

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**LOUISIANA DID NOT FULLY COMPLY
WITH FEDERAL AND STATE
REQUIREMENTS FOR REPORTING AND
MONITORING CRITICAL INCIDENTS
INVOLVING MEDICAID BENEFICIARIES
WITH DEVELOPMENTAL DISABILITIES**

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Christi A. Grimm
Principal
Deputy Inspector General

May 2021
A-06-17-02005

Office of Inspector General

<https://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: May 2021

Report No. A-06-17-02005

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



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.

Federal waivers permit States 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. The Centers for Medicare & Medicaid Services requires States to implement a critical incident reporting system to protect the health and welfare of Medicaid beneficiaries receiving waiver services.

Our objective was to determine whether Louisiana complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings from January 2015 through December 2016.

How OIG Did This Audit

We compared Medicaid emergency room claims with reported critical incidents to determine whether any critical incidents were unreported. We also analyzed data on critical incidents that occurred during our audit period to determine whether critical incidents were reported and followed up on in a timely manner.

Louisiana Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities

What OIG Found

Louisiana did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Specifically, Louisiana did not ensure that: (1) all hospital emergency room visits were reported as critical incidents and (2) all critical incidents were reported or followed up on, or both, within required timeframes. These issues occurred because Louisiana: (1) did not have a process, such as performing analytical procedures on Medicaid claims data, to determine whether there were unreported critical incidents, and (2) was unaware of the extent to which community-based providers were late in reporting and following up on critical incidents.

What OIG Recommends and Louisiana Comments

We recommend that Louisiana: (1) work with community-based providers on processes to identify and report all critical incidents, (2) perform timely analytical procedures to identify unreported critical incidents, (3) ensure that beneficiaries and their families are properly educated and understand that all hospital emergency room visits are critical incidents, (4) track direct service providers' and support coordinators' compliance with the reporting timeframes outlined in the waiver, and (5) correctly track whether direct service providers forward hardcopy critical incident reports to the support coordinator within 24 hours of discovery.

In written comments on our draft report, Louisiana concurred with our first four recommendations but did not concur with our fifth recommendation. For the first four recommendations, Louisiana described corrective actions that it plans to take or has already taken. Regarding our fifth recommendation that it correctly track whether direct service providers forward hardcopy critical incident reports to the support coordinator within 24 hours of discovery, Louisiana stated that with its new critical incident reporting system, direct service providers are now responsible for direct entry of all critical incidents, thus eliminating the need to send hardcopies to the support coordinator. We did not update our recommendation because we have not performed a review of Louisiana's new system for reporting critical incidents. However, we acknowledge that Louisiana's implementation of its new critical incident reporting system appears to have addressed the recommendation.

TABLE OF CONTENTS

INTRODUCTION..... 1

 Why We Did This Audit..... 1

 Objective 1

 Background 1

 Developmental Disabilities Assistance and Bill of Rights Act of 2000 1

 Medicaid Home and Community-Based Services Waiver 2

 Critical Incident Reporting for Community-Based Providers 2

 How We Conducted This Audit..... 3

FINDINGS..... 3

 The State Agency Did Not Ensure That Community-Based Providers Reported
 All Emergency Room Critical Incidents 4

 The State Agency Did Not Ensure That Community-Based Providers Reported
 and Followed Up on Critical Incidents Within Required Timeframes..... 5

RECOMMENDATIONS 7

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE 7

APPENDICES

 A: Audit Scope and Methodology 9

 B: Related Office of Inspector General Reports..... 11

 C: State Agency Comments..... 12

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 Louisiana, individuals with developmental disabilities may reside in an individual's own home, a family home, or shared living arrangements.² Within these community-based settings, provider types include direct service providers and support coordinators³ (collectively known as community-based providers).

OBJECTIVE

Our objective was to determine whether the Louisiana Department of Health (State agency) complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings from January 2015 through December 2016 (audit period).

BACKGROUND

Developmental Disabilities Assistance and Bill of Rights Act of 2000

As defined by the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (the Disabilities Act), "developmental disability" means a severe, chronic disability of an individual.⁴ The disability of the individual is attributable to a mental or physical impairment, or both; must be evident before age 22; and is likely to continue indefinitely. The disability results in substantial limitations in three or more major life areas, including self-care, receptive and expressive language, learning, mobility, self-determination, capacity for independent living, and economic self-sufficiency.

