Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OVERSIGHT OF QUALITY OF CARE IN MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS

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Inspector General

June 2012
OEI-02-08-00170

EXECUTIVE SUMMARY: OVERSIGHT OF QUALITY OF CARE IN MEDICAID HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAMS
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WHY WE DID THIS STUDY

In recent years, States have altered their approach to providing Medicaid-funded long-term care services. Rather than providing the majority of that care in institutions—such as nursing homes—States are now providing more care in homes and other community-based settings. States most often provide this care through 1915(c) home and community-based services (HCBS) waiver programs, and the individuals served by these programs are most commonly disabled and over age 65. In fiscal year 2010, Medicaid expenditures for HCBS waiver programs serving this population totaled an estimated $8.9 billion. Strong oversight of waiver programs is critical to ensuring the quality of care provided to HCBS beneficiaries. The beneficiaries who rely on HCBS waiver programs are among Medicaid's most vulnerable, and the nature of these programs puts them at particular risk of receiving inadequate care.

HOW WE DID THIS STUDY

States must operate their HCBS waiver programs in accordance with certain "assurances," including three assurances related to quality of care. To meet these assurances, States must demonstrate that they have systems to effectively monitor the adequacy of service plans, the qualifications of providers, and the health and welfare of beneficiaries. We based this study on a review of documents from the Centers for Medicare & Medicaid Services' (CMS) most recent quality review of waiver programs from 25 States, as well as information gathered from structured interviews with staff from the 10 CMS regional offices.

WHAT WE FOUND

Seven of the twenty-five States that we reviewed did not have adequate systems to ensure the quality of care provided to beneficiaries. Although CMS renewed the waiver programs in all seven of these States, three did not adequately correct identified problems. Not only did these States fail to correct these problems before renewal of their programs, they also had still not adequately addressed the problems long after renewal. In addition, CMS did not consistently use the few tools it has to ensure that States correct problems related to quality of care.

WHAT WE RECOMMEND

We recommend that CMS: (1) provide additional guidance to States to help ensure that they meet the assurances, (2) require States that do not meet one or more assurances to develop corrective action plans, (3) require at least one onsite visit before a waiver program is renewed and develop detailed protocols for such visits, (4) develop a broader array of approaches to ensure compliance with each of the assurances, and (5) make information about State compliance with the assurances available to the public. CMS concurred with four of the recommendations and partially concurred with our recommendation to require onsite visits.

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OBJECTIVES

1. To determine the extent to which States had systems to ensure the quality of care provided to beneficiaries in home and community-based services (HCBS) waiver programs for the aged and/or disabled.
2. To determine the extent to which the Centers for Medicare & Medicaid Services (CMS) renewed waiver programs in States that did not adequately correct problems related to quality of care.
3. To describe how CMS oversees States' efforts to ensure the quality of care provided under these waiver programs.

BACKGROUND

In recent years, States have altered their approach to providing Medicaid-funded long-term care services. Rather than providing the majority of that care in institutions—such as nursing homes—States are now providing more care in homes and other community-based settings. States most often provide this care through 1915(c) HCBS waiver programs, and the individuals served by these programs are most commonly disabled and over age 65.[1] In fiscal year 2010, Medicaid expenditures for HCBS waiver programs serving this population totaled an estimated $8.9 billion.[2]

Strong oversight of waiver programs is critical to ensuring the quality of care provided to beneficiaries. The beneficiaries served by these programs are among Medicaid's most vulnerable, and the nature of these programs puts beneficiaries at particular risk of receiving inadequate care. Some programs allow beneficiaries to be cared for by individuals with limited professional training, such as family members and neighbors. In addition, beneficiaries may receive care in their homes, isolated from observers who might detect and prevent abuse or mistreatment.

[1] Kaiser Commission on Medicaid and the Uninsured. *Medicaid Home and Community-Based Services Programs: Data Update*, pp. 3-4. Accessed at http://www.kff.org/medicaid/upload/7720-05.pdf on May 18, 2012. See also Kaiser Commission on Medicaid and the Uninsured and the University of California at San Francisco, *Medicaid 1915(c) Home and Community-Based Service Waiver Participants, by Type of Waiver, 2008* Accessed at http://www.statehealthfacts.org/comparetable.jsp?ind=241&cat=4 on April 16, 2011. For background information on section 1915(c) of the Social Security Act, see footnotes 5, 6, and 7.

[2] Preliminary findings from Thomson Reuters, *Medicaid 1915(c) Waiver Expenditures: 2011 Update*, Table 3, October 2011.

