Report in Brief

Date: April 2022

Report No. A-04-18-07078

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 residents with developmental disabilities in group homes. This request was made in response to nationwide media coverage of deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors.

Our objective was to determine whether South Carolina complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical events involving Medicaid beneficiaries with developmental disabilities residing in community-based settings.

How OIG Did This Audit

We reviewed South Carolina's compliance with Intellectually Disabled and Related Disabilities (IDRD) waiver requirements for reporting and monitoring critical events during our audit period. South Carolina provided comprehensive support services to 8,156 individuals with developmental disabilities who were enrolled in the IDRD waiver program. We limited our review to 7,161 beneficiaries who were at least 18 years old as of January 1, 2015.

South Carolina Did Not Fully Comply With Requirements for Reporting and Monitoring Critical Events Involving Medicaid Beneficiaries With Developmental Disabilities

What OIG Found

South Carolina did not fully comply with requirements for reporting and monitoring critical events involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Specifically, South Carolina did not ensure that providers: (1) reported all critical incidents, (2) reported within 24 hours or the next business day all critical events, or (3) always submitted the results of their internal reviews within 10 working days. The detailed findings are listed in the body of the report.

What OIG Recommends and South Carolina Comments

We recommend that South Carolina work with the Department of Disabilities and Special Needs (DDSN) to: (1) ensure that providers follow the reporting requirements for critical events, (2) provide training to providers on recognizing and reporting critical incidents according to reporting requirements, (3) perform analytical procedures such as data matches on Medicaid claims data to identify any unreported critical incidents and investigate as needed, and (4) ensure that providers submit all incident reports to DDSN through the Incident Management System within 24 hours of an incident or the next business day. The detailed recommendations are listed in the body of the report.

In written comments on our draft report, South Carolina concurred with our recommendations and described the corrective actions that it has taken or plans to take to address them. These actions include but are not limited to: (1) revising its policies, procedures, and protocols to provide assurance that incidents will be reported as required; (2) continuing to strengthen and reinforce training with contracted provider agencies to identify and prevent allegations of abuse, neglect, and exploitation and critical incidents; and (3) working with data analytics staff to develop a dashboard of claims data to inform incident detection and reporting efforts.