediate or future remediation action steps that were or will be taken to decrease the likelihood of reoccurrence. If no action steps were taken, the provider must explain why no action steps were necessary (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").

In addition, the State agency must meet quarterly with every community-based provider to discuss critical incident data collected during the previous quarter. This discussion may include but is not limited to the total number of critical incidents during the quarter and any increases or decreases from the previous quarter or previous year; any trends or patterns identified by either the State agency or the community-based provider; and the adequacy, effectiveness, and timeliness of the community-based provider's critical incident report reviews, followup reports, and remediation action steps (HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(e), "Responsibility for Oversight of Critical Incidents or Events").

Findings From Our Prior Audit

Our prior audit found that the State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings from January 2013 through June 2015. Specifically, the State agency did not:

- ensure that community-based providers reported all critical incidents to the State agency;
- ensure that community-based providers conducted administrative reviews of all critical incidents involving serious injuries, dangerous situations, or suicidal acts and submitted their findings within 30 days;

⁵ The HCBS waiver, effective July 1, 2018, no longer includes abuse, neglect, and exploitation as specific categories in the definition of a critical incident. These categories were included in the definition of a critical incident in the HCBS waiver in effect during our prior audit period. Although the HCBS waiver no longer includes these categories, State agency regulations require that mandated reporters report to the State agency when the person knows or has reasonable cause to suspect that an incapacitated or dependent adult has been or is likely to be abused, neglected, or exploited.

- report all restraint usage and rights violations to DRM;
- review and analyze data on all critical incidents;
- investigate and immediately report to the appropriate district attorney’s office or to law enforcement all critical incidents involving suspected abuse, neglect, or exploitation; and
- ensure that community-based providers reported all beneficiary deaths to the State agency appropriately and that the State agency analyzed, investigated, and reported the deaths to law enforcement or Maine’s Office of Chief Medical Examiner (OCME).

Our prior report included seven recommendations to address these findings.

HOW WE CONDUCTED THIS AUDIT

We reviewed the system that the State agency had in place during our audit period (calendar year 2019) for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings.

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

To determine whether the State agency’s corrective actions effectively addressed our previous findings of noncompliance, and whether it has complied with Federal and State requirements for reporting and monitoring critical incidents since our previous audit period, we obtained 1,813 emergency room claims that the State agency paid on behalf of Medicaid beneficiaries with developmental disabilities who resided in community-based settings from January 2019 through December 2019.⁶ We limited our review to the 123 emergency room claims (associated with 123 emergency room visits by 89 beneficiaries who resided in community-based settings) with service dates from October 2019 to December 2019. The beneficiaries were diagnosed with at least 1 of 78 conditions that we determined to be indicative of high risk for suspected abuse or neglect.⁷ We first determined that the 123 emergency room visits met

⁶ We obtained the claims data from the Transformed Medicaid Statistical Information System (T-MSIS). CMS requires States to submit files and data elements in the T-MSIS, which provides a national Medicaid data repository that, among other functions, supports program management, financial management, and program integrity.

⁷ 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.

the definition of a critical incident, and then determined whether the community-based providers reported to the State agency the 123 critical incidents.

Further, we judgmentally selected 50 of the 123 emergency room visits and requested the followup reports from the State agency to determine whether they were submitted by community-based providers.⁸ We also selected 50 reports of rights violations and 50 reports of restraint usage to determine whether they were properly reported by the State agency to DRM.⁹ In addition, we selected 50 allegations of abuse, neglect, or exploitation to determine whether the State agency properly reported them to the appropriate district attorney's office or law enforcement.¹⁰ Finally, we identified 31 beneficiary deaths during our audit period and confirmed whether all Federal and State reporting and monitoring requirements were met.

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

Appendix A contains the details of our audit scope and methodology.

FINDINGS

The State agency implemented the seven recommendations from our prior audit and generally complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings.¹¹ In addition, the corrective actions implemented in response to five of the seven recommendations were effective in addressing the related findings. However, its corrective actions for two recommendations were not fully implemented by the conclusion of our current audit period and, therefore, were only partially effective in addressing two of our previous findings. We concluded that the corrective actions were not fully effective in addressing these findings because the State agency did not ensure that all followup reports

⁸ We sorted the emergency room visits by Medicaid identification number and selected the first 50 visits that were reported as critical incidents by community-based providers.

