**Report in Brief**
Date: March 2020
Report No. A-07-18-06081

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

# Iowa Did Not Comply With Federal and State Requirements for Major Incidents Involving Medicaid Members With Developmental Disabilities

## Why OIG Did This Audit

We are performing reviews in several States in response to a congressional request concerning deaths and abuse of people with developmental disabilities living in group homes.

Federal waivers permit States to furnish an array of home and community-based services to Medicaid members with developmental disabilities so that they may live in community settings and avoid institutionalization. The Centers for Medicare & Medicaid Services (CMS) requires States to implement a critical incident reporting system to protect the health and welfare of the Medicaid members (as Medicaid beneficiaries are referred to in Iowa) receiving waiver services.

Our objective was to determine whether Iowa complied with Federal and State requirements for reporting and monitoring major incidents involving Medicaid members with developmental disabilities from January 2014 through December 2017.

## How OIG Did This Audit

We judgmentally selected and reviewed 817 medical claims for members with developmental disabilities whose claims included diagnoses associated with a high likelihood that a major incident had occurred. We also reviewed Critical Incident Reports contained in Iowa's reporting system.

## What OIG Found

Iowa did not fully comply with Federal and State requirements for reporting and monitoring major incidents involving Medicaid members with developmental disabilities. Specifically, Iowa did not ensure that community-based providers reported all major incidents to the State; ensure that community-based providers documented the resolution of reported major incidents to prevent or diminish the probability of future occurrences; review Critical Incident Reports to determine trends, problems, and issues in service delivery; ensure that community-based providers reported all member deaths to the State; and report all known major incidents to CMS.

## What OIG Recommends and Iowa's Comments

We made procedural recommendations to Iowa, including that it work with community-based providers on how to identify and report all major incidents and to ensure that they appropriately document resolution of major incidents. We also recommended that Iowa perform trend analysis that identifies patterns and trends to assess the health and safety of members and determine whether changes need to be made for service implementation or whether staff training is needed to prevent recurrences of major incidents and to reduce the number or severity of incidents; ensure that community-based providers report to the State all member deaths; include all major incidents reported by Medicaid Managed Care Organizations in Iowa's reports to CMS; and develop and implement internal controls adequate to ensure full compliance with Federal and State requirements.

Iowa concurred with our recommendations and described the actions that it had taken or planned to take to address them.