Healthcare and Family Services Critical Incident Guide For Medicaid Managed Care Plans

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I. Introduction

Health Plans are required to comply with all health, safety and welfare monitoring and reporting required by State and federal statute or regulation, or that is otherwise a condition for a HCBS Waiver. Health plans should identify, address, and seek to prevent the occurrence of Abuse, Neglect and Exploitation. MCOs are required to educate Providers, Enrollees, and Enrollees' family members about the signs of Abuse, Neglect, and Exploitation, and what to do if they suspect Abuse, Neglect or Exploitation. Training sessions should include general indicators of Abuse, Neglect, or Exploitation, and the timeframe requirements for reporting suspected Critical Incidents. Health plans should have processes in place to receive these reports. MCOs are expected to maintain an internal reporting system for tracking the reporting and responding to critical incidents, and for analyzing the event to determine whether individual or systemic changes are needed. MCOs are then required to submit details of the collected Critical Incident data each month and summary data quarterly to HFS, Bureau of Managed Care.

II. Statute and Regulation

Health plans must comply with the statutes and regulations listed below and any other similar or related applicable federal or State laws.

The Department of Human Services Act (20 ILCS 1305/1-1 et seq.),

The Abuse of Adults with Disabilities Intervention Act (20 ILCS 2435/1 et seq.),

The Elder Abuse and Neglect Act (320 ILCS 20/1 et seq.),

The Abused and Neglected Child Reporting Act (325 ILCS 5/1 et seq.)

The critical incident reporting requirements of the HCBS waiver operating agencies, DHS-DRS, DoA, and HFS for incidents and events that do not rise to the level of Abuse, Neglect or Exploitation.

III. Mandated Reporting

Health Plans are mandated reporters. Mandated reporting is defined as *immediate reporting* required from a mandated reporter of suspected maltreatment when the mandated reporter has reasonable cause to believe that an individual known to the mandated reporter in a professional or official capacity may be Abused or Neglected.

If a health plan perceives an immediate threat to the participant's life or safety, they should follow emergency procedures which may include calling ***911***.

IV. Critical Incident Reporting Deliverables

a. Monthly - Critical Incidents Detail Report QA21

This is report should *only* include Critical Incidents for members receiving Long-Term Services and Supports (LTSS). The MCO must use the most current template provided and complete per the data definitions tab of the template. Each managed care program has a template. The MCO is required to submit a report for each managed care program they participate in.

b. Quarterly – Critical Incidents Summary Report QA22

This report should *only* include a summary of Critical Incident occurrences for members receiving Long-Term Services and Supports (LTSS). The MCO must use the most current template provided and complete per the data definitions tab of the template. Each managed care program has a template. The MCO is required to submit a report for each managed care program they participate in.

V. Critical Incident Definitions

a. **Critical Incident (CI) -** actual or alleged abuse, neglect, exploitation, or any incident that has the potential to place a member or member's services at risk, including those that do not rise to the level of abuse, neglect, or exploitation; this includes events that may cause substantial or serious harm to the physical or mental health of a member or the safety of a member's services.

   Please include only members who are enrolled in a HCBS waiver or residing in a Nursing Facility when reporting CIs to HFS in the QA21 and QA22.

b. **Abuse-** (i) a manner of operation that results in excessive or unreasonable costs to the Federal or State health care programs, generally used in conjunction with Fraud; or (ii) the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 CFR Section 488.301), generally used in conjunction with Neglect.

   Abuse includes: physical abuse, verbal abuse, sexual abuse or harassment, mental or emotional abuse, unauthorized restraint, confinement, self-harm, and suicide attempt.

c. **Neglect-** a failure (i) to notify the appropriate health care professional, (ii) to provide or arrange necessary services to avoid physical or psychological harm to a member, or (iii) to terminate the residency of a member whose needs can no longer be met, causing an avoidable decline in function.

   Neglect includes: Passive neglect, Will deprivation, isolation, and self-neglect

   i. **Passive Neglect-** a non-malicious failure to provide the necessities of life including, but not limited to, food, clothing, shelter, or medical care.

   ii. **Willful Deprivation-** a willful denial of medications, medical care, shelter, food, therapeutic devices, or other physical assistance to a person who, because of age, health, or disability, requires such assistance and thereby exposes that person to the risk of physical, mental, or emotions harm because of such denial; except with respect to medical care or treatment when the dependent person has expressed an intent to forego such medical care or treatment and has the capacity to understand the consequences.

d. **Exploitation-** the misuse or withholding of a members assets and resources (belongings and money). It includes, but is not limited to , misappropriation of assets or resources of the alleged victim by undue influence, by breach of fiduciary relationship, by fraud, deception, extortion, or in any manner contrary to law.

e. **Other-** any incident that has the potential to place a member, or a member's services, at risk, but which does not rise to the level of abuse, neglect, or exploitation.

   Other includes but may not be limited to: Unexpected Death, Serious Medical or behavioral health incident that results in emergency treatment, Law Enforcement incidents, Natural Disasters, Elopement, and Missing Person.