Federal and State Governments have an obligation to ensure that public funds are provided to residential, institutional, and community-based providers that serve individuals with

¹ See Appendix B for related work.

² Unlike other States that we have audited, Louisiana considers individuals with developmental disabilities who reside in group homes to be institutionalized.

³ In Louisiana, a support coordinator is a case manager. See New Opportunities Waiver, Appendix D, D-1: Service Plan Development of the waiver.

⁴ P.L. No. 106-402 (Oct. 30, 2000).

developmental disabilities. Further, these providers must meet minimum standards to ensure that the care they provide does not involve abuse, neglect, sexual exploitation, and violations of legal and human rights (the 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 to live in the community and avoid institutionalization. HCBS waiver services complement or supplement the services that are available to participants through the Medicaid State plan and other Federal, State, and local public programs and the support that families and communities provide. Each State has broad discretion to design its waiver program to address the needs of its waiver's target population.

The Office for Citizens with Developmental Disabilities within the State agency administers several of Louisiana's HCBS waiver programs, including the New Opportunities Waiver (the waiver) program (the waiver, Appendix A: Waiver Administration and Operation). We limited our audit to this waiver, which is Louisiana's largest HCBS waiver. The waiver provided 9,191 Medicaid beneficiaries with needed 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 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 incident reporting system (the waiver, Appendix G-1). In its waiver, the State agency stated that it has a critical event, or incident reporting, system.

Critical Incident Reporting for Community-Based Providers

The waiver generally defines a critical incident as abuse, neglect, exploitation, serious injury or illness (suspected or confirmed), death of a beneficiary, or other event that causes harm to an individual, and events that serve as indicators of risk to participant health and welfare, such as hospitalizations, hospital emergency room visits, medication errors, use of restraints, or behavioral incidents. The waiver states that direct service providers must report via phone or fax to the support coordinator a critical incident involving a beneficiary within 2 hours of the discovery of the incident after taking all necessary actions to protect the beneficiary from further harm. The support coordinator is then required to report a critical incident to the State agency by close of business on the next business day following notification of the critical

incident by the direct service provider or the discovery of the critical incident by the support coordinator (the waiver, Appendix G-1(b) and (d)).

During our audit period, the State agency used its Online Tracking Information System (OTIS) as the database to record the information obtained for critical incidents. OTIS records should include the date the incident occurred, the date it was reported, and any followup dates, as well as notes entered by the support coordinators and State agency staff. Each recorded incident is assigned a critical incident report identification number that tracks all the information for that critical incident within OTIS.⁵ During our audit period, the State agency reported 15,960 critical incidents in OTIS.

HOW WE CONDUCTED THIS AUDIT

We obtained: (1) a table of 15,960 reported critical incidents from the State agency that occurred during our audit period and (2) a database of 5,930 hospital emergency room claims data from the Louisiana Medicaid Management Information System (MMIS) that the State agency paid on behalf of beneficiaries covered by the waiver during our audit period. We compared the emergency room claims with the State agency's reported critical incidents to determine whether any emergency room claims were not reported in OTIS. We then collaborated with the State agency to verify whether they were reported. In addition, we analyzed the unreported emergency room claims that resulted in inpatient admissions to determine whether they involved potential abuse or neglect. We also determined whether community-based providers reported and followed up on critical incidents in a timely manner.

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 did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Specifically, the State agency did not ensure that: (1) all hospital emergency room visits were reported as critical incidents and (2) all critical incidents in OTIS were reported or followed up on, or both, within required timeframes. These issues occurred because the State agency: (1) did not have a process, such as performing analytical procedures on Medicaid claims data, to determine whether there were unreported

⁵ OCDD, Operational Instruction #F-5, OCDD-OTIS Definitions.

critical incidents and (2) was unaware of the extent to which community-based providers were late in reporting and following up on critical incidents.

