Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID DATA CAN BE USED TO IDENTIFY INSTANCES OF POTENTIAL CHILD ABUSE OR NEGLECT

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Christi A. Grimm
Principal Deputy Inspector General

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Office of Inspector General

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Report in Brief
Date: July 2020
Report No. A-01-19-00001

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

Medicaid Data Can Be Used To Identify Instances of Potential Child Abuse or Neglect

Why OIG Did This Audit

This audit report is one of a series of OIG reports that addresses the identification, reporting, and investigation of incidents of potential abuse and neglect of our Nation's most vulnerable populations, including children, the elderly, and individuals with developmental disabilities. OIG is committed to detecting and combating such abuse and neglect.

Our objectives were to determine: (1) whether Medicaid claims data can be used to identify incidents of potential child abuse or neglect and, if they can, the number of incidents of potential abuse or neglect of children receiving Medicaid benefits that we identified using hospital emergency rooms (ERs) claims data; (2) whether the incidents were reported to child protective services (CPS) agencies and other appropriate agencies; and (3) who may have committed those incidents and where they occurred.

How OIG Did This Audit

Our audit covered 31,780 Medicaid claims that contained diagnosis codes specifically indicating the treatment of injuries potentially caused by abuse or neglect of Medicaid beneficiaries younger than age 18. These claims related to 29,534 children receiving Medicaid benefits who received ER services from January 1, 2017, through December 31, 2017. For a stratified random sample of 100 Medicaid beneficiaries, we reviewed the medical records and other documentation to determine whether they contained evidence of potential child abuse or neglect. We then determined whether the incidents of potential child abuse or neglect were reported to CPS and other appropriate agencies.

What OIG Found

We determined that Medicaid claims data can be used to identify incidents of potential child abuse or neglect. Using that data, we estimated that 29,260 of the 29,534 Medicaid beneficiaries in our sampling frame were involved with incidents of potential child abuse or neglect that were supported by Medicaid claims data and evidence contained in the medical records. We further estimated that, of the beneficiaries in our population associated with incidents of potential child abuse or neglect, 3,928 were involved with incidents that were not reported to CPS. We also determined that most incidents of potential child abuse or neglect identified in our sample occurred in familiar settings by perpetrators known to the victims. CMS did not identify similar incidents of potential child abuse or neglect during our audit period or encourage the States to identify the incidents.

What OIG Recommends and CMS Comments

We recommend that CMS: (1) issue guidance, such as an Informational Bulletin, to inform States that performing a data analysis to identify Medicaid claims containing one or more diagnosis codes indicating potential child abuse or neglect could help identify incidents of potential child abuse or neglect and help ensure compliance with their mandatory reporting laws and (2) assess the sufficiency of existing Federal requirements to report suspected child abuse and neglect of Medicaid beneficiaries to determine whether CMS should strengthen those requirements or seek additional authorities to provide oversight over the reporting of suspected child abuse and neglect of Medicaid beneficiaries.

In written comments on our draft report, CMS concurred with our second recommendation but did not concur with our first recommendation. Specifically, CMS said that the majority of the sample cases identified in our audit occurred in a home or public place, which does not fall under CMS's jurisdiction for Federal oversight. CMS also stated that claims review may not be timely enough to address acute problems because claims and encounter data can be lagged and transformed as they move through the submission process. CMS added that its regulations require all facilities and their practitioners to comply with the mandatory reporting laws for abuse and neglect applicable to their State. We respectfully disagree with CMS and continue to recommend that CMS inform States that the use of the Medicaid claims data can help identify incidents of potential child abuse or neglect and ensure compliance with their mandatory reporting laws.

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INTRODUCTION

WHY WE DID THIS AUDIT

This audit report is one of a series of Office of Inspector General (OIG) reports that addresses the identification, reporting, and investigation of incidents of potential abuse and neglect of our Nation's most vulnerable populations, including children, the elderly, and individuals with developmental disabilities. We are committed to detecting and combating such abuse and neglect.

Child abuse and neglect is a serious public health issue that is highly prevalent and results in substantial health and economic consequences for the youngest members of society. Children who are abused or neglected may suffer immediate physical injuries as well as emotional and psychological problems that can continue throughout their lives.[1] In 2017, there were approximately 674,000 victims of child abuse and neglect reported to child protective services (CPS) programs, including 1,720 fatalities.[2] Furthermore, a 2015 study estimated that one child in four experiences some form of child abuse or neglect in his or her lifetime.[3, 4] In addition, a 2012 study estimated that the total lifetime economic cost associated with child abuse and neglect cases reported in 2008 in the United States was approximately $124 billion.[5]

OBJECTIVES

Our objectives were to determine: (1) whether Medicaid claims data can be used to identify incidents of potential child abuse or neglect and, if they can, the number of incidents of

[1] Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control, Division of Violence Prevention, *Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities*, 2016. Available online at https://www.cdc.gov/violenceprevention/pdf/can-prevention-technical-package.pdf.

[2] U.S. Department of Health and Human Services (HHS), Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau; *Child Maltreatment 2017*; 2019. Available online at https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment.

[3] D. Finkelhor, H.A. Turner, A. Shattuck, S.L. Hamby, "Prevalence of Childhood Exposure to Violence, Crime, and Abuse: Results From the National Survey of Children's Exposure to Violence," *JAMA Pediatrics*, 2015, 169(8): 746–754.

[4] The estimate in this study included physical abuse, emotional abuse, sexual abuse, neglect, and custodial interference or family abduction.

[5] X. Fang, D.S. Brown, C.S. Florence, J.A. Mercy, "The Economic Burden of Child Maltreatment in the United States and Implications for Prevention," *Child Abuse & Neglect*, 2012, 36(2): 156–165.

potential abuse or neglect[6] of children receiving Medicaid benefits that we identified using hospital emergency rooms (ERs) claims data; (2) whether the incidents were reported to CPS agencies and other appropriate agencies; and (3) who may have committed those incidents and where they occurred.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities, including children up to age 19. Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Children's Health Insurance Program

Children's Health Insurance Program (CHIP) covers uninsured children up to age 19 who have household incomes above the Medicaid income eligibility threshold but whose families cannot afford private coverage. The Federal and State Governments jointly fund CHIP. CHIP is administered by States in accordance with Federal requirements.

Medicaid and CHIP Coverage of Children

In 2017, Medicaid covered approximately 36.8 million children and CHIP covered approximately 9.4 million children at some point during the year.[7] In total, 46.3 million children were covered by Medicaid or CHIP at one point in 2017, which represented more than 60 percent of the approximately 73.7 million children in the United States in that year.[8]

[6] Our audit covered Medicaid and Children's Health Insurance Program (CHIP) beneficiaries younger than age 18. For the purpose of this report, an "incident" is defined as a Medicaid claim involving the treatment of potential abuse or neglect.

[7] CMS, *2017 Annual Children Enrollment Report*. Available online at https://www.medicaid.gov/chip/downloads/fy-2017-childrens-enrollment-report.pdf.

[8] Many States operate their CHIP program as part of Medicaid. For the purpose of this report, "children receiving Medicaid benefits" refers to children receiving either Medicaid or CHIP coverage.

The Child Abuse Prevention and Treatment Act

The Child Abuse Prevention and Treatment Act (CAPTA) provides Federal funding and guidance to States to support prevention, assessment, investigation, prosecution, and treatment of child abuse and neglect and also provides grants to public agencies and nonprofit organizations, including Indian Tribes and tribal organizations, for demonstration programs and projects. Under the CAPTA, each State must have a State law or a statewide program that provides for the reporting of child abuse and neglect.[9] The CAPTA also provides minimum guidelines that States must incorporate in their statutory definitions of child abuse and neglect. The CAPTA defines child abuse and neglect as, at a minimum: "Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation . . . or an act or failure to act, which presents an imminent risk of serious harm."[10]

U.S. Department of Health and Human Services Strategic Plan

The U.S. Department of Health and Human Services (HHS) *Strategic Plan for FY* [fiscal year] *2018–2022* stipulates that several of the strategic objectives are related to the health, safety, and well-being of individuals. For example, Strategic Objective 3.2[11] is to "safeguard the public against preventable injuries and violence or their results." One of HHS's strategies to achieve this objective is to "assess healthcare use and costs associated with violence and unintentional injury, including patient safety events that occur in healthcare settings, to inform actions to prevent injury and violence and describe the return on investment of public health action." In addition, one of HHS's performance goals for this objective is to "decrease the percentage of children with substantiated or indicated reports of maltreatment that have a repeated substantiated or indicated report of maltreatment within 6 months."

State-Mandated Reporting Requirements

All 50 States, the District of Columbia, and the U.S. Territories have laws that mandate the reporting of child abuse that require certain individuals and institutions to report suspected abuse, neglect, or exploitation of children.[12] Most States recognize four major types of maltreatment: neglect, physical abuse, psychological abuse, and sexual abuse. However, each State has its own definition of child abuse or neglect defined in its regulations. These laws vary

[9] 42 U.S.C. § 5106a(b)(1)(A); 42 U.S.C. § 5106a(b)(2)(B)(i).

[10] P.L. No. 93-247, § 3, as added by P.L. No. 111-320, as amended by P.L. No. 114-22.

[11] HHS, *Strategic Plan FY 2018–2022*. Available online at https://www.hhs.gov/about/strategic-plan/strategic-goal-3/index.html.

[12] When we discuss State-mandated reporting requirements in this report, we are referring to the requirements for all 50 States, the District of Columbia, and the U.S. Territories.

in their definitions, scope, and procedures from State to State. Often, the mandated reporting requirement of child abuse is determined by who committed the abuse rather than the harm inflicted on the child. For example, some States require all child sexual abuse to be reported to CPS, but other States only require child sexual abuse committed by a parent or caretaker to be reported to CPS.

Child Protective Services Programs

Each State has a CPS program authorized by State law.[13] State and local CPS programs are considered among the first responders to reports of abuse, neglect, or exploitation of children. Upon receiving an allegation of abuse involving a child, CPS programs typically provide services to protect the child, including an investigation of the allegation, evaluation of the need for interventions to keep the child safe, and ongoing monitoring of the risk of danger to the child. CPS programs also work closely with law enforcement if criminal abuse against a child is suspected.

Medicaid Home and Community-Based Services Waivers

The Social Security Act (the Act) authorizes the Medicaid Home and Community-Based Services (HCBS) waiver program (the Act § 1915(c)). The program permits a State to furnish an array of home and community-based services that assists Medicaid beneficiaries to live in the community and avoid institutionalization. However, States must provide certain assurances to CMS to receive approval for the HCBS waiver, including that necessary safeguards have been undertaken to protect the health and welfare of the beneficiaries receiving services (42 CFR § 441.302). This waiver assurance requires the State to provide specific information regarding its plan or process related to participant safeguards, which includes whether the State operates a critical event or incident reporting system. Therefore, there may be additional reporting requirements for suspected abuse or neglect of Medicaid beneficiaries covered by a HCBS waiver.

Medicaid Fraud Control Units

Each State's Medicaid Fraud Control Unit (MFCU) investigates and prosecutes a variety of health care-related crimes, including abuse or neglect of patients in health care facilities or in board and care facilities.[14] These patients may include vulnerable populations, such as children, disabled individuals, or the elderly. MFCUs operate in 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. MFCUs, which are usually a part of the State Attorney General's office, employ teams of investigators, attorneys, and auditors. OIG, in exercising oversight of the MFCUs, annually recertifies each MFCU, assesses each MFCU's

[13] CPS programs are sometimes called different names in different States, such as Department of Family Services, Department of Social Services, or Department of Youth and Family Services.

[14] The Act § 1903(q).

performance and compliance with Federal requirements, and administers a Federal grant award to fund a portion of each MFCU's operational costs.

The Transformed Medicaid Statistical Information System

The Transformed Medicaid Statistical Information System (T-MSIS) replaced the Medicaid Statistical Information System as the national Medicaid dataset. The T-MSIS was implemented on a State-by-State basis, beginning with a pilot for 12 States in 2011. The purpose of T-MSIS is to improve the completeness, accuracy, and timeliness of national Medicaid data, which would allow States, the Federal Government, and other oversight entities to collaborate and more effectively oversee Medicaid and CHIP. CMS requires States to submit files and data elements in the T-MSIS, which provides a national Medicaid data repository that, among other functions, supports program management, financial management, and program integrity.[15] The T-MSIS dataset contains information about beneficiary eligibility, beneficiary and provider enrollment, service utilization, claims and managed care data, and expenditure data for Medicaid and CHIP.

