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

California Did Not Ensure That Nursing Facilities Always Reported Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries and Did Not Always Prioritize Allegations Properly

Why OIG Did This Audit

This audit report is one in a series of OIG reports addressing the identification, reporting, and investigation of incidents of potential abuse and neglect of our Nation's most vulnerable populations, including Medicaid beneficiaries in nursing facilities. Nursing facility residents are at an increased risk of abuse or neglect when health care professionals and caregivers fail to report incidents of potential abuse or neglect or when allegations of abuse or neglect are not acted upon in a timely manner.

Our objectives were to determine whether California: (1) ensured that nursing facilities reported incidents of potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments and (2) complied with Federal requirements for recording, prioritizing, and investigating allegations of abuse or neglect.

How OIG Did This Audit

Our audit covered 4,965 claims with selected diagnosis codes for Medicaid beneficiaries who resided in California nursing facilities and were transferred to hospital emergency departments from July through December 2017. (We refer to these claims as "incidents.") We reviewed a statistical sample that consisted of: (1) all 18 incidents with diagnosis codes that indicated a significant risk of abuse or neglect and (2) 100 incidents with diagnosis codes that indicated a risk of abuse or neglect.

What OIG Found

California did not ensure that nursing facilities always reported incidents of potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. Of the 118 sampled incidents reviewed, 81 were not the result of potential abuse or neglect; therefore, nursing facilities were not required to report the incidents to the State. However, of the remaining 37 incidents, 8 incidents were the result of potential abuse or neglect and should have been reported to the State: 2 were reported in a timely manner, 4 were not reported in a timely manner, and 2 were not reported to the State by the nursing facilities. Although the State issued guidance to nursing facilities on the proper reporting of potential abuse or neglect, facilities did not always report incidents or report them in a timely manner. For the other 29 incidents, nursing facilities provided documentation that did not contain sufficient information to determine whether the incidents were the result of potential abuse or neglect; therefore, the State was unable to determine whether the requirements for reporting potential abuse or neglect were met.

California complied with Federal requirements for recording allegations of abuse or neglect and generally complied with requirements for investigating allegations; however, California did not always comply with requirements for prioritizing allegations. Specifically, for the 118 sampled incidents, the State received 16 allegations; 8 were properly prioritized by the State, but 8 were not. According to State officials, changes in CMS's requirements contributed to inconsistencies in prioritizing complaints.

What OIG Recommends and California's Comments

We recommend that California: (1) strengthen guidance to nursing facilities on reporting incidents of potential abuse or neglect of Medicaid beneficiaries and (2) ensure that its staff are regularly trained on updated Federal and State requirements to ensure that appropriate priorities are assigned to allegations of abuse or neglect.

California agreed with both of our recommendations and described actions that it planned to take to implement our recommendations, including issuing a notice to remind nursing facilities of their obligation to report incidents of potential abuse or neglect and developing new training material for field staff.