

Report in Brief

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



Why OIG Did This Audit

OIG previously conducted an audit of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes and found that Massachusetts did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents. The report contained five recommendations.

Our objectives were to determine whether Massachusetts implemented the recommendations from our prior audit and complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents.

How OIG Did This Audit

We reviewed Massachusetts' system for reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities during our audit period, July 2018 through June 2019. To determine whether the five recommendations from the prior OIG report were implemented, we reviewed correspondence from Centers for Medicare & Medicaid Services (CMS) and supporting documentation provided by the State. To determine whether the actions taken by Massachusetts effectively addressed our previous findings, we reviewed 147 emergency room claims from April 2019 to June 2019 for 128 beneficiaries residing in group homes who were diagnosed with conditions that we determined to be indicative of high risk for suspected abuse or neglect.

Massachusetts Implemented Our Prior Audit Recommendations and Generally Complied With Federal and State Requirements for Reporting and Monitoring Critical Incidents

What OIG Found

Massachusetts implemented the five recommendations from our prior audit and generally complied with Federal and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in group homes. However, the corrective actions for one recommendation in our prior audit were not effective in addressing one of our previous findings. Specifically, Massachusetts did not ensure all reasonable suspicions of abuse or neglect were reported to the Disabled Persons Protection Commission (DPPC). One possible reason that this issue occurred is because the Massachusetts Department of Developmental Services (DDS) and group home staff were only required to take mandated reporter training on reporting reasonable suspicions of abuse and neglect (a corrective action) once rather than periodically.

Because Massachusetts did not ensure that all reasonable suspicions of abuse or neglect were reported, it did not fulfill all of the participant safeguard assurances it provided to CMS in the Medicaid Home and Community-Based Services Intensive Supports waiver along with the State requirements incorporated under the waiver.

What OIG Recommends and Massachusetts Comments

We recommend that Massachusetts: (1) continue to coordinate with DDS and DPPC to ensure that all reasonable suspicions of abuse and neglect are properly identified, reported, and investigated as needed and (2) require periodic training for DDS and group home staff on reporting reasonable suspicions of abuse and neglect.

In written comments on our draft report, Massachusetts concurred with both of our recommendations and described the actions that it has taken or planned to take to implement them, including holding meetings between DDS and DPPC to review the updated DDS training curriculum on the proper reporting and identification of all reasonable suspicions of abuse and neglect and the addition of annual mandated reporter training for DDS and group home staff.