Recent OIG Audits Related to Potential Abuse or Neglect of Medicaid and Medicare Beneficiaries

OIG is committed to protecting beneficiary health and safety and has issued numerous reports that have detailed problems with the quality of care and the reporting and investigation of potential abuse or neglect at group homes, nursing homes, and skilled nursing facilities (SNFs).[16] OIG's audit reports on critical incident[17] reporting at group homes showed that group home providers did not report up to 15 percent of critical incidents to the appropriate State agencies (A-01-14-00002, A-01-14-00008, A-01-16-00001, A-09-17-02006, and A-03-17-00202). In addition, OIG's recent report on the potential abuse or neglect of Medicare beneficiaries residing in SNFs found that SNFs failed to report many incidents of potential abuse or neglect to State survey agencies and that several State survey agencies failed to report some findings of substantiated abuse to local law enforcement (A-01-16-00509). Furthermore, OIG's recent report on the potential abuse or neglect of Medicare beneficiaries residing in all settings also found that many incidents were not reported to local law enforcement and that CMS was not utilizing Medicare claims data to identify unreported incidents of potential abuse or neglect (A-01-17-00513).

[15] CMS, State Medicaid Director Letter (SMD #13-004), August 23, 2013. Accessed at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf on December 12, 2019.

[16] See Appendix B for a list of previously issued OIG reports on this issue.

[17] The general definition of a "critical incident" includes, but is not limited to, an event involving a facility patient or resident who suffered a serious injury or illness requiring treatment at an ER.

Using Medicaid Claims Data To Protect the Health and Safety of Other Vulnerable Populations

To address the findings in our audit reports on critical incident reporting at group homes, representatives from the OIG, HHS Office of Civil Rights, and the Administration for Community Living formed an interagency partnership. The partnership also coordinated with the Department of Justice, CMS, and State stakeholders. The partnership issued the joint report, *Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight*, in January 2018.[18] This report is a roadmap for States to create better health and safety outcomes in group homes and contains model practices for incident management and investigation, quality assurance, mortality reviews, and incident management audits. These suggested practices include reviewing Medicaid claims data to ensure that serious incidents associated with ER visits and unplanned hospitalizations are reported. In June 2018, CMS issued an Informational Bulletin that encouraged States to review the model practices contained in the joint report as they look to strengthen their quality assurance systems.[19]

In addition, we issued *A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect* (A-01-19-00502) in July 2019.[20] This resource guide explains our approach to using claims data to identify incidents of potential abuse or neglect of vulnerable populations. The resource guide synthesizes our methodologies in identifying unreported critical incidents, particularly those involving potential abuse or neglect. We used methodologies in audits examining a variety of care settings, including nursing facilities and group homes.

A number of States have implemented or are in the process of implementing incident reporting and tracking systems based on the model practices in the joint report. For example, in one State, State agency staff review claims data for beneficiaries covered by a HCBS waiver to determine whether an incident report was submitted, which ensures that the incident can be screened for evidence of abuse and neglect. In addition, the beneficiary's case manager is notified of the incident so that the care plan can be updated and any necessary followup care can be arranged.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 31,780 Medicaid claims nationwide, totaling $46,377,943, for ER services provided to 29,534 Medicaid beneficiaries younger than age 18 from January 1, 2017, through

[18] Available online at https://oig.hhs.gov/reports-and-publications/featured-topics/group-homes/group-homes-joint-report.pdf.

[19] Accessed at https://www.medicaid.gov/federal-policy-guidance/downloads/cib062818.pdf on October 1, 2019.

[20] Available online at https://oig.hhs.gov/oas/reports/region1/11900502.asp.

December 31, 2017 (audit period). The Medicaid claims contained 1 or more of 13 diagnosis codes that specifically indicated child abuse, neglect, or maltreatment was alleged, suspected, or confirmed.[21, 22]

We selected for review a stratified random sample of 100 Medicaid beneficiaries that had at least 1 ER service associated with 1 or more of the 13 diagnosis codes during our audit period. We obtained the medical records and other supporting documentation associated with the Medicaid claims for these beneficiaries and reviewed the records to determine whether the incidents were the result of potential child abuse or neglect. We then determined whether the incidents of potential child abuse or neglect were reported to CPS and other appropriate agencies. We also reviewed the medical records for the 100 Medicaid beneficiaries to determine who may have perpetrated those incidents, where they occurred, and other details regarding the circumstances associated with the incidents of potential child abuse or neglect.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The goal of our audit was not to identify every incident of potential child abuse or neglect. Rather, we determined whether data analysis similar to what we performed in group home and nursing home settings can be used to identify unreported incidents of potential child abuse or neglect. CMS officials informed us that it is possible there are additional Medicaid claims associated with potential child abuse or neglect that may not have been represented in the T-MSIS during the period of our audit. Specifically, CMS officials noted that the T-MSIS data may not be complete for some States and that it is working with the States to ensure that all T-MSIS data are available in the future. Any such improvements in the T-MSIS data will lead to corresponding improvements in the ability to use the data to identify unreported instances of potential child abuse and neglect. We, therefore, consider the number of claims we identified

[21] These 13 diagnoses codes were assigned by the ER staff who treated the Medicaid beneficiaries younger than age 18. We did not identify Medicaid beneficiaries who were injured or ill but not treated at an ER because there would have been no record of their treatment in the data we reviewed. Therefore, there is a possibility that other Medicaid beneficiaries younger than age 18 who were potentially abused or neglected remain unidentified.

[22] There is also a possibility that ER staff did not assign 1 of the 13 diagnosis codes that specifically indicate potential child abuse or neglect. In this regard, we identified an additional 203 diagnosis codes that we determined to be indicative of high risk for potential child abuse or neglect of Medicaid beneficiaries. These codes include assaults, treatment for sexually transmitted diseases, pregnancy tests, exposure to illegal drugs, and newborns affected by maternal use of drugs. We determined that we did not need to review these additional codes to accomplish our audit objectives. Rather than committing additional resources to review these codes, we provided the list of codes for informational purposes only. In addition to the 13 diagnosis codes specifically indicating potential child abuse or neglect, States should use their expertise to determine which additional codes to include in a data analysis. See Appendix C for our list of 203 high-risk diagnosis codes.

in the T-MSIS data to be a conservative estimate of the actual number of Medicaid claims associated with potential child abuse or neglect. After reviewing the possible limitations of these data, we determined that the data were sufficiently reliable for the purposes of our audit objectives.

Appendix A contains details of our audit scope and methodology. Appendix D contains our statistical sampling methodology. Appendix E contains our sample results and estimates.

FINDINGS

We determined that the Medicaid claims data contained in the T-MSIS can be used to identify incidents of potential child abuse or neglect. We identified 31,780 Medicaid claims that contained diagnosis codes specifically indicating the treatment of injuries potentially caused by abuse or neglect of Medicaid beneficiaries younger than age 18. These claims related to 29,534 children receiving Medicaid benefits who received ER services from January 1, 2017, through December 31, 2017. We estimated that 29,260 of the Medicaid beneficiaries were involved with incidents of potential child abuse or neglect that were supported by Medicaid claims data and evidence contained in the medical records. We further estimated that, of the beneficiaries in our population associated with incidents of potential child abuse or neglect, 3,928 were involved with incidents that were not reported to CPS. We also determined that most incidents of potential child abuse or neglect identified in our sample occurred in familiar settings by alleged perpetrators known to the victims. CMS did not identify similar incidents of potential child abuse or neglect during our audit period or encourage the States to identify the incidents.

CMS did not identify the Medicaid claims that indicated potential child abuse or neglect because, according to CMS officials, it did not extract data consisting of Medicaid claims that contained diagnosis codes related to child abuse or neglect. If CMS had encouraged States to utilize the Medicaid claims data, the data may have helped States identify incidents of potential child abuse or neglect and verify compliance with their mandatory reporting laws to protect the safety, health, and rights of Medicaid beneficiaries younger than age 18.

MEDICAID CLAIMS DATA CAN BE USED TO IDENTIFY INCIDENTS OF POTENTIAL CHILD ABUSE OR NEGLECT, AND MOST SAMPLED MEDICAL RECORDS CONTAINED EVIDENCE OF POTENTIAL CHILD ABUSE OR NEGLECT

Medicaid Claims Data Identified More Than 30,000 Incidents of Potential Child Abuse or Neglect

Medicaid claims data contained diagnosis codes that specifically indicated child abuse or neglect was alleged, suspected, or confirmed. We identified 31,780 Medicaid claims that contained diagnosis codes specifically indicating the treatment of injuries potentially caused by abuse or neglect of Medicaid beneficiaries younger than age 18. These claims related to 29,534 children receiving Medicaid benefits who received ER services during our audit period in 48

States, the District of Columbia, and Puerto Rico (Appendix F).[23] The incidents of potential child abuse or neglect were indicated on the Medicaid claims by the use of 1 or more of 13 diagnosis codes that specifically indicate abuse or neglect.

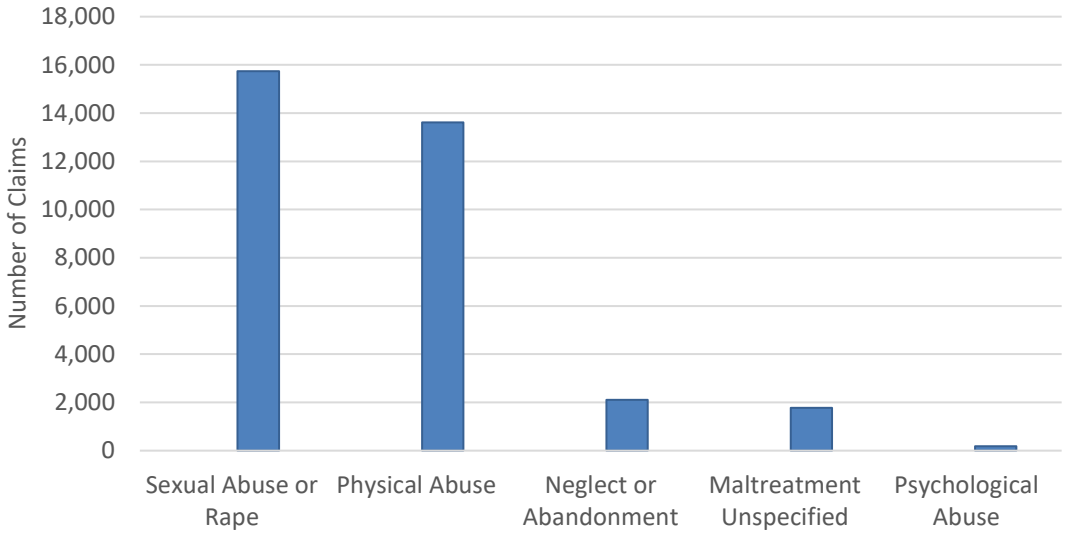
Table 1: The Number of Medicaid Claims Containing a Diagnosis Code Indicating Potential Child Abuse or Neglect From January 2017 Through December 2017

Diagnosis Code	Description	Total Number of Claims	Percentage
T7622	Child sexual abuse, suspected	8,884	28%
Z0472	Encounter for examination and observation following alleged child physical abuse	5,944	19%
T7612	Child physical abuse, suspected	5,306	17%
Z0442	Encounter for examination and observation following alleged child rape	3,841	12%
T7422	Child sexual abuse, confirmed	3,014	10%
T7412	Child physical abuse, confirmed	2,172	7%
T7692	Unspecified child maltreatment, suspected	1,416	4%
T7602	Child neglect or abandonment, suspected	1,120	3%
T7402	Child neglect or abandonment, confirmed	988	3%
T7492	Unspecified child maltreatment, confirmed	366	1%
T744X	Shaken infant syndrome	196	1%
T7432	Child psychological abuse, confirmed	133	0%
T7632	Child psychological abuse, suspected	46	0%
Claims With More Than One Diagnosis Code		(1,646)	(5%)
Total		**31,780**	**100%**

On the basis of their descriptions, we categorized the 13 diagnosis codes into 5 categories: sexual abuse or rape, physical abuse, psychological abuse, neglect or abandonment, and unspecified maltreatment (Figure 1 on the next page).

[23] The T-MSIS data for our audit period were not available for two States. CMS is currently working with States to improve their data submissions and to ensure that all T-MSIS data are available in the future.

