Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF INTERMEDIATE CARE FACILITIES IN NEW YORK WITH HIGH RATES OF EMERGENCY ROOM VISITS BY INTELLECTUALLY DISABLED MEDICAID BENEFICIARIES

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

Daniel R. Levinson
Inspector General

September 2015
A-02-14-01011

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

Intermediate Care Facilities in New York with high rates of emergency room visits by intellectually disabled Medicaid beneficiaries under their care reported on these visits, as required, and potential neglect or abuse was reported and investigated by the appropriate State agencies.

WHY WE DID THIS REVIEW

We initiated this review in response to a congressional request to review the care of intellectually disabled Medicaid beneficiaries in group homes. This is the first in a series of Office of Inspector General reviews of group home providers with high rates of emergency room (ER) visits by intellectually disabled Medicaid beneficiaries under their care.

The objective of this review was to determine whether Intermediate Care Facilities (ICFs) in New York with high rates of ER visits by intellectually disabled Medicaid beneficiaries under their care reported on these visits, as required, and whether potential neglect or abuse was reported and investigated by the appropriate State agencies.

BACKGROUND

The congressional request noted that, in several States, media outlets have raised serious concerns about cases of abuse of intellectually disabled individuals who reside in group homes.

In New York, the Office for People With Developmental Disabilities (OPWDD) oversees ICFs, which serve individuals with intellectual disabilities (e.g., autism, cerebral palsy). ICFs are residential treatment options for individuals whose disabilities severely limit their ability to live independently.

All service providers must protect people receiving OPWDD services and abide by reporting requirements for reportable incidents and abuse allegations. ICFs are required to report to OPWDD all incidents related to ER visits by Medicaid beneficiaries under their care, except those requiring no more than first aid or resulting from illness. Serious incidents are investigated by OPWDD or the New York State Justice Center for the Protection of People with Special Needs (Justice Center), an independent State law enforcement agency. The Department of Health (health department) administers New York's Medicaid program.

HOW WE CONDUCTED THIS REVIEW

We limited our review to New York ICFs in which at least 70 percent of their intellectually disabled Medicaid beneficiaries had an ER visit from 2012 through 2013. Specifically, we reviewed a sample of ER visits made by 109 beneficiaries residing at 12 ICFs and determined: (1) the reasons for the ER visits; (2) whether these ER visits were reported, as required; and (3) OPWDD's or the Justice Center's responses to these reports, when applicable.

WHAT WE FOUND

ICFs in New York with high rates of ER visits by intellectually disabled Medicaid beneficiaries under their care reported on these visits, as required, and potential neglect or abuse was reported and investigated by OPWDD or the Justice Center. However, the vast majority of ER visits we reviewed resulted from circumstances associated with the Medicaid beneficiaries' underlying medical conditions—not from neglect or abuse. Accordingly, this report contains no recommendations.

HEALTH DEPARTMENT COMMENTS

In written comments on our draft report, the health department stated that it was pleased that we had no recommendations.

TABLE OF CONTENTS

INTRODUCTION 1

Why We Did This Review 1

Objective 1

Background 1
The Medicaid Program: How It Is Administered 1
How New York Protects Its Intellectually Disabled Population 2

How We Conducted This Review 3

RESULTS OF AUDIT 3

Intermediate Care Facilities Reported Emergency Room Visits by Beneficiaries Under Their Care 3

New York Investigated Emergency Room Visits for Potential Neglect or Abuse by Intermediate Care Facility Staff 4

HEALTH DEPARTMENT COMMENTS 4

APPENDIXES

A: Audit Scope and Methodology 5

B: Sample Incident Reporting Form (Form OPWDD 147) 7

C: Health Department Comments 9

INTRODUCTION

WHY WE DID THIS REVIEW

We initiated this review in response to a congressional request to review the care of intellectually disabled Medicaid beneficiaries in group homes. This review is the first in a series of Office of Inspector General reviews of group home providers with high rates of emergency room (ER) visits by intellectually disabled Medicaid beneficiaries under their care.

OBJECTIVE

The objective of this review was to determine whether Intermediate Care Facilities (ICFs) in New York with high rates of ER visits by intellectually disabled Medicaid beneficiaries under their care reported on these visits, as required, and whether potential neglect or abuse was reported and investigated by the appropriate State agencies.

BACKGROUND

The Medicaid Program: How It Is Administered

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities, including intellectually and developmentally disabled individuals. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program.