⁹ The State agency provided summary reports of 2,785 restraints and 1,482 rights violations that were reported as critical incidents by community-based providers during our audit period. We selected every 55th restraint (2,785/50) and every 29th rights violation (1,482/50).

¹⁰ The State agency provided a summary report of 1,331 allegations of abuse, neglect, or exploitation that were reported to adult protective services during our audit period. We judgmentally selected 50 of these allegations based on type of allegation, location (county), and level of review.

¹¹ The previous OIG report contained seven recommendations that CMS concurred with as of November 1, 2017. CMS had closed six of the seven recommendations as of December 31, 2021. CMS notified the State agency that it had closed the final recommendation on May 3, 2022.

were submitted by community-based providers within 30 days of each incident and that the Mortality Review Committee conducted a trend analysis based on completed Mortality Review Form aggregate data. As a result, the State agency did not fulfill all of the participant safeguard assurances it provided to CMS in its HCBS waiver and the State requirements incorporated under the waiver.

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

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

Prior Recommendation: Work with community-based providers on how to identify and report all critical incidents

The State agency implemented the Critical Incident Dashboard, which provides critical incident and reporting data to measure compliance in key areas and a process for identifying unreported critical incidents that involves matching data for emergency room visits from EIS and Medicaid claims from the Maine Medicaid Management Information System. It also implemented quarterly meetings with each community-based provider, which include a review of reported and unreported critical incidents. After taking these corrective actions, the percentage of unreported critical incidents decreased to 12 percent. This represents a significant improvement relative to the 34-percent rate of unreported critical incidents identified in our prior audit.

Prior Recommendation: Report appropriately all restraint usage and rights violations to DRM

The State agency implemented procedures to ensure that all restraint usage is reported monthly and rights violations are reported daily to DRM. After taking these corrective actions, the percentage of unreported restraint usage decreased to 14 percent, and the percentage of unreported rights violations decreased to 0 percent. This represents a significant improvement relative to the 99-percent rate of unreported restraint usage and 19 percent of unreported rights violations identified in our prior audit. The unreported restraint usage identified in our current audit was due to a data warehouse issue that resulted in some restraint usage being inadvertently excluded from the monthly report. This issue has since been corrected.

Prior Recommendation: Perform trend analysis and analytical procedures, such as a data match, to provide community-based providers with reports that identify patterns and trends to prevent reoccurrences of critical incidents and determine the number and percentage of critical incidents reported in required timeframes

The State agency implemented procedures to perform trend analysis using the Critical Incident Dashboard. The trend analysis included a review of: (1) the timeliness of reportable events and followup reports and (2) reportable events by beneficiary, type of incident, and provider. In addition, it implemented a process for identifying unreported critical incidents that involves matching data from emergency room visits and Medicaid claims. Furthermore, the State agency meets quarterly with each community-based provider to discuss the results of the trend analysis and data match. We reviewed the records for 10 meetings and confirmed that the State agency and providers discussed these results.

Prior Recommendation: Investigate and immediately report to the appropriate district attorney's office or law enforcement all critical incidents involving suspected abuse, neglect, or exploitation

The State agency implemented procedures to ensure that all allegations involving abuse, neglect, or exploitation were reported to the appropriate district attorney's office or law enforcement. After taking these corrective actions, the percentage of unreported allegations decreased to 4 percent. This represents a significant improvement relative to the 98-percent rate of unreported allegations identified in our prior audit. In addition, the HCBS waiver in effect during our current audit period does not require all allegations to be investigated. Instead, adult protective services staff review each allegation and determine whether it should be assigned to a caseworker for investigation or closed without an investigation (10-149 Code of Maine Rules, State agency, chapter 1, § 3(1)).

Prior Recommendation: Provide training to the State agency's and community-based providers' staffs regarding the HCBS waiver and State requirements for critical incident reporting

The State agency implemented new training internally and for community-based providers on the HCBS waiver and critical incident reporting requirements. In addition, the State agency requires direct support professionals working for community-based providers to complete several web-based trainings, including training on critical incident reporting. These trainings are required for new hires and must be repeated every 36 months. In addition, the State agency provides assistance directly to community-based providers if any areas of concern are identified during their quarterly meetings.

