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

Iowa Implemented Most of Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Major Incidents

Why OIG Did This Audit

We are performing this audit 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 after nationwide media coverage on deaths of individuals with developmental disabilities involving abuse, neglect, or medical errors.

In our previous audit in Iowa, we found that the State did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring those incidents. Our previous audit report contained nine recommendations, and we performed this followup audit to determine whether Iowa implemented these recommendations.

Our objectives were to determine whether Iowa: (1) implemented the recommendations from our prior audit and (2) complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents.

How OIG Did This Audit

We reviewed claims for 1,115 emergency room visits for Medicaid 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 systems.

What OIG Found

Iowa implemented the nine recommendations from our prior audit and generally complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid members with developmental disabilities residing in group homes. However, Iowa's corrective actions for one recommendation in our prior audit were not completely effective in addressing the associated finding. Iowa did not ensure that community-based providers properly reported all major incidents involving members in waiver programs to the State. Although Iowa achieved significant progress since our prior audit, its internal controls did not ensure that providers properly reported all major incidents, because the State did not periodically update the diagnosis code list it used to identify Medicaid claims involving major incidents.

What OIG Recommends and Iowa Comments

We recommend that Iowa continue to strengthen internal controls to ensure full compliance with Federal and State requirements, to include periodically updating the list of diagnosis codes used when reviewing the Medicaid emergency room claims data to ensure that all Critical Incident Reports for major incidents were submitted as required.

Iowa concurred with our findings, agreed with our recommendation, described corrective actions that it had taken or planned to take, and projected the completion dates for the corrective actions. Iowa said that it would audit and update its list of emergency room claim codes to include all the codes that we identified as high-risk diagnosis codes, and that it would review and update this list annually. In addition, Iowa said that to ensure that emergency room visits are more thoroughly evaluated for potential major incidents, it would expand the existing monthly comparison of the primary diagnosis codes on emergency room claims to include the secondary diagnosis codes. Furthermore, Iowa stated that to ensure the adequacy of internal controls for accurately capturing all major data elements, it would update the online Critical Incident Report form and corresponding data extraction methodology. Finally, Iowa said that to ensure that all major incidents are reported and appropriately resolved in a timely manner, it was in the process of developing a centralized technical solution for critical incident reporting of all major incidents involving Medicaid members.