In New York, the Department of Health (health department) administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover, including services to intellectually disabled individuals. New York's Office for People With Developmental Disabilities (OPWDD) provides services to both Medicaid and non-Medicaid-eligible individuals (beneficiaries) with intellectual and developmental disabilities under a cooperative agreement with the health department.

OPWDD oversees ICFs that serve individuals with intellectual disabilities (e.g., autism, cerebral palsy). These facilities are residential treatment options for individuals whose disabilities severely limit their ability to live independently. ICFs provide 24-hour onsite assistance and training, intensive clinical and direct-care services, supervised activities, and a variety of therapies.[1]

[1] ICFs include State-operated and privately operated facilities with 30 or fewer beds and State-operated facilities with more than 30 beds. Privately operated facilities are nonprofit providers only. OPWDD uses the term "privately operated (voluntary)" to describe these facilities. Throughout the report, we refer to these as "privately operated facilities." Presently, for-profit providers are not permitted to obtain the necessary certificates to operate a licensed residential facility for the intellectually and developmentally disabled in New York.

How New York Protects Its Intellectually Disabled Population

The Justice Center for the Protection of People with Special Needs

Created in 2012, the Justice Center for the Protection of People with Special Needs (Justice Center) serves both as a law enforcement agency and as an advocate for people with special needs.[2, 3] Its responsibilities include: (1) ensuring that all allegations of abuse and neglect are fully investigated; (2) operating a hotline for reporting allegations of abuse, neglect, and significant incidents; (3) maintaining a comprehensive statewide database that tracks cases until they are resolved and allows the Justice Center to monitor trends and develop abuse prevention initiatives; and (4) maintaining a list of individuals prohibited from working with people with special needs in New York.

The Office for People With Developmental Disabilities

All service providers must protect people receiving OPWDD services and abide by specific reporting requirements for reportable incidents and abuse allegations (Title 14, Part 624 of the New York Compilation of Codes, Rules and Regulations). ICFs are required to report to OPWDD all incidents related to ER visits by Medicaid beneficiaries under their care, except those requiring no more than first aid or resulting from illness. Serious incidents are investigated by OPWDD or the Justice Center.[4]

OPWDD's Incident Management Unit reviews incident reports submitted by providers through its Incident Report and Management Application, a secure Web-based database. When appropriate, OPWDD coordinates with law enforcement.

Providers identified by OPWDD as showing signs of decreased quality of care may be placed on OPWDD's Early Alert list.[5] The goal of the Early Alert list is to assist providers on the list in getting back into compliance with OPWDD regulations. A provider can be removed from the Early Alert list if:

(1) it complies in full with OPWDD's recommendations and provides evidence to show that issues that were of concern have been corrected and a system has been put in place to prevent recurrence or

[2] N.Y. Exec. Law §. 230, Art. 20.

[3] The Justice Center supports and protects the health, safety, and dignity of the more than 1 million people who receive care from approximately 3,000 State and private facilities and programs operated, licensed, or certified by 6 State agencies, including the health department and OPWDD.

[4] The health department performs routine surveys of ICFs. These surveys include evaluating ICFs' compliance with incident reporting and investigation requirements under Part 624.

[5] Early Alert triggers include: (1) failure to report, investigate, or provide needed individual protections in situations that warrant reporting as allegations of abuse or neglect and (2) trends of substantiated allegations of abuse, neglect, significant injuries of unknown origin, or unexpected deaths among beneficiaries.

(2) it takes action to transition services to another provider or no longer provides OPWDD services.[6]

HOW WE CONDUCTED THIS REVIEW

We limited our review to New York ICFs in which at least 70 percent of their intellectually disabled Medicaid beneficiaries had an ER visit from 2012 through 2013. Specifically, we reviewed a sample of ER visits made by 109 beneficiaries residing at 12 ICFs and determined: (1) the reasons for the ER visits; (2) whether these ER visits were reported; and (3) OPWDD's or the Justice Center's responses to these reports, when applicable.[7]

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.

Appendix A contains the details of our audit scope and methodology.

RESULTS OF AUDIT

ICFs in New York with high rates of ER visits by intellectually disabled Medicaid beneficiaries under their care reported on these visits, as required, and potential neglect or abuse was reported and investigated. Specifically, all serious incidents were investigated by OPWDD or the Justice Center. However, the vast majority of ER visits we reviewed resulted from circumstances associated with the Medicaid beneficiaries' underlying medical conditions—not from neglect or abuse. Accordingly, this report contains no recommendations.

