Report in Brief
Date: May 2019
Report No. A-05-19-00005

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

Four States Did Not Comply With Federal Waiver and State Requirements in Overseeing Adult Day Care Centers and Foster Care Homes

Why OIG Did This Review

Prior Office of Inspector General reviews of State agencies that serve vulnerable adults who receive services through waiver programs have identified multiple health and safety issues that put vulnerable adults at risk. These reviews included adult day care services received at adult day service centers (centers) in Minnesota, Illinois, Wisconsin, and Mississippi and services received at adult foster care homes (homes) in Minnesota. We continue to perform similar reviews in other States.

Our objectives were to (1) summarize the results of our previous reviews of States' compliance with Federal and State requirements for overseeing centers and homes and (2) identify actions that the Centers for Medicare & Medicaid Services (CMS) could take to help States comply with the requirements.

How OIG Did This Review

We reviewed Federal waiver and State requirements for centers and homes where vulnerable adults received services through programs in Minnesota, Illinois, Wisconsin, and Mississippi. We selected 20 centers in each State and 20 homes in Minnesota on the basis of their geographic location and other factors. This series of reviews began in January 2016 and ran through March 2017.

What OIG Found

The four States did not comply with Federal waiver and State requirements in overseeing centers and homes. Our reviews found violations of health and safety and administrative requirements at 96 of the 100 centers and homes reviewed. Specifically, we found 1,141 instances of noncompliance with health and safety and administrative requirements.

State officials in Minnesota, Wisconsin, and Mississippi said that most instances of noncompliance occurred because of low staffing levels that limited the States' oversight and monitoring of facilities and because of insufficient training on State requirements. State officials in Illinois and Minnesota said that the absence of templates for State-required administrative records and unclear State requirements contributed to noncompliance with numerous health and safety and administrative requirements. Noncompliance with health and safety and administrative requirements puts vulnerable adults in the care of the centers and homes at risk.

What OIG Recommends and CMS's Comments

We recommend that CMS work with the States reviewed to ensure that the instances of noncompliance with health and safety and administrative requirements identified in this report are corrected; assist all States in ensuring the health and safety of vulnerable adults by offering technical assistance on staffing models in centers, homes, and other home and community-based services (HCBS) settings; review current training the States provide to centers and homes; and ensure the health and safety of vulnerable adults by offering technical assistance on possible templates for administrative records in centers, homes, and other HCBS settings.

In written comments on our draft report, CMS concurred with our findings and recommendations and described corrective actions that it will take in response to our recommendations.