As a result of not ensuring that providers reported all critical incidents, the State agency did not ensure proper responses to critical incidents or events, as outlined in the safeguard assurances it provided to CMS in the waiver. Furthermore, the State agency cannot take appropriate action to protect the health and welfare of Medicaid beneficiaries with developmental disabilities in a timely manner when community-based providers do not report critical incidents in a timely manner.

THE STATE AGENCY DID NOT ENSURE THAT COMMUNITY-BASED PROVIDERS REPORTED ALL EMERGENCY ROOM CRITICAL INCIDENTS

Community-based providers in Louisiana are required to report to the State agency all critical incidents involving Medicaid beneficiaries with developmental disabilities (the waiver, Appendix G-1(d)). Specifically, community-based providers are required to report hospital emergency room visits, whether the beneficiary was admitted to the hospital or discharged from the emergency room (the waiver, Appendix G-1(b)). Additionally, the waiver states that beneficiaries and family members are responsible for reporting critical incidents to community-based providers (the waiver, Appendix G-1(c) and (d)).

Community-based providers did not report to the State agency all critical incidents involving beneficiaries with developmental disabilities. Specifically, of the 5,930 emergency room visits, the community-based providers did not report 49 percent (2,931 emergency room visits) to the State agency.

In the waiver, the State agency instructed community-based providers to report all emergency room visits as critical incidents. However, the State agency did not provide training to beneficiaries and family members who would be responsible for reporting emergency room visits as critical incidents to community-based providers. Rather, the State agency required community-based providers to develop their own training curriculum for beneficiaries and family members on how to identify and report critical incidents. However, the State agency did not mandate or review training content to ensure that beneficiaries and family members were instructed that all emergency room visits should be reported as critical incidents.

In addition, the State agency did not have a process, such as performing analytical procedures on Medicaid claims data, to determine whether there were unreported critical incidents. Analytical procedures, similar to the procedures we performed for this audit, would help the State agency identify all unreported emergency room visits. In addition, the State agency could use the results to evaluate the need for additional training to community-based providers, beneficiaries, and family members.

As a result of not ensuring that community-based providers reported all critical incidents, the State agency did not ensure that providers responded properly to critical incidents, as outlined

in the safeguard assurances it provided to CMS in the waiver. The State agency cannot investigate and take appropriate action to protect the health and safety of Medicaid beneficiaries with developmental disabilities when critical incidents are not reported.

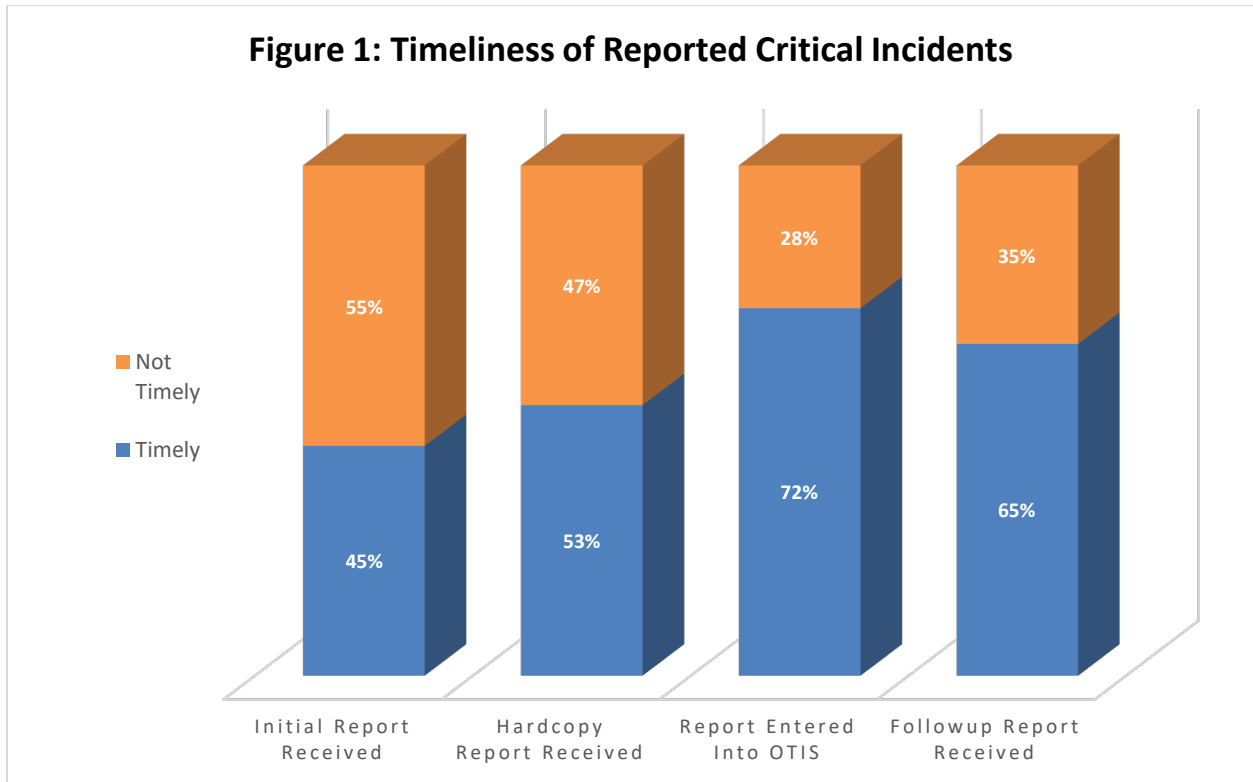
THE STATE AGENCY DID NOT ENSURE THAT COMMUNITY-BASED PROVIDERS REPORTED AND FOLLOWED UP ON CRITICAL INCIDENTS WITHIN REQUIRED TIMEFRAMES

