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

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

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 Louisiana complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities who resided in community-based settings from January 2015 through December 2016.

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.

What OIG Found

Louisiana did not fully comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Specifically, Louisiana did not ensure that: (1) all hospital emergency room visits were reported as critical incidents and (2) all critical incidents were reported or followed up on, or both, within required timeframes. These issues occurred because Louisiana: (1) did not have a process, such as performing analytical procedures on Medicaid claims data, to determine whether there were unreported critical incidents, and (2) was unaware of the extent to which community-based providers were late in reporting and following up on critical incidents.

What OIG Recommends and Louisiana Comments

We recommend that Louisiana: (1) work with community-based providers on processes to identify and report all critical incidents, (2) perform timely analytical procedures to identify unreported critical incidents, (3) ensure that beneficiaries and their families are properly educated and understand that all hospital emergency room visits are critical incidents, (4) track direct service providers' and support coordinators' compliance with the reporting timeframes outlined in the waiver, and (5) correctly track whether direct service providers forward hardcopy critical incident reports to the support coordinator within 24 hours of discovery.

In written comments on our draft report, Louisiana concurred with our first four recommendations but did not concur with our fifth recommendation. For the first four recommendations, Louisiana described corrective actions that it plans to take or has already taken. Regarding our fifth recommendation that it correctly track whether direct service providers forward hardcopy critical incident reports to the support coordinator within 24 hours of discovery, Louisiana stated that with its new critical incident reporting system, direct service providers are now responsible for direct entry of all critical incidents, thus eliminating the need to send hardcopies to the support coordinator. We did not update our recommendation because we have not performed a review of Louisiana's new system for reporting critical incidents. However, we acknowledge that Louisiana's implementation of its new critical incident reporting system appears to have addressed the recommendation.