Figure 1: Claims by Diagnosis Category



Using the claims data, we also reviewed demographic data, such as the beneficiary's age at the time of the claim and sex. The ages of beneficiaries were distributed over all ages of childhood (Figure 2), and the average age was 7 years. Appendix G contains a breakdown of the five categories of diagnosis codes by beneficiary ages. In addition, female beneficiaries were associated with the majority of the 13 diagnosis codes indicating potential child abuse or neglect (Figure 3 on the next page).

Figure 2: Ages of Beneficiaries at Time of Incident

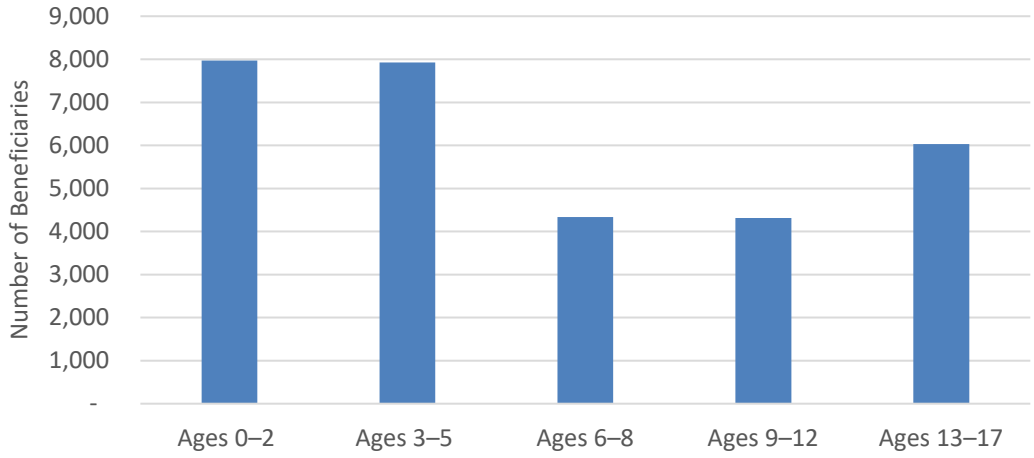
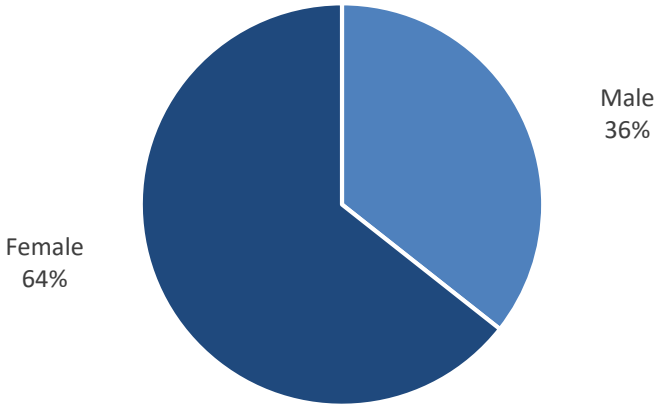


Figure 3: Sex of Beneficiaries



Most of the Medicaid claims were for treatment provided in outpatient settings (91 percent), and the remaining claims were for treatment provided in inpatient settings (9 percent). The total cost of the 28,977 outpatient claims for the treatment of the Medicaid beneficiaries was $8,104,415, an average of $277 per claim; the total cost of the 2,803 inpatient claims for the treatment of the Medicaid beneficiaries was $38,363,528, an average of $13,687 per claim.

A Representative Example of an Incident of Potential Abuse Requiring Outpatient Treatment

An 11-year-old female beneficiary was brought to the ER by her mother for a wellness check required by CPS. The beneficiary's parents share joint custody, and CPS removed the beneficiary from her father's house the previous night after an altercation between the beneficiary and her father. The beneficiary stated that her father screamed at her, grabbed her, picked her up, and dropped her to the ground. The beneficiary also reported that her father has spanked and hit her in the past when she misbehaves. Upon examination, ER staff noted bruising on her back, right lower leg, right forearm, and abrasions on her hip. CPS investigated this incident and found evidence of improper supervision and physical abuse. There is no record that this incident was reported to local law enforcement.

A Representative Example of an Incident of Potential Abuse Requiring Inpatient Treatment

A 4-year-old male beneficiary was brought to the ER by his mother, who suspected physical abuse. The beneficiary's mother noticed welts and scratches over her son's body after she picked him up from his father's house. The father was contacted and stated that the beneficiary was "playing in branches with

other kids." However, the beneficiary told ER staff that he was spanked with a belt by his father and father's girlfriend. He was admitted to the trauma unit and received medical imaging services to rule out internal bleeding after blood was found in his urine. The medical records contained pictures showing bruises over the beneficiary's body. The ER staff reported the incident to both CPS and law enforcement, and the allegations against the father were substantiated by CPS.

Almost All of the Sampled Medical Records Contained Evidence of Potential Child Abuse or Neglect

Of the 100 Medicaid beneficiaries we sampled, 99 had ER medical records that contained evidence of potential abuse or neglect.[24] This evidence included, but was not limited to, witness statements and photographs. We determined that the type of potential abuse and neglect indicated in the medical records was consistent with the diagnosis codes assigned to the Medicaid claims. We were unable to determine whether the remaining one Medicaid claim was for the treatment of injuries as a result of potential abuse or neglect because the hospital could not provide the medical record.[25] Therefore, we concluded that T-MSIS data can be used to identify many incidents of potential child abuse or neglect. On the basis of our sample results, we estimated that 29,260 of the 29,534 Medicaid beneficiaries in our sampling frame were involved with incidents of potential child abuse or neglect that were supported by Medicaid claims data and evidence contained in the medical records. We consider this number to be a conservative estimate, as the T-MSIS may not include all Medicaid claims for incidents of potential child abuse or neglect.[26] We believe the ability to use Medicaid claims in the T-MSIS to identify these incidents will improve as CMS continues to work with States to ensure that their submitted T-MSIS data are complete.

[24] The incidents of potential abuse or neglect associated with the 99 beneficiaries were alleged, suspected, or confirmed at the time of the ER admission. The ER examinations assessed the health and safety of the beneficiaries and did not make a determination whether child abuse or neglect actually occurred.

[25] This hospital was located in Puerto Rico. The hospital medical records staff stated that they did not have any records for the beneficiary selected in our sample. The staff indicated that they might be able to locate the record if we gave them the maiden name of the beneficiary's mother. However, we did not have this information.

[26] The fact that some States have very few beneficiaries in our sampling frame does not necessarily indicate that child abuse or neglect was less prevalent in those States. Rather, it may be attributed to the availability or completeness of T-MSIS data in those States. For example, T-MSIS data for our audit period were not available for two States, and the T-MSIS data for 3 States included less than 10 Medicaid beneficiaries who were treated at ERs for potential child abuse or neglect. CMS is working with the States to ensure that all T-MSIS data are available and complete.

SOME INCIDENTS OF POTENTIAL CHILD ABUSE OR NEGLECT WERE NOT REPORTED TO CHILD PROTECTIVE SERVICES

All 50 States, the District of Columbia, and the U.S. Territories have laws that mandate certain individuals and institutions report suspected abuse, neglect, or exploitation of vulnerable children. Each State has its own definition of child abuse or neglect defined in State regulations. Some incidents of potential child abuse or neglect were not reported to CPS. Of the 100 Medicaid beneficiaries in our sample,[27] we determined that 86 had incidents of potential abuse or neglect that were reported to CPS, 13 had incidents that were not reported to CPS (Appendix H) and 5 of the 13 incidents were also not reported to law enforcement,[28, 29] and 1 had an incident in which it could not be determined whether it was reported to CPS. Accordingly, we estimated that, of the beneficiaries in our population associated with incidents of potential child abuse or neglect, 3,928 were involved with incidents that were not reported to CPS. This estimate includes both incidents that may have fallen under CPS jurisdiction and those that may not have because they did not meet the State's definition of child abuse or neglect. If States utilized their Medicaid claims data for data analysis, they could identify unreported incidents of potential child abuse or neglect involving Medicaid beneficiaries; determine whether the incidents should have been reported in accordance with State requirements; and take appropriate actions, if necessary, to protect the child from danger.

A Representative Example of an Incident of Potential Abuse That Was Not Reported to Child Protective Services

A 15-year-old female beneficiary presented to the ER because she had concerns that she had been physically and sexually abused, which she said occurred on the previous day. The beneficiary arrived at the hospital with her parents and seven siblings who all had the same complaint. Her parents stated that they left their eight children with their aunt at her home while the parents went out for the night. The parents checked in on the children the next morning and then left again to go to a casino. The parents said that when they picked up the children

[27] All beneficiaries were associated with one incident of potential child abuse or neglect. Although three beneficiaries had multiple ER visits during our audit period, we determined that they were associated with the same incident.

[28] We relied on the medical records and responses from CPS and law enforcement agencies to determine whether incidents were reported to CPS or law enforcement. For some incidents, the agencies did not respond to our request, stated that they could not provide the requested information per State regulations, or stated that their reporting system may not have retained the information after a certain time period. In those cases, we relied on only the medical records to make the determinations.

[29] We made a determination only on whether the incidents identified at hospital ERs were or were not reported to CPS. We did not make a determination on whether the incidents met the State's definition of child abuse or neglect because State-mandated reporting requirements are not always clear cut, they are subject to interpretation, and they vary from State to State. Furthermore, the medical records sometimes do not include the complete details of the incident.

that evening, the children told them that they felt mistreated in a variety of ways by their aunt and uncle. The parents said they were concerned that the 15-year-old beneficiary was touched inappropriately and that the other children were potentially drugged. The children complained of dizziness and fatigue after drinking water at the aunt's home. Local law enforcement was contacted. However, there is no record that this incident was reported to CPS.

ALLEGED PERPETRATORS, LOCATIONS, AND TYPES OF POTENTIAL CHILD ABUSE OR NEGLECT IDENTIFIED IN OUR SAMPLE

As part of our audit, we reviewed numerous research studies regarding the characteristics and risk factors associated with child abuse or neglect. We reviewed the medical records for the 100 Medicaid beneficiaries to determine whether the incidents of potential child abuse or neglect were consistent with these studies. Specifically, we reviewed the medical records to determine who may have perpetrated those incidents, where those incidents occurred, and other details regarding the circumstances associated with the incidents of potential child abuse or neglect. In general, the incidents of potential child abuse and neglect in our sample shared many of the known characteristics and risk factors associated with child abuse or neglect.

Most Incidents of Potential Child Abuse or Neglect Occurred in Familiar Settings by Alleged Perpetrators Known to the Victims

Most victims of child abuse or neglect know the perpetrator in some way.[30] In our sample of 100 beneficiaries, 90 of the alleged perpetrators were known to the beneficiary, and almost two-thirds were family members (Figure 4 on the next page). In addition, two-thirds of the alleged incidents occurred in the beneficiary's home or the home of a family member (Figure 5 on the next page).[31]

[30] CDC, National Center for Injury Prevention and Control, Division of Violence Prevention, *Child Maltreatment: Facts at a Glance,* 2014. Available online at https://www.cdc.gov/violenceprevention/pdf/childmaltreatment-facts-at-a-glance.pdf.

[31] We reviewed the medical records and other supporting documentation to determine whether the alleged perpetrators and locations of the incidents of potential child abuse or neglect were identified.