The waiver states that after taking all necessary actions to protect the beneficiary from further harm, direct service providers must report via phone or fax to the support coordinator a critical incident involving a beneficiary within 2 hours after the discovery of the critical incident. If the critical incident is discovered by a support coordinator, he or she must contact the direct service provider within 2 hours after the discovery of the critical incident. The direct service provider is then required to submit a hardcopy of the critical incident report to the support coordinator within 24 hours of discovery of the critical incident. The support coordinator is then required to report a critical incident to the State agency by entering the critical incident report information into OTIS by close of business on the next business day following notification of the critical incident by the direct service provider. Additionally, a direct service provider is required to submit a followup report regarding the critical incident to the support coordinator by the close of the third business day following the initial critical incident report. The waiver also states that the State agency will track the timelines described above (the waiver, Appendix G-1(b)&(d) and Participant Safeguards(a)(G.a.i.a.3)).

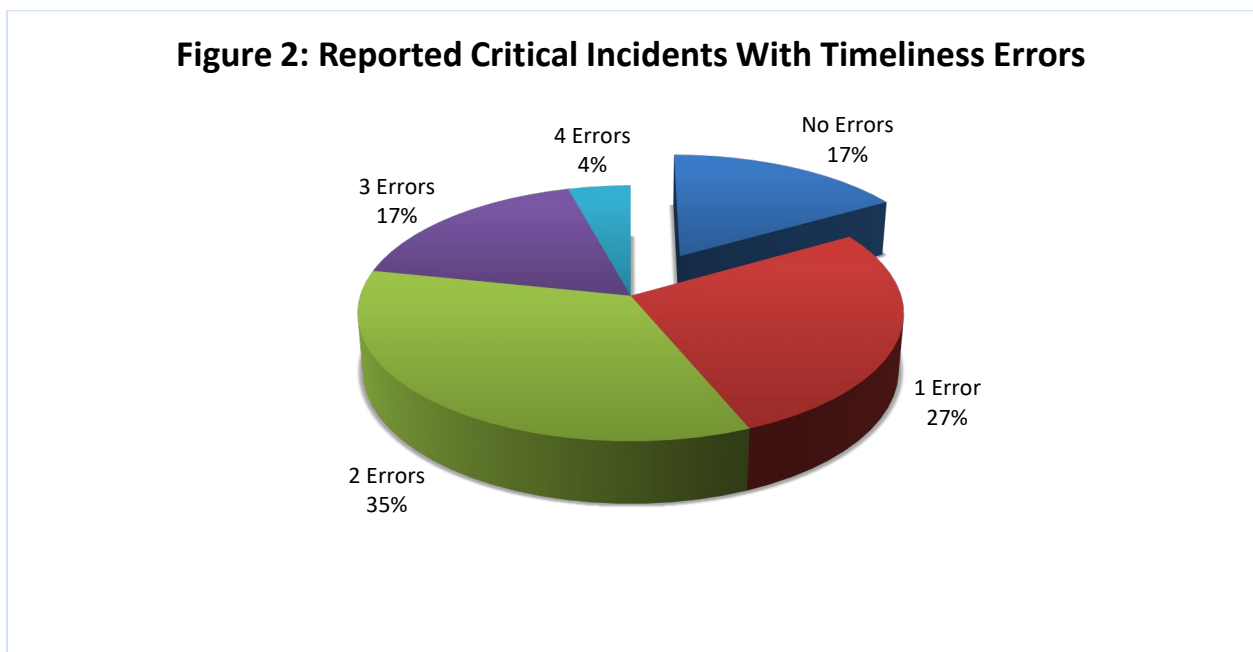
The State agency did not always ensure that critical incidents in OTIS were reported or followed up on, or both, within the required timeframes. Specifically, of the 15,960 critical incidents reported in OTIS during our audit period, we found that:

- community-based providers did not report 8,849 (55 percent) of critical incidents within 2 hours of discovery and did not report 6,748 (42 percent) within 12 hours,
- direct service providers did not forward 7,545 (47 percent) of hardcopy critical incident reports to the support coordinator within 24 hours of discovery and did not forward 5,052 (32 percent) within 48 hours,
- support coordinators did not enter 4,529 (28 percent) of critical incident reports into OTIS by close of the next business day following notification of the critical incident and did not enter 2,709 (17 percent) by close of the second business day following notification, and
- direct service providers did not submit 5,511 (35 percent) of followup reports to the support coordinator by close of the third business day following the initial report and did not submit 3,946 (25 percent) by close of the fifth business day following the initial report.

Figure 1 shows the percentage of reported critical incidents with each timeliness error.



In total, only 17 percent of critical incidents were reported and followed up on in a timely manner while the remaining 83 percent were not, as shown in Figure 2.



The State agency was not aware of these timeliness errors in the critical incident reporting process because it was: (1) not tracking the 2-hour, next-business-day, and third-business-day timeframes, as required in the waiver, and (2) incorrectly calculating the 24-hour timeframe by using the date and time the critical incident was reported to the support coordinator/direct service provider rather than the date and time the critical incident was discovered. The State agency cannot take appropriate action to protect the health and welfare of Medicaid beneficiaries with developmental disabilities in a timely manner when community-based providers do not report critical incidents in a timely manner.

RECOMMENDATIONS

We recommend that the Louisiana Department of Health:

- work with community-based providers on processes to identify and report all critical incidents;
- perform timely analytical procedures, such as data matches, on Medicaid claims data to identify unreported critical incidents and investigate as needed;
- ensure that beneficiaries and their families are properly educated and understand that all hospital emergency room visits are critical incidents and should be reported;
- track direct service providers' and support coordinators' compliance with the reporting timeframes outlined in the waiver; and
- correctly track whether direct service providers forward hardcopy critical incident reports to the support coordinator within 24 hours of discovery.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency concurred with our first four recommendations but did not concur with our fifth recommendation.

The State agency outlined the corrective actions that it has taken and plans to take to address the first four recommendations. These actions include updating operational instructions to ensure that community providers report and enter critical incidents within established timeframes; hiring a program monitor to compare Medicaid emergency room claims data with critical incidents reported in the State's system; developing an online training database for direct service providers, beneficiaries, and beneficiary families; and developing a system report to correctly track compliance for timeliness.

Regarding our fifth recommendation that the State agency correctly track whether direct service providers forward hardcopy critical incident reports to the support coordinator within

24 hours of discovery, the State agency said that with the implementation of its new Statewide Incident Management System (SIMS),⁶ direct service providers are now responsible for direct entry of all critical incidents, thus eliminating the need to send hardcopies to the support coordinator.

The State agency's comments appear in their entirety as Appendix C.