Federal agencies have raised concerns about the quality of care provided under these waiver programs. Most notably, in 2003, the Government Accountability Office found that more than 70 percent of the programs it reviewed had problems with quality of care, such as failure to provide necessary services, weaknesses in beneficiaries' service plans, and inadequate case management.[3] Further, in 2009, CMS found quality-of-care problems in Alaska's waiver programs and took the unprecedented step of placing a moratorium on enrollment in those programs, along with requiring a range of corrective actions.[4]

Medicaid Coverage for Home and Community-Based Services

In 1981, Congress significantly expanded the availability of HCBS by offering States the option of establishing Medicaid 1915(c) HCBS waiver programs.[5] The HCBS waiver authority permits States to waive certain Medicaid requirements to provide a wide range of services to persons who otherwise would receive institutional care.[6]

Each waiver program must serve individuals from one of the following three groups: persons who are aged (65 or older) and/or disabled, persons with intellectual and/or developmental disabilities, and persons with mental illnesses.[7] As noted earlier, the majority of beneficiaries fall into the first group, with over 674,000 aged and/or disabled beneficiaries receiving

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[3] General Accounting Office (now the Government Accountability Office), GAO-03-576, *Long-term Care: Federal Oversight of Growing Home and Community-Based Waivers Should Be Strengthened*, June 20, 2003.

[4] CMS Regional Office Letter to State Medicaid Agency Director, June 26, 2009, *Re: Preliminary Observations, Findings and Required Corrective Actions*, p.1. Accessed at http://www.hss.state.ak.us/dsds/cmsreview/AK_HCBS_Review_Preliminary_Letter_06-26-09.pdf on July 23, 2009.

[5] This program was established under section 1915(c) of the Social Security Act, added by the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35 § 2176.

[6] Under § 1915(c), CMS may waive the following Medicaid requirements: (1) Statewideness—States may cover services in only a portion of the State, rather than in all geographic jurisdictions; (2) comparability of services—States may limit HCBS waiver services to individuals in State-selected target groups who require an institutional level of care; and (3) certain financial eligibility requirements—States may use more liberal income requirements for persons receiving HCBS. See Social Security Act 1915(c)(3); CMS, *Application for a § 1915 (c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria*, pp. 5-6 (January 2008).

[7] Waiver programs for the aged and/or disabled provide assistance to individuals over age 65 and to those with physical or other disabilities under age 65. Such programs would not serve persons from the other two groups, i.e., those who are intellectually or developmentally disabled or those who are mentally ill. See 42 CFR § 441.301(b)(6).

services in 2008.[8] Under these programs, States may provide a wide range of services—such as case management services, homemaker services, and personal care services—in a home or community-based setting for people who are eligible for institutional care.[9]

Federal Requirements Related to Quality of Care

States must operate their waivers in accordance with certain "assurances" identified in Federal regulations.[10] CMS has designated six waiver assurances that States must include as part of an overall quality improvement strategy.[11] Three of these assurances address Federal requirements related to the quality of care provided by waiver programs.[12] These requirements state that each beneficiary must have a written service plan based on an assessment of the individual's needs,[13] each beneficiary must be served by qualified providers,[14] and States must have necessary safeguards to protect the health and welfare of beneficiaries.[15] CMS guidance describes how States are to meet the three quality-of-care assurances.[16]

Before 2004, CMS determined whether States were meeting these assurances by conducting a review of a small sample of beneficiaries at least once during the life of the waiver program. In 2004, CMS transferred the primary responsibility for monitoring waiver programs to the States.[17] Currently, States are responsible for monitoring the quality of their own programs and for developing their own systems to continuously

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[8] Kaiser Commission on Medicaid and the Uninsured and the University of California at San Francisco, *Medicaid 1915(c) Home and Community-Based Service Waiver Participants, by Type of Waiver, 2008*. Accessed at http://www.statehealthfacts.org/comparetable.jsp?ind=241&cat=4 on February 6, 2012.

[9] 42 CFR § 440.180(b).

[10] 42 CFR § 441.301 and 302.

[11] CMS, *Application for a § 1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria*, pp. 9-10 (2008).

[12] The other three assurances relate to verifying that beneficiaries meet level-of-care requirements, having administrative authority for the operation of the waiver, and ensuring financial accountability of the waiver program.

[13] 42 CFR § 441.301(b)(1)(i). Federal regulations use the term "plan of care," while CMS guidance uses the term "service plan." In this report, we use the term "service plan."

[14] 42 CFR § 441.302(a)(1) and (2).

[15] 42 CFR § 441.302(a).

[16] CMS, *Application for a § 1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria*, pp. 9-10 (2008).