Figure 4: Categories of Perpetrators Associated With Incidents of Potential Abuse or Neglect in Sample

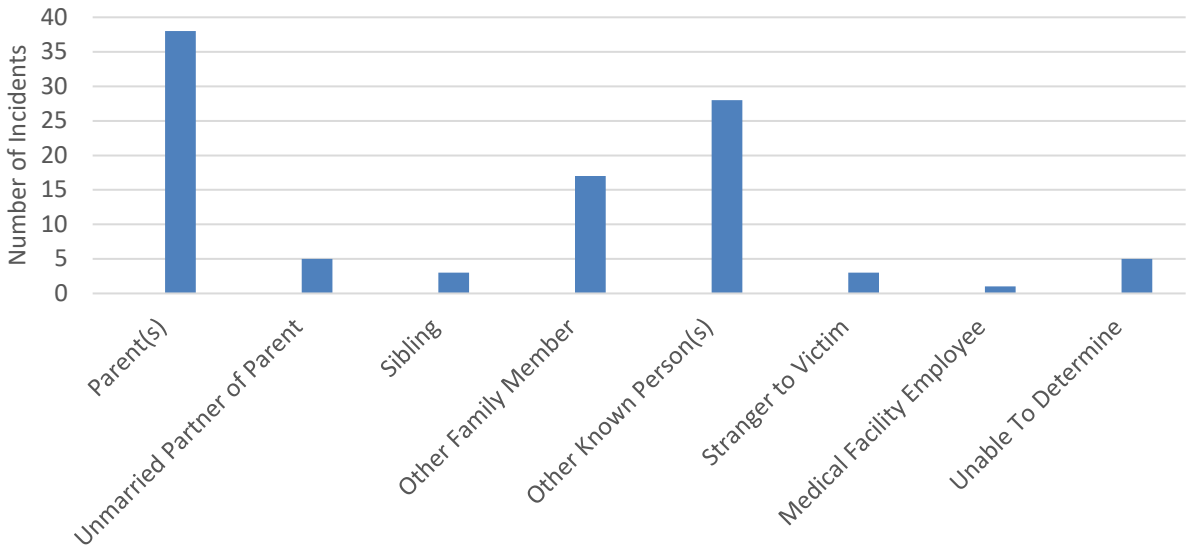
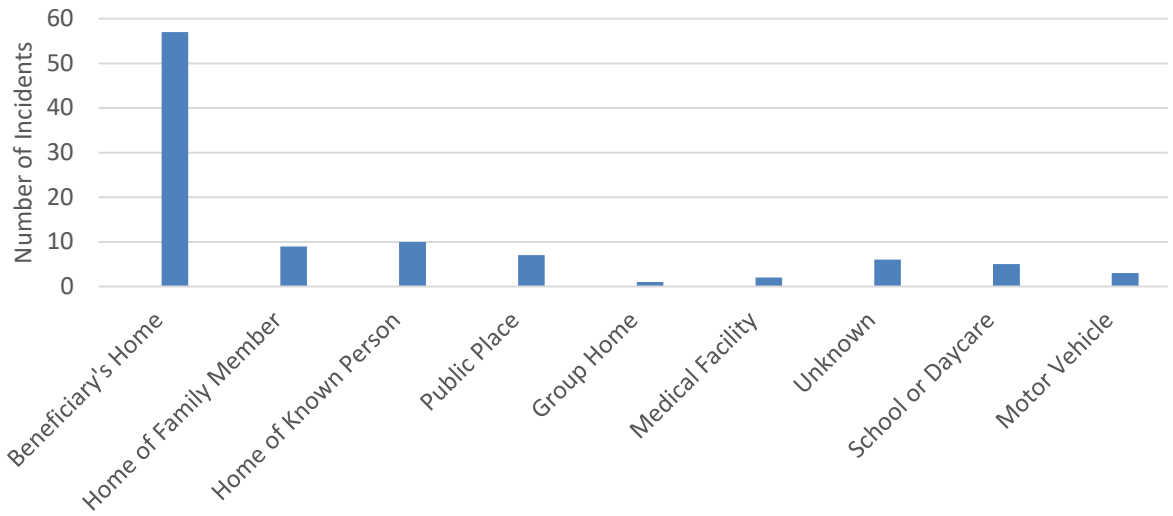


Figure 5: Location of Incidents of Potential Abuse or Neglect in Sample



A Representative Example of an Incident of Potential Child Abuse Committed by an Alleged Perpetrator Known to the Victim

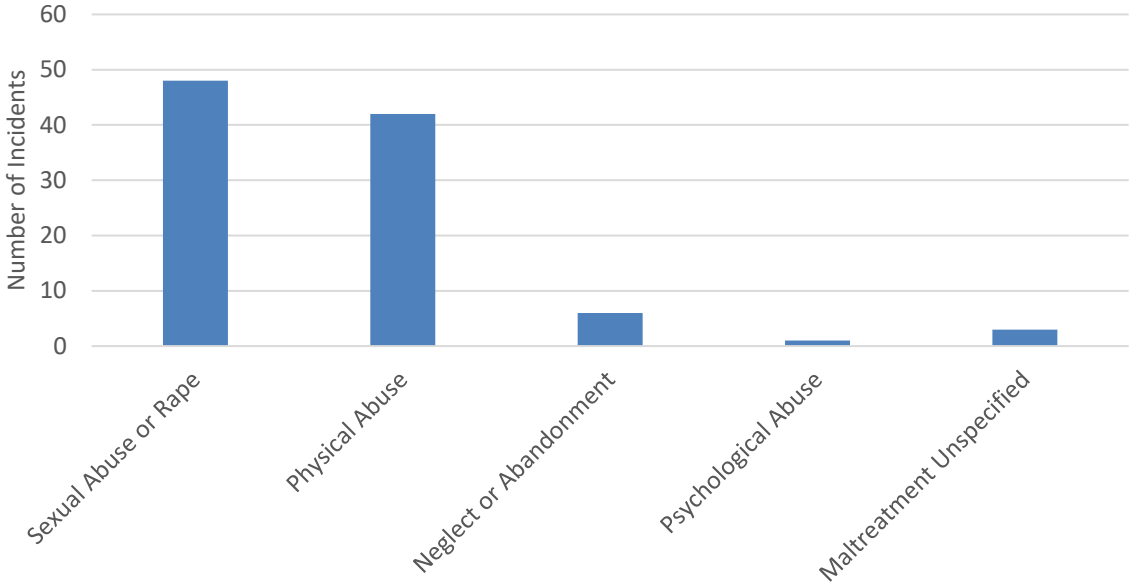
A 2-year-old male beneficiary was brought to the ER because his mother suspected physical abuse. The mother informed ER staff that she left her son with her boyfriend for 3 hours and found multiple bruises on his body when she returned. The beneficiary had bruising throughout the back of the right thigh, right buttock, and right shoulder. The boyfriend told the mother that he

spanked the child too hard. The mother then picked up the child and contacted police to file a report of child abuse. The incident was also investigated by CPS. CPS substantiated the finding of abuse against the mother's boyfriend.

Sexual Abuse or Rape Was the Most Prevalent Type of Potential Child Abuse or Neglect in Our Sample

Studies have shown that as many as 1 in 10 children will be sexually abused before their 18th birthday.[32, 33] We found that almost half the beneficiaries in our sample were brought to the ER for the treatment of sexual abuse or rape. In our sample of 100 beneficiaries, 48 of the associated incidents of potential child abuse or neglect involved alleged sexual abuse or rape (Figure 6).

Figure 6: Incidents by Diagnosis Category in Sample



A Representative Example of an Incident of Potential Sexual Abuse

A 12-year-old female beneficiary was brought to the ER by her mother and aunt after she told her mother that she had been raped by her uncle multiple times a week for the past 11 months. The beneficiary's uncle was living in the same house with her. Her uncle made her perform oral sex and have vaginal

[32] C. Townsend, A.A. Rheingold, "Estimating a Child Sexual Abuse Prevalence Rate for Practitioners: A Review of Child Sexual Abuse Prevalence Studies," *Darkness to Light,* 2013. Accessed at https://www.d2l.org/wp-content/uploads/2017/02/PREVALENCE-RATE-WHITE-PAPER-D2L.pdf on July 1, 2019.

[33] This figure represents contact abuse only, which does not include voyeurism, sexting, or exposure to pornography.

intercourse with him. The beneficiary said that she finally told her mother what was happening to her because she wanted to live a normal life. The incident was reported to, and investigated by, CPS and law enforcement. CPS referred the beneficiary to counseling. Law enforcement identified the suspect and charged him with aggravated sexual battery and aggravated rape of a child. The suspect had still not been apprehended as of the date we contacted local law enforcement to determine whether they were aware of the incident.

Substance Abuse Often Contributed to Incidents of Potential Child Abuse or Neglect

Studies have found that parental substance abuse is a contributing factor for between one-third and two-thirds of children involved with the child welfare system.[34] In our sample of 100 beneficiaries, we identified 14 associated incidents of potential child abuse or neglect that involved suspected substance abuse by the parent or guardian of the beneficiary. However, the number of incidents involving substance abuse could be much higher, as the medical records did not always specifically indicate suspected drug use. For example, in some cases the parents or guardians of the beneficiary were not present for the beneficiary's ER visits; therefore, an assessment of the parent's condition could not be made.

A Representative Example of an Incident of Potential Child Neglect Involving Suspected Substance Abuse

A 1-year-old male beneficiary was brought to the ER for evaluation because his mother had concerns that he was acting strange. At the ER, the beneficiary tested positive for methamphetamine. His mother denied knowing how her son could have been exposed, but she appeared to be under the influence of drugs herself. She was ordered to submit a drug test but tampered with the outcome of the test using a bottle of synthetic urine. The incident was reported to both CPS and law enforcement. CPS removed the beneficiary and his siblings from their home, and the child neglect charges against the mother were substantiated by CPS.

Beneficiary Deaths Potentially Resulting From Child Abuse or Neglect Were Identified in the Medicaid Claims Data

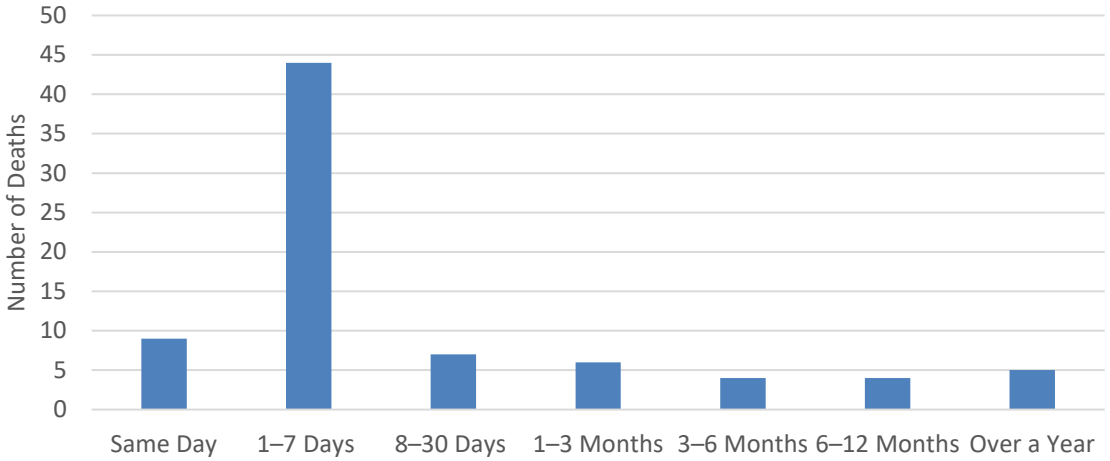
More than four children die from child abuse or neglect each day in the United States.[35] In our sampling frame of 29,534 Medicaid beneficiaries younger than age 18, we identified 79 children

[34] HHS, Administration for Children and Families, *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection*, Washington, DC: U.S. Government Printing Office, 1999. Available online at https://aspe.hhs.gov/report/blending-perspectives-and-building-common-ground.

[35] HHS, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, *Child Maltreatment 2017*, 2019. Available online at https://www.acf.hhs.gov/cb/research-data-technology/statistics-research/child-maltreatment.

who died after an ER service associated with an incident of potential child abuse or neglect. Of the 79 deaths, 9 occurred on the same day the children went to the ER and two-thirds occurred within a week of the ER service (Figure 7). Of the 79 beneficiaries, 54 were younger than age 3.

Figure 7: The Time Between the Treatment of Potential Child Abuse or Neglect and the Death of a Beneficiary



In our sample of 100 beneficiaries, we did not identify any beneficiary deaths. However, two of the beneficiaries in our sample were brought to the ER after a sibling died because of suspected child abuse by a parent.

An Example of an Incident of Potential Abuse Identified After the Death of a Sibling

An 8-year-old female beneficiary was brought to the ER for evaluation because of concerns of physical abuse and methamphetamine exposure after the death of the beneficiary's 4-year-old sibling. (The beneficiary was released to CPS after her ER examination had no acute findings.) The sibling had been wrapped in duct-taped blankets by her mother and mother's boyfriend and repeatedly struck in the head. The sibling later died from complications from multiple injuries and asphyxiation. The incident was reported to both CPS and law enforcement. The mother was found guilty of involuntary manslaughter, first-degree child abuse, and possession of methamphetamine, and the mother's boyfriend was found guilty of first-degree murder, first-degree child abuse, and possession of methamphetamine.

THE USE OF MEDICAID CLAIMS DATA PRESENTS AN OPPORTUNITY FOR STATES TO IDENTIFY POTENTIAL CASES OF CHILD ABUSE OR NEGLECT

There is no Federal requirement that CMS or States detect unreported incidents of potential child abuse or neglect. Although CMS has issued an Informational Bulletin to help States protect the health and welfare of Medicaid beneficiaries with developmental disabilities

residing in group homes, it has not issued similar guidance to help protect Medicaid beneficiaries younger than age 18.