VI. Troubleshooting Deliverables

a. While the Department expects health plans to refer all critical incidents to the appropriate authority per Illinois and federal statutes and regulations within the dictated timelines, the required deliverables should *only* include those members receiving long-term services and supports (LTSS). For example, health plans are still required to report child abuse to the DCFS hotline, but this will no longer be submitted on the CI Detail report, QA21 or counted in the CI Summary report, QA22.

    i. Contracts will be amended as needed to support this.
    ii. SharePoint reporting templates will be amended as well.

b. Health Plans are required to educate providers regarding identifying, preventing, and reporting ANE and other Critical Incidents (CI); processes should be in place to track, report, and analyze the incidents. For example, when a member falls in a nursing facility and is taken to the emergency room for treatment as a result, the nursing facility, based on CI education, would notify the MCO. The CI should be referred to the proper authority, and the MCO should engage staff as needed to ensure member is safe and services are no longer at risk; the MCO would document and monitor this CI in the context of other CIs to identify any trends or individual member related issues that may arise. The CI details should also be reported to the Department monthly.

    i. The key factor is training providers to notify the health plan *when the CI occurs.*
    ii. Reporting a true CI to HFS based on a record review after the fact is a breakdown in the critical incident reporting process. It is a clear sign that further provider education is needed.

c. Quality Assurance Check prior to submission to the Department

    i. This is an important step each MCO should take; reports in general should be checked for completion and accuracy.
    ii. Please do not alter the template formulas; in general, cells that are yellow-filled are for data input.
    iii. Remember to use the feedback you receive from the report reviewer to improve your next report. Often times, reviewers provide feedback in the HFS comments box of a report, but continue to see the same errors.
    iv. This QA check can help to ensure that your report is approved the first time around.

d. **Critical Incidents Detail Report- QA21-** Reporting frequency is monthly; below is a closer look at the data definitions.
    i. Critical Incident – Each category is a separate table. Please use the definitions provided in Section V as a guide.

        1. **Other** is a broad category that can be further defined.
            a. Unexpected Death- this can include the death of the member or even the caregiver if it affected the safety of the member's services. The example listed in the DRS CI Definitions in your contract attachments explains this very well.
            b. Serious Medical Incident that results in emergency treatment- this can include medication errors, unexpected injuries or new diagnosis that can significantly impact a member's health.
            c. Serious Behavioral Health Incident that results in emergency treatment- this can include suicide ideation, sexually problematic behavior, uncontrolled problematic alcohol or substance abuse, or any other mental health emergency.
            d. Law Enforcement-can include problematic possession or use of a weapon, arrest, property damage greater than $50, or other criminal activity that involves law enforcement.
            e. Natural Disasters – this can include fire or other natural disasters as well as loss of home, loss of electrical power in a SLF for longer than 60 minutes.
            f. Elopement – member ran away
            g. Missing Person – members whereabouts are unknown

    ii. Enrollee Name- full member name
    iii. Enrollee Medicaid ID- RIN
    iv. Waiver Type- **non-waiver should no longer be used**; templates will be updated soon to remove this choice.
    v. Incident Summary- should include a brief, but complete description of the incident.
    vi. Date received- date MCO learned of the CI
    vii. Source- the individual or entity who reported the CI to the health plan (or its contracted vendor). The source should ***not*** be the health plan utilization staff or care coordination staff. The source is who reported to those staff. This may be a member, member's family, ER staff, NH staff, or the members IP, etc.
    viii. Incident date- date incident occurred

ix. Date referred- Date the health plan notified the appropriate authority. This should ***not*** include internal referrals to a group or unit within the health plan.

x. Referral Entity- the appropriate authority the health plan reported the CI to. This should ***not*** include any internal group within the MCO such as the MCOs fraud unit.

xi. Date Resolved- date resolved by the MCO; this *does not* imply that the Referral Entity has resolved as well.

xii. Resolution Summary- should include a brief, but complete description of who the health plan reported the incident to **and** what actions the health plan took to ensure the safety of the member's health and services. For example (self-harm), stating that "Care coordinator contacted APS" in the summary is addressing only part of the resolution. A more complete submission may include "Care coordinator contacted APS; care coordinator confirmed member's immediate safety; member is now engaged in care coordination has agreed to additional behavioral health services."

e. **Critical Incident Summary Report- QA22-** Reporting frequency is quarterly. This data should **correspond *exactly*** with the data submitted in the monthly detail for the reporting quarter. Please remember to review this report before submitting to the Department.

VII. Helpful Resources

Children Under 18: 1-800-25A-BUSE (1-800-252-2873) or TTY 1-800-358-5117; below is link to DCFS website with more information.
http://www.illinois.gov/dcfs/safekids/reporting/Pages/index.aspx

Members with disabilities who are age eighteen (18) and older, and seniors living in the community: IDOA, Adult Protective Services (APS) at 1-866-800-1409) or 1-800-206-1327 (TTY); below is a link to DOA for more information.

http://www.illinois.gov/aging/ProtectionAdvocacy/Pages/abuse_reporting.aspx

Members in Nursing Facilities: Department of Public Health's Nursing Home Complaint Hotline at 1-800-252-4343; below is link to IDPH for more information.

http://www.dph.illinois.gov/topics-services/health-care-regulation/complaints

Members aged 18-59 receiving mental health or Developmental Disability services in DHS operated, licensed, certified or funded programs: DHS. Office of the Inspector General (OIG) at 1-800-368-1463 (voice and TTY); below is a link to DHS website with more information.

http://www.dhs.state.il.us/page.aspx?item=32675

Members in Supportive Living Facilities (SLF): HFS' SLF Complaint Hotline at 1-800-226-0768.