[17] CMS, *Interim Procedural Guidance for Assessing HCBS Waivers* (2004).

monitor whether the State is meeting the assurances. CMS also expects States to have strategies to correct any problems uncovered by their monitoring systems.

The three quality-of-care assurances are as follows:

- *Service Plans*. For the service plan assurance, CMS requires each State to demonstrate that it has an adequate system for reviewing the service plans for beneficiaries in waiver programs.[18] Such a system should ensure that the State periodically reviews plans to make sure that all beneficiaries' needs are addressed and that their preferences are considered. CMS also requires each State to submit evidence illustrating its process for ensuring that beneficiaries actually receive the services listed in their plans.
- *Qualified Providers*. For the qualified provider assurance, CMS requires each State to demonstrate that it has designed and implemented an adequate system for ensuring that all waiver services are rendered by qualified providers.[19] Each State must periodically verify that all of its providers meet its licensing and certification requirements, as well as any additional requirements for nonlicensed and noncertified providers established in the waiver application.
- *Health and Welfare*. For the health and welfare assurance, CMS requires each State to demonstrate on an ongoing basis that it is able to identify, address, and seek to prevent instances of abuse, neglect, and exploitation.[20] When such instances are identified, CMS requires the State to take appropriate action and to look for any trends in implementing prevention strategies.

Oversight of HCBS Waiver Programs

CMS set forth its requirements and procedures for oversight of State waiver program operations in guidance documents issued to the States.[21] In accordance with CMS's guidance, States first submit waiver applications to CMS describing the systems they will use to meet each of the assurances.

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[18] CMS, *Updated Interim Procedural Guidance for Conducting Quality Reviews of Home and Community-Based Services (HCBS) Waiver Program*s, pp. 15-16 (February 6, 2007).

[19] Ibid, p. 17.

[20] Ibid, p. 18.

[21] Oversight activities described in this section are found in two CMS guidance documents: *Instructions, Technical Guide and Review Criteria for Applications for a § 1915(c) Home and Community-Based Waiver [Version 3.5]* (January 2008), and *Updated Interim Procedural Guidance for Conducting Quality Reviews of Home and Community-Based Services (HCBS) Waiver Programs* (February 6, 2007).

States must describe the types of data they will collect, as well as their plans for correcting any identified problems. Data collection can include beneficiary surveys or onsite visits. It can also include record reviews to determine whether all services were delivered in accordance with beneficiaries' service plans. If CMS determines that these systems are adequate and the waiver application meets applicable Federal requirements, the waiver program is approved for 3 to 5 years.[22]

To determine whether States meet the required assurances, CMS regional office staff conduct quality reviews in which CMS requests that each State provide evidence from its monitoring systems. This evidence should include summaries of data collected, as well as any actions taken by the State to correct the problems found by its monitoring systems.[23]

After examining the evidence submitted by the State, CMS determines whether the State has met each assurance. CMS provides this information to the State in a report that summarizes CMS's findings and conclusions about the State's compliance with the assurances. CMS may also include in the report recommendations to correct any problems identified during the review. To give the State enough time to correct any problems, CMS sends the report at least a year before the expiration of the State's waiver program.

Generally a year after the quality review, the State submits an application to CMS to renew the waiver program. CMS guidance states that before the agency can approve a program for renewal, it must be confident that the measures the State has taken or plans to take will correct the problems.

If a State does not correct quality-of-care problems, CMS may require the State to develop and implement a corrective action plan.[24] CMS may require such a plan after the State fails to meet one or more assurances during the quality review or at the time of the program's renewal. As part of this plan, each State is expected to specify target dates to address any unmet recommendations and to submit additional evidence illustrating that it has corrected identified problems.

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[22] The initial waiver is for 3 years. Each renewal of the waiver is for 5 years. See 42 U.S.C. § 1396n(c)(3) and 42 CFR § 430.25(h)(2)(i).

[23] Note that CMS guidance refers to this process as "discovery and remediation." See *Instructions, Technical Guide and Review Criteria for Applications for a § 1915(c) Home and Community-Based Waiver [Version 3.5]*, p. 10 (January 2008).

[24] For the purposes of this report, we use the term "corrective action plan" to mean any plan that CMS requires a State to develop so as to correct problems found in a waiver program. CMS generally refers to such plans as either "corrective action plans" or "work plans."

In addition, CMS recommends that its regional offices conduct an onsite review of each waiver program at least once before the program's renewal. The regional offices may also conduct focused onsite reviews of programs that are not meeting all of the assurances. These focused onsite visits address particular problems that CMS has identified and may not include an assessment of all areas. CMS also has the authority to terminate a program that is not meeting one or more assurances.[25]

Related Reports

The Office of Inspector General (OIG) will issue a report on HCBS provided in assisted living facilities (ALFs).[26] That evaluation determines the extent to which States comply with Federal waiver requirements for ALFs.

