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 Arkansas complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings.

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.

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

What OIG Found
Arkansas did not fully comply 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. Specifically, Arkansas did not: (1) ensure that community-based providers properly reported all incidents of suspected adult or child abuse to the appropriate hotline; (2) provide evidence of review and followup action on all incidents of adult or child abuse; and (3) review all deaths of beneficiaries receiving waiver services. These issues occurred because Arkansas did not have controls in place to ensure that incidents of abuse, neglect, or death were reviewed and reported to the appropriate authority. Additionally, Arkansas did not ensure that all incidents involving Medicaid beneficiaries, including incidents of death, were reported because its waiver did not clearly require that incidents that occurred outside of State custody or State facilities be reported. Also, Arkansas did not have adequate internal controls in place to detect unreported incidents.

What OIG Recommends and Arkansas Comments
We recommend that Arkansas: (1) ensure that community-based providers report all suspected adult or child abuse and neglect to the appropriate adult or child abuse hotline; (2) follow waiver guidance for incidents that appear to be abuse that require review and followup; (3) follow waiver guidance to conduct reviews of the deaths of beneficiaries receiving waiver services; (4) consider amending critical incident reporting requirements, including those related to incidents of death, to clearly apply to circumstances in which Arkansas employees or contractors are providing waiver services at a non-State facility or a private home, and a critical incident occurs; and (5) perform analytical procedures, such as data matches, on Medicaid claims data to identify potential critical incidents that have not been reported and investigate as needed. In written comments on our draft report, Arkansas concurred with our first three recommendations and outlined the corrective actions that it has taken or plans to take to address them. Regarding our fourth recommendation, Arkansas stated that all community-based providers are required to report all critical incidents involving waiver beneficiaries. Regarding our fifth recommendation, Arkansas stated that improvements to its current controls allow it to identify potential critical incidents that have not been reported and need investigation.

The full report can be found at https://oig.hhs.gov/oas/reports/region6/61701003.asp.