THE STATE AGENCY’S CORRECTIVE ACTIONS IMPLEMENTED IN RESPONSE TO TWO OF OUR SEVEN PRIOR AUDIT RECOMMENDATIONS WERE ONLY PARTIALLY EFFECTIVE IN ADDRESSING RELATED FINDINGS

The State agency’s corrective actions were not fully implemented during our audit period and, therefore, were only partially effective in addressing findings related to two of our seven prior audit recommendations. We concluded that the corrective actions were not fully effective in addressing these findings because we determined that the State agency did not ensure that all followup reports were submitted by community-based providers within 30 days of each incident and that the Mortality Review Committee conducted a trend analysis based on completed Mortality Review Form aggregate data.

Prior Recommendation: Work with community-based providers to ensure that administrative reviews are conducted and reported appropriately

Federal Medicaid Waiver and State Requirements

Community-based providers are required to submit a followup report to the State agency within 30 calendar days from the date of the initial critical incident.¹² The followup report should outline the date and time of the initial incident, summarize circumstances that caused the incident, and explain if there were any delays in reporting the incident. The followup report should also detail any immediate or future remediation action steps that were or will be taken to decrease the likelihood that the same or a similar incident will reoccur, including either the planned dates of implementation, if applicable, and the party or parties responsible for implementing each action step, or an explanation as to why remediation action steps were not necessary (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,” and 14-197 Code of Maine Rules, State agency, chapter 12, § 3(2)).

Prior Audit and Corrective Actions

We determined that community-based providers did not always: (1) conduct administrative reviews that attempted to identify the cause of critical incidents and recommend preventive or corrective action as necessary and (2) report findings to the State agency within 30 days. In this regard, community-based providers reported through EIS to the State agency 8,678 critical incidents involving serious injuries, dangerous situations, and suicidal acts for 1,781 beneficiaries during our audit period. These reports documented critical incidents that potentially jeopardized the health, safety, and rights of the beneficiaries and included injuries of unknown origin, emergency room visits for serious injuries, and lack of beneficiary

¹² In the HCBS waiver effective July 1, 2018, the term “administrative reviews” was replaced by “followup reports.” Similar to followup reports, community-based providers were required to conduct administrative reviews within 30 days of an incident to identify the cause of a critical incident and recommend preventive or corrective action as necessary.

supervision that resulted in repeated elopements.¹³ The State agency, however, was unable to provide us with copies of the 8,678 administrative reviews associated with these critical incidents. The State agency was also unable to explain why the community-based providers did not submit the administrative reviews or why it did not detect that the community-based providers did not report findings to the State agency for the 8,678 critical incidents. Accordingly, we recommended that the State agency work with community-based providers to ensure that administrative reviews are conducted and reported appropriately.

In response to our prior recommendation, the State agency implemented new procedures to ensure that the community-based providers submit a followup report within 30 calendar days from the date of each incident. The followup report must detail the circumstances surrounding the event and the immediate and future action steps taken to decrease the likelihood that a similar incident will reoccur.

Current Audit

We again determined that community-based providers did not always submit followup reports to the State agency identifying the circumstances of the incident and the remediation action steps taken within 30 calendar days from the date of each incident. Specifically, we reviewed a sample of 50 emergency room visits that met the definition of a critical incident and determined that the community-providers submitted followup reports for 44 (88 percent) of the 50 critical incidents. However, only 39 (78 percent) of the 50 followup reports were submitted within 30 days, as required by the HCBS waiver.

Accordingly, the percentage of followup reports that were not submitted within 30 days decreased from 100 percent in the prior audit to 22 percent in the current audit. However, CMS requires 86 percent of the followup reports to be submitted within 30 days for 4 consecutive quarters before it will consider the recommendation implemented and resolved.¹⁴ Although the implemented corrective action resulted in significant improvement during our audit period, the State agency did not meet the 86-percent threshold that CMS required before considering the recommendation implemented.

The State agency indicated that a small number of community-based providers had difficulty meeting the requirement to submit followup reports within 30 days of the initial critical incident. Specifically, a data analysis in 2020 indicated that 10 community-based providers accounted for more than 50 percent of the late or missing followup reports. As a result of this analysis, the State agency developed a report to identify the 10 community-based providers with the highest number of late or missing followup reports on a monthly basis and provided

¹³ An “elopement” occurs when a beneficiary leaves an area without caregiver supervision or permission.

