HHS OIG Faults State Oversight of Facilities in Medicaid Elderly Waiver Program

Bottom Line

Wisconsin, Illinois, Mississippi, and Minnesota failed to properly oversee facilities that serve vulnerable adults who receive services through the Medicaid Elderly Waiver program, resulting in numerous health and safety violations, according to studies conducted by the Department of Health and Human Services Office of Inspector General (HHS OIG). HHS OIG recommended that the states correct the identified violations, improve provider training programs, and take other steps to ensure future compliance.

Background

Section 1915(c) of the Social Security Act authorizes HHS to waive certain Medicaid requirements so that a State may offer home and community-based services to beneficiaries for whom such services would be more appropriate than institutional care. To receive a waiver, States must set adequate certification requirements for Medicaid providers and ensure that providers meet the requirements.

OIG has conducted health and safety reviews of Head Start grantees, regulated childcare facilities, family adult foster care homes, and other facilities nationwide, and has uncovered numerous statutory and regulatory violations. OIG conducted studies of the Elderly Waiver Program in Mississippi, Illinois, Wisconsin, and Minnesota to determine if there were similar violations that resulted in health and safety risks.

Overall Findings and Recommendations

OIG found that all four States repeatedly failed to comply with Federal waiver and State requirements in overseeing facilities that serve vulnerable adults who receive services through the Medicaid Elderly Waiver program. Specifically:

- In Mississippi, all 20 of the facilities reviewed did not comply with one or more State requirements.
- In Illinois, 18 of the 20 facilities reviewed did not comply with one or more State requirements.
- In Wisconsin, all 20 of the facilities reviewed did not comply with State certification requirements.
- In Minnesota, all 20 of the facilities reviewed did not comply with State certification requirements.

OIG found numerous health and safety violations, including:

- Toxic chemicals in accessible areas;
- Exposed electrical wiring;
- A knife laying outside in the grass;
- Resident rooms that contained water damage, mold, and in one bathroom, a dead rodent;
- Unsanitary environments in the food service area and outside the facility;
- Barbed wire and chain fence just steps from an outdoor seating area.

In addition, OIG found that facilities did not complete all required criminal background checks, did not perform required annual training, and did not complete individual abuse-prevention plans.

In its reports, OIG generally recommended that the States:

- Correct the identified violations;
- Improve certification requirements and oversight of providers; and
- work with providers to improve facilities, staffing, and training.

State-Specific Findings and Recommendations

Mississippi

OIG found 564 violations by adult day care facilities, including 194 violations of health and safety requirements. The remaining 370 violations related to administrative requirements, some of which could significantly affect health and safety. OIG recommended that the State:

- correct all identified violations;
- improve oversight and monitoring of providers; and
- work with providers to improve facilities, staffing, and training.

Illinois

OIG found 105 violations of health and safety and administrative requirements by adult day care facilities. OIG recommended that the State:

- correct all identified violations;
- review training opportunities for adult day care facilities and improve or increase those opportunities as needed;
- consider developing templates for administrative records that Illinois requires; and
- work with care coordinators and the facilities to establish an integrated plan of care in coordination with the entire care team.

Wisconsin

OIG found 208 violations of health and safety and administrative requirements by adult day care facilities. OIG recommended that the State:

- correct all identified violations;
- consider revising staffing standards and caseload thresholds for State surveyors;
- update the certification checklist and promulgate appropriate rules;
- identify and address reasons for low attendance at training programs; and
- increase State agency guidance on certification requirements.

Minnesota

OIG found 200 violations of health and safety and administrative requirements by adult day care facilities. OIG recommended that the State:

- correct all identified violations;
- consider revising staffing standards and caseload thresholds for State licensors, and;
- consider developing templates for required administrative records.