METHODOLOGY

Data Collection and Analysis

We based this study on two data sources: (1) a review of documentation for HCBS waiver programs, and (2) structured interviews with CMS staff from the 10 regional offices.

Scope

To provide the most current assessment of the waiver programs and CMS's review process, we focused on the States that had 1915(c) HCBS waiver programs for the aged and/or disabled that were reviewed under CMS's most recent guidance. Specifically, we reviewed programs for which: (1) CMS had performed its quality review using the most recent guidance, which was updated in February 2007; and (2) the State had applied for renewal using the most recent version of the application, which was updated in January 2008. We identified 33 waiver programs that were administered by 25 States.[27]

Data Collection

Review of Documentation. We requested documentation from the CMS regional office responsible for each of these waiver programs. This documentation spanned from December 2006 through February 2011. Specifically, we requested:

(1) evidence that each State provided to CMS for the quality review regarding the three assurances. This was usually summarized evidence

[25] 42 CFR § 441.304(d).

[26] OIG, *Home and Community-Based Services in Assisted Living Facilities,* OEI-09-08-00360, forthcoming.

[27] In 2009, 110 waiver programs for the aged and/or disabled were in operation.

of the different elements of the State's monitoring systems, such as beneficiary survey results, quarterly reports of home visits, and provider training attendance logs.

(2) documents from CMS's most recent quality review of each State, including the findings report. This report typically includes a detailed description of the State's monitoring systems and of instances in which CMS found that evidence of these systems was inadequate or lacking. It also includes CMS's determination of whether the State met each assurance.

(3) documents from any CMS-conducted onsite visits of the State.

(4) documents about any followup activities that were conducted by CMS or the State after the quality review was completed, including any updates on corrective actions taken by the State.

(5) CMS's assessment of the renewal application, including any documents that the State submitted in response to CMS's inquiries during the review of the application.

Interviews with CMS regional officials. We conducted structured interviews—either in person or over the telephone—with CMS officials from the 10 regional offices. We discussed the quality review process and the evidence that States submitted to demonstrate that they met each assurance. In addition, we asked about how officials ensure that the States met the assurances, including how they use corrective action plans and onsite visits. Finally, we asked for additional information, where necessary, to corroborate and supplement the information from our documentation review.

Analysis

To describe States' monitoring systems to ensure the quality of care provided to beneficiaries, we reviewed the documents from CMS's most recent quality review of each State's programs as well as the information gathered from our interviews. We conducted this analysis by State, rather than by program, because the States are responsible for ensuring that their programs meet the assurances. [28] We considered a State to have met an assurance if CMS determined in its report that "[t]he State substantially meets the assurance" or "[t]he State demonstrates the assurance but CMS recommends improvements." Conversely, we considered a State to be out of compliance with an assurance if CMS determined that "[t]he State does not fully or

[28] Of the 25 States, 19 States had 1 waiver program, 5 States had 2 waiver programs, and 1 State had 4 waiver programs.

substantially demonstrate the assurance" or "[t]he State does not demonstrate the assurance."[29] We also analyzed the data to identify practices of States that met the assurances. These data are generally not available to the public. We conducted this analysis in order to describe the differences among States' monitoring systems, as well as to describe the types of problems generally identified by CMS.

To determine the extent to which CMS renewed waiver programs for States in which the quality reviews found that one or more assurances were not met, we reviewed CMS documents about any followup activities between CMS and the States and the information gathered from the interviews. We then determined how many of these States had still not corrected problems (1) at the time of renewal and (2) as of early 2011.

To determine the extent to which CMS used existing tools to ensure compliance with the assurances, we reviewed CMS documents and interview data. We determined whether CMS officials required States that did not meet one or more of the assurances to develop corrective action plans and whether CMS officials conducted any onsite visits or focused onsite visits with these States.

Limitations

We did not independently assess the accuracy of CMS's determinations about whether States met the three assurances. In addition, our findings cannot be generalized to the other States or their waiver programs.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

[29] CMS guidance instructs staff responsible for conducting quality reviews to select one of these four categories when determining whether a waiver program meets each assurance. See CMS, *Updated Interim Procedural Guidance for Conducting Quality Reviews of Home and Community-Based Services (HCBS) Waiver Programs*, pp. 28-30 (February 6, 2007).