Child abuse and neglect affects all communities, but poverty, substance abuse, and mental illness are risk factors for child maltreatment.[36] Because many children are enrolled in Medicaid based on family income, children receiving Medicaid benefits may be particularly susceptible to child abuse or neglect. However, CMS did not identify the Medicaid claims that indicate potential child abuse or neglect because, according to CMS officials, it did not extract data consisting of Medicaid claims containing diagnosis codes related to child abuse or neglect. In addition, CMS did not encourage States to identify the Medicaid claims that indicate potential child abuse or neglect. If States utilized Medicaid claims data, the data may have helped States verify compliance with their mandatory reporting laws to protect the safety, health, and rights of Medicaid beneficiaries younger than age 18. Accordingly, we identified additional actions that CMS could take to better ensure that vulnerable beneficiaries are protected.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- issue guidance, such as an Informational Bulletin, to inform States that performing a data analysis to identify Medicaid claims containing one or more diagnosis codes indicating potential child abuse or neglect could help identify incidents of potential child abuse or neglect and help ensure compliance with the States' mandatory reporting laws and

- assess the sufficiency of existing Federal requirements to report suspected child abuse and neglect of Medicaid beneficiaries to determine whether it should strengthen those requirements or seek additional authorities to provide oversight over the reporting of suspected child abuse and neglect of Medicaid beneficiaries.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred with our second recommendation to assess the sufficiency of existing Federal requirements to report suspected child abuse and neglect of Medicaid beneficiaries. CMS stated that it will review the existing Federal requirements to report suspected abuse and neglect and will assess the hospital conditions of participation and interpretive guidance for opportunities to strengthen the current language to address reporting of suspected abuse and neglect to the appropriate authorities if appropriate.

[36] CDC, National Center for Injury Prevention and Control, Division of Violence Prevention, *Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities*, 2016. Available online at https://www.cdc.gov/violenceprevention/pdf/can-prevention-technical-package.pdf.

CMS did not concur with our first recommendation to inform States that performing a data analysis to identify Medicaid claims could help identify incidents of potential child abuse or neglect and help ensure compliance with the States' mandatory reporting laws. We summarize CMS's reasons for nonconcurrence and provide our responses below.

CMS's comments are included in their entirety as Appendix I.

CMS JURISDICTION

CMS Comments

CMS stated that the majority of the sample cases identified in our audit occurred in a home or public place, which does not fall under CMS's jurisdiction for Federal oversight. CMS also stated that its regulations require all facilities and their practitioners to comply with the mandatory reporting laws for abuse and neglect applicable to their State, including compliance with timeliness requirements.

OIG Response

Although the majority of the sample cases identified in our audit occurred in a home or public place, the places where these beneficiaries were treated fall under CMS's jurisdiction. Moreover, the treating health professionals who are being paid with Medicaid funds also fall under CMS jurisdiction. Thus, we stand by our recommendations for guidance and analyses that would promote identification and reporting of potential child abuse and neglect.

STATES' ACCESS TO MEDICAID CLAIMS DATA

CMS Comments

CMS noted that ensuring compliance with mandatory reporting requirements is the responsibility of individual States which already have access to Medicaid claims data that contains targeted diagnosis codes related to suspected child abuse or neglect. Moreover, CMS added it worked with States during the transition to T-MSIS and that having access to more robust, timely, and accurate data strengthens its program monitoring, policy implementation, and oversight of Medicaid and CHIP programs.

OIG Response

CMS and States cannot adequately protect children from abuse and neglect if they do not know the harm is occurring. As States already have access to Medicaid claims data that contains targeted diagnosis codes for suspected child abuse or neglect and the transition to T-MSIS has enhanced individual States' ability to identify potential fraud, waste, and abuse, CMS should encourage States to use these data to monitor the reporting of child abuse and neglect. CMS's failure to issue guidance that informs States that Medicaid claims data can help identify

incidents of potential child abuse or neglect represents a missed opportunity to protect Medicaid beneficiaries.

In addition, HHS's Strategic Plan[37] for fiscal years 2018 through 2022 includes several strategic objectives related to the health, safety, and well-being of individuals. For example, Strategic Objective 3.2 is to "safeguard the public against preventable injuries and violence or their results." One of HHS's strategies to achieve this objective is to "disseminate evidence-based strategies to keep children and youth safe from violence and injuries—including child maltreatment, unintentional poisoning, drowning, fires and burns, and infant suffocation." Issuing guidance that informs States that Medicaid claims data can help identify incidents of potential child abuse or neglect could help achieve this objective.

TIMELINESS OF MEDICAID CLAIMS DATA

CMS Comments

CMS said that although our review of claims data provides helpful insight into past incidents of potential abuse and neglect, "this data may not be appropriate to address acute problems or concerns." CMS stated that claims data can be lagged and transformed as they move through the submission process and as a result may not be current. CMS added that it is not sufficient to rely on these data as a primary method for identifying incidents of child abuse or neglect. CMS also said that it is unclear whether analyzing claims data will improve outcomes since we did not assess whether or not the providers were in compliance with State-mandated reporting requirements for the unreported incidents in our sample. CMS described the details of its complaint intake and investigation process, which it said addresses the time-sensitive nature of these issues.

OIG Response

We disagree that claims data may not be appropriate or timely enough to address acute problems or concerns. On average the States processed the claims in our sample 55 days from the dates of service. In fact, the States processed more than 50 percent of all claims in our sample in 30 days or fewer from the dates of service and more than 85 percent of all claims in our sample in 90 days or fewer from the dates of service.

We agree that States should not rely on Medicaid claims data as a primary method for identifying child abuse or neglect. Mandated reporters are the primary method. Rather, we believe States can use the claims data (as a secondary measure) to identify potential incidents of child abuse or neglect of Medicaid beneficiaries that were identified at hospital ERs and

[37] Although the Strategic Plan does not place any legal obligations on the HHS operating divisions, it does define its mission, goals, and the means by which it will measure its progress in addressing specific national problems. HHS Strategic Plan. Available online at https://www.hhs.gov/about/strategic-plan/strategic-goal-3/index.html. Accessed on June 3, 2020.

confirm that the incidents were reported to the appropriate agencies in accordance with each State's mandated reporting requirements, including compliance with timeliness requirements.

Although CMS stated that it continues to prioritize its oversight of surveys and complaint work done by the State survey agencies to address the time-sensitive nature of instances of potential abuse and neglect, previous OIG reviews[38] have found that complaint data are not always addressed in a timely manner and may not be effective for our most vulnerable beneficiaries, especially if they lack a strong family advocate.

We continue to recommend that CMS issue guidance, such as an Informational Bulletin, to inform States that performing a data analysis to identify Medicaid claims containing one or more diagnosis codes indicating potential child abuse or neglect could help identify incidents of potential child abuse or neglect and help ensure compliance with their mandatory reporting laws.

[38] U.S. Department of Health and Human Services, Office of Inspector General, *A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011–2015* (A-01-16-00330), September 2017, and *Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated* (A-01-16-00509), June 2019. Available at https://oig.hhs.gov/oei/reports/oei-01-16-00330.asp and https://oig.hhs.gov/oas/reports/region1/11600509.asp.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 31,780 Medicaid claims nationwide, totaling $46.4 million, for ER services provided to 29,534 Medicaid beneficiaries younger than age 18 from January 1, 2017, through December 31, 2017. The Medicaid claims contained 1 or more of the 13 diagnosis codes that specifically indicated that child abuse, neglect, or maltreatment was alleged, suspected, or confirmed.

We limited our review of internal controls to determining whether CMS had internal controls in place, such as data matches or extracts, to identify incidents of potential child abuse or neglect.

We performed our fieldwork from March 2019 through October 2019.

METHODOLOGY

To accomplish our audit objectives, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- extracted from the T-MSIS inpatient and outpatient claims for services provided from January 1, 2017, through December 31, 2017, and that contained 1 or more of the 13 targeted diagnosis codes;
- identified a sampling frame of 29,534 Medicaid beneficiaries younger than age 18 that had at least 1 ER service associated with 1 or more of the 13 diagnosis codes from January 1, 2017, through December 31, 2017;
- selected a stratified random sample of 100 Medicaid beneficiaries younger than age 18 from the sampling frame;
- obtained from the medical providers the medical records associated with our sample of 100 Medicaid beneficiaries;
- reviewed those medical records to determine:
    - whether the records contained evidence of potential child abuse or neglect,
    - whether incidents of potential child abuse or neglect were reported to law enforcement,
    - whether incidents of potential child abuse or neglect were reported to CPS,

- whether incidents involved suspected substance abuse by the parents or guardians of the beneficiaries,
- the locations of the incidents,
- the alleged perpetrators of the incidents, and
- other details regarding the circumstances associated with the incidents;

- contacted CPS and law enforcement to confirm whether they were informed of incidents of potential child abuse or neglect for all 100 sample items;

- reviewed the Medicaid claims data to determine whether any Medicaid beneficiaries died after an incident of potential child abuse or neglect; and

- discussed the results of our audit with CMS officials and the steps they have taken to identify incidents of potential abuse or neglect of Medicaid beneficiaries younger than age 18.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The goal of our audit was not to identify every incident of potential child abuse or neglect. Rather, we determined whether data analysis similar to what we performed in group home and nursing home settings can be used to identify unreported incidents of potential child abuse or neglect. CMS officials informed us that it is possible there are additional Medicaid claims associated with potential child abuse or neglect that may not have been represented in the T-MSIS during the period of our audit. Specifically, CMS officials noted that the T-MSIS data may not be complete for some States and that it is working with the States to ensure that all T-MSIS data are available in the future. Any such improvements in the T-MSIS data will lead to corresponding improvements in the ability to use the data to identify unreported instances of potential child abuse and neglect. We, therefore, consider the number of claims we identified in the T-MSIS data to be a conservative estimate of the actual number of Medicaid claims associated with potential child abuse or neglect. After reviewing the possible limitations of these data, we determined that the data were sufficiently reliable for the purposes of our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS AND RESOURCE GUIDES

Report Title	Report Number	Date Issued
Pennsylvania Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-03-17-00202	January 2020
A Resource Guide for Using Diagnosis Codes in Health Insurance Claims To Help Identify Unreported Abuse or Neglect	A-01-19-00502	July 2019
CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect	A-01-17-00513	June 2019
Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated	A-01-16-00509	June 2019
Alaska Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-09-17-02006	June 2019
Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight[*]		January 2018
Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance With Applicable Requirements	A-01-17-00504	August 2017
Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities	A-01-16-00001	August 2017
Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00008	July 2016
Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries	A-01-14-00002	May 2016
Review of Intermediate Care Facilities in New York with High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries	A-02-14-01011	September 2015

[*] This joint report was issued by the OIG, Administration for Community Living, and HHS Office for Civil Rights to help improve the health, safety, and respect for the civil rights of individuals living in group homes.

APPENDIX C: LIST OF HIGH-RISK DIAGNOSIS CODES THAT MAY BE INDICATIVE OF POTENTIAL CHILD ABUSE OR NEGLECT

Diagnosis Code*	Description
	Assault
X92	Assault by drowning and submersion
X93	Assault by handgun discharge
X94	Assault by rifle, shotgun and larger firearm discharge
X95	Assault by other and unspecified firearm and gun discharge
X96	Assault by explosive material
X97	Assault by smoke, fire and flames
X98	Assault by steam, hot vapors and hot objects
X99	Assault by sharp object
Y00	Assault by blunt object
Y01	Assault by pushing from high place
Y02	Assault by pushing or placing victim in front of moving object
Y03	Assault by crashing of motor vehicle
Y04	Assault by bodily force
Y08	Assault by other specified means
Y09	Assault by unspecified means
	Treatment for a Sexually Transmitted Disease
Z113	Encounter for screening for infections with a predominantly sexual mode of transmission
Z114	Encounter for screening for human immunodeficiency virus [HIV]
A51	Early syphilis
A52	Late syphilis
A53	Other and unspecified syphilis
A54	Gonococcal infection
A55	Chlamydial lymphogranuloma (venereum)
A56	Other sexually transmitted chlamydial diseases
A57	Chancroid
A58	Granuloma inguinale
A59	Trichomoniasis
A60	Anogenital herpes viral [herpes simplex] infections
A63	Other predominantly sexually transmitted diseases, not elsewhere classified
A64	Unspecified sexually transmitted disease
	Pregnancy Test
Z32	Encounter for pregnancy test and childbirth and childcare instruction
Z320	Encounter for pregnancy test
Z3200	Encounter for pregnancy test result unknown

* These 203 high-risk diagnosis codes are provided for informational purposes only. Because of limited resources, we did not test this list for completeness. There may be additional diagnosis codes that also indicate potential child abuse or neglect.

