

Report in Brief

Date: January 2020

Report No. A-03-17-00202

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 people with developmental disabilities living 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 the community and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) requires States to implement an incident reporting system to protect the health and welfare of the Medicaid beneficiaries receiving waiver services.

Our objective was to determine whether Pennsylvania complied with Federal waiver and State requirements related to 24-hour reportable incidents that involve Medicaid beneficiaries with developmental disabilities residing in community-based settings.

How OIG Did This Audit

Our audit covered 2015 and 2016. We reviewed medical claims for beneficiaries residing in community-based settings who had acute-care hospital stays and emergency room visits with diagnosis codes that we determined to be indicative of high risk for suspected abuse or neglect. We also reviewed 24-hour reportable incident reports that were submitted to Pennsylvania's incident reporting system.

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

What OIG Found

Pennsylvania did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring 24-hour reportable incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings. Specifically, Pennsylvania did not (1) ensure that community-based providers reported thousands of 24-hour reportable incidents within required timeframes, (2) ensure that community-based providers and county and regional investigators analyzed and investigated all beneficiary deaths, and (3) ensure that community-based providers referred all suspicious deaths to law enforcement.

Pennsylvania did not have adequate controls to detect unreported 24-hour reportable incidents and did not have controls in place to ensure that all beneficiary deaths were investigated and that all suspicious deaths were referred to law enforcement. Therefore, Pennsylvania did not fulfill participant safeguard assurances it gave to CMS to ensure the health, welfare, and safety of the 18,770 Medicaid beneficiaries with developmental disabilities covered by the Medicaid waiver in our audit.

What OIG Recommends and Pennsylvania Comments

We recommend that Pennsylvania improve its controls regarding the reporting and monitoring of 24-hour reportable incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. We made specific recommendations for these controls.

Pennsylvania concurred with six of our seven recommendations and described corrective actions that it plans to take or has already taken, but it did not concur with our recommendation that it record the 24-hour reportable incidents noted in our report. Instead, Pennsylvania stated that it plans to focus on recording unreported emergency room visits and hospital stays that contain diagnoses indicative of high risk for suspected abuse or neglect and take remedial action as appropriate. We agree that Pennsylvania should prioritize recording unreported incidents that contain diagnoses indicative of high risk for suspected abuse or neglect but maintain that all unreported 24-hour reportable incidents must be reported.

The full report can be found at <https://oig.hhs.gov/oas/reports/region3/31700202.asp>.