¹⁴ CMS staff selected the 86-percent threshold based on their judgment. It is the same threshold described in the CMS guidance “Modifications to Quality Measures and Reporting in § 1915(c) Home and Community-Based Waivers,” dated March 12, 2014. However, this guidance applies to the performance measures for subassurances required in HCBS waivers and not implemented corrective actions.

additional clarification to these providers regarding the followup reporting requirements. The State agency continued to work with CMS to ensure that it fully implemented our prior recommendation. It stated that it has met the 86-percent threshold for followup reports submitted within 30 days for 4 consecutive quarters as of December 31, 2021, and that CMS notified the State agency on May 3, 2022, it had closed the finding.

Because the State agency did not ensure that community-based providers submitted all followup reports within 30 days, it did not fulfill all of the participant safeguard assurances it provided to CMS in its HCBS waiver and the State requirements incorporated under the HCBS waiver.

Prior Recommendation: Ensure community-based providers report to the State agency all beneficiary deaths and that the State agency analyzes, investigates, and reports these deaths to law enforcement or OCME

Federal Medicaid Waiver and State Requirements

Providers must report to the State agency any critical incidents involving deaths, including but not limited to an unexpected death not attributed to a current medical diagnosis or chronic condition and a natural or expected death caused by a long-term illness, diagnosed chronic medical condition, or age (HCBS waiver, Appendix G-1, *Participant Safeguards: Response to Critical Events or Incidents*, G-1(b), “State Critical Event or Incident Reporting Requirements,” and 14-197 Code of Maine Rules, State agency, chapter 12, § (2)(2)(A)(1)).

An additional followup, the Mortality Review Form, is required for critical incidents that involve death. The case manager or care coordinator must complete the Mortality Review Form and submit it to the critical incident database no later than 10 business days from the date of the critical incident involving the death of an individual who received services from community-based providers. The Mortality Review Committee will conduct trend analysis based on aggregate data from completed Mortality Review Forms and meet quarterly to review any identifiable patterns and trends related to the deaths of individuals who received services. The Mortality Review Committee will also produce an annual report to the Commissioner that outlines trend analysis findings and makes recommendations to improve care (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,” G-1(e), “Responsibility for Oversight of Critical Incidents and Events,” and 14-197 Code of Maine Rules, State agency, chapter 12, § 3(4)).

The State must demonstrate on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation, and unexplained death of beneficiaries covered under the waiver. The State agency must review deaths to determine the percentage of deaths that were reviewed by its adult protective services unit (HCBS waiver, Appendix G, *Participant Safeguards: Quality Improvement: Health and Welfare*, subsection (a)(i)(a)).

A person who knows or has reasonable cause to suspect that an adult has died because of abuse or neglect must report that fact to a law enforcement officer or OCME. A “person” includes a public servant, corporation, partnership, any other legal entity, and any governmental unit (Maine Revised Statutes, Title 22, chapter 958-A, subsection 3478; chapter 711, subsection 3026 (1)).¹⁵

Prior Audit and Corrective Actions

We determined that the State agency did not ensure that community-based providers properly reported all beneficiary deaths. Specifically, one community-based provider did not report 1 of the 133 beneficiary deaths to the State agency. Furthermore, the State agency’s Mortality Review Committee did not take action on 7 of the 132 (5 percent) reported beneficiary deaths specifically because of the lack of information in the critical incident reports submitted by the community-based providers.

In addition, the State agency did not review all deaths or review aggregated death reports to search for trends that it must address; did not demonstrate on an ongoing basis that it identified, addressed, or sought to prevent instances of untimely death; and did not determine the number and percentage of unexplained, suspicious, and untimely deaths for which investigations resulted in the identification of preventable causes.

The State agency maintained that its Mortality Review Committee reviewed 54 of the 133 total beneficiary deaths. However, it was only able to provide us with a spreadsheet containing those 54 beneficiary names and general information regarding each death. This spreadsheet did not contain the details of the State agency’s review. It did not specify any trends the State agency identified, what its reviews entailed, or the outcomes of the reviews, including potential corrective actions.

Therefore, we reviewed the critical incident reports for each of the 133 beneficiary deaths and found that 9 of the beneficiary deaths were unexplained, suspicious, and untimely. Corrective action could have been taken or preventable causes could have been identified for some of these beneficiary deaths, especially those that resulted from a delay in care or a lack of training of community residence staff. An additional 32 (24 percent) of the 133 beneficiary death critical incident records did not contain enough information for us to make a determination of whether the deaths were unexplained, suspicious, and untimely. Accordingly, we recommended that the State agency ensure that community-based providers report to it all beneficiary deaths and that it analyze, investigate, and report these deaths to law enforcement or OCME.