FINDINGS

Seven of the twenty-five States did not have adequate systems to ensure the quality of care provided to beneficiaries

As previously noted, States must meet three assurances designed to protect beneficiaries and ensure the quality of care they receive under the waiver programs. States must develop and implement their own monitoring systems to ensure that they meet each of these assurances. CMS determines whether a State meets each assurance by conducting a quality review. When a State does not demonstrate that it meets one or more assurances during the quality review, the State is unable to ensure the quality of care provided to beneficiaries.

During its quality reviews, CMS found that 7 of the 25 States did not meet 1 or more of the 3 quality-of-care assurances for 1 of their waiver programs. In these cases, the States did not have adequate monitoring systems to ensure quality of care. Three of these seven States did not meet any of the assurances.

Six States did not meet the service plan assurance

A monitoring system for service plans should ensure that the State periodically reviews plans to ensure that beneficiaries' needs are addressed. States must also have systems to verify that beneficiaries actually received the services listed in their plans and that all plans have been assessed and updated at least annually. Without adequate monitoring systems, States may not be able to ensure that the services that they are paying for are actually provided and that beneficiaries are receiving all of the services they need.

CMS found that six States did not have adequate systems to monitor service plans. Notably, one State had no method for determining whether services were provided according to beneficiaries' service plans. As one CMS official noted, "Some States really have no monitoring systems [for service plans] at all." Four States did not review an adequate sample of service plans to ensure that all plans were assessed and updated. CMS allows States to monitor program performance by evaluating the entire population, if it is small enough, or by evaluating a sample of the population. If the sample is not representative of all beneficiaries' service plans, the State cannot claim that it adequately monitors service plans, and CMS cannot conclude that the State complies with the service plan assurance.

Additionally, CMS found that four States had inadequate strategies to correct problems found in the service plans. For example, one of these States discovered that service plans were not being consistently updated but failed to implement any strategies to correct this problem.

In contrast, the States that met this assurance had several practices to ensure the quality of their service plans. For example, one State reviewed service plans multiple times throughout the year and assigned different experts to assess various aspects of the plans. The State also selected a sample of service plans to review to ensure that the services in the plan matched the Medicaid claims submitted for the beneficiaries.

Five States did not meet the qualified provider assurance

A monitoring system for qualified providers should ensure that all providers meet the State's licensing and certification requirements, as well as any additional requirements established in the HCBS waiver application for nonlicensed and noncertified providers. CMS officials noted that it is critical to verify that providers are qualified before they render services to beneficiaries. States without adequate systems for monitoring provider qualifications may expose beneficiaries to providers with poor qualifications or criminal backgrounds.

CMS found that five States did not have adequate systems to ensure that providers are qualified to render care. Notably, CMS identified two States that allowed caregivers to provide services before the State received the results of criminal background checks. One of these States also allowed providers to self-report whether they were qualified without requiring any documentation to support their assertions. Another State did not review an adequate sample of provider records and, therefore, did not adequately monitor its providers. CMS found that another State did not attempt to verify the qualifications of noncertified providers and that some States did not verify that providers received the training necessary to provide services.

In contrast, the States that met this assurance had several practices to ensure that all HCBS providers had appropriate qualifications. For example, one State reviewed provider qualifications and conducted onsite visits with each provider before allowing the provider to enroll in the HCBS program. The State regularly scheduled visits with beneficiaries to assess their satisfaction with providers. It also tracked license expirations electronically, automatically decertifying providers who did not renew their licenses. Several CMS officials stated that using such electronic systems strengthens the monitoring of HCBS providers.

Four States did not meet the health and welfare assurance

A monitoring system for health and welfare should identify instances of beneficiary abuse, neglect, and exploitation. CMS expects that States will take appropriate action when such instances have been identified and implement prevention strategies based on analyses of trends. Without such monitoring systems, the States are not able to adequately ensure the health and welfare of their beneficiaries.

CMS found that four States did not meet the health and welfare assurance. Specifically, two of the four States lacked a system—such as an incident tracking system—to catalog and track instances of alleged abuse, neglect, or exploitation of beneficiaries. One of these States relied solely on self-reported data from beneficiary surveys as its only means of such monitoring, which CMS considered insufficient.

In the two other States, CMS found problems with the existing incident tracking systems. One of these States did not require that incidents of suspected abuse, neglect, or exploitation be reported, so there was no assurance that such incidents were appropriately tracked. The other State did not have adequate documentation of such incidents or adequate documentation of any followup actions that had been taken.

In contrast, the States that met this assurance had several practices to ensure that the health and welfare of beneficiaries were protected. For example, one State interviewed beneficiaries and providers in person and mailed a survey to beneficiaries annually to gauge their satisfaction with the program. If beneficiaries noted concerns, they were relayed to the appropriate program staff for followup. The State also had a system to track and correct incidents of alleged abuse or neglect, as well as a system to collect information on suspicious deaths. Additionally, the State coordinated with other State agencies, when necessary, to review and resolve cases in which beneficiaries' health and welfare were at risk. Several CMS officials stressed the importance of this interagency coordination, which helps a State track whether an incident has been resolved by another agency.