INTERMEDIATE CARE FACILITIES REPORTED EMERGENCY ROOM VISITS BY BENEFICIARIES UNDER THEIR CARE

We determined that ICFs with high rates of ER visits by intellectually disabled Medicaid beneficiaries under their care reported on these visits. We selected 12 ICFs throughout New York that had a high rate of intellectually disabled Medicaid beneficiaries under their care who visited an ER from 2012 through 2013 (audit period).[8] From these providers, we selected 109 beneficiaries with numerous ER visits and reviewed their case files and hospital discharge summaries. We determined that ICFs reported these visits to the appropriate State agencies,

[6] As of December 18, 2014, 12 OPWDD providers were on the Early Alert list: 10 privately operated providers and 2 State-operated providers. One of the State-operated providers on the list was included in our sample of providers visited. Additionally, two privately operated providers included in our sample of providers visited indicated that they previously had been on the Early Alert list and were removed after they proved they were in compliance with OPWDD recommendations.

[7] ICFs document all ER visits; however, not all of these visits require an incident report to New York.

[8] The 12 providers comprised 2 State-operated providers and 10 privately operated providers.

when applicable.[9] Specifically, ICFs completed and submitted OPWDD's form for reporting serious incidents—Form OPWDD 147, *Reportable Incidents and Notable Occurrences*—when applicable. Appendix B contains an example of this form.

We did not find any indications of incidents of abuse or neglect that were not reported according to New York requirements for the ER visits we reviewed.[10] On the basis of our analysis of documentation supporting the selected ER visits and, in some cases, related hospital inpatient stays, we also found that the vast majority of the ER visits we reviewed resulted from circumstances associated with the Medicaid beneficiaries' underlying medical conditions, not from neglect or abuse. For example, many ER visits related to beneficiaries with a feeding tube that had become clogged and needed to be cleared or replaced—a procedure that ICFs were not equipped to handle.

NEW YORK INVESTIGATED EMERGENCY ROOM VISITS FOR POTENTIAL NEGLECT OR ABUSE BY INTERMEDIATE CARE FACILITY STAFF

For each of the 82 reported incidents that we reviewed, we determined that OPWDD or Justice Center officials, or both, were aware of and investigated the incidents and took corrective action, if necessary. For example, in one incident, a beneficiary fell out of a sling while being transferred between rooms at an ICF. The beneficiary was sent to an ER for x-rays and evaluation and, after being medically evaluated, was discharged. The ICF reported the incident as an allegation of abuse or neglect, and the results of the investigation substantiated the allegation. The ICF recommended administrative action against the worker involved and that it implement new guidelines regarding falls.

While incidents of abuse or neglect, and even death, did occur among the intellectually disabled population, we found that New York had in place a system for protecting and advocating the rights of these beneficiaries.

Accordingly, this report contains no recommendations.

HEALTH DEPARTMENT COMMENTS

In written comments on our draft report, the health department stated that it was pleased that we had no recommendations. The health department's comments are included in their entirety as Appendix C.

[9] For each of the ICFs, we also reviewed all reported deaths involving the 109 beneficiaries during our audit period. Seven of the 12 ICFs had a total of 12 reported deaths among the 109 beneficiaries. All 12 reported deaths were from natural causes.

[10] We also determined that the health department's process for surveying ICFs includes incident-reporting compliance.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We limited our review to 145,690 Medicaid claim lines (claims) for ER visits totaling $1,596,090 ($856,877 Federal share) made on behalf of 22,761 intellectually disabled individuals residing in 1,067 certified residential facilities from January 1, 2012, through December 31, 2013. Specifically, we reviewed a sample of ER visits made by 109 beneficiaries residing in 12 ICFs.

We did not assess the overall internal control structure of the various State agencies, the Medicaid program or the ICFs. Rather, we limited our internal control review to those controls related to the objective of our audit.