¹⁵ The HCBS waiver, effective July 1, 2020, states that adult protective services must contact law enforcement and OCME if a beneficiary death may have been connected to or due to abuse, neglect, or exploitation (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”). This requirement was not included in the HCBS waiver, effective July 1, 2018.

In response to our prior recommendation, the State agency implemented a data match with the Maine Center for Disease Control & Prevention (CDC), Office of Data, Research, and Vital Statistics to ensure that all beneficiary deaths are reported by the community-based providers. The State agency also implemented new procedures to ensure that case managers complete the Mortality Review Form. All deaths are reviewed by the adult protective services unit to determine whether additional followup investigations are necessary, and that all deaths involving suspected abuse, neglect, or exploitation are referred to law enforcement or OCME.

Current Audit

We determined that the State agency ensured that all 31 beneficiary deaths during our audit period were reported by community-based providers, had Mortality Review Forms completed by the case manager or care coordinator, and were reviewed by the adult protective services unit. We also identified 4 of the 31 beneficiary deaths that involved suspected abuse or neglect, and we confirmed that they were referred to law enforcement or OCME as required. However, the Mortality Review Committee did not review the Mortality Review Forms for any of the 31 beneficiary deaths to identify patterns and trends and to make recommendations to improve care, as required by the HCBS waiver.

The State agency stated that after our prior report was issued, it disbanded the current committee and established an independent committee composed primarily of clinical experts within the Maine CDC.¹⁶ The State agency asked the Maine legislature for funding to hire a full-time nurse with mortality review expertise to serve as the coordinator for the Mortality Review Committee. In a letter to the legislature, the State agency cited the model practices contained in the *Joint Report: Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight* as one of the primary reasons for this request.¹⁷ A bill to establish the funding for State fiscal year 2021 was scheduled to be voted on in early 2020. However, the legislature was dismissed during the early stages of the COVID-19 pandemic, and no further action was taken on the bill. Nevertheless, a budget initiative was passed in 2021 to approve the funding for State fiscal year 2022,¹⁸ and the State agency reported to us that it has already started the process to hire the coordinator and to establish the Mortality Review Committee.

¹⁶ The Maine CDC is an office within the State agency. Its mission is to provide the leadership, expertise, information, and tools to assure conditions in which all residents of Maine can be healthy.

¹⁷ This report was jointly prepared by the Department of Health and Human Services' OIG, Administration for Community Living, and Office for Civil Rights. It contains model practices that that States can use to protect the health and safety of their residents living in group homes and community-based settings.

¹⁸ State of Maine, chapter 398, H.P. 156–L.D. 221, *An Act Making Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 2021, June 30, 2022, and June 30, 2023*, was approved on July 1, 2021.

Because the State agency did not ensure that the Mortality Review Committee conduct trend analysis based on aggregate data from completed Mortality Review Forms and meet quarterly to review any identifiable patterns and trends related to beneficiary deaths, the State agency did not fulfill all of the participant safeguard assurances it provided to CMS in its HCBS waiver and the State requirements incorporated under the HCBS waiver.

RECOMMENDATIONS

We recommend that the Maine Department of Health and Human Services:

- continue to work with CMS to fully implement the prior recommendation to ensure that followup reports are submitted by community-based providers appropriately and
- ensure that the Mortality Review Committee reviews Mortality Review Form aggregate data to identify patterns and trends and to make recommendations to improve care.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with both of our recommendations and described actions that they had taken or planned to take to implement them. Regarding the first recommendation, the State agency stated that it met the 86-percent standard established by CMS for followup reports submitted within 30 days for 4 consecutive quarters as of December 31, 2021, and that CMS notified the State agency it had closed the finding on May 3, 2022, after the issuance of our draft report. Regarding the second recommendation, the State agency stated that it has hired a panel coordinator for the Aging and Disability Mortality Review Panel and appointments of panel members are in progress. The State agency stated that the work of this panel provides an opportunity for the State to expand and strengthen the analysis of data related to beneficiary deaths and improve the system of care.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 1,813 emergency room claims that the State agency paid on behalf of Medicaid beneficiaries with developmental disabilities who resided in community-based settings from January 2019 through December 2019. We limited our review to the 123 emergency room claims (associated with 123 hospital emergency room visits by 89 beneficiaries who resided in community-based settings) with service dates from October 2019 to December 2019. The beneficiaries were diagnosed with at least 1 of 78 conditions that we determined to be indicative of high risk for suspected abuse or neglect.