CMS renewed the waiver programs of three States that did not adequately correct problems related to quality of care

In instances in which CMS has identified serious problems with a waiver program—such as not meeting an assurance—the State must correct the problems. CMS guidance states that before the agency can approve a program for renewal, it must be confident that the measures that the State has taken, or plans to take, will adequately address the problems.

Although CMS renewed the waiver programs in all seven States that did not meet one or more assurances, three of these States did not adequately correct problems that CMS identified during its quality reviews. Not only did these States fail to correct these problems before the renewal of their programs, but two of them still had not adequately addressed the problems almost 3 years after renewal, and the third had not adequately addressed the problems over a year after renewal.

CMS officials noted that one State had a "pervasive problem" with its approach to quality management and improvement that spanned the State's many waiver programs. By the time of the program's renewal, the State had still failed to provide evidence that it had fixed all the problems uncovered by the quality review. Specifically, the State did not demonstrate to CMS that it had made sufficient progress to ensure that service plans were adequate, consistently revised, or updated. Also, it still could not demonstrate that it could verify the qualifications of noncertified providers or that it could adequately document incidents or any followup related to those incidents. In spite of these problems, CMS renewed the program.

The second State had provided CMS with plans to make improvements. However, by the time of renewal, it could not demonstrate to CMS that it could monitor whether beneficiaries were receiving all of the services identified in their service plans. In addition, it still could not demonstrate that services were provided by qualified providers.

For the third State, CMS officials reported that, although at the time of renewal the State provided evidence of having some monitoring systems, it still could not demonstrate that criminal background checks were reviewed before caregivers were allowed to provide services. In addition, the State still did not appear to have strategies to correct problems uncovered by its existing monitoring systems.

None of the three States had made the necessary changes to their waiver programs, even though for two of them almost 3 years had passed since the time of renewal. For the third State, more than 1 year had passed since the time of renewal. CMS officials explained that, although CMS has the authority to terminate programs when States do not meet assurances, it generally does not do so because these programs serve vulnerable beneficiaries who might be left without critical services.

CMS did not consistently use the few tools it has to ensure that States correct problems related to quality of care

Short of terminating a waiver program, CMS has few tools to ensure that States correct problems found during the quality reviews.[30] Furthermore, CMS does not consistently use the tools at its disposal—such as corrective action plans or onsite visits—to ensure that States make necessary changes and comply with the assurances.

[30] Despite CMS's having placed a moratorium on enrollment in the Alaska waiver programs in 2009, CMS officials reported that the agency needs additional regulatory authority to use such tools in the future.

CMS did not require corrective action plans from three of the seven States that did not meet assurances

CMS may require States to develop and implement corrective action plans if they have not corrected problems and cannot ensure the quality of care provided to beneficiaries. Several CMS officials noted that they would require that a State develop a corrective action plan if it did not meet one or more assurances during the quality review. However, of the seven States that did not meet one or more assurances, CMS did not require three to develop corrective action plans. CMS does not have guidance about when to require corrective action plans, what these plans should contain, or how frequently States should report their progress.

CMS did not conduct onsite visits with two of the seven States that did not meet assurances

CMS guidance recommends that onsite visits be conducted at least once before a waiver program's renewal and that focused onsite visits (i.e., site reviews focusing on particular issues of concern) be conducted for programs that are not meeting all of the assurances. Despite this, CMS did not conduct any onsite visits with two of the seven States that did not meet one or more assurances. Such visits may be useful in determining the extent to which beneficiaries could be negatively affected by problems found during CMS's quality reviews. Notably, CMS did conduct onsite visits with six additional States in our review that had met the assurances. Also, CMS did not conduct focused onsite visits with any of the States in our review. Several officials noted that CMS guidance is limited on when and how to conduct onsite visits and that better protocols for how to conduct reviews during these visits would be helpful.

CONCLUSION AND RECOMMENDATIONS

States must operate their HCBS waiver programs in accordance with certain required assurances, including three related to quality of care. CMS does not directly monitor the delivery of HCBS services to beneficiaries. Rather, CMS requires States to have strong monitoring systems to ensure that (1) the services provided meet beneficiaries' needs, (2) these services are rendered by qualified providers, and (3) instances of abuse and neglect are identified and addressed. If these assurances are not met, beneficiaries' health and safety may be at risk.

