

Report in Brief

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



Why OIG Did This Audit

We have performed audits in several States, including New York, in response to a congressional request concerning deaths and abuse of residents with developmental disabilities in group homes. Federal waivers permit States to furnish an array of home and community-based services to Medicaid beneficiaries with developmental disabilities so that they may live in community settings and avoid institutionalization. CMS requires States to implement a critical incident reporting system to protect the health and welfare of Medicaid beneficiaries receiving waiver services.

Our objective was to determine whether New York ensured that community-based providers complied with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings.

How OIG Did This Audit

We reviewed the State agency's system for provider reporting and monitoring of critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings for calendar year 2017. We reviewed a sample of 30 incidents of potentially unreported abuse and neglect, and a judgmental sample of 48 reported incidents related to beneficiaries with developmental disabilities covered by the HCBS Medicaid waiver.

New York Did Not Fully Comply With Federal and State Requirements for Reporting and Monitoring Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities

What OIG Found

New York did not ensure that providers fully complied with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities residing in community-based settings. Of the 30 incidents of potential abuse and neglect in our sample, 23 incidents were properly reported and investigated; however, 7 incidents were not. Specifically, providers did not properly report three incidents and, for all seven incidents, providers did not meet investigation requirements (four incidents were not investigated on time and three were not investigated adequately). These incidents of potential abuse and neglect were not properly reported because the individuals responsible for reporting them either initially reported them to the wrong authority or erroneously believed that another provider was responsible for reporting them. Investigations were not adequately conducted because: (1) some incidents were not reported on time, thereby delaying initiation of the investigations; and (2) providers' internal policies and procedures for investigating internal incidents were either inadequate or were nonexistent. Because incidents of potential abuse and neglect were not properly reported or investigated, beneficiaries were put at an increased risk of harm.

Of the 48 reported and substantiated incidents of abuse and neglect in our judgmental sample, we found that the associated providers complied with the critical incident reporting and monitoring requirements.

What OIG Recommends and New York's Comments

We recommend that New York: (1) reinforce guidance to the provider community on various specific requirements related to the reporting and investigating of critical incidents; (2) issue guidance and/or provide training to the provider community on the importance of identifying root causes of an incident, and identifying trends in incidents; and (3) review the three internal occurrence investigations identified in our report for compliance with investigative requirements, and make any necessary changes to the incident classifications in accordance with Part 624.

In written comments on our draft report, New York agreed with our recommendations and described steps it has taken and plans to take to address them.