Z3201	Encounter for pregnancy test result positive
Z3202	Encounter for pregnancy test result negative
	Exposure to Illegal Drugs
T40	Poisoning by, adverse effect of and underdosing of narcotics and psychodysleptics [hallucinogens]
T400	Poisoning by, adverse effect of and underdosing of opium
T400X	Poisoning by, adverse effect of and underdosing of opium
T400X1	Poisoning by opium, accidental (unintentional)
T400X1A	Poisoning by opium, initial encounter (unintentional)
T400X2	Poisoning by opium, intentional self-harm
T400X2A	Poisoning by opium, intentional self-harm initial encounter
T400X3	Poisoning by opium, assault
T400X3A	Poisoning by opium, assault initial encounter
T400X4	Poisoning by opium, undetermined
T400X4A	Poisoning by opium, undetermined initial encounter
T400X5	Adverse effect of opium
T400X5A	Adverse effect of opium initial encounter
T400X6	Underdosing of opium
T400X6A	Underdosing of opium initial encounter
T401	Poisoning by and adverse effect of heroin
T401X	Poisoning by and adverse effect of heroin
T401X1	Poisoning by heroin, accidental (unintentional)
T401X1A	Poisoning by heroin, initial encounter (unintentional)
T401X2	Poisoning by heroin, intentional self-harm
T401X2A	Poisoning by heroin, intentional self-harm initial encounter
T401X3	Poisoning by heroin, assault
T401X3A	Poisoning by heroin, assault initial encounter
T401X4	Poisoning by heroin, undetermined
T401X4A	Poisoning by heroin, undetermined initial encounter
T402	Poisoning by, adverse effect of and underdosing of other opioids
T402X	Poisoning by, adverse effect of and underdosing of other opioids
T402X1	Poisoning by other opioids, accidental (unintentional)
T402X1A	Poisoning by other opioids, accidental (unintentional) initial encounter
T402X2	Poisoning by other opioids, intentional self-harm
T402X2A	Poisoning by other opioids, intentional self-harm initial encounter
T402X3	Poisoning by other opioids, assault
T402X3A	Poisoning by other opioids, assault initial encounter
T402X4	Poisoning by other opioids, undetermined
T402X4A	Poisoning by other opioids, undetermined initial encounter
T402X5	Adverse effect of other opioids
T402X5A	Adverse effect of other opioids, initial encounter

T402X6	Underdosing of other opioids
T402X6A	Underdosing of other opioids, initial encounter
T403	Poisoning by, adverse effect of and underdosing of methadone
T403X	Poisoning by, adverse effect of and underdosing of methadone
T403X1	Poisoning by methadone, accidental (unintentional)
T403X1A	Poisoning by methadone, accidental (unintentional) initial encounter
T403X2	Poisoning by methadone, intentional self-harm
T403X2A	Poisoning by methadone, intentional self-harm initial encounter
T403X3	Poisoning by methadone, assault
T403X3A	Poisoning by methadone, assault initial encounter
T403X4	Poisoning by methadone, undetermined
T403X4A	Poisoning by methadone, undetermined initial encounter
T403X5	Adverse effect of methadone
T403X5A	Adverse effect of methadone, initial encounter
T403X6	Underdosing of methadone
T403X6A	Underdosing of methadone, initial encounter
T404	Poisoning by, adverse effect of and underdosing of other synthetic narcotics
T404X	Poisoning by, adverse effect of and underdosing of other synthetic narcotics
T404X1	Poisoning by other synthetic narcotics, accidental (unintentional)
T404X1A	Poisoning by other synthetic narcotics, accidental (unintentional) initial encounter
T404X2	Poisoning by other synthetic narcotics, intentional self-harm
T404X2A	Poisoning by other synthetic narcotics, intentional self-harm initial encounter
T404X3	Poisoning by other synthetic narcotics, assault
T404X3A	Poisoning by other synthetic narcotics, assault initial encounter
T404X4	Poisoning by other synthetic narcotics, undetermined
T404X4A	Poisoning by other synthetic narcotics, undetermined initial encounter
T404X5	Adverse effect of other synthetic narcotics
T404X5A	Adverse effect of other synthetic narcotics, initial encounter
T404X6	Underdosing of other synthetic narcotics
T404X6A	Underdosing of other synthetic narcotics, initial encounter
T405	Poisoning by, adverse effect of and underdosing of cocaine
T405X	Poisoning by, adverse effect of and underdosing of cocaine
T405X1	Poisoning by cocaine, accidental (unintentional)
T405X1A	Poisoning by cocaine, accidental (unintentional) initial encounter
T405X2	Poisoning by cocaine, intentional self-harm
T405X2A	Poisoning by cocaine, intentional self-harm initial encounter
T405X3	Poisoning by cocaine, assault
T405X3A	Poisoning by cocaine, assault initial encounter
T405X4	Poisoning by cocaine, undetermined
T405X4A	Poisoning by cocaine, undetermined initial encounter
T405X5	Adverse effect of cocaine

T405X5A	Adverse effect of cocaine, initial encounter
T405X6	Underdosing of cocaine
T405X6A	Underdosing of cocaine, initial encounter
T406	Poisoning by, adverse effect of and underdosing of other and unspecified narcotics
T4060	Poisoning by, adverse effect of and underdosing of unspecified narcotics
T40601	Poisoning by unspecified narcotics, accidental (unintentional)
T40601A	Poisoning by unspecified narcotics, accidental (unintentional) initial encounter
T40602	Poisoning by unspecified narcotics, intentional self-harm
T40602A	Poisoning by unspecified narcotics, intentional self-harm initial encounter
T40603	Poisoning by unspecified narcotics, assault
T40603A	Poisoning by unspecified narcotics, assault initial encounter
T40604	Poisoning by unspecified narcotics, undetermined
T40604A	Poisoning by unspecified narcotics, undetermined initial encounter
T40605	Adverse effect of unspecified narcotics
T40605A	Adverse effect of unspecified narcotics, initial encounter
T40606	Underdosing of unspecified narcotics
T40606A	Underdosing of unspecified narcotics, initial encounter
T4069	Poisoning by, adverse effect of and underdosing of other narcotics
T40691	Poisoning by other narcotics, accidental (unintentional)
T40691A	Poisoning by other narcotics, accidental (unintentional), initial encounter
T40692	Poisoning by other narcotics, intentional self-harm
T40692A	Poisoning by other narcotics, intentional self-harm initial encounter
T40693	Poisoning by other narcotics, assault
T40693A	Poisoning by other narcotics, assault initial encounter
T40694	Poisoning by other narcotics, undetermined
T40694A	Poisoning by other narcotics, undetermined initial encounter
T40695	Adverse effect of other narcotics
T40695A	Adverse effect of other narcotics, initial encounter
T40696	Underdosing of other narcotics
T40696A	Underdosing of other narcotics, initial encounter
T407	Poisoning by, adverse effect of and underdosing of cannabis (derivatives)
T407X	Poisoning by, adverse effect of and underdosing of cannabis (derivatives)
T407X1	Poisoning by cannabis (derivatives), accidental (unintentional)
T407X1A	Poisoning by cannabis (derivatives), accidental (unintentional) initial encounter
T407X2	Poisoning by cannabis (derivatives), intentional self-harm
T407X2A	Poisoning by cannabis (derivatives), intentional self-harm initial encounter
T407X3	Poisoning by cannabis (derivatives), assault
T407X3A	Poisoning by cannabis (derivatives), assault initial encounter
T407X4	Poisoning by cannabis (derivatives), undetermined
T407X4A	Poisoning by cannabis (derivatives), undetermined initial encounter
T407X5	Adverse effect of cannabis (derivatives)

T407X5A	Adverse effect of cannabis (derivatives), initial encounter
T407X6	Underdosing of cannabis (derivatives)
T407X6A	Underdosing of cannabis (derivatives), initial encounter
T408	Poisoning by and adverse effect of lysergide [LSD]
T408X	Poisoning by and adverse effect of lysergide [LSD]
T408X1	Poisoning by lysergide [LSD], accidental (unintentional)
T408X1A	Poisoning by lysergide [LSD], accidental (unintentional) initial encounter
T408X2	Poisoning by lysergide [LSD], intentional self-harm
T408X2A	Poisoning by lysergide [LSD], intentional self-harm initial encounter
T408X3	Poisoning by lysergide [LSD], assault
T408X3A	Poisoning by lysergide [LSD], assault initial encounter
T408X4	Poisoning by lysergide [LSD], undetermined
T408X4A	Poisoning by lysergide [LSD], undetermined initial encounter
T409	Poisoning by, adverse effect of and underdosing of other and unspecified psychodysleptics [hallucinogens]
T4090	Poisoning by, adverse effect of and underdosing of unspecified psychodysleptics [hallucinogens]
T40901	Poisoning by unspecified psychodysleptics [hallucinogens], accidental (unintentional)
T40901A	Poisoning by unspecified psychodysleptics [hallucinogens], accidental (unintentional) initial encounter
T40902	Poisoning by unspecified psychodysleptics [hallucinogens], intentional self-harm
T40902A	Poisoning by unspecified psychodysleptics [hallucinogens], intentional self-harm initial encounter
T40903	Poisoning by unspecified psychodysleptics [hallucinogens], assault
T40903A	Poisoning by unspecified psychodysleptics [hallucinogens], assault initial encounter
T40904	Poisoning by unspecified psychodysleptics [hallucinogens], undetermined
T40904A	Poisoning by unspecified psychodysleptics [hallucinogens], undetermined initial encounter
T40905	Adverse effect of unspecified psychodysleptics [hallucinogens]
T40905A	Adverse effect of unspecified psychodysleptics [hallucinogens], initial encounter
T40906	Underdosing of unspecified psychodysleptics
T40906A	Underdosing of unspecified psychodysleptics, initial encounter
T4099	Poisoning by, adverse effect of and underdosing of other psychodysleptics [hallucinogens]
T40991	Poisoning by other psychodysleptics [hallucinogens], accidental (unintentional)
T40991A	Poisoning by other psychodysleptics [hallucinogens], accidental (unintentional) initial encounter
T40992	Poisoning by other psychodysleptics [hallucinogens], intentional self-harm
T40992A	Poisoning by other psychodysleptics [hallucinogens], intentional self-harm initial encounter
T40993	Poisoning by other psychodysleptics [hallucinogens], assault
T40993A	Poisoning by other psychodysleptics [hallucinogens], assault initial encounter

T40994	Poisoning by other psychodysleptics [hallucinogens], undetermined
T40994A	Poisoning by other psychodysleptics [hallucinogens], undetermined initial encounter
T40995	Adverse effect of other psychodysleptics [hallucinogens]
T40995A	Adverse effect of other psychodysleptics [hallucinogens], initial encounter
T40996	Underdosing of other psychodysleptics
T40996A	Underdosing of other psychodysleptics, initial encounter
	Newborn Affected by Maternal Use of Drugs
P0412	Newborn affected by maternal cytotoxic drugs
P0414	Newborn affected by maternal use of opiates
P0416	Newborn affected by maternal use of amphetamines
P0417	Newborn affected by maternal use of sedative-hypnotics
P044	Newborn affected by maternal use of drugs of addiction
P0440	Newborn affected by maternal use of unspecified drugs of addiction
P0441	Newborn affected by maternal use of cocaine
P0442	Newborn affected by maternal use of hallucinogens
P0449	Newborn affected by maternal use of other drugs of addiction
P0481	Newborn affected by maternal use of cannabis

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The target population consisted of children receiving Medicaid benefits that had at least 1 ER service associated with 1 or more of the 13 diagnosis codes from January 1, 2017, through December 31, 2017. The 13 targeted codes indicated the beneficiaries may have suffered sexual abuse or rape, physical abuse, psychological abuse, neglect or abandonment, or maltreatment.