During its quality reviews, CMS found that 7 of the 25 States did not meet 1 or more of the 3 required assurances. These States did not have adequate systems to monitor the quality of care provided to beneficiaries. Despite the fact that three of these States did not adequately correct identified problems, CMS renewed their waiver programs. Lastly, CMS did not consistently use its few tools, namely, corrective action plans and onsite visits, to ensure that States correct problems and comply with the assurances.

Together, these findings suggest the need for increased oversight by CMS and monitoring by States to ensure that quality care is provided to beneficiaries in HCBS waiver programs. We recommend that CMS:

Provide Additional Guidance to States to Help Ensure That They Meet the Assurances

CMS should provide additional guidance to States about the elements of strong monitoring systems. As part of this guidance, CMS should identify and provide States with examples of effective practices for meeting each of the assurances, some of which are highlighted in this report. States can use this guidance to improve their monitoring systems and better ensure that their waiver programs provide quality care to beneficiaries. CMS could provide this assistance as a part of its continuing communication with the States.

Require States That Do Not Meet One or More Assurances to Develop Corrective Action Plans

When States do not meet one or more assurances during the quality reviews, CMS should require them to develop a corrective action plan for each waiver program that fails to meet those assurances. CMS should develop standard protocols for these corrective action plans, including when to require them, what States should include in the plans, and how frequently States should report their progress to CMS. This would enable CMS to hold States more accountable.

Require At Least One Onsite Visit Before a Waiver Program is Renewed and Develop Detailed Protocols for Such Visits

CMS should require that regional offices conduct an onsite visit at least once before a waiver program's renewal. CMS should also require regional offices to conduct more frequent onsite visits or focused onsite visits when States do not meet one or more assurances or when States demonstrate continued difficulty in meeting the assurances. By conducting these visits more frequently, CMS would be better able to gauge the extent of any problems noted during its quality reviews and determine whether any progress has been made in correcting these problems.

CMS should also provide detailed protocols for both regular and focused onsite visits that include guidelines for when these visits should be conducted. These protocols should also include instructions for conducting these visits, such as how best to assess States' monitoring systems while onsite.

Develop a Broader Array of Approaches to Ensure Compliance With Each of the Assurances

CMS has the legislative authority to terminate a waiver program with serious problems but rarely does so, as termination may leave thousands of beneficiaries without critical services. Short of termination, CMS has few tools to ensure that States correct problems. CMS should seek a broader array of approaches to address the continual failure of some States to comply with the assurances. These approaches could include seeking additional legislative authority to issue moratoria on future enrollment in poorly performing States. Other approaches could include seeking legislative authority to withhold a portion of Federal funding when other corrective efforts are unsuccessful.

Make Information About State Compliance With the Assurances Available to the Public

CMS should make information available to the public about whether States meet each of the assurances during the quality reviews. CMS could summarize this information or publish the final reports detailing the findings of its quality reviews. CMS could also include information on corrective actions taken by States that did not meet the assurances. Public disclosure would further compel States to comply with the assurances and would provide beneficiaries and their families with needed information about the extent to which States have systems to ensure quality care.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with four of our five recommendations and partially concurred with one. CMS agreed that because of the increase in waiver services and the vulnerabilities of many of the waiver recipients, strong oversight of waiver programs is critical.

CMS concurred with our first recommendation and stated that, through a series of bimonthly Quality Forums with the States, it will ensure that providers receive guidance to improve their monitoring systems. CMS concurred with our second recommendation and stated that it will develop a standard protocol for corrective action plans.

CMS partially concurred with our third recommendation and stated that it plans to develop a standard protocol for conducting site visits. However, it noted that it reserves the discretion to determine when site visits might not be required. It stated that it intends to evaluate the need for site visits on a case-by-case basis, taking into account the seriousness of the possible assurance failures and the availability of CMS resources.

CMS concurred with our fourth recommendation and stated that it will address the issues of intermediate steps for corrections when a State fails to meet an assurance and that it will ensure that all central and regional office staff have knowledge of the options. CMS also stated that it issued a Notice of Proposed Rule Making for the waiver in which it addressed the issue of corrective actions and that it will determine whether legislation is necessary to provide stronger and more viable options. Finally, CMS concurred with our fifth recommendation and stated that it will explore the options for how to best make the disclosure of quality reviews available to the public.

The full text of CMS's comments is provided in the appendix.

