

## 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.