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

Pennsylvania Implemented Our Prior Audit Recommendations for Critical Incidents Involving Medicaid Enrollees With Developmental Disabilities but Should Continue To Take Action To Reduce Unreported Incidents

Why OIG Did This Audit

We previously issued an audit of Pennsylvania as part of a series of audits conducted in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes.

In our previous audit, we found that Pennsylvania did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring such incidents. Our previous audit report contained seven recommendations.

Our objective was to determine whether Pennsylvania implemented the recommendations from our prior audit, *Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities* (A-03-17-00202).

How OIG Did This Audit

We reviewed Pennsylvania's system for the reporting and monitoring of critical incidents involving Medicaid waiver participants with developmental disabilities who were covered by the waiver and resided in community-based settings during the audit period. We also reviewed correspondence and documentation to determine whether Pennsylvania had implemented our previous recommendations and had taken actions that satisfied the intent of our recommendations.

What OIG Found

Pennsylvania implemented or is in the process of implementing the seven recommendations from our previous audit but should continue to take action to further reduce unreported incidents. Since the previous audit report, Pennsylvania experienced a significant overall 74-percent reduction in the percent of hospital stay incidents not reported. However, although the percentage of incidents reported improved, Pennsylvania's changes to implement the recommendations did not ensure that community-based providers properly reported all 24-hour reportable incidents in the electronic incident management system or that supports coordinators notified providers that a 24-hour reportable incident had occurred.

Because Pennsylvania did not detect that some providers did not report all 24-hour reportable incidents, it was not always able to take prompt action to protect waiver participants' health, safety, and rights. However, Pennsylvania's actions involve a multi-year training plan for its current Incident Management Policy and a dashboard to identify unreported incidents and providers that may have incident management processes in need of systemic improvement.

What OIG Recommends and Pennsylvania Comments

We make several recommendations for Pennsylvania to continue to improve its controls regarding the reporting and monitoring of 24-hour reportable incidents involving Medicaid waiver participants with developmental disabilities residing in community-based settings. The full recommendations are in the report.

Pennsylvania concurred with all of our recommendations and described corrective actions that it has taken or plans to take to address our recommendations.