SAMPLING FRAME

We obtained databases of Medicaid claims data from the T-MSIS for all available nationwide ER claims from January 1, 2017, through December 31, 2017, containing targeted diagnosis codes for Medicaid beneficiaries younger than age 18. The extracted Medicaid claims data were from 48 States, Puerto Rico, and the District of Columbia.[39] The 2017 claims data were not available in the T-MSIS for two States. The claims data consisted of 31,780 Medicaid claims nationwide that included 1 or more of the 13 targeted diagnosis codes. We aggregated the claims data by unique beneficiary to obtain the final sampling frame of 29,534 beneficiaries.

SAMPLE UNIT

The sample unit was a beneficiary.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing three strata. Stratum 1 contained the State with the greatest number of Medicaid beneficiaries in our sampling frame.[40] Stratum 2 contained the next 6 States, which had more than 1,000 Medicaid beneficiaries in our sampling frame. Stratum 3 contained beneficiaries from the 43 States with 1,000 or fewer Medicaid beneficiaries in our sampling frame.

[39] For simplicity, we refer to all of these as States. The T-MSIS data for our audit period were not available for two States.

[40] Based on our review of the 20 sample items from Stratum 1, we determined that many of the ERs visits were wellness checks ordered by the CPS agency as a precautionary measure. Therefore, the fact that State 1 had the greatest number of beneficiaries in our sampling frame does not necessarily indicate that child abuse or neglect was more prevalent in that State.

Table 2: Sample Design and Size

Stratum	Beneficiary Count	Number of States (Incl. Puerto Rico and DC)	Frame Size (Beneficiaries)	Sample Size
1	State With Most Beneficiaries	1	5,996	20
2	States With >1,000 Beneficiaries (not including the State in Stratum 1)	6	12,593	40
3	States With ≤1,000 Beneficiaries	43	10,945	40
Total		**50**	**29,534**	**100**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OIG-OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the sampling frame for each stratum. After generating the random numbers for each of these strata, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the number of instances of potential child abuse or neglect for each of the reporting and investigation attributes listed in Appendix E. We also used this software to calculate the two-sided 90-percent confidence interval for each of these estimates.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

CLAIM ATTRIBUTES FOR PROJECTION

Attribute 1: Medical record contained evidence of potential child abuse or neglect

Attribute 2: Incident of potential child abuse or neglect was not reported to CPS

Table 3: Sample Results by Strata

Stratum	Frame Size (Beneficiaries)	Sample Size	Attribute 1	Attribute 2
1	5,996	20	20	0
2	12,593	40	40	9
3	10,945	40	39	4
Total	**29,534**	**100**	**99**	**13**

Table 4: Estimates by Attribute*
(Limits Calculated for the 90-Percent Confidence Interval)

Attribute Description	Statistical Estimates		
	Lower Limit	Point Estimate	Upper Limit
Attribute 1	28,811	29,260	29,534
Attribute 2	2,298	3,928	5,558

* The upper limit calculated using the OIG/OAS statistical software for attribute 1 was 29,710. We adjusted this estimate to reflect the known value of the sampling frame.

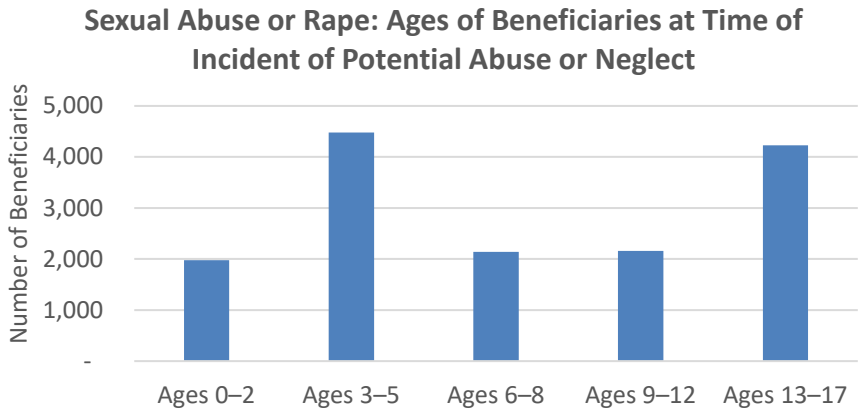
APPENDIX F: NUMBER OF MEDICAID BENEFICIARIES IN OUR SAMPLING FRAME PER STATE TREATED AT EMERGENCY ROOMS FOR POTENTIAL CHILD ABUSE OR NEGLECT

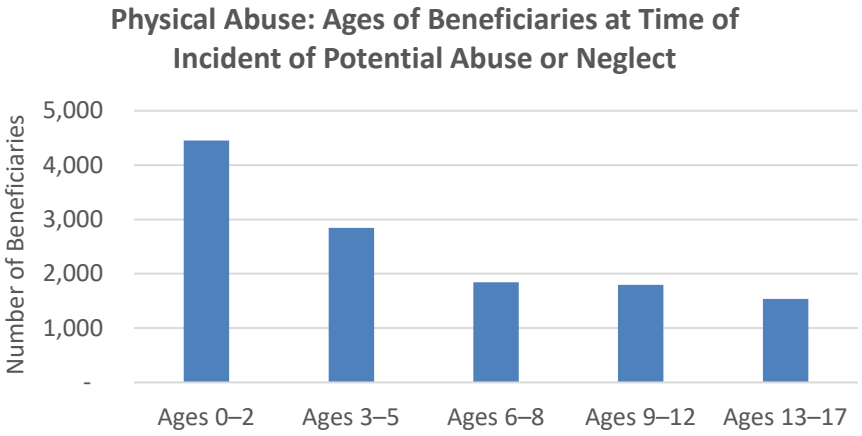
The table below shows the number of beneficiaries in our sampling frame per State who were treated in ERs after incidents of potential child abuse or neglect. The fact that some States have few beneficiaries in our sampling frame does not necessarily indicate that child abuse or neglect was less prevalent in those States. Rather, it may be attributed to the availability or completeness of T-MSIS data in those States or to CPS policies for ordering wellness checks for children at ERs in those States. For example, T-MSIS data for our audit period were not available for Colorado and Wisconsin, and the T-MSIS data for 3 States included less than 10 Medicaid beneficiaries who were treated at ERs for potential child abuse or neglect. In addition, some of the Medicaid beneficiaries in our sample were sent by CPS to the ER after an incident of potential child abuse or neglect, and some States have policies that result in a greater number of these cases being referred to ERs. For these reasons, we could not conduct a State-by-State comparison of the prevalence of Medicaid beneficiaries who presented to the ER after an incident of potential child abuse or neglect. Furthermore, we are presenting the State totals of the Medicaid beneficiaries in our sampling frame only for data transparency purposes.

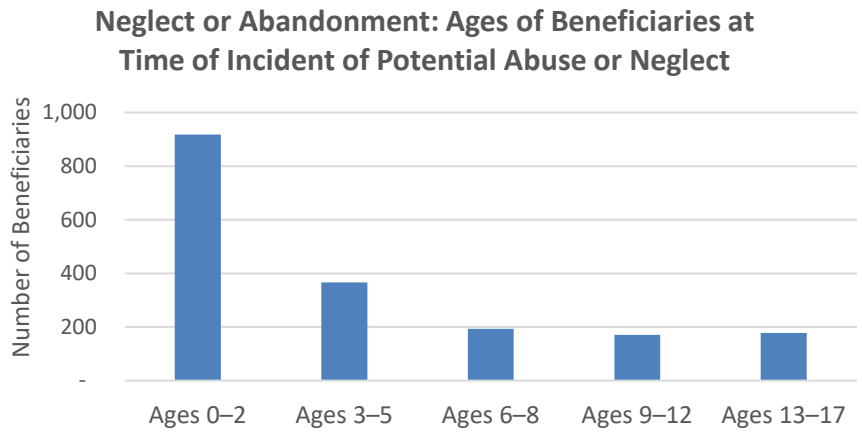
State	Number of Medicaid Beneficiaries Treated for Potential Abuse or Neglect
Stratum 1	
Michigan	5,996
Stratum 1 Total	**5,996**
Stratum 2	
Texas	4,441
New York	2,004
Ohio	1,909
Kentucky	1,607
North Carolina	1,505
Tennessee	1,127
Stratum 2 Total	**12,593**
Stratum 3	
Indiana	811
California	787
Alabama	688
Arizona	677
Oklahoma	659
Virginia	653
Mississippi	622
Oregon	557

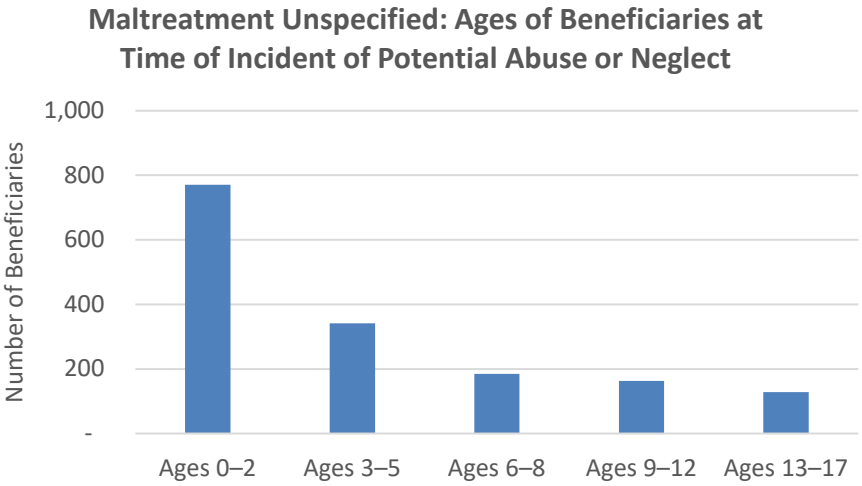
New Jersey	531
Arkansas	481
Massachusetts	457
Puerto Rico	411
Minnesota	393
Delaware	345
West Virginia	343
New Mexico	343
Iowa	295
Connecticut	273
Rhode Island	175
Georgia	169
South Dakota	141
Nebraska	139
Idaho	117
South Carolina	89
Maine	86
Alaska	73
New Hampshire	72
Nevada	72
Vermont	68
Florida	60
Pennsylvania	57
Louisiana	57
North Dakota	54
Hawaii	34
Washington	34
District of Columbia	31
Kansas	30
Missouri	16
Wyoming	16
Illinois	12
Utah	7
Maryland	5
Montana	5
Stratum 3 Total	**10,945**
Total for All Strata	**29,534**

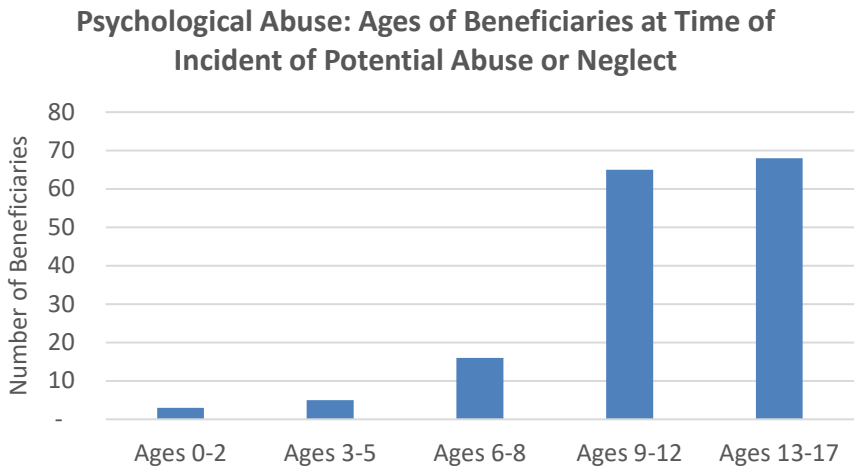
APPENDIX G: INCIDENTS OF POTENTIAL CHILD ABUSE OR NEGLECT BY CATEGORY AND AGE OF BENEFICIARIES








Maltreatment Unspecified: Ages of Beneficiaries at Time of Incident of Potential Abuse or Neglect
Number of Beneficiaries
1,000
800
600
400
200
-
Ages 0–2
Ages 3–5
Ages 6–8
Ages 9–12
Ages 13–17


Psychological Abuse: Ages of Beneficiaries at Time of Incident of Potential Abuse or Neglect
Number of Beneficiaries
80
70
60
50
40
30
20
10
-
Ages 0-2
Ages 3-5
Ages 6-8
Ages 9-12
Ages 13-17

APPENDIX H: SUMMARY OF 13 INCIDENTS NOT REPORTED TO CHILD PROTECTIVE SERVICES[41]

1. A 17-year-old female beneficiary presented to the ER with her mother after she was allegedly raped by her 20-year-old ex-boyfriend. The beneficiary reported to hospital staff that she had had an argument with her mother and ran away to a friend's house. The alleged perpetrator picked up the beneficiary from the friend's house in the middle of the night and brought her to his mother's house. He allegedly then threatened her with a gun and forced her to have sexual intercourse. The beneficiary's mother informed hospital staff that the beneficiary has had a history of CPS involvement through the foster care system. Her mother also reported to hospital staff that the beneficiary had recently become more defiant, had been running away, and had been performing poorly in school. Local law enforcement was actively involved and investigating this incident. According to the medical records, a hospital social worker performed an assessment and determined that there was a low concern for abuse or neglect by the adoptive mother and that the individual who allegedly sexually assaulted the beneficiary was not in a caretaker role. However, the social worker was concerned that the patient had run away and been sexually assaulted and recommended that the mother look into therapy for the beneficiary. The mother also stated that she may have to get CPS involved if the beneficiary continues to be defiant. There is no record that this incident was reported to CPS.

