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

Alaska 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 Review

We have performed reviews in several States in response to a congressional request concerning the number of deaths and cases of 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 (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 Alaska complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings from July 2014 through June 2016.

How OIG Did This Review

We judgmentally selected and reviewed 303 medical claims for beneficiaries residing in community-based settings whose claims included diagnosis codes associated with a high likelihood that a critical incident had occurred. We also reviewed critical incident reports contained in Alaska's reporting system.

What OIG Found

Alaska 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, Alaska did not ensure that community-based providers reported all critical incidents to the State. For the 303 judgmentally selected claims, 68 percent (205 claims) were not reported to Alaska as critical incidents. Alaska officials provided various reasons why a community-based provider may not properly report a critical incident to the State, including that the provider is unaware of the incident, fears retaliation by the employer, or has a general misunderstanding of the reporting requirements.

Alaska did not have a process, such as performing analytical procedures on Medicaid claims data, to determine whether there were unreported critical incidents. Alaska cannot investigate and take appropriate action to protect the health and welfare of Medicaid beneficiaries with developmental disabilities when community-based providers do not report critical incidents. As a result of not ensuring that providers reported all critical incidents, Alaska did not ensure proper responses to critical incidents or events as outlined in the safeguard assurances it provided to CMS in the Federal Medicaid waivers.

What OIG Recommends and Alaska Comments

We recommend that Alaska (1) work with community-based providers on processes to identify and report all critical incidents and (2) perform analytical procedures, such as data matches, on Medicaid claims data to identify potential critical incidents that have not been reported and investigate as needed.

Although Alaska did not concur or nonconcur with our recommendations, Alaska stated that, based on our finding, it had initiated corrective actions to (1) implement additional training to increase providers' ability to identify and report all incidents that meet reporting requirements and (2) establish data-mining processes with analytical procedures, such as data matches, using Medicaid claims data to identify potential unreported critical incidents for further investigation.