Report in Brief
Date: December 2023
Report No. A-01-21-00001

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

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

Why OIG Did This Audit

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

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

How OIG Did This Audit

We reviewed Connecticut's system for reporting and monitoring of critical incidents involving Medicaid enrollees with developmental disabilities during our audit period, January 2020 through December 2020. To determine whether the four recommendations from the prior OIG report were implemented, we reviewed correspondence from CMS and supporting documentation provided by the State. We limited our review to 163 incidents of potential abuse and neglect during the audit period for 138 enrollees between the ages of 18 and 59 who resided in group homes. We also reviewed 57 potential critical incidents involving 51 Medicaid enrollees between the ages of 18 and 59 who resided in group homes.

What OIG Found

Connecticut implemented the four recommendations from our prior audit and generally complied with Federal and State requirements for reporting and monitoring abuse, neglect, and critical incidents involving Medicaid enrollees with developmental disabilities residing in group homes. However, the corrective actions for two recommendations in our prior audit were not effective in addressing one of our previous findings. Specifically, Connecticut did not ensure that group homes reported all incidents involving potential abuse and neglect to DDS. These issues occurred because: (1) Connecticut group homes experienced significant staff hiring and retention problems, and (2) the State agency and DDS did not implement new analytical procedures to detect incidents involving potential abuse and neglect during our audit period.

What OIG Recommends and Connecticut Comments

We recommend that the State agency continue to coordinate with DDS to : (1) provide training for staff of DDS and private group homes on how to monitor and report reasonable suspicions of abuse and neglect, especially in light of the significant staff hiring and retention problems in Connecticut group homes, and (2) use the new analytical procedures to identify potential cases of abuse or neglect involving Medicaid enrollees with developmental disabilities that incurred injuries and are treated in hospital emergency room settings.

In written comments on our draft report, Connecticut concurred with our recommendations and described the actions it has taken or plans to take to address them.