2. A 3-year-old male beneficiary was brought to the ER by his mother and a police officer for evaluation following an alleged sexual assault by a 13-year-old family friend. During a holiday party at a family friend's house, the teenager allegedly took the beneficiary into the hall, pulled down the 3-year-old male beneficiary's pants, and touched his genitals. The beneficiary pushed the teenager away causing the beneficiary to bump his head. The beneficiary's mother contacted law enforcement when she learned of the alleged incident. The hospital social worker reported the alleged incident to a child advocacy center to request therapy for the beneficiary and his mother. However, there is no record that this incident was reported to CPS.

3. A 15-year-old male beneficiary was treated at the hospital ER after being physically assaulted by at least two people outside of his home. He reported that he was punched in the face, arm, and shoulder as he was getting out of his car. The beneficiary's mother tried to help her son but was also assaulted and required medical treatment. There are no records that this incident was reported to CPS or local law enforcement.

[41] We made a determination only of whether the incidents identified at hospital ERs were or were not reported to CPS. We did not make a determination whether the incidents met the State's definition of child abuse or neglect because State-mandated reporting requirements are not always clearcut, they are subject to interpretation, and they vary from State to State. Furthermore, the medical records sometimes do not include the complete details of the incident.

4. A 16-year-old female beneficiary was brought to the ER by her mother for evaluation after she ran away from home for 3 weeks and was allegedly sexually assaulted by an adult male. The beneficiary informed hospital staff that she had run away from home and had been staying at a friend's house. Law enforcement conducted a missing person investigation and opened a human trafficking case on this beneficiary. Law enforcement discovered that she had been picked up from school by five older males. Police found nude photos of the beneficiary posted online by an adult male. There is no record that this incident was reported to CPS.

5. A 14-year-old female beneficiary was brought to the ER by her mother after she was sexually assaulted by an acquaintance on her walk home from school. The perpetrator allegedly followed her home. When she attempted to run from the perpetrator, he grabbed her hair and tried to make her perform oral sex. He then forced her to have sexual intercourse. The beneficiary told her mother what happened. Her mother brought her to the hospital for evaluation. The incident was reported to local law enforcement. However, there is no record that this incident was reported to CPS.

6. A 12-year-old male beneficiary was brought to the ER by his mother after being physically assaulted by students at school. The beneficiary was playing basketball at school when he was hit in the back of the head with a ball and punched in the back of his head and on his face. The teachers separated the students involved in the fight. The beneficiary was sent home, but his mother brought him to the hospital after noticing swelling on his cheek. There are no records that this incident was reported to CPS or local law enforcement.

7. A 12-year-old female beneficiary was brought to the ER by a parent following an incident outside of the beneficiary's apartment complex in which she was physically assaulted by several other children. She had a minor headache and an injured finger. The beneficiary stated that the other children had pulled her hair, hit her face several times, and pushed her, which caused her to hit her head on a metal gate. There are no records that this incident was reported to CPS or local law enforcement.

8. A 3-year-old male beneficiary was brought to the ER by ambulance for evaluation following a car accident in which his father was driving the vehicle. The beneficiary was in the back seat, unrestrained by either car seat or seatbelt. His father had a seizure, which caused the father to lose control of the car and crash into a wall. His father was aware that his son's car seat was not in the car but thought it would be okay because it was only going to be a short drive. According to the beneficiary's parents, law enforcement suspended the father's license and issued him a citation for not having a car seat in the vehicle. There is no record that this incident was reported to CPS.

9. A 16-year-old female beneficiary went to the ER for medical screening following a possible sexual assault. The beneficiary stated that she was raped by a man at a transit station. She complained of vaginal pain but refused a sexual assault exam. The beneficiary lives in a foster home and missed her curfew that evening. Her guardian believed that she made up the story of the sexual assault because she missed curfew and did not want to get in trouble. The beneficiary was interviewed extensively by a police officer. There is no record that this incident was reported to CPS.

10. A 15-year-old female beneficiary went to the ER because of concerns about physical and sexual abuse that had occurred on the previous day. The beneficiary arrived at the hospital with her parents and seven siblings, who all had the same complaint. Her parents stated that they dropped their eight children off at their aunt's house while the parents went out for the night. The parents checked in on the children the next morning and then left the aunt's house again. When the parents picked up the children that evening, the children told the parents that the children felt mistreated in a variety of ways by their aunt and uncle. The parents were concerned that the beneficiary was touched inappropriately and that the children had been potentially drugged. The children complained of dizziness and fatigue after drinking water. Local law enforcement was contacted. However, there is no record that this incident was reported to CPS.

11. A 9-year-old male beneficiary was brought to the ER by ambulance at the request of his mother for examination for possible sexual assault that had occurred 2 days before. His mother told hospital staff that he had been acting strangely but would not provide the hospital with any additional information about the incident. The physical exam was normal. Police interviewed the beneficiary and mother at the hospital. The hospital discharged the beneficiary with his mother, who was to follow up with law enforcement. There is no record that this incident was reported to CPS.

12. A 10-year-old male beneficiary went to the ER with his mother because she was concerned that possible abuse had occurred involving another child in the neighborhood. His mother explained to hospital staff that she found pornographic images on her son's phone. She also reported that her son had been having trouble sleeping and thought it had something to do with the other child. The beneficiary's mother did not allow medical staff to perform a forensic investigation of the child. There are no records that this incident was reported to CPS or law enforcement.

13. A 3-year-old female beneficiary was brought to the ER by her mother after an alleged sexual assault. Her mother stated that her daughter had been inappropriately touched by another child. The incident occurred after the mother dropped her daughter off at a friend's house while she ran an errand. She reported that her daughter "wasn't acting right" when she

returned from the grocery store, and then her daughter told her that her friend's 8-year-old son had touched her private area. A pelvic exam performed at the hospital was normal, and the boy denied the allegation. However, the mother was upset that more had not been done, such as the gathering of evidence using a rape kit or the involvement of law enforcement, and left the ER with her daughter before being given discharge instructions. There are no records that this incident was reported to either CPS or law enforcement.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: June 2, 2020

TO: Christi Grimm
Principal Deputy Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Medicaid Data Can Be Used to Identify Instances of Potential Child Abuse or Neglect* (A-01-19-00001)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to working with states to ensure the health and well-being of all beneficiaries receiving Medicaid benefits, including children under the age of 18.

Patient safety in all facilities that participate in the Medicare and Medicaid programs is a top priority for CMS, and monitoring patient safety and quality of care in these facilities is an essential part of CMS's oversight efforts, and requires coordinated efforts between the federal government and the states. The Conditions of Participation for hospitals, outlined at 42 CFR 482, require that hospitals serving Medicaid beneficiaries must be in compliance with federal, state and local laws. However, as indicated in the report, the majority of incidents of potential abuse and neglect identified in the OIG's sample of Medicaid claims for services provided in emergency rooms occurred outside of healthcare facilities. In cases where beneficiaries living and being cared for at home are brought to the emergency room, it is the responsibility of the individual healthcare providers of that facility to comply with the mandatory reporting laws for abuse applicable to their state. Penalties would be applied by the state. In many instances, these penalties may include jail time or fines for a practitioner that fails to report suspected child abuse and neglect as required under state law.

As the OIG notes in their report, all 50 States, the District of Columbia, and the U.S. Territories have laws that mandate the reporting of child abuse that require certain individuals and institutions to report suspected abuse, neglect, or exploitation of children. While CMS is committed to working with states to protect the health and safety of children receiving Medicaid benefits, it should be noted that ensuring compliance with mandated reporting requirements by providers is the responsibility of individual states who already have access to Medicaid claims data that contains targeted diagnosis codes for Medicaid beneficiaries younger than age 18 related to suspected abuse or neglect.

CMS has worked with states to implement changes to the way in which administrative data is collected by moving from the Medicaid Statistical Information System (MSIS) to the Transformed-MSIS (T-MSIS). As part of the transition to T-MSIS, CMS has strengthened its reporting requirements by standardizing definitions, expanding the data being collected, adding data quality enhancements, and improving the timeliness of data submission by moving from quarterly to monthly state data submissions. Having access to more robust, timely, and

accurate data via T-MSIS strengthens program monitoring, policy implementation, and oversight of Medicaid and CHIP programs. It also enhances CMS' and states' ability to identify potential fraud, waste, and abuse and improve program efficiency.

The OIG's review of claims data provides helpful insight into past incidents involving potential abuse and neglect, including injuries of unknown source, however this data may not be appropriate to address acute problems or concerns. Claims and encounter data can be lagged and transformed as they move from the provider level, to health plans, to the state, then to CMS. With this lag and these transformations, the data may not be current. As such, it is not sufficient to rely on these data as a primary method for identifying incidents of potential child abuse and neglect. Furthermore, it is unclear whether analyzing claims data will improve outcomes as the OIG did not include in their review an analysis to determine whether or not providers were in compliance with state reporting requirements when identifying the incidents in their sample that were not reported to Child Protective Services or local law enforcement.

To address the time-sensitive nature of abuse and neglect issues, CMS has a complaint intake and investigation process. CMS has agreements with state survey agencies to survey participating providers and suppliers and certify whether each entity complies with federal participation requirements. Further, accreditation based on a survey by a CMS approved Medicare accreditation program of a national accrediting organization may be used by CMS to "deem" a provider or supplier as complying with the applicable regulatory standards. For certain types of providers/suppliers, for example hospitals or psychiatric hospitals, Medicaid will also accept accreditation under a CMS-approved Medicare accreditation program as evidence of compliance for Medicaid purposes. State agencies, including law enforcement and child protective services, play an integral role in investigating complaints of abuse and neglect in a variety of health care settings and are responsible for reporting substantiated findings to local law enforcement, and if appropriate, to the Medicaid Fraud Control Units.

CMS remains diligent in our duties to monitor facilities and providers participating in Medicaid across the country, as well as the state agencies that survey them, and we appreciate the ongoing work of the OIG in this area and will continue to work with them as we make improvements to our oversight efforts.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

Issue guidance, such as an Informational Bulletin, to inform States that performing a data analysis to identify Medicaid claims containing one or more diagnosis codes indicating potential child abuse or neglect could help identify incidents of potential child abuse or neglect and help ensure compliance with their mandatory reporting laws.

CMS Response

CMS does not concur with this recommendation. CMS appreciates the OIG's goal of improving the reporting of cases of potential abuse and neglect, however the majority of the sample cases OIG identified in their audit occurred in a home or public place, which does not fall under CMS' jurisdiction for Federal oversight. CMS regulations require all facilities and their practitioners comply with the mandatory reporting laws for abuse and neglect applicable to their state, including compliance with timeliness requirements. CMS continues to prioritize its oversight of

surveys and complaint work done by the state survey agencies to address the time-sensitive nature of instances of potential abuse and neglect. As mentioned above, claims review may not be timely enough to address acute problems as claims and encounter data can be lagged and transformed as they move from the provider level, to health plans, to the state, then to CMS.

OIG Recommendation

Assess the sufficiency of existing Federal requirements to report suspected child abuse and neglect of Medicaid beneficiaries to determine whether CMS should strengthen those requirements or seek additional authorities to provide oversight over the reporting of suspected child abuse and neglect of Medicaid beneficiaries.

CMS Response

CMS concurs with this recommendation. CMS will review the existing Federal requirements to report suspected abuse and neglect and will assess our hospital Conditions of Participation and interpretive guidance for opportunities to strengthen the current language to address reporting of suspected abuse and neglect to the appropriate authorities if appropriate.

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