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

We conducted our audit from September 2020 through February 2022.

METHODOLOGY

To accomplish our audit objectives, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- held discussions with CMS officials and reviewed correspondence between CMS and the State agency officials to gain an understanding of the corrective actions implemented to address the findings related to our prior audit recommendations;
- held discussions with State agency officials and reviewed supporting documentation to confirm that the prior recommendations were implemented;
- obtained a computer-generated file from the State agency of information on all 2,802 Medicaid beneficiaries with developmental disabilities who resided in community-based settings from January 1, 2019, through December 31, 2019;
- extracted from the T-MSIS 1,813 inpatient and outpatient claims for emergency room services containing revenue code 0450 provided from January 1, 2019, through December 31, 2019;¹⁹

¹⁹ Revenue code "0450" is described as Emergency Room—General Classification.

- reviewed the T-MSIS claims data and reconciled these data to the Maine Medicaid eligibility records to ensure that beneficiaries were Medicaid eligible on the date of service;
- evaluated 417 emergency room claims from October 2019 to December 2019 to determine the diagnosis codes that indicated an increased risk of abuse or neglect;²⁰
- identified the 123 emergency room claims for 123 hospital emergency room visits that occurred from October 2019 to December 2019 and contained at least 1 of the 78 diagnosis codes that we determined to be indicative of high risk for suspected abuse or neglect;
- determined the 123 emergency room visits met the definition of a critical incident;
- obtained and reviewed the medical records for the 123 critical incidents;
- requested from the State agency the incident reports submitted by community-based providers for the 123 critical incidents;
- compared the incident report documentation to the T-MSIS data and medical records to determine which of the 123 critical incidents were not reported to the State agency;
- requested from the State agency the followup reports submitted by community-based providers for 50 of the 123 emergency room visits;²¹
- requested confirmation from DRM that 50 selected reports of rights violations and 50 selected reports of restraint usage were properly reported by the State agency to DRM;²²

²⁰ We reviewed 100 percent of the claims in the last quarter of our audit period because we believed it would account for the improvements in the State agency's data match process as it was implemented.

²¹ We sorted the emergency room visits by Medicaid identification number and selected the first 50 visits that were reported as critical incidents by community-based providers.

²² The State agency provided summary reports of 2,785 restraints and 1,482 rights violations that were reported as critical incidents by community-based providers during our audit period. We selected every 55th restraint (2,785/50) and every 29th rights violation (1,482/50).

- requested confirmation from the State agency that 50 selected allegations of abuse, neglect, or exploitation were properly reported by the State agency to the appropriate district attorney’s office or law enforcement;²³
- reviewed records for 10 selected quarterly meetings between the State agency and a community-based provider to verify that the critical incident data collected during the previous quarter were analyzed and discussed at the meetings;
- identified beneficiary deaths that occurred during our audit period and determined whether:
 - community-based providers reported those deaths to the State agency,
 - the State agency had completed Mortality Review Forms,
 - the adult protective services unit of the State agency and the Mortality Review Committee reviewed those deaths, and
 - the State agency reported the deaths to law enforcement or OCME if required; 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.

²³ The State agency provided a summary report of 1,331 allegations of abuse, neglect, or exploitation that were reported to adult protective services during our audit period. We judgmentally selected 50 of these allegations based on type of allegation, location (county), and level of review.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>Massachusetts Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents</i>	A-01-20-00003	04/25/2022
<i>South Carolina Did Not Fully Comply With Requirements for Reporting and Monitoring Critical Events Involving Medicaid Beneficiaries With Developmental Disabilities</i>	A-04-18-07078	04/01/2022
<i>Arkansas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	A-06-17-01003	12/22/2021
<i>California Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	A-09-19-02004	9/22/2021
<i>Louisiana Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	A-06-17-02005	5/5/2021
<i>New York Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	A-02-17-01026	2/16/2021
<i>Texas Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	A-06-17-04003	7/9/2020
<i>Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities</i>	A-07-18-06081	3/27/2020
<i>Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	A-03-17-00202	1/17/2020
<i>A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect</i>	A-01-19-00502	7/23/2019
<i>Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	A-09-17-02006	6/11/2019
<i>Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight</i>	Joint Report*	1/17/2018
<i>Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	A-01-16-00001	8/9/2017

<i>Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	A-01-14-00008	7/31/2016
<i>Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	A-01-14-00002	5/25/2016
<i>Review of Intermediate Care Facilities in New York With High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries</i>	A-02-14-01011	9/28/2015
* This report was jointly prepared by the Department of Health and Human Services' OIG, Administration for Community Living, and Office for Civil Rights.		

