Report in Brief
Date: July 2020
Report No. A-06-17-04003

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

Texas 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. CMS 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 Texas 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 through December 2016.

How OIG Did This Audit

We reviewed Texas' compliance with waiver requirements, including beneficiary death reporting and review; consumer rights complaint tracking; and tracking of allegations of abuse, neglect, and exploitation.

What OIG Found

Texas did not ensure that all beneficiary deaths were reported and reviewed; that all complaints not closed within 10 days were tracked; and that all allegations of abuse, neglect, and exploitation were entered into the Human Services Enterprise Administration Reporting and Tracking (HEART) system. Texas had a procedure to detect unreported deaths but was not following it, did not have a system in place to track complaints not closed within 10 days, and did not have procedures to ensure that allegations were entered into the HEART system.

What OIG Recommends and Texas Comments

We recommend that Texas (1) ensure that procedures are followed to detect unreported deaths; (2) implement a system to ensure that it can track complaints not closed within 10 days; and (3) implement procedures to ensure that investigations of abuse, neglect, and exploitation are entered in the HEART system.

In written comments on our draft report, Texas concurred with our findings and recommendations and described actions that it has taken or plans to take to address them. These actions include increasing the frequency of comparing deaths reported by the provider to death reports from the CARE system, implementing a new system to monitor unreported deaths, and issuing violations and administrative penalties for failure to report deaths.