We performed fieldwork at the Justice Center in Delmar, New York; the Medicaid Management Information System (MMIS) fiscal agent in Rensselaer, New York; and at 12 State-operated and privately operated ICFs throughout New York between March and December 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;

- held discussions with officials from several State agencies to: (1) identify the populations of both the intellectually disabled individuals and the certified residential providers who serve them[11] and (2) gain an understanding of New York's procedures for protecting its intellectually disabled population against incidents of abuse, neglect, or death;

- ran computer programming applications at the MMIS fiscal agent for selected rate codes and categories of service that identified 2,372,217 Medicaid claims submitted by 1,123 certified residential providers for 40,720 intellectually disabled beneficiaries in New York State, totaling $12,142,069,141 ($6,067,281,684 Federal share);

- ran additional computer programming applications at the MMIS fiscal agent, which (1) identified that 22,761 of the 40,720 beneficiaries had a total of 145,690 ER visits charged to Medicaid totaling $1,596,090 ($856,877 Federal share) and (2) identified that 9,547 of the 22,761 beneficiaries also had an inpatient hospital stay related to their ER visits;

- summarized the certified residential providers by category of service and rate code combination (category) and identified both the number of intellectually disabled

[11] New York officials identified the certified residential providers by means of selected rate code and category of service combinations within New York's MMIS. Selected rate codes included 1605, 3822, 4100 4102, 4440, and 4700 4714, and selected categories of service included 269, 285, and 384.

Medicaid beneficiaries served by each residential provider and the number of those beneficiaries who had an ER visit;

- determined which providers, by category, had at least 70 percent of their beneficiaries who had had an ER visit;

- selected a judgmental sample of 12 residential providers throughout New York having a high percentage of beneficiaries with ER visits;

- judgmentally selected 109 beneficiaries from these providers whose ER visits had diagnosis codes that suggested potential incidents of abuse or neglect;[12, 13]

- visited each of the 12 providers and reviewed records associated with selected ER visits and any related inpatient stays to determine: (1) the reasons for the ER visits; (2) whether these ER visits were appropriately reported; and (3) OPWDD's and the Justice Center's responses to these reports, when applicable; and

- discussed our results with State agency officials.

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.

[12] We identified 2,759 Medicaid claims for ER visits and 140 Medicaid claims for inpatient hospital stays associated with the 109 beneficiaries residing in the 12 ICFs.

[13] Diagnoses codes suggesting potential abuse or neglect included, for example, fractures, head lacerations, contusions, open wounds, and choking.

APPENDIX B: SAMPLE INCIDENT REPORTING FORM (FORM OPWDD 147)

Form OPWDD 147 (Revised 6/2013)
For additional guidance in completing this form please see line by line instructions.
NOTE: This form only contains the information available at the time of its completion.

State of New York
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

REPORTING FORM: 14 NYCRR Part 624 - Reportable Incidents and Notable Occurrences

1. AGENCY COMPLETING FORM

2. FACILITY *(if applicable)*

3. PROGRAM TYPE

4. ADDRESS

5. PHONE

6. MASTER INCIDENT NUMBER

7. AGENCY INCIDENT NUMBER

8. WAS A RELATED INCIDENT PREVIOUSLY REPORTED?
1 ☐ YES 2 ☐ NO

TO BE COMPLETED BY STAFF DESIGNATED IN POLICY

9. NAME OF PERSON(S) RECEIVING SERVICES (Last, First)

10. DATE OF BIRTH

11. GENDER
1 ☐ MALE
2 ☐ FEMALE

12. TABS ID *(if applicable)*

13. RECEIVES MEDICATION: 1 ☐ YES 2 ☐ NO 3 ☐ UNKNOWN BY PERSON COMPLETING THIS FORM

14. DATE & TIME INCIDENT WAS
1 ☐ Observed
2 ☐ Discovered

MO.	DAY	YR.	HR.	MIN.	1☐ AM 2☐ PM

15. DATE AND TIME INCIDENT OCCURRED *(if known)*

MO.	DAY	YR.	HR.	MIN	1☐ AM 2☐ PM

16. NUMBER OF PERSONS RECEIVING SERVICES PRESENT AT TIME OF INCIDENT: _____

17. NUMBER OF EMPLOYEES PRESENT AT TIME OF INCIDENT:_____

18. PRELIMINARY CLASSIFICATION (X ONE)

In addition to other required notifications **REPORTABLE INCIDENTS <u>must</u>** be reported to the Justice Center if the program is certified or operated by OPWDD

REPORTABLE INCIDENT – Abuse/Neglect
1 ☐ Physical abuse
2 ☐ Sexual abuse
3 ☐ Psychological abuse
4 ☐ Deliberate inappropriate use of restraints
5 ☐ Use of aversive conditioning
6 ☐ Obstruction of reports of reportable incidents
7 ☐ Unlawful use or administration of a controlled substance
8 ☐ Neglect

