Joint Report from U.S. Department of Health and Human Services' Office of Inspector General (OIG), Administration for Community Living (ACL), and Office for Civil Rights (OCR):

In January of 2018, three agencies operated by the U.S. Department of Health and Human Services, acknowledged systemic shortcomings in protecting residents of HCBS waiver group homes from incidents of abuse and neglect. The Office of the Inspector General (OIG) determined that **up to 99 percent of these critical incidents were not reported to the appropriate law enforcement or state agencies as required**. The report stated, "**Group Home beneficiaries are at risk of serious harm. OIG found that health and safety policies and procedures were not being followed. Failure to comply with these policies and procedures left group home beneficiaries at risk of serious harm. These are not isolated incidents but a systemic problem – 49 States had media reports of health and safety problems in group homes.**"

The report grew out of investigations into under-reporting of critical incidents by group home providers in Connecticut, Massachusetts, and Maine that had been conducted by the OIG in 2015. The reports found drastic under-reporting of incidents resulting in trips to the emergency room and/or hospitalizations by group home providers. Concurrent with those investigations, the Inspector General also looked into critical incident reporting by ICF's in NY State. That investigation determined that NY's ICF's had an excellent record of reporting incidents, and that no actions or recommendations were necessary.

OIG highlighted under-reporting critical incidents of abuse and neglect in privately operated group homes, including "deaths, physical and sexual assaults, suicide attempts, unplanned hospitalizations, near drowning, missing persons, and serious injuries. Critical incidents requiring a minor level of review generally include suspected verbal or emotional abuse, theft, and property damage. For critical incidents that involve suspected abuse or neglect, the HCBS waiver and State regulations also require mandated reporting." It found that in the states under study, "the State agencies did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents involving Medicaid beneficiaries with developmental disabilities."

The report identified four Compliance Oversight Components that "help ensure that beneficiary health, safety, and civil rights are adequately protected, that provider and service agencies operate under appropriate accountability mechanisms, and that public services are delivered consistent with funding expectations."

1. Reliable incident management and investigation processes;
2. Audit protocols that ensure compliance with reporting, review, and response requirements;
3. Effective mortality reviews of unexpected deaths
4. Quality assurance mechanisms that ensure the delivery and fiscal integrity of appropriate community-based services.

In conclusion, the three agencies proposed that the Center for Medicare and Medicaid Services (CMS):

1. Encourage States to implement comprehensive compliance oversight systems for group homes, such as the Model Practices, and regularly report their findings to CMS;
2. Form a "SWAT" team to address, in a timely manner, systemic problems in State implementation of and compliance with health and safety oversight systems for group homes
3. Take immediate action in response to serious health and safety findings, for group homes using the authority under 42 CFR § 441.304(g).

VOR's Comments: Most families who have signed the HCBS Waiver would have had reasonable expectations that the four oversight components listed above were in place all along. The first three of these components are mandatory licensing requirements of Intermediate Care Facilities. As for the "SWAT" teams, isn't that the job that has been expected of Protection and Advocacy agencies in each state? If not, then what *is* expected of them by HHS and CMS? And why do these agencies tell us that our loved ones can receive the same level of care in group homes that they receive in ICF's, and encourage us to leave the ICF's, when they know that these problems remain unchecked in the HCBS waiver system?

The full report is available for download at: https://www.vor.net/images/stories/2017-2018/ACL-group-homes-joint-report.pdf