We did not update our recommendation that the State agency correctly track whether direct service providers forward hardcopy critical incident reports to the support coordinator within 24 hours of discovery because we have not performed a review of the State agency's new system for reporting critical incidents (SIMS) because it was implemented after our audit period. However, we acknowledge that the State agency's implementation of SIMS appears to have addressed our recommendation by eliminating the need for direct service providers to submit hardcopy critical incident reports to support coordinators and replacing it with a more streamlined and efficient approach to reporting critical incidents.

⁶ On July 8, 2019, the State agency phased out the OTIS system for active reporting of critical incidents and implemented the SIMS system.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

From January 2015 through December 2016, the waiver covered 9,191 Medicaid beneficiaries with developmental disabilities. During this period, the State agency reported 15,960 critical incidents involving 4,900 waiver participants. We obtained and analyzed 5,930 Medicaid emergency room claims from the State agency paid on behalf of waiver participants. (Such claims are considered indicative of a critical incident.) We then compared these 5,930 claims with the State agency's 15,960 reported critical incidents and identified 2,931 emergency room claims for which the community-based providers did not report a critical incident to the State agency. We also analyzed reported critical incidents that occurred during our audit period to determine whether they were reported and followed up on in a timely manner.

Our objective did not require an understanding of all 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 incident reporting and monitoring.

We performed audit work at our office in Baton Rouge, Louisiana.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal waiver and State requirements;
- reviewed the State agency's Operational Instruction #F-5: Critical Incident Reporting, Tracking and Follow-Up Activities for Waiver Services (Revised: May 12, 2010);
- held discussions with State agency officials to gain an understanding of State policies and controls related to reporting critical incidents involving beneficiaries with developmental disabilities;
- obtained from the State agency a computer-generated file of information (e.g., name, social security number, date of birth, waiver participation dates) for all Medicaid beneficiaries who were waiver participants during the audit period;
- obtained from the MMIS a computer-generated file containing 5,930 Medicaid emergency room paid claims;

- obtained from the State agency's OTIS system a computer-generated file of 15,960 critical incidents reported for Medicaid beneficiaries who were waiver participants during the audit period;
- reconciled the MMIS data with the State agency's waiver enrollment records to verify the accuracy of the data;
- compared the 15,960 reported critical incidents with the 5,930 Medicaid emergency room paid claims and identified 2,931 Medicaid records that were not reported as critical incidents to the State agency;
- requested that the State agency verify whether these critical incidents were reported;
- identified 211 unreported emergency room visits for which the beneficiary was admitted to the hospital to determine whether the diagnosis codes indicated abuse or neglect;⁷
- compared the State agency's OTIS system death data with the Social Security Administration's Death Master File and determined that there were no unreported deaths;
- analyzed the State agency's OTIS system data and compared it with the State agency's trend analysis reports related to our audit period to determine whether specific requirements (such as reported critical incidents, medication errors, deaths, restraints, and reporting timelines) in these reports were within reason; 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.

⁷ We found no unreported critical incidents involving abuse or neglect.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<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 Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	A-09-17-02006	6/11/2019
<i>Joint Report: Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight</i>	Joint Report ⁸	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-01-14-00002	9/28/2015

⁸ This report was jointly prepared by the Department of Health and Human Services, Office of Inspector General, Administration for Community Living, and Office for Civil Rights.

APPENDIX C: STATE AGENCY COMMENTS

John Bel Edwards
GOVERNOR



Dr. Courtney N. Phillips
SECRETARY

State of Louisiana
Louisiana Department of Health
Office of the Secretary

March 8, 2021

Patricia Wheeler
Regional Inspector General for Audit Service
Office of Audit Services
Region VI 1100 Commerce Street, Room 632
Dallas, TX 75242

Report Number: A-06-17-02005

Dear Mrs. Wheeler,

Thank you for the opportunity to respond to the draft report (A-06-17-2005), *Louisiana Did Not Fully Comply with Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries with Developmental Disabilities*.

The State appreciates the Office of the Inspector General (OIG) allowing the Louisiana Department of Health (LDH) and the Office for Citizens with Developmental Disabilities (OCDD), the opportunity to review the OIG findings for the audit periods reviewed. The State was able to address some of the allegations of non-compliance.