APPENDIX

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: APR 1 2 2012

TO: Daniel R. Levinson
Inspector General

/S/

FROM: Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Oversight of Quality of Care in Medicaid Home and Community-Based Services Waiver Programs" (OEI-02-08-00170)

Thank you for the opportunity to review and comment on the OIG draft report: Oversight of Quality of Care in Medicaid Home and Community-Based Services Waiver Programs (OEI-02-08-00170). The purpose of this report was to: 1) assess the extent to which States had systems in place to ensure the quality of care provided to beneficiaries in home and community-based services (HCBS) waiver programs for the aged and disabled; 2) determine the extent to which the Centers for Medicare & Medicaid Services (CMS) renewed waiver programs in States that did not adequately correct problems related to quality of care; and 3) describe how CMS oversees States' efforts to ensure the quality of care provided under these waiver programs.

As noted by the report, States are increasing their coverage for HCBS over institutional services for Medicaid beneficiaries who have chronic needs, and a primary method of delivery for HCBS is through 1915(c) waiver programs. CMS agrees that, because of this increase and the vulnerabilities of many of the HCBS waiver program recipients, strong oversight of waiver programs is critical.

OIG Findings

The OIG reviewed 33 waiver programs in 25 States that had used the version of the application updated in January 2008.

States must operate their HCBS waiver programs in accordance with certain required assurances, including three assurances related to quality of care. CMS does not directly monitor the delivery of HCBS services to beneficiaries.

The OIG found that during its quality reviews, CMS found that 7 of the 25 States did not meet 1 or more of the 3 required assurances. These States did not have adequate systems in place to monitor the quality of care provided to beneficiaries. In addition, CMS renewed the waiver

programs of three States that did not adequately correct identified problems. Lastly, CMS did not consistently use its few existing tools, namely, corrective action plans and onsite visits, to ensure that States correct problems and comply with the assurances.

OIG Recommendation

The CMS should provide additional guidance to States to help ensure that they meet the assurances.

CMS Response

We concur with the recommendation and will ensure through a series of bi-monthly Quality Forums with the States, conducted by the contractor for Technical Assistance in Quality, that providers receive guidance to improve their monitoring systems. This would include examples of effective practices. These forums will be conducted throughout calendar year 2012. The first forum in this series was held on March 8, 2012. CMS will also present at a session on HCBS waiver quality at the 2012 annual HCBS Conference.

OIG Recommendation

The CMS should require States that do not meet one or more assurances to develop corrective action plans.

CMS Response

We concur with the recommendation and will develop a Standard Operating Protocol for Corrective Action Plans by August 1, 2012, which we will require a State to complete and submit the plan for approval where CMS determines that the State is not meeting one or more of its waiver assurances. We will also inform Regional Office (RO) staff of this requirement.

OIG Recommendation

The CMS should require at least one onsite visit prior to a waiver program's renewal and develop detailed protocols for such visits.

CMS Response

We concur with the recommendation in part. We will develop a Standard Operating Protocol for On-Site Visits by August 1, 2012. The protocol will address the structure of visits to ensure that the findings and outcomes will be useful.

We believe that the efficacy of a site visit must be evaluated prior to any decision to conduct a site visit. For example, where CMS believes that a State meets all of its assurances, the agency reserves the discretion to determine that a site visit may not be required. Additionally, CMS

believes that where a site visit has been conducted and the issues identified overlap multiple waivers (e.g. providers in different State waivers are not properly qualified) one site visit may be considered sufficient. In addition, if it is clear that there are serious issues identified and the State does not challenge the findings, the agency reserves the discretion to determine that a site visit may not be required. Therefore, we intend to evaluate the need for site visits on a case-by-case basis, in which the seriousness of the possible assurance failures and the resources available to both CMS and the ROs resources will be factored into the decision.

OIG Recommendation

The CMS should develop a broader array of approaches to ensure compliance with each of the assurances.

CMS Response

We concur with the recommendation and will address the issues of intermediate steps for corrections when a State fails to meet an assurance and will ensure that all Central Office and RO analysts have knowledge of the options. We issued a Notice of Proposed Rule Making for the 1915(c) HCBS waiver in which we addressed the issue of corrective actions. We will also determine if legislation is necessary to provide stronger and more viable options aside from disapproving an existing waiver when the waiver fails in assurances.

OIG Recommendation

The CMS should make information about State compliance with the assurances available to the public.

CMS Response

We concur with the recommendation in that it supports efforts toward transparency. We will explore this concept and the options for how best to make the disclosure of quality reviews available to the public. This approach may include requiring States to post their quality reviews and action plans to the public.

The CMS would again like to thank OIG for their efforts in reviewing the oversight of quality of care in Medicaid HCBS waiver programs.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Meridith Seife, Deputy Regional Inspector General.

Judy Kellis served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the New York regional office who contributed to the report include Lucía Fort and Shanti Nandiwada; central office staff who contributed include Kevin Farber and Tasha Trusty.

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