REPORTABLE INCIDENT - Significant Incidents
1 ☐ Conduct between individuals receiving services
2 ☐ Seclusion
3 ☐ Unauthorized use of time-out
4 ☐ Medication error with adverse effect
5 ☐ Inappropriate use of restraints
6 ☐ Other mistreatment
7 ☐ Missing Person
8 ☐ Choking, with known risk
9 ☐ Self-abusive behavior with injury

NOTABLE OCCURRENCES

Serious Notable Occurrences
1 ☐ Injury
2 ☐ Unauthorized absence
3 ☐ Death
4 ☐ Choking, with no known risk
5 ☐ Theft/Financial Exploitation
6 ☐ Sensitive Situation
7 ☐ ICF violations

Minor Notable Occurrences
1 ☐ Injury
2 ☐ Theft/Financial Exploitation

19. SPECIFIC LOCATION WHERE INCIDENT OCCURRED

1 ☐ Living Room
2 ☐ Bedroom
3 ☐ Kitchen
4 ☐ Bathroom
5 ☐ Hallway
6 ☐ Staircase
7 ☐ Dining Room
8 ☐ Program Room
9 ☐ Recreation Area
10 ☐ Off-Facility Property
11 ☐ Unknown
12 ☐ Vehicle
13 ☐ Other (Specify)

20. BRIEF DESCRIPTION OF THE INCIDENT

(Continue on separate sheet if necessary)

21. LIST ALL THE IMMEDIATE CORRECTIVE/PROTECTIVE ACTIONS THAT HAVE BEEN TAKEN TO SAFEGUARD THE PERSON(S). THIS SHOULD INCLUDE, BUT IS NOT LIMITED TO, ANY FIRST AID, MEDICAL/DENTAL TREATMENT OR COUNSELING PROVIDED.

(Continue on separate sheet if necessary)

22. AS APPLICABLE, NOTIFICATION TO				
JUSTICE CENTER 1 ☐ YES 2 ☐ N/A	DATE	TIME	JC IDENTIFIER	REPORTED BY
LAW ENFORCEMENT OFFICIALS 1 ☐ YES 2 ☐ N/A	DATE	TIME	LAW ENFORCEMENT AGENCY NAME	

23. PERMANENT RESIDENTIAL ADDRESS AND PHONE NUMBER *(of person listed in #9 above, if different than #4 and #5)*

24. TYPE OF RESIDENCE
1 ☐ SOIRA 2 ☐ VOIRA 3 ☐ SOICF 4 ☐ VOICF 5 ☐ FC 6 ☐ DC 7 ☐ CR 8 ☐ Other: (*Specify*) _____

25. PRINT NAME OF PARTY COMPLETING ITEMS 1-24	TITLE	DATE
26. PRINT NAME OF PARTY REVIEWING ITEMS 1-25	TITLE	DATE

27. NOTIFICATIONS *(as appropriate)*

CONTACT	DATE	TIME	PERSON CONTACTED	REPORTED BY	METHOD
OPWDD IMU *(applies to all providers)*					
DDSOO Director/Agency CEO or Designee					
Family/Guardian/Advocate Notification					
Service Coordinator/Case Manager					
QIDP (*for ICF Resident*)					
Willowbrook CAB (Consumer Adv. Bd.)					
Willowbrook Attorneys (*if applicable*)					
OPWDD Willowbrook Liaison					
MHLS (Mental Hygiene Legal Service)					
Board of Visitors (*if applicable*)					
Coroner/Medical Examiner					
Other					
Other					
Other					
Other					

28. ADDITIONAL STEPS TAKEN TO ENSURE THE INDIVIDUAL'S SAFETY *(Use this section to explain any additions or modifications to immediate protections, item 21, or to add additional information.)*

29. PRINT NAME OF PARTY COMPLETING ITEM 28	TITLE	DATE

APPENDIX C: HEALTH DEPARTMENT COMMENTS

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

August 5, 2015

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-14-01011

Dear Mr. Edert:

The Department of Health is pleased to note that you had no recommendations in the Office of Inspector General's Draft Audit Report A-02-14-01011, entitled "Review of Intermediate Care Facilities in New York with High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries."

Sincerely,

Sally Dreslin

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

cc: Michael J. Nazarko
Robert W. LoCicero, Esq.
Jason A. Helgerson
Dennis Rosen
Jeff Wise
Kerry Delaney
Vincent Sleasman
Jay Kiyonaga
Robert Loftus
James Cataldo
Ronald Farrell
Brian Kiernan
Elizabeth Misa
Ralph Bielefeldt
Diane Christensen
Lori Conway
OHIP Audit SM