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.

The full report can be found at https://oig.hhs.gov/oas/reports/region1/12000003.asp.