APPENDIX C: STATE AGENCY COMMENTS

Janet T. Mills
Governor

Jeanne M. Lam brew, Ph.D.
Commissioner



Maine Department of Health and Human Services
Commissioner's Office
11 State House Station
109 Capitol Street
Augusta, Maine 04333-0011
Tel: (207) 287-3707; Fax: (207) 287-3005
TTY: Dial 711 (Maine Relay)

May 3, 2022

Curtis Roy, Regional Inspector General for Audit Services
U.S. Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region I JFK
Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

Dear Inspector General Roy:

The Maine Department of Health and Human Services is in receipt of your draft report, *Maine Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents*, dated March 30, 2022. The Department thanks the U.S. Department of Health and Human Services' Office of Inspector General for all the work performed in connection with this audit and appreciates the opportunity to comment on the report.

The Department understands that the report reflects the U.S. Department of Health and Human Services Office of Inspector General's follow-up audit findings and recommendations related to the State of Maine's system for reporting and monitoring critical incidents involving Medicaid beneficiaries with intellectual and developmental disabilities residing in community-based settings during calendar year 2019. The Department appreciates the acknowledgement of Maine's success in implementing the recommendations from OIG's prior audit, and agrees with these recommendations in the follow-up report:

- (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) to fully implement the prior recommendation to ensure that follow up reports are submitted by community-based providers appropriately; and
- (2) ensure the Mortality Review Committee reviews Mortality Review Form aggregate data in order to identify patterns and trends and to make recommendations to improve care.

Regarding recommendation 1, community-based providers are required to submit Reportable Event Follow Up Reports for all critical incidents within 30 calendar days of the date of the incident. As noted in the report, the Department has met the standard established by CMS, which is a compliance rate above 86% for the timely submission of follow up reports for four consecutive quarters. On May 3, 2022, we received confirmation from CMS that the standard was met in calendar year 2021, and CMS has now closed this finding, which was the last open finding stemming from the original OIG audit. Maine DHHS no longer has any open findings from that audit.

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Regarding recommendation 2, the report accurately reflects our progress in implementing a formal mortality review committee. The work of the Aging and Disability Mortality Review Panel, established in Maine statute (22 M.R.S.A. §264) provides an opportunity for the Department to expand and strengthen the analysis of data related to deaths of adults receiving home and community-based services and improve the system of care. A panel coordinator has been hired and will begin work in May 2022. Nominations for panel members have been collected and appointments are in progress.

The Department is committed to reviewing deaths as an important part of HCBS participant safeguards. The Department instituted several processes in response to the OIG's prior recommendations, including a data match with Maine CDC Data, Research and Vital Statistics to ensure all deaths of HCBS participants have been reported by providers. The Department further ensures that initial mortality review is done by the deceased's case manager, and that Adult Protective Services (APS) reviews information about deaths for indications of abuse, neglect or exploitation. APS follows established protocol in the event that abuse, neglect or exploitation is suspected, including reporting to the Office of the Chief Medical Examiner and law enforcement. These processes have worked well since the OIG's first audit report in 2017, and we look forward to enhancing our review of deaths with the trend analyses that the panel will undertake as part of its responsibilities.

The Department is committed to continuous quality oversight to ensure the health, welfare and protection of individuals with intellectual and developmental disabilities in Maine. The Department appreciates the continued collaborative efforts of self-advocates, family members, advocates, community-based providers, and our federal partners at OIG and CMS in achieving the improvements summarized in the report and in maintaining compliance going forward.

Sincerely,



Jeanne M. Lambrew, Ph.D.
Commissioner

JML/klv

cc: Benjamin Mann, Deputy Commissioner of Finance, DHHS
Paul Saucier, Director, Office of Aging and Disability Services, DHHS