LDH/OCDD has operational instructions that require participants, families, support coordinators and providers to (1) report all critical incidents, and to (2) report them in a timely fashion. The State intends to put processes in place to provide improvement in oversight of these activities.

As instructed by your letter dated January 22, 2021, attached are LDH's written comments (Attachment A), which include a statement of concurrence with each of the recommendations, and the improvement activities that the State has developed (or will develop) to ensure that LDH addresses the concerns identified in the audit.

LDH/OCDD appreciates the opportunity to respond to this audit. You may contact Paul Rhorer, OCDD Program Manager 3, by telephone at (225) 342-8804 or by email at paul.rhorer@la.gov with any questions concerning this matter.

Sincerely,

A handwritten signature in black ink, appearing to read "Dr. Courtney N. Phillips".

Dr. Courtney N. Phillips

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ATTACHMENT A
State of Louisiana responses to OIG recommendations

Report Number: A-06-17-02005

FINDINGS:

1. THE STATE AGENCY DID NOT ENSURE THAT COMMUNITY-BASED PROVIDERS REPORTED ALL EMERGENCY ROOM CRITICAL INCIDENTS.

2. THE STATE AGENCY DID NOT ENSURE THAT COMMUNITY-BASED PROVIDERS REPORTED AND FOLLOWED UP ON CRITICAL INCIDENTS WITHIN REQUIRED TIMEFRAMES.

OIG RECOMMENDATIONS

<p>Recommendation #1: Work with community-based providers on processes to identify and report all critical incidents;</p>
<p>State Response: The State concurs with this recommendation.</p> <p>The State will review and update its operational instructions regarding reporting timelines. The timelines will guarantee that community providers are able to first ensure that the participant is safe, and then report/enter the critical incident within the established timelines.</p> <p>The State will work closely with the Local Governing Entities to develop Corrective Action Plans (CAP) for those community providers who do not report timely.</p>
<p>Recommendation #2: Perform timely analytical procedures, such as data matches, on Medicaid claims data to identify unreported critical incidents and investigate as needed;</p>
<p>State Response: The State concurs with this recommendation.</p> <p>The State has hired a program monitor with a PhD in statistics. The program monitor will work closely with the Office for Citizens with Developmental Disabilities (OCDD) Business Analytics Section to pull data from the Medicaid emergency room claims data. The program monitor will compare the claims data to the critical incidents data reported in the new incident management data system (SIMS). The State is developing the process to implement this recommendation.</p>
<p>Recommendation #3: Ensure that beneficiaries and their families are properly educated and understand that all hospital emergency room visits are critical incidents and should be reported;</p>
<p>State Response: The State concurs with this recommendation.</p> <p>Education and Training: OCDD training, quality, and information technology sections will develop an online training database, and require that all community providers (direct care agency staff and Support Coordination agencies) complete Critical Incident Reporting</p>

Training and the Abuse and Neglect training at least annually. Families and participants may be included in these trainings when applicable. This database system will track the completion of these trainings, and generate reports on those completing the training as required.

The State has revised the Plan of Care (POC), which now requires that the Support Coordinator discuss with participants and families the necessity of timely reporting critical incidents (as required by the Centers for Medicare and Medicaid Services (CMS)). The families and/or participants must sign the acknowledgment in the POC to acknowledge that the Support Coordinator has discussed critical incident reporting, and that the Support Coordinator has given the family the Support Coordination Agency phone number, and instructions for timely reporting. The completion of this acknowledgment in the POC is mandatory. This policy became effective February 18, 2021.

Recommendation #4: Track direct service providers' and support coordinators' compliance with the reporting timeframes outlined in the waiver; and

State Response: The State concurs with this recommendation.

The State will ensure that there is a report developed in SIMS that will correctly track compliance for timelines as outlined in an operational instruction.

Recommendation #5: Correctly track whether direct service providers forward hardcopy critical incident reports to the support coordinator within 24 hours of discovery.

State Response: The State does not concur with this recommendation because it is no longer applicable.

With the implementation of SIMS, the direct service provider agency is responsible for the direct entry of all critical incidents, thus eliminating the need to send a hard copy to the support coordination agency absent extraordinary circumstances.